# DEPARTMENT of HEALTH and HUMAN SERVICES

## Agency for Healthcare Research and Quality

***FY 2008 Annual Performance Report***

## Introduction

This FY 2008 Annual Performance Report provides information on the Agency for Healthcare Research and Quality's (AHRQ) actual performance and progress in achieving the goals established in the FY 2008 Annual Performance Plan which was published in February 2008 as part of AHRQ's FY 2009 Justification of Estimates for Appropriations Committees (http://www.ahrq.gov/about/cj2009/cj2009.pdf) and Online Performance Appendix (http://www.ahrq.gov/about/cj2009/cj2009opa.pdf).

The goals and objectives contained within this document support the Department of Health and Human Services' Strategic Plan (available at http://aspe.hhs.gov/hhsplan/2007/).

Transmittal Letter

**Agency for Healthcare Research and Quality**
HHS FY 2008 Annual Performance Report
Data Quality Assurance Statement

The Department of Health and Human Services hereby publishes the AHRQ component of the FY 2008 Annual Performance Report which features program performance data that has been provided by my Operating Division. As required by the Reports Consolidation Act of 2000, the Secretary of the Department of Health and Human Services (HHS) will provide an assessment of the completeness and reliability of the performance data presented in this report. As part of this assessment, the Secretary will describe any material inadequacies in the accuracy, completeness, and reliability of the data and will identify actions that can be taken to resolve such inadequacies.

I recognize that the Secretary relies upon the assurances provided by my Operating Division in providing this assessment. To the best of my knowledge, the performance data reported by my Operating Division for inclusion in this FY 2008 Annual Performance Report is accurate, complete, and reliable.

_____ _____

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

***Table of Contents***

## *Summary of Measures and Results Table*

| Fiscal Year | Total Number of Targets | Targets with Results Reported | Percent of Targets with Results Reported | Total Targets Met | Percent of Targets Met |
|---|---|---|---|---|---|
| 2005 | 47 | 47 | 100% | 47 | 100% |
| 2006 | 41 | 40 | 98% | 39 | 96% |
| 2007 | 41 | 36 | 88% | 34 | 94% |
| 2008 | 47 | 41[1] | 87% | 36 | 88% |
| 2009 | 38[2] | | | | |

[1]Six (6) measures for Health Insurance Decision Tools under the Value Portfolio received no funding.
[2]Data are not yet available for FY 2009

## *Performance Detail (by Activity)*

### *Health Costs, Quality and Outcomes (HCQO):*

### Comparative Effectiveness

In FY2007, AHRQ created the new Comparative Effectiveness Portfolio. The long-term objective of the Portfolio is to improve patients' quality of care and health outcomes through informed decision making by patients, providers and payers. In an effort to measure if this goal is being achieved, AHRQ plans to track the data for a subset of Quality and Effectiveness of Care Measures that focus on the priority conditions that guide the work of the Effective Health Care Program. In FY2008, the portfolio initiated work to identify and review the Quality and Effectiveness of Care Measures and to limit the measures to a subset in the priority condition areas. Thus far, measures have been identified but a subset based on priority conditions has not yet been selected.

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

One important measure the Effective Health Care Program uses to evaluate its success is the amount of evidence made available to the public. In FY 2008, the program met its target and released seven systematic reviews. The program also exceeded its target of releasing eight summary guides by releasing twelve summary guides including two Spanish-language version summary guides for consumers. The performance goal was set at an approximate target level, and the deviation from that level is slight. This information is shown in the Performance Table, key outcome/output #4.4.5.

All reports produced by the program are available on the Effective Health Care Web site, www.EffectiveHealthCare.ahrq.gov. The Web site also includes features for the public to participate in the Effective Health Care Program. Users can sign up to receive notification when new reports are available. They can also be notified when draft Key Questions for proposed research, draft Reviews and other features are posted for comment, and comments can be submitted through the Web site. The public is also invited to use the Web site to nominate topics for research by the Effective Health Care Program.

There is growing interest in, and attention to, enhancing the role of the Effective Health Care Program's research in our health care system and many organizations are disseminating evidence from the Effective Health Care Program to their constituents. For example, Consumer Reports Best Buy Drugs, a public education product of Consumers Union, uses findings from the program to help clinicians and patients determine which drugs and other medical treatments

work best for certain health conditions. In addition to disseminating the consumer materials and reports via the website, Best Buy Drugs has an outreach program that links to existing groups with statewide reach and credibility throughout the medical community. The National Business Group on Health uses findings from the Effective Health Care Program in their Evidence-based Benefit Design initiative to provide employers and their employees best available evidence for designing benefits and making treatment choices. Medscape and the American Academy of Family Physicians offers continuing medical educational based on comparative effectiveness reviews and numerous other organizations use the findings in their deliberations on patient care, formulary design, and areas for needed research.

In FY 2008, key outcome/output #1.3.25 was to work with AHRQ Effective Health Care's Eisenberg Center, Scientific Resource Center, and Stakeholder Group to identify methods for systematically identifying organizations that are disseminating systematic reviews and summary guides. The FY 2008, AHRQ worked with the Eisenberg Center, Scientific Resource Center and Stakeholder Group to develop processes for identifying organizations that are disseminating systematic reviews and summary guides. This process is not yet complete. We have not completed identifying methods for systematically identifying organizations that are disseminating systematic review and summary guides. The performance goal was set at an approximate target level, and the deviation from that level is slight. In FY 2009 the program will finish identifying methods for identifying organizations that are disseminating program products, will obtain baseline data for this performance measure, and will set target for 2010 – 2019.

In FY 2008, key outcome/output #1.3.26 was met. The Program worked with AHRQ's Medicaid Medical Directors Learning Network to develop a process for identifying how products from the Comparative Effectiveness Portfolio are used by these state clinical policymakers. In FY 2009 the Program will obtain baseline data and set targets for this performance measure.

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

| # | Key Outcomes/ Outputs | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|
| 1.3.24 | Develop Quality and Effectiveness of Care Measures (subset of those endorsed by the National Quality Forum and analyzed in the National Health Care Quality Report)[1] | List of priority conditions for research under Medicare Modernization Act released | AHRQ launched new Effective Health Care Program, authorized under Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 | N/A | AHRQ created new Comparative Effectiveness Portfolio | Identify measures and limit to a subset based on priority conditions; work with AHRQ's planning, evaluation, and analysis contractors to limit to ~3 metrics to be tracked | Measures have been identified but a subset based on priority conditions has not yet been selected. | 1st and 2nd Qtr – Obtain baseline data for identified measures<br><br>3rd and 4th Qtr – Set targets for quality measures for 2010 - 2019 |
| 4.4.5 | Increase # of systematic reviews (SR)) and summary guides (SG) produced per year | NA | 4 SR<br><br>1SG | N/A | 4 SR<br><br>8 SG | 7 SR<br><br>8 SG | 7 SR<br><br>12 SG (includes 2 summary guides translated into Spanish) | 7 SR<br><br>8 SG |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1.3.25 | Increase # of organizations disseminating systematic reviews and summary guides to their constituents [2] | NA | NA | NA | NA | Work with AHRQ Effective Health Care's Eisenberg Center, Scientific Resource Center, and Stakeholder Group to identify methods for systematically identifying organizations that are disseminating systematic reviews and summary guides | Have not completed identifying methods for systematically identifying organizations that are disseminating systematic review and summary guides. | 1st and 2nd Quarter – Obtain baseline data for this performance measure<br><br>3rd and 4th Quarter – Set targets for FY 2010 – 2019 |
| 1.3.26 | Increase amount of evidence from the Comparative Effectiveness (CE) Portfolio policymakers use as a foundation for population-based policies [3] | NA | NA | NA | NA | Work with the Medicaid Medical Directors (AHRQ Learning Network) and Health Plans to identify methods for systematically reviewing policy decisions for references to evidence from the Portfolio | Worked with Medicaid Medical Directors Learning Network to develop process for identifying how CE Portfolio products are used by these state clinical policymakers | 1st and 2nd Quarter – Obtain baseline data for this performance measure<br><br>3rd and 4th Quarter – Set targets for FY 2010 – 2019 |

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

### *Prevention/Care Management*

The Prevention/Care Management Portfolio met all its stated objectives in FY 2008.

In fiscal year 2008, two portfolios of work were combined to form the new Prevention/Care Management Portfolio. The mission of the new Portfolio is to improve the quality, safety, efficiency, and effectiveness of the delivery of evidence-based preventive services and chronic care management in ambulatory care settings. We seek to accomplish our mission by: 1. supporting clinical decision making for preventive services through the generation of new knowledge, the synthesis of evidence, and the dissemination and implementation of evidence-based recommendations; and, 2. supporting the evidence base for and implementation of activities to improve primary care and clinical outcomes through health care redesign; clinical-community linkages; self management support; integration of health information technology; and care coordination.

The portfolio fulfills AHRQ's congressionally mandated role to convene the United States Preventive Services Task Force (USPSTF) to conduct scientific evidence reviews of a broad array of clinical preventive services (screening, counseling and preventive medication) and to develop recommendations for the health care community. The portfolio provides ongoing administrative, research, technical, and dissemination support to the USPSTF, which is an independent panel of nationally renowned, non-federal experts in prevention and evidence-based medicine comprising primary care clinicians (e.g., internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists) with strong science backgrounds.

The USPSTF develops and releases evidence-based recommendations for the health care provider community to improve the delivery of appropriate preventive services in the clinical setting. The multi-year process of generating a recommendation begins with a solicitation of topic nominations through a Federal Register notice and consultation with stakeholders. The USPSTF prioritizes nominated topics for review and for updating. From the pool of USPSTF prioritized topics, portfolio staff select specific clinical preventive service(s) based on Agency and Departmental strategic goals to focus the portfolio's work. In 2008, the USPSTF released new recommendations for 10 clinical preventive services, and work was either initiated or continued on approximately 30 topics.

As reflected in key outcome measures for fiscal years 2008 and 2009 and to continue through 2014, portfolio staff have prioritized screening for colorectal cancer because current rates of uptake of screening for colorectal cancer are low, colorectal cancer is the third most common cancer in the United States, and there are health disparities in receipt of the service.

AHRQ commissioned two reports to assist the USPSTF in updating its 2002 recommendation on screening for colorectal cancer. These included a systematic evidence review conducted by the Oregon Evidence-based Practice Center and a decision analysis of colorectal cancer screening tests by age to begin and end and screening intervals. This work was conducted by the Cancer Intervention and Surveillance Modeling Network (CISNET).

Working with the researchers and portfolio staff, the Task Force determined the scope for both the systematic evidence review and the decision analysis, with the goal that these two reports would provide complementary information about the important clinical questions that could inform effective use of screening in practice. The systematic review focused on the accuracy and potential harms of newer and previously-recommended CRC screening technologies. The decision analysis focused on projected benefits to a cohort beginning CRC screening at age 40 years or later for different screening strategies, different beginning and ending ages, and different intervals for re-screening

after a normal test. These two reports were presented to USPSTF and finalized in FY 2008. Manuscripts based on these comprehensive reports were submitted to *Annals of Internal Medicine* in FY 2008. These manuscripts along with the updated recommendation statement of the USPSTF on screening for colorectal cancer will be released in FY 2009.

