Performance Budget Submission To DHHS

Fiscal Year 2009

Agency for Healthcare Research and Quality

Introduction

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

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

The AHRQ Congressional Justification and Online Performance Appendix can be found at http://www.ahrq.gov/about/budgtix.htm.

I am pleased to present the Agency for Healthcare Research and Quality's Fiscal Year 2009 Performance Budget. We all benefit from safe, effective, and efficient health care. Our performance-based budget demonstrates our continued commitment to assuring sound investments in programs within these three areas that will make a measurable difference in health care for all Americans. The Agency's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. In support of this mission, AHRQ is committed to improving patient safety by developing successful partnerships and generating the knowledge and tools required for long term improvement.

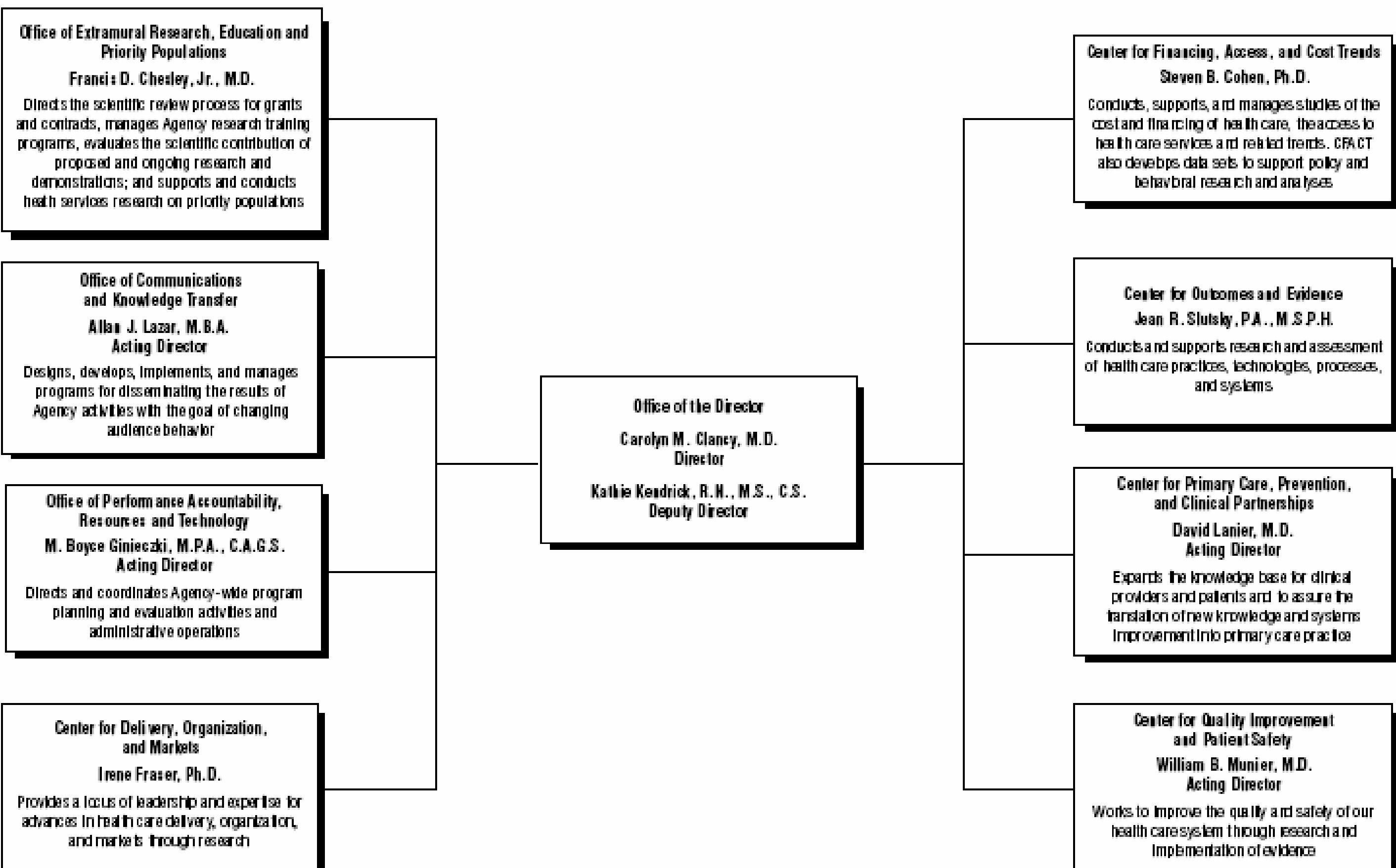
AHRQ continues to improve patient care through the Effective Health Care Program. As authorized by MMA, this program has begun a series of state-of-the-science reviews of existing scientific information on effectiveness and comparative effectiveness of health care interventions, including prescription drugs. In October 2007, AHRQ released *Comparative Effectiveness of Percutaneous Coronary Interventions and Coronary Artery Bypass Grafting for Coronary Artery Disease.* The report found that patients with mid-range coronary artery disease are more likely to get relief from painful angina and less likely to have repeat procedures if they get bypass surgery rather than balloon angioplasty with or without a stent. The report also found that for mid-range coronary artery disease, bypass surgery and angioplasty patients had about the same survival rates and similar numbers of heart attacks, but that bypass surgery presents a slightly higher risk of stroke within 30 days of the procedure. Coronary artery disease, a common type of heart disease, affects about 15 million Americans and is the leading cause of death for men and women.

AHRQ released its fourth annual reports on quality and disparities in 2007. These reports serve as tools for monitoring health care delivery by summarizing information, making clear where improvement is most needed, and facilitating the use of common measures. We are seeing results of efforts to improve quality of care. The 2007 Quality Report demonstrates that we are making steady progress in improving quality of care. For selected aspects of patient safety in hospitals, improvements over 10 percent were found, with much larger improvements associated with public reporting efforts by the nation's hospitals and nursing homes. At the same time, there are still areas in need of major improvements. In contrast, the 2007 Disparities Report founds that despite some examples of improvement, pervasive disparities related to race, ethnicity, and socioeconomic status persist.

AHRQ is excited about a new initiative in FY 2009 – the Health Insurance Decision Tool. This initiative will facilitate the development of state-specific affordable health plans for low income individuals and to provide state decision makers with the tools and information they need to design effective programs and policies for reducing the numbers of uninsured Americans. This initiative will advance the President's goal to provide access to basic health insurance at an affordable price. In addition, this initiative will provide Federal decision makers with the information they need for evaluating states' proposals, and could assist in understanding the impacts of other Federal initiatives, for example, consumer driven health plans, on the overall U.S. healthcare system.

With our continued investment in successful programs that develop useful knowledge and tools, I am confident that we will have more accomplishments to celebrate. The end result of our research will be measurable improvements in health care in America, gauged in terms of improved quality of life and patient outcomes, lives saved, and value gained for what we spend.

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


U.S. Department of Health and Human Services
Agency for Healthcare Research and Quality
Office of Extramural Research, Education and Priority Populations
Francis D. Chesley, Jr., M.D.
Directs the scientific review process for grants and contracts, manages Agency research training programs, evaluates the scientific contribution of proposed and ongoing research and demonstrations; and supports and conducts health services research on priority populations
Office of Communications and Knowledge Transfer
Allan J. Lazar, M.B.A.
Acting Director
Designs, develops, implements, and manages programs for disseminating the results of Agency activities with the goal of changing audience behavior
Office of Performance Accountability, Resources and Technology
M. Boyce Ginieczki, M.P.A., C.A.G.S.
Acting Director
Directs and coordinates Agency-wide program planning and evaluation activities and administrative operations
Center for Delivery, Organization, and Markets
Irene Fraser, Ph.D.
Provides a locus of leadership and expertise for advances in health care delivery, organization, and markets through research
Office of the Director
Carolyn M. Clancy, M.D.
Director
Kathie Kendrick, R.N., M.S., C.S.
Deputy Director
Center for Financing, Access, and Cost Trends
Steven B. Cohen, Ph.D.
Conducts, supports, and manages studies of the cost and financing of health care, the access to health care services and related trends. CFACT also develops data sets to support policy and behavioral research and analyses
Center for Outcomes and Evidence
Jean R. Slutsky, P.A., M.S.P.H.
Conducts and supports research and assessment of health care practices, technologies, processes, and systems
Center for Primary Care, Prevention, and Clinical Partnerships
David Lanier, M.D.
Acting Director
Expands the knowledge base for clinical providers and patients and to assure the translation of new knowledge and systems improvement into primary care practice
Center for Quality Improvement and Patient Safety
William B. Munier, M.D.
Acting Director
Works to improve the quality and safety of our health care system through research and implementation of evidence
AHRQ
AHRQ Pub. No. 07-M010
May 2007

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Executive Summary

Introduction and Mission

The U.S. health care system is considered by many to be the finest in the world. Americans are living longer, healthier lives, thanks to significant advances in biomedical and health services research. The translation of research findings into clinical practice has raised awareness of the importance of appropriate preventive services—such as timely screenings for cancer, heart disease, and other serious conditions—and the crucial role that maintaining a healthy lifestyle plays in maintaining health and enhancing quality of life.

However, our health care system faces many challenges: improving the quality and safety of health care, ensuring access to care, increasing value for health care, reducing disparities, increasing the use of health information technology, and finding new avenues for translating research into practice. We have made progress in meeting these challenges, but we can and must do better. Failure to improve health care delivery substantially is likely to impede realizing the full benefits of current breakthroughs in molecular medicine that can lead to personalized treatments.

As one of 12 agencies within the Department of Health and Human Services, the Agency for Healthcare Research and Quality (AHRQ) supports health services research initiatives that seek to improve the quality of health care in America. AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. The Agency works to fulfill this mission by conducting and supporting health services research, both within AHRQ as well as in leading academic institutions, hospitals, physicians' offices, health care systems, and many other settings across the country. The Agency has a broad research portfolio that touches on nearly every aspect of health care. AHRQ-supported researchers are working to answer questions about:

- Clinical practice.
- Outcomes of care and effectiveness.
- Evidence-based medicine.
- Primary care and care for priority populations.
- Health care quality.
- Patient safety/medical errors.
- Organization and delivery of care and use of health care resources.
- Health care costs and financing.
- Health care system and public health preparedness.
- Health information technology.

The ultimate goal is to disseminate AHRQ's research findings -- resulting in healthier, more productive individuals and an enhanced return on the Nation's substantial investment in health care.

Overview of AHRQ Budget

AHRQ's FY 2009 Estimate level of $325,664,000 is a decrease of $8,900,000 or 2.7 percent from the FY 2008 Enacted level. At this level AHRQ will support ongoing efforts to improve the quality, safety, outcomes, access to and cost and utilization of health care services.

AHRQ has three budget activities: Research on Health Care Costs, Quality and Outcomes (HCQO), the Medical Expenditure Panel Survey (MEPS), and Program Support (PS). The FY 2009 Estimate for the HCQO budget activity totals $267,664,000 a decrease of $8,900,000 from the FY 2008 Enacted level. MEPS continues to provide the only national source for annual data on how Americans use and pay for medical care. The FY 2009 Request of $55,300,000 maintains the support provided at the FY 2008 level. Finally, Program Support is maintained at the FY 2008 Enacted level to cover required costs related to the overall operation of the Agency.

Earlier this year AHRQ realigned our research portfolios within the HCQO budget activity. AHRQ went from 10 research portfolios to 6 research portfolios. The new research portfolios include: Comparative Effectiveness, Prevention/Care Management, Value Research, Health Information Technology, Patient Safety, and Other Quality, Effectiveness and Efficiency Research. The FY 2009 Performance Budget is displayed by these new portfolios.

***Program increases*:**

HCQO: Value (+$6,000,000): The FY 2009 Request includes $9,730,000 for Value Research, an increase of $6,000,000 from the FY 2008 President's Budget. AHRQ's Value Research priority includes research related to the Value-driven Healthcare Initiative and a new Initiative – the Health Insurance Decision Tool. The entirety of the increase is directed to a new initiative – Health Insurance Decision Tool. This initiative will facilitate the development of state-based affordable health plans for low income individuals and to provide state decision makers with the tools and information they need to design effective programs for reducing the numbers of uninsured Americans. This initiative will advance the President's goal to provide access to basic health insurance at an affordable price. In addition, this initiative will provide Federal decision makers with the information they need for evaluating states' proposals, and could assist in understanding the impacts of other Federal initiatives, for example, consumer driven health plans, on the overall U.S. healthcare system.

HCQO: Other Quality, Effectiveness and Efficiency – Research Management (+$2,322,000): The FY 2009 Estimate provides $1,280,000 for required increases within AHRQ's budget, including rent increases, funds for the Unified Financial Management System (UFMS), and data costs, as well as funds for one additional FTE for the Affordable Choice Decision Tool initiative. In addition, the AHRQ request includes funding to support the President's Management Agenda e-GOV initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process. An additional $1,042,000 is provided for pay raise costs in FY 2009.

