



**DEPARTMENT
of HEALTH
and HUMAN
SERVICES**

Agency for Healthcare Research and Quality

FY 2012 Online Performance Appendix

Introduction

The FY 2012 Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2012 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the Summary of Performance and Financial Information (SPFI). These documents are available at <http://www.hhs.gov/budget/>.

The FY 2012 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2010 Annual Performance Report and FY 2012 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS SPFI summarizes key past and planned performance and financial information.

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Performance Detail (by Activity)

Research on Health Costs, Quality and Outcomes (HCQO):

Patient-Centered Health Research/Effective Health Care

The Patient-Centered Health Research/Effective Health Care portfolio conducts and supports comparative effectiveness research in response to Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. In addition, it builds research infrastructure and capacity, allowing future studies to address questions where data are currently not sufficient to provide guidance about competing alternatives and to improve the efficiency with which the research infrastructure is able to respond to pressing health care questions. Research activities are performed using rigorous scientific methods within a previously-established process that emphasizes stakeholder involvement and transparency, that was designed to prioritize among pressing health issues, and whose products are designed for maximum usefulness for health care decision makers.

Patient-Centered Health Research is designed to inform health-care decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options. The evidence is generated from research studies that compare drugs, medical devices, tests, surgeries, or ways to deliver health care.

AHRQ works very hard to involve stakeholders, including other HHS OPDIVs, in the comparative effectiveness research process. This begins with the identification and prioritization of research questions. One example of how we have done this is by holding expert meetings on a given clinical topic. We invite stakeholder representatives from public and private payers, federal agencies, patient/consumer groups, foundations, product developers, and professional societies, in addition to clinical researchers. The goals of the meeting are to identify clinical problems for which new research will inform treatment decisions for patients and providers (especially beneficiaries of the Medicare and Medicaid programs) and to identify, in partnership with stakeholders, clinically-or policy-relevant research questions related to the topic.

This provides credibility to our research, helps us avoid prioritizing topics that have no relevance to real-world issues, and reduces potential duplication. Additionally, we engage key stakeholder informants and technical experts (including HHS OPDIVs) to provide additional input to AHRQ in finalizing key questions for the research review. These key stakeholder informants and technical experts are invited to peer review draft reports. The draft key questions and draft reports are also posted on the Effective Health Care Web site (www.EffectiveHealthCare.ahrq.gov) for the public to review and provide comments. Finally, we have dedicated staff liaisons to HHS OPDIVs to ensure continual communication in this important area.

In FY 2012, the portfolio will use Evidence Synthesis funds to continue to assess the science already available or in the pipeline on cutting edge issues identified through horizon scanning activities and context changing events, including but not limited to clinical, system level, organization and behavior changing events as they directly relate to patients in a reforming health system. These funds will support approximately 14 contracts. Recommendations for research will be produced that consider the timing, cost, and feasibility of research that would

address key PCHR questions, in addition to the predicted value of the information generated. Please note, all PHCR performance targets reflect investments made with PHS Evaluation funds only. Beginning in FY 2011, AHRQ receives funding from the Patient-Centered Outcomes Research Trust Fund (PCORTF) to disseminate research findings and build research and data capacity for PCHR. Following development of the spend plan for these funds, AHRQ will readjust these targets.

Current activities related to the Patient-Centered Health Care Portfolio performance measures:

1.3.24: Decrease mortality from and increase receipt of recommended care for subset of diseases measured and reported on in the National Health Care Quality Report.

The purpose of this measure is to gauge the impact of the PCHR portfolio's research on long-term health outcomes. In the process of developing this measure, AHRQ determined this measure will not accurately capture the work and impact of the Effective Health Care Program. We are currently working to develop an alternate measure to more accurately measure the program's impact on improving patients' quality of care and health outcomes through informed decision-making.

1.3.25: Increase the dissemination of Effective Health Care (EHC) Program products to clinicians, consumers, and policymakers to promote the communication of evidence.

One way to capture the dissemination of Effective Health Care Program Products is through the request for printed products made to AHRQ's Publication Clearinghouse. This measure reflects the number of major orders (more than 50 print copies) for Effective Health Care Program products.

1.3.26: Increase the percentage of stakeholders who report they use Effective Health Care Program products as a resource. This measure captures how important subsets of stakeholders, Medicaid Medical Directors, use Effective Health Care Program products as a resource in decision-making. We are continuing to further develop and expand this measure so that we can capture data on how other key stakeholder groups, specifically clinicians, are using the program's materials to help inform decisions.

1.3.55: Increase the use of Effective Health Care (EHC) Program Products in evidence-based clinical practice guidelines, quality measures and measure sets in EHC priority areas to enhance decision-making. Citation of Effective Health Care Program products and publications in guidelines and measures can serve as a proxy for program impact, especially if the cited documents underpin guideline recommendations and/or the rationale for the use of a measure. This measure, in development, will capture this information.

4.4.5: Increase the cumulative number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers. This measure shows the cumulative number of products produced by the Effective Health Care Program. These products - Systematic Reviews, Summary Guides, and Effective Health Care Research Reports – contain information on the effectiveness, benefits and harms of different treatment options and can be used by patients, providers and policymakers to make informed health-care decisions.

Performance Trends: One measure the Effective Health Care Program uses to evaluate its success is the amount of evidence made available to the public. This information is reported in key outputs #4.4.5A, #4.4.5B, and #4.4.5C in the performance tables below. In FY 2006, the program released four systematic reviews and one summary guide. In FY 2007, the program released four systematic reviews and eight summary guides. In FY 2008, the program released seven systematic reviews and 12 summary guides including two guides that were translated into Spanish. In FY 2009, the program released six systematic reviews, 16 new research reports,

and 13 summary guides including some translated into Spanish. In FY 2010, the program met or exceeded targets by producing 18 systematic reviews, 14 new research reports, and 19 summary guides. In FY 2011 we expect to continue to meet our targets. In FY 2012, the portfolio will continue to increase the cumulative number of products available for use by clinicians, consumers, and policymakers.

Measures #1.3.25 and #1.3.26 track the amount of dissemination and use of the Effective Health Care Program products. In FY 2010, we were pleased to exceed our targets for both these measures. Since both of these measures are relatively new (established in FY 2009) and FY 2010 was the first year we set targets, we are not going to readjust our out-year targets at this time; however, we will evaluate the targets again after we have additional data.

Long-Term Objective 1: Improve patients' quality of care and health outcomes through informed decisionmaking by patients, providers, and policymakers.

Measure	Fiscal Year	Target	Result
1.3.24: Decrease mortality from and increase receipt of recommended care for subset of diseases measured and reported on in the National Health Care Quality Report (Developmental) (Interim Output) (Qualitative)	2012	Identify more appropriate measure, set baseline and targets	Dec 30, 2012 (Not Started)
	2011	Identify more appropriate measure, set baseline and targets	Dec 30, 2011 (Active)
	2010	Initiate development of alternate measure to more accurately measure the program goals	On-going development of alternate measure to more accurately measure the program goals (Target Met)
	2009	1st/2nd Qtrs Obtain baseline measures	Continued to work with contractors to develop the measure. (Target Met)
		3rd/4th Qtrs Set targets for FY 2010-2019	
	2008	Measures have been identified but a subset based on priority conditions has not yet been selected	Identify Measures and limit to a subset based on priority conditions (Target Met)
2007	AHRQ created new Comparative Effectiveness Portfolio	New Comparative Effectiveness Portfolio created (Target Met)	

Measure	Fiscal Year	Target	Result
1.3.25: Increase the dissemination of Effective Health Care (EHC) Program products to clinicians, consumers, and policymakers to promote the communication of evidence about the comparative effectiveness of different medical interventions (Quantitative)	2012	1030 Orders	Oct 30, 2012
	2011	1030 Orders	Oct 31, 2011
	2010	981 Orders	1681 Orders (Target Exceeded)
	2009	Set Baseline	934 Orders (Baseline)
	2008	N/A	N/A

Measure	Fiscal Year	Target	Result
1.3.26: Increase the percentage of stakeholders who report they use Effective Health Care (EHC) Program products as a resource (Quantitative)	2012	24 % of stakeholders	Oct 30, 2012
	2011	24 % of stakeholders	Oct 30, 2011
	2010	20 % of stakeholders	25 % of stakeholders (Target Exceeded)
	2009	Set Baseline	20 % of stakeholders (Baseline)
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
1.3.55: Increase the use of Effective Health Care (EHC) Program Products in evidence -based clinical practice guidelines, quality measures and measure sets in EHC priority areas to enhance decision making (Qualitative)	2012	TBD ¹	Oct 30, 2012 (Not Started)
	2011	Establish Targets	Oct 30, 2011 (Active)
	2010	Initiate development of measure	Initiated development of measure (Target Met)
	2009	N/A	N/A
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
4.4.5A: Increase the cumulative number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers - Systematic Reviews (SR) (Quantitative)	2012	65 SRs	Sep 30, 2013
	2011	60 SRs	Sep 30, 2012
	2010	24 SRs	39 SRs (Target Exceeded)
	2009	22 SRs	21 SRs (Target Not Met but Improved)
	2008	15 SRs	15 SRs (Target Met)
	2007	8 SRs	8 SRs (Target Met)

Measure	Fiscal Year	Target	Result
4.4.5B: Increase the cumulative	2012	97 SGs	Sep 30, 2013

¹ Out year target to be determined once measure is developed and approved.

number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers - Summary Guides (SG) (Quantitative)	2011	88 SGs	Sep 30, 2012
	2010	40 SGs	53 SGs (Target Exceeded)
	2009	29 SGs	34 SGs (Target Exceeded)
	2008	12 SGs	21 SGs (Target Exceeded) ²
	2007	N/A	9 SGs (Target Not In Place)

Measure	Fiscal Year	Target	Result
4.4.5C: Increase the cumulative number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers - Effective Health Care Research Reports (RRs) (Quantitative)	2012	51 RRs	Sep 30, 2013
	2011	39 RRs	Sep 30, 2012
	2010	30 RRs	30 RRs (Target Met)
	2009	N/A	16 RRs (Target Not In Place)
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Data Source	Data Validation
1.3.24	TBD	TBD
1.3.25	Requests for copies of AHRQ publications (ordered by title and publication number) are made to the AHRQ Publications Clearinghouse. Data will be provided bi-annually from the Publications Clearinghouse on the number of organizations requesting more than 50 copies of AHRQ comparative effectiveness research reports and summary guides.	Effective Health Care Program staff will develop and document a methodology that will be used annually to check data
1.3.26	Data from this output is available from AHRQ's Medicaid Medical Director's Learning Network (MMDLN). At an annual meeting, members of MMDLN report on how they use AHRQ's comparative effectiveness research reports and summary guides.	MMDLN members report their usage in a written document and AHRQ staff follow-up with members to verify information provided
1.3.55	AHRQ's National Guidelines Clearinghouse and AHRQ's National Quality Measures Clearinghouse	TBD

²The result includes 2 SG translated into Spanish.

Measure	Data Source	Data Validation
4.4.5A	All AHRQ systematic reviews are entered into a database, which is used to populate the AHRQ Effective Health Care Program Web site, http://effectivehealthcare.ahrq.gov/ .	Effective Health Care Program staff will develop and document a methodology that will be used annually to check data
4.4.5B	All AHRQ summary guides are entered into a database, which is used to populate the AHRQ Effective Health Care Program Web site, http://effectivehealthcare.ahrq.gov/ .	Effective Health Care Program staff will develop and document a methodology that will be used annually to check data
4.4.5C	All AHRQ research reports are entered into a database, which is used to populate the AHRQ Effective Health Care Program Web site, http://effectivehealthcare.ahrq.gov/ .	Effective Health Care Program staff will develop and document a methodology that will be used annually to check data

Prevention/Care Management

The foundation of a healthy democracy is a healthy, productive populace. Preventing disease and helping patients maximize health and function over the life span are two essential activities of a well-functioning health care system. High-quality, accessible, effective primary care, which encompasses a continuum of care from prevention through the management of complex chronic diseases, is an essential component of a health care system that improves and sustains the health of the American public. In FY 2008, two portfolios of work were combined to form the new Prevention/Care Management Portfolio (P/CM). AHRQ's Prevention/Care Management Portfolio works to improve the delivery of primary care services to meet the needs of the American population for high quality, safe, effective, and efficient clinical prevention and chronic disease care.

The portfolio seeks to accomplish its mission by:

- 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,
- 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.

Also, to accomplish this work, the Prevention/Care Management Portfolio supports health services and behavioral research, facilitates the translation of evidence into effective primary care practice, and maximizes the investment of Federal resources through a commitment to collaborative partnerships with Federal partners and other stakeholders committed to improving the health of the Nation.