USPSTF recommendations provide one essential foundation for dissemination, implementation, and integration activities within the portfolio. The Prevention/Care Management portfolio advances the delivery of appropriate, evidence-supported clinical services through myriad means: publication of articles in scientific peer-reviewed journals, utilization of information technology interfaces (Web access and the "*electronic* Preventive Services Selector", a downloadable interactive PDA program), convening of meetings to facilitate knowledge transfer between stakeholders, generation of products targeting priority populations, forming and sustaining strategic partnerships, and developing effective tools for system integration.

Because of the portfolio's strategic focus on colorectal cancer screening, specific activities are underway to improve rates of the delivery of this service. In FY 2008, a situation analysis of colorectal cancer screening was completed. This report served as a guide for portfolio staff of activities underway to increase the uptake of colorectal cancer screening nationally and for strategic planning. In FY 2008, portfolio staff are full and active members of the National Colorectal Cancer Roundtable, and a joint project is underway with Federal and non-Federal partners to translate implementation guidance into more accessible electronic formats to improve the delivery of screening. This electronic tool should be finalized in FY 2009.

In FY 2008, portfolio staff also prioritized a counseling service, Counseling to Promote a Healthy Lifestyle, which includes diet and physical activity. The reasons for prioritizing this topic include: the importance of poor diet and limited physical activity as factors associated with poor health outcomes; the rates of both are high among American adults; the opportunity for the USPSTF to develop improved methods to systematically review and update evidence on counseling by primary care clinicians; and, possibilities for demonstrating effective linkages among clinical practices and community programs to improve healthy behaviors.

The new Prevention/Care Management Portfolio encompasses activities designed to enhance the delivery of evidence-based services that improve care for patients with chronic diseases, especially "complex patients" who have more than one illness. The Portfolio is stimulating knowledge generation at the intersection of prevention and care management through a research grants program designed to support improvements in the care of complex patients. The funding opportunity announcement for this program was released in FY 2008; 35 applications were received; 18 have been funded.

These activities are reflected in key outcome measures provided below.

**Evaluation of the U.S. Preventive Services Task Force Recommendations for Clinical Preventive Services**

The purpose of the study was to determine how U.S. Preventive Services Task Force (USPSTF) recommendations are integrated into health plans and how to improve dissemination of these recommendations. The USPSTF is an independent panel of experts in primary care and prevention that systematically review the evidence of effectiveness and develop recommendations for clinical preventive services. This study used three separate but interrelated phases: 1) literature review and evaluation design of published and unpublished literature; 2) semi-structured phone and in-person interviews; and, 3) analysis of key cross-cutting themes related to the adoption, integration, and delivery of the USPSTF recommendations in health plans.

The study reported that USPSTF recommendations are integrated in health plans through: 1) printed publications such as health plan provider manuals on clinical preventive services and other publications; 2) electronic use of health information technology tools such as electronic medical records (EMRs), clinical reminders, and order sets for clinicians; and, 3) incorporation into the plan's patient health education materials that are distributed to the member population.

Suggestions for improving dissemination of the recommendations included: 1) developing new prevention tools designed for nurses delivering counseling recommendations; 2) disseminating more information about the USPSTF methodology to certain members of the health plan staff; and, 3) AHRQ staff attending provider professional meetings and presenting on a few of the Task Force recommendations.

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

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

| # | Key Outcomes/ Outputs | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|
| 2.3.4 | Increase the percentage of men and women age 50 or older who report having been screened for colorectal cancer (based on NHQR/NHDR) | N/A | N/A | N/A | N/A | Finalize evidence report and decision analysis screening for colorectal cancer<br><br>Finalize dissemination & implementation situational analysis for screening for colorectal cancer.<br><br>AHRQ Prevention staff participate as full members of National Colorectal Cancer Round (CRC) Table | Evidence report and decision analysis completed. Evidence report and decision analysis on CRC submitted to *Annals of Internal Medicine*.<br><br>D&I situational analysis for screening for CRC completed and disseminated.<br><br>AHRQ staff participated as members of the CRC Round Table. | Release updated USPSTF recommendation on screening for colorectal cancer.<br><br>Finalize modification of ACS colorectal screening implementation toolkit (via IAA with CDC) to electronic format. |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 2.3.5 | Increase rates of additional Portfolio-prioritized clinical preventive service(s) | N/A | N/A | N/A | N/A | Publish Federal Register notice soliciting new topic nominations for USPSTF review.<br><br>USPSTF will prioritize nominated topics for review.<br><br>Portfolio will prioritize clinical preventive service(s) in alignment with strategic goal areas. | Solicitation for nominations for new topics published in the Federal Register February 20, 2008.<br><br>The USPSTF prioritized four topics for potential review.<br><br>Portfolio prioritized clinical preventive service: Counseling to Promote a Healthy Lifestyle (Healthy Diet and Physical Activity). | Finalize work plan for an EPC evidence report and dissemination & implementation situational analysis for additional Portfolio-prioritized clinical preventive service(s). |
| 2.3.6 | Improve integration of Prevention and Care Management activities | N/A | N/A | N/A | N/A | Launch new Prevention/ Care Mgmt Portfolio and create key outcome measures for Care Mgmt | Launched new Prevention/ Care Mgmt Portfolio and awarded 18 grants to support "Optimizing Prevention & Healthcare Management in Complex Patients". | Award 3-5 collaborative grants to accelerate the pace of discovery and achieve the goals of the "Optimizing Prevention and Healthcare Management for the Complex Patients". |

### *Value*

The cost of health care has been growing at an unsustainable rate, even as quality and safety challenges continue. Finding a way to achieve greater value in health care – reducing unnecessary costs and waste while maintaining or improving quality – is a critical national need. AHRQ's Value Portfolio aims to meet this need by producing the measures, data, tools, evidence and strategies that health care organizations, systems, insurers, purchasers, and policy-makers need to improve the value and affordability of health care. The aim is to create a high-value system, in which providers produce greater value, consumers and payers choose value, and the payment system rewards value. Beginning in 2007, one priority within the Portfolio has been creation and support of Chartered Value Exchanges (CVEs), regional collaboratives which use evidence-based measures, data and research to support transparency, public reporting, alignment of financial incentives, and quality improvement initiatives to drive value at the local level. In 2010, AHRQ will continue to support the Value Portfolio through four interrelated activities:

- **Chartered Value Exchanges**.
  Because the goal of the portfolio is not simply to produce evidence but to facilitate evidence-based improvements in efficiency and value, a central component of the portfolio is working with providers, purchasers, health plans, consumers, policy-makers and others who are using measures, data and evidence to bring about change. A key component of this effort is a new family of Chartered Value Exchanges (CVEs) created as part of the Value-Driven Healthcare Initiative. CVEs are regional and state collaboratives, consisting of public and private payers, providers, plans and consumers, and in some cases State data organizations, Quality Improvement Organizations, and health information exchanges. These organizations work in tandem to improve community-wide quality and value, through public reporting, payment incentives, and quality improvement initiatives. CVEs are expected to have access to quality information about physician groups in their area, drawn from Medicare and private plan data.

  AHRQ's goal for 2008 was to hold two solicitations and charter 25 CVEs. The first solicitation alone brought 14 CVEs, and we will be chartering a second group in September. While AHRQ expected the CVEs to represent 300,000 people by the end of 2008, the first cohort alone brought 61.9 million people – largely because the CVEs themselves were large, in most cases covering entire states.

  The most important feature of the CVEs, however, is not their size but their capacity. Much of this capacity results from their composition – all include at least four stakeholders (health plans, providers, consumers, and purchasers) and in some cases state data organizations or Quality Improvement Organizations as well. AHRQ is reinforcing their knowledge base and expertise through a Learning Network. This Learning Network gives all the CVEs access to organized peer learning, webinars, one-on-one consulting, and other support by top researchers, consultants, and peers. To launch the Learning Network, AHRQ convened a meeting with the CVEs that featured AHRQ evidence, products and tools. Overall, the CVEs found the meeting to be very useful, and participant feedback included comments such as, "This was excellent/very helpful – it's great to be actively engaged in a dialogue with peers." One example of how the Learning Network impacts individual CVEs is illustrated by the Louisiana CVE's interest in several AHRQ products featured in a Learning Network webinar. Following the webinar, the Louisiana CVE requested one-on-one technical assistance for using the Preventable Hospitalization Costs Mapping Tool, the Quality Indicators and a new tool under development, the Efficiency and Quality Improvement Portal. AHRQ experts provided them with one-on-one assistance on these tools. In addition, because of their interest in strategies for sustainability, the Louisiana CVE currently is serving as a pilot site to test a model of CVE sustainability.

  For 2010 AHRQ will continue the planned growth in the number of CVEs to 35. Because the CVEs coming in have been unexpectedly large, by 2010 we will be able to place increasing emphasis on growing the evidence and tools that they and others need, thereby expanding the evidence, lessons and tools available through the Learning Network.

- **Measures and data for transparency.**
  Any effort to build value must rest on evidence-based measures and solid, Federal, State and local data on cost and quality. AHRQ has a long history of development and maintenance of measures and data that the Department, private purchasers, states and providers are using for quality reporting and improvement. Examples include the CAHPS®, Quality Indicators, National Healthcare Quality and Disparities Reports, Health Information

Exchanges, Culture of Safety measures, the Healthcare Cost and Utilization Project, and the Medical Expenditure Panel Survey.

A second component of the Value initiative in 2008, therefore, was a focus on improving and expanding measures, data and tools so that they could be used to support transparency, public reporting, and quality improvement. We saw several major successes: The National Quality Forum endorsed 41 of our Quality Indicators for public reporting, and CMS selected nine of these for use in Inpatient Payment. CMS also began to report data from AHRQ's Hospital CAHPS measure. The National Healthcare Quality and Disparities Report had an efficiency chapter for the first time, and we published a comprehensive Evidence Review on Efficiency measures. By the second quarter of 2008, 12 states had public report cards, more than double the number anticipated for the full year. By the end of 2008, we expect that market-level cost data will be available in at least 4 states. In 2010, we will continue to use our expertise in data and measurement to build and refine measures, data and tools that can be used to track, report and improve value and efficiency. A major push for 2010 will be developing further synergies among AHRQ's measurement and data efforts.

- **Evidence to support reporting, payment and improvement strategies.** A third component of the Value-Driven Healthcare Initiative is to provide evidence on when and how public reporting strategies are most likely to work, the payment strategies and community approaches most likely to improve value, and the redesign initiatives likely to reduce waste. Through this activity, the CVEs and others had access to 15 new tools, reports and evaluations (triple the number anticipated for the whole year) on topics such as provider incentives, consumer incentives, measuring efficiency, consumer-friendly public reporting templates, ways to identify populations with high numbers of potentially preventable hospital admissions, strategies for achieving waste, etc. This material provided the core curriculum for the Learning Network and also achieved wide visibility across the country with employers, providers, consumers, and others seeking major improvements in value. A priority for 2010 is continuing to build the evidence base for value and efficiency, and we expect at least 10 new tools and reports.

- **Coordination forum for public payers.** The federal government is the largest purchaser of health care, and therefore value-driven health care can not succeed without the active collaboration of federal payers in this effort. In FY 2008 AHRQ established a forum to facilitate coordination across public payers and this work will continue.

**Current Plans to Support the Value Portfolio in FY 2009**

The CVEs we recruited represent a large segment of the American population, in many cases including entire states. The program chartered 25 CVEs (of which 24 continue), representing a much larger combined population (124 million) than we had originally anticipated (300,000). Given the broad areas and populations represented, for FY 2009 we plan to focus on these existing CVEs, to help them in their community-wide and state-wide public reporting, payment, and quality improvement efforts. AHRQ will support the CVEs by re-competing a new contract for the CVE Learning Network to provide technical assistance to the CVEs via Webinars, in-person meetings, a private CVE Web site and one-on-one consulting.

