DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2016

Agency for Healthcare Research and Quality

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Agency for Healthcare
Research and Quality

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I am very pleased to present the FY 2016 Congressional Justification. This budget details the activities and effort needed to fulfill AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work with the U.S. Department of Health and Human Services (HHS) and with other partners to make sure that the evidence is understood and used.

AHRQ is well known for our research and collaboration with our public- and private-sector partners to improve the quality and safety of health care in such critical areas as reducing health care-associated infections and other potential harms when patients receive health care services. I am proud to announce that an AHRQ report released at the end of 2014 shows that hospital care was much safer in 2013 than in 2010. The report estimated that there were 1.3 million fewer harms to patients, 50,000 lives saved, and $12 billion in health care cost reductions from 2010 to 2013. The causes of this remarkable improvement are not fully understood, but are almost certainly related to AHRQ's patient safety activities, which have produced evidence over the past decade about how to improve safety, and to CMS' Partnership for Patients initiative, which provided technical assistance and focused hospitals' attention on the problem. The FY 2016 Budget includes $76.0 million in funding to continue patient safety research and will allow AHRQ to capitalize on its successful efforts to prevent and reduce healthcare-associated infections in hospitals and expand activities to the outpatient and long-term care settings. The FY 2016 Budget includes an additional $1 million, for a total of $10 million in support of the Presidential initiative on Combating Antibiotic-Resistant Bacteria.

The FY 2016 Budget also proposes an exciting new $12.0 million initiative to improve the care of people with multiple chronic conditions (MCC). The number of people with MCC is growing and currently comprises over one-quarter of the U.S. population and two-thirds of Medicare beneficiaries. Two-thirds of total health care spending in the United States is devoted to the care of people with multiple chronic conditions. Moreover, these individuals are at high risk for adverse health outcomes and have higher rates of disability, poor quality of life, and premature death. The purpose of this initiative is to optimize care for patients with MCC by 1) providing clinicians with evidence-based tools to develop integrated care plans that improve care coordination by comprehensively taking account of patients' health conditions, values, preferences, and relevant life circumstances, and 2) collecting and analyzing nationally representative data to examine the impact of integrated care plans and new care models on health care utilization and the quality of care provided to people with MCC.

AHRQ seeks to promote economy, efficiency, accountability, and integrity in the management of our research dollars to ensure that AHRQ is an effective steward of its finite resources. With our continued investment in successful programs that develop useful knowledge and tools, 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.

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Richard G. Kronick, Ph.D.
Director, Agency for Healthcare Research and Quality

Table of Contents

Letter from the Director i
Table of Contents ii
Organizational Chart iv

Performance Budget Overview
Introduction and Mission 1
Overview of AHRQ Budget Request by Portfolio 4
FY 2016 Performance Overview 6
Discretionary All-Purpose Table 8
AHRQ Discretionary Mechanism Table 9

Budget Exhibits
Appropriation Language 11
Amounts Available for Obligation 12
Summary of Changes 13
Budget Authority by Activity 15
Authorizing Legislation 16
Appropriations History 17
Appropriations Not Authorized by Law 18

Narrative by Activity

Research on Health Costs, Quality, and Outcomes (HCQO) 19

I. Patient Safety
A. Portfolio Overview 22
B. FY 2016 Justification by Activity Detail 22
C. Mechanism Table 27
D. Funding History 27

II. Health Services Research, Data and Dissemination
A. Portfolio Overview 28
B. FY 2016 Justification by Activity Detail 28
C. Mechanism Table 36
D. Funding History 36

III. Health Information Technology
A. Portfolio Overview 37
B. FY 2016 Justification by Activity Detail 37
C. Mechanism Table 40
D. Funding History 40

IV. U.S. Preventive Services Task Force (USPSTF)
A. Portfolio Overview 41
B. FY 2016 Justification by Activity Detail 41
C. Mechanism Table 44
D. Funding History 45

Key Performance Tables for HCQO 46

Medical Expenditure Panel Survey (MEPS)
A. Portfolio Overview 61
B. FY 2016 Justification by Activity Detail 61
C. Mechanism Table 65
D. Performance Summary 65
E. Funding History 68

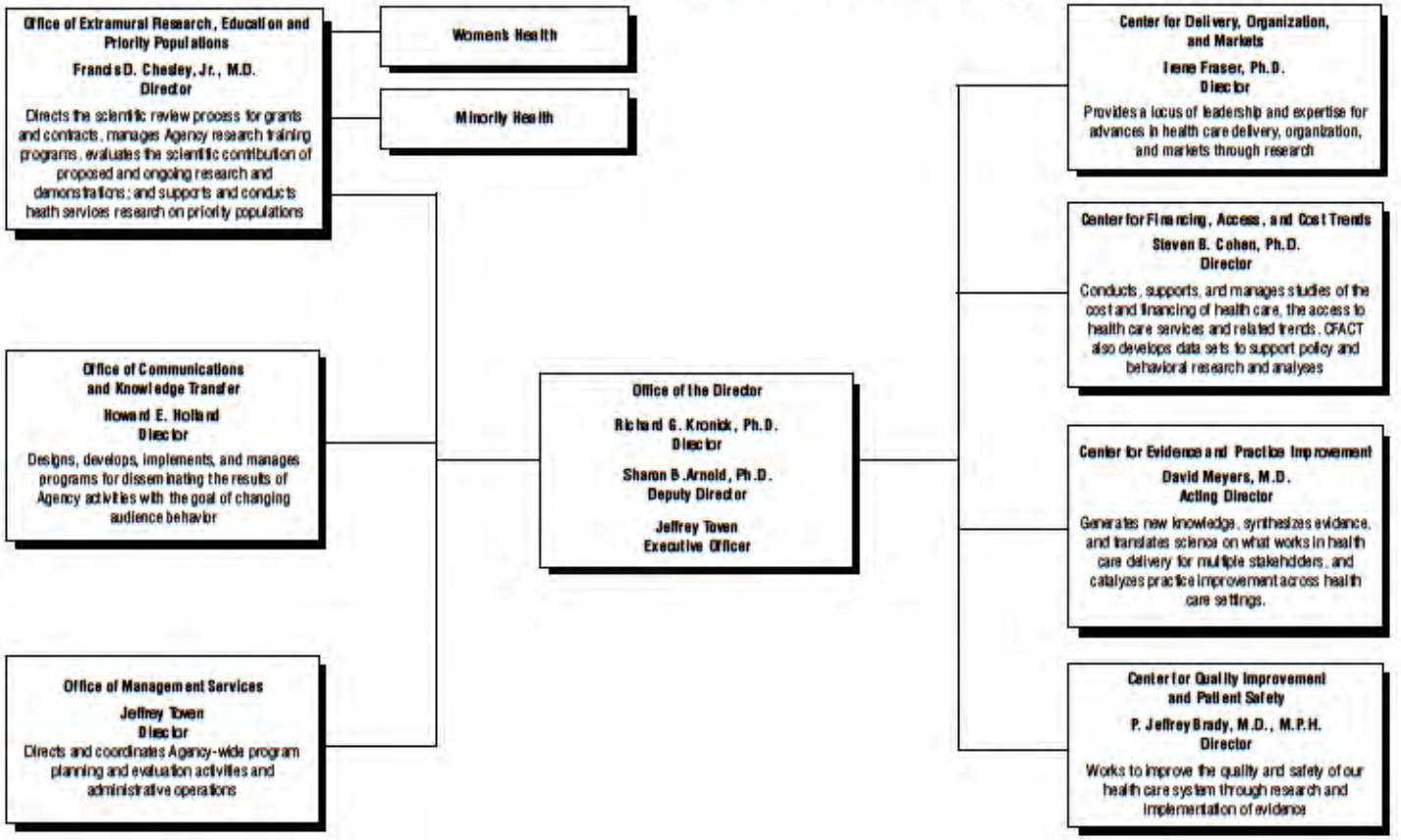
Program Support
A. Portfolio Overview 69
B. FY 2016 Justification by Activity Detail 69
C. Mechanism Table 71
D. Funding History 71

Supplementary Tables
Budget Authority by Object Class 73
Salaries and Expenses 75
Detail of Full-Time Equivalent Employment (FTE) 76
Detail of Positions 77
Physicians Comparability Allowance Worksheet 78
FTEs Funded by the Affordable Care Act 79

Patient-Centered Outcomes Research Trust Fund 80

Significant Items in Appropriations Committee Reports ..... N/A

U.S. Department of Health and Human Services
Agency for Healthcare Research and Quality



AHRQ Pub. No. 14-M005
Replaces AHRQ Pub. No. 13-M016
Revised July 2014

Performance Budget Overview

A. Introduction and Mission

AHRQ's FY 2016 Budget continues to support both AHRQ's mission and the four priorities first articulated in the FY 2015 Congressional Justification. AHRQ's mission is to produce evidence to make health care safer, higher quality, more accessible, equitable and affordable, and to work within the U.S. Department of Health and Human Services (HHS) and with other partners to make sure that the evidence is understood and used. To accompany this mission, AHRQ is focusing on the following research priorities:

Priority 1: Improve health care quality. The FY 2016 President's Budget supports this priority through both discretionary appropriated funding and mandatory funding through the Patient Centered Outcomes Research Trust Fund (PCORTF).

The FY 2016 President's Budget provides $12.0 million for an initiative that Optimizes Care for Patients with Multiple Chronic Conditions. People with multiple chronic conditions (MCC) represent a growing segment of the population and currently comprise over one-quarter of the U.S. population and two-thirds of Medicare beneficiaries. Two-thirds of total health care spending in the United States is devoted to the care of persons with multiple chronic conditions. Moreover, these individuals are at high risk for adverse health outcomes and have higher rates of disability, poor quality of life, and premature death. The purpose of this initiative is to optimize care for patients with MCC by 1) providing clinicians with evidence-based tools to develop integrated care plans[1,2] that comprehensively reflect patients' health conditions, values, preferences, and relevant life circumstances, and 2) collecting and analyzing nationally representative data to examine the impact of integrated care plans and new care models on health care utilization and the quality of care provided to people with MCC. This initiative aligns with the HHS Strategic Framework on Multiple Chronic Conditions and seeks to develop, test, and disseminate tools that enhance clinicians' abilities to develop integrated care plans that fully reflect the factors and circumstances that affect patients' efforts to manage their health. It also will examine how new care models and services that are transforming the health care delivery system may better serve the needs of people with MCC. Of the $12.0 million requested, $9.0 million is provided within the Health Services Research, Data, and Dissemination (HSR) portfolio for contracts to conduct this research. An additional $3.0 million is provided in the Medical Expenditure Panel Survey (MEPS) budget activity for data collection and analysis.