Program decreases:

HCQO: Patient Safety (-$2,059,000): The FY 2009 Estimate provides $32,055,000 for the patient safety program, a decrease of $2,059,000 from the prior year. The Patient Safety Program is comprised of two research components: Patient Safety Threats and Medical Errors and Patient Safety Organizations (PSOs). The FY 2009 decreases occur within the patient safety threats and medical errors program. Of the total, $1,881,000 is from reductions in inter-agency agreements (IAAs) related to data standards and the remaining $178,000 will come from patient safety IAAs.

HCQO: Other Quality, Effectiveness and Efficiency (-$15,163,000): The FY 2009 Estimate for the Other Quality, Effectiveness and Efficiency portfolio includes a reduction of $15,163,000 from the FY 2008 Enacted level of $156,800,000. The reductions are as follows:

- MRSA (-$5,000,000): The FY 2008 Enacted level provided $5,000,000 for contract activities to reduce infections from methicillin-resistant staphylococcus aureus and related infections (MRSA). With the additional $5,000,000 provided in FY 2008, AHRQ will work closely with CDC to identify gaps in the prevention, diagnosis, and treatment of MRSA and related infections across the healthcare system. In conjunction with CDC and other health care agencies within DHHS and within the Federal government, AHRQ will use available mechanisms to fund research, implementation, measurement, and evaluation regarding practices that identify and mitigate these infections. This research will be done through one year contracts in FY 2008 and does not continue into FY 2009.

- Research and Training Grants (-$7,277,000): The FY 2009 Estimate provides for $25,415,000 (61 grants) in non-competing research grants funds for HCQO: Other Quality, Effectiveness and Efficiency – a decrease of $7,277,000 (70 grants) from the FY 2008 level of $32,692,000. A total of $7,277,000 in non-patient safety research and training grants funded in prior years ended in FY 2009. AHRQ will not re-invest these funds in new investigator-initiated research grants in FY 2009.

  The 61 grants funded in FY 2009 support a variety of research activities including research related to clinical practice, health care quality, organization and delivery of care and use of health care resources, and health care costs and financing. An example of grants that will be funded in FY 2009 includes CAHPS® grants. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. Health care organizations, public and private purchasers, consumers, and researchers use CAHPS results to: assess the patient-centeredness of care; compare and report on performance; and improve quality of care. Also included in FY 2009 are career development awards. Examples of grant titles funded in FY 2009 include: Chronic Care Quality Improvement Learning Laboratory, Evaluating Treatment Options and Patterns of Care in Early Pregnancy Failure, and Spaced Education to Optimize Prostate Cancer Screening.

- Research Contracts and IAAs (-$2,886,000): The FY 2009 Estimate reduces contract and IAA support by $2,886,000. The reductions in FY 2009 will impact the

level of outgoing IAA support AHRQ can provide in partnership with other agencies, as well as a small reduction to planning and evaluation contracts. The FY 2009 Estimate will allow AHRQ to continue to fund research contracts and IAAs that support research on health care quality, organization and delivery of care and use of health care resources, and health care costs and financing. Examples of contracts that will be funded in FY 2009 include: National Quality Measures Clearinghouse (NQMC), National Guideline Clearinghouse (NGC), Healthcare Cost and Utilization Project (HCUP), and contracts and IAAs support the development and release of the annual *National Healthcare Quality Report* and its companion document, the *National Healthcare Disparities Report.*

All Purpose Table

Discretionary All-Purpose Table
Agency for Healthcare Research and Quality
(dollars in thousands)

PROGRAM	**FY 2007 Enacted**	**FY 2008 Enacted**	**FY 2009 President's Budget**	**Change from FY 2008 Enacted Level**
RESEARCH ON HEALTH COSTS, QUALITY AND OUTCOMES				
Budget Authority	$0	$0	$0	$0
PHS Evaluation	260,983	276,564	267,664	-8,900
Subtotal, HCQO	**260,983**	**276,564**	**267,664**	**-8,900**
FTEs	273	277	278	1
MEDICAL EXPENDITURES PANEL SURVEY				
Budget Authority	0	0	0	0
PHS Evaluation	55,300	55,300	55,300	0
Subtotal, MEPS	55,300	55,300	55,300	0
PROGRAM SUPPORT				
Budget Authority	0	0	0	0
PHS Evaluation	2,700	2,700	2,700	0
Subtotal, PROGRAM SUPPORT	2,700	2,700	2,700	0
FTEs	22	22	22	0
SUBTOTAL				
Budget Authority	0	0	0	0
PHS Evaluation	318,983	334,564	325,664	-8,900
TOTAL OPERATIONAL LEVEL	318,983	334,564	325,664	-8,900
FTEs	295	299	300	1

Mechanism Tables

Mechanism Tables – Total AHRQ

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

	Number FY 2007 Enacted	Amount FY 2007 Enacted	Number FY 2008 Enacted	Amount FY 2008 Enacted	Number FY 2009 Budget Request	Amount FY 2009 Budget Request
Research Grants: Non-Competing	125	32,292	144	53,098	129	51,991
Research Grants: New & Competing	171	47,882	69	15,647	23	10,977
Research Grants:Supplemental		0		0		0
Total, Research Grants	296	80,174	213	68,745	152	62,968
CONTRACTS and IAAs		123,852		147,719		142,274
MEPS		55,300		55,300		55,300
TOTAL CONTRACTS/IAAs		179,152		203,019		197,574
RESEARCH MANAGEMENT		59,542		62,800		65,122
TOTAL, AHRQ		318,868		334,564		325,664

Mechanism Tables – Non-Patient Safety

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Non-Patient Safety Mechanism Summary
(Dollars in Thousands)

	FY 2007 Enacted Number	FY 2007 Enacted Dollars	FY 2008 Enacted	FY 2008 Enacted Dollars	FY 2009 Budget Request	FY 2009 Budget Request Dollars
Research Grants: Non-Competing	87	19,357	91	28,986	61	25,415
Research Grants: New & Competing	109	19,205	44	5,706	4	3,500
Research Grants: Supplemental		0		0		0
TOTAL RESEARCH GRANTS	**196**	**38,562**	**135**	**34,692**	**65**	**28,915**
CONTRACTS and IAAs		81,464		102,838		99,452
MEPS		55,300		55,300		55,300
TOTAL CONTRACTS/IAAs		**136,764**		**158,138**		**154,752**
RESEARCH MANAGEMENT		59,542		62,800		65,122
TOTAL		**234,868**		**255,630**		**248,789**

Mechanism Tables – Patient Safety

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

	FY 2007 Enacted Number	FY 2007 Enacted Dollars	FY 2008 Enacted	FY 2008 Enacted Dollars	FY 2009 Budget Request	FY 2009 Budget Request Dollars
Research Grants: Non-Competing	38	12,935	53	24,112	68	26,576
Research Grants: New & Competing	62	28,677	25	9,941	19	7,477
Research Grants: Supplemental		0		0		0
TOTAL RESEARCH GRANTS	**100**	**41,612**	**78**	**34,053**	**87**	**34,053**
CONTRACTS and IAAs		42,388		44,881		42,822
MEPS		0		0		0
TOTAL CONTRACTS/IAAs		**42,388**		**44,881**		**42,822**
RESEARCH MANAGEMENT		0		0		0
TOTAL		**84,000**		**78,934**		**76,875**

AHRQ Exhibits and Narrative

Appropriation Language

Agency for Healthcare Research and Quality

Healthcare Research and Quality

For carrying out titles III and IX of the Public Health Service Act, [and] part A of Title XI of the Social Security Act, *and section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,* amounts received from Freedom of Information Act fees, reimbursable and interagency agreements, and the sale of data shall be credited to this appropriation and shall remain available until expended. *Provided,* That the amount made available pursuant to section 937(c) of the Public Health Service Act shall not exceed [$334,564,000] *$325,664,000*.

Language Analysis

Language Provision	Explanation
"and section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,"	Includes Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 which authorizes AHRQ to conduct and support research with a focus on outcomes, comparative clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services. From FY 2005 to FY 2007, AHRQ has spent $15 million annually for this program. In FY 2008 and FY 2009 this support increases to $30 million per year.

Amounts Available for Obligation

DEPARTMENT OF HEALTH AND HUMAN SERVICESAGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Amounts Available for Obligation 1/

Appropriation	**2007**	**2008**	**2009**
Annual	$0	$0	$0
Reduction pursuant to Section 122 of P.L. 108-447	$0	$0	$0
Subtotal, adjusted appropriation	$0	$0	$0

Offsetting Collections from: Federal funds pursuant to Title IX of P.L. 102-410, (Section 937(c) PHS Act)

	2007	2008	2009
HCQO	$260,880,000	$276,564,000	$267,664,000
MEPS	$55,300,000	$55,300,000	$55,300,000
Program Support	$2,688,000	$2,700,000	$2,700,000
Subtotal, adjusted appropriation	$318,868,000	$334,564,000	$325,664,000
Unobligated Balance Lapsing	$115,000	---	---
Total obligations	$318,983,000	$334,564,000	$325,664,000

1/ Excludes the following amounts for reimbursements:
FY 2007: $27,263,000 ($7,713,000 for NRSAs and $19,550,000 for other reimbursements).
FY 2008: $27,263,000 ($7,713,000 for NRSAs and $19,550,000 for other reimbursements).
FY 2009: $27,263,000 ($7,713,000 for NRSAs and $19,550,000 for other reimbursements).

Summary of Changes

2008 Appropriation - $0
(Obligations) - (334,564,000)

2009 Estimate - $0
(Obligations) - (325,664,000)

Net change - $0
(Obligations) (-8,900,000)

A. Increases: Built-in

	2008 Current Budget Base Pos. (FTE)	2008 Current Budget Base Budget Authority	Change from Base Pos. (FTE)	Change from Base Budget Authority
1. Annualization of 2008 pay raise	(--)	(41,229,000)	(--)	(+295,000)
2. January 2009 Pay Raise 2.9% for civilian & 3.4% for Commissioned Corps	(--)	(41,229,000)	(--)	(+907,000)
3. Rental payments to GSA.	(--)	(4,160,000)	(--)	(+97,000)
4. One Less Day of Pay	(--)	(41,229,000)	(--)	(-158,000)
5. UFMS Tap Increase	(--)	(887,000)	(--)	(576,000)
6. Inflation Costs on Other Objects			(--)	(+404,000)
Subtotal, Built-in			**(--)**	**(+2,121,000)**

B. Increases: Program

	2008 Current Budget Base Pos. (FTE)	2008 Current Budget Base Budget Authority	Change from Base Pos. (FTE)	Change from Base Budget Authority
1. Research of Health Costs, Quality, & Outcomes; increase for Affordable Choices Decision Tool	(277)	(276,564,000)	(+1)	(+ 6,201,,000)
Subtotal, Program			**(+1)**	**(+ 6,201,000)**

A. Decreases: Built-in

	2008 Current Budget Base	2008 Current Budget Base Budget Authority	Change from Base Pos. (FTE)	Change from Base Budget Authority

	Pos. (FTE)			
1. Absorption of the built-in increases			-	(-2,121,000)
Subtotal, Built-in			**-**	**(-2,121,000)**

B. Decreases: Program

	2008 Current Budget Base Pos. (FTE)	2008 Current Budget Base Budget Authority	Change from Base Pos. (FTE)	Change from Base Budget Authority
1. Research of Health Costs, Quality, & Outcomes Program			(--)	(-15,101,000)

Total Increases			**(+1)**	**(+8,322,000)**
Total, Decreases			**(--)**	**(-17,222,000)**
Net change, Budget Authority				
Net change, Obligations			**(--)**	**(-$8,900,000)**

Budget Authority by Activity

Budget Authority by Activity 1/
(Dollars in thousands)

	2007 FTE	2007 Amount	2008 FTE	2008 Amount	2009 FTE	2009 Amount
1. Research on Health Costs, Quality, & Outcomes BA	0	0	0	0	0	0
PHS Evaluation	[273]	[260,983]	[277]	[276,564]	[278]	[267,664]
Total Operational Level	273	260,983	277	276,564	278	267,664
2. Medical Expenditures Pane Surveys BA	---	0	---	0	---	0
PHS Evaluation		[55,300]		[55,300]		[55,300]
Total Operational Level.		55,300		55,300		55,300
3. Program Support BA		0		0		0
PHS Evaluation	[22]	[2,700]	[22]	[2,700]	[22]	[2,700]
Total Operational Level	22	2,700	22	2,700	22	2,700
Total, Budget Authority	0	0	0	0		0
Total PHS Evaluation	[295]	[318,983]	[299]	[334,564]	[300]	[325,664]
Total Operations	295	318,983	299	334,564	300	325,664

1/ Excludes the following amounts for reimbursements:
FY 2007: $27,263,000 ($7,713,000 for NRSAs and $19,550,000 for other reimbursements). FY 2008: $27,263,000 ($7,713,000 for NRSAs and $19,550,000 for other reimbursements). FY 2009: $27,263,000 ($7,713,000 for NRSAs and $19,550,000 for other reimbursements).