The program will continue to produce evidence and tools for the CVEs, such as the EQUIPs tool now under development, which will allow CVEs to build their own Web sites for reporting information on hospital utilization, costs, and quality; and, the program will produce evidence-based decision guides for CVEs on performance measurement and public reporting.

HCUP staff will continue nurturing their relationships with States to increase the number of States reporting hospital cost data.

**Comparison of FY08 Actual Performance with FY08 Target Levels of Performance:**
**1.3.27** Increase the number of people who are served by community collaboratives that are using evidence-based measures, data and interventions to increase health care efficiency and quality.
**Target:** 300,000
**Actual Performance:** 124 million
Because of widespread interest, geographic areas that the CVE collaboratives serve are much larger than originally expected.

**1.3.28** Increase the # of Chartered Value Exchanges (CVEs)
**Target:** 25
**Actual Performance:** 25
Because of high interest among Community Leaders, 25 community collaboratives applied and were chartered to become CVEs.

**1.3.29** Increase the number of states of communities reporting market-level hospital cost data.
**Target:** 4
**Actual Performance:** AHRQ's HCUP staff have worked hard to build relationships with the States producing the data, and have convinced States of the value of producing cost-level hospital data, resulting in availability of cost-level information for 2006 data by diagnosis for the following 16 States: AZ, FL, IA, KY, MD, NV, NJ, NY, NC, OR, RI, UT, VT, WA, WV, and WI. Due to the States interest in CVEs, the program decided to produce cost data for each of those mentioned above. In FY 2009 the program will assess the ambitiousness of current targets.

**1.3.30** Increase the number of communities or states with public report cards.
**Target:** 5
**Actual Performance:** 15
Due to the extraordinary effectiveness of the Learning Network, a total of15 CVEs have stakeholder organizations that are engaged in public reporting of physician and/or hospital data. CVEs include larger geographic areas (and more stakeholder organizations) than was originally expected, resulting in more states with public report cards. In FY 2009 the program will assess the ambitiousness of current targets.

**1.3.31** Increase the number of new reports, tools, evaluations available for CVEs
**Target:** 5
**Actual Performance:** 13
The Learning Network was able to respond to high CVE demand for reports and tools; therefore, at least 13 reports, tools or evaluations were created for CVEs in FY 08. These included 8 community inventory modules to help the CVEs assess projects underway in their communities across the 8 CVE focus areas; 4 tools created as part of a consumer engagement toolkit; 1 guide for public reporting performance information. In FY 2009 the program will assess the ambitiousness of current targets.

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

| # | Key Outcomes/ Outputs | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|
| 1.3.27 | Increase the number of people who are served by community collaboratives that are using evidence-based measures, data and interventions to increase health care efficiency and quality | NA | NA | NA | NA | 300,000 People | 124 million | 124 million |
| 1.3.28 | Increase the # of Chartered Value Exchanges (CVEs) | NA | NA | NA | NA | 15 | 25 | 25 |
| 1.3.29 | Increase the total number of states or communities reporting market-level hospital cost data | NA | NA | NA | NA | 4 | 16 | 16 |
| 1.3.30 | Increase the total number of communities or states with public report cards | NA | NA | NA | NA | 5 | 15 | 18 |
| 1.3.31 | Increase the total number of new reports, tools, evaluations available for CVEs | NA | NA | NA | NA | 5 | 13 | 23 |

## *Other Quality, Effectiveness and Efficiency Research*

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

- Effectiveness Research: A*ssure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.* To assure the effectiveness of health care research and information is to assure that it leads to the intended and expected desirable outcomes. Supporting activities that improve the effectiveness of American health care is one of AHRQ's strategic goals. Assuring that providers and consumers get appropriate and timely health care information and treatment choices are key activities supporting that goal.

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

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

Research and Training Grants

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

**CAHPS®.** CAHPS is a multi-year initiative of AHRQ. Originally, "CAHPS" referred to AHRQ's "Consumer Assessment of Health Plans Study." However, in 2005, AHRQ changed this to "Consumer Assessment of Health Providers and Systems." This name better reflects the evolution of CAHPS from its initial focus on enrollees' experiences with health plans to a broader focus on consumer experience with health care providers and facilities. AHRQ first launched the program in October 1995 in response to concerns about the lack of reliable information about the quality of health plans from the enrollees' perspective. The survey was adopted by the Centers for Medicare and Medicaid Services (CMS), U.S. Office of Personnel Management and the National Committee for Quality Assurance for public reporting and accreditation purposes. As of 2008, 141,000,000 Americans are enrolled in health plans for which CAHPS data are collected. Over time, the program has expanded beyond its original focus on health plans to address a range of health care services and meet the various needs of health care consumers, purchasers, health plans, providers, and policymakers. The program has been through two scopes of work, CAHPS I and CAHPS II. Grants for CAHPS III were awarded in June 2007. These grants focus on quality improvement strategies and strengthening approaches to the reporting of CAHPS data.

CMS now requests all acute care hospitals to field the CAHPS Survey for Hospitals and report the data to CMS. Hospitals who fail to report these data on a quarterly basis will not receive the full market-basket update. CMS then publishes survey results on their *HospitalCompare* website so that consumers and other interested and parties can compare hospital performance.

In 2008, AHRQ released these new CAHPS Surveys:

- CAHPS Survey for Home Health Care
- CAHPS Clinician and Group Survey (visit-specific and 6 point scale versions)

We are also working on two sets of supplemental items: health literacy (to supplement the hospital instrument) and health IT (to supplement the health plan instrument).

These surveys are in addition to our existing ambulatory and facility surveys:

<u>CAHPS Ambulatory Care Surveys</u>

- Health Plan Survey, which includes versions for:
    - Medicare population
    - Fee-for-service and managed care settings

And supplemental items addressing:

    - Health literacy
    - Cultural competence
    - People with mobility impairments
    - Medicare Part D prescription drug plan

- Clinician & Group Survey
- ECHO Survey (for assessment of behavioral healthcare)
- Home Health Care Survey
- Adult Dental Care Survey
- American Indian Survey

<u>CAHPS Facility Surveys</u>

- CAHPS Hospital Survey
- Supplemental health literacy items
- CAHPS In-Center Hemodialysis Survey
- CAHPS Nursing Home Resident Survey
- CAHPS Nursing Home Family Survey

In FY 2007 AHRQ increased the number of Americans who have access to CAHPS data to 41 percent over the baseline of 100 million users – 141 million users of CAHPS information (see performance table 1.3.23). We did not, however, increase this number in FY 2008. Below we describe some of the factors that affected our ability to increase the number of CAHPS users for FY '08, as well as our plans for boosting the use of surveys in the coming fiscal year.

▪*Surveys released in FY 2008 need time to take root.* Neither the CAHPS Home Health Care Survey nor the new versions of the Clinician/Group Survey have not been available for use for very long and

so have not been publicized to the extent that they could be. We address what we are doing to change this below.

▪*Provision of support for existing surveys takes resources.* It takes a certain amount of resources to develop a CAHPS survey, and it takes continuing resources to maintain its use. CMS decides every year whether or not to field a number of CAHPS surveys, including the Medicare, hospital, prescription drug and nursing home surveys. To support their use of these surveys, the project officer meets with CMS twice a month to learn of and respond to concerns or questions related to their use. In the past year, we have assisted CMS in development of: a press event to announce the publication of CAHPS Hospital Survey results on the *HospitalCompare* website, and a presentation to the National Quality Forum to obtain their endorsement for the CAHPS Home Health Care Survey. Both of these were time-consuming and critical activities to maintain CAHPS survey use. We also provide technical assistance to all organizations and individuals who request this. Our family of surveys continues to grow each year but the number of AHRQ staff persons who provide support has not grown accordingly.

▪*Some surveys reach market saturation.* There are some surveys for which we will not see additional users because we have reached market saturation. For example, virtually all of the acute care hospitals in the country report their Hospital CAHPS survey results to CMS because they will not receive their market-basket update if they don't. So, though we need to continue support of this survey—responding to calls from users, responding to questions from CMS, developing an annual chart book that shows where hospitals across the nation are succeeding and where they need to improve CAHPS scores; renewing our endorsement by NQF—we will see no increase in users because we've hit the ceiling. The same is true of the CAHPS Health Plan Survey. Users of this survey include CMS for the Medicare population, OPM for federal employees, and the National Committee on Quality Assurance for managed care plans. These users collectively obtain millions of CAHPS surveys each year and it would be an ineffective use of scarce resources to even identify the organizations who do not participate in one of these networks. So, again, we will see no improvement in numbers for this survey but will need to continue provision of technical assistance.

Plans for increasing use of CAHPS surveys in the coming year include the following:

- Presentation of the 11th CAHPS User Meeting
- Highlight use of the Clincian/Group survey
- Publicize use of Home Health Care CAHPS
- Provide updated reporting information
- Work with users on improving quality

**CERTs**. The Centers for Education & Research on Therapeutics (CERTs) demonstration program is a national initiative to conduct research and provide education that advances the optimal use of therapeutics (i.e., drugs, medical devices, and biological products). The program consists of 14 research centers and a Coordinating Center and is funded and run as a cooperative agreement by AHRQ in consultation with the U.S. Food and Drug Administration (FDA). The CERTs receive funds from both public and private sources, with AHRQ providing core financial support -- $13 million in FY 2010. The research conducted by the CERTs program has three major aims:

- To increase awareness of both the uses and risks of new drugs and drug combinations, biological products, and devices, as well as of mechanisms to improve their safe and effective use.
- To provide clinical information to patients and consumers; health care providers; pharmacists, pharmacy benefit managers, and purchasers; health maintenance organizations and health care delivery systems; insurers; and government agencies.

- To improve quality while reducing cost of care by increasing the appropriate use of drugs, biological products, and devices and by preventing their adverse effects and consequences of these effects (such as unnecessary hospitalizations).

**Inappropriate Antibiotic Use in Children: Measure 4.4.1**

Results show that from FY 2005 through FY 2008, the average number of antibiotic prescriptions for U.S. children ages 1-14 has fluctuated, with no statistically significant net change. In FY 2004, baselines rates were established (0.56 prescriptions per child). In FY 2007 the target was a 1.8% drop; the actual result was a 13.3% drop (0.52 prescriptions per child), which exceeded our target. In FY 2008, the target was a 1.8% drop, and the actual result was a 10.7% increase (0.58 prescriptions per child). The result for FY 2008 (0.58 prescriptions per child) is 2.9% higher than the FY 2004 baseline estimate (0.56 prescriptions per child), which is not a statistically significant difference for the measurement tool. Therefore, there was no effect on overall program or activity performance.

Notwithstanding annual fluctuations, the target has remained at a 1.8% drop each year. Continued examination of trends over time will assist in determining whether the targeted decline in use is realistic, achievable, and accurately reflects "appropriate" levels of prescribing. During FY 2008, the target was not achieved.

This goal includes children, a priority population for AHRQ. Reduction in antibiotic use by children is expected to reduce adverse reactions associated with medications and the cost of medical care. Reduced use may also lessen the rates of resistant organisms, an important public health problem. A two-pronged approach to reduced use is needed, through both the clinician and the caregiver. .

