DEPARTMENT
OF
HEALTH AND HUMAN SERVICES

Agency for Health Care Research and Quality

FISCAL YEAR 2004 PERFORMANCE PLAN

FISCAL YEAR 2003 REVISED FINAL PLAN

FISCAL YEAR 2002 PERFORMANCE REPORT

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Executive Summary

Agency Mission and Vision

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

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

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

Overview of the Plan and Performance Report

The AHRQ Performance Plan is a companion piece to the AHRQ Strategic Plan and to the FY 2004 Budget Request. In this document the initial FY 2004 and revised FY 2003 Performance Plans have been merged with the FY 2002 Performance Report to comply with the format developed by the Department of Health and Human Services (DHHS).

The 2004 Performance Plan being submitted is the final stage in the extensive review, reorganization and revision of AHRQ's Performance Plan. This new organization will allow AHRQ to more tightly integrate budget and performance management over the coming years. In addition, moving the Agency's Plan from a process-oriented system focused on outputs to a more outcomes oriented performance measurement system will increase its clarity and usefulness as a strategic management tool. This document reflects the agencies transition from goals which were closely aligned with the "Cycle of Research" to goals which are more closely reflect the Agency's vision, mission and strategic goals. As a result, the FY2002 Performance Report continues to be organized around the seven goals identified in the FY 2002 Congressional Justification. Beginning with the 2003 Performance Plan, however, performance goals will be more closely aligned with the agencies strategic goals and performance measures will include both output and outcome measures. Specifically, these changes include:

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

- Individual sections devoted to a single strategic goal. Each section will contain the Strategic Goal and Strategic Objectives, followed by the Performance Goal, Performance Measure, and Strategies.
- Use of the results by AHRQ and issues related to data availability and integrity as well as the identification of key factors that influence success have been rewritten and incorporated with the performance goals they support.
- Strategies receive a greater focus, as they give direction and guidance to AHRQ staff and outline how we will achieve our goals.
- Program performance is integrated throughout the document to make clear how the Agency is building on previous successes as it plans for out-year performance.

These revisions will enable AHRQ to determine how well the basic knowledge which forms the core of AHRQ's work provides information which can be turned into actions by policy makers, those who make clinical decisions, purchasers and providers who make decisions about what services to use, pay for and how to organize those services.

FY 2002 Performance Highlights

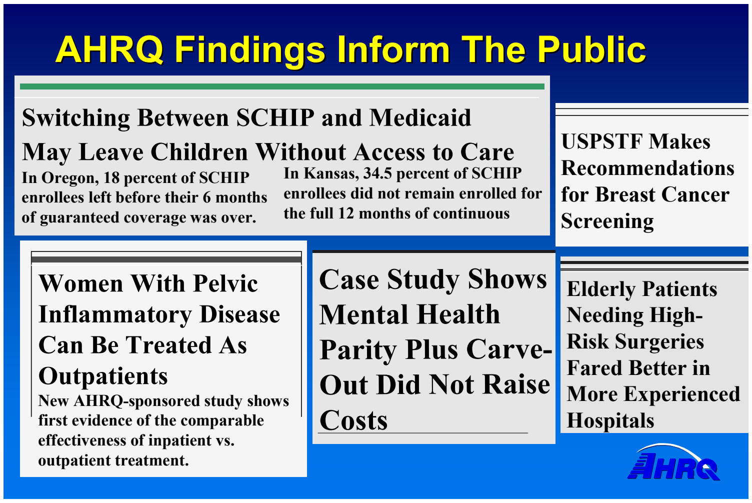
The Agency's mission is to conduct and sponsor research that will help improve the outcomes and quality of health care, reduce costs, address patient safety and medical errors, and broaden access to effective services. AHRQ's ability to sustain a high level of performance during fiscal year 2002 is evidenced by how its research has ultimately been used to provide better health care delivery services.

From Evidence-based Knowledge to Implementation: Selected Examples of How AHRQ Research Helps People

Among other recommendations, the AHRQ-sponsored US Preventive Services Task Force recommended this past year that:

- mammography screening, with or without clinical breast examination, occur every one to two years for women ages 40 and over. The USPSTF published two earlier breast cancer screening recommendations, in 1989 and 1996, that both endorsed mammography for women over age 50. The USPSTF is now extending that recommendation to all women over age 40 but found that the strongest evidence of benefit and reduced mortality from breast cancer is among women ages 50-69. The recommendation acknowledges that there are some risks associated with mammography, e.g., false-positive results that lead to unnecessary biopsies or surgery but that these risks lessen as women get older.
- clinicians discuss the potential benefits of taking tamoxifen to reduce the risk of breast cancer with female patients who are at high risk for the disease.
- clinicians also discuss the benefits and harms of aspirin therapy with healthy adult patients who are at increased risk of coronary heart disease (CHD), primarily heart attacks. Recent studies found that regular use of aspirin reduced the risk of CHD by 28 percent in persons who had never had a heart attack or stroke but who were at increased risk. Those considered at increased risk for CHD are men over the age of 40, post-menopausal women, and younger persons with risk factors for

    CHD, e.g., those that smoke and/or have diabetes and hypertension. Every year, more than 1 million Americans die from heart attacks and other forms of CHD.
  - all adults age 50 and over get screened for colorectal cancer, the nation's second leading cause (after lung), of cancer deaths.   Currently less than half of all Americans over 50 are being screened.
  - primary care clinicians screen their adult patients for depression. Formal screening can make it easier to identify depression, a common (five to nine percent of adult patients in primary care settings suffer from depression, 50% of cases go undetected) and treatable condition that often is not recognized by patients or their doctors. It's estimated that depression increases health care utilization and costs $17 billion in lost workdays each year.



AHRQ Findings Inform The Public

Switching Between SCHIP and Medicaid May Leave Children Without Access to Care

In Oregon, 18 percent of SCHIP enrollees left before their 6 months of guaranteed coverage was over.

In Kansas, 34.5 percent of SCHIP enrollees did not remain enrolled for the full 12 months of continuous

USPSTF Makes Recommendations for Breast Cancer Screening

Women With Pelvic Inflammatory Disease Can Be Treated As Outpatients

New AHRQ-sponsored study shows first evidence of the comparable effectiveness of inpatient vs. outpatient treatment.

Case Study Shows Mental Health Parity Plus Carve-Out Did Not Raise Costs

Elderly Patients Needing High-Risk Surgeries Fared Better in More Experienced Hospitals

- Free software released this past summer (2002) by AHRQ provides the nation's hospitals with a quick and relatively easy-to-use quality check on their in patient care. AHRQ's Inpatient Quality Indicators (IQI) software can be downloaded via this Agency Web address: www.ahrq.gov/data/hcup/inpatqi.htm.

- AHRQ along with the Centers for Medicare & Medicaid Services (CMS), and the US Office of Personnel Management (OPM) officially launched a new government Web site designed to help benefit managers, consumer advocates, and state officials communicate with their audiences about health care quality. The site, http://www.TalkingQuality.gov, provides step-by-step instructions on how to implement a quality measurement and reporting project such as a health plan report card.

- AHRQ funded research showed that women with mild to moderate pelvic inflammatory disease (PID) – a leading cause of infertility – who are treated as outpatients have recovery and reproductive outcomes similar to those for women treated in hospitals. Treating the approximately 85,000 women with mild/moderate who are currently hospitalized as outpatients may save approximately $500 million each year.

- Florida's "passive re-enrollment" policy, which does not require parents to take steps to prove that their children are still eligible for the State Children's Health Insurance Program (SCHIP), results in a significantly lower percentage of children losing coverage than in states that require parents to verify periodically their children's eligibility. This research finding is part of a set of studies being conducted under the Child Health Insurance Research Initiative (CHIRI™), sponsored by AHRQ, the David and Lucile Packard Foundation and the Health Resources and Services Administration (HRSA). The study found that only five percent of children in Florida SCHIP fell off the rolls at re-enrollment, as compared to one-third to one-half of children in Kansas, Oregon, and New York. Currently, only a handful of states have passive re-enrollment policies in place.

- A new questionnaire added to AHRQ's Medical Expenditure Panel Survey (MEPS) found that while a majority of parents report that their experiences with health care for their children are good, there are significant variations by age, race/ethnicity and type of insurance coverage. This data provides the first nationally-representative information about parent's experiences with health care for their children.

- Using a managed care "carve-out" arrangement to provide equal coverage for mental health services did not raise costs for one large employer. AHRQ-funded researchers examined the impact of a state's mental health parity mandate on a large employer group that simultaneously implemented a managed care "carve-out" for its mental health and substance abuse benefits. Carve-outs are services provided within a standard health benefit package but delivered and managed by a separate organization. The researchers compared plan costs, use patterns and access in the one year prior to the changes with the three years following the changes.

- A nationwide study sponsored by AHRQ showed that Black and Hispanic HIV patients are only about half as likely as non-Hispanic whites to participate in clinical trials of new medications designed to slow the progression of the disease.

- Patients who take beta blockers (drugs to slow the heart rate and reduce contractions of the heart muscle) prior to bypass surgery appear to have improved survival and fewer complications during and after the procedure, according to an AHRQ study. Researchers indicate that up to 1,000 lives potentially could be saved each year by giving patients beta blockers. The study was the first ever to examine the outcomes of beta blocker use before bypass surgery.

- AHRQ-funded research led by Mount Sinai School of Medicine found that hospitalized patients with abnormal vital signs, mental confusion and problems with eating or drinking in the 24 hours prior to discharge are more likely not to be able to resume normal activities and face greater chance of hospital readmission or death. Therefore, hospital and insurance plan guidelines that shorten length of hospital stays should build in a safety check to measure clinical stability prior to discharge.

- Elderly patients who had any of 14 high-risk cardiovascular or cancer operations in hospitals performing a high volume of their particular procedure were more likely to survive than those who went to hospitals with a low volume of their type of surgery, according to a nationwide study sponsored by AHRQ. Going to the high-volume hospitals made the biggest difference for patients undergoing surgery for cancer of the pancreas. Only four percent of such patients at highest-volume hospitals died, compared to 16 percent at lowest-volume hospitals. The study also found that hospital volume was important for patients undergoing heart valve replacement, abdominal aneurysm repair, and surgery for lung, stomach or bladder cancer. For each these procedures, death rates at the highest-volume hospitals were between two percent to five percent lower than at the lowest-volume hospitals.

- AHRQ-funded research conducted by the Stanford University Patient Education Research Center found that the Chronic Disease Self-management Program (CDSMP) can help prevent or delay disability, even in patients with heart disease, hypertension or arthritis. The CDSMP is a 17-hour course taught by trained lay people that teaches patients with chronic disease how to better manage their symptoms, adhere to medication regimens and maintain their functional ability.

- AHRQ funded the design of a new tool that helps identify nursing home residents at relatively low risk for death from lower respiratory infection (LRI) - which means patients may be treated safely without transferring them to a hospital. LRIs, primarily pneumonia, are the leading causes of hospitalization and death among nursing home residents. The new tool helps clinicians determine the severity of the illness and the risk of death, which can help them choose the location for treatment more quickly. Residents at low risk of dying may be managed best in the nursing home, which may prevent complications or discomfort that can occur from a hospital admission.

- AHRQ released *A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach*. This new publication, the newest from AHRQ's Put Prevention Into Practice Program, helps guide clinicians in the development of a system for delivering clinical preventive services in the primary care setting. Research shows that the most effective and accepted preventive services are not delivered regularly in the primary care setting. For example, in 1997 pneumococcal disease caused 10,000-14,000 deaths, but only 43 percent of persons aged 65 and older received a pneumococcal vaccine.

- AHRQ published Prevention Quality Indicators—a free tool for detecting potentially avoidable hospital admissions for diabetes and other illnesses which can be effectively treated with high-quality, community-based primary care. The AHRQ Prevention Quality Indicators will allow users to measure and track hospital admissions for uncontrolled diabetes and 15 other conditions using their own hospital discharge data and will provide the information needed to improve the quality of primary care for these illnesses in a community or state.

- AHRQ released a new synthesis of AHRQ-funded research on diabetes management which shows that providers can help patients achieve good glycemic control and postpone major complications of the disease through a combination of intensive drug therapy and a team approach to care. The synthesis, *Improving Care for Diabetes Patients Through Intensive Therapy and a Team Approach*, is based on AHRQ-supported research that has examined what can be achieved when treating patients in an office practice. The synthesis indicates that the components of effective management of diabetes include: 1) more frequent use of two oral medications, or one oral medication plus insulin; 2) three or more daily injections for insulin recipients; 3) four or more visits per year for many patients; and visits with both physicians and nurse practitioners. *Improving Care for Diabetes Patients* reflects the substantial investment AHRQ has made in research addressing conditions like diabetes, as well as how to translate those research findings into improved clinical practice. AHRQ also announced the release of a new fact sheet showing that racial and ethnic minorities are at greater risk for diabetes, and that certain minorities also have much higher rates of diabetes-related complications and death. This fact sheet, *Diabetes and Disparities Among Racial and Ethnic Minorities*, is based on a review of research articles that appeared in peer-reviewed journals.

- Analysis funded by AHRQ and others found that data on nurse staffing levels (in eleven states among 799 hospitals covering 6 million patients) confirms that there is a direct link between the number of registered nurses and the hours they spend with patients and whether patients develop a number of serious complications or die while in the hospital.

- AHRQ's significant investment in bioterrorism research has lead to the following:

    - Researchers at the University of Alabama at Birmingham and Research Triangle Institute have developed Web-based training modules to teach health professionals how to address varied biological agents. Separate modules exist for ER practitioners, radiologists, pathologists, and infection control specialists. These clinicians can obtain continuing medical education (CME) credit at this site: http://www.bioterrorism.uab.edu.
    - Through collaborations with the University of Maryland, Emory University, District of Columbia Hospital Association, and Booz-Allen Hamilton, a questionnaire has been developed that can help assess the current level of preparedness of hospitals or health systems and their capacity to respond to bioterrorist attacks. The Department of Defense is already using this assessment in pilot work.
    - In collaboration with the New York City Department of Health and the Mayor's Office of Emergency Management, AHRQ's Integrated Delivery System Research Network (IDSRN) based at the Weill Medical College of Cornell University has developed a computer simulation model for city-wide response planning for bioterrorist attacks. This model for mass prevention of disease in the event of a bioterrorist attack was validated by a live exercise funded by the Department of Justice.
    - Researchers at the Children's Hospital of Boston are exploring the feasibility of building decision support models for information systems using linked health care data. These information systems would help to link the public health infrastructure with the clinical care delivery system to speed reporting and enhance rapid dissemination of relevant information. A preliminary product is a literature review that clarifies the potential of Web-based systems for clinicians to obtain timely information and report potential bioterrorist events to public health authorities.
    - Researchers at the University of Pittsburgh and Carnegie-Mellon are continuing the development of a "Real-time Outbreak and Disease Surveillance (RODS) System" for bioterrorist events. The purpose of RODS is to provide early warning of infectious disease outbreaks, possibly caused by an act of bioterrorism, so that treatment and control measures can be initiated to protect and save large numbers of people.

- The Science Applications International Corporation (SAIC) in collaboration with Johns Hopkins University, George Washington University, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has completed extensive work on assessing and recommending improvement in the linkages between the medical care, public health, and emergency preparedness systems to detect and respond to bioterrorist events.
- Among others, AHRQ's User Liaison Program's May 2002 teleconference disseminated bioterrorism research findings to over 500 state and local health policymakers, information that helped them assess and strengthen the capacity of the health care system within their jurisdictions.
- The Primary Care Practice-Based Research Network at the University of Indiana is using a city-wide electronic medical records system as a model for surveillance and detection of potential bioterrorism events across a wide range of health care facilities, including primary care practices, public health clinics, emergency rooms, and hospitals

PROGRAM PERFORMANCE REPORT SUMMARY

	Measures in Plan	Results Reported	Results Met	Unreported
1999	40	40	40	0
2000	53	40	53	0
2001	54	54	54	0
2002	60	60	60	0
2003	36	NA	NA	NA
2004	23*	NA	NA	NA

* 9 Measures associated with 6 Long Term Performance Goals
14 Measures associated with 14 FY2004 Performance Goals

PART I - OVERVIEW OF PERFORMANCE MEASUREMENT

"What we really want to get at is not how many reports have been done, but how many people's lives are being bettered by what has been accomplished. In other words, is it being used, is it being followed, is it actually being given to patients? [W]hat effect is it having on people?”

Congressman John Porter, Chairman, House Appropriations Subcommittee on Labor, HHS, and Education, 1998

Introduction and Rationale

The purpose of research is to produce information that can inform decision-making. There is increasing awareness among those who provide and receive health care services, those who pay for those services and those who are making policy decisions that health care should be research led and that the services which are provided should be evidence-based. As a result, research agencies must find a way to demonstrate the benefits of the research produced, not only in terms of how many research findings are published in professional journals but how the investment in research results in practical everyday applications that can be used by people who need information to make decisions about health care.

Demonstrating that research has led to tangible effects in the care provided to individual patients is difficult. Impact is not always immediate. For example, it may be several years for a health care organization, that has adopted a policy based on research funded by AHRQ, to learn what effect it has had on overall patient care. Knowing that some clinicians or health systems are changing their practice is different from knowing how overall practice patterns are being influenced and what the effect is on clinical outcomes.

To address the need to demonstrate the impact of research on people’s health, AHRQ staff developed a “pyramid of outcomes” model that includes four levels of impact. At the base level is the impact on knowledge and further research development, at the top is the impact on patient outcomes.

This model of assessing impact of AHRQ-sponsored research forms the basis for the development of performance measures. Similarly, AHRQ must ensure that performance measures are developed to assess the impact of the research investment at all levels of the pyramid.

Performance measures aimed at the base of the pyramid focus on research that contributes to the health care knowledge base, leads to future research, or both. Research at this level includes the development of tools and research methods, instruments and techniques to assist clinical decision-making, and identify areas that do not have a sufficient evidence base. The process indicators that are developed to measure performance at this level of the pyramid assess the quantity or quality of activities that have the potential to contribute, at least indirectly, to helping AHRQ meet its strategic goals or to monitor the establishment of major new initiatives or implementation of improvements in core activities where significant resources are involved or the potential for significance of the ultimate impact is high.

Output indicators are developed aimed at capturing the impact at the second and third level of the pyramid. Research at the second level of impact is research that results in the creation of a policy or program by a professional organization, health plan, hospital, legislative body, regulator or accrediting organization. Similarly, impact at level three of the pyramid is defined as research that results in a change in what clinicians or patients do, or changes in a pattern of care.

AHRQ has developed outcome indicators to measure impact at the fourth level of the pyramid, that is impact on the quality of care, actual health outcomes, cost of treatment or access to health care. Often, however, the connection between a particular research project and health outcome is indirect and can take years to emerge. As a result, AHRQ has developed measures that utilize a "convergence of evidence" approach to establish a connection between research and outcomes. This involves identifying bodies of research which, when considered together, establish a connection between research and outcomes.

AHRQ Performance Indicators

Phase of initiative	Year One – research initiative starts	Years 3 - 5 – results received	Years 3 - 10 – results used in health care system
Indicator type	Process indicators	Output indicators	Outcome indicators
Indicator examples	Grants funded, creation of reports, partnerships formed	Publications, web site, dissemination, research findings, reports, products available for use in health care system	Results of evaluation studies, users stories, analysis of trend/other data

REPORT/PLAN ROAD MAP AND BUDGET LINKAGE

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

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

The first two budget lines are where Agency programs are funded. The goals associated with each of the budget lines represent core activities funded in each. The following two tables illustrate how the GPRA goals are aligned with the AHRQ budget lines.

Table I, representing the GPRA goals for FY 2002, uses the cycle of research as a basic framework underpinning the development of goals and measures for AHRQ's budget line: Research on Health Care Costs, Quality and Outcomes.

TABLE 1: GPRA FRAMEWORK FY 2002

What the Indicators Address	GPRA Goal
Budget line 1: Research on Health Care Costs, Quality, and Outcomes	
Cycle of Research Phase 1: Needs Assessment	**GPRA Goal 1:** Establish Future Research Agenda Based on User's Needs.
Cycle of Research Phase 2: Knowledge Creation	**GPRA Goal 2:** Make significant contributions to the effective functioning of the US health care system through the creation of new knowledge.
Cycle of Research Phase 3: Translation and Dissemination	**GPRA Goal 3:** Foster translation of new knowledge into practice by developing and providing information, products, and tools on outcomes, quality, access, cost and use of care.
Cycle of Research Phase 4: Evaluation	**GPRA Goal 4:** Evaluate the effectiveness and impact of AHRQ research and associated activities.
Lead role for quality initiative	**GPRA Goal 5:** Support Department-wide initiatives to improve health care quality through leadership and research.
Budget line 2: Medical Panel Expenditure Surveys	
Core MEPS activities	**GPRA Goal 6:** Collect current data and create data tapes and associated products on health care use and expenditures for use by public and private-sector decision makers and researchers.
Budget line 3: Program Support	
Agency management activities: contracts management and the AHRQ Intranet.	**Goal 7:** Support the overall direction and management of AHRQ.