The FY 2016 President's Budget includes $5.0 million for a new effort to improve substance abuse (prescription drug and opioid) treatment. This funding is a component of a department-wide action plan being developed to ensure that this public health epidemic is addressed with resources commensurate with the national need. Increasing access to substance abuse treatment, including medication assisted treatment, is essential to effectively addressing

1 The Standards and Interoperability (S&I) Framework, Longitudinal Coordination of Care Work Group**.** December 2012. *Care Plan Terms & Proposed Definitions.* http://wiki.siframework.org/file/view/Care%20Plan%20Glossary_v25.doc/404538528/Care%20Plan%20Glossary_v25.doc accessed on September 4, 2014.

2 CMS. 2011. *Programs of All-Inclusive Care for the Elderly (PACE).* Chapter 8, Assessment and Care Planning. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pace111c08.pdf accessed on September 4, 2014.

prescription drug abuse. Primary care settings offer a tremendous opportunity for expanding access to medication assisted treatment, especially in rural areas that may lack access to community-based, specialty treatment centers. Due in part to a lack of knowledge about what works, relatively few primary care professionals and practices are providing evidence-based substance abuse treatment including medication assisted treatment. To respond to this need, AHRQ will invest $1 million to conduct a systematic evidence review on the implementation of medication assisted treatment in primary care settings. The evidence review will summarize what is known about the effects of alternative approaches to medication assisted treatment on patient outcomes, and identify where more research is needed. In addition, AHRQ will support $4 million of grants to develop and test new methods, processes, and tools for better implementing these treatment strategies.

AHRQ will use mandatory funding in FY 2016 provided through the PCORTF to improve health care quality and patient health outcomes. Work will be ongoing for regional cooperative grants awarded in FY 2015 (up to $45 million each year) that will accelerate the dissemination and implementation of PCOR findings into primary care practice. This will be a "boots on the ground" effort to help small- and medium-sized practices that typically do not have the quality improvement methods in place that have been implemented by some large health care systems. The initiative will be working with up to 6,000 primary care physicians caring for up to 9 million patients. The grantees will improve patient health through focusing on improving implementation of the Million Hearts™ campaign ABCS (**a**spirin use among people with heart disease, **b**lood pressure control, high blood **c**holesterol control, and **s**moking cessation advice and support) working towards the Million Hearts goal to prevent one million heart attacks and strokes by 2017. Working directly with primary care practices, the grantees will use evidence-based quality improvement techniques that may include practice assessment, benchmarking and feedback, expert consultation, local peer learning, clinical decision support, and practice facilitation (a type of organizational coaching). These grants will be rigorously assessed by an external evaluator that will examine improvements in patient health outcomes and delivery of the ABCS and whether and how quality improvement techniques allow for rapid and sustainable dissemination and implementation of PCOR evidence, including building capacity for evidence use by primary care practices.

Priority 2: Make health care safer. This priority builds on AHRQ's current patient safety research. The FY 2016 President's Budget provides $76.0 million for the patient safety portfolio. Included in this total is $14.5 million in continued funding for research grants and contracts related to the FY 2015 President's Budget Patient Safety Initiative. Our work in patient safety has primarily been focused in the hospital setting, where we have seen tremendous progress. Adverse events, such as hospital acquired infections, falls, pressure ulcers, and adverse drug events, declined by 17% between 2010 and 2013, with 1.3 million fewer adverse events, and an estimated 50,000 fewer deaths and $12 billion in cost savings. Building on our many successes in the hospital setting, FYs 2015 and 2016 will focus research on other settings of care, beginning with primary care and nursing home care safety – two health care settings in which patient safety research has not historically been focused. A total of $10.0 million in continuation grant support is also provided for AHRQ's "Patient Safety Learning Laboratories." These are places and professional networks where interrelated threats to patient safety can be identified by multidisciplinary teams which will engage in rapid prototyping techniques that stimulate patient safety improvements. A total of $34.0 million will be directed towards work to reduce healthcare associated infections, of which $10.0 million will be directed to AHRQ's efforts to address the growing threat of antibiotic resistant bacteria. Approximately $4.0 million will support the extension of the nationwide implementation of the Comprehensive Unit Safety Program (CUSP) to address the problem of persistently high rates of catheter-associated urinary tract infections

(CAUTI) and central line-associated blood stream infections (CLABSI) in some ICU settings. AHRQ will continue to work closely with colleagues at the CDC and CMS to disseminate and implement the evidence developed by AHRQ research, particularly with CMS' Quality Innovation Networks and the Partnership for Patients-funded Hospital Engagement Networks.

Priority 3: Increase accessibility. This priority focuses on providing evidence on changes in health insurance coverage and the associated impact on the health and financial security of the uninsured, on labor markets, on health care providers, particularly those in the safety net, and on employer and employee decisions with respect to employer-sponsored insurance. The FY 2016 President's Budget provides $68.9 million to support the Medical Expenditure Panel Survey (MEPS). MEPS is the only national source for comprehensive annual data on how Americans use and pay for medical care. The survey collects detailed information from families on access, use, expenses, insurance coverage and quality. The MEPS is designed to provide annual estimates at the national level of the health care utilization, expenditures, sources of payment and health insurance coverage of the U.S. civilian non-institutionalized population. The funding requested primarily supports data collection and analytical file production for the MEPS family of interrelated surveys, which include a Household Component (HC), a Medical Provider Component (MPC), and an Insurance Component (IC). In addition to collecting data that support annual estimates for a variety of measures related to health insurance coverage, healthcare use and expenditures, MEPS provides estimates of measures related to health status, demographic characteristics, employment, access to health care and health care quality. This year, applied research based upon MEPS led to the formulation and adoption of two CHIP policy recommendations by the Medicaid and CHIP Payment Advisory Commission (MACPAC): (1) Eliminate CHIP premiums for children in families under 150 percent of the Federal Poverty Line and (2) Re-authorize CHIP in 2015.

Priority 4: Improve health care affordability, efficiency and cost transparency. This priority focuses on producing evidence that will increase the affordability, efficiency and quality of health care for all Americans. The FY 2016 Request provides $1.5 million in new research on paying for value. The Administration is committed to increasingly link payments to quality and value, and not simply to the volume of health care services delivered. We are proposing an initiative that would fund targeted research to identify types of health care that are amenable to strong financial incentives. We will take into consideration the level at which incentives are given, the interaction between type of service and level of care, external versus internal incentives, and how to deal with issues of gaming, risk selection, teaching to the test, and whether strong incentives would be likely to increase or decrease racial/ethnic or socioeconomic disparities. For those health care services that are not amenable to strong financial incentives, we will identify alternative innovative accountability mechanisms that might be used.

B. Overview of AHRQ Budget Request by Portfolio

AHRQ Budget Detail
(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 P.B. +/- FY 2015 Enacted
Research on Health Costs, Quality, and Outcomes (HCQO):				
Patient Safety	$71,584	$76,584	$75,977	-$607
Health Services Research, Data and Dissemination	$111,072	$112,207	$112,274	+$67
Health Information Technology	$29,572	$28,170	$22,877	-$5,293
U.S. Preventive Services Task Force	$22,904	$11,590	$11,649	+$59
Budget Authority	*$0*	*$11,590*	*$11,649*	*+$59*
PHS Evaluation Funds	*$15,904*	*$0*	*$0*	*$0*
USPSTF - Prevention and Public Health Fund	*$7,000*	*$0*	*$0*	*$0*
Value	$3,252	$0	$0	$0
Subtotal HQCO	**$238,384**	**$228,551**	**$222,777**	**-$5,774**
HCQO, Budget Authority	*0*	*$228,551*	*$134,889*	*-$93,662*
HCQO, PHS Evaluation Funds	*$231,384*	*$0*	*$87,888*	*+$87,888*
HCQO, Prevention and Public Health Funds	*$7,000*	*$0*	*$0*	*$0*
Medical Expenditure Panel Survey	**$63,811**	**$65,447**	**$68,877**	**+$3,430**
Program Support	**$68,813**	**$69,700**	**$72,044**	**+$2,344**
Total Budget Authority	**$0**	**$363,698**	**$275,810**	**-$87,888**
Total PHS Evaluation Funds	**$364,008**	**$0**	**$87,888**	**+$87,888**
Total Prevention and Public Health Fund	**$7,000**	**$0**	**$0**	**$0**
PCORTF Transfer 1/	**$65,402**	**$101,306**	**$115,636**	**+$14,330**
Total Program Level	**$436,410**	**$465,004**	**$479,334**	**+$14,330**

1/ Mandatory Funds

AHRQ's total program level at the FY 2016 President's Budget is $479.3 million, an increase of $14.3 million or +3.1 percent from the FY 2015 Enacted level. This increase is entirely attributable to growing amounts of mandatory funds available to be transferred from the Patient-Centered Outcomes Research Trust Fund (PCORTF), which are expected to total $115.6 million in FY 2016. AHRQ's Budget includes $275.8 million in budget authority and $87.9 million in PHS Evaluation funds.

Within Research on Health Costs, Quality and Outcomes, the research and specific funding changes for programs that fit within them are:

- Patient Safety Research is funded at $76.0 million at the FY 2016 President's Budget level, a decrease of $0.6 million from the prior year. FY 2016 funding provides $35.0 million for general research support relating to Patient Safety Risks and Harms. These funds will focus on continued investments in research to identify and prevent risks and hazards, as well as

efforts to translate promising safe practices identified through research into tools and resources that facilitate changes in practice, delivery, and communication patterns. The Patient Safety budget also provides $34.0 million directed to research with a focus on prevention of Healthcare-Associated Infections (HAIs), the same level of support as the prior year. Included in this total is $10.0 million in support of the President's National Strategy for Combating Antibiotic-Resistant Bacteria (CARB). In addition, support will be provided to continue the operation of the Patient Safety Organizations (PSO) program ($7.0 million).

- Health Services Research, Data and Dissemination is funded at $112.3 million, an increase of $0.1 million from the FY 2015 Enacted level. The FY 2016 President's Budget provides support for a new initiative that Optimizes Care for Patients with Multiple Chronic Conditions (MCC). The purpose of this initiative is to optimize care for patients with MCC by 1) providing clinicians with evidence-based tools to develop integrated care plans that comprehensively take account of patients' health conditions, values, preferences, and relevant life circumstances, and 2) collecting and analyzing nationally representative data to examine the impact of integrated care plans and new Affordable Care Act-supported care models on health care utilization and the quality of care provided to people with MCC. AHRQ is requesting $9.0 million within the HSR portfolio and $3.0 million from the Medical Expenditure Panel Survey for this initiative. The FY 2016 President's Budget also provides $5 million to abuse treatment efforts. This funding is part of a larger HHS initiative to ensure that this public health epidemic receives resources commensurate with both the Department's attention to this issue and the national need for additional federal efforts. AHRQ's role in the HHS initiative is to generate evidence that will be needed by other parts of HHS to improve treatment across the country.