Authorizing Language 1/

	2008 Amount Authorized	2008 Enacted	2009 Amount Authorized	FY 2009 Budget Request
Research on Health Costs, Quality, and Outcomes: Secs. 301 & 926(a) PHSA	SSAN	$0	SSAN	$0
Research on Health Costs, Quality, and Outcomes: Part A of Title XI of the Social Security Act (SSA) Section 1142(i) 2/ 3/ Budget Authority Medicare Trust Funds 4/ 3/ Subtotal BA & MTF	Expired 5/		Expired 5/	
Program Support: Section 301 PHSA	Indefinite	$0	Indefinite	$0
Evaluation Funds: Section 937 (c) PHSA	Indefinite	$334,564,000	Indefinite	$325,664,000
Total appropriations		$334,564,000		$325,664,000
Total appropriation against definite authorizations	----	----	----	----

SSAN = Such Sums As Necessary

1/ Section 487(d) (3) (B) PHSA makes one percent of the funds appropriated to NIH and ADAMHA for National Research Service Awards available to AHRQ. Because these reimbursable funds are not included in AHRQ's appropriation language, they have been excluded from this table.

2/ Pursuant to Section 1142 of the Social Security Act, FY 1997 funds for the medical treatment effectiveness activity are to be appropriated against the total authorization level in the following manner: 70% of the funds are to be appropriated from Medicare Trust Funds (MTF); 30% of the funds are to be appropriated from general budget authority.

3/ No specific amounts are authorized for years following FY 1994.

4/ Funds appropriated against Title XI of the Social Security Act authorization are from the Federal Hospital Insurance Trust Funds (60%) and the Federal Supplementary Medical Insurance Trust Funds (40%).5/ Expired September 30, 1994.

Appropriations History Table

Year	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriation
2000 Budget Authority	$26,667,000	$104,403,000	$19,504,000	$116,424,000
2000 PHS Evaluation Funds	179,588,000	70,647,000	191,751,000	88,576,000
2000 Total 1/	**$206,255,000**	**$175,050,000**	**$211,255,000**	**$205,000,000**
Rescission Budget Authority	$26,667,000	$104,403,000	$19,504,000	$115,223,000
Rescission PHS Evaluation Funds	179,588,000	70,647,000	191,751,000	88,576,000
Rescission Total 1/	**$206,255,000**	**$175,050,000**	**$211,255,000**	**$203,799,000**
2001 Budget Authority	$ -0-	$123,669,000	$ -0-	$104,963,000
2001 PHS Evaluation Funds	249,943,000	99,980,000	269,943,000	164,980,000
2001 Total 1/	**$249,943,000**	**$223,649,000**	**$269,943,000**	**$269,943,000**
Rescission Budget Authority	$ -0-	$123,669,000	$ -0-	$104,816,000
Rescission PHS Evaluation Funds	249,943,000	99,980,000	269,943,000	164,980,000
Rescission Total	**$249,943,000**	**$223,649,000**	**$269,943,000**	**$269,796,000**
2002 Budget Authority	$ -0-	$168,445,000	$291,245,000	$2,600,000
2002 PHS Evaluation Funds	306,245,000	137,800,000	-0-	296,145,000
2002 Total	**$306,245,000**	**$306,245,000**	**$291,245,000**	**$298,745,000**
2003 Budget Authority	$ -0-		$202,645,000	$ -0-
2003 PHS Evaluation Funds	250,000,000		106,000,000	303,695,000
2003 Bioterrorism	-0-		5,000,000	5,000,000
2003 Total	**$250,000,000**	**$0**	**$313,645,000**	**$308,695,000**
2004 Budget Authority	$ -0-	$ -0-	$ -0-	$ -0-
2004 PHS Evaluation Funds	279,000,000	303,695,000	303,695,000	318,695,000
2004 Total	**$279,000,000**	**$303,695,000**	**$303,695,000**	**$318,695,000**
2005 Budget Authority	$ -0-	$ -0-	$ -0-	$ -0-
2005 PHS Evaluation Funds	303,695,000	303,695,000	318,695,000	318,695,000
2005 Total	**$303,695,000**	**$303,695,000**	**318,695,000**	**318,695,000**
2006 Budget Authority	$ -0-	$318,695,000	$	$
2006 PHS Evaluation Funds	318,695,000		323,695,000	318,692,000
2006 Total	**318,695,000**	**318,695,000**	**323,695,000**	**318,692,000**
2007 Budget Authority	$ -0-	$318,692,000	$318,692,000	$ -0-
2007 PHS Evaluation Funds	318,692,000	-0-	-0-	318,983,000
2007 Total	**318,692,000**	**$318,692,000**	**$318,692,000**	**318,983,000**
2008 Budget Authority	$ -0-	$329,564,000	$329,564,000	$ -0-
2008 PHS Evaluation Funds	329,564,000	-0-	-0-	334,564,000
2008 Total	**$329,564,000**	**$329,564,000**	**$329,564,000**	**$334,564,000**
2009 Budget Authority	$ -0-	$	$	$
2009 PHS Evaluation Funds	325,664,000			
2009 Total	**$325,664,000**	**$**	**$**	**$**

1/ Includes proposed $5.0m from the Public Health and Social Services Emergency Fund.

Summary of Research on Health Costs, Quality and Outcomes (HCQO)

TOTAL	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
Budget Authority	$0	$0	$0	$0
PHS Evalulation Funds	$260,986,000	$276,564,000	$267,664,000	($8,900,000)
FTEs	271	277	278	1

FY 2009 Authorization………Title III and IX and Section 937(c) of the Public Health Service Act and Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.
Allocation Method……………..Competitive Grant/co-operative agreement, Contracts, and Other.

Summary

AHRQ requests $267,664,000 for Research on Health Costs, Quality and Outcomes (HCQO) at the FY 2009 Estimate level – a decrease of $8,900,000 from the FY 2008 Enacted level. These funds are being financed using PHS Evaluation Funds.

Research Priorities
Within the HCQO budget activity, AHRQ supports research related to six research priorities. A summary of each research priority is provided below. Additional details related to these priorities can be found beginning on page 20.

- Comparative Effectiveness. The FY 2009 Request includes $30,000,000 for comparative effectiveness research, the same level of support as the FY 2008 Enacted level. The goal of this research priority is to provide high-quality research to help everyone, including patients, health care providers (including nurses, doctors and other clinicians), and policymakers to make the best health decisions. One of the greatest challenges is finding reliable and practical data that can inform these decisions. The Comparative Effectiveness priority is dedicated to fulfilling this need through high-quality research and getting that information to you, someone who needs to make health care decisions.

- Prevention and Care Management. The FY 2009 Request includes $7,100,000 for research related to prevention and care management. This request maintains the level of support provided the prior year. This research priority focuses on two areas: translating evidence-based knowledge into current recommendations for clinical preventive services that are implemented as part of routine clinical practice to improve the health of all Americans; and research to improve care and reduce disparities for common chronic conditions like diabetes, asthma and heart disease.

- Value Research. The FY 2009 Request includes $9,730,000 for Value Research, an increase of $6,000,000 from the FY 2008 President's Budget. The Value Research priority includes research related to the Value-driven Healthcare Initiative and a new Initiative – the Health Insurance Decision Tool. Support for the Value-driven Healthcare Initiative is maintained at $3,730,000 in FY 2009. The FY 2009 Request includes $6,000,000 for the Health Insurance Decision Tool. This new initiative provides an integrated set of decision tools to assist States in the development of innovative programs which are consistent with the President's goal to provide access to basic health insurance at an affordable price.

- Other Quality, Effectiveness and Efficiency Research. The FY 2009 Request includes $143,959,000 for Other Quality, Effectiveness and Efficiency Research, a net decrease of $12,841,000 from the FY 2008 Enacted level. Overall, decreases of $15,163,000 include the following: $7,277,000 reduction in research and training grants related to AHRQ's three strategic plan goals, $5,000,000 drop in funding for research related to methicillin-resistant staphylococcus aureus and related infections (MRSA), and $2,886,000 in research contracts and IAAs. The FY 2009 Estimate does provide for two increases: $1,042,000 in pay raise costs for AHRQ staff, and $1,280,000 in required increases for research management costs including rent increases, funds for the Unified Financial Management System (UFMS), and data costs.

  AHRQ's research related to quality, effectiveness and efficiency touches on nearly every aspect of health care, including the research management costs that support the overall direction of AHRQ. AHRQ supports research grants, contracts and IAAs related to:
  - Effectiveness research -- Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices;
  - Efficiency Research -- Achieve wider access to effective health care services and reduce health care costs.
  - Quality Research -- Reduce the risk of harm from health care services by promoting the delivery of appropriate care that achieves the best quality outcome.

- Health Information Technology (Health IT). The FY 2009 Request includes $44,820,000 for Health Information Technology (Health IT) research, the same level of support as the FY 2008 Enacted level. In FY 2009, $7,477,000 in grants related to the Ambulatory Patient Safety Program will end. AHRQ will re-invest these funds in new Health IT grants to support the next phase of the Ambulatory Patient Safety Program.

  AHRQ's research on health information technology (Health IT) is a key element to the nation's 10-year strategy to bring health care into the 21st century by advancing the use of information technology. The AHRQ initiative includes more than $166 million in grants and contracts in 41 states to support and stimulate investment in health IT, especially in rural and underserved areas. Through these and other projects, AHRQ and its partners will identify challenges to health IT adoption and use, solutions and best practices for making health IT work, and tools that will help hospitals and clinicians successfully incorporate new IT.

- Patient Safety Research. The FY 2009 Request includes $32,055,000 for Patient Safety research, a decrease of $2,059,000 from the FY 2008 Enacted level. A total of $25,055,000 (-$2,059,000 from the prior year) is provided for research related to patient safety threats and medical errors and $7,000,000 (+$0 from the prior year) is provided

for research related to the Patient Safety and Quality Improvement Act of 2005 and patient safety organizations (PSOs).

AHRQ's patient safety research priority is aimed at identifying risks and hazards that lead to medical errors and finding ways to prevent patient injury associated with delivery of health care. AHRQ supports research that provides information on the scope and impact of medical errors, identifies the root causes of threats to patient safety, and examines effective ways to make system-level changes to help prevent errors. Dissemination and translation of these research findings and methods to reduce errors is also critical to improving the safety and quality of health care. To make changes at the system level, there also must be an environment, or culture, within health care settings that encourages health professionals to share information about medical errors and ways to prevent them.

5-Year Table Reflecting Dollars and FTEs

Funding for the HCQO program during the last five years has been as follows:

Year	Dollars	FTEs
2004	$245,695,000	268
2005	$260,695,000	264
2006	$260,695,000	270
2007	$260,986,000	273
2008	$276,564,000	277

I. Comparative Effectiveness

Comparative Effectiveness	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
Personalized Health Care	$0	$0	$0	$0
Effective Health Care	$15,000,000	$30,000,000	$30,000,000	$0
TOTAL	$15,000,000	$30,000,000	$30,000,000	$0

FY 2009 Authorization……………………..…….Title III and IX and Section 937(c) of the Public Health Service Act and Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.
Allocation Method……………………....……………...Research grants, contracts, and Other.

A. Program Description and Accomplishments

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

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

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

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

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

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

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

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

B. Funding History

Funding for the Comparative Effectiveness program during the last five years has been as follows:

Year	Dollars
2004	$ 0
2005	$15,000,000
2006	$15,000,000
2007	$15,000,000
2008	$30,000,000

C. Budget Request

AHRQ requests $30,000,000 for Comparative Effectiveness Research at the FY 2009 Estimate. These funds are being financed using PHS Evaluation Funds. In FY 2009, a total of $30,000,000 will support:

- Expanded outreach to stakeholders to engage them in the Effective Health Care Program. Topics for research in the Effective Health Care Program are selected and refined based on input from the public. The Effective Health Care Program considers public suggestions and examines the impact and relevance of the proposed topics to the Medicare, Medicaid, and SCHIP populations.
- Comparative and effectiveness reviews to inform decisions and promote Effective Health Care for Medicare, Medicaid and SCHIP Stakeholders. As shown in the output table (#4.4.5), FY 2009 funding will allow AHRQ to develop 9 Systematic Review. These outputs are a critical component to reach our long-term objective to improve a patient's quality of care and health outcomes through informed decision making.
- Advancement of systematic review methodologies. The first step in this process is the posting of a draft Methods Guide for Comparative Effectiveness Reviews for public comment. The second is to edit the Guide and publish it, both on the Effective Health Care Web site and in the scientific literature.
- Effectiveness research to address important knowledge gaps confronting health care decision makers.
- Multi-center research cooperatives for comparative and clinical effectiveness studies.
- Translation and dissemination work of the John M. Eisenberg Clinical Decisions and Communications Science Center. As shown in the output table (#4.4.5), FY 2009 funding will allow for 10 Summary Guides to be produced.
- Building and enhancing the research and methodological capacity for conducting comparative and effectiveness research and for the integration of evidence into practice and decision-making.
- Evaluating new clinical data sources and important clinical information (e.g., lab values, blood pressure readings) and perform more rigorous comparisons of treatments to draw inferences about complex clinical outcomes. This will increase the ability for clinicians to provide the right treatment to the right patient.
- Develop a Protocol for Research on Analytic Performance and Effectiveness of Genomic and Other Laboratory Tests and Clinical Decision Support (CDS) Tools for Gene-based Test Information

- Training and development of the new generation of comparative effectiveness researchers. It is expected that 3 to 4 career development awards will be made in FY 2008, with 3 to 5 years funding commitment for each award. Training and development activities will be closely tied to the programmatic strategic directions and the needs and challenges as identified by the Effective Health Care Program.