In FY 2008, the USPSTF released 10 recommendations on preventive services. In FY 2009, it released 11 new recommendations. In FY 2010, as part of an effort to increase the transparency of its methods and processes, the Task Force developed a new process to post all *draft* recommendation statements for public comment. The public comment period for each posted draft recommendation statement is open for four weeks. Public comment is solicited on the various sections of the draft recommendation statement. The comments are then reviewed by the Task Force to determine whether changes might be made to improve the *final* recommendation statement. In FY 2010, the USPSTF posted 3 draft recommendation statements for public comment and released 5 final recommendations on preventive services.

AHRQ continued to provide a high level of support to the USPSTF in FY 2010 and will increase its support in with the expectation that the USPSTF will increase the number of recommendation statements released in FY 2012.

Current activities related to the Prevention/ Care Management Portfolio performance measures:

Measure 2.3.7: Increase the percentage of older adults who receive appropriate clinical preventive services. The provision of clinical preventive services is an important indicator of the quality of primary care. When considering how to measure AHRQ's performance in improving clinical decision making for preventive services, several issues arise such as how to assess overall performance when there are USPSTF recommendations covering a variety of preventive services, and how to assess receipt of services that are appropriate (not too few or too many) for different populations. This performance measure addresses these issues and aligns with other national efforts to create a measure that reflects provision of clinical preventive services. In support of this measure, the Portfolio also funds work to increase our understanding of what are appropriate clinical preventive services for older adults and adults with multiple chronic conditions. This includes methodological work as well as grant-funded research.

In April 2010, the Portfolio sponsored an expert panel meeting to begin the work of collaborating with other stakeholders to create a national measure of appropriate clinical preventive services for older adults. During the two-day meeting, experts developed an overarching framework for developing composite measures based on available evidence on the effectiveness of clinical preventive services, and provided input on specifications for the development of composite measure(s). Also in 2010, the Portfolio held a one-day meeting of the 18 researchers who received two- to three-year grants in 2008 that focus on how to prioritize preventive services for patients with multiple chronic conditions.

In FY 2012, the portfolio will publish a report on how to estimate net benefit (benefits minus harms) of preventive services in older adults; and, the portfolio will have a final candidate set of composite measures of appropriate clinical preventive services for older adults.

Measure 2.3.8: Increase the number of adults with chronic conditions who: 1) experience high quality care coordination; 2) receive self management support; or, 3) have access to clinical care coordinated with resources in the community. Hallmarks of high quality primary care include care that is coordinated, patient-centered, and that supports a patient in taking care of his/her chronic conditions. This developmental performance measure addresses these elements that also are associated with the effective design of primary care. Most recent result: In 2010, AHRQ funded a report to identify and characterize models linking clinical practices with community resources to improve the delivery of preventive services. In May, AHRQ convened a summit of health care and health policy stakeholders on Linking Primary Care and Community Organizations for Prevention. In September, a final report was released that included the proceedings from the Summit as well as a literature review and case studies on models that successfully linked primary care practices with community resources to improve clinical outcomes.

In June 2010, AHRQ funded 14 two-year grants to support systematic studies of on-going, successful efforts to transform the delivery of primary care in the U.S. In 2009, AHRQ released a Practice Coaching Manual. The Practice Coaching Manual is designed to support the transformation of primary care safety net practices to deliver care in ways consistent with the Expanded Care Model. This includes improved care coordination and strengthened linkages to community resources. In 2010, AHRQ funded a Practice-based Research Network to implement and evaluate the manual. Results are expected in 2011.

AHRQ funded and provided technical assistance in producing a culturally appropriate curriculum for clinical teams to support self-management support. In 2010, this curriculum was implemented in over 40 clinics within the Indian Health Service.

In 2010, AHRQ developed an inventory of measures of care coordination in primary care for use in evaluation and quality improvement activities. In 2012, the Portfolio will have a final candidate set of measures of care coordination in primary care, a Web site and established learning community to support the integration of mental health and primary care, final multimedia resources for self management support, and findings from projects on how to improve management and treatment of obesity in primary care practices with linkages to community resources.

Measure 2.3.9: Increase rates of adults who report receiving counseling about a healthy diet and physical activity from their primary care practice. In FY 2008, Portfolio staff prioritized a counseling service, Counseling to Promote a Healthy Lifestyle, which includes diet and physical activity, to further focus the activities of the Portfolio. The reasons for prioritizing this topic included: 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. Most recent result: In March 2010, the Oregon Evidence-based Practice Center presented a draft evidence report on behavioral counseling to promote physical activity and a healthy diet to the USPSTF. A manuscript based on the final report was published in *Annals of Internal Medicine* on December 7, 2010. Both the final evidence report and manuscript are available on the USPSTF web site (<http://www.uspreventiveservicestaskforce.org/uspstf/uspsphys.htm>).

In 2012, the Portfolio will produce final materials targeted to primary care clinicians, policy makers and the general public that synthesize the updated USPSTF recommendation on counseling to promote physical activity and a healthy diet, incorporate the complementary recommendations of the Community Preventive Services Task Force and findings from PBRN projects on how to improve management and treatment of obesity in primary care practices with linkages to community resources. A strategic decision was made by the portfolio to delay the development of a dissemination and implementation situational analysis for counseling to promote a healthy diet and physical activity to allow for incorporation of additional stakeholder input. The situational analysis will be available in 2012 to help inform and disseminate materials related to this recommendation.

Long-Term Objective: To improve the quality, safety, efficiency, and effectiveness of the delivery of evidence-based preventive services and chronic care management in ambulatory care settings.

Performance Trends: At this time, performance trends are not available. The Prevention/Care Management Portfolio was formed in 2008; the relatively new portfolio is working to develop performance measures and anticipates having baseline data in 2012.

Measure	Fiscal Year	Target	Result
2.3.7: Increase the percentage of older adults who receive appropriate	2012	Final candidate set of composite measures of appropriate clinical	Sep 30, 2012 (Not Started)

clinical preventive services (Quantitative)		preventive services for older adults	
	2011	Final evidence reports on understanding prevention in older adults: focusing on patient values and one on geriatric syndromes	Sep 30, 2011 (Active)
		Findings from the grant program, Optimizing Prevention and Healthcare Management in Complex Patients	Sep 30, 2011 (Active)
	2010	Develop specifications for 2 composite measures	Expert panel meeting to inform the development of a composite measure(s) on appropriate receipt of clinical preventive services in older adults Made Progress; Draft measure(s) developed Oct 30, 2012 (Active)
		Obtain findings from the grant program, Accelerating the Development of Methods for the Study of Complex Patients	Made Progress; On-going Sep 30, 2011 (Active)
	2009	N/A	N/A
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
2.3.8: Increase the number of adults with chronic conditions who: 1) experience high quality care coordination; 2) receive self management support; or, 3) have access to clinical care coordinated with resources in the community. (Qualitative)	2012	Produce a final candidate set of measures of care coordination in primary care	Sep 30, 2012
	2011	Final report on implementation of a toolkit to facilitate change in primary care and the role of practice coaching	Sep 30, 2011
	2010	Develop culturally-appropriate curriculum for clinical teams to support self management	Curriculum is being implemented in IHS collaboratives. This work continues on an on-going basis in the out-years. (Target Met)
		Develop report on current state of knowledge and models linking clinical practices with community resources	Final Report released on Summit - Linking Primary Care and Community Organizations for Prevention (Target Met)
	2009	N/A	N/A

	2008	N/A	N/A
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
2.3.9: Increase rates of adults who report receiving counseling about a healthy diet and physical activity from their primary care practice. (Qualitative)	2012	Produce final materials on counseling to promote physical activity and a healthy diet	Sep 30, 2012
	2011	Release updated USPSTF recommendation(s) on counseling to promote a healthy diet and physical activity	Sep 30, 2012 (Active)
	2010	Develop evidence reports on counseling to promote a healthy diet and physical activity	Draft evidence report on behavioral counseling to promote physical activity and a healthy diet presented to the USPSTF Manuscript based on final evidence report published in Annals of Internal Medicine on 12/7/10. link (Target Met)
		Develop dissemination and implementation situational analysis for counseling to promote a healthy diet and physical activity.	Sep 30, 2011 (Active)
	2009	N/A	N/A
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Data Source	Data Validation
2.3.7	Measure is under development. Depending on the components selected for the composite measure, data from the MEPS, the National Health Interview Survey, the Behavioral Risk Factor Surveillance System and/or the National Health and Nutrition Exam Survey may be used.	All potential data sources considered to date are national data sets that have been validated.
2.3.8	Measure is under development. Use of the CAHPS to capture one aspect of care coordination may be considered. Other data sources to be determined.	Prior to placing survey and related reporting products in the public domain, a rigorous development, testing, and vetting process with stakeholders is followed. Survey results are analyzed to assess internal consistency, construct validity, and power to discriminate among measured

Measure	Data Source	Data Validation
		providers has been validated.
2.3.9	MEPS and/or the Behavioral Risk Factor Surveillance System	Both are national data sets and have been validated.

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 – along with increased transparency of provider performance information, are critical national needs. AHRQ's Value portfolio aims to meet these needs by producing the measures, data, tools, evidence and strategies that health care organizations, systems, insurers, purchasers, and policymakers need to improve the value, affordability and transparency of health care. The aim is to assist the Department in fulfilling its mission to help Americans receive high quality, efficient, affordable care by creating a high-value system, in which providers produce greater value, consumers and payers choose value, and the payment system rewards value. AHRQ will continue to support the Value portfolio through three interrelated activities:

- **Evidence and data to support policy, reporting, payment, and improvement strategies.**
- **Measures and tools for policy-making, transparency, and improvement**
- **Implementation partnerships.**

Current activities related to the Value Portfolio performance measures:

1.3.29: Increase the number of States or communities reporting market-level hospital cost data. The maximum number possible (16 states) reporting market-level hospital cost data was achieved for this measure in 2009. This was achieved much more quickly than was anticipated by the program. The aim of this project, a priority under the previous administration, was to capture hospital cost data for states that could produce it and agreed to make it available to the public via HCUPnet, an on-line statistics tool available at <http://hcupnet.ahrq.gov/>. Producing this data required funding and staff by each state, and only a total of 16 states had the resources, staff, and agreed to produce this data to be shared with the public. AHRQ staff work with the states through a *voluntary* partnership, the Healthcare Cost and Utilization Project (HCUP) to collect this data, and additional states do not opt to make their cost data available to the public at this time, and it is not anticipated to change in near future years. However, AHRQ staff continue to work with states through the HCUP project, and if additional states do agree to make their cost data available to the public, it will be added to HCUPnet. This measure was officially retired in FY 2011.

1.3.30: Increase the cumulative number of communities or States with public report cards. Reporting provider performance through public report cards is a relatively new science. At the time we developed this measure, only a handful of entities were publicly reporting on provider performance, with little or no evidence on the best way to create public report cards. Recognizing this need, and given the importance of transparency of health care performance information for consumers, AHRQ began to create evidence-based measures, tools and resources to assist with the creation of new public reports or improvement of earlier reports. We have since developed a more precise measure to capture our work in this area (see Measure 1.3.53) to replace this measure. In FY 2010, the program achieved 19 of the cumulative target of 20 communities or states with public report cards. This measure was officially retired at the end of FY 2010.

1.3.31: Increase the cumulative number of databases, data enhancements, articles, analyses, reports, and evaluations on healthcare value. This measure captures the creation of new evidence and data on healthcare value which is critical for implementing evidence-based strategies to improve quality and efficiency of health care. We met our target of a cumulative total of 28 in FY 2010. The increase included new emergency department data, analyses on topics such as hospital readmissions and a report on elements of model public reports.

1.3.50: SYNTHESIS. Increase the cumulative number of AHRQ measures, tools, upgrades, and syntheses available on healthcare value. To determine if healthcare quality and efficiency are increasing, we must be able to measure it. This new synthesis measure was created to capture the creation of tools, new measures and upgrades to existing measures and data tools based on syntheses of evidence that will help organizations and communities to measure quality and efficiency of care. We originally set a target of 48 to capture a subset of new measures and tools. However, given that FY 2010 is a baseline year for this new measure, we captured all of the measures, tools and upgrades that apply to healthcare value in this first year, which led us to a total of 108 for FY10 (exceeding the target of 48). Now that our baseline has been established, we have adjusted our out-year targets to include the base of 108 plus projected development of new measures, tools etc. in future years.

1.3.51: DISSEMINATION. Increase the cumulative number of measures, datasets, tools, articles, analyses, reports, and evaluations on healthcare value that are disseminated. After new evidence is created, it must be disseminated to key decision-makers (purchasers, health plans, States, consumers and others) who can use it to implement strategies to increase transparency, quality and efficiency in health care. This new measure will allow us to assess our dissemination efforts to these key stakeholders. In FY 2010, we exceeded our goal of 10 and convened 21 dissemination opportunities to share AHRQ data and evidence with our key stakeholders. Vehicles used for dissemination included webinars, in-person presentations and exhibit booths at conferences targeting Chartered Value Exchange stakeholders and researchers and others using HCUP data. We had not anticipated the large number of HCUP data presentations and exhibits when we developed this new measure (baseline is FY10), which is why the target was exceeded by 11. We've adjusted our targets for future years to account for additional HCUP data presentations and other dissemination opportunities.