Effective Health Insurance Initiative

AHRQ, in collaboration with the Office of the Assistant Secretary for Planning and Evaluation, will lead a new $30 million initiative funded in the Public Health and Social Services Emergency Fund that will examine how features of health insurance benefit packages affect health care utilization, costs, and outcomes. The goal of this study is to produce rigorous evidence about how the structure of health insurance can be modernized in a way that improves outcomes while controlling costs.

This new project will use a gold standard randomized controlled trial study design to update the Health Insurance Experiment, a pioneering trial funded by the then-Department of Health, Education, and Welfare that has shaped the structure of health insurance plans ever since. The Health Insurance Experiment, conducted in the 1970s, produced valuable information about the effects of cost sharing on utilization and outcomes, but much has changed in the intervening forty years, including the proliferation of managed care, narrow networks, the increasing importance of pharmaceuticals and tiered prescription drug benefits, and the growth of value-based insurance designs. As a result of the many changes in insurance design and delivery models over the past forty years, updated estimates of patient response to variations in cost sharing are needed to facilitate the design of insurance policies that maximize value to patients.

Please see the Public Health and Social Services Emergency Fund's FY 2016 President's Budget for additional details.

- Health Information Technology Research is funded at $22.9 million, a decrease of $5.3 million from the FY 2015 level. The FY 2016 President's Budget level provides $6.9 million in new research grants for investigator-initiated health IT research, providing a total of $20.0 million in research grant support.

- U.S. Preventive Services Task Force (USPSTF) is funded at $11.6 million at the FY 2016 President's Budget level, a slight increase of $0.1 million from the prior year. The USPSTF is

an independent, volunteer panel of national experts in prevention and evidence-based medicine whose mission is to improve the health of all Americans by making evidence-based recommendations about the effectiveness of clinical preventive services and health promotion. AHRQ provides ongoing scientific, administrative and dissemination support to assist the USPSTF in meeting their mission.

The Medical Expenditure Panel Survey (MEPS) will be funded at $68.9 million, an increase of $3.4 million from the FY 2015 Enacted. This funding level will allow MEPS to operate at current levels. In addition, an increase of $3.0 million is proposed related to AHRQ's new initiative to Optimize Care for Patients with MCC. These new funds will support collecting and analyzing nationally representative data to examine the impact of integrated care plans and new care models on health care utilization and the quality of care provided to people with MCC.

Program Support (PS) will be funded at $72.0 million, an increase of $2.3 million or +3.4 percent over the FY 2015 Enacted level. Of the total increase, $1.5 million is associated with our physical relocation to 5600 Fisher's Lane. A total of $0.7 million is required to support a 1.3 percent pay increase and $0.1 million is provided for inflationary increases for operating expenses.

Full Time Equivalents (FTEs)

The workforce at AHRQ includes talented scientific, programmatic, and administrative staff who work to fulfill AHRQ's mission. The table below summarizes current full- time equivalent (FTE) levels funded with PHS Evaluation Funds and the PCORTF.

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
FTEs – PHS Evaluation Funds	294	300	300
FTEs – PCORTF	13	25	25
FTEs – Other Reimbursable	7	6	6

C. Overview of Performance

AHRQ's mission is to produce evidence to make health care safer, higher quality, more accessible, equitable and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used. AHRQ's portfolios, programs, and activities operationalize the Agency's mission and priorities. The funding of specific programs and activities is driven by research priorities focusing on: 1) improving health care quality and patient health outcomes; 2) producing evidence to make health care safer; 3) increasing accessibility by providing evidence on the effects of health insurance coverage expansions; and 4) improving health care affordability, efficiency and cost transparency.

Throughout fiscal year 2014, portfolios and programs have reported on key accomplishments, including: Patient Safety – reduced the rate of catheter-associated urinary tract infections (CAUTI) by 15.2% from baseline; and, increased the number of tools, evidence-based information, and products available for use by healthcare organizations; Health IT – improved Personal Health Information Management (PHIM) by building the evidence and providing information to people about managing their health in ways that are meaningful and useful to them; Health Services Research, Data and Dissemination – supported measurement, data collection, and dissemination and translation activities of AHRQ-funded research, products, and

tools through the use of: Consumer Assessment of Healthcare Providers and Systems (CAHPS) worked with the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare and Medicaid Services (CMS) and developed a CAHPS Survey called the Quality Health Plan Survey (QHP); the MONAHRQ software (My Own Network, Powered by AHRQ) released a redesigned version (MONAHRQ 5.0) for States' to use to build public healthcare reporting websites that analyzes, summarizes, and presents information in a format ready for use by consumers and other decision makers; and, the AHRQ Quality Indicators (QIs) used by many organizations, hospitals, and healthcare systems to measure and report on quality and performance; and, Medical Expenditure Panel Survey (MEPS) – collected data on how Americans use and pay for medical care, and used this data for the formulation and adoption of two Children's Health Insurance Program (CHIP) policy recommendations by the Medicaid and CHIP Advisory Commission (MACPAC).

Also, AHRQ's mission and research priorities support the HHS Strategic Goals to Strengthen Health Care; Advance Scientific Knowledge and Innovation; Advance the Health, Safety and Well-Being of the American People; and Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs.

AHRQ continues to work with HHS and OMB to set performance goals and measures that support activities meaningful to the Agency, and that support the President's Management Agenda, HHS Priority Goals, and Strategic Reviews.

Discretionary All-Purpose Table 1/

(dollars in thousands)

Program	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
RESEARCH ON HEALTH COSTS, QUALITY AND OUTCOMES				
Patient Safety	**$71,584**	**$76,584**	**$75,977**	**-$607**
Budget Authority	*$0*	*$76,584*	*$75,977*	*-607*
PHS Evaluation Fund	*$71,584*	*$0*	*$0*	*$0*
Health Services Research, Data and Dissemination	**$111,072**	**$112,207**	**$112,274**	**+$67**
Budget Authority	*$0*	*$112,207*	*$24,386*	*-87,821*
PHS Evaluation Fund	*$111,072*	*$0*	*$87,888*	*+$87,888*
Health Information Technology	**$29,572**	**$28,170**	**$22,877**	**-$5,293**
Budget Authority	*$0*	*$28,170*	*$22,877*	*-5,293*
PHS Evaluation Fund	*$29,572*	*$0*	*$0*	*$0*
U.S. Preventive Services Task Force	**$22,904**	**$11,590**	**$11,649**	**+$59**
Budget Authority	*$0*	*$11,590*	*$11,649*	*+59*
PHS Evaluation Fund	*$15,904*	*$0*	*$0*	*$0*
Prevention and Public Health Fund 3/	*$7,000*	*$0*	*$0*	*$0*
Value Research	**$3,252**	**$0**	**$0**	**$0**
Budget Authority	*$0*	*$0*	*$0*	*0*
PHS Evaluation Fund	*$3,252*	*$0*	*$0*	*$0*
Budget Authority	**$0**	**$228,551**	**$134,889**	**-$93,662**
PHS Evaluation	**$231,384**	**$0**	**$87,888**	**+$87,888**
ACA Funds - Prevention and Public Health Fund 2/	*$7,000*	*$0*	*$0*	*$0*
Subtotal, HCQO Program Level	**$238,384**	**$228,551**	**$222,777**	**-$5,774**
MEDICAL EXPENDITURE PANEL SURVEY				
Budget Authority	$0	$65,447	$68,877	+$3,430
PHS Evaluation	$63,811	$0	$0	$0
Subtotal, MEPS	**$63,811**	**$65,447**	**$68,877**	**+$3,430**
PROGRAM SUPPORT				
Budget Authority	$0	$69,700	$72,044	+$2,344
PHS Evaluation	$68,813	$0	$0	$0
Subtotal, Program Support	**$68,813**	**$69,700**	**$72,044**	**+$2,344**
SUBTOTAL				
Budget Authority	**$0**	**$363,698**	**$275,810**	**-$87,888**
PHS Evaluation	**$364,008**	**$0**	**$87,888**	**+$87,888**
ACA Funds - Prevention and Public Health Fund 3/	**$7,000**	**$0**	**$0**	**$0**
Subtotal	**$371,008**	**$363,698**	**$363,698**	**$0**
PCORTF Transfer 2/	$65,402	$101,306	$115,636	+$14,330
TOTAL PROGRAM LEVEL	**$436,410**	**$465,004**	**$479,334**	**+$14,330**
FTEs				
Budget Authority	**0**	**300**	**300**	**0**
PHS Evaluation	**294**	**0**	**0**	**0**
ACA Funds - Prevention and Public Health Fund 2/	**0**	**0**	**0**	**0**
ACA Funds - PCORTF Transfer 2/	**13**	**25**	**25**	**0**
TOTAL PROGRAM LEVEL	**307**	**325**	**325**	**0**

1/ Excludes funding and FTE from other HHS operating divisions provided through reimbursable agreements.

2/ Mandatory funds.

AHRQ Discretionary Mechanism Table 1/

(Dollars in Thousands)

	FY 2014 Enacted		FY 2015 Enacted		FY 2016 Request	
	No.	Dollars	No.	Dollars	No.	Dollars
RESEARCH GRANTS						
Non-Competing						
Patient Safety	37	12,192	55	17,113	100	32,365
Health Serv Res, Data & Diss	91	27,277	82	26,824	106	32,936
Health Information Technology	36	14,212	59	18,298	33	13,087
U.S. Preventive Services Task Force	7	1,325	0	0	0	0
Value	0	0	0	0	0	0
Medical Expenditure Panel Survey	0	0	0	0	0	0
Total Non-Competing	171	55,006	196	62,235	239	78,388
New & Competing						
Patient Safety	64	19,826	50	18,357	26	9,235
Health Serv Res, Data & Diss	103	26,030	109	25,939	65	17,969
Health Information Technology	24	10,243	15	6,383	22	6,889
U.S. Preventive Services Task Force	14	4,063	0	0	0	0
Value	0	0	0	0	0	0
Medical Expenditure Panel Survey	0	0	0	0	0	0
Total New & Competing	197	60,162	174	50,679	113	34,093
RESEARCH GRANTS						
Patient Safety	101	32,018	105	35,470	126	41,600
Health Serv Res, Data & Diss	194	53,307	191	52,763	171	50,905
Health Information Technology	60	24,455	74	24,681	55	19,976
U.S. Preventive Services Task Force	21	5,388	0	0	0	0
Value	0	0	0	0	0	0
Medical Expenditure Panel Survey	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	368	115,168	370	112,914	352	112,481
CONTRACTS/IAAs						
Patient Safety		39,566		41,114		34,377
Health Serv Res, Data & Diss		57,765		59,444		61,369
Health Information Technology		5,117		3,489		2,901
U.S. Preventive Services Task Force		10,516		11,590		11,649
Value		3,252		0		0
Medical Expenditure Panel Survey		63,811		65,447		68,877
TOTAL CONTRACTS/IAAs		180,027		181,084		179,173
RESEARCH MANAGEMENT		68,813		69,700		72,044
GRAND TOTAL						
Patient Safety		71,584		76,584		75,977
Health Serv Res, Data & Diss		111,072		112,207		112,274
Health Information Technology		29,572		28,170		22,877
U.S. Preventive Services Task Force		15,904		11,590		11,649
Value		3,252		0		0
Medical Expenditure Panel Survey		63,811		65,447		68,877
Research Management		68,813		69,700		72,044
GRAND TOTAL		364,008		363,698		363,698

1/ Does not include ACA funds from the PCORTF.