D. Performance Analysis

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

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

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

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

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

II. Prevention/Care Management

	FY 2007 Enacted	FY 2008 Omnibus Level	FY 2009 Estimate
Prevention/Care Management	$7,100,000	$7,100,000	$7,100,000
TOTAL	$7,100,000	$7,100,000	$7,100,000

FY 2009 Authorization…Title III and IX and Section 937(c) of the Public Health Service Act.
Allocation Method……..Competitive Grants/Co-operative agreement, Contracts, and Other.

A. Program Description and Accomplishments

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

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

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

system integration.

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

B. Funding History

Funding for the Prevention/Care Management program during the last five years has been as follows:

Year	Dollars
2004	$7,100,000
2005	$7,100,000
2006	$7,100,000
2007	$7,100,000
2008	$7,100,000

C. Budget Request

AHRQ requests $7,100,000 for Prevention and Care Management Research at the FY 2009 Estimate level – a level equal with FY 2008 Enacted level. These funds are being financed using PHS Evaluation Funds. These funds will allow AHRQ to continue funding important research on prevention and care management, including the following activities:

- provide ongoing support to the grants initiative, Optimizing Prevention and Healthcare Management for the Complex Patient
- support Evidence-based Practice Centers to conduct systematic evidence reviews for use by the USPSTF in making recommendations on clinical preventive services
- generate and synthesize knowledge of how new recommendations and evidence-based services are incorporated into clinical practice and/or health care systems
- promote the implementation and use of appropriate evidence-based clinical services
- convene the USPSTF 3 times during the fiscal year
- support the training of preventive medicine residents in evidence-based medicine

In addition, as shown in our performance tables below, in FY 2009 AHRQ will release an updated USPSTF recommendation on screening for colorectal cancer. Clinical preventive services recommended by the United States Preventive Services Task Force have been demonstrated to improve health outcomes when delivered appropriately. Along with the release of the updated recommendation, AHRQ will finalize a modification of American Cancer Society (ACS) colorectal screening implementation toolkit (via an Inter-agency Agreement with CDC) to an electronic format. This electronic toolkit will help ARHQ meet the following outcome: By 2014, increase by 3% the percentage of men and women age 50 or older who report having been screened for colorectal cancer using data tracked by AHRQ's NHQR and NHDR.

AHRQ faces many challenges in being able to measure the impact of the Prevention

Portfolio on screening rates, including the availability of trend data. Specifically, the prevention/care management portfolio does not direct or control how preventive services usage data are gathered via the NHIS or how and when the data are presented in the NHQR and NHDR. For example, the 2004 NHQR provided separate estimates for 1) the number of men and women over age 50 who reported having received fecal occult blood testing (FOBT) in the past 2 years, and 2) the number of men and women over age 50 who reported ***ever*** having a flexible sigmoidoscopy/colonoscopy.

In the 2006 NHQR, the rates of colorectal cancer screening that were reported were for **one combined variable** that included adults age 50 and older who reported ever having received a sigmoidoscopy, colonoscopy, or proctoscopy or who report fecal occult blood test within the past 2 years, 2000 and 2003. It is therefore not possible to determine what the rates of screening specific to FOBT or flexible sigmoidoscopy/colonoscopy were. Changes in the way screening rate data are gathered and reported make it impossible to track improvements in screening rates from year to year based on the original baseline rates. AHRQ is working to address this challenge.

D. Performance Analysis

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

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

								nominated topics for review. Portfolio will prioritize clinical preventive service(s) in alignment with strategic goal areas.	situational analysis for additional Portfolio-prioritized clinical preventive service(s).	

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

#	Key Outputs	FY 2004 Ac-tual	FY 2005 Ac-tual	FY 2006 Tar-get/ Est.	FY 2006 Ac-tual	FY 2007 Tar-get/ Est.	FY 2007 Ac-tual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
2.3.6	Improve integration of Prevention and Care Management activities	NA	NA	NA	NA	NA	NA	Launch new Preven-tion/ Care Mgmt Portfolio and create key outcome measures for Care Mgmt	TBD	TBD
	Prevention/ Care Manage-ment Portfolio Appropriat-ed Amount ($M)	$7.1 M	$7.1 M	$7.1 M	$7.1 M	$7.1 M	$7.1 M	$7.1 M	$7.1 M	

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

III. Value

Value Research	FY 2007 Enacted	FY 2008 Omnibus Level	FY 2009 Estimate
Value-driven Health Care Initiative	$3,730,000	$3,730,000	$3,730,000
Health Insurance Decision Tool	$0	$0	$6,000,000
TOTAL	**$3,730,000**	**$3,730,000**	**$9,730,000**

FY 2009 Authorization….Title III and IX and Section 937(c) of the Public Health Service Act.
Allocation Method………… ………………………………………….. Contracts, and Other.

A. Program Description and Accomplishments

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

Value-driven Healthcare Initiative

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

- **Chartered Value Exchanges**. Central to the Value-driven Initiative is a new family of Chartered Value Exchanges (CVEs). CVEs are local collaboratives, consisting of public and private payers, providers, plans and consumers, and in some cases State data organizations, Quality Improvement Organizations, and health information exchanges, who are committed to publicly reporting cost and quality information in their communities, and working in tandem to improve quality and value. Twice a year, AHRQ will be soliciting applications from community collaboratives seeking to become Chartered Value Exchanges. The first solicitation opened in October, 2007, and the first CVEs announced in early 2008. This activity supports the measure for increasing the number of CVEs. CVEs will have access to quality information about physician groups in their area, drawn from Medicare and private plan data. The ultimate aim of CVEs is timely, comparative data on provider quality and some measure of price or efficiency, presented in a consumer-friendly format.
- **Measures and data for transparency:** Evidence-based measures and solid, local data on cost and quality are crucial to creation of Value-Driven healthcare. AHRQ has a long history of development and maintenance of measures and data that the Department, private purchasers, states and providers are using for quality reporting and improvement. Examples include the CAHPS®, Quality Indicators, National Healthcare Quality and Disparities Reports, Health Information Exchanges, Culture of Safety measures, and the Healthcare Cost and Utilization Project.

- **Evidence to support reporting, payment and improvement strategies.** A third

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

Health Insurance Decision Tool

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

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

This initiative will facilitate the development and implementation of state-specific affordable health plans for low income individuals in the U.S., and will provide state decision makers with the tools and information they need to design effective programs for reducing the

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

B. Funding History

Funding for the Value Research program during the last five years has been as follows:

Year	Dollars
2004	$ 0
2005	$ 0
2006	$ 687,060
2007	$3,730,000
2008	$3,730,000

C. Budget Request

The FY 2009 Request includes $9,730,000 for Value Research, an increase of $6,000,000 from the FY 2008 Omnibus level. The Value Research priority includes research related to the Value-driven Healthcare Initiative and a new Initiative – Health Insurance Decision Tool. Support for the Value-driven Healthcare Initiative is maintained at $3,730,000 in FY 2009. The FY 2009 Request includes $6,000,000 for our new proposal – Health Insurance Decision Tool.

Value-driven Healthcare Initiative
AHRQ requests $3,730,000 for the Value-driven Health Care Initiative. This will permit us to accomplish the following:

- Increase the number of Chartered Value Exchanges to 30 and continue and expand a Learning Network to support them.
- Increase to 8 the number of states or communities reporting market-level data on cost
- Continue to develop, test, validate and support quality and efficiency measures needed for transparency
- Expand availability of local data on quality and efficiency, along with national benchmarks and other comparisons.
- Expand to 15 the number of communities and states with public report cards,
- Produce at least 5 new reports, tools, or evaluations available for CVEs.
- Continue a coordination forum for public payers

Health Insurance Decision Tool
AHRQ requests $6,000,000 for initiating the development of the Health Insurance Decision Tool at the FY 2009 Estimate level. The funds for this initiative will be used to acquire the essential data on health plan benefits, costs, and consumer choice, including a focus on

information on plans and consumer choice in the individual market, to initiate the development of the microsimulation model and resultant decision tools, and in the provision of technical support for applications. The four components of the initiative are:

- A data collection and analysis component aimed at producing information currently lacking with respect to benefit design and consumer behavior including the individual market.
- The development of a microsimulation model to estimate the plan elements described above based both on existing knowledge and the knowledge developed on health plan benefits and cost.
- The production of a user friendly interactive decision tool for estimating the impact of specific proposed state plans (take up, cost of plan, expected use and expenditures of beneficiaries).
- The provision of technical assistance in plan design and the use of the Health Insurance Decision Tool.

In FY 2009, the funds will be used to acquire health benefit data in MEPS and initiate the Health Insurance Decision Tool development. This will entail the collection of essential data on the benefits and costs of insurance plans held by MEPS sample participants to be nationally representative of the experience of the civilian non-institutionalized population in the U.S. The MEPS Household Component sample size consists of 14,500 households. Based on new and existing data, an interim version of the Health Insurance Decision Tool will be developed to:

- provide State specific estimates of eligible uninsured population;
- estimate utilization profiles with health insurance take-up (take up rates are a model input);
- and estimate person and family level plan costs and out of pocket health care expenditures

Funds will also be used to develop measures for inclusion in a MEPS Self Administered Questionnaire, to facilitate analyses and modeling efforts on consumer choice of plans.

Based on the information generated in the data development and analysis tasks, this initiative will result in the development of a user friendly decision tool that would be available to the states either through the web or on CD. The decision tool would allow state defined values for eligibility criteria, benefits offered, and market and population characteristics to be entered and would then calculate estimates of alternative program costs based on an interoperable dataset formed through direct linkages between MEPS household and policy booklet data, and potentially other sources and additional statistical linkages to MEPS State specific employer data and individual health insurance data on the number and types of private health insurance plans, all run through a microsimulation model developed under the initiative. The modeling tool would provide States with the essential information necessary to inform the development of the benefit structure of a “basic plan” and estimated program costs based on the number of new enrollees and their expected utilization patterns. In addition, the tool could also be used to determine the costs of high risk individuals, who might be difficult to cover under a basic plan.

An integrated set of performance measures have been developed to facilitate a timely and comprehensive development of the Health Insurance Decision Tool with detailed out year targets. The performance measures consist of 1) producing nationally representative estimates of health plan benefits, costs, and consumer behavior on coverage decisions in

2010, which will include the release of a MEPS Public Use file on health plan benefits; 2) the production of a health insurance decision tool to facilitate specification of health plan benefit structure by 2011, with collection of essential data and their abstraction initiated in 2009; 3) the development of the microsimulation model and interactive health insurance decision tool to estimate take-up, use of services and cost of coverage for basic coverage plans in 2011, with interim model outputs to quantify the change in behavior of use of services based on acquisition of coverage; and 4) Tool deployment in 2011 through tool dissemination to States, with the goal of a at least 5 States using the Health Insurance Decision Tool to design a health insurance plan.

D. Performance Analysis

Value Driven Health Care:

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

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

Health Insurance Decision Tools (HIDT)

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Target/ Est.	FY 2006 Actual	FY 2007 Target/ Est.	FY 2007 Actual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
1.3.32	Produce nationally representative estimates of health plan benefits, costs, and consumer behavior on coverage decisions	NA	NA	NA	NA	NA	NA	NA	Develop draft specifications for estimation weights that will produce national estimates	2010 Nationally representative estimates of health plan benefits, costs, and consumer behavior on coverage estimates
1.3.33	Produce model to inform plan benefit structure	NA	NA	NA	NA	NA	NA	NA	Initial modeling of change in behavior of use of services based on acquisition of coverage	2011 Plan benefit structure model
1.3.34	Produce decision tools to facilitate specification of plan benefit structure.	NA	NA	NA	NA	NA	NA	NA	Initiate data collection and abstraction	2011 Decision tools to facilitate specification of plan benefit structure
1.3.35	Data Products by 2010: MEPS Public Use file on health plan benefits	NA	NA	NA	NA	NA	NA	NA	Collection of data on health plan benefits and costs in MEPS	2010 Abstraction of policy booklet data including a focus on the individual market Produce MEPS Public Use Files with health benefits data
1.2.2	Tool Development by 2011: Microsimulation model to estimate take-up, use of services and cost of coverage for basic coverage plans.	NA	NA	NA	NA	NA	NA	NA	Develop interim version of tool Generate State specific estimates of eligible uninsured population; model utilization and expenditure behavior; estimates of plan costs	2011 Develop the microsimulation model and interactive decision tool
1.2.3	Tool Deployment by 2011: Provide HIDT to States; At least 5 States use HIDT to design health insurance plan	NA	NA	NA	NA	NA	NA	NA	Meet with leaders from 5 states to prioritize HIDT content	2011 Provide HIDT to at least 5 States to use to design health insurance plan
	Appropriated Amount ($ Million)	$0	$0	$0	$0	$0	$0	$0	$6.0 M	

IV. Other Quality, Effectiveness and Efficiency Research

	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
Other Quality, Effectiveness and Efficiency Research	$151,153,000	$156,800,000	$143,959,000	($12,841,000)
TOTAL	$151,153,000	$156,800,000	$143,959,000	($12,841,000)

FY 2009 Authorization………Title III and IX and Section 937(c) of the Public Health Service Act.
Allocation Method……………..Competitive Grant/co-operative agreement, Contracts, and Other.