TABLE 2: REVISED GPRA FRAMEWORK FOR FY2003

Beginning in FY 2003, AHRQ has redesigned its strategic management system and revised its GPRA goals to align more closely with the Agency's strategic plan. Table 2 shows this revision and realignment and the strategies AHRQ will use to accomplish these goals.

What the Indicators Address	GPRA Goal and Strategies for Meeting the Goal
Budget line 1: Research on Health Care Costs, Quality, and Outcomes	
Strategic Goal 1: Support Improvements in the quality, safety and outcome of healthcare	**To have measurable improvement in the quality, safety and outcome of healthcare for Americans**. • The National Healthcare Quality Report • The National Healthcare Disparities Report • HCUP Quality Indicators • Translating Research Into Practice (TRIP) • Consumer Assessment of Healthcare Plans (CAHPS®) • Accelerating the implementation of existing quality measures and safety practices • Developing capacity and new practices for quality and safety improvements • Detecting safety hazards and monitoring improvements in healthcare safety and quality • Centers for Education and Research on Therapeutics (CERTS) • Evidence-based Practice Centers (EPCs) • U.S. Preventive Services Task Force (USPTF) • National Guidelines Clearinghouse (NGC)
Strategic Goal 2: Identify Strategies to Improve Access, Foster Appropriate Use and Reduce Unnecessary Expenditures	**To develop the evidence base for policy makers and health systems to use in making decisions about what services to pay for, how to structure those services, and how those services are accessed.** • Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED) • Integrated Delivery System Research Networks (IDSRNs) • Primary Care Based Research Networks (PBRNs) • HIV Research Network • Healthcare Cost and Utilization Project (HCUP)
Strategic Goal 3: Build capacity to improve the quality of health care	**To build the capacity for improving the Quality of Health Care Delivery through Research and Training.** • National Research Service Awards (NRSAs) • Dissertation Research Grants • Career Development Awards

	• Minority Research Infrastructure Support Program (M-RISP) • Building Research Infrastructure & Capacity Program (BRIC)
Budget line 2: Medical Panel Expenditure Surveys	
Core MEPS activities	**To provide comprehensive, relevant and timely data on health care use and expenditures for use by public and private sector decision makers and researchers.** • Household Component (HC) • Medical Provider Component (MPC) • Insurance Component (IC)
Budget line 3: Program Support	
Enhance the value of AHRQ as the leader in Healthcare Outcomes, Quality, Cost, Use and Access	**Maximize the value of AHRQ by developing efficient and responsive business processes, aligning human capital policies and practices with AHRQ's mission, building an integrated and reliable information technology infrastructure** • Developing efficient and responsive business processes • Strategic management of human capital • Building an integrated and reliable information technology infrastructure • Integration of budget and performance

This realignment will help AHRQ determine how well the basic knowledge which forms the core of AHRQ's work provides information that can be turned into actions by clinical decision makers, purchasers and providers who make decisions about what services to use and pay for and how to structure those services, as well as by policy makers.

PART II GOAL-BY-GOAL PERFORMANCE MEASUREMENT

The FY 2004 Performance Plan continues AHRQ's transition from a plan focused on outputs to a plan more focused on outcomes. The impact of research on health outcomes is rarely immediate or direct. The results of AHRQ's investments, and its impact on the quality, safety, cost, use or access to health care should be measured as a whole, rather than as a single component. As a result, the outcome measures we have chosen reflect the outcomes we expect to achieve over a span of several fiscal years. The indicators chosen to report are often the results of programs of research that have been underway for several years and reflect investments in building new knowledge. The key is translation of that knowledge into information that is useful to our users. For example, in FY 2003-04 AHRQ will track preventable hospitalizations for complications of pediatric asthma, the number of hospitalizations for elderly patients that could be prevented through the use of influenza immunizations and the number of premature infants who develop Respiratory Distress Syndrome (RDS) as a measure of success in improving health care outcomes. Each of these indicators reflect the impact of investments which AHRQ has made in developing new knowledge and developing useful tools which providers can use to take the theoretical and make it practical. In the Final FY 2004 Performance Plan AHRQ will use the National Healthcare Quality Report and the National Healthcare Disparities Report to identify other indicators to report the success of AHRQ's programs.

In addition, AHRQ identified program outputs for each goal for the fiscal year. These program outputs will be used to show progress the programs are making to achieve the overall outcome goal. For example, while reporting the number of hospitalizations for complications of pediatric asthma as a program output, AHRQ is committed to producing evidence reports on topics that will form the basis for future translation and implementation projects. Reporting the Agency's program activities in this way will provide a clearer picture of where the agency is going and it's progress towards meeting its goals.

Finally, in future Performance Plan submissions, an analysis of the program will be incorporated into the goal-by-goal discussion. For this report, FY 2002 results are addressed in Appendix II, Fiscal Year 2002 Performance Report Summary.

The following tables present, by budget line, a selection of the long-term performance goals and fiscal year targets for AHRQ. Some measures come from the results of OMB Program Assessment Rating Tool (PART) reviews of the following AHRQ programs:

- Healthcare Cost and Utilization Project (HCUP)
- Consumer Assessment of Health Plans (CAHPS®)
- Translating Research Into Practice (TRIP)
- Medical Expenditure Panel Survey (MEPS)

BUDGET LINE 2.1 – RESEARCH ON HEALTH CARE COST, QUALITY AND OUTCOMES

Goal 1: To have measurable improvement in the outcomes, quality and safety of healthcare for Americans

Performance Goal	FY Targets	Actual Performance	Reference
By 2010, at least 5 organizations will use HCUP databases, products or tools to improve health care quality for their constituencies by 10% , as defined by the AHRQ quality Indicators Baseline: FY '00 – quality indicators developed	**FY04** Two new organizational users of HCUP will develop interventions using HCUP QI's One organizational user will implement an intervention based on the QI's/ **FY03** Two organizational users of HCUP will develop interventions using HCUP QI's **MEASURE NEW IN FY 03**		1 (1.1)
By 2008, CAHPS® data will be more easily available to the user community and the number of consumers who use information from CAHPS® to make choices about their healthcare will increase by 20%. (Baseline FY 2002)	**FY04** Produce a CAHPS® module for consumer assessments of hospital quality Establish baseline for number of consumers using Nursing Home CAHPS® **FY03** Produce a CAHPS® module for consumer assessments of health and services received in nursing homes **FY 02 New Measure** Obtain baseline number of people with access to CAHPS® data	Baseline developed: Access – 90 million Americans	5 (4.3)
By 2010, evidence, translation tools and implementation strategies exist for improving the overall quality and safety of health of the American public so that: • By 2010, reduce to 105,613 admissions, the rate of hospitalizations for pediatric asthma in persons under age 18. • By 2010, reduce to 520,441 the number of immunization-preventable pneumonia hospital admissions of persons aged 65 and older. • By 2010, reduce to 11,570 the number of	**FY04** Reduce by 5% below the baseline: • the rate of hospitalizations for pediatric asthma in persons under age 18. • the number of admissions for immunizations-preventable pneumonia for persons aged 65 or older. • the number of admissions for immunization-preventable influenza for persons aged 65 or older. • the number of premature babies who develop RDS. **FY03** Establish Validated Baselines Following are FY 2000 baseline estimates: Pediatric Asthma – 150,876 Pneumonia – 743,487 Influenza – 16,529 RDS – 5,707		1 (1.)

immunization-preventable influenza hospital admissions of persons aged 65 and older. - By 2010, reduce to 500 per live births the number of premature babies who develop Respiratory Distress Syndrome (RDS).			
Report on national trends in health care quality	**FY04** Report on progress in core measure set. Identify private sector data to be used in future reports. **FY03** Produce first annual quality report. Establish baseline data in core set of measures		
By 2004 6 health facilities or regional initiatives to implement interventions and service models on patient safety improvements will be in place	**FY04** 6 Teams will be in place **FY03** Awards to be made to at least 6 facilities or initiatives		5 (5.1)
By 2004 at least 10 states or major health care systems will have on-site Patient Safety Improvement Corp (PSIC) staff in place	**FY04** 10 States or major health care systems will have on site experts in Patient Safety **FY03** A Patient Safety Improvement Corp training program will be established. **FY02** Planning study completed	Completed	5 (5.1)
Identify the number and types of adverse events, no-harm events, and near miss events reported in demonstration projects	**FY04** Report on the number and types of adverse events **FY03** Develop reporting mechanism and data structure for Demonstration projects		5 (5.1)
By 2006, six national message format and clinical vocabulary standards would be identified/recommended by HHS as ready for voluntary adoption and deployment.	**FY04** 3 message format and clinical vocabulary standards will be recommended by HHS as ready for voluntary adoption and deployment **FY03** Develop Consensus on standards		5 (5.5)
By 2008 nursing homes will have evidence-based information needed to make informed purchasing strategies related to IT	**FY04** 5 technologies currently shown to be effective in other clinical settings will be tested in nursing homes to evaluate the impact on safety, quality and cost of care		5 (5.5)

Goal 2: To develop the evidence base for policy makers and health systems to use in making decisions about what services to pay for, how to structure those services, and how those services are accessed.

Performance Goal	FY Targets	Actual Performance	Reference
Increase the number of partners contributing data to the HCUP databases by 5% above FY2000 baseline	**FY04** 5% increase over FY00 baseline **FY03** Increase the number of partners required		4(4.1)

Goal 3: To build the capacity for improving the Quality of Health Care Delivery through Research and Training

Performance Goal	FY Targets	Actual Performance	Reference
Increase the number of minority researchers trained as health services researchers by 5% annually	**FY04** 5% increase over FY03 baseline **FY03** New Measure Establish baseline		4 (4.2)
Support training programs for junior-level researchers and mid-career scientists	**FY04** Maintain baseline **FY03** Establish Baseline # programs		4 (4.2)

BUDGET LINE 2.2 – MEDICAL EXPENDITURE PANEL SURVEY (MEPS)

Goal 4: To provide comprehensive, relevant and timely data on health care use and expenditures for use by public and private sector decision makers and researchers

Performance Goal	FY Targets	Actual Performance	Reference
By 2008, point in time data from the MEPS survey will be available within 12-Months	FY04 – 12 months FY03 – 12 months FY02 – 12 months FY01 – 12 months FY00 – 12 months	 12 months 12 months 12months	
Insurance Component tables will be available within 6 months of collection	FY04 – 7 months FY03 – 7 months FY02 – 7 months FY01 – 7 months FY00 – 7 months	 7 months 7 months 7 months	
MEPS Use and Demographic Files will be available 12 months after final data collection	FY04 – 15 months FY03 – 17 months FY02 – 19 months FY01 – 23 months FY00 – 28 months	 19 months 23 months 28 months	
Full Year Expenditure Data	FY04 – 12 months FY03 – 18 months FY02 – 21 months FY01 – 24 months FY00 – 33 months	 21 months 24 months 33 months	

BUDGET LINE 2.3 – PROGRAM SUPPORT

Goal 5: Maximize the value of AHRQ by developing efficient and responsive business processes, aligning human capital policies and practices with AHRQ's mission, building an integrated and reliable information technology infrastructure

Performance Goal	Targets	Actual Performance	Reference
By FY 2007, Get to Green on the Presidents Management Agenda Initiatives -Human Capital	**FY04** Develop a plan to recruit new or train existing staff to acquire skills necessary to fill identified gaps **FY03** Identify gaps in agency skills and abilities Integrate competency models into organizational processes Finalize the identification of technical competencies Engage a consultant to evaluate options and develop a plan for vertically & horizontally collapsing organizations Continue to reduce organizational levels		🏛 8
	FY02 Develop a model for leadership and core competencies in AHRQ	Completed	
	Reduce the Number of Managers	- # of supervisory positions eliminated: 7	
	Reduce Organizational Levels	- # of organizational levels eliminated : 2	
	Redeploy Staff to Mission-Critical Positions	- # of administrative FTE's redeployed to support program functions : 12	
-Expanded E-government Increase IT Organizational Capability	**FY04** Complete implementation of the control review cycle Implement the evaluation cycle Integrate capital planning processes with enterprise architecture processes **FY03** Implement the planning cycle Implement the select review cycle Initiate efforts for the control review cycle		
	FY02 Establish IT project accountability Establish IT capital planning governance Stand up the IT Investment Review Board Develop integrated business transactions with contracts and budget Define operating procedures for capital planning's four cycles	Completed	

Improve IT Security/Privacy	**FY04** Continue risk assessments on AHRQ's second tier systems Implement the business continuity and contingency program plans		🏛 8
	FY03 Continue risk assessments on AHRQ's mission critical systems Implement incident response plans and procedures Develop network security plans Develop anti-virus program plan Develop authentication program plan		
	FY02 Establish security and privacy governance Complete the second cycle of NIST self assessments Complete risk assessments of seven of AHRQ's mission critical systems	Completed	
Establish IT Enterprise Architecture	**FY04** Develop the target architecture Create the migration plan Integrate enterprise architecture processes with capital planning processes		
	FY03 Continue to carry out business process assessments of key business lines Establish enterprise architecture governance Develop the baseline architecture Develop the technical reference model Establish technical standards Implement general desktop and network upgrades to reflect the technical architecture		
	FY02 Stand up the enterprise architecture program office Implement the Enterprise Architecture Management System	Completed	
-Budget and Performance Integration	**FY04** Implement planning system Complete initial PART reviews on all major agency programs		🏛 8
	FY03 Develop and test planning system that links budget and performance Conduct initial PART Reviews on selected agency programs		
	FY02 Conduct initial PART reviews on selected agency programs	Completed PART reviews on 5 agency programs	

BUDGET LINE 2.1
Research on Health Care Cost, Quality and Outcome

Funding Levels:	FY 2002	$247,645,000 (Actual)
	FY 2003	$194,000,000 (President's Budget)
	FY 2004	$221,000,000 (Request)

2.1.1 Performance Goal 1: To have measurable improvement in the quality, safety and outcome of health care for Americans

OUTCOME OF HEALTH CARE

PROGRAM DESCRIPTION AND CONTEXT

At its most basic level, providing high quality health care is doing the right thing, at the right time, in the right way, for the right person. The challenge that health care providers and health systems managers face everyday is knowing what the right thing is, when the time is right, and what the right way is. Patients and their families are also faced with making choices about treatments and care settings with little information on the relative quality, risks and benefits available to them.

One of the AHRQ's most important priorities is to translate and disseminate the findings of research supported by the Agency into tools and information that can be used by its customers to make good health care decisions and to improve the outcomes of care. The research supported by AHRQ has historically concentrated on conditions that are common, costly, and for which there is substantial variation in practice. This research includes many of the conditions that represent major expenditures for Medicare and Medicaid. AHRQ's research attempts to reduce inappropriate variation and provide the health care decision maker with information on what care is appropriate, which clinical services work best in what circumstances and for which patients, how much is enough, and what resources are used to provide it. Outcomes research also attempts to help decision makers understand the implications of structural and financing changes in the health care system on the outcomes of care delivered in the system.

Outcomes and effectiveness research seeks to understand the end results of particular health care practices and interventions. Outcomes include effects that people experience and care about, such as change in the ability to function. In particular, for individuals with chronic conditions—where cure is not always possible—end results include quality of life as well as mortality. By linking the care people get to the outcomes they experience, outcomes research has become the key to developing better ways to monitor and improve the quality of care.

Strategies to Improve Health Outcomes

At the requested level, AHRQ's programs assist with Secretarial initiatives, particularly in the area of chronic illness, such as diabetes and asthma. Comprehensive primary care services can reduce the morbidity associated with these illnesses. Hospital admission rates for "ambulatory care sensitive conditions" serve as a marker for both impaired access to primary care and sub-optimal quality of primary care delivered. Disparities in admission rates for racial and ethnic minorities and low-income populations have been well documented.

Programs that support AHRQ's efforts to improve the outcomes include: Centers for Education and Research on Therapeutics (CERTS); Evidence-based Practice Centers (EPCs); the U.S. Preventive Services Task Force (USPTF); and, the National Guidelines Clearinghouse (NGC).

Centers for Education and Research on Therapeutics (CERTS)

The CERTS program is a national initiative designed to increase the awareness of the benefits and risks of new, existing, or combined uses of therapeutics through education and research. The CERT's program grew out of recognition that physicians need more information about the therapies they prescribe. Although information is available through the pharmaceutical industry, continuing medical education programs, professional organizations, and peer reviewed literature, comparative information about the risks and benefits of new and older agents and about drug interactions is limited.

The research conducted by the CERT's program contributes to improving the health of Americans. The program does this by increasing awareness of both the appropriate use and risks of new drugs, drug combinations, biological products, devices and mechanisms. This clinical information is used to improve their safe and effective use by physicians, patients, pharmacists, pharmacy benefit managers, purchasers, insurers government agencies and others.

Translating Research Into Practice (TRIP)

Translating research findings into sustainable improvements in clinical outcomes remains a substantial obstacle to improving the quality of health care in America. What has been learned in the research setting is often not incorporated into daily clinical practice. To address this gap, AHRQ funded in September 2000, 13 new projects to evaluate different strategies for translating research findings into clinical practice. The aim of these three-year cooperative agreements was to identify sustainable and reproducible strategies to:

- Help accelerate the impact of health services research on direct patient care; and,
- Improve the outcomes, quality, effectiveness, efficiency, and/or cost effectiveness of care through partnerships between health care organizations and researchers.

These new projects join 14 others funded in 1999 as part of a major initiative by AHRQ to close the gap between knowledge and practice or between what we know and what we do to ensure continuing improvements in the quality of the nation's health care.

The 14 studies supported in the initial phase of the TRIP initiative address a variety of health care problems, primarily through randomized controlled trials. These studies, which represent important prototypes of what is possible under ideal circumstances, generally require an elaborate strategy for superimposing data collection on the demands of routine practice.

The second phase of this initiative, TRIP-II, is aimed at applying and assessing strategies and methods that were developed idealized practice settings or that are in current use but have not been evaluated. Furthermore, increased demands for accountability in health care, including reporting of clinical performance using standardized quality measures, have created a sense of urgency regarding improvement within health care organizations. With this as a basis, TRIP-II focuses on implementation techniques and factors such as organizational and clinical characteristics associated with successfully translating research findings into diverse applied settings, including AHRQ-sponsored Practice Base Research Networks (PBRNs).

Evidence-based Practice Centers (EPC's)

As the lead federal agency for enhancing the quality, appropriateness, and effectiveness of healthcare services and access to such services, AHRQ conducts and funds research that develops and presents evidence-based information on healthcare outcomes, quality, cost, use and access. Included in AHRQ's legislative mandate is support of syntheses and widespread dissemination of scientific evidence, including dissemination of methods or systems for rating the strength of scientific evidence. These research findings and syntheses assist providers, clinicians, payers, patients, and policymakers in making evidence-based decisions regarding the quality and effectiveness of health care.

As a part of its charge to improve the quality and effectiveness of health care through the development of state-of-the-art health care information, and to respond to significant changes within the health care industry, AHRQ established 12 Evidence-based Practice Centers in 1997. AHRQ has become a science partner with private and public-sector organizations in their efforts to improve the quality, effectiveness and appropriateness of clinical practice.

Since 1997, the EPC's have conduced more than 80 systematic reviews and analyses of scientific literature on a wide spectrum of topics, incorporating the results and conclusions into evidence reports and technology assessments.

The EPC program contributes to AHRQ's goal of improving the health of the American public by producing synthesis of clinical research findings through systematic methods for searching, reviewing, and evaluating the clinical literature. Evidence reports and technology assessments are used by systems of care, professional societies, health plans, public and private purchasers, states, and other entities as the scientific foundation for development and implementation of their own clinical practice guidelines, clinical pathways, review criteria, performance measures, and other clinical quality improvement tools, as well as for formulation of evidence-based policies related to specific health care technologies.

U.S. Preventive Services Task Force (USPSTF)

Premature or early deaths and disabilities due to preventable causes continue to extract a significant toll in the US. Health care providers and health care organizations play an essential role in national prevention efforts, by delivering effective vaccines, screening patients for early disease or risk factors, counseling about health lifestyles, and prescribing preventive medications. Despite steady progress in the delivery of effective preventive care, important gaps remain. For example, as of 1998 more than one-third of women over 50 had not had a mammogram and breast exam in the last two years to screen for breast cancer, and more than a third of older adults had not received a flu shot that year. Inequities in preventive care also contribute to the disparities in the health of specific populations, such as racial and ethnic minorities, the elderly, and the poor and disabled.