Budget Exhibits – Table of Contents

Budget Exhibits

Appropriation Language....11
Amounts Available for Obligation....12
Summary of Changes....13
Budget Authority by Activity....15
Authorizing Legislation....16
Appropriations History....17
Appropriations Not Authorized by Law....18

Appropriation Language

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

HEALTHCARE RESEARCH AND QUALITY

For carrying out titles III and IX of the PHS Act, part A of title XI of the Social Security Act, and section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, $363,698,000*, of which $87,888,000 shall be from funds available under section 241 of the PHS Act: Provided*, That section 947(c) of the PHS Act shall not apply in fiscal year **[2015]** *2016*: *Provided further*, That in addition, 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 **[September 30, 2016]** *expended. (Department of Health and Human Services Appropriations Act, 2015.)*

Amounts Available for Obligation

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Amounts Available for Obligation 1/

	2014 Actual 2/	FY 2015 Enacted	FY 2016 President's Budget
Appropriation:			
Annual	$0	$363,698,000	$275,810,000
Subtotal, adjusted appropriation	$0	$363,698,000	$275,810,000
Offsetting Collections from:			
Federal funds pursuant to Title IX of P.L. 102-410, (Section 947(c) PHS Act)			
HCQO	$231,098,000	$0	$87,888,000
MEPS	$63,811,000	$0	$0
Program Support	$68,812,000	$0	$0
Subtotal, adjusted appropriation	$363,721,000	$0	$87,888,000
Unobligated Balance Lapsing	$287,000	---	---
Total obligations	$364,008,000	$363,698,000	$363,698,000

1/ Excludes funding from other HHS operating divisions provided through reimbursable agreements.
2/ Reflects actual obligations. Excludes obligations from other reimbursable funds.

Summary of Changes

2015 Total estimated budget authority	$363,698,000
(Obligations)	**($363,698,000)**
2016 Total estimated budget authority	$275,810,000
(Obligations)	**($363,698,000)**
Net change	-$87,888,000
(Obligations)	**($0)**

Increases	2015 Estimate (FTE)	2015 Estimate Budget	Change from Base (FTE)	Change from Base Budget Authority
A. Program Support (Built-in)				
1. Salary and Benefits	300	47,421,000	0	+761,000
	(300)	(47,421,000)	(0)	(+761,000)
2 Increase costs to move to 5600 Fishers Lane and	0	0	0	+1,583,000
and inflation on other object classes	(0)	(0)	(0)	(+1,583,000)
Subtotal, Built-in			**0**	**+2,344,000**
			(0)	**(+2,344,000)**
B. Program				
1. Health Services Research, Data and Dissemination	0	112,207,000	0	0
	(0)	(112,207,000)	(0)	(+67,000)
2. U.S. Preventive Services Task Force	0	11,590,000	0	+59,000
	(0)	(11,590,000)	(0)	(+59,000)
3. Medical Expenditure Panel Survey	0	65,447,000	0	+3,430,000
	(0)	(65,447,000)	(0)	(+3,430,000)
Subtotal, Program			**0**	**+3,489,000**
			(0)	**(+3,556,000)**
Total Increases			**0**	**+5,833,000**
			(0)	**(+5,900,000)**

Summary of Changes Continued

Decreases	2015 Estimate		Change from Base	
A. Program Support (Built-in)	(FTE)	Budget	(FTE)	Budget Authority
Subtotal, Built-in			**--**	**0**
			(0)	**(0)**
B. Program				
1. Health Services Research, Data and Dissemination	0	112,207,000	0	-87,821,000
	(0)	(112,207,000)	(0)	(0)
2. Patient Safety	0	76,584,000	0	-607,000
	(0)	(76,584,000)	(0)	-(607,000)
3. Health Information Technology	0	28,170,000	0	-5,293,000
	(0)	(28,170,000)	(0)	-(5,293,000)
Subtotal, Program	**0**	**0**	**0**	**-93,721,000**
	(0)	**(0)**	**(0)**	**-(5,900,000)**
Total Decreases			**0**	**-93,721,000**
			(0)	**-(5,900,000)**
Net change, Budget Authority			**0**	**-87,888,000**
Net change, Obligations			**(0)**	**(0)**

Budget Authority by Activity

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Budget Authority by Activity 1/
(Dollars in thousands)

	FY 2014 Actual		FY 2015 Base		FY 2016 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
1. Research on Health Costs, Quality, & Outcomes BA	---	0	---	$228,551	---	134,889
PHS Evaluation	[0]	[$231,384]	---	---	[0]	[$87,888]
Total Operational Level	0	231,384	---	228,551	0	222,777
2. Medical Expenditures Panel Surveys BA	---	---	---	65,447	---	68,877
PHS Evaluation	---	[63,811]	---	---	---	---
Total Operational Level	---	63,811	---	65,447	---	68,877
3. Program Support BA	---	---	300	69,700	300	72,044
PHS Evaluation	[294]	[68,813]	---	---	---	---
Total Operational Level	294	68,813	300	69,700	300	72,044
Total, Budget Authority	0	0	300	$363,698	300	275,810
Total PHS Evaluation	[294]	[364,008]	---	---	[0]	[$87,888]
Total Operations	294	$364,008	300	$363,698	300	$363,698

1/ Excludes funding and FTE from other HHS operating divisions provided through reimbursable agreements. Also, excludes mandatory funding from the Prevention and Public Health Fund and the PCORTF.

Authorizing Legislation 1/

	FY 2015 Amount Authorized	FY 2015 Appropriations Act	2016 Amount Authorized	FY 2016 President's Budget
Research on Health Costs, Quality, and Outcomes:				
Secs. 301 & 926(a) PHSA.....	SSAN	$228,551,000	SSAN	$134,889,000
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/	
Medical Expenditure Panel Surveys:				
Sec. 947(c) PHSA.....	SSAN	$65,447,000	SSAN	$68,877,000
Program Support:				
Section 301 PHSA.....	Indefinite	$69,700,000	Indefinite	$72,044,000
Evaluation Funds:				
Section 947 (c) PHSA	Indefinite	$0	Indefinite	$87,888,000
Total appropriations.....		$363,698,000		$363,698,000
Total appropriation against definite authorizations.....	----	----	----	----

SSAN = Such Sums As Necessary

1/ Section 487(d) (3) PHSA makes one percent of the funds appropriated to NIH 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, 2005.

AHRQ Appropriations History

	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriation	
2008					
Budget Authority	$ -	$ 329,564,000	$ 329,564,000	$ -	
PHS Evaluation Funds	$ 329,564,000	$ -	$ -	$ 334,564,000	
Total	$ 329,564,000	$ 329,564,000	$ 329,564,000	$ 334,564,000	
2009					
Budget Authority	$ -	$ 323,087,000	$ 90,598,000	$ -	
PHS Evaluation Funds	$ 325,664,000	$ 51,913,000	$ 243,966,000	$ 372,053,000	
ARRA Funding P.L. 111-5	$ -	$ -	$ -	$ 1,100,000,000	1/
Total	$ 325,664,000	$ 375,000,000	$ 334,564,000	$ 1,472,053,000	
2010					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 372,053,000	$ 372,053,000	$ 372,053,000	$ 397,053,000	
Total	$ 372,053,000	$ 372,053,000	$ 372,053,000	$ 397,053,000	
2011					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 610,912,000	$ -	$ 397,053,000	$ 372,053,000	
Total	$ 610,912,000	$ -	$ 397,053,000	$ 372,053,000	
2012					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 366,397,000	$ 324,294,000	$ 372,053,000	$ 369,053,000	
Total	$ 366,397,000	$ 324,294,000	$ 372,053,000	$ 369,053,000	
2013					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 334,357,000	$ -	$ 364,053,000	$ 365,362,000	
Total	$ 334,357,000	$ -	$ 364,053,000	$ 365,362,000	
2014					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 333,697,000	$ -	$ 364,008,000	$ 364,008,000	
Total	$ 333,697,000	$ -	$ 364,008,000	$ 364,008,000	
2015					
Budget Authority	$ -	$ -	$ 373,295,000	$ 363,698,000	
PHS Evaluation Funds	$ 334,099,000	$ -	$ -	$ -	
Total	$ 334,099,000	$ -	$ 373,295,000	$ 363,698,000	
2016					
Budget Authority	$ 275,810,000	$ -	$ -	$ -	
PHS Evaluation Funds	$ 87,888,000	$ -	$ -	$ -	
Total	$ 363,698,000	$ -	$ -	$ -	

1/ In FY 2009, the American Recovery and Reinvestment Act (ARRA) provided $1,100,000,000 for research that compares the effectiveness of medical options. Of this total, $400,000,000 was transferred to the National Institute of Health and a total of $400,000,000 was allocated at the discretion of the Secretary of the Department of Health and Human Services. A new Federal Coordinating Council helped set the agenda for these funds. The remaining $300,000,000 was available for the AHRQ. These funds were obligated in FY 2009 and FY 2010.

Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level in Last Year of Authorization	Appropriations in Last Year of Authorization	Appropriations in FY 2015
Research on Health Costs, Quality, and Outcomes……	FY 2005	Such Sums As Necessary	$260,695,000	$363,698,000

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

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 P.B. +/- FY 2015 Enacted
TOTAL				
--BA	$0	$228,551,000	$134,889,000	-$93,662,000
--PHS Eval	$231,384,000	$0	$87,888,000	$87,888,000
--Prev. & Public Hlth Fund	$7,000,000	$0	$0	$0
Total Program Level	$ 238,384,000	$ 228,551,000	$ 222,777,000	-$5,774,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act and Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.