A. Program Description and Accomplishments

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

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

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

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

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

CAHPS®. CAHPS is a multi-year initiative of AHRQ. Originally, "CAHPS" referred to AHRQ's "Consumer Assessment of Health Plans Study." However, in 2005, AHRQ changed this to "Consumer Assessment of Health Providers and Systems." This name better reflects the

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

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

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

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

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

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

CERTs. The Centers for Education & Research on Therapeutics (CERTs) demonstration

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

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

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

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

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

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

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

Research Contracts and IAAs

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

- Contracts and IAAs support the development and release of the annual *National Healthcare Quality Report* and its companion document, the *National Healthcare Disparities Report.* These reports measure quality and disparities in four key areas of health care: effectiveness, patient safety, timeliness, and patient centeredness. In addition, AHRQ provides a *State Snapshots* Web tool was launched in 2005. It is an application that helps State health leaders, researchers, consumers, and others understand the status of health care quality in individual States, including each State's strengths and weaknesses. The 51 State Snapshots—every State plus Washington, D.C.—are based on 129 quality measures, each of which evaluates a different segment of health care performance. While the measures are the products of complex statistical formulas, they are expressed on the Web site as simple, five-color "performance meter" illustrations.

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

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

  - Nearly 10 percent of all hospital admissions—2.9 million stays—were related to depression. Although the number of stays principally for depression remained relatively stable between 1995 and 2005, the number of stays with depression as a *secondary* diagnosis rose by 166 percent over the same time period.
  - In 2005, there were about 368,600 hospital stays for infections with MRSA (an antibiotic-resistant infection). In that year, hospital stays for these infections were more than three times higher than in 2000 and nearly 10 times higher than in 1995.
  - In 2004, traumatic brain injuries were the cause of 6.9 hospital stays per 10,000 persons and totaled $3.2 billion in hospital costs. Hospitalizations for the most serious type of brain injury had declined 21 percent between 1994-2001, but increased about 38 percent by 2004, reaching the previous high in 1995 and 1996.

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

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

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

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

- Previously, AHRQ has made several investments in systems research to help moderate infections with Methicillin Resistant Staphylococcus Aureus, or MRSA. MRSA and related bacteria in hospital settings as part of its patient safety portfolio. Two examples are: Testing Techniques to Radically Reduce Antibiotic Resistant Bacteria (Methicillin Resistant Staphylococcus aureus, or MRSA); and, Reducing Healthcare Associated Infections (HAI): Improving patient safety through implementing multi-disciplinary interventions. With the

additional $5,000,000 provided in FY 2008, AHRQ will work closely with CDC to identify gaps in the prevention, diagnosis, and treatment of MRSA and related infections across the healthcare system. In conjunction with CDC and other health care agencies within DHHS and within the Federal government, AHRQ will use available mechanisms to fund research, implementation, measurement, and evaluation regarding practices that identify and mitigate these infections.

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

B. Funding History

Funding for the Other Quality, Effectiveness and Efficiency Research program during the last five years has been as follows:

Year	Dollars
2004	$159,109,000
2005	$143,077,000
2006	$153,908,000
2007	$151,153,000
2008	$156,800,000

C. Budget Request

The FY 2009 Estimate level provides support of $143,959,000 for Other Quality, Effectiveness and Efficiency research, a net decrease of $12,841,000 from the FY 2008 Enacted level. In FY 2009, reductions for this portfolio total $15,163,000 from the FY 2008 Enacted level of $156,800,000. The reductions are as follows:

- MRSA (-$5,000,000): The FY 2008 Enacted level provided $5,000,000 for contract activities to reduce infections from methicillin-resistant staphylococcus aureus and related infections (MRSA). With the additional $5,000,000 provided in FY 2008, AHRQ will work closely with CDC to identify gaps in the prevention, diagnosis, and treatment of MRSA and related infections across the healthcare system. In conjunction with CDC and other health care agencies within DHHS and within the Federal government, AHRQ will use available mechanisms to fund research, implementation, measurement, and evaluation regarding practices that identify and mitigate these infections. This research will be done through one year contracts in FY 2008 and does not continue into FY 2009.

- Research and Training Grants (-$7,277,000): The FY 2009 Estimate provides for $25,415,000 (61 grants) in non-competing research grants funds for HCQO: Other Quality, Effectiveness and Efficiency – a decrease of $7,277,000 (70 grants) from the FY 2008 level of $32,692,000. A total of $7,277,000 in non-patient safety research and training grants funded in prior years ended in FY 2009. AHRQ will not re-invest these funds in investigator-

initiated research grants in FY 2009. The FY 2009 Estimate level will provide for noncompeting research grant commitments for several grants programs, including the CAHPS and CERTs programs.

In FY 2009, the CAHPS program will ensure that data will be more easily available to the user community and the number of consumers who have accessed CAHPS information to make health choices will increase by over 50 percent (see performance table 1.3.23). If AHRQ meets this target for FY 2009, 144 million consumers will have access to CAHPS information. Funding for CAHPS grants total $3 million in both FY 2008 and FY 2009. A total of $10.9 million is provided in FY 2008 and 2009 in continuation grant support for the CERTs program. This program expects decreases in hospitalization for upper GI bleeding due to adverse events of medication or inappropriate treatment of peptic ulcer disease in those between 65 and 85 years of age and decreased number of admissions will continue to generate a per year drop in per capita charges for GI bleeding. The target selected for FY 2008 is a 5% drop. The target selected for FY 2009 is a 6% drop.

- Research Contracts and IAAs (-$2,886,000): The FY 2009 Estimate reduces contract and IAA support by $2,886,000. The reductions will impact the level of outgoing IAA support in partnership with other agencies as well as a small reduction to planning and evaluation contracts. However, this level of support will allow AHRQ to continue core research contracts and IAAs that support Other Quality, Effectiveness and Efficiency research.

  Contracts that will continue in FY 2009 include the HCUP. HCUP has set an effectiveness goal that by 2010, at least 5 organizations will use HCUP databases, products or tools to improve health care quality for their constituencies by 5 percent, as defined by AHRQ Quality Indicators. By increasing the number of organizations using HCUP and the Quality Indicator tools, we support the overall program goal. HCUP's long term goal for efficiency is to achieve wider access to effective health care services and reduce health care costs. Expanding to add new states and by increasing the number of Partners that contribute ambulatory surgery and emergency department data we improve national and regional representation. AHRQ added data from Oklahoma to HCUP this year. AHRQ also added three new ambulatory surgery databases (KS, OH, SD) and five new emergency department databases (AZ, FL, KS, OH, SD). They were selected based on the diversity—in terms of geographic representation and population ethnicity—they bring to the project, along with data quality performance and their ability to facilitate timely processing of data. Currently, 38 statewide data organizations participate in HCUP.

The increases for HCQO's Other Quality, Effectiveness and Efficiency research total $2,886,000. The increases are all related to research management costs. The FY 2009 Estimate level provides $1,042,000 for pay raise costs for AHRQ as a whole. An additional $1,280,000 is provided in FY 2009 for required research management increases within AHRQ's budget, including rent increases, funds for the Unified Financial Management System (UFMS), and data costs, as well as support for one additional FTE. The AHRQ request also includes funding to support the President's Management Agenda e-GOV initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process.

D. Performance Analysis

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

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

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

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

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

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Ac-tual	FY 2007 Target	FY 2007 Ac-tual	FY 2008 Target	FY 2009 Target	Out-Year Target
4.4.3	Reduce hospitalization for upper gastrointestinal bleeding due to the adverse effects of medication or inappropriate treatment of peptic ulcer disease, in those between 65 and 85 year of age	Baseline 55/10,000	55/ 10,000	2% drop	54.38/ 10,000	2.0 drop	51.56/ 10,000	1.8% drop	3% drop	2014 reduce to 45/ 10,000
4.4.4	The decreased number of admissions for upper gastrointestinal (GI) bleeding will generate a per year drop in per capita charges for GI bleeding. (Reductions are compared to baseline).	$96.54 Baseline	$93.20 per capita (3.4% drop)	$93.64 3% drop	$93.36 per capita (3.2% drop)	$92.68 4% drop	$91.81 per capita (4.9% drop)	$91.71 per capita (5% drop)	$90.75 per capita (6% drop)	2012 (10% drop)

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

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Target/ Est.	FY 2006 Actual	FY 2007 Target/ Est.	FY 2007 Actual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
1.3.15	Increase # of partners	36 states	5 new out-patient data-sets	Increase # of part-ners	21 AS 17 ED	Increase # of part-ners	24 AS 22 ED	Increase # of partners	Increase # of partners	2010 5%
1.3.22	Inc # of organizations (O) using HCUP databases, products or tools to improve health care quality for their constituencies by 5%, as defined by AHRQ QIs	2 new Os 1 imple-menta-tion	4 imple-menta-tions	3 Os and 1 imple-men-tation will use HCUP/ QIs to asses QI Impact in at least 1 O	3 new Os : Organ for Econ Coop. & Develop-ment CT Office of Hlth Care Acc-ess Dallas-Fort Worth Hosp-Council Canada's Public Rpts Impact: CO Hlth & Hosp Assoc	3 Os and 1 imple-menta-tion will use HCUP/ QIs to assess QI Impact in at least 1 O	3 new Os: CO Hlth Inst. OH Dpt. of Hlth Harvard Van-guard Med Assoc & Atrias Hlth. Impact: Univ. Hlth Systm Con-sortium	Impact will be observed in 1 new organizati on after the developm ent and imple-men-tation of an interventi on based on the QIs	3 new organizati ons will use HCUP/ QIs to assess potential areas of quality improvem ent, and at least of them will develop and implemen t an interventi on based on the QIs Impact will be observed in 1 new organiza-tion after the develop-ment and imple-men-tation of an interven-tion based on the QIs	2010 5 organi-zations

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

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

V. Health Information Technology

	FY 2007 Enacted	FY 2008 President's Budget	FY 2008 Enacted	FY 2009 Estimate
Health Information Technology	$49,886,000	$44,820,000	$44,820,000	$44,820,000
TOTAL	$49,886,000	$44,820,000	$44,820,000	$44,820,000

FY 2009 Authorization………Title III and IX and Section 937(c) of the Public Health Service Act.
Allocation Method……………..Competitive Grant/co-operative agreement, Contracts, and Other.

A. Program Description and Accomplishments

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

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

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

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

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

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

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

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

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

B. Funding History

Funding for the Health Information Technology program during the last five years has been as follows:

Year	**Dollars**
2004	$49,886,000
2005	$61,326,000
2006	$49,886,000
2007	$49,886,000
2008	$44,820,000

C. Budget Request

AHRQ requests $44,820,000 for research related to Health Information Technology, the same level of support as the FY 2008 Enacted level. This request includes $29,388,000 in new and continuation support for grants, contracts and IAAs to support the Ambulatory Safety and Quality Program (ASQ) and other health IT activities. In FY 2009, AHRQ will re-invest $7,477,000 in grants related to the Ambulatory Patient Safety Program. These new Health IT grants will support the next phase of the Ambulatory Patient Safety Program (ASQ). The ASQ

Program offers an integrated approach to improving ambulatory safety and quality of care. Where effective strategies exist to drive ambulatory safety and quality, such as Health IT, there is a need for research to demonstrate value, as well as best approaches to broader diffusion, implementation and effective use. In particular, the high risk associated with medication use in ambulatory care and across transitions in care provides some urgency for targeted health services interventions related to medication management. Effective strategies to improve ambulatory care will be limited by the capacity of current electronic health systems to measure and report on ambulatory safety and quality.

To achieve measurable improvements, in FY 2007 AHRQ announced four funding opportunities that comprise the ASQ Program to address research needs that share a common focus on ambulatory care clinicians, patients, and information technology. The themes of these funding opportunities focused on Health IT and will continue through FY 2009. A summary of that funding is below:

- Ambulatory Patient Safety Program (ASQ): $29,388,000
    - New FY 2009 Grants ($7,477,000)
    - Continuation of ASQ Grants funded in FY 2007 ($14,000,000)
    - Health IT CERTs Grant ($1,000,000)
    - Clinical Decision Support Demonstrations ($ 3,000,000)
    - Other Contracts and IAAs related to ASQ ($3,911,000)

In addition, the FY 2009 budget request will allow AHRQ to award projects which develop and disseminate evidence on the use of health IT to improve quality. AHRQ will also be able to continue to partner with our Federal and private sector stakeholders to promote our shared goals. If effectively disseminated, this evidence can inform key stakeholder policy and practice and increase adoption of Health IT which improves quality. Without this evidence, the effort required to overcome barriers to adoption is frequently called into question and efforts to move forward can stagnate. A key challenge to reaching FY 2009 performance goals are the many factors outside of AHRQ control which influence use of Health IT, including payment policy, regulatory requirements and clinical practice standards. Specific activities include:

- National Resource Center for Health IT: $4,000,000
- Portfolio Assessment and Evaluation Activities: $3,000,000
- Dissemination, Translation and Other Rapid Cycle Research Activities: $8,432,000

D. Performance Analysis

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

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

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

VI. Patient Safety

Patient Safety Research	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
Patient Safety Organizations	$5,756,000	$7,000,000	$7,000,000	$0
Patient Safety Threats and Medical Errors	$28,358,000	$27,114,000	$25,055,000	($2,059,000)
TOTAL	$34,114,000	$34,114,000	$32,055,000	($2,059,000)

FY 2009 Authorization………Title III and IX and Section 937(c) of the Public Health Service Act.
Allocation Method……………..Competitive Grant/co-operative agreement, Contracts, and Other.