The USPSTF as well as AHRQ's Put Prevention Into Practice (PPIP) program make significant contributions to the Department of Health and Human Services prevention activities. The USPSTF, first convened in 1984, is charged with systematically reviewing the evidence of the effectiveness of a wide range of clinical preventive services, including screening tests, counseling, immunizations, and chemo-prevention. The PPIP program then works to translate information from USPSTF reports into a format that meets the needs of a wide variety of patients, clinicians, health plans, and health care purchasers.

National Guideline Clearinghouse (NGC)

The NGC is a publicly available, Web-based database of evidence-based clinical practice guidelines and related documents. Updated weekly with new content, the NGC is a partnership between AHRQ, the American Medical Association (AMA) and the American Association of Health Plans (AAHP) Foundation.

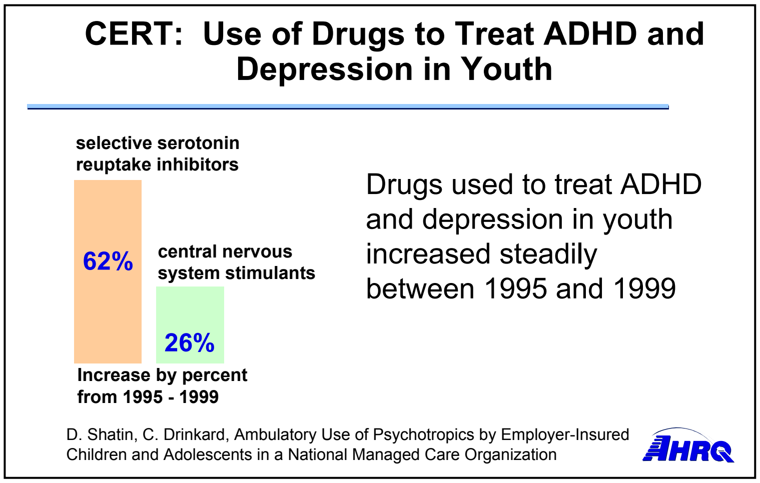
In its two years of operation, the NGC has become a resource for physicians, nurses and other health care professionals as well as purchasers and policy makers. Individual physicians and other clinicians can review and use the NGC in clinical decision making and patient counseling; health care organizations and integrated delivery systems can use information accessible through the NGC to adopt or adapt guidelines for their networks; medical specialty and professional societies can use NGC resources in their own guideline development efforts; employers and other large purchasers can use information from the NGC to assist them in making health care benefits purchasing decisions; educational institutions can incorporate information accessible through the NGC into their curricula and continuing education activities; and, state and local governments can use the NGC in their quality assurance and program oversight efforts.

PROGRAM PERFORMANCE ANALYSIS

One of the most important priorities of AHRQ is to translate and disseminate the findings of research supported by the Agency into tools and information that can be used by its customers to make good health care decisions and to improve the outcome of care. The research supported by AHRQ has historically concentrated on conditions that are common, costly, and for which there is substantial variation in practice. This research includes many of the conditions that represent major expenditures for Medicare and Medicaid. AHRQ's research attempts to reduce inappropriate variation and provide health care decision-makers with information on what care is appropriate, which clinical services work best in what circumstances and for which patients, how much is enough, and what resources are used to provide it. Outcomes research also helps decision-makers understand the implications of structural and financing changes in the health care system on the outcomes of care delivered in the system.

Centers for Education and Research on Therapeutics

Neither patients nor their caregivers should have to guess which therapies are best or live in fear that a mistake will be made in treatment. This is the basis of AHRQ's Centers for Education and Research on Therapeutics/CERTs program. AHRQ was given authority to support the CERTS initiative under the Food and Drug Modernization Act of 1997. Between 1999 and 2000, AHRQ established seven centers under the CERTS program, each of which focuses on therapies used in a particular population or therapeutic area, e.g., condition. The CERTs conduct research and provide education that will advance the optimal use of drugs, medical devices and biological products.


CERT: Use of Drugs to Treat ADHD and Depression in Youth

Drugs used to treat ADHD and depression in youth increased steadily between 1995 and 1999

D. Shatin, C. Drinkard, Ambulatory Use of Psychotropics by Employer-Insured Children and Adolescents in a National Managed Care Organization

While drugs, medical devices, and biological products improve health for thousands of people, side effects, misuse, and overuse of products can seriously impair the health of many others. Many patients potentially could benefit from a therapy but do not receive it through lack of information, oversight, or in the mistaken belief that the therapy will do them harm. In addition, studies conducted prior to FDA approval may not test medical products in combination with other therapies often used by the same patients. Further, once approved, drugs and devices often are used for purposes other than those for which they were approved - sometimes these uses are supported by studies but not always. Finally, some side effects of medical products emerge only after they have been approved for sale - when large numbers of people begin to use them.

The CERTs program aims to fill these information gaps by answering important questions that have not been addressed and implementing effective educational interventions for current and future caregivers. The CERTs is also a critical complement to FDA's post-marketing studies. Besides AHRQ, the participants in the CERTs include academic organizations, managed care organizations, drug and device companies, practitioners, commercial research groups and consumer groups. The following are a few examples of how the CERTs seek to improve health through the best use of medical therapies.

Why are patients with certain types of heart disease not taking medicines that may save their lives? Aspirin, inexpensive and available over-the-counter, greatly reduces the risk of heart attack, stroke, and related death for people with coronary artery disease (CAD; blockage of the blood vessels that supply blood to the heart). Similarly, another class of drugs, beta-blockers, have been shown to help people with congestive heart failure (CHF). Data collected by the Duke University CERT confirmed that 13 percent of people with CAD were not taking aspirin, and 55 percent of people with CHF were not taking a beta-blocker. More importantly, the people with CAD whom were not taking aspirin were almost twice as likely to die within one year as those that were.

The news was only slightly better for people with CHF who were not taking a beta-blocker; they had 1.5 times the risk of dying compared with people who were taking the medicine. The Duke CERT is now investigating ways to get the right life-saving medicines to the right people. Once more is understood about why people may not be taking these medicines, programs to overcome these barriers and save lives can be designed.

Monitoring anti-HIV drug levels. The ability of drugs to help women and children with HIV can be affected by the way they take the drugs and how their bodies handle the medicine. The University of North Carolina CERT developed a screening test for kids to measure the levels of anti-HIV drugs called protease inhibitors in the bloodstream. The test will determine whether the level of drugs is too high or too low as a result of a problem in the way the drug was taken or absorbed.

Research involving the test had an unexpected, important finding: giving anti-HIV drugs to babies with water can speed the passage of the drugs through babies' systems before they have a chance to work. Giving drugs with infant formula greatly improves results. In another case, the test showed high levels of protease inhibitor in a child whose parent had readjusted the dose of the drug without telling anyone. Some patients were not getting their drugs at all. In one case, a child's mother was too ill herself to medicate her child, but only through the screening test could the problem be uncovered.

The test demonstrated that there might be a big difference between what a doctor prescribes and what is at work in the body. Providing this test to HIV-infected individuals can go a long way in ensuring that people are getting the level of drugs they need. The test also may help reduce the incidence of drug-resistant viruses and the cost of caring for patients with HIV.

Rethinking antibiotics before dental treatment. Many people are prescribed antibiotics before they go to the dentist in the belief that it will reduce the risk of endocarditis (infection of the heart lining and valves). Because conventional wisdom suggests that patients with heart problems are at risk, this preventive measure has been recommended for more than 45 years. The University of Pennsylvania CERT conducted a study to evaluate and quantify the risk of such infection. They found that the incidence of infection remained the same even after the introduction of widespread antibiotic prophylaxis and that neither dental work in general nor any individual procedures were associated with infective endocarditis - with the possible exception of tooth extraction. The study also determined that flossing daily slightly reduced the risk of infection. Efforts are under way by the researchers to have these findings incorporated into American Heart Association guidelines. These findings will affect an important source of antibiotics used without benefit.

Evidence-Based Practice Centers

While outcomes research is developing new knowledge on what works in health care, for whom, and under what conditions to improve practice in the years ahead, AHRQ's Evidence-based Practice Centers (EPCs) program synthesizes the existing literature to inform practice improvements today. AHRQ's 12 EPCs develop evidence reports and technology assessments on therapies and technologies that are common, expensive, and/or significant for the Medicare and Medicaid populations. The EPCs systematically review and analyze the published scientific literature to develop the reports. Since 1997, the EPCs have conducted more than 80 systematic reviews and analyses of the literature on a wide spectrum of topics and they have incorporated the results and conclusions into evidence reports and technology assessments. Some of these reviews are ongoing, and others have been published.

EPC - Technology Assessment: Actinic Keratoses

CMS revised its Medicare Coverage Issues Manual to include a national coverage policy permitting coverage for the treatment of actinic keratoses (AK), a common skin condition that is often the precursor of skin cancer. The decision to cover the treatment of AKs was based largely on the AHRQ technology assessment for Actinic Keratoses treatment. This assessment suggested that the presence of AKs is associated with the development of squamous cell carcinoma (SCC) more than other factors. SCC has the potential to metastasize and accounts for a large percentage of all non-melanoma skin cancer deaths in the Medicare population.

Users of these reports and assessments include doctors, medical and professional associations, health system managers, researchers, consumers organizations, and policymakers. These public- and private-sector organizations use the reports as the basis for developing their own clinical guidelines, performance measures, and other quality improvement tools and strategies. The reports and assessments often are used in formulating reimbursement and coverage policies. All EPCs collaborate with other medical and research organizations so that a broad range of experts can be included in the development process.

Professional associations that create clinical practice guidelines, as well as federal agencies, academic institutions, patient groups and health systems are using AHRQ's evidence reports and technology assessments. Examples include the development of a guideline by the American Psychiatric Association (APA) based on the evidence report, "Depression Treatment with New Drugs"; use by the VA of the meta-analysis on Testosterone Suppression Treatment for Prostate Cancer as part of its continuing medical education program; and, the development of a practice guideline by the American Academy of Pediatrics (AAP) based on the evidence report on "Diagnosis of Attention-Deficit/Hyperactivity Disorder." The AAP has released a second guideline on the management of this disorder, also based on an AHRQ-sponsored evidence report, prior to launching a three-year, multi-faceted campaign to promote the implementation of these guidelines in practice. The program will include a variety of media events, development of physician tool kits, patient materials, and educational curricula and conferences, all designed to facilitate improvements in clinical practice and patient behavior consistent with the scientific evidence outlined in the EPC evidence reports.

The National Guideline Clearinghouse™ (NGC), an Internet resource for evidence-based clinical practice guidelines located at www.guideline.gov has now been operational for three years. The NGC was developed by AHRQ, in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AAHP), to be a resource for physicians, nurses and other health care professionals.

NGC has more than 1,000 clinical practice guidelines submitted by over 165 health care organizations and other entities. New guidelines are being added to NGC weekly. Over the last three years, NGC has had over four million visitors, processed over 40 million requests, and received over 81 million hits. NGC now has over 46,000 visits a week. AHRQ does not require users of the National Guideline Clearinghouse to register in order to use the site. However, AHRQ recently completed the second customer satisfaction survey of NGC that does provide some insight into who uses the site. Physicians represented the largest portion of survey respondents (40.6%) followed by nurses and/or nurse practitioners (18.9%). 93.5% of respondents rated their overall satisfaction with NGC as either “fairly satisfied” or “very satisfied” compared with 89.1% for the first annual survey. Respondents to the survey also provided many useful comments on how they used it in their clinical work. For instance, a number of respondents reported using NGC to identify guidelines for adaptation in their health system or institution and a desire to find the best approach to treating their patients.

The University of Michigan Health System (UMHS) in Ann Arbor has developed a program entitled Guidelines Utilization, Implementation, Development and Evaluation Studies (GUIDES). Now in its sixth year, UMHS has 10 of its guidelines in the National Guideline Clearinghouse (NGC).

“We consider the NGC a wonderful enhancement to our existing processes, and this is true across the spectrum of activity. The NGC is especially valuable in disseminating our work to colleagues in other institutions, and the variety of users is impressive. We have received inquiries from all over the world, and from a range of organizations.”

Dr. Renee Stiles, Project Manager, GUIDES.

The U.S. Preventive Services Task Force

AHRQ links prevention research with clinical practice by sponsoring the U.S. Preventive Services Task Force (USPSTF) and the Put Prevention Into Practice (PPIP) program. The Task Force synthesizes the evidence-base and the PPIP program promotes the application of the Task Force results.

The USPSTF is a critical source of information on what does and does not work in the health care system specific to prevention. First convened in 1984, the USPSTF is an independent panel of preventive health experts charged with evaluating the scientific evidence for the effectiveness of a range of clinical preventive services including common screening tests, immunizations, counseling for health behavior change and chemo-prevention and producing age- and risk-factor-specific recommendations for these services.

In FY 2002, the USPSTF announced several important recommendations which when implemented will significantly improve the quality of preventive services received by the American public. Of these recommendations two particularly are of note: screening for depression and the frequency for mammography.

Depression Screening

In May 2002, the USPSTF concluded that asking all patients who walk into offices for tests, physicals and appointments two simple questions about whether they have experienced some of the warning signs of depression. These questions can swiftly begin to identify 90 percent of people who suffer from major depression.

The recommendation is the latest manifestation of the growing recognition that depression is one of the most common - and most commonly undiagnosed and untreated - chronic illnesses. About 19 million American adults suffer from depression and estimates suggest that as many as two-thirds do not get treatment. The new recommendations could bring many of these people into treatment and add millions to the numbers who are taking antidepressants.

The two questions that ought to become part of the basic repertoire of every patient visit are: "Over the past two weeks, have you felt down, depressed or hopeless?" and "Over the past two weeks, have you felt little interest or pleasure in doing things?"

If a patient answers yes to either question, the task force recommended that doctors offer patients written or oral questionnaires. These ask more specific questions and establish whether the problems are transient or persistent. If the problems have lasted throughout the previous two weeks and have interfered with the patient's ability to perform day-to-day tasks doctors may make a diagnosis of depression.

But screening is only the first step in the task force's recommendation. Asking, 'Are you depressed?' and having the patient say, 'Yes,' and then moving on is not enough. A patient must have access to the right therapy or medicines.

Screening for Breast Cancer

In February 2002, DHHS Secretary Tommy G. Thompson announced an updated USPSTF that calls for screening mammography, with or without clinical breast examination, every one to two years for women ages 40 and over. This recommendation affirms the DHHS' existing position on the value of mammography.

"The Federal Government makes a clear recommendation to women on mammography: if you are 40 or older, get screened for breast cancer with mammography every one to two years." Secretary Thompson said further, "While developing technology certainly holds the promise for new detection and treatment methods, mammography remains a strong and important tool in the early detection of breast cancer. The early detection of breast cancer can save lives."

Breast cancer is the most common cancer among women in the US. In 2001, an estimated 192,200 women were diagnosed with breast cancer while 40,600 women died from the disease.

In addition to age other factors may increase a woman's risk of breast cancer. The strongest risk factors are a family history of breast cancer in a mother or sister, having already been diagnosed with breast cancer or having had a previous breast biopsy showing atypical hyperplasia, an irregular pattern of cell growth.

"Mammography is an important tool for detecting breast cancer," said Janet Allan, Ph.D., R.N., Vice Chair of the USPSTF. "Clinicians and women should discuss individual risk factors to determine when to have a first mammogram and how often to have them after that."

QUALITY OF HEALTH CARE

PROGRAM DESCRIPTION AND CONTEXT

The US has many of the world's finest health care professionals, academic health centers and other research institutions. Patients sometimes receive excessive services that undermine the quality of care and needlessly increase costs. At other times, they do not receive the services that have proven to be effective at improving health outcomes and even reducing costs.

A recent Institute of Medicine (IOM) report titled, "Crossing the Quality Chasm: A New Health System for the 21st Century" concluded, "Quality problems are everywhere, affecting many patients. Between the health care we have and the care we could have lies not just a gap but a chasm." In the report, the IOM proposed 13 recommendations to build a stronger healthcare system over the next decade.

One of AHRQ's strategic goals is to strengthen the quality of healthcare measurement and track improvements in the care available to Americans. To achieve this goal AHRQ has invested in the development and testing of measures of quality, as well as studies of the best ways to collect, compare and communicate these data, and identifying and widely disseminating effective strategies to improve quality of care. To facilitate the use of this information in the health care system, the Agency focuses on research that determines the most effective ways to improve health care quality, including promoting the use of information on quality through a variety of strategies such as information dissemination and assessing the impact of health care organization and financing.

Meeting the needs of consumers, practitioners, and policymakers will depend in part on the availability of valid and useable measures of the quality of care. AHRQ will translate the findings from health services research, effectiveness studies, technology assessments, and clinical practice guidelines into quality of care measures and methods for everyday settings. Basic research will develop more refined measures and improvement strategies. Applied research and development will test the validity and reliability of the measurement instruments and facilitate their use in different population subgroups such as minority groups, chronically ill, disabled, elderly, and children and in various care settings. Demonstration projects will assess the use of measures and tools in performance management systems and quality improvement activities.

STRATEGIES TO IMPROVE THE QUALITY OF HEALTH CARE:

The National Quality Report

The Agency's reauthorization calls for the development of a national report on the quality of healthcare in the US. In developing this report, the Agency is called on by Congressional legislation to expand the Medical Expenditure Panel Surveys (MEPS) to collect information on quality. In addition, the Agency is charged with assuring coordination with the private sector in the development of the report.

The Agency's coordination of the development of a National Quality Report is also responsive to the President's Quality Commission report, which concluded, "The lack of comprehensive information on the quality of American health care is unacceptable." Finally, the also recent Institute of Medicine's Commission on Medical Errors called for a national report on progress on the issue. These mandates in sum envision a report that goes beyond a compilation of available data and statistics to provide a framework for those public and private entities with an interest in improving the quality and safety of patient care.

Healthcare Cost and Utilization Project (HCUP) Quality Indicators

Health care decision-makers need user-friendly data and tools to help them assess the effects of health care programs and policy changes, accurately measure outcomes, community access to care, utilization and cost of care.

To meet this need, AHRQ has developed a set of quality indicators (QIs) that use hospital administrative data to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time. These indicators represent a refinement and further development of the Quality Indicators developed in the early 1990's as part of the Healthcare Cost and Utilization Project (HCUP).

The AHRQ QIs are a set of quality indicators that have been organized into three modules: Prevention, Inpatient and Patient Safety QIs.

Using these modules hospital and hospital systems can use AHRQ QIs to help answer questions such as:

- How does our hospital's cesarean section rate compare to the state or nation?
- Do other hospitals have similar mortality rates following hip replacement?
- How does the volume of coronary artery bypass graft in my hospital compare with other hospitals?

State data organizations and community health partnerships can use AHRQ QIs to ask questions that provide initial feedback about clinical areas appropriate for further, more in-depth analysis, such as:

- What can the pediatric AHRQ QIs tell us about the adequacy of pediatric primary care in our community?
- How does the hysterectomy rate in our area compare with the state and national average?

State hospital associations can use the AHRQ QIs to do quick hospital quality and primary care access screens. Other potential users include managed care organizations, business-health coalitions, state data organizations, and others poised to begin assessments using hospital discharge data to answer questions such as:

- Can we design community interventions in areas surrounding hospitals that have higher rates of diabetes complications?
- Which Quality Indicators can be incorporated into performance management initiatives for our member hospitals?

Finally, federal policymakers can use the AHRQ QIs to track health care quality in the

US over time and to assess whether health care quality is improving, for example:

- How does the rate of coronary artery bypass grafts vary over time and across regions of the US?
- What is the national average for bilateral cardiac catheterization (a procedure generally not recommended) and how has this changed over time?

Consumer Assessment of Healthcare Plans (CAHPS®)

CAHPS® makes available consumers' ratings of the quality of care and services they get from their health plans. This information is used by other consumers to make informed choices among health plans, by health care purchasers – such as employers or Medicaid programs – to select plans to offer their employees or beneficiaries, and by plans for quality monitoring and improvement. CAHPS® already has been used by more than 20 states, 10 employer groups and a wide range of health plans and companies. For example, CAHPS® was adopted by the Office of Personnel Management for use by the Federal Employees Health Benefits Program to survey federal employees and report the findings to help about nine million federal employees choose health plans during the federal open season. CAHPS® also merged with the HEDIS (Health Plan Employer Data and Information Set) Member Satisfaction Survey and will be used by the National Committee for Quality Assurance to evaluate and accredit managed care plans for 40 million Americans. Finally, the Centers for Medicare and Medicaid Services (CMS) has used a specially developed version of CAHPS® to survey over 130,000 Medicare enrollees in managed care plans. The result of this survey, which was released in February 1999, was available to help CMS's 39 million beneficiaries who will be selecting a health plan.