1.3.53: Increase the cumulative number of AHRQ measures and tools used in national, state, or community public report cards. As noted in Measure 1.3.30, transparency of health care performance information has become a top priority to help increase the quality of care that consumers receive. AHRQ has created evidence-based measures, tools and resources to assist with the creation of new public reports or improvements to earlier reports. This new measure more precisely captures the work that AHRQ contributes to evidence-based public reporting of performance measurement. We reached a cumulative total of 19 states or national entities using AHRQ evidence in their public reports in FY 2010, exceeding our target of 18.

1.3.54: Increase the cumulative use of AHRQ articles, analyses, reports, evaluations, measures, datasets, and tools on healthcare value. Implementation of AHRQ's evidence, including data and measures, by health care researchers, purchasers, plans, clinicians and others is a high priority for the agency. We tracked 10 uses of AHRQ datasets and measures on healthcare value by a variety of our key stakeholders in FY10, including the use of HCUP data by researchers for evidence published in peer-reviewed journals and the use of AHRQ Prevention Quality Indicators by states to assess their record of preventable hospitalizations.

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

Performance Trends: The program successfully met or exceeded each of its performance targets.

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

Measure	Fiscal Year	Target	Result
1.3.29: Increase the number of States or communities reporting market-level hospital cost data (Quantitative)	2012	N/A ³	N/A
	2011	Measure Retired	N/A
	2010	16	16 (Target Met)
	2009	16	16 (Target Met)
	2008	4	16 (Target Exceeded)
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
1.3.30: Increase the cumulative number of communities or States with public report cards (Quantitative)	2012	N/A ⁴	N/A
	2011	Measure Retired	N/A
	2010	19	19 (Target Met)
	2009	18	18 (Target Met)
	2008	5	15 (Target Exceeded)
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
1.3.31: Increase the cumulative number of databases, data enhancements, articles, analyses, reports, and evaluations on health care value that are disseminated. (Output) (Quantitative)	2012	76	Oct 31, 2012
	2011	56	Oct 31, 2011
	2010	28	28 (Target Met)
	2009	18	21 (Target Exceeded)
	2008	5	13 (Target Exceeded)

³ Measure retired FY 2011.

⁴ Measure retired FY 2010.

	2007	N/A	N/A
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Measure	Fiscal Year	Target	Result
1.3.50: SYNTHESIS_Increase the cumulative number of AHRQ measures, tools, upgrades, and syntheses available on healthcare value. (Quantitative)	2012	138	Oct 31, 2012
	2011	127	Oct 31, 2011
	2010	41	108 (Target Exceeded)
	2009	N/A	N/A
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
1.3.51: DISSEMINATION_Increase the cumulative number of measures, datasets, tools, articles, analyses, reports, and evaluations on healthcare value that are disseminated. (Quantitative)	2012	60	Oct 30, 2012
	2011	40	Oct 31, 2011
	2010	10	21 (Target Exceeded)
	2009	N/A	N/A
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
1.3.53: Increase the cumulative number of AHRQ measures and tools used in national, state, or community public report cards. (Quantitative)	2012	23	Oct 31, 2012
	2011	22	Oct 31, 2011
	2010	18	19 (Target Exceeded)
	2009	N/A	N/A
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
1.3.54: Increase the cumulative use of AHRQ articles, analyses, reports, evaluations, measures, datasets, and tools on healthcare value and strategies. (Quantitative)	2012	26	Oct 31, 2012
	2011	23	Oct 31, 2011
	2010	10	10 (Target Met)
	2009	N/A	N/A
	2008	N/A	N/A

	2007	N/A	N/A
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Measure	Data Source	Data Validation
1.3.29	AHRQ staff and contractors for Quality Indicators and Chartered Value Exchanges Learning Network	A yearly review of the posted National State or Community report cards and the number of AHRQ measures they contain, plus the number of report cards that rely upon the use of AHRQ tools such as EQUIPS and the Quality Indicators Learning Institute contractor.
1.3.30	Annual review of AHRQ and contractor tracking systems of completed databases, articles, etc. on health care value.	A yearly review of the posted National State or Community report cards and the number of AHRQ measures they contain, plus the number of report cards that rely upon the use of AHRQ tools such as EQUIPS and the Quality Indicators Learning Institute contractor.
1.3.31	AHRQ staff and contractors for Quality Indicators and Chartered Value Exchanges Learning Network	A yearly review of the posted National State or Community report cards and the number of AHRQ measures they contain, plus the number of report cards that rely upon the use of AHRQ tools such as EQUIPS and the Quality Indicators Learning Institute contractor
1.3.50	Data contained in applications for Chartered Value Exchanges	Reviewed by AHRQ and contractor for validity
1.3.51	AHRQ records	Review of AHRQ records
1.3.53	HCUPnet	Data published on HCUPnet Web site and verified by HCUP Project Officers
1.3.54	Tools tracked by contractor	AHRQ Project Officer oversees contractor work

Health Information Technology

As the Nation's lead research agency on health care quality, safety, efficiency, and effectiveness, AHRQ plays a critical role in the nation's effort to drive adoption and meaningful use of Health Information Technology (Health IT). Established in 2004, the purpose of the Health IT portfolio at AHRQ is to develop and disseminate evidence and evidence-based tools to inform policy and practice on how health IT can improve the quality of American health care. This portfolio serves numerous stakeholders, including health care organizations planning, implementing, and evaluating health IT, health services researchers, policymakers and other decisionmakers. The portfolio achieves these goals through funding research grants and contracts, synthesizing findings, and developing and disseminating findings and tools.

Program Assessments

The Health IT portfolio underwent a program assessment in 2008 and received a Results Not Demonstrated rating. The assessment cited that: (1) the program lacked performance measures to gauge how well it was developing and disseminating research on how well health IT can improve the quality of health care; (2) the program's Web site struggled to reach its intended audience and lacked practical information; and, (3) the program lacked an efficiency measure. It developed an approved improvement plan, addressed the issues cited, and met or exceeded all improvement goals.

Current activities related to the Health IT Portfolio performance measures:

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>). AHRQ's Health IT Portfolio established an FY 2009 baseline of \$6,023 /grantee and set an FY 2010 target of \$5,842 /grantee for production of its 2010 summaries. We exceeded this expectation, spending \$5,538/grantee to produce the 2010 summaries. The reduction was achieved by reporting on a higher number of funded projects while not increasing funding required for the reporting. The Portfolio established an FY 2012 goal of \$5,378 / grantee, a planned 5% reduction.

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. The Portfolio has worked with National Center for Health Statistics for two years on this data set and found significant challenges in obtaining the desired data. During that time, the Portfolio has also worked closely with the Office of the National Coordinator for Health IT on development of the ONC Strategic Plan for Health IT. Since the current measure does not reflect the Portfolio's role in achieving the Administration's priorities as defined by meaningful use of health IT, we anticipate working to retire this measure and adopt measures that closely align with the ONC Strategic Plan for Health IT, and accurately reflect the Portfolio's legislatively mandated role.

Performance Trends: The Health IT portfolio at AHRQ set several ambitious performance measures in 2004, and saw steady progress on all of the measures. The changing health IT landscape defined by the HITECH provisions of ARRA and changing research needs of its customers requires that the program evaluate its measurement strategy, retire measures that no longer make sense, and adopt new measures in support of these broader initiatives. As a result, the program has retired its historical performance measures and embarked on efforts to define appropriate measures and data sources. The program has established a project with

experts in the field of performance measurement to develop a logic model and associated measures. In addition, the program has extended a project, begun in 2007, to identify data sources for potential performance measures.

Long-Term Outcome: To demonstrate how Health IT affects the quality, safety, and efficiency of healthcare.

Measure	Fiscal Year	Target	Result
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). (Outcome) (Quantitative)	2012	\$5,378 /grantee	Sep 30, 2012
	2011	\$5,451 /grantee	Sep 22, 2011
	2010	\$5,842 /grantee	\$5,538 /grantee (Target Exceeded)
	2009	Set Baseline	\$6,023 /grantee (Baseline)
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
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 (Outcome) (Qualitative)	2012	Identify more appropriate measure, set baseline and targets	Sep 30, 2012 (Not Started)
	2011	Initiate development of alternate measure to more accurately measure the program goals	Sep 30, 2011 (Active)
	2010	Establish reliable data source and set baseline	Examination of alternate data source (i.e., American Hospital Association survey) (Made Progress)
	2009	Work with data analysis to clean up NAMCS raw data files, and/or find a new data source, and/or consider revising measure	Conducted data analysis of NAMCS raw data files (Made Progress)
	2008	Review data provided by NAMCS	Inconsistencies identified with the dataset (Made Progress)
	2007	Set Baseline	Awaiting NAMCS data; CDC data delayed (Made Progress)

Measure	Data Source	Data Validation
1.3.48	AHRQ Internal Figures	<p>AHRQ Internal Figures – the process includes capturing the per-grantee cost of: developing and posting annual performance summaries for each grant; developing and posting a series of products (short and long summaries) of research findings upon grant completion; and posting final reports in the National Technical Information Service database of government research. The program will monitor the process of developing and publishing these reports online by attaching resource costs to each step of the process by creating a Gantt chart to map the current process, including who currently performs each step of the process and the time that each step takes. Multiplying this by personnel costs and then summing the total costs for each step of the process will produce an annual estimate of the cost to produce these documents per grantee.</p>
1.3.52	TBD	TBD

Patient Safety

The Patient Safety Portfolio's mission 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. This mission is accomplished by funding health services research in the following activities: Patient Safety Threats and Medical Errors, Patient Safety Organizations (PSOs), Patient Safety and Medical Liability Reform, and Healthcare-Associated Infections (HAIs). Projects within the program seek to inform multiple stakeholders including health care organizations, providers, policymakers, researchers, patients and others; disseminate information and implement initiatives to enhance patient safety and quality; and maintain vigilance to prevent patient harm.

IT investments within this portfolio focus on the AHRQ Web M&M (Morbidity and Mortality) site. This is an Internet-based, monthly, peer-reviewed journal featuring analysis of near misses and actual cases of medical error.

Program Assessment and Looking Forward

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 also supporting 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. At the same time, the Patient Safety Program appreciates a clear need to balance investments in data development/reporting and dissemination and implementation with funding for more fundamental research in patient safety. This balance will support ongoing knowledge creation and a continuous cycle of improvement that encompasses both the discovery and application of safe healthcare practices.

These measures better reflect an emphasis on implementation of evidence-based practices and reporting on their impact.

Currently, two Patient Safety measures have updated data to report for FY 2010.

- 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 86 tools are included in the inventory. The FY 2010 target was 86 tools.
- For measure 1.3.40, "Patient Safety Organizations (PSOs) listed by DHHS Secretary," AHRQ has currently listed 80 PSOs in 30 states and the District of Columbia (December 29, 2010). The baseline for this measure was established in FY 2009.

The Program had already taken the following actions in 2008 to improve performance and continues to consider options for improving program evaluation efforts as follows:

- Measuring the number of 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 PSOs become listed. (Please see <http://www.pso.ahrq.gov/listing/psolist.htm>)
- 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 Patient Safety program underwent a program assessment in 2003, and was found to be performing adequately. The review cited improvements in the safety and quality of care as a strong attribute of the program. As a result of the program assessment, 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 Patient Safety Program has also benefited from a robust effort aimed at evaluating the impact of projects that have been funded under this portion of AHRQ's budget. In April 2009, summaries of the findings were published in a special issue of the journal Health Services Research (available at <http://www.hsr.org/hsr/issue.jsp?vid=44&iid=2.2>). The contents include a description of the evaluation framework and approach, along with other articles that address AHRQ Contributions to patient safety knowledge, experiences with implementation research, the Patient Safety Improvement Corps, and trends and challenges in measuring safety outcomes.

Current activities related to the Patient Safety Portfolio performance measures:

1.3.5: Annual percentage reduction in the cost per capita of treating hospital-acquired infections per year Baseline actual in 2003: \$4, 437.28 per capita. HAIs are the most common complication of hospital care and are one of the top 10 leading causes of death in the United States, accounting for an estimated 1.7 million infections and 99,000 associated deaths in 2002. The financial burden attributable to these infections is estimated at \$28 to \$33 billion in excess health care costs each year.

AHRQ is re-evaluating the current measure and considering alternative indicators for its HAI portfolio, in the context of Department-wide efforts to prevent HAIs as described in the HHS HAI National Action Plan. The new measure would replace the existing measure #1.3.5 with a more focused one that captures decreases in the rate of HAIs.