NOTE: AHRQ's entire patient safety program includes the Health IT program as well. Those funds ($44,820,000 in FY 2009) are not included in the table above.

A. Program Description and Accomplishments

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

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

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

Research Grants

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

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

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

Training Programs

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

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

Resources/Tools

- AHRQ also supports the AHRQ Patient Safety Network (AHRQ PSNet). It is a national Web-based resource featuring the latest news and essential resources on patient safety. The site offers weekly updates of patient safety literature, news, tools, and meetings

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

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

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

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

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

B. Funding History

Funding for the Patient Safety program during the last five years has been as follows:

Year	Dollars
2004	$29,612,000
2005	$34,192,000
2006	$34,114,000
2007	$34,114,000
2008	$34,114,000

C. Budget Request

The FY 2009 Estimate provides $32,055,000 for this program, a decrease of $2,059,000 from the prior year. The Patient Safety Program is comprised of two research components: Patient Safety Threats and Medical Errors and Patient Safety Organizations (PSOs).

Patient Safety Threats and Medical Errors
The FY 2009 Request includes $25,055,000 for patient safety threats and medical errors, a decrease of $2,059,000. Of the decrease, $1,881,000 is from reductions in inter-agency agreements (IAAs) related to data standards and the remaining $178,000 will come from patient safety IAAs. The Request level will enable us to provide continued support for a number of ongoing research contracts, IAAs, and research grants including:

- The AHRQ PSNet and the AHRQ WebM&M, both of which have a growing user base and high levels of customer satisfaction based on annual customer satisfaction surveys
- Patient safety grants focused on diagnostic error, ambulatory care patient safety intervention tool kit development, CERTS pediatric patient safety
- PSIC “graduates” fellowship training
- Patient safety evaluation activities
- The patient safety research coordinating center
- Patient safety implementation projects conducted through our ACTION program
- TeamSTEPPS™ technical assistance
- Support of the World Health Organization’s “High 5s” program (e.g., developing standard operating procedures for selected patient safety topics in at least 7 countries and measuring their impact)
- Patient safety knowledge transfer projects

In terms of performance measures, in FY 2007 the patient safety portfolio was able to provide a baseline for the number of U.S. healthcare organizations using AHRQ-supported tools to improve patient safety – 382 hospitals. The FY 2008 target for this measure is 439 hospitals, increasing to 504 hospitals in FY 2009. In addition, AHRQ intends to 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. FY 2007 efforts focused on developing a baseline measure. The FY 2007 baseline for the inventory of evidence-based tools is 61 – AHRQ goal is to develop and additional 7 tools in 2008 (for a total of 68) and 8 additional tools in FY 2009 (for a total of 76).

(Patient Safety Organizations (PSOs)
The Patient Safety and Quality Improvement Act (PSQIA) of 2005 amended the Public Health Service Act to encourage a culture of safety in health care organizations. It provides legal protection of information voluntarily reported to patient safety organizations (PSOs). To encourage health care providers to work with the PSOs, the Act provides Federal confidentiality and privilege protections. The Act prohibits the use of these analyses in civil, administrative, or disciplinary proceedings and limits their use in criminal proceedings. AHRQ is developing plans to help implement the Act as a science partner to the PSOs and health care providers. The Agency's goals are to help advance the methodologies that identify the most important causes of threats to patient safety, identify best practices for addressing those threats, and share the lessons learned as widely as possible. Specific work specified in the Act includes: 1) establishing the Network of Patient Safety Databases (NPSD) that will allow PSOs to share non-identifiable patient safety information, using common formats for consistent reporting, 2) reporting trends and patterns of health care error based on NPSD information in the National Healthcare Quality and Disparities Reports, and 3) providing technical assistance to PSOs. Additional work includes: 1) establishing systems to help PSOs de-identify information (information on an individual, stored in the database or on file that cannot be linked to the name or address of that individual) for submission to the NPSD and 2) establishing systems to enhance the interoperability of information gathered by PSOs. Funding for this important Act will continue at the FY 2009 Estimate level at $7,000,000, maintaining the FY 2008 funding level. This level of support will enable AHRQ, working with the Secretary, to provide a list of the PSOs in FY 2009 (see measure 1.3.40).

D. Performance Analysis

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

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out-Year Target
1.3.37	Increase the percentage of hospitals in the U.S. using computer-only patient safety event reporting systems (PSERS) (This replaces PART			Baseline	12%	NA	NA	NA	24%	2017 48%

	measure #2).									
1.3.38	Increase the number of U.S. healthcare organizations using AHRQ-supported tools to improve patient safety from the 2007 baseline (new portfolio measure)					Base-line	382 hos-pitals	440	500	2017 1528
1.3.39	Increase the number of patient safety events reported to the Network of Patient Safety Databases (NPSD) from baseline. (This replaces measure #1)	NA	NA	NA	NA	NA	NA	NA	Baseline TBD	2017 increase to 200%
1.3.5	Reductions associated with reductions in hospitaliza-tions with infections due to medical care. (Reductions are compared to previous year's results).					-2%	On-going 09/30/09	-2%	-2%	2017 TBD

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

Medical Expenditure Panel Survey (MEPS)

	FY 2007 Enacted	FY 2008 President's Budget	FY 2008 Enacted	FY 2009 Estimate
Budget Authority	$0	$0	$0	$0
PHS Evaluation Funds	$55,300,000	$55,300,000	$55,300,000	$55,300,000
FTEs	NA	NA	NA	NA

FY 2009 Authorization………Title III and IX and Section 937(c) of the Public Health Service Act.
Allocation Method………………………………………………………………Contracts, and Other.

A. Program Description and Accomplishments

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

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

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

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

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

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

B. Funding History

Funding for the MEPS budget activity during the last five years has been as follows:

Year	Dollars
2004	$55,300,000
2005	$55,300,000
2006	$55,300,000
2007	$55,300,000
2008	$55,300,000

C. Budget Request

The FY 2009 Request for the MEPS totals $55,300,000 in PHS evaluation funds, maintaining the FY 2008 President's Budget level. The MEPS Household component of the survey is supported at $35,700,000, the Medical Provider component totals $10,400,000 and the insurance component is supported at $9,200,000.

The FY 2009 funding for MEPS will be used to maintain the sample size and content of the MEPS Household and Medical Provider Surveys necessary to satisfy the congressional mandate to submit an annual report on national trends in health care quality and to prepare an annual report on health care disparities. The MEPS Household Component sample size is maintained at 14,500 households in 2009 with full calendar year information. These sample size specifications for the MEPS permit detailed analyses of the quality of care received by special populations meeting precision specifications for survey estimates. This design, in concert with the survey enhancements initiated in prior years, significantly enhances AHRQ's capacity to report on the quality of care Americans receive at the national and regional level, in terms of clinical quality, patient satisfaction, access, and health status both in managed care and fee-for-service settings.

The MEPS Household Component:
These funds will also permit the continuation of an oversample in MEPS of Asian and Pacific Islanders and individuals with incomes <200% of the poverty level. These enhancements, in concert with the existing MEPS capacity to examine differences in the cost, quality and access to care for minorities, ethnic groups and low income individuals, will provide critical data for the National Healthcare Quality Report and the National Healthcare Disparities Report. The MEPS Computer Assisted Personal Interview System (CAPI) is transitioning to a windows based system beginning with the household data collection in 2007. Developmental work was initiated in FY 2005 and will be completed in FY 2009.

The MEPS Insurance Component:
Funds will also be allocated to the MEPS Insurance Component to maintain improvements in the availability of data to the States. In FY 2009, data on employer sponsored health insurance will be collected to support separate estimates for all 50 States and these funds would be used to enhance the tabulations we provide to the States to support their analysis of private, employer sponsored health insurance.

The Medical Provider Component:
FY 2009 funds will also support the MEPS Medical Provider Component, a survey of medical providers, facilities and pharmacies that collects detailed data on the expenditures and sources of payment for the medical services provided to individuals sampled for the MEPS. Such data are essential to improve the accuracy of the national medical expenditure estimates derived from the MEPS and to correct for the item non-response on expenditures by household sample participants.

Recent enhancements to the estimation capabilities of the MEPS Household Component have also been realized and permit the generation of health care utilization, expenditure and health insurance coverage estimates for some large metropolitan areas and for the ten largest states. This has resulted in visible improvements in the analytic capacity of the survey without any additional increments to the sample size.

MEPS - Marginal Cost
The Baseline MEPS sample consists of approximately 15,000 households and 35,000 individuals, and includes over-sampling of African-Americans, Hispanics, Asians and low income households. With respect to desired levels of precision for survey estimates, a relative standard error (RSE) specification of less than or equal to 10 percent is recommended for survey estimates that characterize policy relevant population subgroups which include racial and ethnic minorities (RSE (X) = standard error (X) divided by the estimate X.). This precision target is not currently being met for estimates of the health care utilization and expenditure patterns for American Indians/Alaskan Natives, subgroups of individuals of multiple races (e.g. race classifications of both African-American and other race), specific Hispanic subgroups (e.g., Puerto Rican, Cuban, Dominican) and Asian population subgroups (e.g., Chinese, Vietnamese, Asian Indian). The FY 2009 cost estimate for MEPS would allow for the following sample yields for these racial and ethnic minority population subgroups in MEPS that have relative standard errors above 10 percent-- an average cost of $6,507 per household for the household and medical provider components of the MEPS survey.

MEPS Over-sampling

Subgroup	Baseline – FY 2009 Estimate For Individuals	Baseline – FY 2009 Estimate of Relative Standard Error (for mean expenditures)
Asians	1,300	7.8%
Chinese	160	16.0%
Hispanic Subgroup:Puerto Ricans	700	11.5%
Hispanic Subgroup:Cuban	300	33.2%
Hispanic Subgroup:Dominican	225	19.0%
American Indian/Alaskan Native	400	13.2%

Multiple Race	575	9.0%

The cost components related to the household and medical provider component of MEPS for a full panel of 7,500 households over 3 years are provided on the following page:

Cost Components	**Baseline**
Households	Full MEPS consists of 15,000 households
(1) Sample Selection	$0.6 M
(2) Management	$1.1M
(3) Hire/Train Household/Medical Provider Survey Staff	$3.4M
(4.a) Conduct Household Interviews	$20.7M
(4.b)Data Collection-Medical Providers	$10.9M
(5) Data Processing/Production of Analytical Files	$12.1M
Total Cost	$48.8M
Cost per Household	$6,507

Costs associated with (1) the sample frame preparation and sample selections for the MEPS Household and Medical Provider Surveys and (2) the management tasks are fixed, while costs associated with the remaining data collection and data processing components are variable.

In 2007, a marginal cost analysis was completed to determine the marginal cost of increasing the degree of oversampling in the MEPS sample among certain minority sub-groups. This oversampling would allow estimates for these subgroups to be more precise, allowing the implications of program and policies to be more accurately estimated for these groups using MEPS data. As indicated, many estimates for these subgroups have relative standard errors that are higher than the recommended maximum threshold of 10%. The marginal cost to reach the recommended RSE of 10% for these minority subgroups in 2009 and 2010 is $4,000 per additional minority household surveyed, relative to the $6,507 cost per household.
The table below indicates the percent reduction in relative standard errors in survey estimates that could be achieved by a targeted MEPS sample augmentation of 1,000 additional households.

Subgroup	Reduction in RSE (for mean expenditures) with MEPS Sample Augmentation
Asians	24%
Chinese	24%
Hispanic Subgroup :Puerto Ricans	15%
Hispanic Subgroup :Cuban	23%
Hispanic Subgroup :Dominican	26%
American Indian/Alaskan Native	24%
Multiple Race	16%

D. Performance Analysis

Long-Term Objective 1:

#	Key Outcomes	FY 2004 Ac-tual	FY 2005 Ac-tual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out-Year Target
1.3.16	Insurance Component tables will be available within months of collection	7	7	6	6	6	6	6	Re-establish baseline – new design	2010 TBD
1.2.4	MEPS Use and Demographic Files will be available months after final data collection	12	11	11	11	11	11	11	11	2010 11
1.3.18	Number of months after the date of completion of the MEPS data will be available	12	12	12	12	11	11	11	11	2010 10
1.3.20	Increase the number of MEPS Data Users	Base-lines: 10 active Data Center Projs. (DCP) 15,900 Tables Com-pendia (TC) 13,101 HC/IC Net	14 DCP 16,200 TC 11,600 HC /IC	Exceed baseline standard	33 DCP 19,989 TCP 14,809 HC/IC	Exceed base-line stand-ard	Need to establish new baseline- Web site redesign	Establish new baseline	Exceed baseline standard	2010 TBD

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

Program Support

	FY 2007 Enacted	FY 2008 President's Budget	FY 2008 Enacted	FY 2009 Estimate
Budget Authority	$0	$0	$0	$0
PHS Evaluation Funds	$2,700,000	$2,700,000	$2,700,000	$2,700,000
FTEs	22	22	22	22

FY 2009 Authorization………Title III and IX and Section 937(c) of the Public Health Service Act.
Allocation Method………………………………………………………………Contracts, and Other.