One of the 4 new CERTs research centers recently awarded in FY 2007 is aimed at improving outcomes for children by optimizing the use of therapeutics. A preliminary project that is part of a multi-year effort initiated in the 3rd quarter of FY 2008 will assess the feasibility and reliability of performance metrics for otitis media with effusion in primary care practice. These metrics, based on guidelines by the American Academy of Pediatrics, were developed by the American Medical Association and approved for accountability by the National Quality Forum. However, these measures have never been evaluated in practice. One of the measures specifically assesses the appropriate use of antibiotics in children between the ages of two months and twelve years who have otitis media with effusion. This evaluation, once complete and disseminated through participating professional organizations, should facilitate implementation of the research findings and thereby have a direct impact on AHRQ performance measure 4.4.1: reduce antibiotic inappropriate use in children between the ages of one and fourteen.

**Congestive Heart Failure Readmission Rates: Measure 4.4.2**

Results show that from FY 2005 through FY 2007, the actual rates of readmission for congestive heart failure during the first six months in those between 65 and 85 years of age have trended downward, showing no statistically significant difference between the target and actual rates. In FY 2004, baselines rates were established (38% readmission rate). In FY 2005, the target was a 2.6% drop and the actual result was a 2.7% drop (36.99% readmission rate). In FY 2006, the target was a 2.7% drop and the actual result was a 0.7% drop (36.74% readmission rate). In FY 2007, the target was a 1.4% drop and the actual result was a 0.6% drop (36.51% readmission rate).

However, the most recent results from FY 2008 did meet and exceed the corresponding target. In FY 2008, the target was a 1.4% drop and the actual result was a 13.0% drop (31.91% readmission rate). We do not know why FY2008 experienced such a large drop in the rate of CHF readmission rates. Continued examination of trends over time will assist in determining whether the targeted

decline is realistic, achievable, and accurately reflects "appropriate" levels of measurement. An independent evaluation will be completed in FY 2009 to assess the need for modification of targets based upon trends.

In FY 2008, efforts have continued to reduce the congestive heart failure hospital readmission rates in those between 65 and 85 years of age. For example, another research center is aimed at improving evidence based heart failure therapy and its consequences. An ongoing study by this CERT will create a hybrid national surveillance system to monitor the safety and effectiveness of heart failure therapies using augmented American Heart Association's Get with the Guidelines – Heart Failure (AHA GWTG-HF) database with longitudinal links to Medicare claims data. As well the researchers will evaluate a personalized feedback, education and quality improvement system for improving heart failure care. This project, once complete and disseminated through peer-reviewed publications and participating professional organizations, will have a direct impact on AHRQ performance measure 4.4.2: reduce congestive heart failure hospital readmission rates during the first six months in those between 65 and 85 years of age by implementing the research findings.

Within the Comparative Effectiveness Portfolio, the PART goals that were previously established for the Pharmaceutical Outcomes area have largely been met. Hospital readmissions for CHF have declined annually, as have the rate and per capita cost of hospitalization for upper GI bleeding. The one measure with equivocal change is inappropriate antibiotic use in children, which was targeted as an absolute decline in the number of U.S. prescriptions for antibiotics in children between the ages of 1 and 14. This measure merits reconsideration in the planned independent evaluation of measures in FY2009.

**Upper GI Bleeding: Measures 4.4.3 and 4.4.4**

Results show that from FY 2005 through FY 2007, the actual rate of hospitalizations for upper GI bleeding due to adverse effects of medication or inappropriate treatment of peptic ulcer disease in those between 65 and 85 years of age have consistently met or slightly exceeded the targets. In FY 2004, baselines rates were established (55/10,000). In FY 2006, the target was a 1.1% drop and the actual result was a 2% drop (54.38/10,000). In FY 2007, the target was a 2% drop and the actual result was a 5.2% drop (51.56/10,000).

The most recent results from FY 2008 did meet the corresponding target. In FY 2008, the target was a 1.8% drop and the actual result was a 3.5% drop (49.75/10,000). Although FY2007 and FY2008 had approximately double the targeted decrease in hospitalizations for GI bleeding, we retained the previously modeled FY2009 target of a 3% decrease pending a planned evaluation in FY2009 as described above under 4.4.2.

Results show that from FY 2005 through FY 2007, the number of admissions for GI bleeding have generated a per year drop in per capita charges for GI bleeding and our targets have consistently been met. In FY 2004, baselines rates were established ($96.54 per capita). In FY 2006, the target was a 3% drop and the actual result was a 3.2% drop ($93.36 per capita). In FY 2007, the target was a 4% drop and the actual result was a 4.9% drop ($91.81 per capita).

The most recent results from FY 2008 did meet the corresponding target. In FY 2008, the target was a 5% drop and the actual result was a 5.1% drop ($87.10 per capita). Given the past trend, we believe it is reasonable to expect that hospitalization for upper GI bleeding due to adverse events of medication or inappropriate treatment of peptic ulcer disease in those between 65 and 85 years of age will decrease, and the decreased number of admissions will continue to generate an annual drop in per capita charges for GI bleeding. The target selected for FY 2009 is a 6% drop. The target

selected for FY 2010 is a 7% drop. In FY 2009 the program will assess the ambitiousness of current targets.

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

The CERTs program recently initiated a warfarin interaction study to better define the relative safety of commonly used antibiotics and antifungals when co-administered with warfarin. The safety outcome will be major bleeding complications of warfarin, as confirmed by medical record review. This study will test the hypothesis that in a cohort of warfarin users, the risk for major gastrointestinal (GI) bleeding complications differs among the specific study antimicrobials. At present, clinicians cannot make evidence-based choices when prescribing antibiotics and antifungals with warfarin, because the overall quality of interaction literature for warfarin is poor. These data on the relative safety of antimicrobials would inform clinical decisions for this vulnerable population. This research, once complete, will have a direct impact on AHRQ's performance measure 4.4.3: reduce hospitalization for upper gastrointestinal bleeding due to the adverse effects of medication or inappropriate treatment of peptic ulcer disease, in those between 65 and 85 year of age by implementing the research findings.

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

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

- Between 1997 and 2006, there were substantial increases in hospitalizations for skin and subcutaneous tissue infections (81 percent), blood infections (48 percent), degenerative joint disease (76 percent), and non-specific chest pain (59 percent). This compares to a 14 percent increase in all discharges.

- Blood transfusions occurred in one out of every ten hospital stays that included a procedure in 2006. Discharges with blood transfusions have increased 117 percent from 1997 to 2006, making this the largest as well as the fastest growing of the most common procedures

performed during a hospital stay.

- Between 1993 and 2006, the number of infants born by C-section grew at an average annual rate of 4 percent. Several complications of C-section births grew more quickly, including post-birth respiratory problems (6 percent), jaundice (7 percent), and feeding problems (11 percent).

- Patients living in the lowest income communities had a higher rate of hospitalization for depression (161 stays per 100,000 population) than persons in the highest income communities (112 stays per 100,000 population).

In FY 2008 AHRQ met our performance target (see performance table 1.3.15) to increase the number of partners contributing outpatient data to the HCUP databases. The number of State Ambulatory Surgery Databases (AS) increased by 3 partners (California, Maine, and Oklahoma) and the number of State Emergency Department Databases (ED) increased by 3 partners (California, Maine, and New York). They were selected based on the diversity –in terms of geographic representation and population ethnicity—they bring to the project, along with data quality performance and their ability to facilitate timely processing of data. This outcome exceeded the goal by adding 6 new Partner databases instead of 4. Evidence of the addition of the databases can be found on the HCUP-US website which illustrates the project's partners and databases by state, year, and type.

HCUP was able to achieve this goal by actively searching out non-traditional sources of outpatient data, providing in-depth support with data partners and establishment of long term relationships with data providers. HCUP has matured to the point of having incorporated most of the available and viable data collections that met the long established criteria for the project. Because HCUP teams with organizations that already collect data for various purposes, the project is, of course, limited by the number of U.S. states with established inpatient and outpatient data collections. Therefore, we decided to look beyond our current organizational partnerships and shift focus from exploring one of the remaining non-HCUP states to expanding HCUP data sources in order to improve the robustness of national estimates. This included redefining the data criteria and looking beyond public institutions in order to cast a wider net for potential data sources. The goal of the new data sources was to fill the gaps in the Nation's data created in states where data is either not available or states with statewide data systems that may not have the option to participate as HCUP Partners. By reaching beyond traditional sources, we were successful in uncovering previously unknown inpatient and outpatient data such as in the state of Wyoming which subsequently joined the HCUP partnership. A concentrated effort was made to secure additional emergency department databases to enable the development of HCUP's first nationwide emergency department database.

HCUP and the Quality Indicators projects also began development of a new AHRQ tool – a website builder that would allows any organization or Agency to input their data and then output a website. It is being developed to be used by anyone with access to hospital discharge data and will allow users to generate quality, cost, and utilization statistics for websites that will be hosted on local servers by individual organizations. These websites will provide information in a uniform way using uniform measures at whatever level the host user chooses (e.g., county-level, hospital-level) to various audiences (e.g., patients/consumers, constituent hospitals, public health officials). These efforts, along with others to speed up the production of HCUP databases, increase data representativeness, examine data linkages, facilitate the inclusion of clinical information in administrative data, and begin development of EQUIPS work to ensure future program performance and support of the Agency's portfolios.

Another widely used HCUP tool is the AHRQ QIs which are a set of quality measures developed from HCUP data. This measure set is organized into four modules—Prevention, Inpatient, Patient Safety, and Pediatrics. The Prevention Quality Indictors (PQIs) focus on ambulatory care sensitive conditions that identify adult hospital admissions that evidence suggests could have been avoided, at least in part, through high-quality outpatient care. Inpatient Quality Indicators (IQIs) reflect quality of care for adults inside hospitals and include: Inpatient mortality for medical conditions; inpatient mortality for surgical procedures; utilization of procedures for which there are questions of overuse, underuse, or misuse; and volume of procedures for which there is evidence that a higher volume of procedures maybe associated with lower mortality. Patient Safety Indicators (PSIs) also reflect quality of care for adults inside hospitals, but focus on potentially avoidable complications and iatrogenic events. Pediatric Quality Indicators (PDIs) both reflect quality of care for children below the age of 18 and neonates inside hospitals and identify potentially avoidable hospitalizations among children. These measures are publicly available as part of an AHRQ supported software package.

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

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

The AHRQ QIs are widely used for quality improvement and public reporting initiatives. Many of the AHRQ QIs have been endorsed by the National Quality Forum for public reporting. There are currently over 2,000 subscribers to the AHRQ QI listserv and approximately 150 inquiries being received monthly. Several states are using the QIs for public reporting on hospital quality. Most recently, Kentucky became the 12th state to use the AHRQ Quality Indicators in a hospital level public report card. The Kentucky Hospital Association used a subset of the Quality Indicators in its 2007 Report. The report can be found at http://chfs.ky.gov/ohp/healthdata/. Kentucky's hospital level report includes the AHRQ Inpatient and Prevention Quality Indicators. The state of Connecticut has used the AHRQ QIs to produce a report called "Preventable Hospitalizations in Connecticut: An Updated Assessment of Access to Community Health Services." The report can be found at http://www.ct.gov/ohca/lib/ohca/publications/2008/prev_hosp.pdf).