1.3.37: Increase the percentage of hospitals in the U.S. using computer-only patient safety event reporting systems. Hospitals are increasingly utilizing electronic systems to report patient safety events. The use of these systems has increased between 2006 and 2009, from 12 to 23% respectively. AHRQ has determined that the optimal time interval for surveying hospitals for this information is every three years. Therefore, we will administer a revised survey instrument in 2012 and again in 2015. The program will reevaluate this measure and develop an approach to better capture the work of the portfolio around hospitals and patient safety event reporting.

1.3.38: Increase the number of U.S. healthcare organizations per year using AHRQ-supported tools to improve patient safety. As an indicator of the number of healthcare organizations using AHRQ-supported tools to improve patient safety, the Agency relies in part on the Hospital Survey of Patient Safety. Some organizations that use the survey voluntarily submit their data to a comparative database for aggregation. In 2010, data from 885 hospitals was available in the database. Out-year targets have been adjusted to 900 hospitals. It is anticipated that as many as 1,000 organizations will have submitted information to the HSOPS comparative database by 2012. Interest in other AHRQ tools and resources has also remained strong, based on for example, on-going participation in webinars describing resources, electronic downloads, and orders placed for various products.

1.3.39: Increase the number of patient safety events reported to the Network of Patient Safety Databases (NPSD). This measure indicates the level of PSO activity in collecting patient safety event data from healthcare providers using the Common Formats. As reporting to the NPSD is voluntary, the number of events reported does not necessarily translate into an occurrence rate of patient safety events in healthcare. The FY 2012 target will be established after several months of NPSD operations.

1.3.40: Patient Safety Organizations (PSOs) listed by DHHS. AHRQ's count of listed PSOs functions as a practical measure of start up operations for the AHRQ PSO program in FY 2009 and 2010. This measure indicated success in implementing AHRQ's administrative responsibilities under the Patient Safety Act and Rule, and the measure demonstrated a high level of interest in the private sector in becoming a Federally listed PSO. AHRQ believes that the number of PSOs has reached maturity. We note a dramatic drop off in applications for PSO listing in FY 2010 compared to FY 2009. AHRQ anticipated the possibility of a decreasing count in PSOs. We began to experience this decrease in 1st quarter FY 2011, as our current count of PSOs (as of December 29, 2010) is 80. AHRQ does continue to receive requests for new listings, albeit at a much slower rate. PSOs are voluntary and not funded by the government and numerous PSOs have not been able to succeed in developing a successful business model. For this reason, we expect this number to be balanced with the number of de-listed PSOs.

AHRQ promotes PSOs and the Common Formats in multiple speaking engagements and forums. In addition, we provide technical assistance to both current PSOs and entities considering becoming a PSO to explain the process of listing as a PSO, receiving contracts from providers, and using the Common Formats.

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. This measure indicates the output of AHRQ's Patient Safety Portfolio. An important result of the initiative is the availability of tools and resources that can be utilized by healthcare organizations to improve the care they deliver, and, specifically, patient safety. An expanding set of evidence-based tools is available as a result of ongoing investments to generate knowledge through research, including optimal ways to synthesize and disseminate new knowledge. In FY2010, five (5) new resources were released, raising the number of currently available tools for use by healthcare organizations to 86.

Performance Trends: The program exceeded the FY 2009 goal for listing PSOs as it reached 75 PSOs. This higher than expected number of listed PSOs within the first year is believed to be due in part to high interest in the rule.

The program also met the FY 2010 goal for the number of tools available in AHRQ's inventory of evidence-based tools to improve patient safety and reduce the risk of patient harm. At the end of FY 2010, 86 such tools were available.

Long-Term Outcome: 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., Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS),

Hospital Survey of Patient Safety (HSOPS), Patient Safety Indicators (PSIs), and the Medical Office Survey on Patient Safety Culture.)

Measure	Fiscal Year	Target	Result
1.3.5: Annual percentage reduction in the cost per capita of treating hospital-acquired infections per year Baseline actual in 2003: \$4, 437.28 per capita (Outcome) (Quantitative)	2012	\$4,008.94	Oct 31, 2014
	2011	\$4,010.94	Oct 31, 2013
	2010	\$4,092.8	Oct 31, 2012
	2009	\$4,176.33	Oct 31, 2011
	2008	\$4,261.56	N/A
	2007	\$4,348.53	N/A

Measure	Fiscal Year	Target	Result
1.3.37: Increase the percentage of hospitals in the U.S. using computer-only patient safety event reporting systems (PSERS) (Outcome) (Quantitative)	2012	24%	Sep 30, 2012
	2011	24%	N/A
	2010	24%	N/A
	2009	24 %	23 % (Target Not Met)
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
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) (Outcome) (Quantitative)	2012	1000 Hospitals	Sep 30, 2012
	2011	900 Hospitals	Sep 30, 2011
	2010	580 Hospitals	885 Hospitals (Target Exceeded)
	2009	500 Hospitals	622 Hospitals (Target Exceeded)
	2008	450 Hospitals	519 Hospitals (Target Exceeded)
	2007	Set Baseline	382 Hospitals (Baseline)

Measure	Fiscal Year	Target	Result
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.(Outcome) (Qualitative)	2012	Establish out-year targets	Sep 30, 2012 (Not Started)
	2011	Establish Baseline	Sep 30, 2011 (Active)
		NPSD Operational	Sep 30, 2011 (Active)
	2010	Publish technical specification	Publication of Common

		for Common Format (V1.1)	Formats 1.1 (Target Met)
	2009	Baseline	Publication of Common Formats 1.0 (Target Met)
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
1.3.40: Patient Safety Organizations (PSOs) listed by DHHS Secretary (Outcome) (Quantitative)	2012	85 listed PSOs	Sep 30, 2012
	2011	85 listed PSOs	Sep 30, 2011
	2010	85 listed PSOs	88 listed PSOs (Target Exceeded)
	2009	Set Baseline	68 listed PSOs (Baseline)
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
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 (Outcome) (Quantitative)	2012	98 tools	Oct 31, 2012
	2011	92 tools	Oct 31, 2011
	2010	86 tools	86 tools (Target Met)
	2009	76 tools	81 tools (Target Exceeded)
	2008	68 tools	73 tools (Target Exceeded)
	2007	Set Baseline	61 tools (Baseline)

Measure	Data Source	Data Validation
1.3.5	HCUP/PSIs	Ongoing HCUP/PSI validation activities (HCUP and QI Project Officers use established methodology to check data)
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

Measure	Data Source	Data Validation
1.3.39	PSO Privacy Protection Center - www.psoppc.org	Common Formats Version 1.1 - AHRQ has issued technical specifications which specify the code that needs to be programmed into electronic reporting systems to accurately send data. The technical specifications detail the valid values for data elements, the order for data completion, and the format it must be electronically submitted in. The detailed technical specifications for programming code ensure the data submitted is technically accurate. These technical specifications are also available for download at www.psoppc.org
1.3.40	AHRQ PSO web site	AHRQ PSO web site is updated weekly to reflect total number of PSOs
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

Crosscutting Activities Related to Quality, Effectiveness, and Efficiency Research

Unlike AHRQ's other research portfolios, Crosscutting Activities Related to Quality, Effectiveness and Efficiency funds projects that support all of HCQO's research portfolios. Crosscutting Activities conducts investigator-initiated and targeted research that focus on health services research in the areas of quality, effectiveness and efficiency. Creation of new knowledge is critical to AHRQ's ability to answer questions related to improving the quality of health care. Crosscutting Activities also supports Measurement and Data Collection Activities, Dissemination and Translation of Research, and Other Health Services Research.

The Crosscutting portfolio includes program investments with complementing IT activities. These activities are driven by and support the business and measurement required for the Agency to be successful in creating data repositories and, then, translating and disseminating the research results to appropriate parties. The IT projects assist with data dissemination, translation and measurement of success across AHRQ portfolios.

Examples of projects that help portfolios with measurement in health care include the Consumer Assessment of Healthcare Providers and Systems (CAHPS), Healthcare Cost and Utilization Project (HCUP), Quality Indicators (QIs), and the National Healthcare Disparities and Quality Reports (NHDR/QR). Additional information about these activities is found in the next section.

Current activities related to the Quality, Effectiveness, and Efficiency Research

- **CAHPS**

The long-term goals of CAHPS are to ensure that: consumers/patients have accurate and timely information about health care providers and facilities to inform their selection decisions, and providers and health care facilities have accurate information from their patients to use as a basis for quality improvement efforts. CAHPS has set a program performance goal of ensuring that CAHPS data will be more easily available to the user community and the number of consumers who have accessed CAHPS information to make health care choices will increase by over 50 percent from the FY 2002 baseline of 100 million. By moving to create surveys for a range of providers beyond the widely used CAHPS health plan surveys, including clinicians, hospitals, nursing homes, and dialysis facilities, CAHPS is rapidly expanding the capacity to collect data that can be utilized to make more informed choices by the purchasers who contract with and the consumers who visit these providers.

- **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 – \$11.5 million in both FY 2009 and 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).

In FY 2011, AHRQ will recompute the CERTs program within Crosscutting Activities. The continuation of the existing measures can only be determined after successful applicants are determined in the fourth quarter of FY 2011. Following the award of the new CERTs grants, AHRQ will review the existing measures to see if any of the measures can continue or if new measures will need to be developed.

- **HCUP.** Efforts to improve the quality, safety, effectiveness, and efficiency of health care and reduce disparities in the United States require detailed knowledge about how the health care delivery system works now and how different organizational and financial arrangements affect this performance. Improving health care requires easy access to detailed information and data on costs, access to health care, quality, and outcomes that can be used for research and policymaking at the national, State, and local levels. It also requires tools to measure and track progress in these areas. The Healthcare Cost and Utilization Project (HCUP) provides the necessary data through a long-standing partnership with State data organizations, hospital associations, and private data organizations. HCUP is a family of health care databases and related software tools and products that support the mission of AHRQ. HCUP includes the largest collection of all-payer, encounter-level data in the United States, beginning in 1988. It includes detailed information on 90 percent of all inpatient stays in the country – including information about the diagnosis, the procedures, the cost, and who paid for the care, as well as encrypted non-identifiable demographic information. For over 25 States, it also includes ambulatory surgery and emergency department data. Support for the HCUP contract totaled \$4.1 million in FY 2010.

Expand and Improve Data and Tools

The HCUP databases have been a powerful resource for the development of tools that can be applied to other similar databases by health services researchers and decisionmakers. The expanded data and tools can then be translated to inform decisionmaking and improve health care delivery. A major achievement in 2008 and 2009 was creation and release of the largest all-payer emergency department database in the United States. The first Nationwide Emergency Department Sample (NEDS) database was created to enable national analyses of emergency department (ED) utilization patterns and support public health professionals, administrators, policymakers, and clinicians in their decisionmaking regarding this critical source of care. The NEDS contains clinical and non-clinical information on patients, regardless of payer—including those covered by Medicare, Medicaid, private insurance, and the uninsured. The ED serves a dual role in the U.S. health care system infrastructure as a point of entry for approximately 50 percent of inpatient hospital admissions and as a setting for treat-and-release outpatient visits.

Performance Trends by Program:

HCUP

Over the past 5 years, the cumulative number of partners contributing data to HCUP databases has been steadily increasing resulting in a more robust and representative data resource. In FY 2010, AHRQ has met our performance target (see performance table 1.3.15) to increase by 3 the number of partners contributing data to the HCUP databases. The number of State Emergency Department Databases increased by one partner - Kentucky. In addition, AHRQ added data from Louisiana and Pennsylvania for a total of 42 statewide data organizations participating in HCUP.

QIs: Over the past 5 years, the number of new organizations using the AHRQ Quality Indicators has steadily increased. In 2005, there were 3 state organizations that publicly reported the AHRQ Quality Indicators at the hospital level. In 2010, that number rose to 22 state organizations.

1.3.15: Cumulative number of partners contributing data to HCUP databases will exceed by 5% the FY 2000 baseline of 39. Efforts to improve the quality, safety, effectiveness, and efficiency of health care and reduce disparities in the United States require detailed knowledge about how the health care delivery system works now and how different organizational and financial arrangements affect this performance. Improving health care requires easy access to detailed information and data on costs, access to health care, quality, and outcomes that can be used for research and policymaking at the national, State, and local levels. It also requires tools to measure and track progress in these areas. The Healthcare Cost and Utilization Project (HCUP) provides the necessary data through a long-standing partnership with State data organizations, hospital associations, and private data organizations. By increasing the number of organizations using HCUP and the Quality Indicator tools, we support the overall program goal. Expanding to add new States and increasing the number of Partners that contribute ambulatory surgery and emergency department data improves national and regional representation. Over the past 5 years, the cumulative number of partners contributing data to HCUP databases has been steadily increasing resulting in a more robust and representative data resource. In FY 2010, AHRQ met our performance target (see performance table 1.3.15) to increase the number of partners contributing outpatient data to the HCUP databases by 3. The number of State Emergency Department Databases increased by one partner - Kentucky. In addition, the number of Inpatient Databases increased by two partners – Louisiana and Pennsylvania. Currently, the total number of partners contributing data to HCUP databases include: 42 Inpatient Databases, 28 Ambulatory Surgery Databases, and 28 Emergency Department Databases.