A. Program Description and Accomplishments

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

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

Improve Financial Performance
AHRQ is currently yellow in this PMA activity – with a progress rating of green. AHRQ anticipates Green status upon demonstration to the Office of Finance at DHHS effective use of financial information to drive results in key areas of operations and when AHRQ develops and implements a plan to continuously expand the scope to additional areas of operations. AHRQ has successfully completed the FY 2007 target of examining and refining internal controls to

address improving improper payments, including assessing controls over financial reporting. In FY 2008 AHRQ will continue participation in the Department's A-123 internal control efforts and to implement all corrective actions for deficiencies reported as a result of the FMFIA/A-123 internal control processes identified in FY 2007.

Expanding Electronic Government

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

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

Performance Improvement Initiative

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

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

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

B. Funding History

Funding for the Program Support budget activity during the last five years has been as follows:

Year	Dollars
2004	$2,700,000
2005	$2,700,000
2006	$2,700,000
2007	$2,700,000
2008	$2,700,000

C. Rationale for Budget Request

The FY 2009 Request for the Program Support totals $2,700,000, the same level of support as the prior year. AHRQ will continue to strive for green in all Presidential Management Agenda areas. In FY 2009, AHRQ will:

- Fully implement the Departmental Learning Management System (LMS) for training and development needs (Strategic Management of Human Capital);
- Complete updating of all internal controls following AHRQ’s conversion to UFMS (Improve Financial Management);
- Fully meet milestones established for E-gov green status for FY 2009 (Information Technology and E-Gov); and
- Maintain “green” status on the Program Improvement initiative.

D. Performance Analysis

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

5.1.4	Improve IT Security/ Pri-vacy Output	Refined risk assess-ments Imple-mented business contin-uity and contin-gency program plans Devel-oped authen-tication program plan	Fully inte-grated security ap-proach EA and capital planning process	Test and insure mainten ance of security level	Per-formed required testing to insure main-tenance of security level	Certify and accredit all Level 2 Infor-mation systems Begin imple-menta-tion of Public Key Infra-struc-ture with applica-tions	Certified and accredit-ed all Level 2 Informa-tion systems Began imple-menta-tion of Public Key Infra-structure with applica-tion	Certify and accredit all Level 3 informa-tion sys-tems Review and update security program to reflect cur-rent guidance and man-dates	Integrate and align AHRQ's security program with HHS's Secure One security program	On-going: Maintain status for Improved IT Security/ Privacy Output
5.1.5	Establish IT Enterprise Architecture	Target architec-ture devel-oped Migration plan created Inte-grated EA process-es with capital planning process-es	Used EA to derive gains in business value and im-prove perfor-mance related to AHRQ mission	Level 3 maturity in EA	Began work towards Level 3 maturity in EA as defined by HHS	Con-tinue Level 3 EA plan	Com-pleted Level 3 EA plan	Implement Level 3 EA plan Comply with EA activity as defined by HHS	Comply with HHS EA require-ments	On-going: Maintain status for HHS EA require-ments
5.1.6	Get to Green and maintain status for Performance Improvement initiative	Planning System - Implemen ted phase for tracking budget and perf.	Impleme nted addi-tional phases of Plan-ning System	Design and pilot software for facilitat-ing budget and perf. integra-tion	Visual Perfor-mance Suite soft-ware de-signed and piloted	Begin implm. of soft-ware to facilitate budget and perf. improve Con-duct internal align-ment of meas-ures by strate-gic goal areas	Began to implemt. software with the portfolios Com-pleted internal alignment of meas-ures	Continue imple-mentation of software within the portfolios	Maintain "Green" status on Perf. Improve-ment initiative	Ongoing: Maintain status for Perf. Improve-ment initiative
	Appropriated Amount ($ Million)	$2.7 M	$2.7 M	$2.7 M	$2.7 M	$2.7 M	$2.7 M	$2.7 M	$2.7 M	

Supplementary Tables
Budget Authority by Object Class

Personnel Compensation	FY 2008 Estimate	FY 2009 Estimate	Increase or Decrease
Full-time permanent (11.1)	22,348,000	23,020,000	+672,000
Other than full-time permanent (11.3)	7,920,000	8,159,000	+239,000
Other personnel compensation (11.5)	1,131,000	1,166,000	+35,000
Military Personnel (11.7)	1,448,000	1,491,000	+43,000
Civilian Personnel Benefits (12.1)	7,583,000	7,812,000	+229,000
Military Personnel Benefits (12.2)	869,000	895,000	+26,000
Benefits to Former Employees (13.1)	0	0	0
Pay Costs	**41,299,000**	**42,543,000**	**+1,244,000**

Object Class	FY 2008 Estimate	FY 2009 Estimate	Increase or Decrease
Travel and transportation of persons (21.0)	610,000	623,000	+13,000
Transportation of Things (22.0)	32,000	33,000	+1,000
Rental payments to GSA (23.1)	4,160,000	4,285,000	+125,000
Rental payments to others (23.2)	99,000	101,000	+2,000
Communications, utilities, and miscellaneous charges (23.3)	575,000	588,000	+13,000
Printing and reproduction (24.0)	1,090,000	1,123,000	+33,000
Other services (25.2)	12,581,000	13,420,000	+839,000
Purchases of goods & services from government accounts (25.3)	17,799,000	15,918,000	-1,881,000
Research and Development Contracts (25.5)	187,220,000	181,654,000	-5,566,000
Operation and maintenance of equipment (25.7)	798,000	816,000	+18,000
Supplies and materials (26.0)	374,000	382,000	+8,000
Equipment (31.0)	1,182,000	1,208,000	+26,000
Grants, subsidies, and contributions (41.0)	66,745,000	62,970,000	-3,775,000
Total Non-Pay Costs	**293,265,000**	**283,121,000**	**-10,144,000**

Total	FY 2008 Estimate	FY 2009 Estimate	Increase or Decrease
Total obligations by object class	**334,564,000**	**325,664,000**	**-8,900,000**

Salaries and Expenses

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Salaries and Expenses
Total Appropriation

Personnel Compensation	FY 2008 Estimate	FY 2009 Estimate	Increase or Decrease
Full-time permanent (11.1)	$22,348,000	$23,020,000	+$672,000
Other than full-time permanent (11.3)	$7,920,000	$8,159,000	+$239,000
Other personnel compensation (11.5)	$1,131,000	$1,166,000	+$35,000
Military Personnel (11.7)	$1,448,000	$1,491,000	+$43,000
Civilian Personnel Benefits (12.1)	$7,583,000	$7,812,000	+$229,000
Military Personnel Benefits (12.2)	$869,000	$895,000	+$26,000
Benefits to Former Employees (13.1)	$0	$0	$0
Subtotal Pay Costs	**$41,299,000**	**$42,543,000**	**+$1,244,000**

Non Pay Object Classes	FY 2008 Estimate	FY 2009 Estimate	Increase or Decrease
Travel (21.0)	$610,000	$623,000	+$13,000
Transportation of Things (22.0)	$32,000	$33,000	+$1,000
Rental payments to others (23.2)	$99,000	$101,000	+$2,000
Communications, utilities, and miscellaneous charges (23.3)	$575,000	$588,000	+$13,000
Printing and reproduction (24.0)	$1,090,000	$1,123,000	+$33,000
Other services (25.2)	$12,581,000	$13,420,000	+$839,000
Operations and maintenance of equipment (25.7)	$798,000	$816,000	+$18,000
Supplies and materials (26.0)	$374,000	$382,000	+8,000
Subtotal Non-Pay Costs	**$16,159,000**	**$17,086,000**	**+$927,000**

Totals	FY 2008 Estimate	FY 2009 Estimate	Increase or Decrease
Total Salaries and Expenses	**$57,458,000**	**$59,629,000**	**+$2,171,000**

Detail of Full-Time Equivalent Employment

Office	2007 Actual	2008 Estimate	2009 Request
Office of the Director (OD)	19	19	19
Office of Performance Accountability, Resources and Technology (OPART)	54	54	54
Office of Extramural Research, Education, and Priority Populations (OEREPP)	34	34	34
Center for Primary Care, Prevention, and Clinical Partnerships (CP3)	26	27	27
Center for Outcomes and Evidence (COE)	31	33	33
Center for Delivery, Organization and Markets (CDOM)	26	26	26
Center for Financing, Access, and Cost Trends (CFACT)	49	49	50
Center for Quality Improvement and Patient Safety (CQuIPS)	25	25	25
Office of Communications and Knowledge Transfer (OCKT)	31	32	32
Total	**295**	**299**	**300**

Year	Average GS Grade
2004	12.8
2005	12.6
2006	12.6
2007	12.6
2008	12.6
2009	12.6

Detail of Positions

Position	2007 Actual	2008 Estimate	2008 Estimate
Executive Level I	0	0	0
Executive Level II	0	0	0
Executive Level III	0	0	0
Executive Level IV	0	0	0
Executive Level V	0	0	0
Subtotal	0	0	0
Total Executive Level Salaries	$0	$0	$0

Position	2007 Actual	2008 Estimate	2008 Estimate
Total SES	4	5	5
Total SES Salaries	$182,485	$187,960	$193,411

Position	2007 Actual	2008 Estimate	2008 Estimate
GS-15	53	53	54
GS-14	60	61	61
GS-13	44	43	43
GS-12	26	27	27
GS-11	13	13	13
GS-10	2	2	2
GS-9	12	13	13
GS-8	7	7	7
GS-7	11	10	10
GS-6	4	4	4
GS-5	3	3	3
GS-4	0	0	0
GS-3	1	1	1
GS-2	0	0	0
GS-1	0	0	0
Subtotal	236	237	238
Average GS grade	12.6	12.6	12.6
Average GS salary	$77,897	$80,816	$83,160

Significant Items

FY 2008 HOUSE REPORT NO. 110-231

Health Information Technology Strategic Plan

1. HOUSE (Rept. 110-231) p. 184
Within the total available, the Committee does not provide funding requested by the Administration for the new “network of networks” under the personalized health care initiative. The Committee is concerned that HHS has yet to develop a detailed, integrated, and coherent implementation plan for achieving health information technology strategic goals, as recommended by the General Accounting Office. The Committee includes report language within the Office of the National Coordinator for Health Information Technology that requests a report that identifies specific program objectives; details the timelines and performance benchmarks to achieve these objectives; and links specific initiatives and resources to these program objectives. The report also should include information on health information technology activities funded through AHRQ.

Action Taken or to be Taken:
AHRQ’s Health IT portfolio supports the Agency’s overall mission to improve the quality, safety, efficiency and effectiveness of health care through the informed use of Health IT. Prior to 2007, funding commitments had targeted hospitals, health information exchange and rural settings. Subsequently healthcare stakeholders described an increasing need for evidence development and dissemination on Health IT use in the ambulatory setting. In FY2007, the Health IT portfolio at AHRQ began the Ambulatory Safety and Quality Program (ASQ). The overall goals for this program address the broad topics of medication management, evidence-based care, patient centered care, and quality measurement. This program began to address these goals by soliciting and awarding funding to innovative projects developing robust Health IT capabilities and evidence of the subsequent impact on quality and safety. A significant achievement during this time was the delivery of a Report to Congress on standards for electronic prescribing, mandated by the Medicare Modernization Act and produced by AHRQ in collaboration with CMS. This Report has led to a proposed regulation, requiring the use of selected standards for Medicare beneficiaries, which enjoys widespread support from the health care community because of its solid foundation of evidence.

In 2008, AHRQ has continued the ASQ progam and is developing funding opportunities to produce further evidence of the benefits and demonstrate effective use of Health IT, measure the impact of these projects and overall progress towards our long-range goals, and disseminate those findings to relevant stakeholders. We work in partnership with key public stakeholders, including the Office of the National Coordinator, CMS, HRSA, and DoD, and private stakeholders including providers, patients, payers, purchasers, relevant experts and their representative organizations. In 2009, AHRQ will continue to pursue the goals of the ASQ program through projects which build upon the lessons of our previous work and iteratively assesses our progress.

Safe Patient Handling and Movement

2. HOUSE (Rept. 110-231) p. 184/185

The Committee is concerned about the consequences of manual patient lifting, transferring and movement in hospitals, nursing homes and other patient care settings that can be a detriment to quality patient care, including increased risk of injury to patients from being lifted and moved without assistive equipment and patient injuries including skin tears, skin ulceration, falls and shoulder dislocations. The Committee is further concerned by findings that a nurse on a typical shift lifts 1.8 tons and that work-related injuries to nurses frequently result in loss of work time and can be debilitating, career ending events, and that injury and fear of injury are listed as top reasons why nurses leave the profession thereby exacerbating the already critical nursing shortage. The Committee urges AHRQ to undertake or commission a study to determine the impact of utilizing assistive devices and patient-lifting equipment on patient injuries and outcomes, the health and safety of nurses, and the financial implications of using available technology.

Action Taken or to be Taken:

AHRQ acknowledges the importance of the concern raised by the House and Senate Committees and will add this to the topics for investigation within the patient safety portfolio.