FY 2014 authorization……..……..……..Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

Summary

AHRQ's Program Level for Research on Health Costs, Quality, and Outcomes (HCQO) at the FY 2016 Request Level is $222.8 million, a decrease of $5.8 million or -2.5 percent from the FY 2015 Enacted level. This includes $134.9 million in discretionary budget authority and $87.9 million in PHS Evaluation Funds.

AHRQ Budget Detail

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 P.B. +/- FY 2015 Enacted
Research on Health Costs, Quality, and Outcomes (HCQO):				
Patient Safety	$71,584	$76,584	$75,977	-$607
Health Services Research, Data and Dissemination	$111,072	$112,207	$112,274	+$67
Health Information Technology	$29,572	$28,170	$22,877	-$5,293
U.S. Preventive Services Task Force	$22,904	$11,590	$11,649	+$59
Budget Authority	*$0*	*$11,590*	*$11,649*	*+$59*
PHS Evaluation Funds	*$15,904*	*$0*	*$0*	*$0*
USPSTF - Prevention and Public Health Fund	*$7,000*	*$0*	*$0*	*$0*
Value	$3,252	$0	$0	$0
Subtotal HQCO	**$238,384**	**$228,551**	**$222,777**	**-$5,774**
HCQO, Budget Authority	*0*	*$228,551*	*$134,889*	*-$93,662*
HCQO, PHS Evaluation Funds	*$231,384*	*$0*	*$87,888*	*+$87,888*
HCQO, Prevention and Public Health Funds	*$7,000*	*$0*	*$0*	*$0*

The AHRQ mission is pursued by four research portfolios within HCQO:

- Patient Safety Research: 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.

- Health Services Research, Data and Dissemination: This portfolio funds foundational health services research through research grants and contracts to our research community. In addition, this portfolio funds critical data collection and measurement activities, dissemination and translation, and program evaluation.

- Health Information Technology Research: Health IT research develops and disseminates evidence and evidence-based tools to inform policy and practice on how Health IT can improve the quality of American health care.

- U.S. Preventive Services Task Force: The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in prevention and evidence-based medicine whose mission is to improve the health of all Americans by making evidence-based recommendations about the effectiveness of clinical preventive services and health promotion. This portfolio provides ongoing scientific, administrative, and dissemination support to assist the USPSTF in meeting its mission.

Major Changes by Research Portfolio
The major changes in HCQO by research portfolio are provided below.

***Program increases at FY 2016 President's Budget Level*:**

HCQO: Health Services Research, Data and Dissemination (+$0.1 million): The FY 2016 President's Budget level provides $112.3 million for the Health Services Research, Data and Dissemination (HSR) portfolio, an increase of $0.1 million from the FY 2015 Enacted. Within this amount, the FY 2016 President's Budget provides $9.0 million in research contracts within HSR (and $3.0 million for the Medical Expenditure Panel Survey budget activity) to support an initiative to Optimize Care for Patients with Multiple Chronic Conditions. A total of $5.0 million is also provided to support prescription drug overdose prevention efforts.

HCQO: U.S. Preventive Services Task Force (+$0.1 million): The FY 2016 President's Budget provides $11.6 million for the USPSTF, a slight increase of $0.1 million from the prior year. The USPSTF is an independent, volunteer panel of national experts in prevention and evidence-based medicine whose mission is to improve the health of all Americans by making evidence-based recommendations about the effectiveness of clinical preventive services and health promotion. AHRQ provides ongoing scientific, administrative and dissemination support to assist the USPSTF in meeting their mission.

Program decreases at FY 2016 President's Budget Level:

HCQO: Patient Safety Research (-$0.6 million): The FY 2016 President's Budget provides $76.0 million, a decrease of $0.6 million from the prior year. FY 2016 funding provides $35.0 million for general research support relating to Patient Safety Risks and Harms. These funds will focus on

continued investments in research to identify and prevent risks and hazards, as well as efforts to translate promising safe practices identified through research into tools and resources that facilitate changes in practice, delivery, and communication patterns. The Patient Safety budget also provides $34.0 million directed to research with a focus on prevention of Healthcare-Associated Infections (HAIs), the same level of support as the FY 2015 President's Budget level. Included in this total is $10.0 million in support of the Presidential-level initiative on Combating Antibiotic-Resistant Bacteria (CARB). Support will also be provided to continue the operation of the Patient Safety Organizations (PSO) program ($7.0 million).

HCQO: Health Information Technology (-$5.3 million): The FY 2016 President's Budget provides $22.9 million for the Health Information Technology portfolio, a decrease of $5.3 million from the FY 2015 Enacted level. The FY 2016 President's Budget provides $20.0 million in research grants support, a decrease of $4.7 million from the FY 2015 Enacted level. A total of $2.9 million, a decrease of $0.6 million from the prior year, is provided for research contracts that synthesize and disseminate evidence on the meaningful use of health information technology.

Patient Safety

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 P.B. +/- FY 2015 Enacted
TOTAL				
--BA	$0	$76,584,000	$75,977,000	-$607,000
--PHS Eval	$ 71,584,000	$0	$0	$0

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2014 Authorization……..……..……..……..Expired.
Allocation Method……....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Program Description and Accomplishments

The Patient Safety Portfolio's mission is to prevent, mitigate, and decrease patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients. This mission is accomplished by funding health services research in the following activities: Patient Safety Risks and Harms, Patient Safety Organizations (PSOs), Patient Safety and Medical Liability Reform, and Healthcare-Associated Infections (HAIs). Projects within the program seek to inform multiple stakeholders including health care organizations, providers, policymakers, researchers, patients and others; disseminate information and implement initiatives to enhance patient safety and quality; establish cultures in healthcare organizations that support patient safety; and maintain vigilance through adverse event reporting and surveillance in order to prevent patient harm. The program is directly aligned with the mission of the Department of Health and Human Services and leverages collaborative projects with other federal and non-federal entities to achieve positive impacts.

B. FY 2016 Justification by Activity Detail

Patient Safety Research Activities
(in millions of dollars)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Patient Safety Risks and Harms	$30.584	$35.584	$34.977
Patient Safety Organizations (PSOs)	7.000	7.000	7.000
Patient Safety and Medical Liability Reform	0.000	0.000	0.000
Healthcare-Associated Infections (HAIs)	34.000	34.000	34.000
Patient Safety Research Activities	**$71.584**	**$76.584**	**$75.977**

Overall Budget Policy:

Patient Safety Risks and Harms: The Patient Safety Research Program focuses on the risks and harms inherent in the delivery of health care for a variety of conditions in all health care settings, including the hospital, ambulatory and long-term care facilities, and the home. These

activities are vital for understanding the factors that can contribute to patient safety events ("adverse events"), and how to prevent them. Research funded in FY 2014 and 2015 builds on past successes and focuses on the expansion of projects that have demonstrated impact in improving healthcare safety, including ongoing support for the dissemination and implementation of successful initiatives that integrate the use of evidence-based resources such as TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety) and the Surveys on Patient Safety Culture. This activity supported $14.4 million in new grants in FY 2014, including a $5.0 million new initiative to establish "Patient Safety Learning Laboratories." These are places and professional networks where interrelated threats to patient safety can be identified by multidisciplinary teams which will engage in rapid prototyping techniques that stimulate patient safety improvements. The FY 2015 Enacted level directs $15.0 million to the new Patient Safety initiative --Extending Safety to Patients in All Settings, and $5.0 million is provided for additional Patient Safety Learning Laboratories for a total of $10.0 million in FY 2015.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level provides $35.0 million for this activity, a decrease of $0.6 million from the FY 2015 Enacted level. A total of $14.5 million in continuation funding for grants and contracts continues at this level for an initiative proposed in FY 2015 – Extending Safety to Patients in All Settings. The remaining funds will continue to advance the discovery and application of knowledge that increases patient safety. A total of $10.0 million is provided in continuation funding for the Patient Safety Learning Laboratories program.

The FY 2016 President's Budget level provides $23.8 million to support core patient safety research grants. Of that total $20.7 million is provided for continuing grants and $3.1 million in new grant funding. In terms of contracts, this activity will fund $11.2 million in research contracts that support patient safety improvements in healthcare, including continued support of TeamSTEPPS® online resources and the Surveys on Patient Safety Culture. These projects address the challenges of healthcare teamwork and coordination among provider teams as well as the establishment of cultures in healthcare organizations that are conducive to patient safety. Both of these issues are widely recognized as foundational bases on which patient safety can be improved. TeamSTEPPS® and the Safety Culture Surveys are also supporting the work of other agencies, such as CMS, which incorporate use of these resources as part of their quality improvement activities.

Patient Safety Organizations (PSOs): The Patient Safety Act (2005) provides protection (privilege) to providers throughout the country for quality and safety improvement activities. The Act promotes increased patient safety event reporting and analysis, as adverse event information reported to a Patient Safety Organization (PSO) is protected from disclosure in medical malpractice cases. This legislation supports and stimulates advancement of a culture of safety in health care organizations across the country, leading to provision of safer care to patients. HHS issued regulations to implement the Patient Safety Act, which authorized the creation of PSOs, and AHRQ administers the provisions of the Patient Safety Act dealing with PSO operations. AHRQ, in conjunction with the Office of the Secretary and the Office for Civil Rights, continues to make significant progress in administering the Patient Safety Act. In addition, AHRQ continues to expand the development of common definitions and reporting formats (Common Formats) that define patient safety events. Standardization of quality and safety reporting was authorized by the Patient Safety Act, and promulgation of these Common Formats fosters accelerated learning by allowing aggregation and analysis of events collected by Patient Safety Organizations and annual national reporting on patient safety. AHRQ has periodically updated the Common Formats for

acute care hospitals, which include technical specifications for electronic implementation of the Common Formats by PSOs and vendors of patient safety event reporting software. AHRQ is currently developing a "surveillance" version of the Common Formats for hospitals that will allow establishment of rates of adverse events, benchmarking, and trending. This version of the AHRQ Common Formats, called Quality and Safety Review System (QSRS), will, when completed and tested, replace the current HHS surveillance system – the Medicare Patient Safety Monitoring System or MPSMS – that has been in operation for over 10 years and is used to track progress in the Partnership for Patients. As demand warrants, AHRQ will continue over time to develop Common Formats for health care settings beyond the acute care hospital setting. Finally, AHRQ continues to conduct compliance reviews authorized by the Patient Safety Act to be sure that PSOs are operating in conformance with statute and regulations. AHRQ has funded the PSO program at $7.0 million in FY 2014 and 2015.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level provides $7.0 million for this activity, the same level of support as the FY 2015 Enacted level. These funds will be used to maintain PSO operations, including listing of new PSOs, relisting of existing PSOs, delisting of PSOs that are no longer operative, compliance review of listed PSOs, and technical assistance to PSOs. Funds will also support continued development of AHRQ's Common Formats, including version 2.0 of hospital event reporting Formats, QSRS, and expansion of Formats for use in other settings (e.g., nursing homes). In addition, funds will support aggregation of national PSO data, including receipt of data from PSOs, preparation of this data for transfer to the Network of Patient Safety Databases (NPSD), and preparation for analysis of national data at the NPSD.