HCUP has matured to the point of having incorporated most of the available and viable data collections that met the long established goal 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, HCUP expects to exceed the goals established over the past 9 years and to have reached the natural conclusion of this target. We plan to establish new ambitious goals aimed at future targets for FY 2012 and beyond.

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. One widely used HCUP tool is the AHRQ Quality Indicators (QIs) -- a

set of quality measures developed from HCUP data. Support for QIs total \$0.4 million in both FY 2010 and 2011. This measure set is organized into four modules—Prevention, Inpatient, Patient Safety, and Pediatrics. These measures are free and made publicly available as part of an AHRQ supported software package. The AHRQ QIs are widely used for quality improvement and public reporting initiatives. We saw several major successes in FY 2009 most notably the addition of 4 additional states now doing hospital level public reporting of the AHRQ Quality Indicators and the CMS adoption of the AHRQ QIs in its 2009 IPPS Rule. In FY09, New Jersey, California, Nevada and Oklahoma became the 13th, 14th, 15th and 16th states to use the AHRQ Quality Indicators in a hospital level public report card. As the result of FY08 NQF endorsement of select AHRQ QIs, a growing number of States are using the Quality Indicators for public reporting of hospital quality. The number of additional organizations in FY10 that use Healthcare Cost and Utilization Project (HCUP) databases, products, or tools in health care quality improvement efforts has increased by 3. The State of Illinois, the Illinois Hospital Association, and the Minnesota Community Measurement (an Aligning Forces for Quality site) used the AHRQ Quality Indicators in their public reports on hospital quality. By FY2012, it is anticipated that the number of additional organizations will increase as a result of the CMS IPPS rule that incorporated the AHRQ PSIs into Hospital Compare.

CERTs:

With the exception of the antibiotic prescription measure (for which external evaluators have suggested important refinements to discern appropriate antibiotic prescribing), all CERTs performance measures were met or exceeded.

In FY 2011, AHRQ will recompetes the CERTs program within Crosscutting Activities. The continuation of the existing measures can only be determined after successful applicants are determined in the fourth quarter of FY 2011. Following the award of the new CERTs grants, AHRQ will review the existing measures to see if any of the measures can continue or if new measures will need to be developed.

4.4.1: Inappropriate Antibiotic Use in Children

Results show that from FY 2005 through FY 2009, the average number of antibiotic prescriptions for U.S. children ages 1-14 has fluctuated, with no statistically significant net change. In FY 2004, baseline rates were established (0.56 prescriptions per child). The result for FY 2009 (0.55 prescriptions per child) did not show a statistically significant difference from the FY 2004 baseline estimate (0.56 prescriptions per child.) In FY 2010, the target was a drop to 0.51 prescriptions per child; the actual FY 2010 result of 0.49 prescriptions per child exceeded this target.

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, and should contribute to a lessened risk of antibiotic resistance emerging in the pediatric and general population.

Multiple CERTs Research Centers are working to reduce inappropriate use of antibiotics, with the University of Pennsylvania CERT making this goal a primary focus of their Center. They promote microbial stewardship and efforts to minimize inappropriate antibiotic treatments for pediatric infections by accurate diagnoses and application of treatment guidelines from the Centers for Disease Control and the American Academy of Pediatrics. Products from the University of Pennsylvania and other CERTs research centers include publications in peer-reviewed journals, as well as presentations at national meetings of healthcare professional

organizations. An example from FY 2010 was the April 2010 publication in the Journal of the Infection Control and Hospital Epidemiology that examined childcare center exclusion policies and directors' opinions on the use of antibiotics. The study was undertaken in light of evidence that childcare center directors often exclude ill children until antibiotics are prescribed, despite many acknowledging their lack of efficacy for a variety of conditions. The authors surveyed 135 childcare centers for their exclusion practices for a variety of conditions and noted wide variation in policies. The authors suggested that interventions to promote judicious use of antibiotics should include dissemination of model childcare policies as well as educational materials via campaigns.

4.4.2: Congestive Heart Failure Readmission Rates:

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 consistently downward. In FY 2004, baseline rates were established (38% 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). In FY 2008, the target was a 1.4% drop and the actual result was a 4.4% drop (34.89% readmission rate).

In FY 2009, there was a 1.7% increase in the readmission rate (to 35.48%) relative to 2008, where the FY 2009 target was a 1.4% drop. We suspected that the large absolute and relative decline in the CHF readmission rate in 2008 explained the anomalous increase, and found in comparing the 2009 readmission rate (35.48%) to the 2007 value (36.51%) that there had been a 2.9% decline over the 2 year period, which was consistent with two consecutive years of the 1.4% annual decline that had been targeted for 2008 and 2009.

The FY 2010 results show a substantial drop in readmissions to 27.7%, reflecting a 21.9% decrease over the FY 2009 rate of readmissions. The FY 2010 decline is reassuring in light of the increased rate seen in FY 2009 and demonstrates the consistent downward trend in congestive heart failure readmissions. The unusually large decline in FY 2010 relative to FY 2009 signals some year-to-year instability in the measure, which we noted last year is currently based on data from 4 states.

In FY 2010, multiple CERTs efforts have contributed to improved treatment of congestive heart failure hospital readmission rates; these efforts include indirect efforts to track and improve adherence to medication use in patients with cardiovascular disease, as well as direct work in improving the coordination and processes of treating congestive heart failure. The latter includes continuation of the CERTs productive partnership with the American Heart Association (AHA) and exploration of factors in the AHA's Get with the Guidelines – Heart Failure (AHA GWTG-HF) database with longitudinal links to Medicare claims data for those between 65 and 85 years of age. One example is directly relevant to whether performance measures may improve heart failure treatment and thereby contribute to a decline in readmissions: a CERT research center with a thematic focus on improving therapeutics in cardiovascular health published a study in the American Heart Journal on the relationship between emerging measures of heart failure processes of care and clinical outcomes. Using a clinical database linked to Medicare claims, they examined processes of care, including use of beta-blockers, aldosterone antagonists, warfarin, implantable cardioverter-defibrillators, and disease management for their association with cardiovascular readmissions and mortality at 60-days and 1-year. Of all the performance measures, only the use of evidence-based beta-blockers was associated with lower risk of 60-day or 1-year readmission, with an expected decrease of 5

– 7% in readmissions with each 10% increase in the use of evidence-based beta-blockers. In terms of mortality reduction, all measures except referral to disease management reduced the risk of mortality at 1 year post-discharge

4.4.3 and 4.4.4 CERTs: Upper GI (Gastrointestinal) Bleeding

Results show that from FY 2006 through FY 2008, 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, baseline rates were established (55/10,000). In FY 2007, the target was a 2-percent drop and the actual result was a 5.2-percent drop (51.56/10,000). In FY 2008, the target was a 1.8-percent drop and the actual result was a 3.5-percent drop (49.75/10,000). In FY 2009, the target was a 1.8-percent drop and the actual result was a 3-percent drop (48.25/10,000).

AHRQ proposed to preserve the 1.8% rate of decline for FY 2010 in light of findings from an external evaluation that anticipated the likelihood of a population increase in the risk of GI bleeding due to multiple factors. These include: the aging of the U.S. population, anticipated decline in proton pump inhibitor use due to FDA advisories regarding their use with antiplatelet drugs such as clopidogrel, and the current economic recession which will likely lead to lessened medical contact and use of gastroprotective agents, and at the same time, likely increase population consumption of alcoholic products. In FY 2010, the hospitalization rate for GI bleeding was 47.09/10,000 representing a 2.4% decline relative to FY 2009, which did not achieve the 3.5% rate of decline target.

Results show that from FY 2006 through FY 2008, 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, baseline rates were established (\$96.54 per capita). In FY 2007, the target was a 4% drop (\$92.68) and the actual result was a 4.9% drop (\$91.81 per capita). In FY 2008, the target was a 5% drop (\$91.71) and the actual result was a 9.8% drop (\$87.10 per capita).⁵ Results from FY 2009 met and exceeded the corresponding target. In FY 2009, the target was a 6% drop (\$90.75) and the actual result was a 13.2% drop (\$83.81 per capita). In FY 2010, the absolute target of \$89.78 per capita costs was exceeded, with the actual per capita costs declining by 8.4% to \$82.24 per capita.

In support of this measure and its improvements in 2010, at least 4 crosscutting CERTs Centers are working on projects that either directly or indirectly influence the risk of GI bleeding. These include multiple efforts to optimize the use of the anticoagulant warfarin, including efforts to educate clinicians and patients about how to achieve stable warfarin blood levels and therapeutic action, and to improve its monitoring so that excessive anticoagulation is avoided. Adverse drug-drug interactions, including those which may increase the risk of bleeding from warfarin, have also been targeted for reduction. FY 2010 efforts included a major publication from the CERTs in the journal *Circulation* that addressed minimizing the risks of anticoagulants and platelet inhibitors and which detailed drug-, patient-, and provider-associated risks and factors that influenced them. The authors noted opportunities in better monitoring and process improvement to improve the benefits and reduce the risks of antithrombotic therapies. .

CAHPS

⁵ In the 2008 Citizen's Report, the percentage reduction from based was erroneously reported as 5.1%; the correct percentage reduction from baseline was 9.8%.

1.3.23: The number of consumers who have access to customer satisfaction data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to make health care choices. The Home Health Care CAHPS (HH CAHPS) is the current focus of this measure. The purpose of the HH CAHPS is to obtain patient assessment of the quality of care they receive from home health care providers. The Centers for Medicare and Medicaid Services (CMS) requires that all Medicare certified home health agencies throughout the United States which have a patient count of 60 or higher: a) participate in a ‘dry run’ of collecting and reporting HH CAHPS data to CMS prior to October 2010; b) report HH CAHPS data on a quarterly basis beginning in October beginning in October 2010. These data will be available to the public via CMS website beginning in 2012. The program anticipates that this will be of most interest to users of home health care services. This would include at least 3 million Medicare beneficiaries based on the latest data.

In FY 2007, CAHPS met the performance target (see performance measure 1.3.23) to increase 40 percent over the baseline of the user community. In FY 2007 AHRQ increased this usage to 41 percent over the baseline of 100 million users – 141 million users of CAHPS information – and maintained this performance level in 2008. In FY 2008, the program did not meet its target of increasing the number of using 42 percent over the baseline. This is due to the fact that no new major organization adopted the CAHPS tool and therefore, no increase in usage was noted. In FY 2009, the program proposed a 44% increase over the baseline. We did not meet this goal because a) ABMS (American Board of Medical Specialties) has moved more slowly than we anticipated in use of the Clinician/Group CAHPS Survey as part of their accreditation process and b) CMS did not begin using the Home Health Care Survey in the beginning of 2009 as they had projected. The program is no longer using the previous data source for this measure as data has not been available for reporting on an annual basis. However, CAHPS did

obtain a 1M increase in the “number of consumers” measure from another source: the CAHPS Clinician Group Survey (CG CAHPS). Though there is not yet one single large-scale user for this survey, we are seeing increasing use on the state (Minnesota and Massachusetts) and community level. In the past year, medical groups in these locations submitted 1M completed surveys to the CAHPS Clinician Group Survey Database. That puts the 2010 figure at 142M consumers. Health care reform legislation mentions the use of this survey for various efforts; for example, to develop a “Physician Compare” website and make these data available to the public. We have not included projected estimates of use from these efforts at this time.

Our ability to meet future goals will depend on how many organizations implement the Surveys for PCMH, Cancer CAHPS and Surgical CAHPS. Given that there is a requirement for CMS to obtain CAHPS Health Plan data for CHIPRA reporting, we expect to see increased use of this survey by state Medicaid programs in the out-years.

Crosscutting Activities Related to Quality, Effectiveness and Efficiency Research

Measure	Fiscal Year	Target	Result
1.3.15: Cumulative number of partners contributing data to HCUP databases will exceed by 5% the FY	2012	TBD ⁶	Sep 30, 2011 (Not Started)
	2011	add 3 databases	Sep 30, 2011

⁶ Prior to FY 2012, HCUP expects to exceed the goals established for this measure. The natural conclusion of this target will have been met. HCUP plans to establish new ambitious goals aimed at future targets for FY 2012 and beyond.