These, and other successful uses of CAHPS®, is a testament to the importance of sustained basic and applied health services research in producing practical information for everyday health decision making.

SAFETY OF HEATLH CARE

PROGRAM DESCRIPTION AND CONTEXT

Patient safety is a top priority in the nation today. It is estimated that up to 98,000 Americans die each year as a result of preventable medial errors (Kohn 1999). The majority of these errors are a result of systemic problems rather than poor performance by individual providers. Although the US provides some of the best health care in the world there are a significant number of patients that are being harmed as a result of the process of health care.

In FY 2001, AHRQ re-named the Center for Quality Measurement and Improvement (CQMI) the Center for Quality Improvement and Patient Safety (CQuiPS). This lends evidence to AHRQ's efforts to refocus activities to improve the quality of health care Americans receive and address preventable patient errors by reducing the risk of patients being harmed by the process of health care.

The goal of patient safety is to reduce the risk of injury and harm from preventable medical errors. This goal can be accomplished by removing or minimizing of hazards that increase the risk of injury to patients. Three steps must be followed to ensure that the number of medical errors are contained. These steps are:

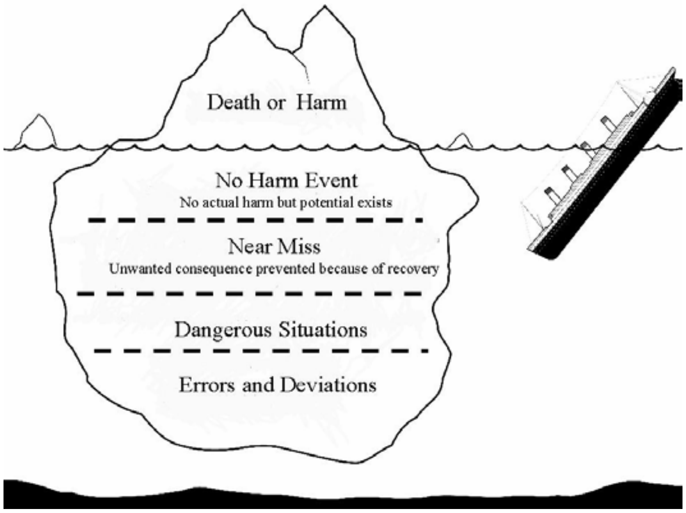
- Identify the causes of preventable errors and the hazard that increase the risk of injury to patients;
- Implement patient safety practices that eliminate known hazards and reduce the risk of injury to patients and create a positive safety culture; and,
- Maintain vigilance to ensure that a safe environment continues and a positive safety cultures are maintained.

The key words or phrases here are risk, adverse events, no-harm events, near miss, and detection.

Risk is the possibility/probability of occurrence or recurrence of an event multiplied by the severity of the event. Hazard is anything that can cause harm. An event is a deviation in an activity or technology that leads towards an unwanted, negative consequence. Events can be classified in three different categories.

An adverse event is an occurrence during clinical care which results in physical or psychological injury or harm to a patient or harm to the mission of the organization. A no-harm event is an event that has occurred but resulted in no actual harm although the potential for harm may have been present. Lack of harm may be due to the robust nature of human physiology or pure luck. An example of such a no-harm event would be the issuing of an incompatible unit of blood for a patient but the unit was not transfused and was returned to the blood bank.

A near miss is an event in which the unwanted consequences were prevented because there was a recovery by identification and correction of the failure, either planned or unplanned. Heinreich developed the iceberg concept of accidents and errors. The part of the iceberg above the water represents events that cause major harm; below the water are no-harm events as well as near misses.



STRATEGIES FOR IMPROVING PATIENT SAFETY

The overall goal of reducing medical errors and improving quality and patient safety is an overall DHHS goal that is shared among AHRQ and all other DHHS agencies. AHRQ's research contribution focuses on creating basic knowledge and evaluating the strength of existing evidence which provides information that can be turned into actions by those who make clinical decisions, purchasers and providers who make decisions about what services to use, pay for and how to structure those services, as well as by public policy makers.

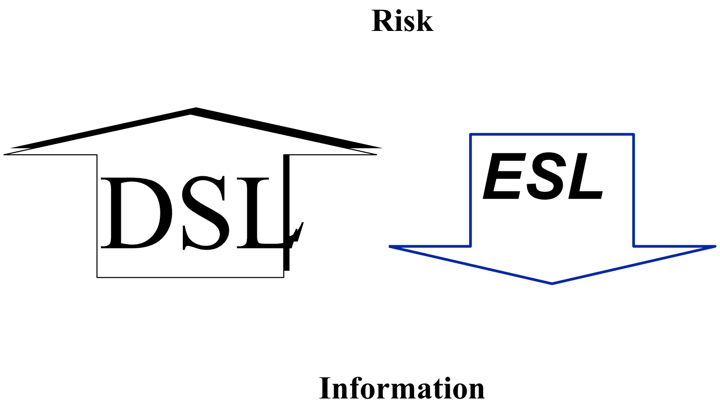
In cooperation with other DHHS agencies AHRQ will seek to improve the quality healthcare and reduce medical errors by: 1) accelerating the implementation of existing quality measures and safety practices; 2) developing capacity and new practices for quality and safety Improvements; and, 3) detecting safety hazards and monitoring improvements in healthcare safety and quality.

The Agency believes the best way to approach improving patient safety is through an integrated set of activities to design and test best practices for reducing errors in multiple settings of care; develop the science base to inform these efforts, as well as to improve provider training in the reduction of errors; capitalize on the advances in information technology to translate proven effective strategies into widespread practice; and, build the capacity to further reduce errors in the future. AHRQ's goal of improving the quality and safety of the healthcare that Americans receive cannot be achieved in a single year but must follow a systematic progression of activities over a number of years.

In FY 2004, activities will build on the progress made in FYs 2002 and 2003 and activities directed at stage two of the medical error "epidemic" will be added to the AHRQ portfolio with a primary focus on minimizing the risk of preventable injuries.

Detecting Safety Hazards and Monitoring Improvement in Safety and Quality

Detection is the first step in error management. From an organizational point of view it is important that error detection rate be high because errors that are not detected can have disastrous consequences. Thus one of the goals of error management is to increase detection and reporting rates to decrease risk of harm to patients. Detection Sensitivity Level (DSL) is the number of events reported to an organization. High reporting rates indicate a high DSL while few events reported indicates a low DSL. To achieve a high DSL an organization must eliminate impediments to reporting. Event Severity Level (ESL) is the level risk of the events reported. Over time the event severity level should go down as an indicator of successful error management while the detection sensitivity level (DSL) remains high. DSL represents information while ESL represents risk.



Developing a system that will consistently and reliably identify potential hazards to patient safety will require developing a national system of patient safety reporting and monitoring. For example, existing data collection mechanisms, if properly coordinated and standardized, could provide a powerful national asset as an early warning system for patient safety hazards providing pooled data for analysis to develop solutions to patient safety problems and for tracking progress in patient safety.

In addition, a successful monitoring system will require a direct investment in IT infrastructure and enhancements to improve safety monitoring. Health care is well behind other industries in harnessing the potential of information technology. Developing the healthcare IT infrastructure is key to monitoring the improvements in patient safety. The development of options and information to support investments in IT infrastructure, including cooperative agreements to encourage IT investment and develop national models of IT infrastructure.

Finally, developing data standards and vocabulary to ensure that patient safety information can be pooled, analyzed, and used to identify hazards and safety practices will be essential. The lack of standardized coding and language could result in a healthcare information system “Tower of Babel”. This initiative, in conjunction with the Department’s other agencies, will strive toward the development of patient safety information standards, development of voluntary consensus on those standards and incorporation of those standards into existing Departmental databases.

Accelerate the Implementation of Existing Patient Safety Practices

In July 2001, the Agency released a report, entitled "Making Health Care Safer: A Critical Analysis of Patient Safety Practices," which examined the evidence supporting 79 promising safety interventions. Many of these proven lifesaving interventions, such as the use of medications to reduce the risk of heart attacks and infections in surgical patients, are not consistently implemented.

Key to developing and implementing this strategy will be implementing local safety improvement priorities and improving the information available to the public on patient safety. Healthcare organizations and systems must be challenged to implement proven patient safety practices. Participating organizations and systems should be encouraged to develop their own practice implementation practices from those identified in the Agency's FY 2001 report and will be provided funding to facilitate the system's investment in implementing those practices. Finally, these organizations and systems will be required to generate information on the barriers faced in implementing the practices as well as measure the impact of the intervention on patient safety. Cooperative agreements will include a provision to make continued funding of the program contingent upon a demonstrated ability to implement the identified priorities and measure their impact.

In addition, in order to improve the information available to the public on patient safety the Agency will use CAHPS® to provide information about patient's experience of care; to improve the relevance of systems-based information on patient safety for the public; support value-based purchasing initiatives; and, to develop mechanisms for public reporting on evidence-based safety interventions.

Developing Capacity and New Practices for Safety Improvement

The Agency's July 2001 report on patient safety interventions identified a number of promising interventions for which more effectiveness evidence is required prior to general implementation. Many potential patient safety practices drawn primarily from non-medical fields, such as the use of simulators, bar coding, "swipe" technology, and crew resource management, require additional study to clarify their value in the health care environment. The success of this strategy will depend on the continuing development and evaluation of new safety interventions, improving local patient safety infrastructure and capacity, and developing reliable information for purchasers and the public to support wise decision-making.

PROGRAM PERFORMANCE ANALYSIS

Help for Patients and Consumers of Health Care

Americans are demanding greater value and quality in their health care. To achieve these goals in today's rapidly changing health care environment, consumers need solid, reliable information to help them choose among health care plans, practitioners and facilities, and to participate more actively in their personal health care decisions. AHRQ plays a unique role in helping to provide the information consumers need and want. In FY 2002 AHRQ has continued to build on previous successes. For example:

CAHPS and Small Business Innovation Research Award

The State of Washington's Health Care Authority is using a decision support tool originally developed through an AHRQ grant that incorporates CAHPS® (among other data) to help state employees and retirees choose among health plans. The tool was developed as *Health Plan Select*, however, as customized by Washington State, is called *Compare-A-Plan*.

Because the volume of information about health plans can be confusing, the tool is intended to help consumers learn about their health plan choices then compare and choose a plan. To accomplish this, the Web-based tool integrates price, benefits, physician choice and health plan performance measures such as CAHPS and HEDIS. Beginning with the state's fall open enrollment period in late October 2001, *Compare-A-Plan* will be on the Washington State government's Web site.

- AHRQ and CMS collaborated with the CAHPS® consortium to develop a Medicare CAHPS Disenrollee Survey of beneficiaries enrolled in managed care plans that was fielded by CMS in FY 2000. Approximately 80 percent of this survey related to quality. By obtaining the reason for disenrollment, it is possible to distinguish between those that are unrelated to quality (e.g., moving out of the area that the plan serves) and those that are related to quality (e.g., limited access to specialists).

- In collaboration with the California Health Care Foundation and the Pacific Group on Health, a version of CAHPS® has been developed to assess care provided at the group practice level. This is in response to strong consumer interest in more detailed information about the ability of physicians in group practices to provide quality care. In CAHPS® II, AHRQ will work on the development of reports to convey survey results to consumers as well as to the group practices assessed. An additional goal is to develop strategies for working with physicians to improve areas that consumers identify as troublesome.

- A partnership between the CAHPS® consortium and the Foundation for Accountability, with support from the David and Lucille Packard Foundation, has led to the development of a CAHPS® survey to identify children with special health care needs and collect additional information on the extent to which health plans are meeting their health care needs. This tool is already in use by numerous state Medicaid and SCHIP (State Children's Health Insurance Program) agencies to assist them in meeting the

Blue Cross of California and CAHPS

Shifting the focus from cost savings to improving quality, Blue Cross of California is changing its method of rewarding its physicians. Beginning January 1, 2002, the health plan will award bonuses to its HMO physicians and medical groups based on quality of care and patient satisfaction. The latter measure will be determined through the use of Consumer Assessment of Satisfaction (CAS) survey data, which has been derived from the AHRQ HMO CAHPS survey.

requirements set forth in the 1997 Balanced Budget Act. Also, the NCQA has included this survey as a requirement in the HEDIS reporting set.

Continuing to add to the family of CAHPS® surveys, CMS and AHRQ are also collaborating on the development of a CAHPS® survey to obtain consumers' assessments of health and services received in nursing homes. The data, collected from nursing home residents and next of kin, will be used to help persons choose a nursing home.

AHRQ is proud of the two-pronged approach taken in its patient safety work. The approach allows the Agency to focus on building the science while translating the results of previously funded research into practice. AHRQ has been funding projects in patient safety for a number of years. Building on previous work, the $50 million dollar investment AHRQ made in FY 2001 in patient safety research went to fund a variety of projects, many of which were new research initiatives. While many of these new projects are expected to take three years to compete, the results of previous investments are now being incorporated into practice. Research results are being used in a number of ways including:

- The web address www.qtdrugs.org is a unique educational and research tool developed by AHRQ's CERT located at the University of Arizona Health Sciences Center. This site currently contains a list of 72 drugs that can sometimes cause life threatening abnormalities in heartbeats or arrhythmia. Caregivers around the world can use this site to look up specific drugs that might pose a risk to their patients and submit clinical cases of drug-induced arrythmias to the registry. Researchers are using the information submitted to develop profiles of people most at risk for drug-induced arrythmias and to develop a genetic test that can identify them at advance.
- Patients and their families can use new consumer tip sheet, available in English and Spanish, to play a more active role in ensuring that they get the best health care possible and to help Americans from falling victim to medical errors.
- Health care administrators and others now have information about 73 patient safety practices that are likely to improve patient safety and 11 practices which have been highly proven to work but are not performed routinely in the nation's hospitals and nursing homes. For example, Voluntary Hospitals of America and Premier, Inc. has used this report to guide their member hospitals in selecting projects to improve safety.
- To help patients consider the safety of their care, AHRQ worked with CMS and other organizations to support the work of the National Quality Forum, a voluntary consensus standard setting organization, to develop a list of events that were so significant and so preventable that their occurrence should trigger an investigation of the safety practices of the organization in which they occurred. An example of such an event is surgery on the wrong site. This list is now completed and available to the public.

New Analysis Confirms a Direct Link Between Nurse Staffing and Patient Complications and Deaths in Hospitals

Analysis of data on nurse staffing levels confirms that there is a direct link between the number of registered nurses and the hours they spend with patients and whether patients develop a number of serious complications or die while in the hospital. Funded by the HRQ, investigators reexamined and refined their previous analysis released by the Health Resources and Services Administration (HRSA) in April 2001 as part of an ongoing collaboration within the Department of Health and Human Services to improve nursing care in American hospitals.

Among other things, the study found that:

- Lower staffing levels of RNs among a hospital's nurses were associated with rates of serious complications such as pneumonia, upper gastrointestinal bleeding, shock, and cardiac arrest, including deaths among patients with these three complications, as well as sepsis or deep vein thrombosis. These complications occurred three to nine percent more often than in hospitals with higher RN staffing.
- Rates for urinary tract infections, a less serious but common infection among hospital patients, and length of time spent in the hospital were also higher in hospitals with lower RN staffing.
- Low RN staffing at hospitals makes it more likely that some patients will suffer pneumonia, shock and cardiac arrest, and gastrointestinal bleeding, and that some patient may die as a result.

LONG TERM GOALS AND FY2004 TARGETS

The following goals represent AHRQ's view of the future. Success is contingent upon adequate funding.

Long Term Performance Goal	FY2004 Targets
By 2010, at least 5 organizations will use HCUP databases, products or tools to improve health care quality for their constituencies by 10%, as defined by the AHRQ quality Indicators Baseline: FY '00 – quality indicators developed	**FY04** Two new organizational users of HCUP will develop interventions using HCUP QI's and one organizational user will implement an intervention based on the QI's
By 2008, CAHPS® data will be more easily available to the user community and the number of consumers who use information from CAHPS® to make choices about their healthcare will increase by 20%. (Baseline FY 2002)	**FY04** Produce a CAHPS® module for consumer assessments of hospital quality Establish baseline for number of consumers using Nursing Home CAHPS
By 2010, evidence, translation tools and implementation strategies exist for improving the overall quality and safety of health of the American public so that:	**FY04**
• By 2010, reduce to 105,613 admissions, the rate of hospitalizations for pediatric asthma in persons under age 18.	• 5% decrease over baseline
• By 2010, reduce to 520,441 the number of immunization-preventable pneumonia hospital admissions of persons aged 65 and older.	• 5% decrease over baseline
• By 2010, reduce to 11,570 the number of immunization-preventable influenza hospital admissions of persons aged 65 and older.	• 5% decrease over baseline
• By 2010, reduce to 500 per live births the number of premature babies who develop Respiratory Distress Syndrome (RDS).	• 5% decrease over baseline
By 2006, six national message format and clinical vocabulary standards would be identified/recommended by HHS as ready for voluntary adoption and deployment.	3 message format and clinical vocabulary standards will be recommended by HHS as ready for voluntary adoption and

	deployment
By 2008 nursing homes will have evidence-based information needed to make informed purchasing strategies related to IT	5 technologies currently shown to be effective in other clinical settings will be tested in nursing homes to evaluate the impact on safety, quality and cost of care

FY2004 PERFORMANCE GOALS AND TARGETS

FY2004 Performance Goal	FY2004 Targets
Report on national trends in health care quality	Report on progress in core measure set. Identify private sector data to be used in future reports.
By 2004, 6 health facilities or regional initiatives to implement interventions and service models on patient safety improvements will be in place	6 Teams will be in place
By 2004 at least 10 states or major health care systems will have on-site Patient Safety Improvement Corp (PSIC) staff in place	10 States or major health care systems will have on site experts in Patient Safety
Identify the number and types of adverse events, no-harm events, and near miss events reported in demonstration projects	Report on the number and types of adverse events

2.1.2 Performance Goal 2: To develop the evidence base for policy makers and health systems to use in making decisions about what services to pay for, how to structure those services, and how those services are accessed.

PROGRAM DESCRIPTION AND CONTEXT

Adequate access to health care services continues to be a challenge for many Americans. This is particularly true for the poor, the uninsured, and members of minority groups, and rural residents. In addition, the changing organization and financing of care has raised new questions about access to a range of health services including emergency and specialty care. At the same time examples of inappropriate care, including over utilization and misuse of services, continue to be documented. Through ongoing development of nationally representative and more specialized databases, the production of public-use data products, and research and analyses conducted by AHRQ staff, the Agency addresses critical policy issues pertaining to the access, cost and use of health care.

Research related to the effects of payment and organizational structures and processes on the cost, quality and equity of health care services are essential components of this research initiative. Research results are intended to: 1) improve clinical practice; 2) improve the health care system's ability to provide access to and deliver high quality, high-value health care; and, 3) provide policymakers with the ability to assess the impact of payment and organizational changes on outcomes, quality, access, cost, and use of health care services.

Responding to the IOM report, "Crossing the Quality Chasm," AHRQ will fund applications that provide rigorous, objective, and essential evidence required by public and private decision-makers seeking to understand and improve the health care system, to make changes in health care delivery, insurance, and financing, and to manage the system in a manner that would induce efficient, effective, equitable, accessible and timely health care.

Important issues to be addressed by such research include:
1) How do different payment methodologies and financial incentives within the health care system affect health care quality, costs, and access?
   a) How do payment methodologies affect the behavior of health care organizations and individual providers?
   b) Which payment arrangements among patients, providers, and health plans enhance patient-centered knowledge of and involvement with treatment regimens?
   c) How do payment policies affect decisions about the purchase and selection of health services and health insurance?
   d) What is the role of quality in such decisions?
   e) What are the effects of such decisions on health care costs?

2) What has been the impact of purchaser and public sector initiatives on quality, costs, and access to health care and health insurance? Of particular interest is the impact of

employer and coalition efforts on the quality and cost-effectiveness of care in the marketplace, the impact of state efforts to monitor and improve access and quality and the impact of public and private payment changes on access to health care and to health insurance for vulnerable populations.

3) What organizational structures and processes are most likely to sustain high-quality, efficient, effective, timely, and accessible health care?

4) How do different patterns and levels of market competition affect the quality and cost of care?

In addition, AHRQ will fund projects in basic methodological work to support such research, including: development of payment methodologies; improvements in analytical and empirical methods required to simultaneously address issues of efficiency, quality, and equity; and, improvement in data collection methods and qualitative methods needed to understand the structure of new health care organizations and an evolving health care system.