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

| # | Key Outcomes/ Outputs | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|
| 4.4.1 | The number of prescriptions of antibiotics per child aged 1 to 14 in the U.S. | 0.59 per year | 0.60 per year | 0.53 per year | 0.52 per year | 0.52 per year | 0.58 per year | 0.51 per year |

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

| # | Key Outcomes/ Outputs | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 4.4.2 | The percentage of hospital readmissions within 6 months for congestive heart failure in patients between 65 and 85 years of age. | 36.99% | 36.74% | 35.5% | 36.51% | 35% | 31.91% | 34.5% |

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

| # | Key Outcomes/ Outputs | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|
| 4.4.3 | The decrease in the rate of hospitalization for upper gastro-intestinal bleeding due to the adverse effects of medication or inappropriate treatment of peptic ulcer disease in patients between 65 and 85 years of age. | 0%<br>(no change) | 1.1%<br>drop | 2%<br>drop | 5.2%<br>drop | 1.8%<br>drop | 3.5%<br>drop | 3%<br>drop |
| 4.4.4 | The cost per capita of hospital admissions for upper gastro-intestinal bleeding among patients aged 65 to 84. | 3.4% drop<br>($93.20) | 3.2% drop<br>($93.36) | 4% drop<br>($92.68) | 4.9%<br>($91.81) | 5% drop<br>$91.71 | 5.1% drop<br>$87.10 | 6% drop<br>$90.75 |

**Long-Term Objective 4:** Achieve wider access to effective health care services and reduce health care costs.

| # | Key Outcomes/ Outputs | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|
| 1.3.15 | Increase # of partners contributing data to HCUP databases by 5% above FY 2000 baselines[1] | 5 new outpatient datasets | 21 Ambulatory Surgery (AS)<br><br>17 Emergency Department (ED) | Increase # of partners contributing to HCUP databases | 24 AS<br><br>22 ED | Increase # of partners contributing to HCUP databases | 27 AS<br><br>25 ED | Increase # of partners providing data by 3 |
| 1.3.22 | Number of additional organizations per year that use Healthcare Cost and Utilization Project (HCUP) databases, products or tools in health care quality improvement efforts. | 2 organizations | 3 new organizations<br><br>Organization for Economic Cooperation & Development<br><br>CT Office of Health Care Access<br><br>Dallas-Fort Worth Hospital Council<br><br>Canada's Public Reports<br><br>Impact – CO Health & Hospital Association | 3 organizations and 1 implementation will use HCUP/ QIs to assess QI<br><br>Impact in at least 1 organization | 3 new organizations – CO Health Institute<br><br>OH Department of Health<br><br>Harvard Vanguard Medical Association & Atrias Health<br><br>Impact – University Health-system Consortium | Impact will be observed in 1 new organization after the development and implementation of an intervention based on the QIs | 5 new organizations<br><br>Kentucky Hospital Association<br><br>SSM Health Care<br><br>IN CHCS<br><br>Robert Wood Johnson<br><br>University Hospital<br><br>Impact observed in 1 new organization. St. Tammany Parish Hospital | 3 new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least of them will develop and implement an intervention based on the QIs<br><br>Impact will be observed in 1 new organization after the development and implementation of an intervention based on the QIs |

[1] This measure is annual and represents additional partner data per year. The Healthcare Cost and Utilization Project (HCUP) is a family of health care databases and related software tools and products developed through a Federal-State-industry partnership and sponsored by AHRQ. HCUP databases bring together the data collection efforts of 39 State data organizations, hospital associations, private data organizations, and the Federal government in a voluntary data sharing partnership to create a national information resource of patient-level health care data. HCUP executes memorandums of agreements with its state-level data partners which specify the partnering arrangements and data permissions and restrictions. At present, only HCUP has held discussions with all the remaining U.S. States that collect and release hospital data to pursue partnership. Four States do not collect hospital inpatient data.

**Long-Term Objective 5:** Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.

| # | Key Outcomes/ Outputs | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1.3.23 | # of consumers who have accessed CAHPS information to make health care choices | 135 Million<br><br>Completed ICH-CAHPS survey | 138 Million<br><br>Completed surveys | Inc 40% over baseline (140 million) | 41% (141 Million) | 42% (142 million) | 41% (141 Million) | 44% (144 million) |

### *Health IT*

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

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

- Demonstration of best practices for health information exchange, through projects like the Midsouth eHealth Alliance in Tennessee. The Midsouth alliance seeks to 1) improve patient care, 2) decrease ED utilization, 3) reduce hospital stays, 4) contain costs and 5) reduce overlapping tests with its health information exchange efforts (http://www.midsoutheha.org/documents/MSeHA%20Newsletter%20January%202008.pdf). Currently entering its fourth year of existence, this data exchange serves all major emergency rooms in Memphis with over 50 million laboratory results and other encounter information available on nearly 1 million individuals.

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

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

The Health IT program at AHRQ set several ambitious performance measures in 2004, and has seen steady progress on all of the measures and some notable achievements. To meet the President's goals of widespread adoption of electronic medical records, we partnered with CMS to test and recommend e-prescribing standards for national adoption, which was a requirement of the Medicare Modernization Act of 2003. This major achievement began in May 2005, and over two years several pilot projects were solicited, awarded and conducted, and a detailed evaluation was performed. The result has been a mandated Report to Congress in April 2007, and a Notice of Proposed Rulemaking from CMS to require use of the ready standards for Medicare beneficiaries. We have continued this productive partnership with CMS by co-funding a pilot testing more standards in September 2008, which may lead to further standard adoption in 2010. Electronic prescribing is widely believed to be a component in improving the quality, safety, and efficiency of healthcare. Without data standards, however, e-prescribing cannot achieve its potential. Pilot testing e-prescribing standards revealed which standards were ready for widespread distribution and which require additional work. As this technology develops further we look forward to showing the Nation the best ways to use e-prescribing to improve the safety and quality of health care.

EHR adoption has slowly increased, and our 2007 goal of 15% of providers adopting was met. Our grants and contracts have produced significant insight into the best practices in implementation and use of EHRs, and continue to advance this field of knowledge. Examples include recent peer-reviewed publications showing that e-prescribing can reduce drug costs, and that medical malpractice suits are reduced among providers that use EHRs. External barriers to adopt continue to pose a challenge, including the capital required from providers to purchase the system and uncertainty in the market for these products.

Similarly, hospitals have continued to steadily adopt computerized physician order entry, and in 2007 that technology is being utilized by 27% of providers across the Nation. We have developed evidence and tools that inform the best use of this technology, and will continue to disseminate those tools through our public and private partnerships. This year the Leapfrog Group used an AHRQ-funded evaluation tool in their annual evaluation of hospital adoption of best safety practices.

In FY 2008, the following results were obtained from measures which have now been discontinued (see Discontinued Performance Measures section below): **1.3.8** - Most Americans will have access to and utilize a Personal Health Record (PHR) - a tool was developed and deployed to assess the perspectives of Medicare beneficiaries and their use of personal health records; **1.3.6** - Increase physician adoption of Electronic Health Records (EHRs) – according to a National Center for Health Statistics (NCHS) survey 38.4% of physicians use electronic medical records; **1.3.36** - Increase the number of ambulatory clinicians using electronic prescribing to over 50% - a 6% increase was reported by the Surescripts National Progress Report on Electronic-Prescribing; **1.3.9** - Engineered Clinical Knowledge will be routinely available to users of EHRs – Health IT awarded two contracts to support the development, adoption, implementation and evaluation of best practices using clinical decision support.

Decision support is a critical next step beyond adoption of health IT, and represents significant potential for good information systems to help deliver high quality health care. Some of the basic building blocks

are in place, as seen through CCHIT certification criteria for health IT. Our programs will develop and demonstrate the most effective use of evidence-based information to inform the Nation's health care providers and policy makers.

The AHRQ Health IT Program has embarked on a plan to improve the performance and management of the program and has met or exceeded all time PART improvement plan deadlines. In FY08 the program developed and gained OMB approval of an efficiency measure. In addition, in activities begun in FY08 and completed in FY09, the program gained feedback on how to improve its website by conducting focus groups of program stakeholders and summarizing the results, developed multiple "how to guides" for the NRC website and developed and gained OMB approval of a long term performance measure.

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

| # | Key Outcomes/ Outputs | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|
| 1.3.52 | The percentage of visits to doctors' offices at which patients with coronary artery disease are prescribed antiplatelet therapy, among doctors' offices that use electronic health records with clinical decision support | N/A | N/A | Baseline | Aug 2009 | TBD | TBD | TBD |
| 1.3.48 | Average cost per grantee of development and publication of annual performance reports and final reporting products on the AHRQ National Resource Center for Health IT (NRC) website (http://healthit.ahrq.gov). | N/A | N/A | N/A | N/A | N/A | N/A | Baseline |

## *Patient Safety*

The Patient Safety Program is comprised of two key components: (1) coordination of support for the creation, synthesis, dissemination, implementation and use of knowledge about patient safety threats and medical errors and (2) operation of a program to establish Patient Safety Organizations (PSOs) which are a fundamental element of the Patient Safety and Quality Improvement Act (Patient Safety Act) of 2005. The Patient Safety Act provided needed protection (privilege) to providers throughout the country for quality and safety review activities. By fostering increased event reporting and peer review, through removal of the threat of disclosure in medical malpractice cases, this legislation is anticipated to support and spur advancement of a culture of safety in healthcare organizations across the country. AHRQ administers the provisions of the Patient Safety Act dealing with PSO operations. The Department of Health and Human Services (HHS) has issued regulations to implement the Patient Safety Act, which authorizes the creation of Patient Safety Organizations (PSOs). The final rule will become effective on January 19, 2009. Interim Guidance currently guides HHS implementation and interpretation of the Patient Safety Act.

The Patient Safety Program's goal as stated historically is to prevent, mitigate and decrease the number of medical errors, patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients. The Program funds grants, contracts, and interagency agreements (IAAs) to support projects that identify the threats; identify and evaluate effective practices; educate, disseminate, and implement to enhance patient safety and quality; and maintain vigilance.

The Patient Safety Program, which formally commenced in FY 2001, began with AHRQ awarding $50 million for 94 new projects aimed at reducing medical errors and improving patient safety. Throughout the past seven years, AHRQ has funded many additional projects and initiatives in a number of areas of patient safety and health care quality. As a result, a large body of research continues to emerge, and numerous surveys, reporting and decision support systems, training and technical assistance opportunities, taxonomies, publications, tools, and presentations are available for general use. AHRQ has addressed these patient safety issues independently and in collaboration with public and private sector organizations.

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

**Research Grants**

- Through a study funded by AHRQ for which preliminary findings are currently available, it is estimated that 95% of hospitals have some type of reporting system. This is based on a nationally representative sample of 2,000 hospitals with an 81% survey response rate. Only about 12% of the respondents had a fully computerized system. (FY 2005 funding = $165,909). Plans include a repeat survey of hospitals to update this estimate during FY2009.