Patient Safety and Medical Liability Reform Research Activity: Patient Safety and Medical Liability Reform research focuses on the following goals: (1) putting patient safety first and working to reduce preventable injuries; (2) fostering better communication between doctors and their patients; (3) ensuring that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and (4) reducing liability premiums. Demonstration and planning grants funded in FY 2010 ($23.0 million) are addressing medical liability reform models (e.g., health courts, safe harbors for evidence-based practices) and/or some of the limitations of the current medical liability system – cost, patient safety, and administrative burden. In addition to the grants funded in FY 2010, there was also a competitively bid evaluation contract ($2.0 million). These grants were provided using multi-year funding in FY 2010. All planning grants are now completed and have submitted their final reports. All but one demonstration grant ended in June of 2014. One grant will end in July 2015. Final data from a comprehensive evaluation will be completed by fall 2015. AHRQ demonstration funding allowed a number of existing, smaller-scale projects to expand to additional sites, and enabled other grantees to refine and enhance ongoing activities. As the data analyses from demonstration grants are being completed, many encouraging results are emerging from these projects. AHRQ is currently developing and field testing in 14 hospitals in three health systems across the country an educational toolkit or resource for Communication and Resolution Programs which packages best practices from the grants funded under this initiative.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level does not include funds for new projects in this area.

Healthcare-Associated Infections (HAIs) Research Activity: The Agency is working collaboratively with other HHS components to design and implement initiatives to reduce HAIs. In FY 2014, AHRQ continued to work in close collaboration with HHS partners including CDC,

CMS, NIH, and the Office of the Assistant Secretary for Health. In FY 2014 and 2015, AHRQ will build on past successes and extend these collaborative efforts to support a portfolio of grant- and contract-funded projects that will both buttress research to advance our knowledge regarding effective approaches for reducing HAIs and at the same time promote the implementation of proven methods for preventing HAIs. In FY 2014 and FY 2015, AHRQ's HAI budget of $34.0 million is supporting HAI-related grants in the amount of $11.8 million in FY 2014 and $15.4 million in FY 2015, and the remaining funds are supporting HAI-related contracts. These grants and contracts will investigate methods of controlling HAIs in diverse healthcare settings and will address the major types of HAIs. In addition, contracts funded by the HAI budget will extend the nationwide implementation of the Comprehensive Unit-based Safety Program (CUSP – see Program Portrait below), an evidence-based approach, to reduce the toll from several forms of HAI. Moreover, in FY 2015, in support of the President's National Strategy for Combating Antibiotic-Resistant Bacteria (CARB), HAI projects will expand the development and pilot testing of approaches for conducting antibiotic stewardship programs, which seek to reduce inappropriate antibiotic use, including a focus on ambulatory and long-term care settings. These projects will also test novel strategies for preventing transmission and infection with antimicrobial resistant pathogens.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level provides $34.0 million for this activity, the same level of support as the FY 2015 Enacted level, including a targeted amount of $10.0 million for CARB related projects in support of the President's National Strategy. These funds will continue to advance the generation of new knowledge and promote the application of proven methods for preventing HAIs. The investments to be made will include $17.8 million in HAI research grants and $16.2 million in HAI contracts. The grants will support the generation of new knowledge about improved methods for preventing and reducing HAIs, including further expansion of efforts to investigate and promote antibiotic stewardship approaches, with a focus on ambulatory and long-term care settings, in support of the CARB effort. Of the contract amount, $3.0 million will likewise support the development and pilot testing of approaches for carrying out antibiotic stewardship programs, including those that are tailored to ambulatory and long-term care settings, and $1.2 million in contract funding will address emerging HAI issues and evolving opportunities to resolve them. In addition, $4.0 million will support the extension of the nationwide implementation of CUSP (see Program Portrait on the following page) to address the problem of persistently elevated rates of catheter-associated urinary tract infections (CAUTI) and central line-associated blood stream infections (CLABSI) in some ICU settings and will support further phases of current CUSP projects. For the CUSP investments, the emphasis on implementation is consistent with AHRQ's unique role in accelerating the widespread adoption of evidence-based approaches to prevent HAIs. The combination of research and implementation is the most effective way to ensure progress toward ultimately eliminating the national scourge of HAIs, which is also the ultimate goal of the HHS National Action Plan to Prevent HAIs.

AHRQ is working actively to coordinate HAI activities with other HHS OPDIVs and to share its evidence and products with them. AHRQ is collaborating with CMS, CDC, and OASH on the HHS Agency Priority Goal that seeks to reduce CAUTI rates by 10 percent by the end of FY 2015. In this effort, AHRQ provides evidence about the reduction of CAUTI rates in its nationwide CUSP for CAUTI project, shares its effective approaches for preventing CAUTI, and provides data from its Medicare Patient Safety Monitoring System (MPSMS) for tracking nationwide CAUTI rates. AHRQ is holding monthly meetings with CDC, with additional phone calls in between, to coordinate and align HAI-related activities, provide information on new evidence and publications, and develop collaborative projects that will benefit from both OPDIVs' expertise. AHRQ has been

collaborating with CMS on the Partnership for Patients (PfP), providing science and measurement expertise and MPSMS data for tracking progress against Hospital-Acquired Conditions, and is working with CMS on the post-PfP Safety Across the Board initiatives. AHRQ is also cooperating with CMS on the QIO 11th Statement of Work. Expert staff of other OPDIVs, including CDC and CMS, serves on the Technical Expert Panels of AHRQ's HAI projects. Moreover, AHRQ is completing its Synthesis project, which is developing a summary of the results of AHRQ-funded HAI projects. A first product of this effort, a volume entitled *Advances in the Prevention and Control of HAIs*, which contains articles on implementation approaches, written by leaders of AHRQ's HAI projects, has been posted on AHRQ's website. Additional articles in two journal supplements and a project report will provide the results of the projects. The evidence and approaches from AHRQ's HAI projects are thus being made readily available to HHS OPDIVs as well as to the HAI prevention and patient safety communities.

Program Portrait: Comprehensive Unit-based Safety Program (CUSP) to prevent Healthcare-Associated Infections: Catheter-Associated Urinary Tract Infections (CAUTI) and Central Line Associated Blood Stream Infections (CLABSI) in ICU settings.

FY 2015 Enacted Level:	$ 9.168 million
FY 2016 PB Level:	$ 4.000 million
Change:	$ –5.168 million

The Keystone Project, which first deployed the Comprehensive Unit-based Safety Program (CUSP) in more than 100 Michigan intensive care units (ICUs), reduced the rate of central line-related blood stream infections by two-thirds within 3 months, and within 18 months, the Project saved more than 1,500 lives and nearly $200 million. The CUSP approach involves improvement in safety culture, teamwork, and communication, together with a checklist of evidence-based safety practices.

AHRQ subsequently funded the nationwide expansion of CUSP for CLABSI. The over 1,000 ICUs that implemented CUSP reduced the rate of CLABSI by more than 41 percent in 18 months, thereby preventing over 2,100 CLABSIs, saving more than 500 lives, and averting over $36 million in excess costs. AHRQ then funded a nationwide project that ends in FY 2015 to promote the use of CUSP to reduce CAUTI, in which interim results have shown significant reductions in CAUTI rates, as well as similar projects to address other HAIs and settings. Despite the positive results of the CUSP projects directed to CLABSI and CAUTI, there are persistently elevated rates of these infections in some ICU settings. Therefore, in FY 2016, AHRQ will invest $4 million in a new targeted effort to address the causes of these persistently elevated ICU rates and enhance the effectiveness of CUSP for reducing these rates, as well as supporting further phases of current CUSP projects such as Safe Surgery. The decrease of $5.1 million from the prior year reflects lower resource needs in FY 2016 as AHRQ takes the opportunity to complete the penetration of CUSP into ICUs to reach units that did not volunteer to be among the early participants, as opposed to launching new nationwide CUSP projects to expand the application of CUSP to new HAIs and settings, as in previous FYs and as may be the case in future FYs. This decrease does not indicate a reduced commitment by AHRQ to address HAIs through CUSP and other programs.

C. Mechanism Table

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

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	37	12,192	55	17,113	100	32,365
New & Competing……	64	19,826	50	18,357	26	9,235
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**101**	**32,018**	**105**	**35,470**	**126**	**41,600**
TOTAL CONTRACTS/IAAs.....		**39,566**		**41,114**		**34,377**
TOTAL.....		**71,584**		**76,584**		**75,977**

D. Funding History

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

Year	Dollars
2011	$65,585,000
2012	$65,585,000
2013	$66,584,000
2014	$71,584,000
2015	$76,584,000

Health Services Research, Data and Dissemination

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 P.B. +/- FY 2015 Enacted
TOTAL				
--BA	$0	$112,207,000	$24,386,000	-$87,821,000
--PHS Eval	$ 111,072,000	$0	$87,888,000	$87,888,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2014 Authorization……..……..……..……..Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

Health Services Research, Data and Dissemination (HSR) funds research grants and contracts related to health services research. HSR examines how people get access to health care, how much care costs, and what happens to patients as a result of the care they receive. The principle goals of HSR are to identify the most effective ways to organize, manage, finance, and deliver high quality care, reduce medical errors, and improve patient safety. This portfolio conducts investigator-initiated and targeted research that focus on health services research in the areas of quality, effectiveness and efficiency through research grants and research contracts. Creation of new knowledge is critical to AHRQ's ability to answer questions related to improving the quality of health care. This portfolio also supports Measurement and Data Collection Activities and Dissemination and Translation of Research to help fulfill the mission of HSR.