STRATEGIES TO IMPROVE ACCESS, FOSTER APPROPRIATE USE AND REDUCE UNNECESSARY EXPENDITURES

Excellence Centers to Eliminate Ethnic/Racial Disparities

The health of Americans has improved over the past few decades, but not all Americans have benefited equally. Many ethnic and racial groups have not shared in the advances in health outcomes and health care. To understand the causes and factors of these inequalities, AHRQ in September 2000 awarded grants to nine centers to conduct a series of related studies. Now known as "Excellence Centers to Eliminate Ethnic/Racial Disparities" (EXCEED), the grants bring together teams of both new and experienced investigators in a five-year effort to analyze underlying causes and contributing factors for racial and ethnic disparities in health care and to identify and implement strategies for reducing and eliminating them. The centers of excellence approach enables an assembly of a critical mass of investigators to address a group of projects linked by a central theme, such as communication or cultural competency. In addition, the centers are able to train new investigators with an interest in minority health services research.

The EXCEED program joins a series of AHRQ initiatives aimed at improving the health and health care of priority populations and eliminating racial and ethnic disparities in health outcomes and in health care access and service delivery. AHRQ expects that lessons learned from understanding and eliminating racial and ethnic disparities in health and health care as well as the practical tools and strategies to eliminate these disparities would be generalizable beyond the communities studied. By focusing on the attributes of the ethnic and racial groups, the underlying etiologies for the disparities, and components and conditions of interventions to eliminate the disparities, these projects should produce findings that are widely applicable for minority as well as majority populations across the county.

Integrated Delivery System Research Networks

The Integrated Delivery System Research Networks (IDSRN) is a new model of field-based research that links the nation's top researchers with some of the largest health care systems to conduct research on cutting edge issues in health care on an accelerated timetable.

The IDSRN was developed explicitly by AHRQ to capitalize on the research capacity of, and research opportunities occurring within, integrated delivery systems. The network creates, supports, and disseminates scientific evidence about what works and what does not regarding measurement systems and organizational "best practices" related to care delivery and research diffusion. It also provides a cadre of delivery-affiliated researchers and sites to test ways to adapt and apply existing knowledge.

As a group, the IDSRN provides health services in a wide variety of organizational care settings to over 34 million Americans, including the privately insured, Medicare and Medicaid patients, the uninsured, ethnic and racial minorities, and rural and inner-city residents. Moreover, each of the nine IDSRN partners have the following three unique attributes that make it particularly well suited for conducting time-sensitive research:

- Available Data: each of the IDSRN partners collect and maintain administrative, claims, encounter and other data on large populations that are clinically, demographically and geographically diverse.
- Research Experience: IDSRN partners include some of the country's leading health services researchers with expertise in quantitative and qualitative methodologies as well as first hand knowledge of emerging issue areas which have critical policy or managerial implications.
- Management authority to implement health care interventions: IDSRN partners have responsibility for managing delivery systems and are in a position to implement financial and organizations strategies, e.g., selective contracting with physicians and hospitals for specific approaches to diffuse clinical guidelines within the system.

Primary Care Based Research Networks

Over the past decade, Primary Care Based Research Networks (PBRNs) have emerged as a promising approach to the scientific study of primary care. A PBRN is a group of ambulatory practices devoted principally to the primary care of patients, affiliated with each other, and often with an academic or professional organization, in order to investigate questions related to community-based practice. Typically, PBRNs draw on the experience and insight of practicing clinicians to identify and frame research questions whose answers can improve the practice of primary care. By linking these questions with rigorous research methods, the PBRN can produce research findings that are immediately relevant to the clinician and, in theory, more easily assimilated into everyday practice. In addition, data is readily available which will provide useful information on who receives care, where and how often.

In September 2001, 18 PBRN networks were awarded continuation grants (cooperative agreements) to conduct network-defining surveys, using standardized instruments. The surveys will provide baseline data on the clinicians enrolled in each network, the services provided, and the characteristics of patients receiving those services. Potential uses of the data include practice benchmarking and guiding the selection and design of specific PBRN research projects. Four of the networks were awarded additional funds to pilot test and evaluate electronic methods of collecting and aggregating practice-derived research data. Two networks were awarded additional funds to assess clinician and patient knowledge and attitudes about protecting the privacy and confidentiality of research data.

AHRQ's overall goal is to improve the capacity of PBRNs to expand the primary care knowledge base and to establish mechanisms that will assure that new knowledge is incorporated into actual practice and its impact is assessed.

HIV Research Network

As new HIV/AIDS therapies become available, policymakers require reliable information about the type and costs of the health care services persons with HIV disease are receiving – such that informed resource-allocation decisions can be made. The HIV Cost and Services Utilization Study (HCSUS) is the first major research effort to collect information on a nationally representative sample of people receiving HIV care. HCSUS is examining costs of care, utilization of services, access to care, quality of care, quality of life, unmet needs for medical and non-medical services, social support, satisfaction with medical care, and knowledge of HIV therapies.

HCSUS is composed of a core study and several supplemental studies. The core study has enrolled a national sample of 2,864 HIV-infected adults who were receiving ongoing or regular medical care in the first 2 months of 1996. Respondents were sampled from 28 urban areas and 24 clusters of rural counties in the US. Patients receiving services in hospitals, clinics, and private practice settings were enrolled. HCSUS over-sampled women and members of staff model health maintenance organizations to obtain more precise information on these specific populations. Supplemental studies are examining HIV care delivery in rural areas, prevalence of mental and substance abuse disorders, oral health of HIV-positive individuals, and issues related to HIV-infected persons over 50 years of age. A consortium of private and government institutions are conducting HCSUS. Local and national advisory groups have been established to facilitate communication between the HIV community and the research consortium.

The HIV Network goal is to provide timely and relevant information to policymakers about the resources utilized to treat persons with HIV. It is important to obtain timely data because quickly occurring therapeutic advances, the shifting epidemiology of HIV infection, and the rapid diffusion of managed care are having a major effect on patterns of health care resource utilization for HIV. Nearly $9 billion was spent in 2002 by Medicaid, Medicare, the Department of Veterans Affairs, and the Ryan White CARE Act to treat those with HIV.

Healthcare Cost and Utilization Project

The unprecedented volume and pace of change in the US health care system and the non-uniform changes that are occurring across the country require a new information paradigm that is scientifically sound for use at the national, regional, and state levels.

The Healthcare Cost and Utilization Project (HCUP) is a federal-state-industry partnership to build a standardized, multi-state health data system that is made available to the public. Maintained by AHRQ, HCUP comprises a family of administrative longitudinal databases—including state-specific hospital-discharge databases and a national sample of discharges from community hospitals—and powerful, user-friendly software that can be used with both HCUP data and with other administrative databases.

HCUP databases fill a unique niche and are increasingly being tapped by analysts and researchers interested in hospital utilization, access, charges, quality, and outcomes. The data are used to: describe patterns of care for uncommon as well as common diseases; analyze hospital procedures; and, study the care of population subgroups such as minorities, children, women, and the uninsured. Researchers and policymakers use HCUP data to identify, track, analyze, and compare trends at the national, regional, and state levels.

FY2004 PERFORMANCE GOALS AND TARGETS

Performance Goal	FY2004 Targets
Increase the number of partners contributing data to the HCUP databases by 5% above FY2000 baseline	5% increase over FY00 baseline

2.1.3 Performance Goal 3: To build the capacity for improving the Quality of Health Care Delivery through Research and Training

PROGRAM DESCRIPTION AND CONTEXT

Today's health environment continues to change rapidly. Consolidation of health plans, movement of patients and providers into managed care settings, efforts to contain rising health care costs, fears that cost containment measures will lower the quality of care, and persistent problems in access to care and health insurance coverage for many Americans are issues of great concern.

Public and private purchasers are experimenting with new, untested financing strategies, organizational arrangements and delivery approaches. Health plans and providers are seeking to measure and improve the effectiveness and cost-effectiveness of the care they purchase or provide.

Decision-makers at all levels in the health care system rely on this critical knowledge to inform effective choices. For example:

- Purchasers are looking for value, for high-quality care at a reasonable cost.
- Patients and caregivers want to make informed decisions about preventive and other primary care services, treatments, providers, and health care plans.
- Clinicians need information to make the best possible decisions for and with their patients.
- Health plans need information to determine which services to cover.
- Institutional providers (hospitals, groups, systems of care, et al.) need information to make decisions.
- Policymakers need to understand the ramifications of available policy options.

Health services research addresses these issues by providing information to help people make decisions at the clinical, system and policy levels. Ensuring this requires an adequate number of highly qualified research scholars. AHRQ therefore continues its commitment to support the education of future research leaders through a variety of research and institutional training programs.

STRATEGIES TO IMPROVE THE QUALITY OF HEALTH CARE DELIVERY THROUGH RESEARCH AND TRAINING

National Research Service Awards

AHRQ supports 24 US academic institutions that offer advanced health services research training. These programs provide tuition support and stipends to qualified pre-doctoral and postdoctoral students.

Dissertation Research Grants

Dissertation research funding is available for students conducting doctoral-level research on some aspect of the health care system. These grant awards are often the first step toward establishing a career in health services research.

Career Development Awards

AHRQ began to support career development activities in FY 2000. These awards, provided to individuals embarking on a research career, allow individuals time and resources to gain experience in carrying out actual research. The intent is to provide transitional support for newly-trained investigators in order to launch them on research careers. This program supports two career development programs:

- Mentored Clinical Scientist Development Award (K08) in Health Services Research. This research award provides support for the development of outstanding clinician research scientists with a focus on development as an independent scientist.
- Independent Scientist Award (K02) in Health Services Research. The K02 provides support for newly-independent investigators with a clinical or research doctoral degree.

Minority Research Infrastructure Support Program

AHRQ is committed to the Department's Initiative to Eliminate Racial and Ethnic Disparities in Health and the complementary Healthy People 2010 Goal to eliminate disparities in health. A critical component in achieving these goals is to expand the nation's health workforce to be more diverse and representative of the racial and ethnic populations.

In FY 2001, AHRQ launched the Minority Research Infrastructure Support Program (M-RISP). The goals of the M-RISP program are to increase the number of minority health services researchers and to build capacity for institutions to conduct health services research intended to improve health for racial and ethnic minorities.

Building Research Infrastructure & Capacity Program (BRIC)

In order to build research capacity in states that have not traditionally been involved in health service research, the Building Research Infrastructure & Capacity Program (BRIC), funds four two-year planning grants to pilot test the feasibility of developing a new program to broaden the geographic distribution of AHRQ funding and enhance the competitiveness for research funding of institutions located in states that have a low success rate for grant applications from AHRQ. These grants will stimulate sustainable improvements in capacity and/or multi-disciplinary centers supporting investigators and multiple research projects with a thematic focus.

PROGRAM PERFORMANCE ANALYSIS

Developing the Evidence Base for Policy Makers and Health Systems to Use in Making Decisions About What Services to Pay for, How to structure Those Services, And How Those Services Are Accessed.

Women with Pelvic Inflammatory Disease Treated as Outpatients Have Long Term Outcomes Comparable to Those Treated as Inpatients

Women with mild to moderate pelvic inflammatory disease (PID)—a leading cause of infertility—who are treated as outpatients have recovery and reproductive outcomes similar to those for women treated in hospitals. Each year, about 1.2 million women are treated for PID, a sexually transmitted disease that causes infection and inflammation of all or some of the pelvic organs. Untreated, it can cause chronic pelvic pain, ectopic pregnancy, and infertility. Over 100,000 women with PID are hospitalized each year, and about 15 percent of them have acute and serious versions of the disease that require intensive inpatient treatment. But for approximately 85,000 women with mild or moderate PID, who currently are being hospitalized, treating them as outpatients may save approximately $500 million each year.

New Case Study Indicates that Mental Health Parity Did Not Raise Costs for a Large Employer Who Used a Managed Care Arrangement

Using a managed care "carve-out" arrangement to provide equal coverage for mental health services did not raise costs for one large employer. Researchers examined the impact of a state's mental health parity mandate on a large employer group that simultaneously implemented a managed care "carve-out" for its mental health and substance abuse benefits. Carve-outs are services provided within a standard health benefit package but delivered and managed by a separate organization. The researchers, compared plan costs, use patterns and access in the one year prior to the changes with the three years following the changes.

Although the number of people treated for mental health problems increased nearly 50 percent, the costs to the plan for mental health services declined by almost 40 percent over the four-year study period. Costs for employees and spouses together remained flat over the study period while costs for children and adolescents declined by 64 percent. Most of this decline was due to reducing the lengths of stay for inpatient mental health treatment. Managed care did not limit access to outpatient treatment; there was nearly a 50 percent increase in the number of people using outpatient treatment with no change in the average number of visits.

Black and Hispanic HIV Patients Are Less Likely to Get Experimental Medications

A nationwide study sponsored by AHRQ showed that black and Hispanic HIV patients are only about half as likely as non-Hispanic whites to participate in clinical trials of new medications designed to slow the progression of the disease. Together, blacks and Hispanics comprise roughly 48 percent of the HIV patient population: 33 percent and 15 percent respectively.

Black and Hispanic patients' limited attempts to obtain experimental HIV medications may reflect lack of awareness of clinical trials in minority communities, as well as suspicion and distrust of trials and researchers. Black patients were less than half as likely as white non-Hispanic patients to try to obtain an experimental HIV medication. Findings suggest that to boost minority participation in trials, structural barriers such as research-entry criteria, enrollment and tracking procedures, and study center operations, as well as clinical researchers' attitudes and practices need to be examined. Other factors contributing to a reduced likelihood of participation in a clinical trial were having less than a high school education, being in a commercial HMO, and receiving primary care eight miles or more from where the clinical trial was held.

FY2004 PERFORMANCE GOALS AND TARGETS

Performance Goal	FY2004 Targets
Increase the number of minority researchers trained as health services researchers by 5% annually	5% increase over FY03 baseline
Support training programs for junior-level researchers and mid-career scientists	Maintain baseline

BUDGET LINE 2.2
Medical Expenditure Panel Surveys (MEPS)

Funding Levels:	FY 2002	$48,500,000 (Actual)
	FY 2003	$53,300,000 (President's Budget)
	FY 2004	$55,300,000 (Request)

2.2.1 Performance Goal 4: To Provide Comprehensive, Relevant and Timely Data on Health Care Use and Expenditures for Use by Public and Private Sector Decision Makers and Researchers

PROGRAM DESCRIPTION AND CONTEXT

MEPS is designed to provide policymakers, health care administrators, businesses, and others with continual, timely, comprehensive information about health care use and costs in the US and to improve the accuracy of their economic projections.

MEPS collects data on the specific health services that Americans use, how frequently they use them, the cost of these services and how they are paid for, as well as data on the cost, scope, and breadth of private health insurance held by and available to the US population.

MEPS is unparalleled for the degree of detail in its data, as well as its ability to link data on health services spending and health insurance to the demographic, employment, economic, health status, and other characteristics of survey respondents. Moreover, MEPS is the only national survey that provides a foundation for estimating the impact of changes in sources of payment and insurance coverage on different economic groups or special populations of interest, such as the poor, elderly, families, veterans, the uninsured, and racial and ethnic minorities.

MEPS is designed to help understand how the dramatic growth of managed care, changes in private health insurance, and other dynamics of today's market-driven health care delivery system have affected and are likely to affect the kinds, amounts, and costs of health care that Americans use. MEPS also is necessary for projecting who benefits from and who bears the cost of changes to existing health policy and the creation of new policies.

MEPS has been used by:

- CMS and other DHHS agencies, the Congressional Budget Office, the Office of Management and Budget, the Department of the Treasury, the Physician Payment Review Commission, Prospective Payment Assessment Commission, and other federal government agencies.
- The Heritage Foundation, Lewin-VHI, Urban Institute, RAND Corporation, Project Hope, and other foundations and think-tanks.

- Health insurance companies, pharmaceutical firms, health care consultants, and other health-related businesses.
- Academic institutions and individual researchers.

MEPS provides answers to hundreds of questions, including:

- How health care use and spending vary among different sectors of the population, such as the elderly, veterans, children, disabled persons, minorities, the poor, and the uninsured.
- How the health insurance of households varies by demographics, employment status and characteristics, geographic locale, and other factors.

MEPS also answers key questions about private health insurance costs and coverage, such as how employers' costs vary by region. The answers to these and other MEPS questions enable Congress, the federal government's executive branch, and other public- and private sector policymakers to:

- Make timely national estimates of individual and family health care use and spending, private and public health insurance coverage, and the availability, costs, and scope of private health insurance among Americans.
- Evaluate the growing impact of managed care and of enrollment in different types of managed care plans.
- Examine the effects of changes in how chronic care and disability are managed and financed.
- Assess the impact of changes in employer-supported health insurance.
- Evaluate the impact of changes in federal and state health care policies.
- Examine access to and the costs of health care for common diseases and conditions, prescription drug use, and other health care issues.

STRATEGIES TO IMPROVE INFORMATION AVAILABLE TO DECISION MAKERS:

Household Component (HC) of MEPS

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

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

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

Medical Provider Component (MPC) of MEPS

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

Insurance Component (IC) of MEPS

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

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

PROGRAM PERFORMANCE ANALYSIS

Developing the Evidence Base for Policy Makers and Health Systems to Use in Making Decisions About What Services to Pay For, How to Structure Those Services and How Those Services are Accessed

New National Survey Details Americans Experiences with Health Care Services

Recent MEPS data indicates that the slightly more than half of Americans age 18 and older (53.8 percent) who do not live in institutions or serve in the military always received urgent medical care as soon as they wanted it in calendar year 2000. While there was very little difference between blacks and whites aged 18 to 64 in their reports of timeliness of receiving urgent care, 51.5 percent and 52.9 percent respectively, only 41.2 percent of Hispanics reported always receiving urgent care when they wanted it.

Among those aged 18 to 64, people without insurance were more likely than those with coverage to report sometimes or never receiving urgent care as soon as they wanted (28.6 percent, uninsured; 19.1 percent, publicly insured; and 16.1 percent, privately insured).

The questions were taken from AHRQ's CAHPS® survey tool that assesses people's experiences with their own health plans. Respondents were asked about the timeliness in which they received urgent and routine medical care and they also were asked about their experiences during care. These measures will be included in the AHRQ National Quality Report due out in 2003.

Medication Use in Long Term Care

Using the MEPS institutional component data from 1996, AHRQ developed a national prescription drug file which will be useful to assess a broad set of issues related to drug prescribing in nursing homes. This file will enable studies of drug complications and outcome studies to determine the benefits and negative impacts of prescribing practices in nursing homes.

LONG TERM GOALS AND FY2004 TARGETS

The following goals represent AHRQ's view of the future. Success is contingent upon adequate funding.

Performance Goal	FY2004 Targets
By 2008, point in time data from the MEPS survey will be available within 12-Months after final data collection	Data available within 12 months after final data collection

FY2004 PERFORMANCE GOALS AND TARGETS

Performance Goal	FY2004 Targets
Insurance Component tables will be available within 7 months of collection	Tables available within 7 months after final data collection
MEPS Use and Demographic Files will be available 12 months after final data collection	Available 15 months after final data collection
Full Year Expenditure Data	Data available 12 months after final data collection

BUDGET LINE 2.3
Program Support

Funding Level:	FY 2002	$2,585,000 (Actual)
	FY 2003	$2,700,000 (President's Budget)
	FY 2004	$2,700,000 (Request)

2.3.1 Performance Goal 5: Maximize the Value of AHRQ by Developing Efficient and Responsive Business Processes, aligning Human Capital policies and practices with AHRQ's mission, and building an integrated and reliable information technology infrastructure.

PROGRAM DESCRIPTION AND CONTEXT

In FY 2000, AHRQ conducted an Agency-wide workforce and workload analysis that identified major work processes and functions, captured data on the competencies of the current workforce and estimated levels of future workforce capacities. In FY 2001, the Agency began following up on the 2000 Study in four areas: 1) a refinement and expansion of Agency work functions and activities that captures more detailed administrative and operational processes; 2) refinement of the staff competencies needed to perform the work of the Agency; 3) review of the Agency's recruitment and selection activities and processes in order to make recommendations for improvement; and, 4) the development of a multi-year strategy to systematically address the Agency's structure, technology and workforce related issues.

Developing Efficient and Responsive Business Processes

The Agency's five-year workforce restructuring plan, as approved by the Office of the Secretary, focuses on periodic analysis of the manner in which the Agency conducts its work and how well the existing structures, technology, and systems support this work.