2000 baseline of 39 (Output) (Qualitative)			(Active)
	2010	3 additional databases	42 Inpatient Databases 28 Ambulatory Surgery Databases 28 Emergency Dept Databases (Target Met)
	2009	28 AS 27 ED	40 Inpatient Databases 28 Ambulatory Surgery Databases 27 Emergency Dept. Databases (Target Met)
	2008	27 AS 25 ED	39 Inpatient Databases 27 Ambulatory Surgery Databases 25 Emergency Dept. Databases (Target Met)
	2007	24 AS 22 ED	24 Ambulatory Surgery Databases 22 Emergency Dept Databases (Target Met)

Measure	Fiscal Year	Target	Result
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. (Output) (Quantitative)	2012	7 Organizations	Oct 31, 2012
	2011	5 Organizations	Oct 31, 2011
	2010	3 Organizations	3 Organizations (Target Met)
	2009	3 Organizations	3 Organizations (Target Met) ⁷
	2008	3 Organizations	5 Organizations (Target Exceeded) ⁸
	2007	3 Organizations	3 Organizations (Target Met) ⁹

Measure	Fiscal Year	Target	Result
1.3.23: The number of consumers who have access to customer satisfaction data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to make	2012	144 Million	Dec 31, 2012
	2011	143 Million	Dec 31, 2011
	2010	145 Million	142 Million (Target Not Met but Improved)

⁷ 3 new organizations- Nevada State Hospital Association Oklahoma State Hospital Association Wisconsin State Hospital Association

⁸ 5 new organizations – Kentucky Hospital Association; SSM Health Care; IN CHCS; Robert Wood Johnson; University Hospital

⁹ 3 new organizations – CO Health Institute; OH Department of Health; Harvard Vanguard Medical Association & Atrias Health

health care choices. (Outcome) (Quantitative)	2009	144 Million	141 Million (Target Not Met)
	2008	142 Million	141 Million (Target Not Met)
	2007	140 Million	141 Million (Target Exceeded)

Measure	Fiscal Year	Target	Result
4.4.1: The number of prescriptions of antibiotics per child aged 1 to 14 in the U.S. (Outcome) (Quantitative)	2012	TBD ¹⁰	TBD
	2011	0.51 prescriptions per child	Sep 30, 2011
	2010	0.51 prescriptions per child	0.49 prescriptions per child (Target Exceeded)
	2009	0.51 prescriptions per child	0.55 prescriptions per child (Target Not Met but Improved)
	2008	0.52 prescriptions per child	0.58 prescriptions per child (Target Not Met)
	2007	0.53 prescriptions per child	0.52 prescriptions per child (Target Exceeded)

Measure	Fiscal Year	Target	Result
4.4.2: The percentage of hospital readmissions within 6 months for congestive heart failure in patients between 65 and 85 years of age (Outcome) (Quantitative)	2012	TBD ¹¹	TBD
	2011	34 % readmission rate	Oct 31, 2011
	2010	34 % readmission rate	27.7 % readmission rate (Target Exceeded)
	2009	34.5 % readmission rate	35.48 % readmission rate (Target Not Met)
	2008	35 % readmission rate	31.91 % readmission rate (Target Exceeded)
	2007	35.5 % readmission rate	36.51 % readmission rate (Target Not Met but Improved)

Measure	Fiscal Year	Target	Result
4.4.3: The decrease in the rate of hospitalization for upper gastrointestinal bleeding due to the adverse effects of medication or inappropriate treatment of peptic ulcer disease in patients between 65 and 85 years of age (Outcome) (Quantitative)	2012	TBD ¹²	TBD
	2011	-1.8 %	Oct 31, 2011
	2010	-3.5 %	-2.4% (Target Not Met)
	2009	-3 %	-3 % (Target Met)
	2008	-1.8 %	-3.5 % (Target Exceeded)

¹⁰⁻¹⁴ The CERTs program will be recompleted in FY 2011, and the continuation of the existing measures and out-year targets can only be determined after successful applicants are accepted to the program.

	2007	-2 %	-5.2 % (Target Exceeded)
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Measure	Fiscal Year	Target	Result
4.4.4: The cost per capita of hospital admissions for upper gastrointestinal bleeding among patients aged 65 to 84. (Outcome) (Quantitative)	2012	TBD ¹³	TBD
	2011	\$83.81 per capita	Oct 31, 2011
	2010	\$89.78 per capita	\$82.24 per capita (Target Exceeded)
	2009	\$90.75 per capita	\$83.81 per capita (Target Exceeded)
	2008	\$91.71 per capita	\$87.1 per capita (Target Exceeded)
	2007	\$92.68 per capita	\$91.81 per capita (Target Exceeded)

Measure	Data Source	Data Validation
1.3.15	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.
1.3.22	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 Clinician Group Survey	Prior to placing survey and related reporting products in the public domain, a rigorous development, testing, and vetting process with stakeholders is followed. Survey results are analyzed to assess internal consistency, construct validity, and power to discriminate among measured providers.
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 meets OMB standards for adequate response rates, and timely release of public use data files.
4.4.2 4.4.3 4.4.4	HCUP	HCUP and QI Project Officers use established methodology to check data.

MEPS

The Medical Expenditure Panel Survey (MEPS), first funded in 1995, is the only national source for comprehensive annual data on how Americans use and pay for medical care. The survey collects detailed information from families on access, use, expenses, insurance coverage and quality. Data are disseminated to the public through printed and Web-based tabulations, microdata files and research reports/journal articles. Data from the MEPS have become a linchpin for public and private economic models projecting health care expenditures and utilization. The MEPS is designed to provide annual estimates at the national level of the health care utilization, expenditures, sources of payment, and health insurance coverage of the U.S. civilian non-institutionalized population. The MEPS consists of a family of interrelated surveys, which include a Household Component (HC), a Medical Provider Component (MPC), and an Insurance Component (IC). In addition to collecting data that support annual estimates for a variety of measures related to health insurance coverage, healthcare use and expenditures, MEPS provides estimates of measures related to health status, demographic characteristics, employment, access to health care and health care quality. The survey also supports estimates for individuals, families and population subgroups of interest. The data collected in this ongoing longitudinal study also permit studies of the determinants of insurance take-up, use of services and expenditures as well as changes in the provision of health care in relation to social and demographic factors such as employment and income; the health status and satisfaction with care of individuals and families; and the health needs of specific population groups such as racial and ethnic minorities, the elderly and children.

The IT portion of this portfolio is a key to the success of data collection, synthesis and dissemination. Recent upgrades to the system allow AHRQ to provide more timely data – a crucial factor for the success of this program.

Current activities related to the Medical Expenditure Panel Survey (MEPS) Program performance measures:

1.3.19: Increase the number of topical areas tables included in the MEPS Tables

Compendia. The MEPS Tables Compendia is a source of important data that is easily accessed by all users. Expanding the content and coverage of these tables furthers the utility of the data for all. The following data was added to the Compendia: FY 2008 – prescribed drug tables; FY 2009 – updated and expanded state-level estimate tables; and FY 2010 variables from the diabetes care supplement were added. Additional tables will be added in FY 2011 and FY 2012.

1.3.16, 1.3.17, 1.3.18, and 1.3.21: Improve the timeliness of the MEPS data.

During FY 2010, release of the following public use files contributed to achievement of the FY 2010 measure target:

- Q4 (FY 2010/Jul-Sep) – 2008 Dental Visits File, 2008 Home Health File, 2008 Other Medical Expenses File, 2008 Outpatient Visits File, 2008 Hospital Inpatient Stays File, 2008 Emergency Room Visits File
- Q3 (FY 2010/Apr-Jun) – 2008 Full Year Population Characteristics File, 2008 Jobs File, 2009 Point-in-time File
- Q2 (FY 2010/Jan-Mar) – No public use files released during this time due to production schedule.

- Q1 (FY 2010/Oct-Dec) – 2007 Hospital Inpatient Stays Files, 2007 Prescribed Medicines File, 2007 Person Round Plan File, 2007 Medical Conditions File, 2007 Full year Consolidated File, MEPS Panel 11 Longitudinal Data File

At the time the MEPS-HC contract was awarded the delivery schedule for the 2009 public use files was accelerated one month based on historical release dates. For 2010 and beyond the public use files delivery schedule was accelerated an additional month.

The acceleration of the delivery schedule for public use data files (one month for 2009 and an additional month for 2010 and beyond) has placed greater emphasis on the efficiency of data collection, data processing and the preparation needed for release of data products to the public. As a result coordination meetings and discussions have taken place between contractors (Westat for data collection and processing, and Social Scientific Systems for data preparation and release of data products) to establish potential areas of concern and to address them in a proactive manner.

The following steps have and will continue to be taken in an effort to release public use files at an earlier date: 1) data editing now takes place in waves (batch processing) rather than data processing taking place all at once at the completion of data collection. 2) processing of multiple data sets now takes place concurrently rather than consecutively, thus multiple processes take place at any given point in time. 3) duplicative processes have either been eliminated or combined with similar processes. 4) review time of intermediate steps was reduced. The contractor has eliminated a number of edits or streamlined such processes where they were determined to provide minimal benefit in relation to the resources utilized. Contractor editing staff have been cross-trained in order to more efficiently distribute work assignments.

The accelerated data delivery schedule increases the timeliness of the data and thus maximizes the public good through the use of the most current medical care utilization and expenditure data possible. Such data is used for policy and legislative analyses at the Federal, state and local levels as well as the private health care industry and the health services research community in an effort to improve the health and well-being of the American people.

1.3.20 Increase the number of MEPS Data users. A number of methods are used annually to market MEPS data to the user community (policymakers at all levels of government, public and private concerns and academic research centers). To this end a number of MEPS workshops are offered throughout the year. Two MEPS workshops are conducted annually, at no cost to the attendee, at the John Eisenberg building located in Rockville, Maryland. Each workshop offers a full day of interactive lecture, followed by a full day of hands-on analytical work, aided by content and programming experts. In addition, MEPS workshops are held annually throughout the U.S. at a number of professional meetings such as: American Public Health Association, Academy Health, the annual AHRQ Conference, American Sociological Association, Gerontological Society of America, and International Conference on Health Policy Statistics, as well as at the Centers for Disease Control and Prevention. Also, the MEPS website (www.meps.ahrq.gov) is readily available to the public as well as the health services research community where the most recent MEPS data is available at no cost. A MEPS list server is also maintained. The purpose of the list server is to allow the free exchange of all e-mailed correspondence (questions and answers) pertaining to the use of the MEPS database. Users may also receive a periodic digest of MEPS Household Component public use file releases, MEPS Insurance Component tables, scheduled data use workshops, and new MEPS publications by signing up to receive the MEPS free e-mail update service.

1.3.49: Reduce the average number of field staff hours required to collect data per respondent household for the MEPS. The purpose of this measure is to improve the efficiency of the data collection. In 2007, a baseline of 14.2 staff hours was established for data collection. Collection times were reduced in FY 2008 to 13.5 hours and FY 2009 to 13.0 hours. Most recently, FY 2010, the target of 12.8 was not met but produced an actual result of 13.2 field staff hours.

During 2010, field staff (interviewers) found it increasingly difficult to persuade respondents to take part in the MEPS survey, resulting in increased hours per completed case due to: 1) There being an increase in the number of contacts (nine in total and five to six face-to-face) required to complete data collection; and 2) Some cases required more than one interviewer to complete data collection from the respondent. Based on results from an incentive experiment conducted in 2008 all indications are that an increase in the respondent incentive (recently approved to increase from \$30 to \$50) will promote greater cooperation from the respondent thus necessitating fewer contacts and interviewers (time/hours) to complete a case.

Performance Trends: The MEPS Program has met or exceeded most program assessment data timeliness goals. In addition, due to modifications to the MEPS Insurance Component survey design and data processing, calendar year estimates of employer-based health insurance costs and availability were provided a full year earlier than in previous years.