B. FY 2016 Justification by Activity

Health Services Research, Data and Dissemination
(in millions of dollars)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Health Services Research Grants	$53.489	$52.763	$50.905
(Investigator-Initiated)	*($45.882)*	*($45.882)*	*($43.971)*
Health Services Contract/IAA Research	$23.788	$26.725	$31.752
Measurement and Data Collection	$15.665	$17.054	$17.054
Dissemination and Translation	$18.130	$15.665	$12.563
Total, HSR Data and Dissemination	**$111.072**	**$112.207**	**$112.274**

Overall Budget Policy:

Health Services Research Grants: Health Services Research grants, both targeted and investigator-initiated, focus on research in the areas of quality, effectiveness and efficiency. These activities are vital for understanding the quality, effectiveness, value, appropriateness of health care services. Investigator-initiated research is particularly important. New investigator-initiated research and training grants are essential to health services research – they ensure that

an adequate number of both new ideas and new investigators are created each year. Investigator-initiated research grants allow extramural researchers to pursue the various research avenues that lead to successful yet unexpected discoveries. In this light, the investigator-initiated grant is seen as one of the most vital forces driving health services research in this country. The FY 2014 Final level provides $53.5 million in Health Services Research grants. Of this total, $45.9 million supports investigator-initiated research projects. The FY 2015 Enacted provides $52.8 million for this activity, a decrease of $0.7 million from the FY 2014 level. The FY 2015 Enacted provides $45.9 million in investigator-initiated grants, the same level of support as the prior year.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level provides $50.9 million for this activity, a decrease of $1.9 million from the FY 2015 Enacted level. Support for non-competing research grants totals $32.9 million, an increase of $6.1 million from the FY 2015 level. This level of support does not include non-competing costs for the Centers for Education and Research on Therapeutics (CERTs) grants. These 5-year grants end in FY 2015. The mission of CERTs is to conduct research and provide education that will advance the optimal use of drugs, medical devices, and biological products; increase awareness of the benefits and risks of therapeutics; and improve quality while cutting the costs of care. The last iteration of the CERTs program funded 4 research centers and a central scientific coordination center within HSR (totaling $3.9 million in FY 2015) and 1 center each in the Health IT portfolio ($0.95 million) and Patient Safety portfolio ($1.0 million in FY 2015). AHRQ will conduct an evaluation of this program in FY 2015 to assess the program to date and formulate recommendations about the next iteration of this project. Depending on the result of that evaluation, funding may be provided within the FY 2016 Request level for the CERTs.

Support for new research grants is $18.0 million at the FY 2016 President's Budget level, a decrease of $8.0 million from the FY 2015 Enacted level. Of the new research grant funding, $14.0 million is directed to new investigator-initiated projects. In total, the FY 2016 President's Budget level supports of $44.0 million in investigator-initiated grant funding, a decrease of $1.9 million from the FY 2015 Enacted level. AHRQ has worked diligently to provide new grant funding for investigator-initiated research while also funding grant and contract research needed to support all of the Agency's priority areas of research.

The FY 2016 President's Budget also provides $4.0 million in new grants to develop and test new methods, processes, and tools for better implementing prescription drug abuse treatment efforts. Increasing access to substance abuse treatment, including medication-assisted treatment (MAT), is essential to effectively addressing prescription drug abuse. This is a component of a department-wide action plan being developed to ensure that this public health epidemic is addressed with resources commensurate with the national need. Primary care settings offer a tremendous opportunity for expanding access to MAT, especially in rural areas that may lack access to community-based, specialty treatment centers. Due in part to a lack of knowledge about what works, relatively few primary care professionals and practices are providing evidence-based substance abuse treatment including MAT. To respond to this need, in FY 2016, in coordination with SAMHSA and NIH's National Institute on Drug Abuse, AHRQ requests $4.0 million to stimulate research and evaluation of best practices in the implementation and integration of MAT in primary care settings including private practices and community health centers. Studies will identify effective implementation strategies and service delivery models by which evidence-based MAT practices can be integrated into primary care settings.

Health Services Contract/IAA Research: Health Services Contract/IAA Research Activities provides support health services research activities that impact quality, effectiveness and efficiency of health care. Included in Health Services Contract/IAA Research is support for rapid cycle health services research activities. The aim of these rapid cycle research contract mechanisms is to accelerate the diffusion of results into practice. One of AHRQ's most active rapid cycle research contract mechanisms is ACTION - Accelerating Change and Transformation in Organizations and Networks. ACTION is a model of field-based research designed to promote innovation in health care delivery by accelerating the diffusion of research into practice. The ACTION II network includes 17 large partnerships and more than 350 collaborating organizations that provide health care to an estimated 50 percent of the U.S. population. In addition to support of rapid cycle research, this activity provides funding to a variety of contracts that support administrative activities that are related to research including support for grant review, ethics reviews, data management, data security and events management support. Contract support was also provided for evaluation activities, and inter-agency agreements with other Federal partners. In FY 2014 AHRQ provided $23.8 million for this activity. This level of funding is $26.7 million in budget authority in FY 2015.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level provides $31.8 million for this activity, an increase of $5.0 million from the FY 2015 Enacted level. A total of $9.0 million will be directed to support the new initiative to Optimize Care for people with multiple chronic conditions (MCC). (See additional details below). AHRQ has also provided $1.5 million to support an initiative on paying for value. The Administration is committed to increasingly link payments to quality and value, and not simply to the volume of health care services delivered. We are proposing an initiative that would fund targeted research to identify types of health care that are amenable to strong financial incentives. We will take into consideration the level at which incentives are given, the interaction between type of service and level of care, external vs internal incentives, and how to deal with issues of gaming, risk selection, teaching to the test, and whether strong incentives would be likely to increase or decrease racial/ethnic or socioeconomic disparities. For those health care services that are not amenable to strong financial incentives, we will identify alternative accountability mechanisms that might be used. Finally, an additional $1.0 million will be provided to conduct a systematic evidence review on the implementation of medication-assisted treatment in primary care settings related to prescription drug abuse treatment efforts. The evidence review will summarize what is known about the effects of alternative approaches to medication-assisted treatment on patient outcomes, and identify where more research is needed.

NEW INITIATIVE: Optimizing Care for People with Multiple Chronic Conditions

People with multiple chronic conditions (MCC) represent a growing segment of the population and currently comprise over one-quarter of the U.S. population and two-thirds of Medicare beneficiaries. Two-thirds of total health care spending in the United States is devoted to the care of persons with multiple chronic conditions. Moreover, these individuals, who are disproportionately represented among senior citizens and individuals with disabilities, are at high risk for adverse health outcomes, use more health care services and have higher levels of medical expenditures, and have higher rates of disability, poor quality of life, and premature death.

These high costs and poor outcomes reflect the fact that individuals with MCC often receive care that is fragmented, inefficient, and ineffective. This, in turn, is at least in part due to the fact that

managing multiple chronic conditions is very complicated. From the clinical perspective, this is partly because clinical care guidelines typically focus on single conditions without recognizing the potential contraindications or appropriate prioritization of treatments for multiple conditions. From the perspective of patients and their caregivers, the burden of recommended treatments may be so high that adherence is extremely challenging even with robust cognitive and social resources.

In light of the these pressing needs, AHRQ can contribute to systemic improvement toward providing more comprehensive and coordinated care for people with MCC through facilitating the use of care plans designed to help patients meaningfully work with their care teams to manage their conditions. However, to be meaningful and achievable, such plans must take account of a wide-range of non-clinical patient-specific factors that clinical teams rarely know or try to identify. Even those clinicians who recognize the importance of capturing such information rarely have the tools to do so. This project is designed to help clinicians readily fill this gap, by giving them the tools they need to create *integrated care plans*, which systematically reflect both clinical and other key patient considerations.[1,2]

Clinician Tools for Developing Integrated Care Plans

The first part of this initiative is designed to enhance clinicians' abilities to develop integrated care plans that fully reflect the factors and circumstances that affect patients' efforts to manage their health conditions, interact effectively with the health care system, and achieve their health and quality of life goals. These factors go beyond a patient's physical and behavioral health conditions, typically captured in current health records, and include the individual's values and preferences, as well as his or her life circumstances (such as social support, dementia, pain level, transportation, and practical assistance at home). Integrated care plans that systemically draw upon all this information would enhance the capacity of ambulatory clinical teams to engage in productive shared decision making with patients, and improve satisfaction with clinical care.[3] They could also increase the likelihood that patients would want and be able to better manage their own conditions, thereby increasing the potential for improved patient health outcomes and quality of life at lower cost.[4] (To learn more about the potential value of integrated care plans, please watch this AHRQ video.)

Toward this end, this project will: identify what data is needed to accomplish these goals; develop and test methods for collecting the data; create clinical decision support tools built on the data; evaluate the initiative; and disseminate the results. We anticipate awarding through a competitive process, one four-year contract in the amount of $9.0 million to accomplish the following:

1. Identify a concise set of patient contextual data including values and preferences for health and health care (standard information about characteristics and circumstances, such as preference for watchful waiting versus aggressive intervention, health literacy level, pain level, access to transportation, and amount of practical assistance at home).

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[1] The Standards and Interoperability (S&I) Framework, Longitudinal Coordination of Care Work Group. December 2012. *Care Plan Terms & Proposed Definitions.* http://wiki.siframework.org/file/view/Care%20Plan%20Glossary_v25.doc/404538528/Care%20Plan%20Glossary_v25.doc accessed on September 4, 2014.

[2] CMS. 2011. *Programs of All-Inclusive Care for the Elderly (PACE).* Chapter 8, Assessment and Care Planning. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pace111c08.pdf accessed on September 4, 2014.

[3] Institute of Medicine. 2014. *Capturing social and behavioral domains in electronic health records: Phase 1.* Washington, DC: The National Academies Press.

[4] *AHRQ's Self Management Support resource page http://www.orau.gov/ahrq/sms_home.html accessed on September 4, 2014.*

This step will build on the on-going work of the Institute of Medicine to capture information about social and behavioral domains in EHRs.

2. Develop and test functionality and tools for information systems that dynamically collect contextual data from patients with MCC (e.g., web-based, mobile health (mHealth), EHRs, PHRs).
3. Create and test clinical decision support and care implementation tools that guide clinical teams and patients in the creation of integrated care plans.
4. Evaluate the information system tools and how well they collect dynamic contextual data; clinical decision support and care plan implementation tools; and the impact of integrated care plans on the delivery of care, patient and provider satisfaction, and health care utilization and health outcomes.
5. Disseminate, based on the findings of the evaluation, the resulting evidence-based set of patient contextual data, information systems, and tools to support clinical teams in implementing integrated care plans.

Analysis of Trends in MCC Care

This practical, patient-centered approach to improving the care of people with MCC will be complemented by an analysis of national trends in care for those with MCC. Please see the MEPS section, beginning on page 61 for additional details on the MEPS portion of this initiative.