- Develop and implement a plan for identifying, obtaining, storing and using programmatic and operations management and performance data to help inform resource allocation decisions.
- Prioritize established work processes and develop a plan to conduct business process reviews. These reviews will be designed to ensure that the following issues are addressed: Are there unnecessary managerial and organizational levels?; Is decision making authority appropriately delegated?; and, Do managers have sufficient authority to carry out their responsibilities and manage their programs?
- Initiate a business process review of the AHRQ grants process from conception of a grant announcement to tracking of publications coming from completed grants with the goal being to make this process more effective and efficient.

Strategic Management of Human Capital

In FY 2000, AHRQ estimated future workforce requirements based on projected workload, retirement, and attrition trends. In FY 2001, the Agency built on the outcomes of the 2000 Study by continuing to refine its workforce planning tools and conduct additional organizational assessments through four initiatives: 1) development of a more detailed model of the Agency's work that captures the administrative, operational, and programmatic functions and activities; 2) refinement of the core, technical, and leadership competencies needed to perform functions and activities outlined in the model of the Agency's work; 3) review of the Agency’s recruitment and selection processes to include recommendations for improvements; and, 4) development of a multi-year strategy designed to identify resources, tools, and information needed to meet the changing demands of their work as well as streamline costs.

The first initiative in FY 2001 involved the development of a detailed model of AHRQ's functions and activities to outline AHRQ's current work. The agency used this model as an assessment tool for such things as future workload analyses and assessment of gaps in work activities.

In the second initiative, the competencies identified in the Spring 2000 effort were refined and validated to create competency models based on the more detailed functions and activities model. These models assist the agency in recruiting, selection, training, development and performance assessment activities.

The third initiative, the recruiting and selection process assessment, benchmarking, and recommendations task, resulted in four primary recommendations for improving AHRQ's processes for recruiting and selecting new employees. These recommendations are currently being evaluated for implementation.

Building an Integrated and Reliable Information Technology Infrastructure

AHRQ is continuing to undertake a comprehensive review of its business processes and products. This will undoubtedly change how the Agency forwards its work daily as well as how information flows within the organization. This review will also redefine AHRQ’s information technology architecture so that not only does it meet multiple statutory requirements, such as GISRA and Clinger-Cohen but also so that it meets the management and organizational needs of the Agency. Evolving technologies, such as Web-based applications, provide opportunities for the Agency to accomplish work in new, more efficient and timely ways. The IT infrastructure developed must be adaptable to meet new requirements and while maintaining information security and critical infrastructure protections.

Developing Efficient and Responsive Business Processes

Since the creation of AHRQ by Congress in 1989, Agency has realized significant growth both in staffing and budget and has been given ever-increasing responsibilities with regard to conducting research that will lead to improvements in the quality, cost and financing, access, organization and delivery of healthcare to all Americans. The Agency has undergone a number of organizational changes during this time to reflect this growth and expanding mission.

The relative youth and size of AHRQ has allowed the Agency to develop and evolve in a carefully considered, systematic manner. The principals that have guided this growth include:

An organizational structure that stresses simplified, shared decision-making:

- Avoidance of redundancies;
- Clear lines of communication and authority;
- A clear emphasis on employee involvement in all Agency matters; and,
- Recognition of employee accomplishments and contributions.

The results of the application of these principals are clearly reflected in at least two ways:

- In the most recent two Department Human Resource Management Index surveys, AHRQ scored higher than any other OPDIV on employee organizational satisfaction in a variety of management areas.
- AHRQ is an essentially flat organization. There are no more than three management levels anywhere in the Agency, which allows for timely decision-making and simplified communications.

To complement the organizational efficiencies already realized, the organizational changes the Agency is undertaking are expected to achieve the following workforce restructuring objectives:

☑ Reduce the Number of Managers
☑ Reduce Organizational Levels
☑ Reduce Time Taken to Make Decisions
☑ Increase Span of Control
☑ Re-assign Staff to Mission-Critical Positions

Consistent with the Department's and OMB workforce restructuring goals, by the end of FY 2002, the Office of Management alone will abolish three Divisions (from 6 to 3, a 50% reduction) and reduce the number of administrative positions by twelve (from 53 to 41, a 22% reduction). The effects of FY 2002 agency-wide restructuring actions are summarized in a table on the following page.

Number of organizational units/levels to be eliminated: • Division of Human Resources Management, OM • Division of Information Technology Management, OM • Division of Grants Management, OM • Division of Research Policy, Coordination & Analysis, ORREP	4
Number of supervisory positions to be eliminated: • Deputy Director, Office of Management • Director, Division of Information Technology Management/OM • Director, Division of Human Resources Management/OM • Supervisory Human Resources Specialist/DHRM/OM • Director, Division of Grants Management • Supervisory Budget Analyst • Director, Division of Research Policy, Coordination & Analysis, ORREP	7

Number of administrative FTEs to be redeployed to support research program functions: • 8 FTEs which supported HR functions • 2 FTEs which supported grants business management functions • 1 Deputy Director, OM • 1 analyst which supported administrative services functions	12

The Agency's five-year restructuring plan, submitted to OMB in June 2001, focused on periodic analysis of the manner in which the Agency conducts its work and how well the existing structures, technology, and systems support this work. The Agency will eliminate any supervisory positions below the Division Director level and Deputy Director positions, (with the exception of the Agency Deputy Director,) will become incumbent only and will not be back-filled. The Agency is also reviewing its various administrative and operational support systems and, working closely with others in the Department, looking to consolidate these systems to promote efficiency and effectiveness. The Agency will also periodically assess the capacity of its workforce to meet its mission requirements. The plan is consistent with other management reform initiatives including making greater use of performance-based contracting and contracting with small and minority owned businesses, expanding the application of on-line procurement, and the Agency's recently submitted A-76 FAIR Act Report.

The Agency's Five Year Restructuring Plan is designed to address three strategic workforce goals:

1. Evaluation of Agency work processes and functions and refinement and/or consolidation of these functions and processes to promote efficiencies and effectiveness.
2. Acquisition, development, and maintenance of a talented, diverse workforce.
3. Development and maintenance of an Agency infrastructure conducive to maximum employee productivity and satisfaction.

Building an Integrated and Reliable Information Technology Infrastructure

In fiscal year 2002, AHRQ began development of an integrated e-Government program. The intent of this program is to increase gains in business performance. This is a particularly important priority since AHRQ carries out the MEPS program, an important and unique resource for public and private sector decision-makers. No other surveys, either federal or private sector, provide this level of detailed information on health care cost, use, and insurance coverage. Moreover, AHRQ is the lead agency in DHHS on patient safety efforts including the Patient Safety Task Force project to coordinate the integration of data collection on medical errors and adverse events. This project is to be carried out in conjunction with the Centers for Disease Control, the Food and Drug Administration and the Centers for Medicare and Medicaid Services. The major priorities are to integrate information and business processes across agency boundaries, share information more quickly, automate internal processes and work more efficiently with the commercial medical community, academic institutions and research bodies.

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

- Provide quality customer service and operations support to AHRQ's centers and offices;
- Ensure that AHRQ's IT initiatives are selected and managed to deliver quality solutions that contribute to the Agency's mission and objectives; and,
- Ensure AHRQ's IT initiatives are aligned with departmental and agency enterprise architectures.

In addition to the strategic goals in support of the agency mission, the IT services team's function is to support AHRQ business operations through the effective and efficient application of IT products and services. Accompanying this mission is the vision of providing timely access to reliable and secure information that supports the business operations of the Agency, serving as a model for best practices in IT management throughout HHS.

e-Government Implementation Approach[2]

The Agency has adopted a specific implementation model. This model takes a balanced approach to e-Government, based on four cornerstones (refer to figure 1, next page).

- Customer relationship management - AHRQ must constantly know who their customers are, what they want, and how to best meet their needs.
- Organizational capability - Prepare the organization for change by implementing controls to better manage specific e-Government initiatives. This includes implementing governance, rigorous IT capital planning processes and establishing a balanced portfolio of e-Government initiatives. Establishing this cornerstone is especially important, as this is the area where the overall utility of specific projects are assessed and the development of efforts is managed and implemented.
- Enterprise architecture - This area ensures the relationships between enterprise IT architecture and business operations are fashioned as a partnership. When these two essential elements work together, they act as a force multiplier for customer relationship management.
- Security/Privacy – Finally, customers must have trust in not only the business operations they participate in, but also the operations' supporting information technology. Customers must know that information is used only for its intended purpose and that the information is secure, stable and not vulnerable to intrusion.

With each area properly managed, supported by specific tasks performed under time definite goals and milestones, this framework ensures that AHRQ's e-Government implementation moves forward in a balanced, deliberate manner.

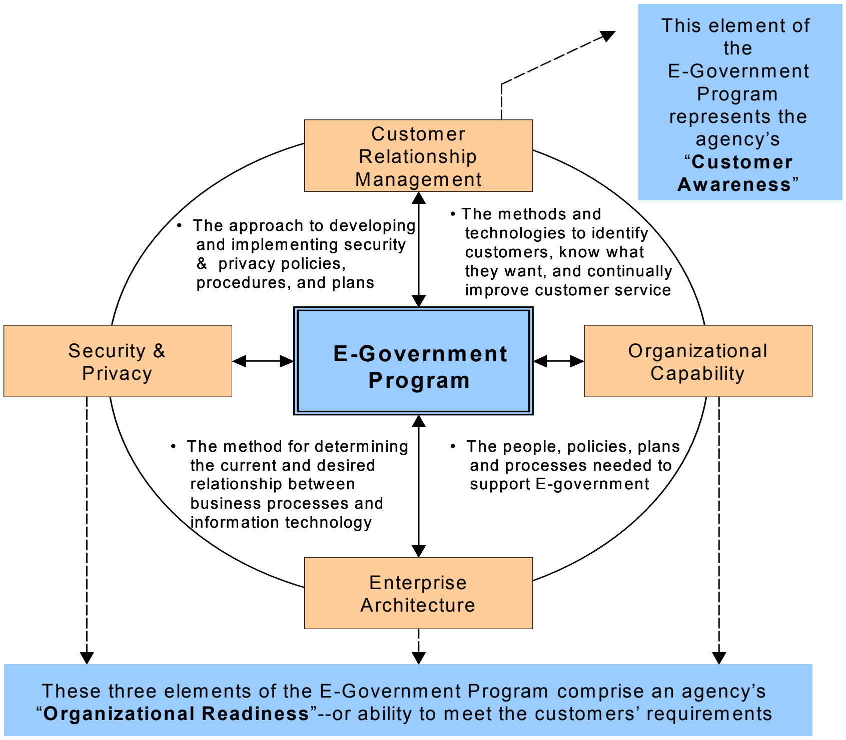


Figure 1

Integrating Budget and Performance Management

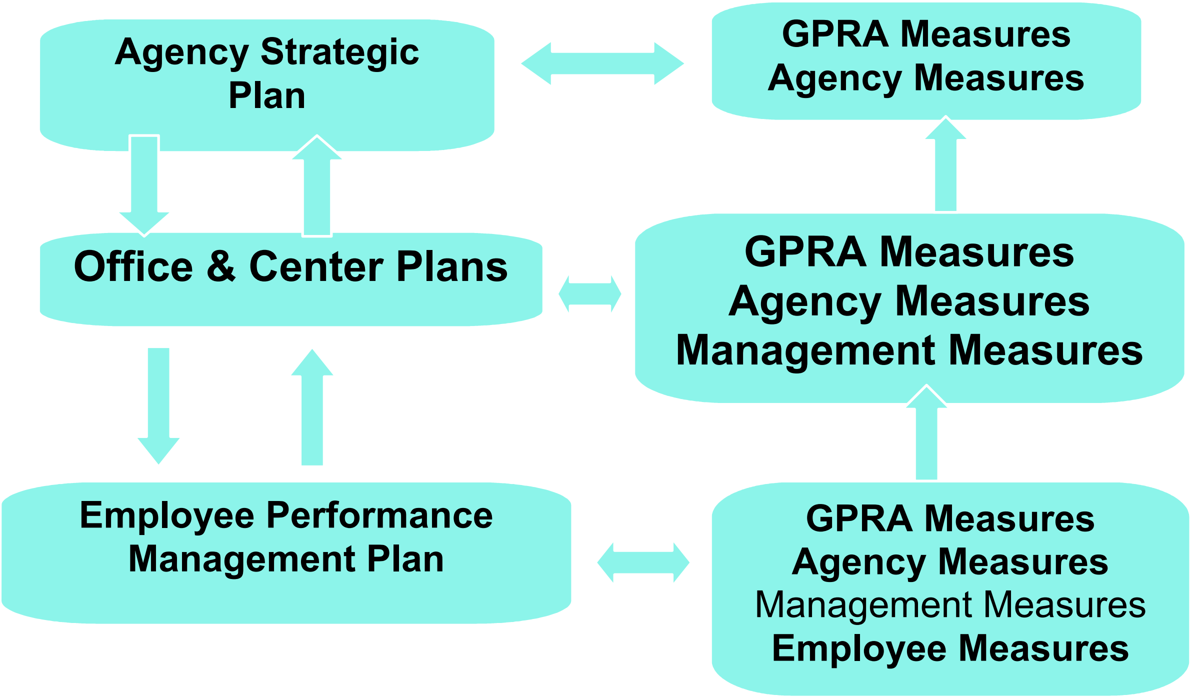
General program direction and budget and performance integration is accomplished through the collaboration of the Office of the Director (with its four administrative offices) and six research centers that have programmatic responsibility for portions of the Agency's research portfolio. The Agency links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

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

2. This model is based on concepts of the e-Government program first developed at the Department of Labor.

and their staffs review their accomplishments in relation to the annual operations plans and draft the next year's plans. The results of the reviews contribute significantly to the performance reports that are influential in revising the operations plans and in turn the Agency strategic plan.

Strategic Management at AHRQ



As a result of the increased emphasis on strategic planning, the Agency has shifted from a focus on output and process measurement to a focus on outcome measures. A detailed description of this progress can be found in the FY 2002 performance report and initial FY 2004 performance plan.

AHRQ's commitment to budget and performance integration is reflected not only in how programs are evaluated but also in the organizational structure of the Agency itself. In 2002, AHRQ reorganized it's management structure, aligning those who are responsible for budget formulation, execution and providing services and guidance in all aspects of financial management with those who are responsible for planning, performance measurement and evaluation within the Immediate Office of the Director.

Finally, AHRQ worked with the Office of Management and Budget (OMB) to complete comprehensive program assessments on four key programs within the Agency: The Medical Expenditure Panel Survey (MEPS); the Healthcare Cost and Utilization Project (HCUP); the Consumer Assessment of Healthcare Plans Survey (CAHPS®); and, the grant component of the Agency's Translation of Research into Practice (TRIP) program. These reviews provided 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.

FY2004 PERFORMANCE GOALS AND TARGETS

Performance Goals	FY 2004 Targets
-Human Capital	Develop a plan to recruit new or train existing staff to acquire skills necessary to fill identified gaps
-Expanded E-government	Complete implementation of the control review cycle Implement the evaluation cycle Integrate capital planning processes with enterprise architecture processes
Improve IT Security/Privacy	Continue risk assessments on AHRQ’s second tier systems Implement the business continuity and contingency program plans
Establish IT Enterprise Architecture	Develop the target architecture Create the migration plan Integrate enterprise architecture processes with capital planning processes
-Budget and Performance Integration	Implement planning system Complete initial PART reviews on all major agency programs

APPENDIX I

AHRQ Strategic Planning Framework

AHRQ Strategic Plan

The strategic plan will serve as the road map for AHRQ activities through 2002. The current plan was released in December 1998 after an extensive planning process and was made widely-available for comment. In 2001, AHRQ published its second "Request for Ideas" (RFI) soliciting ideas from the Agency's customers and the general public for priorities in the context of planning for the new strategic plan. In addition, the National Advisory Committee (NAC) to AHRQ is providing feedback to the agency and several NAC members have agreed to participate in an ad hoc advisory planning group.

AHRQ assesses the progress made toward achieving each of the goals as part of the annual planning and budget development process. These assessments are integral to AHRQ's compliance with the Government Performance and Results Act (GPRA) of 1993 and provide the backdrop against which the next year's activities are planned. The completion of the 2000 performance report provided valuable information to the Agency on progress toward strategic goals. Results have been used to gather new knowledge, improve research management and strengthen dissemination activities.

AHRQ has identified three strategic goals, each of which will contribute to improving the quality of health care for all Americans.

AHRQ Goal 1. Support Improvements in Health Outcomes

AHRQ seeks to support research to understand and improve decision-making at all levels of the health care system, the outcomes of health care and in particular what works for whom, when, and at what cost.

AHRQ Goal 2. Strengthen Quality Measurement and Improvement

AHRQ is interested in a broad array of research topics, including studies to develop valid and reliable measures of the process and outcomes of care, causation and prevention of errors in health care, strategies for incorporating measures of quality improvement into programs and dissemination and implementation of validated quality improvement mechanisms.

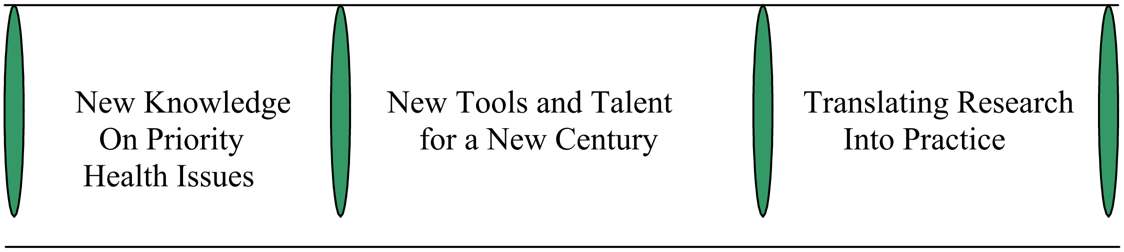
AHRQ Goal 3. Identify Strategies To Improve Access, Foster Appropriate Use, and Reduce Unnecessary Expenditures

AHRQ will focus on whether particular approaches to health care delivery and financing, or characteristics of the health care market, alter behaviors in ways that improve access and promote cost-effective use of health care resources.

Organization, Programs, Operations, and Strategies

The main focus of AHRQ research is on the delivery of health care and identifying ways to measure and improve it. Most of the Agency's research portfolio consists of extramurally funded work from leading universities and other research institutions throughout the nation. The portfolio also contains a body of intramural research. Issues related to the quality, cost and use of as well as access to health care are studied through extramural and intramural research. Extramural research is the primary source of studies on outcomes and effectiveness. AHRQ sponsored and conducted research measures the effectiveness of the services that deliver preventive, diagnostic, and therapeutic care, compares them with existing practice and evaluates the ability of the health care system to deliver them effectively. The Agency has an increasing focus on patient safety and the reduction in medical errors as well as research that will accelerate and magnify the impact of research on clinical practice and patient outcomes. Through the Translating Research Into Practice (TRIP) agenda, the Agency sponsors applied research to develop sustainable and replicable models and tools to improve the quality, outcomes, effectiveness, efficiency and cost effectiveness of health care.

The Research Pipeline



The AHRQ portfolio reflects a “pipeline” of activities that together build the infrastructure, tools, and knowledge for improvements in the American health care system. This pipeline begins with the funding of new research that answers important questions about what works in American health care (*New Knowledge on Priority Health Issues*).

The second section in the pipeline (*New Tools and Talent for a New Century*) is focused on more applied research and translates new knowledge into instruments for measurement, databases, informatics and other applications that can be used to assess and improve care.

The final section of the pipeline is where the first two investments come together by closing the gap between what we know and what we do *(Translating Research Into Practice*). AHRQ funds research and demonstrations to translate the knowledge and tools into measurable improvements in the care Americans receive.

AHRQ Audiences

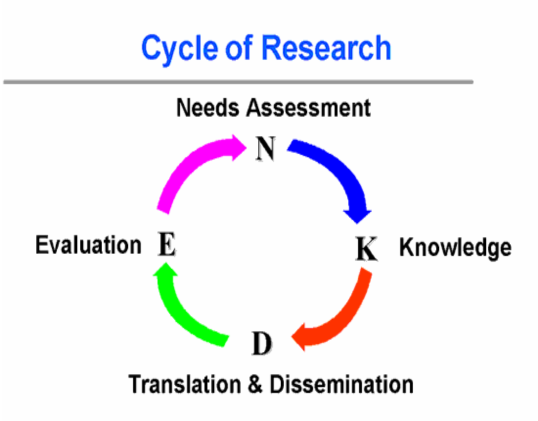
Agency activities begin and end with the end-users of Agency research. AHRQ customers require evidence-based information to inform health policy decisions. Health policy choices in this context represent three general levels of decision-making:

Clinical Decisions - Information is used every day by clinicians, consumers, patients and health care institutions to make choices about what works, for whom, when, and at what cost.