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

- In September 2008, AHRQ awarded $3,708,799 for 13 risk-informed intervention grants. These 3-year projects build on previously funded risk assessment projects funded by AHRQ and

support risk-informed development and implementation of safe practice interventions that have the potential of eliminating or reducing medical errors, risks, hazards, and harms associated with the process of care in the ambulatory setting. The objectives of the projects are to (1) Identify, develop, test, and implement safe practice interventions in ambulatory care settings, and (2) Share the findings and lessons learned about the challenges and barriers to developing and implementing these interventions through toolkits. (Source: http://www.ahrq.gov/qual/risk08.htm)

**Training Programs**

- The Patient Safety Improvement Corps (PSIC) is a partnership program between the Agency for Healthcare Research and Quality (AHRQ) and the Department of Veterans Affairs (VA). The primary goal is to improve patient safety by providing the knowledge and skills necessary to:
  - Conduct effective investigations of reports of medical errors (e.g., close calls, errors with and without patient injury) by identifying their root causes with an emphasis on underlying system causes.
  - Prepare meaningful reports on the findings.
  - Develop and implement sustainable system interventions based on report findings.
  - Measure and evaluate the impact of the safety intervention (i.e., that will mitigate, reduce, or eliminate the opportunity for error and patient injury).
  - Ensure the sustainability of effective safety interventions by transforming them into standard clinical practice.

- The PSIC program content includes a number of topics, tools, and methods designed to help participants reduce medical error and improve patient safety (e.g., patient safety science, human factors, root cause analysis, health care failure mode and effects analysis, probabilistic risk assessment, medical error reporting and analysis, measurement, evaluation, communication, leading and sustaining organizational change, safety culture assessment, high reliability organizations' characteristics and operations, TeamSTEPPS™ team training, mistake-proofing in the delivery of health care, just culture, and other topics such as the Patient Safety and Quality Improvement Act of 2005, patient safety organizations, patient safety indicators, and the National Healthcare Quality and National Healthcare Disparities Reports). Source: http://www.ahrq.gov/about/psimpcorps.htm.

- The first Patient Safety Improvement Corps (PSIC) class (2003-04) consisted of teams from 15 states and included 19 hospitals/healthcare systems, 14 departments of health, and one quality improvement organization.

- In FY 2005, the PSIC trained students from 19 states and the District of Columbia, representing 35 hospitals/health care systems. In FY 2006, the PSIC trained students from 16 states representing 19 hospitals/health care systems.

- The fourth and final class was conducted in FY 2007. It was composed of 92 students representing 23 teams including 32 hospitals/hospital systems and 5 quality improvement organizations.

- Each year, PSIC exceeded the target number of organizations. With the fourth class, the PSIC has trained a team in every state in the U.S. Additionally, AHRQ produced a PSIC DVD which provides a self-paced, modular approach to training individuals involved in patient safety activities at the institutional level. This interactive, 8-module DVD provides information on the investigation of medical errors and their root causes; identification, implementation, and evaluation of system-level interventions to address patient safety concerns; and steps

necessary to promote a culture of safety within a hospital or other health care facility. (FY 2009 funding for PSIC = $300,000)

- It has been an expectation that "graduates" from the PSIC program will both use their PSIC training to become change agents in their home organizations and go on to implement as well as train others using the knowledge, skills, and patient safety improvement techniques delivered in their PSIC training. For example, as a result of participating in the PSIC, the State of Maine, in 2008 and 2009, is attempting to train all hospitals in the use of TeamSTEPPS. The Connecticut Hospital Association and team members from the Connecticut Department of Public Health have also studied Connecticut's adverse event reporting system. This effort helped the Department of Public Health's Quality in Health Care Advisory Committee, which developed formal recommendations to enhance the effectiveness of the state's adverse event reporting system. The Committee's recommendations were incorporated in legislation enacted by the Connecticut legislature in May 2004. In October 2005, the New York State Department of Health rolled out their PSIC-based training program including more than 700 people from the state's free-standing diagnostic and treatment centers (e.g., Ambulatory Surgery Centers, End Stage Renal Disease Dialysis Centers, Community Healthcare Centers) and selected Department of Health clinics. In Georgia, the Georgia Hospital Association (GHA) developed their PSIC based on GHA's staff participation in the 2004-2005 PSIC program. The GHA PSIC used 5 two-day face-to-face workshops, 8 Webinars, and 4 networking audio conferences. This training enabled the GHA PSIC program attendees to go back to their organizations, train additional staff, and implement patient safety improvement programs.

**Resources/Tools**

- AHRQ also supports the AHRQ Patient Safety Network (AHRQ PSNet). It is a national Web-based resource featuring the latest news and essential resources on patient safety. The site offers weekly updates of patient safety literature, news, tools, and meetings ("What's New"), and a vast set of carefully annotated links to important research and other information on patient safety ("The Collection"). Supported by a robust patient safety taxonomy and Web architecture, AHRQ PSNet provides powerful searching and browsing capabilities, as well as the ability for diverse users to customize the site around their interests (My PSNet). In addition, AHRQ funds the WebM&M (Morbidity and Mortality Rounds on the Web). WebM&M is an online journal and forum on patient safety and health care quality. This site features expert analysis of medical errors reported anonymously by readers, interactive learning modules on patient safety ("Spotlight Cases"), Perspectives on Safety, and forums for online discussion. Use of these sites has increased over the past 3 years, from approximately 57,000 web sessions in April 2005, to more than 190,000 in April 2008. (Funding for the PSNet and WebM&M total $1.3 million in FY 2009)

- In the Institute of Medicine's 1999 report on medical errors, they suggested that systemic failures were important underlying factors in medical error and that better teamwork and coordination could prevent harm to patients. The IOM recommended that health care organizations establish team training programs for personnel in critical care areas such as emergency departments, intensive care units, and operating rooms. As a follow up, AHRQ, in partnership with the Department of Defense, developed a teamwork training program – TeamSTEPPS™. It is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among health care professionals. It includes a comprehensive set of ready-to-use materials and training curricula necessary to integrate teamwork principles successfully into an organization's health care system. TeamSTEPPS™ is presented in a multimedia format, with tools to help a health care

organization plan, conduct, and evaluate its own team training program. It includes five components: 1- an instructor guide, 2-a multimedia resource kit including a CD-ROM and DVD with 9 video vignettes about how failures in teamwork and communication can place patients in jeopardy, and how successful teams can work to improve patient outcomes; 3-a spiral-bound pocket guide; 4-PowerPoint® presentations; and 5-a poster that tells staff that the organization is adopting TeamSTEPPS™. In addition, AHRQ has a technical assistance contract in place to support those interested in implementing TeamSTEPPS™. TeamSTEPPS National Implementation continues to grow and expand. As of the end of FY08, the project has trained or registered 651 individuals for TeamSTEPPS Master Trainers representing 147 different organizations across the U.S. TeamSTEPPS is now part of the 9th Scope of Work for Quality Improvement Organizations (QIOs). All QIOs have received initial Master Team Training. To date, Master Trainers reported that they have trained 4,780 individuals from 119 organizations. (FY 2007 funding = $2.6 million; technical assistance in FY 2008 and FY 2009)

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

**AHRQ HAI Initiatives**

The Agency has funded numerous projects to reduce healthcare-associated infections (HAIs), including MRSA infections. Following are brief descriptions of some of these projects and initiatives.

AHRQ HAI Research Initiatives

•HAI ACTION Project. In September 2007, AHRQ awarded task orders to five Accelerating Change and Transformation in Organizations and Networks (ACTION) partners to mitigate HAIs at 34 hospitals. For 6 months, multidisciplinary teams at each hospital used AHRQ-supported evidence-based tools for improving infection safety to facilitate changes in clinician behaviors and habits, care processes, and the safety culture. In addition, AHRQ has funded an assessment program, led by Indiana University, to coordinate project tasks and activities, provide technical assistance to the hospitals, and examine information gleaned from the project. Also, the Agency plans to develop an HAI project toolkit, which will include a case study for health care organizations interested in learning how the HAI project participants implemented infection safety training, the challenges they faced, and how they addressed them.

- Patient Safety Improvement Corps (PSIC) Fellowship Program on HAIs. The Patient Safety Improvement Corps (PSIC) is a partnership program between AHRQ and the Department of Veterans Affairs to improve patient safety by providing the knowledge and skills necessary to investigate medical errors and develop and evaluate sustainable system interventions to prevent them. The PSIC Fellowship Program on HAIs is a 1-day program to provide PSIC graduates with an overview of HAIs and to demonstrate different and successful approaches to prevention, reduction, or mitigation of HAIs from different perspectives including public and private hospital systems, communities, and regions.

    - MRSA Collaborative Research Initiatives. In October 2007, Congress appropriated $5 million to AHRQ to identify and help suppress the spread of MRSA and related HAIs. Until then, the only large-scale study that had produced evidence on how to reduce

serious HAIs and maintain that reduction was supported by AHRQ and carried out in 127 Michigan hospitals from 2003 to 2006. This new effort to reduce MRSA builds on that experience. In developing the action plan that AHRQ is funding, the Agency has worked in collaboration with the CDC and the Centers for Medicare & Medicaid Services (CMS). This action plan will use electronic and administrative data, surveillance, and implementation strategies to:

- Reduce the burden of MRSA infections via novel interventions aimed at critical control points in a community/region.
- Determine scope, risk factors, and control measures for hospital-acquired, community-onset MRSA infections.
- Test methods to reduce hospitalization from community-acquired MRSA.
- Understand the role of inter-facility MRSA transmission on overall infection rates.
- Understand the role of nursing home transmission on overall rates and delineate interventions that are effective in reducing such transmission.

- Other proposed MRSA collaborative projects are as follows:
  - Reduction of *Clostridium Difficile* Infections in a Regional Collaborative of In-patient Healthcare Settings
  - Reducing the Overuse of Antibiotics by Primary Care Clinicians Treating Patients in Ambulatory and Long-term Care Settings
  - Improving the Measurement of Surgical Site Infection (SSI) Risk Stratification and Outcome Detection
  - Produce Rapid National, Regional and State-level Estimates of HAIs to Evaluate the Impact of Inter-Agency HAI Initiatives
  - Reduction Of Infections Caused by Carbapenem Resistant *Enterobacteriaceae* (KPC producing organisms) Through Application Of Recently Developed CDC/HICPAC Recommendations

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

Currently, only one Patient Safety measure has data to report for FY 2008. For measure 1.3.41, "Increase the number of tools that will be available in AHRQ's inventory of evidence-based tools to improve patient safety and reduce the risk of patient harm," a total of 73 tools are included in the inventory.

The Program took the following actions in 2008 to improve performance:

- Measuring the number of Patient Safety Organizations (PSOs) that become certified based on Patient Safety and Quality Improvement Act legislation. The list of certified PSOs is available on an ongoing basis as PSO's become listed.
- Establishing annual targets around the Patient Safety and Quality Improvement Act.

- Updating performance measures and targets. Patient Safety continues efforts to develop a data source to capture the use of AHRQ-supported tools. The program is writing a work assignment to identify and consolidate consolidated data collection into a single source.

The Patient Safety program received a PART review in 2003, and received an Adequate rating. The review cited improvements in the safety and quality of care as a strong attribute of the program. As a result of the PART review, the program continued to take actions to prevent, mitigate and decrease the number of medical errors, patient safety risks and hazards associated with health care and their harmful impact on patients. The program continues to develop decision support systems, taxonomies, publication, and tools. For more information on programs that have been evaluated based on the PART process, see www.ExpectMore.gov.