Spina Bifida

3. HOUSE (Rept. 110-231) p. 185

The Committee supports the expansion and development of the national spina bifida patient registry and encourages AHRQ to lead the effort to validate quality patient treatment data measures for the registry being developed with CDC. The Committee requests that AHRQ report to Congress on the status of this effort as part of the fiscal year 2009 budget justification. The Committee provides $55,300,000 for the Medical Expenditures Panel Surveys (MEPS), which is the same as the fiscal year 2007 funding level and the budget request. The MEPS provide data for timely national estimates of health care use and expenditures, private and public health insurance coverage, and the availability, costs, and scope of private health insurance benefits. This activity also provides data for analysis of changes in behavior as a result of market forces or policy changes on health care use, expenditures, and insurance coverage; develops cost/savings estimates of proposed changes in policy; and identifies the impact of changes in policy for subgroups of the population.

Action Taken or to be Taken:

With guidance from the spina bifida community, CDC continues to make considerable progress in creating a standardized clinic registry to systematically collect data on patient care and outcomes. CDC will share the current clinic information form and other information relevant to creation of quality measures with AHRQ. AHRQ will work closely with CDC and the spina bifida community on identification and validation of potential quality measures. Quality measures may be able to be derived from the current clinic information form and registry, or may need to be newly developed. AHRQ will share its expertise in quality measurement and validation (e.g., guidance included on the National Quality Measures Clearinghouse website; expertise of staff and advisors for the National

Healthcare Quality Report and the National Healthcare Disparities Report; expertise of staff and other experts for the AHRQ Quality Indicators; expertise of our survey groups [CAHPS and MEPS]) to ensure that spina bifida clinics can be assessed and compared for quality of care, and that individual clinics will have sufficient data to improve care quality, should there be an identified need. CDC expects the registry to be implemented in 6-8 pilot sites (clinics) in fiscal year 2008 and to have data to analyze by fiscal year 2009. AHRQ will work with CDC on the registry throughout this period.

FY 2008 SENATE REPORT NO. 110-107

Deep Vein Thrombosis

4. Senate (Rept. 110-107) p. 176

Numerous studies conducted on deep vein thrombosis [DVT] have shown that there is a gap between knowledge and practice. A recent large scale national study found that only one-third of acute hospital patients who were at risk for DVT actually received the pharmacological or mechanical prophylaxis according to established guidelines. The Committee urges AHRQ to disseminate and make available evidence-based information to healthcare providers and patients as a step toward reducing the risks of serious and life-threatening complications from DVT.

Action Taken or to be Taken:

AHRQ agrees that DVT is a serious health issue and distributes over 20 evidence-based clinical practice guidelines on preventing and treating DVT through the National Guideline Clearinghouse (NGC) accessible at www.guideline.gov. AHRQ also distributes summaries of 14 quality measures relating to DVT through the National Quality Measures Clearinghouse accessible at www.qualitymeasures.ahrq.gov.

Investigator-initiated Research

5. Senate (Rept. 110-107) p. 176

The Committee values AHRQ for its critical role in supporting health services research to improve health care quality, reduce costs, advance patient safety, decrease medical errors, eliminate health care disparities, and broaden access to essential services. However, the Committee is troubled that AHRQ's investigator-initiated research portfolio has languished, even though many of the sentinel studies that have changed the face of health and health care in the United States are the result of researchers' ingenuity and creativity. To advance scientific discovery and the expansion of knowledge, AHRQ should invest at least as much on an investigator-initiated research agenda as it does on intramural health services research. The Committee urges the Department to expand funding for AHRQ's investigator-initiated research in its fiscal year 2009 budget request

Action Taken or to be Taken:

While targeted research investments comprise a large portion of our budget, we view investigator-initiated research as the foundation of our research portfolio. It is the basic research that provides the evidence-base for many of AHRQ's programs and activities, including patient safety and health care quality. In FY 2008, the Agency plans to continue its investment in investigator-initiated type of research that supports studies that are

intended to improve the health care for all Americans. AHRQ will provide $3.7 million for new investigator-initiated research in FY 2008. The Agency will continue to work with the Department, OMB, and the Committee to develop ways to best leverage our resources to expand funding in investigator-initiated research.

Safe Patient Handling

6. Senate (Rept. 110-107) p. 176
The Committee is concerned about the consequences of manual patient lifting in hospitals, nursing homes and other patient care settings that increase the risk to patients of injuries such as skin tears, skin ulceration, falls and shoulder dislocations. Moreover, workplace injuries to nurses, such as back, shoulder and neck injuries, exacerbate the nursing shortage with loss of work time or debilitating, career-ending injuries. The Committee urges AHRQ to study the impact of utilizing assistive devices and patient lifting equipment on patient injuries and outcomes, as well as the health and safety of nurses.

Action Taken or to be Taken:
AHRQ acknowledges the importance of the concern raised by the House and Senate Committees and will add this to the topics for investigation within the patient safety portfolio.

Spina Bifida

7. Senate (Rept. 110-107) p. 176
The Committee encourages AHRQ to continue its efforts to validate quality patient treatment data measures for the National Spina Bifida Patient Registry being developed in partnership with the Centers for Disease Control and Prevention. The Committee requests that the Agency report on the status of this effort in its fiscal year 2009 congressional budget justification.

Action Taken or to be Taken:
With guidance from the spina bifida community, CDC continues to make considerable progress in creating a standardized clinic registry to systematically collect data on patient care and outcomes. CDC will share the current clinic information form and other information relevant to creation of quality measures with AHRQ. AHRQ will work closely with CDC and the spina bifida community on identification and validation of potential quality measures. Quality measures may be able to be derived from the current clinic information form and registry, or may need to be newly developed. AHRQ will share its expertise in quality measurement and validation (e.g., guidance included on the National Quality Measures Clearinghouse website; expertise of staff and advisors for the National Healthcare Quality Report and the National Healthcare Disparities Report; expertise of staff and other experts for the AHRQ Quality Indicators; expertise of our survey groups [CAHPS and MEPS]) to ensure that spina bifida clinics can be assessed and compared for quality of care, and that individual clinics will have sufficient data to improve care quality, should there be an identified need. CDC expects the registry to be implemented in 6-8 pilot sites (clinics) in fiscal year 2008 and to have data to analyze by fiscal year 2009. AHRQ will work with CDC on the registry throughout this period.

Unit-of-use Packaging

8. Senate (Rept. 110-107) p. 176

The Committee is aware that the Institute of Medicine has recognized the potential benefits provided to patients by unit-of-use packaging, which are drug products dispensed directly to patients in containers that provide enough medication for use during a specified time interval. The Committee urges AHRQ to conduct a comprehensive study to evaluate unit-of-use packaging and design approaches that would support various patient populations in their medication self-management, including children, chronically ill patients, patients taking prescription narcotics, and patients taking antibiotics.

Action Taken or to be Taken:

AHRQ is sponsoring several projects through the Centers for Education and Research on Therapeutics (CERTs) on safe transmittal of pharmaceuticals. One CERT is developing an initiative to look at the impact on patient adherence of packing medications in " bubble" packaging that apportions their medications according to when on each day they should take them.

FY 2008 CONFERENCE REPORT NO. 110-424

Preventing Medical Errors

10. Conference (Report No. 110-424) p. 148
The conferees encourage AHRQ to look favorably on proposals that would proactively detect medical errors and preemptively control injury via compact medical devices that acquire, analyze and filter data from multiple, disparate, wireless and wired sources.

Action Taken or to be Taken:
Traditionally the approach to the identification of risks and hazards to patient safety and medical error has relied on retrospective approaches to the problem, using chart review, event reporting from health professionals and the use of administrative data. In order to support a more proactive approach to the identification of risks and hazards and medical error, AHRQ has and continues to support proactive risk assessment efforts through both grant and contract projects. Beginning in fiscal year 2004, AHRQ funded seven grant projects ($1.4 million) to explore different approaches to proactive risk assessment. In FY 2007, the Agency funded 20 new proactive risk assessment projects ($4.0 million) in the area of ambulatory care. AHRQ has also supported over 25 grants and 4 contracts ($25.5 million) looking a proactive identification of risks and hazards and medical errors using what has become known as clinical triggers which come from the medical record and other clinical information systems. The integration of clinical information and device systems to detect risks and hazards proactively and to manage complex clinical operations in a dynamic and proactive manner is an area of great promise. AHRQ will continue to encourage researchers to explore these issues as well implement systems such as Triggers into vendor electronic health records (EHRs). In summary, AHRQ has and is funding over 52 grants and 3 contracts in the area of proactive risk assessment and detection of risk and hazards and medical error. These activities are an import part of AHRQ's patient safety portfolio of research and implementation efforts. We will continue to support such efforts in the future.

Healthcare Model

11. Conference (Report No. 110-424) p. 148
The conferees encourage AHRQ to investigate the feasibility of an open-source, no-cost license computer model capable of predicting the effects of health care policy alternatives for the purpose of improving health care quality and cost-effectiveness. The model should be developed with a consortium of university partners and be capable of predicting costs and health impacts.

Action Taken or to be Taken:
AHRQ will investigate the feasibility of the development of such of an open-source, no-cost license computer model.

Special Requirements

FY 2009 HHS Enterprise IT Fund – PMA e-GOV Initiatives

The AHRQ will contribute $255,000 of its FY 2009 budget to support Department enterprise information technology initiatives as well as the President's Management Agenda (PMA) Expanding E-Government initiatives. Operating Division contributions are combined to create an Enterprise Information Technology (EIT) Fund that finances both the specific HHS information technology initiatives identified through the HHS Information Technology Capital Planning and Investment Control process and the PMA initiatives. These HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability. The HHS Department initiatives also position the Department to have a consolidated approach, ready to join in PMA initiatives.

Of the amount specified above, $78,327 is allocated to support the President's Management Agenda Expanding E-Government initiatives for FY 2009. This amount supports the PMA E-Government initiatives as follows:

PMA e-Gov Initiative	FY 2009 Allocation
Business Gateway	$0
E-Authentication	$0
E-Rulemaking	$0
E-Travel	$0
Grants.Gov	$12,651
Integrated Acquisition	$0
Geospatial LOB	$0
Federal Health Architecture LoB	$57,024
Human Resources LoB	$610
Grants Management LoB	$1,325
Financial Management LoB	$1,054
Budget Formulation & Execution LoB	$701
IT Infrastructure LoB	
Integrated Acquisition – Loans and Grants	$4,962
Disaster Assistance Improvement Plan	$0
TOTAL	$78,327

Prospective benefits from these initiatives are:

Grants.gov: Allows HHS to publish grant funding opportunities and application packages online while allowing the grant community (state, local and tribal governments, education and research organizations, non-profit organization, public housing agencies and individuals) to search for opportunities, download application forms, complete applications locally, and electronically submit applications using common forms, processes and systems. In FY 2007, HHS posted over 1,000 packages and received 108,436 application submissions – more than doubling 52,088 received in FY 2007 with NIH substantially increasing its applications submissions from 47,254 to 89,439 submissions. AHRQ continues to migrate to grants.gov in accordance with the NIH established timeline.

Lines of Business-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs. AHRQ participates in all departmental FHA activities and is prepared to leverage any and all agency appropriate information shared as a result of this effort.

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital. HHS has been selected as a Center of Excellence and will be leveraging its HR investments to provide services to other Federal agencies.

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. An HHS agency, Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence and has applied to be a GMLOB consortia lead. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes. AHRQ participates in all grants management solutions applicable to the agency.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Integrated Acquisition Environment for Loans and Grants: Managed by GSA, all agencies participating in the posting and/or awarding of Loans and Grants are required by the Federal Funding Accountability and Transparency Act (FFATA) to disclose award information on a publicly accessible website. Cross-government cooperation with the Office of Management and Budget's Integrated Acquisition Environment initiative in determining unique identifiers for Loans & Grants transactions furthers the agency in complying with the Transparency Act, which enhances transparency of federal program performance information, funding, and Loans & Grants solicitation.

Exhibit 300: Capital Asset Plan and Business Case Summaries

AHRQ's FY 2009 *Exhibit 300: Capital Asset Plan and Business Case Summaries* will be posted on the HHS website by February 19, 2008. The URL is www.hhs.gov/exhibit300.

Unified Financial Management System – Operations and Maintenance (UFMS O&M)

The Program Support Center, through the Service and Supply Fund, manages the ongoing Operations and Maintenance (O & M) activities for UFMS. The scope of O & M services includes post deployment support and ongoing business and technical operations services, as well as an upgrade of Oracle software from version 11.5.9 to version 12.0.   AHRQ will use $1,116,614 for these O&M costs in FY 2009.

HHS Consolidated Acquisition System (HCAS)

The HHS Consolidated Acquisition System (HCAS) initiative is a Department-wide contract management system that will integrate with the Unified Financial Management System (UFMS). The applications within the HCAS are Compusearch PRISM and a portion of the Oracle Compusearch Interface (OCI). PRISM is a federal contract management system that streamlines the procurement process. PRISM automates contract writing, simplified acquisitions, electronic approvals and routing, pre-award tracking, contract monitoring, post award tracking, contract closeout and reporting. AHRQ will use $80,626 to support the completion of HCAS implementation in FY 2009.