Health Care Organizations Policy Decisions - Health plan and system administrators, policymakers and purchasers are confronted daily by choices on how to improve the health care system’s ability to provide access to and deliver high-quality, high-value care.

Public Policy Decisions – AHRQ research is used by policymakers to expand their capability to monitor and evaluate the impact of system changes on outcomes, quality, access, cost and use and to devise policies designed to improve the performance of the system. These decisions include those made by federal, state and local policymakers and those that affect the entire population or certain segments of the public.

AHRQ Cycle of Research



Producing meaningful contributions to the nation and to research on health care requires continuous activity focused on iterative improvement in priority setting, on developing research initiatives and on research products and processes. The following research cycle describes the processes AHRQ uses to conduct its ongoing activities in order to make the most productive use of its resources.

Needs Assessment

AHRQ's research agenda is based on an assessment of gaps in the knowledge base and on the needs of patients, clinicians, institutions, plans, purchasers and state and federal policymakers for evidence-based information. Input gained during the needs assessments feeds directly into the research initiatives undertaken by the Agency as well as the products developed from research findings to facilitate use in health care.

Knowledge Creation

AHRQ will support and conduct research to produce the next generation of knowledge needed to improve the health care system. Building on the last 13 years of investment in outcomes and health care research, AHRQ will focus on national priority areas for which much remains unknown.

Translation and Dissemination

Simply producing knowledge is not sufficient; findings must be useful and made widely available to practitioners, patients and other decision makers. The Agency will systematically identify priority areas for improving care through integrating findings into practice and will determine the most effective ways of doing this. Additionally, AHRQ will continue to synthesize and translate knowledge into products and tools that support its customers in problem solving and decision-making. It will then actively disseminate the knowledge, products, and tools to appropriate audiences. Effective dissemination involves forming partnerships with other organizations and leveraging resources.

Evaluation

Knowledge development is a continuous process. It includes a feedback loop that depends on evaluation of the research's utility to the end user and impact on health care. In order to assess the ultimate outcomes of AHRQ research, the Agency will place increased emphasis on evaluation of the impact and usefulness of Agency-supported work in health care settings and policymaking. The evaluation activities will include a variety of projects, from smaller, short-term projects that assess process, outputs and interim outcomes to larger, retrospective projects that assess the ultimate outcomes/impact of AHRQ activities on the health care system.

Priority Populations

Health services research has consistently documented the persistent, and at times great, disparities in health status and access to appropriate health care services for certain groups. The Agency's reauthorization legislation, the Healthcare Research and Quality Act of 1999 (Public Law 106-129) mandated the creation of an Office of Priority Populations to continue and build the research and associated activities that AHRQ undertakes on health care for priority populations to eliminate disparities. These populations include racial and ethnic minorities, women, children (including adolescents), the elderly, people with special needs (disabilities, chronic illness, end-of-life issues), low income populations and those from inner-city and rural (including frontier) areas with health care delivery issues. In FY 2000, AHRQ developed the structure for the Agency's Office of Priority Populations Research (OPPR) to continue focusing on developing science-based information to address issues of access to care, outcomes, quality, and the cost and use of services for each of these priority populations. In 2001 the Office of Priority Populations Research was established. A nationwide search is currently underway to recruit a leader in the field to serve as the Director of that office. Until a Director is recruited, the Deputy Director of the Agency has responsibility for overseeing OPPR priorities.

Training

AHRQ assures a strong infrastructure for health services research through investments in training and the support of young investigators. Critical areas of emphasis include:

- bringing diversity to the health services research workforce by increasing the number of trained minority researchers;
- instituting training programs to build research capacity in states that have not traditionally been involved in health services research, but are interested in developing the needed infrastructure;
- training programs for junior-level researchers and mid-career scientists to emerging and innovative research methods; and,
- training programs that build curricula and foster innovative training approaches.

Partnerships and Coordination with Other Federal Agencies

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

Most of the Agency's partnerships are related to:

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

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

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

Cross Walk: Selected DHHS Draft Strategic Goals and Objectives (FY 2003 – 2008) With AHRQ's 2003 Performance Measures and Activities

DHHS Draft Goals and Objectives FY 2003 – FY 2008	AHRQ Performance Measures and Activities
Objective 1.1 Reduce risky behaviors and other factors that contribute to the development of chronic diseases, especially diabetes and asthma.	Key Outcomes: Reduce by 5% the hospitalization rates for pediatric asthma. Decrease by 5% the number of premature babies who develop Respiratory Distress Syndrome (RDS). Reduce by 5% the immunization-preventable pneumonia or influenza in patients 65 and older.
Objective 2.1 Build the capacity of the health care system to respond to public health threats in a more timely and effective manner.	See on-going bioterrorism activities noted under "From Evidence-based Knowledge to Implementation: Selected Examples of How AHRQ Research Helps People," pages 8-9 above.
Objective 2.2 Improve the safety of food, drugs, biological products, and medical device. and **Objective 4.2** Accelerate private sector development of new drugs, biologic therapies, and medical technology.	Centers for Education and Research on Therapeutics (CERTS): CERTS is a national initiative designed to increase the awareness of the benefits and risks of new, existing, or combined uses of therapeutics since information about the risks and benefits of new and older agents and about drug interactions is limited. The research conducted by the CERT's increases awareness of both the appropriate use and risks of new drugs, drug combinations, biological products, devices and mechanisms.
Objective 3.1 Create new, affordable health insurance options. and **Objective 3.3** Strengthen and improve Medicare.	Key Outcomes in re: the Medical Expenditure Panel Survey/MEPS: Provide timely national estimates of health care use and expenditures, private and public health insurance coverage, and the availability, costs and scope of private health insurance benefits among the U.S. population. Analyze changes in behavior as a result of market forces or policy changes (and the interaction of both) on health care use, expenditures, and insurance coverage. Provide information on access to medical care, quality and satisfaction for the US

	population and for those with specific conditions, and for important sub-populations. Develop cost and savings estimates of proposed changes in policy. Identify the impact of changes in policy for key subgroups of the population (i.e., who benefits and who pays more). Consumer Assessment of Health Plans Survey (CAHPS®): CAHPS® makes available consumers' ratings of the quality of care and services they get from their health plans. This information is used by other consumers to make informed choices among health plans, by health care purchasers – such as employers or Medicaid programs – to select plans to offer their employees or beneficiaries, and by plans for quality monitoring and improvement. CAHPS® already has been used by more than 20 states, 10 employer groups and a wide range of health plans and companies.. CAHPS® also merged with the HEDIS (Health Plan Employer Data and Information Set) Member Satisfaction Survey and will be used by the National Committee for Quality Assurance to evaluate and accredit managed care plans for 40 million Americans. Finally, the Centers for Medicare and Medicaid Services (CMS) has used a specially developed version of CAHPS® to survey over 130,000 Medicare enrollees in managed care plans.
Objective 4.3 Strengthen and diversify the base of qualified health and behavioral science researchers.	Key Outcomes: Increase the number of minority researchers trained as health services researchers. Build research capacity in states that have not traditionally been involved in health services research, by supporting the development of the needed infrastructure. Support training programs for junior-level researchers and mid-career scientists to

	emerging and innovative research methods. Support training programs that build curricula and foster innovative training approaches.
Objective 5.1 Reduce medical errors. and **Objective 5.4** Improve consumer and patient protections.	Key Outcomes: Nationally, 12 health facilities or regional initiatives will be funded to implement interventions and service models on patient safety improvements by 2004. On-site patient safety experts in 10 states and technical assistance to improve patient safety by 2004. Program Outputs: Invest $3 million in new activities designed implement local safety improvements priorities by providing incentives to put systems-based interventions in place in healthcare organizations. Invest $2 million in new programs designed to provide technical assistance to states and provide on-site patient safety experts to improve local capacity. Produce at least one synthesis of research findings and practical applications of AHRQ's research which will be available to clinical decision makers, health systems and policy makers. Report the interim data on the extent the patient safety best practices identified in the July 2001 EPC report have been adopted by health care institution. Identify the number and types of adverse events, no-harm events, and near miss events reported in demonstration projects.
Objective 5.2 Increase the Appropriate Use of Effective Health Care Services.	The Integrated Delivery System Research Networks (IDSRN) is model of field-based research that links the nation's top researchers with some of the largest health care systems to conduct research on cutting edge issues in health care on an accelerated timetable. The IDSRN was developed

	explicitly to capitalize on the research capacity of, and research opportunities occurring within, integrated delivery systems. The network creates, supports, and disseminates scientific evidence about what works, and what does not work in terms of data and measurement systems and organizational "best practices" related to care delivery and research diffusion. It also provides a cadre of delivery-affiliated researchers and sites to test ways to adapt and apply existing knowledge. As a group, the IDSRN provides health services in a wide variety of organizational care settings to over 34 million Americans, including the privately insured, Medicare and Medicaid patients, the uninsured, ethnic and racial minorities, and rural and inner-city residents.
Objective 5.3 Increase consumer and patient use of health care quality information.	Maintain the number of projects being funded that bring healthcare quality information to the public in an understandable, user-friendly manner that facilitates its use in decision-making. Produce the National Healthcare Quality Report and the National Healthcare Disparities Report. Identify a core set of quality measures to be used to report on progress in improving the overall quality of health care.
Objective 5.5 Accelerate the development and use of an electronic health information infrastructure.	Through various mechanisms AHRQ is funding research what provide the following knowledge: Factors that influence adoption of emerging health care information technologies; Costs and organizational challenges associated with the adoption of health care information technology; Specific implementation challenges related to emerging applications such as telemedicine, computerized prescription order entry, and electronic medical records both in general facilities as well as in

	specialized facilities such as nursing homes; The impact that information sharing within and among local organizations has on health care quality; The desired effects of information technology achieved in routine use; The specific implementation challenges related to emerging applications in a variety of facilities; and, From the standpoint of health care outcomes, determining if it is better (and how much better) to invest in online healthcare applications, such as online disease management, than to invest in other health and medical care inputs.
Objective 8.5 Enhance the use of electronic commerce in service delivery and record keeping. and **Objective 8.6** Achieve integration of budget and performance information.	Key Outcomes: BPR of grants process, complete with recommendations, will be complete by end of FY2003. Succession plans for key Agency leadership roles will be in place by beginning of FY 04. AHRQ recruitment and retention plan will be designed to fill gaps identified in the assessment of current Agency workforce competencies. Conduct a review of AHRQ’s FAIR Act Inventory. Identify and evaluate existing and new technologies to support AHRQ’s revised business processes.

DEPARTMENT
OF HEALTH
AND HUMAN
SERVICES

Appendix II

FISCAL YEAR 2002 PERFORMANCE (REPORT) SUMMARY

Summary of Performance Objectives
(DRAFT September 5, 2002)

Budget Line 1: Research on Health Costs, Quality, and Outcomes

GPRA Goal 1: Establish research agenda based on user's needs.*
(*B is Budget; CB is commitment base)

Performance Objective	FY Targets	Actual Performance	Reference
Objective 1.1: Define direction of FY project funding priorities, in large part, by needs assessment activities.	02: Agency research agenda covering strategic goal areas for FY 2002 priorities (investigator-initiated research, national quality report, national disparities report) is documented by March 2002 based on consultations with various groups.	Completed.	CB
	01: Agency research agenda covering strategic goal areas for FY 2001 priorities (patient safety and informatics) is documented based on consultations with various groups.	Completed.	CB
	00: Agency research agenda covering the 3 strategic research goals and the new FY 2000 closing the gap initiatives are documented based on consultations with various groups.	Completed.	B:3
	99: Agency research agenda covering the 3 strategic research goals is developed in FY 99 and documented based on consultations with various groups.	Completed. P. 40 and Appendix 5.	

GPRA Goal 2: Make significant contributions to the effective functioning of the U.S. health care system through the creation of new knowledge.

Performance Objective	FY Targets	Actual Performance	Reference
01 - 02 Objective 2.1: Determine annually the salient findings from research in each of the three areas (outcomes; quality; and cost, access, and use) and develop plan for next steps translation and dissemination.	02: • Produce an annual report on at least 18 science advances covering the three research goal areas (outcomes; quality; cost, access, and use).	Completed.	CB
	• For each finding, specific steps in translation and dissemination are identified and initiated.	Completed.	
	• Generate 2 - 3 synthesis reports on research findings and practical	Completed.	

	applications on Agency priority topics. 01: Produce an annual report on at least 12 science advances covering the three research goal areas (outcomes; quality; cost, access, and use) For each finding, specific steps in translation and dissemination are identified and initiated. Generate 2 - 3 synthesis reports on research findings and practical applications on Agency priority topics.	Completed.	CB
00 Objective 2.1: Determine annually the salient findings from research in each of the three areas (outcomes; quality; and cost, access, and use) and develop plan for next steps translation and dissemination.	00: Annual report on science advances in three research goal areas. • At least four major findings in each area that have potential to save significant amounts of money, improve quality, save lives or prevent physical suffering, or change the organization and delivery of health care. • For each finding, specific steps in translation and dissemination are identified and initiated.	Completed. Completed. Completed.	CB
99 Objective 2.1: Determine the salient findings from research for three priority populations and develop plan for next steps in translation and dissemination.	99: A report produced that synthesizes research on the major health concerns of at least three priority populations.	Completed.	
Objective 2:2: Achieve significant findings from AHRQ sponsored and conducted research.	02: Findings from at least 20 AHRQ sponsored or conducted research are used by public and private partners to improve health care. 01: Same as 00, except changed to 40 findings. 00: Findings from at least 25 AHRQ sponsored or conducted research are published in major peer reviewed professional publications (*New England Journal of Medicine, Journal of American Medical Association*, etc.); receive national press coverage; are used in Federal or State policymaking; are used	Completed. Completed. 400% increase: 250 citations for AHRQ findings (20 listed). 32 examples of major media coverage; 7 examples of usage	CB CB CB

	by professional associations or health plans as the basis of strategies to achieve quality; or are used to establish coverage decisions by health care purchasers, managed care organizations, or insurers, including Medicare or Medicaid. 99: Findings from at least 10 AHRQ sponsored or funded research are published in major peer reviewed professional publications (*New England Journal of Medicine, Journal of American Medical Association*, etc.); receive national press coverage; are used in Federal or State policymaking; are used by professional associations or health plans as the basis of strategies to achieve quality; or are used to establish coverage decisions by health care purchasers, managed care organizations, or insurers, including Medicare or Medicaid.	50 citations for AHRQ findings; 7 examples of major media coverage; 7 examples of usage.	
01 - 02 Objective 2.3: Initiate FY Research Initiatives	02: Funding of a minimum of 100 projects; 30% of these projects address priority populations. 01: Funding of a minimum of 60 projects in the following areas: • 40 projects in reducing medical errors and enhancing patient safety • 10 projects in informatics applications in health care • 10 projects in quality improvement through improvements in health care working conditions	Completed. Completed.	B:64 B:31-35 B:33 B:36-37
00 Objective 2.3: Implement FY 2000 priority (1) A New Research on Priority Health Issues.	• Funding of a minimum of 10 projects that address gaps in knowledge about the priority problems faced by Medicare and Medicaid. • Funding of a minimum of 10 projects to address eliminating disparities in health care with particular emphasis on disparities that exist for racial and ethnic minorities.	43 projects funded More then 30 projects funded	B:19-20 B:50-51
99 Objective 2.3 Initiate FY 99 Research Initiatives	Funding of a minimum of 21 projects in: • consumers use of information on quality • strengthen value-based purchasing • measure national health care quality	56 projects funded.	

	• vulnerable populations • translating research into practice Funding of a minimum of 17 projects in: • Outcomes for the elderly and chronically ill • Clinical preventive services • CERTS • Improving the quality of children's health	 51 projects funded.	

Goal 3: Foster translation and dissemination of new knowledge into practice by developing and providing information, products, and tools on outcomes; quality; and access, cost, and use of care.

Performance Objective	FY Targets	Actual Performance	Reference
01 - 02 Objective 3.1: Maximize dissemination of information, tools, and products developed from research results for use in practice settings. NOTE: in the FY 2001 plan, objective 3.1 and 3.2 have been consolidated.	02: • Number of state and local governments trained and/or receiving technical assistance through User Liaison Program (ULP). • At least 20 partnerships to disseminate and implement research findings are formed with public and private-sector organizations. • Synthesis of at least 5 grant portfolio areas on quality of care across Agency goals for persons with chronic care needs produced and disseminated with particular focus on outreach to managed care executives.	 Completed. Completed. Completed.	CB
	01: • At least 5 public-private partnerships are formed to implement research findings for decision-makers. • Formation of a minimum of 10 partnerships to support dissemination of AHRQ products through intermediary organizations, such as health plans and professional organizations. • Number of hits on the Web site. • Number of inquiries handled on web site. • Number of uploaded documents. • Number of state and local governments trained in the understanding and use of health services research findings through	 Completed. 16.7 million 4,006 3,730 425	CB for all web site measures and ULP

	ULP Workshops.		
00 & 99 Objective 3.1: Promote distribution of AHRQ publications, products, and tools through intermediary organizations.	00: Formation of a minimum of 5 partnerships to support dissemination of AHRQ products through intermediary organizations, such as health plans and professional organizations. 99: Formation of a minimum of 5 partnerships to support dissemination of AHRQ products through intermediary organizations, such as health plans and professional organizations.	Over 30 public/private and public/public partnerships formed. Over 30 public/private and public/public partnerships formed.	CB
01 - 02 Objective 3.2: Develop and facilitate the use of new tools, talent, products, and implementation methodologies stemming from research portfolio. (This is objective 3.3 in FY 99-00.)	02: • Produce evidence summaries for use in Federal direct care provider's efforts to create guidelines. • Evidence-based practice centers (EPCs) will produce a minimum of 18 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality by improving practice. • Fund at least 10 projects in tool and data development.	Completed. Completed. Completed.	CB CB CB
	01: • Produce evidence summaries for use in Federal direct care provider's efforts to create guidelines. • EPCs will produce a minimum of 12 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality by improving practice. • Support a minimum of 165 pre- and post-doctoral trainees. • Support up to 3 Minority Research Infrastructure Support Program IM-RISP) grants in order to develop the health services research capabilities of traditionally minority-serving institutions. • Support up to 6 Building Research Infrastructure and Capacity (BRIC) two-year planning grants in EPSCOR states and states which historically	Completed. Completed. Completed. Completed. Completed.	CB

	have received little or no research support from AHRQ.		
	• Fund at least 10 projects in tool development.	Completed.	
99 – 00 Objective 3.2: Maximize dissemination of information, tools, and products developed from research results for use in practice settings. (Becomes Objective 3/1 in FY 01.)	00:		
	• Number of hits on the Web site	18.8 million hits	B:57
	• Number of inquiries handled on web site.	3,500	B:57
	• Number of Uploaded documents	4,400	B:57
	• Reports from user surveys on how the information requested was used.	Completed	B:59
	• Number of State and local governments trained in the understanding and use of health services research findings through User Liaison Program (ULP) Workshops.	State - 50 Local - 29	CB
	+ Meetings held	17 meetings	CB
	+ Number of attendees	1196 attend	CB
	+ States represented	50 States + D.C.	CB
	• Reports from annual participants on how the information was used in decision-making.	Met	CB
	• Statistics on usage of National Guideline Clearinghouse including number of hits, requests, organizations, and total users.	Hits: 32,234,401 Requests: 18,207,430 Orgs: 58,803 User sessions 1.5 million	B:24-25
	• Survey of a sample of NGC users to understand the impact of use on decisions and patient care.	902 respondents evaluation completed in mid-year 2001	B25:
	• At least 10 purchasers/businesses use AHRQ findings to make decisions.	11 examples listed	
Goal 3 continued: Objective 3.2	99:		
	• Number of hits on the Web site	15.5 million	
	• Number of inquiries handled on web site.	2,950	
	• Number of Uploaded documents	4,000	
	• Number of State and local governments trained in the understanding and use of health services research findings through User Liaison Program (ULP) Workshops	48 states; 4 territories; 30 county govts.; & 9 city govts.	