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

| # | Key Outcomes | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|
| 1.3.37 | Increase the percentage of hospitals in the U.S. using computer-only patient safety event reporting systems (PSERS) | N/A | 12% | N/A | N/A | N/A | N/A | 24% |
| 1.3.38 | Increase the number of U.S. healthcare organizations per year using AHRQ-supported tools to improve patient safety from the 2007 baseline (new portfolio measure) | N/A | NA | Baseline | 382 hospitals | 450 | Data expected Dec. 2009 | 500 |
| 1.3.39 | Increase the number of patient safety events (e.g. medical errors) reported to the Network of Patient Safety Databases (NPSD) from baseline. | NA | NA | NA | NA | NA | NA | Baseline (expected to be set in December of 2009) |
| 1.3.5 | Percentage reduction in the cost per capita of treating hospital-acquired infections per year | NA | NA | -2% | Data expected 09/30/09 | -2% | Data expected 10/30/10 | -2% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Baseline actual in 2003: $4,437.28 per capita | | | | | | | |
| 1.3.40 | Patient Safety Organizations (PSOs) listed by DHHS Secretary | N/A | N/A | N/A | N/A | Final Regulation published | PSO Final Regulation Issued | PSOs listed by Secretary |
| 1.3.41 | Increase the number of tools available in AHRQ's inventory of evidence-based tools to improve patient safety and reduce the risk of patient harm | NA | NA | Baseline | 61 | 68 | 73 | 76 |

### *MEPS*

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

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

Because of the need for timely data, performance goals for MEPS have focused on providing data in a timely manner. The MEPS program has met or exceeded all of its data timeliness goals. These performance goals require the release of the MEPS Insurance component tables within 6 months of data collection; the release of MEPS Use and Demographic Files within 11months of data collection; the release of MEPS Full Year Expenditure data within 11months of data collection; and, the release

of the Point-in-time, Utilization and Expenditure Files within 11 months of data collection. Also, the program continues to exceed the baseline standard for increasing the number of MEPS Data Users, and the program added Prescribed Drug Tables to the MEPS Tables Compendia. In addition, the program has expanded the depth and breadth of data products available to serve a wide range of users. To date, almost 200 statistical briefs have been published. The MEPS data table series has expanded to include 8 topic areas on the household component and 9 topic areas on the Insurance Component. In addition, specific large state and metro area expenditure and coverage estimates have been produced, further increasing the utility of MEPS within the existing program costs. Since its inception in 1996, MEPS has been used in several hundred scientific publications, and many more unpublished reports.

- The MEPS has been used to estimate the impact of the recently passed Medicare Modernization Act (MMA) by the Employee Benefit Research Institute (the effect of the MMA on availability of retiree coverage), by the Iowa Rural Policy Institute (effect of the MMA on rural elderly) and by researchers to examine levels of spending and co-payments (Curtis, et al, Medical Care, 2004)

- The MEPS data has been used extensively by the Congressional Budget Office, Department of Treasury, Joint Taxation Committee and Department of Labor to inform Congressional inquires related to health care expenditures, insurance coverage and sources of payment and to analyze potential tax and other implications of Federal Health Insurance Policies.

- MEPS data on health care quality, access and health insurance coverage have been used extensively in the Department's two annual reports to Congress, the National Healthcare Disparities Report and the National Healthcare Quality Report.

- The MEPS has been used in Congressional testimony on the impact of health insurance coverage rate increases on small businesses.

- The MEPS data have informed studies of the value of health insurance in private markets and the effect of consumer payment on health care, which directly align with the *Health Care Value Incentives Component of the HHS Priorities for America's Health Care* and the *Secretary's 500 Day Plan Priority of Transforming the Health Care System.*

- The MEPS-IC has been used by a number of States in evaluating their own private insurance issues including eligibility and enrollment by the State of Connecticut and by the Maryland Health Care Commission; and community rating by the State of New York. As part of the Robert Wood Johnson Foundation's State Coverage Initiative, MEPS data was cited in 69 reports, representing 27 states.

- The MEPS data has been used extensively by the Government Accountability Office to determine trends in Employee Compensation, with a major focus on the percentage of employees at establishments that offer health insurance, the percentage of eligible employees who enroll in the health insurance plans, the average annual premium for employer-provided health insurance for single workers, and the employees' share of these premiums.

- MEPS data have been used in DHHS Reports to Congress on expenditures by sources of payment for individuals afflicted by conditions that include acute respiratory distress syndrome, arthritis, cancer, chronic obstructive pulmonary disease, depression, diabetes, and heart disease.

- MEPS data are used to develop estimates provided in the *Consumers Checkbook Guide to Health Plans*, of expected out of pocket costs (premiums, deductibles and copays) for Federal employees and retirees for their health care. The *Checkbook* is an annual publication that provides comparative information on the health insurance choices offered to Federal workers and retirees.

- MEPS data has been used by CDC and others to evaluate the cost of common conditions including arthritis, injuries, diabetes, obesity and cancer.

This year AHRQ entered into an agreement with the Census Bureau to enable researchers and others to use MEPS data that cannot be released to the public in Research Data Centers run by the Census Bureau. This move is key to increase the availability of MEPS data and allow more people to use MEPS data for important research and policy analysis.

For FY 2009, the program will produce additional data for MEPS tables compendia. Tables on children's use of preventive health services for 2006 and 2007 will be added to increase the breadth of data available by the program.

Before AHRQ reorganized research portfolios, MEPS was part of the Data Collection and Dissemination portfolio. This portfolio received a PART review in 2002, and received a Moderately Effective rating. The review cited the Medical Expenditure Panel Survey (MEPS) as a strong attribute of the program. As a result of the PART review, the program continues to take actions to reduce the number of months that MEPS data is made available after the date of completion of the survey, increase the number of MEPS data users, and increase the number of topical areas tables included in the MEPS Tables Compendia. For more information on programs that have been evaluated based on the PART process, see www.ExpectMore.gov.

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

| # | Key Outcomes | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|
| 1.3.16 | Insurance Component tables will be available within months of collection | 7 | 6 | 6 | 6 | 6 | 6 | Re-establish baseline – new design |
| 1.3.17 | MEPS Use and Demographic Files will be available months after final data collection | 11 | 11 | 11 | 11 | 11 | 11 | 11 |
| 1.3.18 | Number of months after the date of completion of the Medical Expenditure Panel Survey data will be available | 11 | 11 | 11 | 11 | 11 | 11 | 11 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1.3.19 | Increase the number of topical areas tables included in the MEPS Tables Compendia | Access Tables added | Access Tables added | Add Insurance Tables | Insurance Tables Added | Add Prescribed Drug Tables | Prescribed Drug Tables Added | Update State level tables |
| 1.3.20 | Increase the number of MEPS Data Users<br><br>Baseline FY 2005:<br>10 DCP<br>15,900 TC<br>13,101 HC/IC | 10 Data Center Projects (DCP)<br><br>15,900 Tables Compendia (TC)<br><br>13,101 Household Component/Insurance Component (HC/IC) | 14 DCP<br><br>16,200 TCP<br><br>11,600 HC/IC | Exceed baseline standard | 23 DCP<br><br>19,989 TCP<br><br>14,809 HC/IC | Exceed baseline standard | 41 DCP | Exceed baseline standard |
| 1.3.21 | The number of months required to produce MEPS data files (i.e. point-in-time, utilization and expenditure files) for public dissemination following data collection. | N/A | 12 months | 11 months | 11 months | 11 months | 11 months | 11 months |

## *Program Support*

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

**Strategic Management of Human Capital**
AHRQ is currently green in this PMA activity – with a progress rating of green as well. The FY 2007 target for this PMA activity was to implement the HHS Performance Management Program (PMAP). This target was successfully completed. The current rating period began in January 2007 and will end in December 2007. Utilizing an automated performance management system (GoalOwner), all non-SES employees have been placed on a plan with quantifiable measures, outcomes, and expected results. AHRQ staff is working closely with Departmental officials to select a vendor which will be used throughout HHS to automate the performance management process. Once that decision is made, AHRQ will begin to “sunset” the GoalOwner system and migrate towards the new

automated performance management system. In FY 2008, this PMA activity worked towards core competency assessment, development and implementation for the Agency's mission critical activities; and assessed the performance management system and proposed modifications to improve the program and process based on comments and feedback from our OPM Program Activity Assessment Tool (PAAT) assessment.

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

**Expanding Electronic Government**
AHRQ is currently green in this PMA activity – with a progress rating of green as well. AHRQ's major activities for this PMA activity include: 1) Government Paperwork Elimination Act (GPEA), 2) Security, and 3) Full participation in HHS PMA activities that intersect with the mission of the Agency. These activities continue to result in efficiencies in time and improvement in quality. AHRQ's current activities include:

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

**Performance Improvement Initiative**

AHRQ is currently green in this PMA activity – with a progress rating of green as well. General program direction is accomplished through the collaboration of the Office of the Director and the offices and centers that have programmatic responsibility for portions of the Agency's research portfolio. AHRQ created a framework to provide a more thoughtful and strategic alignment of its activities. This framework represents the Agency's collaborative efforts on strategic opportunities for growth and synergy. As the result of increased emphasis on strategic planning, the Agency continues the shift from a focus on output and process measurement to a focus on outcome measures where feasible. These outcome measures cascade down from our strategic goal areas of safety/quality, effectiveness, efficiency and organizational excellence. Portfolios of work (combinations of activities that make up the bulk of our investments) support the achievement of our highest-level outcomes.

In FY 2008, AHRQ continued the implementation of strong budget and performance integration practices through the use of structured Project Management processes. AHRQ has begun a campaign to design and implement a quality improvement process for managing major programs that support the Agency's strategic goals and Departmental strategic goals and specific objectives.

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

**Long-Term Objective 1:** Get to Green and maintain status on President's Management Agenda (PMA).

| # | Key Outcomes/ Outputs | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|
| 5.1.1 | Get to Green on Strategic Management of Human Capital Initiative | Cascade performance management system<br><br>Reduced mission support positions by 11 FTE | Completed assessment of core competency and leader-ship models<br><br>Identified strategies to infuse new talent into AHRQ | Implement HHS Performance Improvement Initiative | Completed implementation of HHS Performance Improvement Initiative | Develop core competencies for selected Agency staff and develop strategies for implementation | Core competencies developed and implementation strategies completed. | Fully implement Departmental Learning Management System (LMS) for training and development needs |
| 5.1.2 | Maintain a low risk improper payment risk status | Up-dated AHRQ Improper Payment Risk Assessment<br><br>Increased awareness of risk management within AHRQ | Participated in Department A-123 Internal Control efforts related to improper payments | Continue to participate in Department A-123 Internal Control efforts | Continued to participate in Department A-123 Internal Control efforts | Complete all requirements related to OMB revised Circular A-123<br><br>Begin to update internal controls following AHRQ's conversion to UFMS | Requirements related to OMB revised Circular.<br><br>Continued to update internal controls. | Complete updating of all internal controls following AHRQ's conversion to UFMS |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 5.1.3 | Expand E-government by increasing IT Organiza-tional Capability | Fully Implemented integrated EA, Capital Planning and investment review processes | Completed level 3 maturity in EA as directed by HHS | Develop fully integrated Project Management Office with standardized processes and artifact | On-going | Extend PMO operations and concepts to AHRQ IT investments | On-going | Fully meet mile-stones established for E-government green status for FY 09 |
| 5.1.4 | Improve IT Security/ Privacy Output | Fully integrated security approach EA and capital planning process | Per-formed required testing to insure maintenance of security level | Certify and accredit all Level 2 Information systems<br><br>Begin implementation of Public Key Infrastructure with applications | Certified and accredited all Level 2 Information systems<br><br>Began implementation of Public Key Infrastructure with application | Certify and accredit all Level 3 information systems<br><br>Review and update security program to reflect current guidance and mandates | Certified and accredited all Level 3 information systems.<br><br>Reviewed and updated security program. | Integrate and align AHRQ's security program with HHS's Secure One security program |
| 5.1.5 | Establish IT Enterprise Architecture | Used EA to derive gains in business value and improve performance related to AHRQ mission | Began work towards Level 3 maturity in EA as defined by HHS | Continue Level 3 EA plan | Completed Level 3 EA plan | Implement Level 3 EA plan<br><br>Comply with EA activity as defined by HHS | Implemented Level 3 EA plan.<br><br>Continued to comply with EA activity set forth by HHS. | Comply with HHS EA requirements |
| 5.1.6 | Get to Green and maintain status for Performance Improvement initiative | Implemented additional phases of Planning System | Visual Performance Suite software designed and piloted | Begin implementation of soft-ware within the port-folios of work to help facilitate budget and performance integration<br><br>Conduct internal alignment of measures by strategic goal areas | Began to implement software with the portfolios<br><br>Completed internal alignment of measures | Continue implementation of software within the portfolios | Continued implementation of software within the portfolios | Maintain "Green" status on Program Improvement initiative |