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

Measure	Fiscal Year	Target	Result
1.3.16: Insurance Component tables will be available within months of collection (Output) (Quantitative)	2012	6 months	Sep 30, 2012
	2011	6 months	Oct 31, 2011
	2010	6 months	6 months (Target Met)
	2009	Set Baseline	6 months (Baseline)
	2008	6 months	6 months (Target Met)
	2007	6 months	6 months (Target Met)

Measure	Fiscal Year	Target	Result
1.3.17: MEPS Use and Demographic Files will be available months after final data collection (Output) (Quantitative)	2012	10.5 months	Oct 31, 2012
	2011	10.5 months	Oct 31, 2011
	2010	11 months	11 months (Target Met)
	2009	11 months	11 months (Target Met)

	2008	11 months	11 months (Target Met)
	2007	11 months	11 months (Target Met)

Measure	Fiscal Year	Target	Result
1.3.18: Number of months after the date of completion of the Medical Expenditure Panel Survey data will be available (Output) (Quantitative)	2012	10.5 months	Oct 31, 2012
	2011	10.5 months	Oct 31, 2011
	2010	10.8 months	10.8 months (Target Met)
	2009	11 months	11 months (Target Met)
	2008	11 months	11 months (Target Met)
	2007	11 months	11 months (Target Met)

Measure	Fiscal Year	Target	Result
1.3.19: Increase the number of topical areas tables included in the MEPS Tables Compendia (Output) (Qualitative)	2012	Add additional tables to MEPS.	Sep 30, 2012 (Not Started)
	2011	Add additional tables to MEPS-HC TC	Sep 30, 2011 (Active)
	2010	Add additional variables to MEPS net	Variables from Diabetes Care Supplement added (Target Met)
	2009	Update State Level tables	Updated State Level Estimates (Target Met)
	2008	N/A	N/A
	2007	N/A	N/A

Measure	Fiscal Year	Target	Result
1.3.20: Increase the number of MEPS Data users: Baseline FY 2005 : 10 DCP; 15,900 TC; 13,101 HC/IC (Qualitative)	2012	Exceed baseline standard	Sep 30, 2012 (Not Started)
	2011	Exceed baseline standard	Sep 30, 2011 (Active)
	2010	Establish baseline standard	39 DCP (Target Met)
	2009	41 DCP	41 DCP (Target Met)
	2008	Exceed baseline standard	41 DCP (Target Met)
	2007	19,989 DCP	19,989 DCP (Target Met)
14,809 HC/IC		14,809 HC/IC	

			(Target Met)
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Measure	Fiscal Year	Target	Result
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. (Outcome) (Quantitative)	2012	10.5 months	Oct 31, 2012
	2011	10.6 months	Oct 31, 2011
	2010	10.8 months	10.8 months (Target Met)
	2009	11 months	11 months (Target Met)
	2008	11 months	11 months (Target Met)
	2007	11 months	11 months (Target Met)

Measure	Fiscal Year	Target	Result
1.3.49: The average number of field staff hours required to collect data per respondent household for the MEPS (at level funding). (Efficiency) (Quantitative)	2012	12.6 hours	Oct 31, 2012
	2011	12.7 hours	Oct 31, 2011
	2010	12.8 hours	13.2 hours (Target Not Met)
	2009	13 hours	13 hours (Target Met)
	2008	13.5 hours	13.5 hours (Target Met)
	2007	Set Baseline	14.2 hours (Baseline)

Measure	Data Source	Data Validation
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	Data published on website
1.3.19	MEPS website	Data published on website
1.3.20	Annual workshop, presentation, publication lists	CFACT documents
1.3.21	MEPS website	Data published on website
1.3.49	Interviewer Management System (IMS)	The number of field staff hours required to collect data per respondent household for the MEPS is logged by field staff in an automated system. Data quality and validation is monitored in several ways:

Measure	Data Source	Data Validation
		1) validation interviews are conducted for a sample of respondents, in which questions concerning the interview process are asked; 2) response rates are monitored to ensure that they stay high; and 3) the duration of interviews are tracked to ensure that interviewers are following proper protocol and not skipping questions during the interview

Program Support

This budget activity supports the strategic direction and overall management of the AHRQ, including funds for salaries and benefits of 304 FTEs. The principles which guide the Agency's management structure include:

- An organizational structure that stresses simplified, shared decisionmaking.
- Avoidance of redundancies in administrative processes.
- Ensuring clear lines of communication and authority.
- A strong emphasis on employee involvement in all Agency matters.
- Recognizing and rewarding employee accomplishments and contributions to the AHRQ's mission.

Strategic Direction

Strategic Management of Human Capital

The Agency's "Making AHRQ Great" (MAG) is an initiative designed to create a positive work environment leading to increased productivity and employee satisfaction. People are AHRQ's most valuable asset and we are continuing the internal focus on "MAKING AHRQ GREAT" for the 3rd straight year.

In addition, an on-line orientation guide was posted on the AHRQ Intranet for new employees in November 2010; and a tri-fold survival guide (which contains critical and key information at a glance for new employees) was developed and is distributed to new employees. The AHRQ New Employee Orientation requires the assignment of a mentor for the first few weeks of an individual's employment with the Agency. In addition to a mentor, new employees are also required to attend a two-hour orientation session which helps gain a better understanding of AHRQ and the role they play in helping us achieve our mission. The mentor is also responsible for reviewing the On-line New Employee Handbook located on our intranet and responding to any questions or issues which may arise in the first few weeks of employment.

The Agency is also recompeting the contract for the Agency's Alternative Dispute Resolution (ADR) specialist to resolve informal disputes and thereby reduce the filing of formal complaints through EEO and the merit system process. There was positive employee feedback to continue this program.

The TARP (Term Appointment Review Panel) reviewed Agency term appointments. To date (November 2010), 90% of these positions have undergone review and there are less than five (5) TARP positions to undergo review within the next calendar year.

The MAG Worklife Quality Team continued to convene noonday seminars and workshops for staff, focusing on relevant worklife issues such as dealing with difficult colleagues and implementing AHRQ core values in the workplace. The AHRQ Talk Show, a new format for the midday seminars (sponsored by the MAG Worklife Workgroup) featured distinguished panelists who tell personal stories about how one of AHRQ's core values made a difference in their lives and influenced how they approach their worklife at AHRQ. The AHRQ Talk Show was moderated by AHRQ's ADR specialist. The first Talk Show drew more than 60 participants and audience participation is encouraged and welcomed. Feedback from participants was very positive.

The Senior Leadership Team (SLT) participated in a professional development/team building retreat. The purpose of the retreat was to address critical Agency priorities, improve internal operations, and cultivate a supportive/nurturing network among the team. The outcome of this particular retreat clarified AHRQ's programmatic efforts related to Quality Improvement and Quality Measurement. The SLT is currently working on the scope of the Agency's role and identifying appropriate resources (fiscal and human).

Based on our ongoing internal efforts to improve the culture of the Agency and develop our employees, AHRQ has seen steady increases in scores on the Employee Viewpoint Survey (EVS) – with a 10% increase in overall scores from FY 09. This year, AHRQ ranked #4 in the Department in overall employee satisfaction. In addition, the Agency's retention rate is very high.

Improve Financial Performance

AHRQ is working to demonstrate to the Office of Finance at HHS effective use of financial information to drive results in key areas of operations and to develop and implement a plan to continuously expand the scope to additional areas of operations. AHRQ has completed the review and updating of all internal controls in light of the transition to an integrated, department-wide financial management solution – the Unified Financial Management System (UFMS). In addition, AHRQ continued to participate in the Department's A-123 internal control efforts and implemented all corrective actions for deficiencies reported as a result of the FMFIA/A-123 internal control processes identified in prior years. In FY 2010, AHRQ updated all internal controls based on the transition to the HHS Consolidated Acquisition Solution (HCAS). In addition, AHRQ continues to maintain a low-risk status for improper payments. In FY 2011, AHRQ will continue work on Program Integrity Activities, including the development of a Program Risk Assessment Tool. In FY 2012, AHRQ will update the Program Risk Assessment and Mitigation Strategy Tool based on feedback and continue to participate in the Department's A-123 Internal Control activities.

Electronic Government

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 and research priorities of the agency.
- Ensuring 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 and adopted by HHS as well as OMB directives. This uniformity improves application integration (leveraging of existing systems) as well as reducing cost and development time.
- Providing quality customer service and operations support to AHRQ's centers, offices and outside stakeholders. This objective entails providing uniform tools, methods, processes, practices 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.

- Ensuring the protection of AHRQ data; commensurate with current and future legislation and OMB directives. AHRQ's security program goals focus on executing the defined goals developed in our strategic and tactical plans which are targeted at three key areas: People, Process and Technology. These goals include but are not limited to: implementation of LOB Information and Security and Privacy Awareness training, System Development Life Cycle and FIPS 140-2 compliant encryption solutions. AHRQ continues to ensure 98 percent or higher of AHRQ's employees will complete the LOB Information Security and Privacy Awareness training. AHRQ will continue to follow the modified systems development life cycle to ensure that security is addressed throughout each project phase. The Agency will deploy encryption solutions for mobile devices, removable media, and data and will ensure FDCC settings are applied to all desktops, laptops, and ensure servers are deployed with departmental approved standard security settings.

In FY 2012, IT activities will continue to develop internal program management policies and procedures in line with guidance being issued by HHS.

Performance Improvement

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.

Performance data will be tracked electronically using the Agency's electronic performance tracking system and published as soon as it becomes available. Also, work will continue with program staff to establish and display a close alignment of projects and how they support AHRQ's performance measures and the Department's strategic goal areas.

In FY 2009, AHRQ continued the implementation of strong budget and performance integration practices through the use of structured Project Management processes. In FY 2010, AHRQ has successfully aligned its performance measures with the new 2010-2015 HHS Strategic Plan goals and objectives. Also, 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. In 2012, AHRQ will continue to support and comply with HHS performance requirements.

AHRQ has successfully completed comprehensive program assessments on six key programs within the Agency: The Medical Expenditure Panel Survey (MEPS); the Healthcare Cost and Utilization Project (HCUP); the Consumer Assessment of Healthcare Plans Survey (CAHPS®); the Patient Safety portfolio; the former Pharmaceutical Outcomes portfolio; and most recently the Health Information Technology portfolio. These reviews provide the basis for the Agency to move forward in more closely linking high quality outcomes with associated costs of programs.

Long-Term Outcome: Improve performance in all areas of Program Support

Measure	Fiscal Year	Target	Result
5.1.1: Improve AHRQ's strategic management of human capital (Output) (Qualitative)	2012	Conduct a systematic review of staffing within selected flagship research programs. Assess current skill sets, staffing levels, and retirement eligibility to develop a plan to address future competency needs	Sep 30, 2012 (Not Started)
	2011	Upon Departmental approval, fully implement the new HHS-wide automated performance management system	Sep 30, 2011 (Active)
	2010	Fully comply with all Departmental procedures for HR management	AHRQ fully complied with all Departmental HR management initiatives (Target Met)
	2009	Fully implement Departmental Learning Management System (LMS) for training and development needs	Complied with all Departmental procedures for HR management. Completed report on workforce needs and required skill sets. (Target Met)
	2008	Develop core competencies for selected Agency staff and develop strategies for implementation	Core competencies developed and implementation strategies completed. (Target Met)
	2007	Implement HHS Performance Improvement Initiative	Completed implementation of HHS Performance Improvement Initiative (Target Met)

Measure	Fiscal Year	Target	Result
5.1.2: Maintain a low risk improper payment risk status (Output) (Qualitative)	2012	Update Program Risk Assessment and Mitigation Strategy Tool	Sep 30, 2012 (Not Started)
	2011	Develop ARRA Risk Assessment and continue to participate in the Department's A-123 Internal Control efforts	Sep 30, 2011 (Active)
	2010	Complete updating of all internal controls following AHRQ's conversion to HCAS	Completed updating of all internal controls following AHRQ's conversion to HCAS (Target Met)
	2009	Met all requirements for Department's A-123 Internal Control efforts	Met all requirements for Department's A-123 Internal Control efforts. (Target Met)

	2008	Complete all requirements related to OMB revised Circular A-123 Begin update internal controls following AHRQ's conversion to UFMS	Requirements related to OMB revised Circular. Continued to update internal controls. (Target Met)
	2007	Continue to participate in Department A-123 Internal Control efforts	Continued to participate in Department A-123 Internal Controls efforts. (Target Met)

Measure	Fiscal Year	Target	Result
5.1.3: Expand E-government by increasing IT Organizational Capability (Output) (Qualitative)	2012	Continue to develop internal IT program management policies and procedures in line with guidance being issued by HHS	Sep 30, 2012 (Not Started)
	2011	Continue to develop internal IT program management policies and procedures in line with guidance being issued by HHS	Sep 30, 2011 (Active)
	2010	Continue to develop internal IT program management policies and procedures in line with guidance being issued by HHS	On-going (Target Met)
	2009	Develop internal IT program management policies and procedures in line with guidance being issued by HHS	On-Going (Target Met)
	2008	Extend PMO operations and concepts to AHRQ IT investments	On- going (Target Met)
	2007	Develop fully integrated Project Management Office with standardized processes and artifact	Ongoing (Target Met)

Measure	Fiscal Year	Target	Result
5.1.4: Improve IT Security/Privacy Output (Output) (Qualitative)	2012	Continue to conduct contractor oversight audits with the focus of increasing AHRQ's overall security posture and situational awareness.	Sep 30, 2012 (Not Started)
	2011	Implement a FIPS 140-2 compliant email encryption solution	Sep 30, 2011 (Active)
	2010	Fully implement FDCC and standard security configurations of all systems	Fully (100%) compliant with FDCC and HHS standard security configurations for all AHRQ systems (Target Met)

	2009	Integrate and align AHRQ's security program with HHS's Secure One security program	Integrated and aligned AHRQ's security program with HHS's Secure One security program (Target Met)
	2008	Certify and accredit all Level 3 information systems Review and update security program with HHS's Secure One security program	Certified and accredited all Level 3 information systems. Reviewed and updated security program. (Target Met)
	2007	Certify and accredit all Level 2 Information systems Begin implementation of Public Key Infrastructure with application	Certified and accredited all Level 2 information systems. Began implementation of Public Key Infrastructure with applications. (Target Met)