	+ Meetings held. + Number of attendees + States represented. • Statistics on usage of National Guideline Clearinghouse including number of hits, requests, organizations, and total users. • At least 5 purchasers/businesses use AHRQ findings to make decisions.	18 834 48 13,590,013 21 examples listed.	
Objective 3.3 (This becomes objective 3.2 in FY 01. Objective 3.3 is discontinued in FY 01.) 99 - 00 Objective 3.3: Develop and facilitate the use of new tools, talent, products, and implementation methodologies stemming from research portfolio.	00: • Demonstration of use of at least 3 AHRQ research findings in systematic efforts to Translate Research Into Practice. • Funding of a minimum of 5 major projects that will develop products, tools, or methodologies for implementing research findings into practice in significant segments of the health care system (i.e., potential to be generalizable across health care systems, provider-types, or clinical areas.) • At least 2 new tools, products, or methodologies become available from projects funded between FY 1993 and FY 1996. • Support a five percent increase, at a minimum, in number of pre- and post-doctoral trainees.	Met 29 Projects funded 23 Listed 40% Increase	
Goal 3, continued: Objective 3.3	99: • Evidence-based Practice Centers (EPCs) produce a minimum of 12 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality by improving practice (i.e., practice guidelines, quality measures, and other quality improvement tools). At least four reports are being used by customers to develop practice guidelines or other interventions. • The AHRQ software product, CONQUEST 2.0 released in FY 1999 containing new measures, including measures for new conditions, and updated measures. Contract awarded to create web-based product for more	10 produced;3 in press; 30 under development Released March 1999; contract awarded ’00	

	timely updating of information contained within product.		
	• Funding of a minimum of 5 major projects that will develop products, tools, or methodologies for implementing research findings into practice in significant segments of the health care system (i.e., potential to be generalizable across health care systems, provider-types, or clinical areas.)	13 examples provided	
	• At least two new tools, products, or methodologies become available from projects funded between FY 1993 and FY 1996	13 examples provided	
	• Support a minimum of 150 pre- and post-doctoral trainees.	167 trainees	

GPRA Goal 4: Evaluate the effectiveness and impact of AHRQ research and associated activities.

Performance Objective	FY Targets	Actual Performance	Reference
01 - 02 Objective 4.1 Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care. NOTE: 99 - 00 Objectives 4.1 and 4.2 have been consolidated in the FY 01 plan.	02: • Evaluate the impact of the CERTS program in disseminating information regarding therapeutics to at least 3 health care providers or others in order to improve practice.	Completed.	CB
	• Evaluation to determine whether AHRQ funded studies in methodological development have been effective in developing at least 3 new research techniques, whether the techniques are being implemented, and how these studies could be improved.	Completed.	
	• Evaluation of the outcomes of the pharmaceutical studies the Agency has funded to assess impact.		
	• Interim assessment of the impact of the management system for tracking project profiles.	Completed.	
	• Qualitative review by experts of results of one major research initiative to assess quality and productivity and potential impact.	Completed.	CB
	• Evaluate private sector use of at least 5 AHRQ findings.	Completed.	
	• Identify at least 5 private sector uses		

	of AHRQ findings, and describe any assessment of the impact on clinical practice and/or patient care. *Evidence-based Practice Centers* • Use of evidence reports and technology assessments to create quality improvement tools in at least 10 organizations. • For at least four evidence reports or technology assessments per year, work with partners to measure how the reports or assessments were used and what impact they had on clinical decision making and patient care. • Findings from at least 3 evidence reports or technology assessments will effect State or Federal health policy decisions. • Use of evidence reports or technology assessments and access to NGC site formed organizational decision making in at least 4 cases and resulted in changes in health care processes, quality, or health outcomes. 01: *Evidence-based Practice Centers* • Use of evidence reports and technology assessments to create quality improvement tools in at least 10 organizations. • For at least four evidence reports or technology assessments per year, work with partners to measure how the reports or assessments were used and what impact they had on clinical decision making and patient care. *Research* • At least 3 examples of how research informed changes in policies or practices in other federal agencies.	Completed. Completed. Completed. Completed. Completed. Completed. Completed. Completed.	CB
Goal 4 continued: 01 Objective 4.1 Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care. *Cont.*	• Findings from at least 3 evidence reports or technology assessments will effect State or Federal health policy decisions. • Use of evidence reports or technology assessments and access to NGC site informed organizational decision-making in at least 4 cases and resulted in changes in health care procedures or health outcomes.	Completed. Completed.	CB

	Quality Measures • Achievable Benchmarks of Care are used for quality improvement activities by Peer Review Organizations • Use of dental performance measures by dental service and insurance organizations. • HCUP quality indicators incorporated into efforts by hospital associations and hospitals to improve the quality of care. *National Guideline Clearinghouse* • At least 10 users of the National Guideline Clearinghouse will use site to inform clinical care decisions • Guideline development or quality improvement efforts by users will be facilitated through use of NGC in at least 5 cases. • NGC information will be used to inform health policy decisions in at least 2 cases. • Improvements in clinical care will result from utilization of NGC information in at least 3 cases. *Training Programs* • Two thirds of former pre- and postdoctoral institutional award trainees are active in the conduct or administration of health services research.	Completed. Completed. Completed. Completed. Completed. Completed. Completed. Completed.	CB CB CB CB
00 Objective 4.1 (& 4.2): Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care. * Objectives 4.1 and 4.2 were inadvertently the same. They have been consolidated to simplify the reporting.	00: • AHRQ's HCUP Quality Indicators(QIs) will be redesigned based on consultations with state policy makers, researchers, hospital associations, and others about their past use of the QIs. By the end of March 2001, a new set of quality indicators will be defined and feedback obtained from a new set of HCUP QI users. In addition, AHRQ will provide access to recent national-level QI information via both the Internet and through published reports, with special focus on disseminating information to hospital users and organizations with responsibility for hospital quality	HCUP QIs defined National-level QI information posted to Internet Sept 2000	CB

	reporting. - Use of evidence reports and technology assessments to create quality improvement tools in at least 10 organizations. - For at least four evidence reports or technology assessments per year, work with partners to measure how the reports or assessments were used and what impact they had on clinical decision making and patient care. - At least three examples of how research informed changes in policies or practices in other Federal agencies. - AHRQ will report on the extent to which CONQUEST assists those who are charged with carrying out quality measurement and improvement activities and the extent to which it helps further state-of-the-art in clinical performance measurement. - CAHPS® has assisted the Health Care Financing Administration (HCFA) in informing Medicare beneficiaries about their health care choices. The use and impact of this information is determined by surveying a sample of these beneficiaries. - At least one quality measure from Q-span (or instances where AHRQ research contributes to the development of measures) are used in the Health Plan Employer Data Information Set (HEDIS) by the National Committee for Quality Assurance (NCQA), measurement activities of the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), or other organizations monitoring health care quality.	16 examples listed 4 examples listed Completed 4 examples listed Completed. Completed. Results published in July 2001 ABC System of performance profiling cited	
Goal 4 continued: 99 Objective 4.1 Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care. *Cont.*	99: - An evaluation of the outcomes of outcomes research and the impact of AHRQ-supported outcomes and effectiveness research on clinical practice. - An evaluation and synthesis of (1) primary care research supported by	Completed. Progress report	

	AHRQ and (2) an assessment of the current state of the science and future directions for primary care research.		
	• AHRQ’s state data strategy will be redesigned based on consultations with state policy makers, researchers, hospital associations, and others about their past use of data from the Healthcare Cost and Utilization Project (HCUP) as well as additional data needs.	Completed.	
	• Results of the evaluation of the Consumer Assessment of Health Plan Study (CAHPS®) will be used to improve the usability and usefulness of the tool. Findings are expected to show whether (a) the survey-based information from CAHPS® helps consumers make better health care decisions, (b) the information increases consumer confidence when choosing health care plan, and (3) CAHPS® is used by public and private organizations.	Preliminary results.	
	• Evaluation studies on: (1) the quality and usefulness of the evidence reports and technology assessments produced by the Evidence-based Practice Centers and (2) the impact of the use of these products on the health care system will be developed and initiated in FY 1999.	Final report received in June 2000.	
01 - 02 Objective 4.2: Evaluate the impact of MEPS data and associated products on policymaking and research products.	02: • Have a fully functional MEPS-based MEDSIM model to allow simulation of the potential impact of programmatic changes in health care financing and delivery Dec 2002.		CB
	• Produce baseline FY statistics on number of MEPS-based articles published in peer review journals.	Completed.	CB
	• Conduct customer satisfaction survey for MEPS workshop participants to assess how MEPS data is being used to inform research and public policy.	Completed.	CB
	• Develop marketing plan to promote the MEPS-IC data to state officials Dec 2002.		CB
	• At least 5 examples of how research using MEPS has been used to inform	Completed.	CB

	decisions by Federal, state and private sector policymakers. 01: • Use of MEPS data in AHRQ research applications will increase by 10 percent over number received in baseline period of 2000 • Feedback from MEPS workshop participants indicating that they were useful and timely. • At least 5 examples of how research using MEPS has been used to inform decisions by Federal, state and private sector policymakers. 00: See above 4.1 for 00	Not attained. Completed. Completed.	CB CB CB
99: Objective 4.2: Evaluate major dissemination mechanisms.	• AHRQ Clearinghouse customer satisfaction rated at 98%. • Customer satisfaction data on AHRQ consumer publications (useful/relevant) rated at 90%.	Met. 81.3%	CB
01 Objective 4.3 n/a 00 Objective 4.3: Evaluate the impact of MEPS data and associated products on policymaking and research projects.	• Use of MEPS data in 1% of research applications received by AHRQ. • Distribution of MEPS data sets to at least 2500 requestors. • At least 5 examples of how research using MEPS has been used to inform decisions by Federal, state, and private sector policymakers. • Feedback from recipients of MEPS data indicating that the data were timely, useful, and of high significance.	MEPS used in 31% of funded projects 5,700 data sets; 379 CD ROMs 15 examples given Met.	

GPRA Goal 5: Support initiative to improve health care quality through leadership and research.

Performance Objective	FY Targets	Actual Performance	Reference
00 - 02 Objective 5.1: Conduct research to help to measure the current status health of care quality in the Nation.	02: • Integration of at least one private sector data source into the national quality report by 31 December 2002. 01: • QI Taxonomy meeting held under the auspices of the QuIC. • Number of grants and contracts	Completed. Completed.	B:35-36 CB

99 Objective 5.1: Provide leadership for the Executive Branch's Quality Interagency Coordination Task Force (QuIC)	funded in FY2001 that will help to fill gaps in the information available to assess the national quality of care, or will help to expand the use of current measures to provide a broader or richer picture of quality.	Completed.	
	00:		
	• Data sources identified that will contribute information as part of the mosaic picture of quality of care in the Nation.	Final recommend. March 2001	CB
	• Develop and begin to test some questions to be added to existing data collection activities to provide a better picture of quality.	Survey completed. Fielded during FY 2001	CB
	• Develop framework for National Healthcare Quality Report.	Final report 30 March 2001	B:35
	• Provide leadership for the Executive Branch's Quality Interagency Coordination Task Force (QuIC).	Met: (details pp.110-111)	CB
	99:		
	• Collaborative work groups are established under the QuIC under take projects with direct application to improving quality of care.	Met.	
	• In addition to the work on specific projects chosen by the QuIC, communication is facilitated on common issues such as: 1) Implementation of the Bill of Rights and Responsibilities from the President's Commission on Consumer Protection and Quality in the Health Care Industry; And 2) organization or management strategies to improve quality of care.		
Goal 5 continued: 00 - 02 Objective 5.2: Facilitate use of quality information to improve health care in the Nation.	02:		
	• Funding of at least 5 projects bringing healthcare information to the public in an understandable, user friendly manner which facilitates its use in decision making.		CB
	01:		
	• Number of grants to improve patient safety.	Funded > 40.	B:31-35
	• Adoption of Agency sponsored research and tools developed by one or more users to facilitate consumers/purchaser/decision- maker use of information about quality	Completed.	

99 Objective 5.2: Conduct research to expand the tool box of measures and risk adjustment methods available help to measure the current status of quality in the nation.	00: • Development of at least one tool that can be used by large group purchasers in assisting their beneficiaries to choose the health care plan, provider, or hospital that best meets their needs.	3 examples given.	CB
	99: • Inventory of measures and risk adjustment methods currently in use by Federal Agencies will be developed.	Met.	
	• Assessment of measures and risk adjustment methods needed by Federal Agencies will be conducted.	Met.	
00 - 02 Objective 5.3: Improve quality measurement.	02: Adoption of at least one quality measure to be developed from our vulnerable populations RFA by a national accrediting organization.		CB
	01: • Identification of collaborators for research projects on electronic medical records integrated with guidelines (e.g., from the Guideline Clearinghouse) or QI indicators (e.g., CONQUEST, QI Taxonomy project, HCUP measures).	Completed.	CB CB
99 Objective 5.3: Inform health care organizational leaders and others how to design quality into their systems	• Adoption of Living With Illness children's health measure by NCQA.	Completed.	
	00: • Sponsor research to fill existing gaps in quality measures in areas of high need.	Met. (Details p.112)	
	99: • Review research conducted that identifies appropriate ways of redesigning health care delivery systems to reduce errors.	Met.	
00: Discontinued 99 Objective 5.4: Improve understanding of how to ensure that research affects clinical practice as appropriate	99: Research on effective dissemination of information to decisions makers including patients, clinicians, organizational leaders, purchasers, and public policy makers conducted.	Met.	

Budget Line 2: Medical Panel Expenditure Surveys

GPRA Goal 6: Collect current data and create data tapes and associated products on health care use and expenditure for use by public and private-sector decision makers and researchers. (MEPS)

Performance Objective	**FY Targets**	**Actual Performance**	**Reference**
99 - 02 Objective 6.1: Release and disseminate MEPS data and information products in timely manner for use by researchers, policy makers, purchasers, and plans.	02: • Develop a method to facilitate user's custom cross tabulations of MEPS data.	Completed.	CB
	• Conduct six MEPS data user workshops.	Completed.	
	• Expand MEPS list-server participation by 20%.	Completed.	
	• Produce 4 Findings and at least one Chartbook.	Completed.	
	• Develop Frequently Asked Questions Section for MEPS web site.	Completed.	
99 - 02 Objective 6.1: Release and disseminate MEPS data and information products in timely manner for use by researchers, policy makers, purchasers, and plans. *Cont.*	01: • In FY2001, 1997 Use and Expenditures, 2000 Point-in-Time, and 1998 Health Insurance and Demographics MEPS public use data files will be released.	Completed.	CB
	• Response time for requests received for information, assistance or specific products is as promised 95 percent of time	Completed.	CB
	00: • Core MEPS public use files (PUFs) available through Web site and CD-ROM within 9-18 months after data collection completed.	Available within 12 months	CB
	• Specific products due in FY2000: + 1999 point-in-time file + 1997 expenditure data available + 1996 full panel file available	Released: -July 2000 -Available 1st quarter 2001 -Jan 2000	CB
	• Customer satisfaction data from use of MEPS tapes and products rated at least 90%.	Rated at 90%	CB
	• Response time for requests received from policymakers, purchasers and plans for MEPS data tapes, analyses, and/or reports responded to within promised time frames 95% of time.	96% within 4 days	CB
	99: • Core MEPS public use files (PUFs)	Significant progress	CB

	available through Website and CD-ROM within 9-12 months after data collection completed. • Specific products due in FY 1999: + 1997 point-in-time file. + 1996 full-year expenditure file. + 1996 full-year event, job, and condition files. + 1998 point- in- time file.	made. Delivered: March 1999 Dec. 1999 Job and Condition Files delivered November 1999 and August 1999 respectively; event files will be available by March, 2000	CB
Goal 6 continued: Objective 6.1	• Research findings and survey reports developed and disseminated for use by policy makers and researchers including *MEPS Research Findings*, *MEPS Highlights*, chart books, peer-reviewed journal articles, book published on contributions of expenditure surveys to policy making, publications oriented toward non-researchers.) • Customer satisfaction data from use of MEPS tapes and products rated at 85%. • Requests received from policy makers, purchasers and plans for MEPS data tapes, analyses, and/or reports responded to within promised time frames 85% of the time.	30+ publications related to MEPS Ratings between 86-96% Requests filled within 5 days uniformly.	B:A5-A-6 CB CB
Goal 6 continued: 99 - 02 Objective 6.2: Facilitate use of MEPS data and associated products as tools by extramural researchers, policy makers, purchasers, and plans.	02: • Determine the feasibility of existing mechanisms to provide off-site access to confidential MEPS data. • Expand data center capacity by 10% over FY 01 level. 01: • Establish baseline for Data Center use capacity. 00: • Data centers operational + # requests for use of the centers + # user-days at the data centers + # projects completed 99: • Inclusion of MEPS data in extramural research grants with AHRQ and other funders. • Plan for extramural researcher access to MEPS data fully implemented	Completed. Completed. Deferred to Jan 2001 Included in 20 applications, 5 funded. Met. Fully up Feb. 2000.	CB CB CB CB

01 - 02 Objective 6.3: Modify MEPS to support annual reporting on quality, health care disparities, and research on long-term care in adults and children with special needs.	02:		
	• Process and make available data to be included in the National Quality Report.	Completed.	B:78
	• Begin data collection to support the disparities report Sept 2002.	Completed.	B:78
	01:		
	• Data collection begins on the treatment of common clinical conditions over time for a nationally representative portion of the population in support of the National Healthcare Quality Report.	Completed.	CB
	• LTC Measures:		CB
	1. Have developed data use agreements (DUA) with HCFA to assess and begin data development related to the MDS.	Completed.	
	2. Design MEPS over sample of adults with functional limitations and children with special needs.	Not funded.	
	3. Produce one report related to LTC.	Completed.	
	4. Have developed IAA with NCHS for LTC frame development activities.	Not funded.	
	5. Submit at least one peer-reviewed publication in the area of LTC.	Completed.	
00 Objective 6.3: Modify and enhance MEPS to enable reporting on the quality of health care in America as part of FY 2000 Priority (3), A New Tools for a New Century.	00: • The design decisions necessary for the expansion of MEPS databases in order to collect data that will support the National Healthcare Quality Report are completed by August 2000. The design decisions will be operationalized in the coming fiscal years.	Met. (Details pp. 117-119)	
99 Objective 6.3: Modify and enhance MEPS to enable reporting on the quality of health care in America.	99:		
	• MEPS Household Survey: Interviews with 9,000 previously surveyed families to obtain calendar year 1998 health care data, and with 5,600 new families.	Met.	
	• MEPS Medical Provider Survey: Interviews with approximately 3,000 facilities, 12,000 office-based providers, 7,000 hospital-identified physicians, and more than 500 home health providers.	Met.	
	• MEPS Insurance Component (MEPS-IC): Interviews with more than	Met.	

	40,000 employers and 1,000 insurance carriers. - MEPS data collection successfully moved to ongoing survey mode from data collection every ten years.	Met.	

Budget Line 3: Program Support

GPRA Goal 7: Support the overall direction and management of AHRQ

Performance Objective	**FY Targets**	**Actual Performance**	***Reference***
Objective 7.1 is mandatory (Capital Assets) but not applicable to AHRQ.			
00-99 Objective 7.2:Maintain acquisition performance management system to ensure: (1) timely completion of transactions, (2) vendor and customer satisfaction, and (3) efficient and effective use of resources.	01: DISCONTINUED 00: - Internal customer satisfaction rated at minimum of 4.5/5. - External customer satisfaction rated at 4.5/5. - Customer satisfaction survey results assessed and used to implement changes to improve and enhance services. 99: - Internal customer satisfaction rated at minimum of 4.5/5. - External customer satisfaction rated at 4/5. - Customer satisfaction survey results assessed and used to implement changes to improve and enhance services.	Rated 4.2 Rated 4.6 Met. 4.4 4.0 Met.	CB CB CB CB
Goal 7 continued: 00-99 Objective 7.3. Continued enhancement and expansion of Agency Intranet site to ensure staff have immediate access to all current information.	01: DISCONTINUED 00: - Customer satisfaction rated at minimum of 3.5/4. - Demonstration through customer satisfaction surveys that the daily work of staff has been facilitated by the Intranet. - Assessment of customer satisfaction surveys and use of such surveys to implement changes to improve and enhance services as necessary. 99: - Customer satisfaction rated at	3.2/5.0 Met. Met. 3.1/4	CB CB CB

	minimum of 3.5/4. • Customer satisfaction surveys assessed and used to implement changes to improve and enhance services as necessary.	Met.	
Goal 7 continued: 01-02 Objective 7.4 Establish and maintain a secure Agency computer network infrastructure.	02: • Perform initial tests, (periodically, beginning in 2nd quarter of FY 2002) to evaluate the preliminary policies and procedures. 01: • Preliminary policies and procedures for reducing security risks will be developed by the end of FY 2001. • Initial criteria for reporting security incidents will be established by the end of CY 2001. • Initial procedures for responding to security incidents will be established by the end of CY 2001. • Implementation of a Secure Phase 1 LAN for analysis of intramural research and survey data will be completed by end of FY-01. • Implementation of a Phase 1 firewall, intrusion detection and virus control system will be in place by end of CY 2001. • Initial security awareness training will begin by end of CY 2001.	Completed. Completed. Completed. Completed. Completed. Completed. Completed.	CB CB