## *Agency Support for HHS Strategic Plan*

| HHS Strategic Goals | Safety/Quality – Reduce the risk of harm from health care services by promoting the delivery of appropriate care that achieves the best quality outcome. | Efficiency – Achieve wider access to effective health care service and reduce health care costs. | Effectiveness – Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices. | Organizational Excellence – Develop efficient and responsive business practices |
|---|---|---|---|---|
| **1: Health Care** Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care. | | | | |
| **1.1** Broaden health insurance and long-term care coverage. | | | | |
| **1.2** Increase health care service availability and accessibility. | X | | | |
| **1.3** Improve health care quality, safety, cost and value. | X | X | X | |
| **1.4** Recruit, develop and retain a competent health care workforce. | X | | X | |
| **2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness** Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats. | | | | |
| **2.1** Prevent the spread of infectious diseases. | | | | |
| **2.2** Protect the public against injuries and environmental threats. | | | | |
| **2.3** Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery. | X | | | |
| **2.4** Prepare for and respond to natural and man-made disasters. | | | | |
| **3: Human Services** Promote the economic and social well-being of individuals, families and communities. | | | | |
| **3.1** Promote the economic independence and social well-being of individuals and families across the lifespan. | | | | |
| **3.2** Protect the safety and foster the well-being of children and youth. | | | | |
| **3.3** Encourage the development of strong, healthy and supportive communities. | | | | |
| **3.4** Address the needs, strengths and abilities of vulnerable populations. | | | | |
| **4: Scientific Research and Development** Advance scientific and biomedical research and development related to health and human services | | | | |
| **4.1** Strengthen the pool of qualified health and behavioral science researchers. | | | X | |
| **4.2** Increase basic scientific knowledge to improve human health and development. | | | | |
| **4.3** Conduct and oversee applied research to improve health and well-being. | X | | X | |
| **4.4** Communicate and transfer research results into clinical, public health and human service practice. | X | X | | |

## *Summary of Findings and Recommendations from Completed Program Evaluations*

See narrative for Prevention and Care Management.

## *Data Source and Validation*

**Program**

| Measure Unique Identifier | Data Source | Data Validation |
|---|---|---|
| 1.3.5 | HCUP/PSIs | On-going HCUP/PSI validation activities (HCUP and QI Project Officers use established methodology to check data) |
| 1.3.6 | Office of the National Coordinator (ONC) Annual Survey of Health IT Adoption | ONC and their contractor uses established methodology to check their data. |
| 1.3.8 | Report to Congress and subsequent Notice of Proposed Rulemaking | This is a factual statement supported by the work products of the partnership. |
| 1.3.9 | Certification Commission for Healthcare Information Technology (CCHIT) | CCHIT Certification Criteria states the criteria for the measure. |
| 1.3.15 | HCUP database | HCUP Project Officer monitors the number of partners and reports by identifying the new data added to the existing baseline. |
| 1.3.16 | MEPS website | Data published on website |
| 1.3.17 | MEPS website | Monthly meetings with contractor, careful monitoring of field progress and instrument design, quality control procedures including benchmarking with other national data sources. |
| 1.3.18 | MEPS website | Monthly meetings with contractor, careful monitoring of field progress and instrument design, quality control procedures including benchmarking with other national data sources. |
| 1.3.19 | MEPS website | Data published on website |
| 1.3.20 | MEPS data: List of ongoing projects | Publications |
| 1.3.21 | MEPS website | Monthly meetings with contractor, careful monitoring of field progress and instrument design, quality control procedures including benchmarking with other national data sources. |
| 1.3.22 | HCUP database | HCUP and QI Project Officers work with Project Contractors to monitor the field and collect specific information to validate the organizations use and outcomes. |
| 1.3.23 | CAHPS database<br>National CAHPS Benchmarking Database | Prior to placing survey and related reporting products in the public domain a rigorous development, testing and vetting process with stakeholders is followed.<br>Survey results are analyzed to assess internal consistency, |

| | | |
|---|---|---|
| | | construct validity and power to discriminate among measured providers. |
| 1.3.25 | Survey | Prior to implementing a survey, a rigorous development, testing and vetting process with stakeholders will be followed |
| 1.3.26 | Survey | Prior to implementing a survey, a rigorous development, testing and vetting process with stakeholders will be followed |
| 1.3.27 | Data contained in applications for Chartered Value Exchanges | Reviewed by AHRQ and contractor for validity |
| 1.3.28 | AHRQ records | Review of AHRQ records |
| 1.3.29 | HCUPnet | Data published on HCUPnet website and verified by HCUP Project Officers |
| 1.3.30 | Battelle (QI contractor) tracking | AHRQ QI Project Officers use established methodology to check data |
| 1.3.31 | Tools tracked by contractor | AHRQ Project Officer oversees contractor work |
| 1.3.36 | AHRQ has a contract to develop this data source. TBD | AHRQ staff will follow established methodology. |
| 1.3.37 | Survey to be completed every 3 years (contract TBD) | Survey contractor will develop methods to validate survey data |
| 1.3.38 | Surveys/case studies | AHRQ staff (OCKT) and evaluation contractor (TBD) to develop methods to validate survey data and conduct case studies |
| 1.3.39 | PSOs (and the privacy center contractor that builds the NSPD) | The privacy center contractor monitors the number of reports in the NPSD that is submitted through the PSOs |
| 1.3.40 | PSOs listed by DHHS Secretary | PSOs listed by DHHS Secretary |
| 1.3.41 | AHRQ FOAS, grant awards, and contract records | AHRQ staff (i.e., project officers, portfolio leads, grants management and contracts staff) monitor project completion and dissemination of results |
| 1.3.48 | AHRQ Internal Figures | AHRQ Internal Figures |
| 1.3.52 | NAMCS | NAMCS |
| 2.3.4 | NHQR/NHDR | Data is validated annually by federal public release data sources including NHQR/NHDR. Data are analyzed, synthesized and reported using established methodology. |
| 2.3.5 | The data source is dependent on the prioritized service(s) and could include national sources such as the NHQR/NHDR and/or internal Prevention/CM databases | TBD based on the prioritized services(s). |
| 2.3.6 | Internal Prevention/CM planning documents | Reviewed by Prevention/CM Portfolio staff and AHRQ Senior |

| | | |
|---|---|---|
| | | Leadership Team |
| 4.4.1 | MEPS | The MEPS family of surveys includes a Medical Provider Survey and a Pharmacy Verification Survey to allow data validation studies in addition to serving as the primary source of medical expenditure data for the survey. The MEPS survey has been cleared by OMB and meets OMB standards for adequate response rates, and timely release of public use data files. |
| 4.4.2 | HCUP | HCUP and QI Project Officers use established methodology to check data. |
| 4.4.3 | HCUP | HCUP and QI Project Officers use established methodology to check data. |
| 4.4.4 | HCUP | HCUP and QI Project Officers use established methodology to check data. |
| 4.4.5 | Effective Health Care Program database | Effective Health Care Program staff will develop and document a methodology that will be used annually to check data |
| 5.1.1 | Departmental quarterly updates on PMA | As the beta site for the Department's Performance Management Appraisal Program (PMAP), AHRQ was required to complete the Performance Appraisal Assessment Tool (PAAT). Out of 100 total points possible, the Agency scored an 87 which, according to OPM, is considered as having "effectiveness characteristics present" – the highest level possible under this rating system. |
| 5.1.2 | Departmental quarterly updates on PMA; UFMS, IMPAC II, and Payment Management System | SAS 70 Reviews, A-123 reviews, and A-133 audits |
| 5.1.3 | Departmental quarterly updates on PMA | PMA compliance and complies with Departmental standards |
| 5.1.4 | Departmental quarterly updates on PMA | PMA compliance and complies with Departmental standards |
| 5.1.5 | Departmental quarterly updates on PMA | PMA compliance and complies with Departmental standards |
| 5.1.6 | Departmental quarterly updates on PMA | PMA compliance and complies with Departmental standards; AHRQ logic models and Portfolio plans |

## *Discontinued Performance Measures*

| # | Key Outcomes/ Outputs | FY 2005 Actual | FY 2006 Actual | FY 2007 Target | FY 2007 Actual | FY 2008 Target | FY 2008 Actual | FY 2009 Target |
|---|---|---|---|---|---|---|---|---|
| 1.3.8 | Most Americans will have access to and utilize a Personal Health Record (PHR) | 2 EHR Improvements IHS and NASA Health IT | Partnered with CMS on PHR technology | Partner with one HHS Operating Division | Partnered with CMS on PHR technology | Develop tool to assess consumer perspectives on the use of personal electronic health records | Developed and deployed tool to assess perspectives of Medicare beneficiaries on using PHRs (as part of Medicare PHR Demonstration project). | 10 organizations will use tools to assess consumer perspectives on the use of personal EHRs |
| 1.3.6 | Increase physician adoption of Electronic Health Records (EHRs) | 10% Baseline | 21.9% of physician practices use e-prescribing | 15% from baseline | 24.9% | Increase 20% from baseline | 38.4% (NCHS 4-8/08 survey – full or partial EMR systems) | Increase 25% from Baseline |
| 1.3.36 | Increase the number of ambulatory clinicians using electronic prescribing to over 50% | N/A | 12% | 15% | on-going | 20% | Developing new data source or 6% (Surescripts National Progress Report on Electronic-Prescribing) | Re-baseline (Develop data source, methodology and baseline) |
| 1.3.9 | Engineered Clinical Knowledge will be routinely available to users of EHRs | National summit with National Coordinator for Health HIT and AMIA | Initiated standards development and adoption of Engineered Clinical Knowledge | Standards development organizations will be in early development of tools enabling engineered clinical knowledge transfer | CCHIT certification criteria includes clinical decision support | Award 2 projects that will deliver best practice recommendations to key stakeholders to create engineered clinical knowledge | Awarded two contracts totaling $5M to support the development, adoption, implementation and evaluation of best practices using clinical decision support | 2 projects will deliver best practice recommendations to create engineered clinical knowledge |

## *Disclosure of Assistance by Non-Federal Parties*

Preparation of Annual Performance Reports and Annual Performance Plans is an inherently governmental function that is only to be performed by Federal Employees. No material assistance was received from non-Federal parties in the preparation of the AHRQ FY 2008 Annual Performance Report.