Measure	Fiscal Year	Target	Result
5.1.5: Establish IT Enterprise Architecture (Output) (Qualitative)	2012	Comply with HHS EA requirements for FY 2012	Sep 30, 2012 (Not Started)
	2011	Comply with HHS EA requirements for FY 2011	Sep 30, 2011 (Active)
	2010	Comply with HHS EA requirements for FY 2010	On-going (Target Met)
	2009	Comply with HHS EA requirements	On-Going (Target Met)
	2008	Implement Level 3 EA plan Comply with EA activity as defined by HHS	Implemented Level 3 EA plan Complied with EA activity as defined by HHS (Target Met)
	2007	Continue Level 3 EA plan	Complemented Level 3 EA plan (Target Met)

Measure	Fiscal Year	Target	Result
5.1.6: Meet all performance goals related to performance and budget integration (Output) (Qualitative)	2012	Comply with HHS performance and budget integration requirements for FY 2012	Sep 30, 2012 (Not Started)
	2011	Comply with HHS performance and budget integration requirements for FY 2011	Sep 30, 2011 (Active)
		Properly align all measures with HHS Strategic Plan Goals and Objectives	Sep 30, 2011 (Active)
	2010	Comply with HHS performance and budget integration requirements for FY 2010	Complied with all HHS performance requirements: 2010-2015 HHS Strategic

			Plan, SPFI, and data reporting (Target Met)
	2009	VPS implement within the portfolios	VPS implemented within the portfolios (Active)
		Began of development of WBS for all projects	Began development of WBS for all major projects (Target Met)
	2008	Continue implementation of software within the portfolios	Continued implementation of software within the portfolios (Target Met)
	2007	Begin implementation of software within the portfolios of work to help facilitate budget and performance integration	Completed internal alignment of measures by strategic goals and began implementation of software within the portfolios (Target Met)
		Conduct internal alignment of measures by strategic goal areas	

Measure	Data Source	Data Validation
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 5.1.5		
5.1.6	Departmental quarterly updates	Compliance with Departmental standards; AHRQ logic models and portfolio plans

AHRQ Support for HHS Strategic Plan

The Agency's internal structure and activities are organized under a series of portfolios and programs that contribute to AHRQ's overarching strategic goals and those of the Department. AHRQ's portfolios of healthcare research include: Patient Centered Health Research, Prevention and Care Management, Value Research, Health Information Technology, Patient Safety, and Crosscutting activities. Combined, these portfolios and data programs reflect the priorities of DHHS, AHRQ, and those of the health care system. Specifically, AHRQ supports the priorities of the Department at the strategic goal and objective levels through the following activities:

	AHRQ Goal 1: Safety/Quality- Reduce the risk of harm from health care services by promoting the delivery of appropriate care that achieves the best quality outcome	AHRQ Goal 2: Efficiency- Achieve wider access to effective health care service and reduce health care costs.	AHRQ Goal 3: Effectiveness- Assure that providers and consumers/patients use beneficial and timely health care information to make informed decision/choices.	AHRQ Goal 4: Organizational Excellence – Develop efficient and responsive business practices
1 Transform Health Care				
1.A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured				
1.B: Improve health care quality and patient safety	X			
1.C: Emphasize primary and preventive care linked with community prevention services				
1.D: Reduce the growth of health care costs while promoting high-value, effective care		X	X	
1.E: Ensure access to quality, culturally competent care for vulnerable populations				
1.F: Promote the adoption of health information technology	X			
2 Advance Scientific Knowledge and Innovation				
2.A: Accelerate the process of scientific discovery to improve patient care			X	

2.B: Foster innovation at HHS to create shared solutions				
2.C: Invest in the regulatory sciences to improve food and medical product safety				
2.D: Increase our understanding of what works in public health and human service practice				
3 Advance the Health, Safety and Well-Being of Our People				
3.A: Ensure the safety, well-being, and healthy development of children and youth				
3.B: Promote economic and social well-being for individuals, families, and communities				
3.C: Improve the accessibility and quality of supportive services for people with disabilities and older adults				
3.D: Promote prevention and wellness			X	
3.E: Reduce the occurrence of infectious diseases				
3.F: Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies				
4 Increase Efficiency, Transparency and Accountability of HHS Programs				
4.A: Ensure program integrity and responsible stewardship of resources			X	X
4.B: Fight fraud and work to eliminate improper payments				
4.C: Use HHS data to improve the health and well-being of the American people		X	X	
4.D: Improve HHS environmental, energy, and economic performance to promote sustainability				
5 Strengthen the Nation's Health and Human Services Infrastructure and Workforce Advance scientific and biomedical research and development related to health and human services.				
5.A: Invest in the HHS Workforce to help meet America's health and human service needs today and				X

tomorrow				
5.B: Ensure that the Nation’s health care workforce can meet increased demands				
5.C: Enhance the ability of the public health workforce to improve public health at home and abroad				
5.D: Strengthen the Nation’s human services workforce				
5.E: Improve national, state, and local, and tribal surveillance and epidemiology capacity				

Improve health care quality and patient safety (Strategic Objective 1.B)

AHRQ’s Patient Safety portfolio’s mission 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. This mission is accomplished by funding health services research in the following activities: Patient Safety Threats and Medical Errors, Patient Safety Organizations (PSOs), Patient Safety and Medical Liability Reform, and Healthcare-Associated Infections (HAIs). Projects within the program seek to inform multiple stakeholders including health care organizations, providers, policymakers, researchers, patients and others; disseminate information and implement initiatives to enhance patient safety and quality; and maintain vigilance to prevent patient harm.

The portfolio will continue to support several programs that have been successful in furthering improvements in the safety and quality of healthcare in the United States. Projects such as TeamSTEPPS, the Surveys of Patient Safety Culture, and Simulation and the Partnerships in Implementing Patient Safety (PIPS) have produced a variety of knowledge, information, and resources will be continued, in an effort to replicate and expand their past contributions. One measure of the portfolio’s performance is the number of tools and resources that are available to the field. Since these initiatives are designed to generate useful tools and information that promote quality and patient safety improvements, they also directly support the portfolio goals, as well as those of HHS.

Reduce the growth of health care costs while promoting high-value, effective care (Strategic Objective 1.D)

The Value portfolio seeks to 1) measure and track quality and cost, 2) identify strategies to improve both, and 3) partner with the field to implement what we know – three goals directly aligned with the HHS Strategic objective to “produce the measures, data, tools, and evidence that health care providers, insurers, purchasers, and policymakers need to improve the value and affordability of health care.” The Value portfolio performance measures will track our progress in these three areas by capturing the number of measures, databases, tools and evidence-based products being developed, enhanced, disseminated to and used by key stakeholders.

Promote the adoption of health information technology (Strategic Objective 1.F)

The Agency supports this effort through the work undertaken by the Health Information Technology (Health IT) Portfolio. The Health IT Portfolio develops and synthesizes the best evidence on how health IT can improve the quality of American health care, disseminates that

evidence, and develops evidence-based tools for adoption and meaningful use of health IT. By building and synthesizing the evidence-base and through the development of resources and tools, the portfolio has played a key role in the Nation's drive to adopt and meaningfully use health IT.

Accelerate the process of scientific discovery to improve patient care (Strategic Objective 2.A)

The Patient-Centered Health Research (PCHR) portfolio conducts and supports comparative effectiveness research in response to Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Research activities are performed using rigorous scientific methods that emphasize stakeholder involvement and transparency. The portfolio's products provide evidence on the effectiveness, benefits, and harms of drugs, medical devices, tests, surgeries, or ways to deliver health care. This research will continue to accelerate the process of scientific discovery to improve patient care by informing the health-care decisions of patients, clinicians and policymakers, thus moving research into practice.

Promote prevention and wellness (Strategic Objective 3.D)

AHRQ's Prevention/Care Management portfolio works to improve the delivery of primary care services to meet the needs of Americans for high-quality, safe, effective, and efficient clinical preventive and chronic disease service. It supports health services and behavioral research, facilitates the translation of evidence into effective primary care practice, and maximizes the investment of Federal resources through a commitment to collaborative partnerships with Federal partners and other stakeholders committed to improving the health of the Nation.

The portfolio will support new grants to improve the effectiveness of prevention and chronic care for patients with multiple chronic conditions and will continue to fulfill the Agency's Congressional mandate to convene and provide scientific, technical, administrative, and dissemination support of the U.S. Preventive Services Task Force (USPSTF).

Ensure program integrity and responsible stewardship of resources (Strategic Objective 4.A)

A set of internal measures were developed to address improved management of finance and risk, E-government and IT security/Privacy, and performance management. Based on the results of specific risk assessment of Recovery Act funds and a Program Risk Assessment and Mitigation Strategy, it was determined that AHRQ had a low risk for improper payments. The Agency will continue these efforts and will try to expand the scope of testing where possible. The IT Security and Privacy Output goals focus on the implementation of effective Information and Security and Privacy Awareness training, System Development Life Cycle and FIPS 140-2 compliant encryption solutions. AHRQ maintains a 98 percent or higher completion rate of its employees for the Information Security and Privacy Awareness training. IT continues to deploy encryption solutions for mobile devices, removable media, and data, and will ensure FDCC settings are applied to all desktop, laptops, and servers with departmental approved standard security settings. Portfolios and programs will continue work to set performance goals and targets that are meaningful, update and report results in internal and HHS performance databases, and seek to retire goals which are no longer meaningful to the Agency.

Use HHS data to improve the health and well-being of the American people (Strategic Objective 4.C)

AHRQ supports this effort through the work undertaken by the Medical Expenditure Panel Survey (MEPS), Healthcare Cost and Utilization Project (HCUP), Quality Indicators (QIs), the

Consumer Assessment of Health Providers and Systems (CAHPS), the Survey Users Network, the National Healthcare Disparities and Quality Reports (NHDR/QR), and the HIV Research Network. The data collection, measurement, and survey activities of these programs allow us to collect detailed information from families on access, use, expenses, insurance coverage and quality; document the health status of the population and of important subgroups; collect information about the diagnosis, procedures, cost, and medical practice patterns; report and evaluate patients' experience with health care systems and providers; identify disparities in health status and use of health care by race or ethnicity, socioeconomic status, region, and other population characteristics; describe our experiences with the health care system; monitor trends in health status and health care delivery; identify health problems; support health services research; choose high quality care in facilities and settings, including hospitals, nursing homes, health plans, physician offices and others; and, provide information for making changes in public policies and programs.

Also, the Value Portfolio develops and expands measures, data and tools to support transparency, public reporting, payment initiatives, and quality improvement. Most of the States doing public reporting are opting to use AHRQ measures, and we have just launched a new tool that incorporates these measures – My Own Network powered by AHRQ (MONAHRQ) – to give States, communities, and others the software they need to build their own Web sites for public reporting and quality improvement. Creation and enhancement of new quality and efficiency measures and tools will be a priority for 2012, and progress on these critical activities will be captured by the Portfolio's measures.

Invest in the HHS Workforce to help meet America's health and human service needs today and tomorrow (Strategic Objective 5.A)

AHRQ implements rigorous recruitment strategies to ensure the hiring of top talent, strengthening the workforce by developing staff skills, improving competencies, and retaining talent to ensure that the HHS workforce reflects the diversity of the Nation it serves. In FY 2012, the Agency is planning to conduct a systematic review of staffing within selected flagship research programs, including the assessment of current skill sets, staffing levels, and retirement eligibility.

Full Cost Table

Summary of Full Cost
(Budgetary Resources in Millions)

HHS Strategic Goals and Objectives	OPDIV		
	FY 2010	FY 2011	FY 2012
1 Transform Health Care	\$229	\$229	\$183
1.B: Improve health care quality and patient safety	\$188	\$188	\$142
1.D: Reduce the growth of health care costs while promoting high-value, effective care	\$13	\$13	\$13
1.F: Promote the adoption of health information technology	\$28	\$28	\$28
2 Advance Scientific Knowledge and Innovation	\$21	\$21	\$22
2.A: Accelerate the process of scientific discovery to improve patient care	\$21	\$21	\$22
3 Advance the Health, Safety, and Well-Being of the American People	\$16	\$16	\$23
3.D: Promote prevention and wellness	\$16	\$16	\$23
4 Increase Efficiency, Transparency, and Accountability of HHS Programs	\$86	\$85	\$91
4.A: Ensure program integrity and responsible stewardship of resources	\$23	\$22	\$27
4.C: Use HHS data to improve the health and well-being of the American people	\$63	\$63	\$64
5 Strengthen the Nation's Health and Human Service Infrastructure and Workforce	\$45	\$46	\$47
5.A: Invest in the HHS workforce to help meet America's health and human service needs today and tomorrow	\$45	\$46	\$47
Total	\$397	\$397	\$366

Disclosure of Assistance by Non-Federal Parties

Preparation of Online Performance Appendix 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 2012 Online Performance Appendix.