Alignment with National Health Priorities

This initiative aligns with the *HHS Strategic Framework on Multiple Chronic Conditions* as it seeks to improve health care for individuals with MCC.[1] Two of the four overarching goals of the *Strategic Framework* are to "provide better tools and information to healthcare, public health, and social services workers who deliver care to individuals with multiple chronic conditions" and to "facilitate research to fill knowledge gaps about, and develop interventions to benefit, individuals with multiple chronic conditions." The initiative also examines how provisions in the Affordable Care Act that stimulate the development of new care models and services may better serve the needs of people with MCC. The proposed project directly fulfills the Department's MCC goals and supports evaluation of provisions of the Affordable Care Act.

The timing and purpose of this project is also well aligned with CMS's rule that allows Medicare to make a separate payment, outside of a face-to-face visit, for managing the care of patients with two or more chronic conditions[2]. As this new payment policy is implemented, the MCC project will enhance the evidence-base and tools available to healthcare professionals as they offer additional chronic care management services.

Measurement and Data Collection: Monitoring the health of the American people is an essential step in making sound health policy and setting research and program priorities. Data collection and measurement activities allow us to document the quality and cost of health care, track changes in quality or cost at the national, state, or community level; identify disparities in health status and use of health care by race or ethnicity, socioeconomic status, region, and other

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[1] U.S. Department of Health and Human Services. December 2010. *Multiple Chronic Conditions—A Strategic Framework: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions.* Washington, DC. http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf accessed on September 3, 2014.

[2] *CMS Fact Sheets. July 2014. Proposed policy and payment changes to the Medicare Physician Fee Schedule for Calendar Year 2015. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-07-03-1.html accessed on September 3, 2014.*

population characteristics; describe our experiences with the health care system; monitor trends in health status and health care delivery; identify health problems; support health services research; and provide information for making changes in public policies and programs. AHRQ's Measurement and Data Collection Activity coordinates AHRQ data collection, measurement and analysis activities across the Agency. In FY 2014 AHRQ supported data and measurement activities at approximately $15.7 million including support for the following flagship projects: Healthcare Cost and Utilization Project (HCUP), AHRQ Quality Indicators (AHRQ QIs), the Survey Users Network, the National Healthcare Disparities and Quality Reports (NHDR/QR), and the HIV Research Network (HIVRN). At the FY 2015 Enacted level, this total increases to $17.1 million. The entirety of the increase is related to the move of MONAHRQ® from the Value portfolio to this activity. MONAHRQ® is a desktop software tool that enables organizations - such as state and local data organizations, regional reporting collaboratives, hospitals and hospital systems, and health plans - to quickly and easily generate a health care reporting Website. Our continued support of MONAHRQ is important given its direct link to both Departmental and ACA priorities. Public reporting to help consumers choose safer and higher quality providers has been a major strategy for the Department, and the ACA has heightened the importance of this strategy.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level provides $17.1 million for this activity, the same level of support as the prior year. This funding level supports the following flagship projects: Healthcare Cost and Utilization Project (HCUP), AHRQ Quality Indicators (AHRQ QIs), the Survey Users Network, the National Healthcare Disparities and Quality Reports (NHDR/QR), the HIV Research Network (HIVRN), and MONAHRQ®. Examples of the statistical briefs that come from AHRQ's HCUP project is provided on page 35.

Dissemination and Translation: AHRQ's dissemination and implementation activities foster the use of Agency-funded research, products, and tools to achieve measurable improvements in the health care services patients receive. AHRQ research, products, and tools are used by a wide range of audiences, including individual clinicians; hospitals, health systems, and other providers; patients and families; payers, purchasers, and health plans; and Federal, state, and local policymakers. AHRQ's dissemination and implementation activities are based on assessments of these audiences' needs and how best to foster use of Agency products and tools, plus sustained work with key stakeholders to develop ongoing dissemination partnerships. In addition, AHRQ sponsors knowledge transfer activities designed to assist users through learning networks and tailored, hands-on technical assistance.

Support for Dissemination and Translation activities was $18.1 million in FY 2014 and $15.7 million in the FY 2015 Enacted level. These funds will continue critical dissemination and implementation activities, including the development and distribution of materials to assist consumers and patients in shared decision making with their clinicians; adoption of tools to enhance delivery systems and reduce health care-associated infections, such as AHRQ's Comprehensive Unit-based Safety (CUSP) Program; support for learning networks for state Medicaid Medical Directors and others; assist providers to use findings from AHRQ's Evidence-based Practice Program, the National Quality Measures Clearinghouse (NQMC) and companion National Guideline Clearinghouse (NGC); and promotion of AHRQ's Congressionally mandated National Healthcare Quality Report and National Healthcare Disparities Report.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level provides $12.6 million for this activity, a decrease of $3.1 million from the FY 2015 Enacted. This decrease was a result of a re-prioritization of research activities in this portfolio. AHRQ will increase our efforts with

other public- and private-sector organizations to leverage our resources in FY 2016. As a result, we will maintain support for the AHRQ projects funded in FY 2015, but will re-scale to accommodate the decreased funding. These funds will build on the dissemination and implementation activities described above, as well as AHRQ's investments in health information technology and data products and tools, such as AHRQ's Quality and Patient Safety Indicators. These funds will also facilitate the promotion and use of the Agency's data and measurement resources, including HCUP and Medical Expenditure Panel Survey (MEPS). In addition, these funds will continue support of the National Quality Measures Clearinghouse (NQMC) and companion National Guideline Clearinghouse (NGC).

Research Highlight: HCUP Statistical Briefs

The Healthcare Cost and Utilization Project (HCUP) is a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership and sponsored by AHRQ. HCUP databases bring together the data collection efforts of State data organizations, hospital associations, private data organizations (HCUP Partners), and the Federal government to create a national information resource of encounter-level health care data. HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988. It currently includes data for over 95% of hospitalizations, and includes emergency data from 32 states and ambulatory surgery data from 34 states. These databases enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to health care programs, and outcomes of treatments at the national, State, and local market levels. Researchers have published over 3,000 peer-reviewed articles using HCUP data. The data are used by federal, state, and local policy-makers to track or project the impact of changes in policy or practice on safety, quality, access and cost. AHRQ also publishes statistical briefs using the data to highlight data and trends of particular interest.

Statistical Brief #177: Hospital Inpatient Utilization Related to Opioid Overuse Among Adults, 1993–2012

- The rate of hospital stays involving opioid overuse among adults increased more than 150 percent between 1993 and 2012. By 2012, there were 709,500 total opioid-related hospital stays representing a rate of 295.6 stays per 100,000 population.
- In 1993, the national rate of hospital stays involving opioid overuse among adults was 116.7 per 100,000 population, with the highest rates in select subgroups: men (144.0 per 100,000 population), people aged 25–44 years (188.6 per 100,000 population), and people living in the Northeast (264.0 per 100,000 population).
- By 2012, hospital stays involving opioid overuse had increased by 150 percent, with the largest rates of increase among subgroups with relatively lower rates in 1993 (women, people aged 85 years and older, and people living in the Midwest).
- In 2012, rates for various age groups were much more similar, the Northeast was no longer a notable outlier, and rates for men and women were nearly equal.
- Medicaid had the largest proportion of stays involving opioid overuse (43 percent) in 1993, but Medicare had the largest annual increase over time. By 2012, Medicaid and Medicare each were billed about one-third of all opioid-related stays.

See http://hcup-us.ahrq.gov/reports/statbriefs/sb177-Hospitalizations-for-Opioid-Overuse.jsp

Statistical Brief #185: Utilization of Intensive Care Services, 2011

- In 2011, 26.9 percent of hospital stays in 29 States involved intensive care unit (ICU) charges, accounting for 47.5 percent of aggregate total hospital charges.
- Common conditions and procedures with high ICU utilization varied across body systems. The highest rate of ICU use (93.3 percent) was for respiratory disease with ventilator support. Cardiac conditions accounted for 8 of the 18 conditions and procedures with high ICU utilization. ICU utilization for cardiac conditions ranged from 40.6 percent for stays for chest pain to 70.3 percent for stays for acute myocardial infarction with major complications or comorbidities.
- Hospital stays that involved ICU services were 2.5 times more costly than other hospital stays.
- ICU services were on average three times more likely when patients experienced major complications or comorbidities.
- Greater utilization of ICUs tended to occur in hospitals that were large, private/for profit, located in metropolitan areas, trained medical students, and had a high-level trauma center.

See http://hcup-us.ahrq.gov/reports/statbriefs/sb185-Hospital-Intensive-Care-Units-2011.jsp

C. Mechanism Table

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Health Services Research, Data and Dissemination
(Dollars in Thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	91	27,277	82	26,824	106	32,936
New & Competing……	103	26,030	109	25,939	65	17,969
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**194**	**53,307**	**191**	**52,763**	**171**	**50,905**
TOTAL CONTRACTS/IAAs.....		**57,765**		**59,444**		**61,369**
TOTAL.....		**111,072**		**112,207**		**112,274**

D. Funding History

Funding for the Health Services Research, Data and Dissemination portfolio during the last five years has been as follows:

Year	Dollars
2011	$111,789,000
2012	$108,377,000
2013	$111,072,000
2014	$111,072,000
2015	$112,207,000

Health Information Technology

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 P.B. +/- FY 2015 Enacted
TOTAL				
--BA	$0	$28,170,000	$22,877,000	-$5,293,000
--PHS Eval	$ 29,572,000	$0	$0	$0

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2014 Authorization……..Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

The purpose of AHRQ's Health Information Technology (Health IT) portfolio is to rigorously show how Health IT can improve the quality of American health care. The portfolio develops and synthesizes the best evidence on how health IT can improve the quality of American health care, disseminates that evidence, and develops evidence-based tools for adoption and meaningful use of health IT. By building and synthesizing the evidence-base and through the development of resources and tools, the portfolio has played a key role in the Nation's drive to adopt and meaningfully use health IT.

The portfolio operates in coordination with other Federal health IT programs, particularly the Office of the National Coordinator for Health IT (ONC). AHRQ's legislatively authorized role is to fund research on whether and how health IT improves healthcare quality. For the past decade, AHRQ-funded research has consistently informed and shaped the programs and policy of ONC, CMS, the Veteran's Administration, and other Federal entities. AHRQ's Health IT portfolio will continue to produce field-leading research and summarized evidence synthesis to inform future decisions about health IT by healthcare stakeholders and policymakers.

B. FY 2016 Justification by Activity Detail

Health Information Technology Research Activities
(in millions of dollars)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Research Grants on Utilizing Health IT to Improve Quality	$23.976	$24.681	$19.976
Synthesizing and Disseminating Evidence on the Meaningful Use of Health IT	$3.489	$3.489	$2.901

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Developing Resources and Tools for Policymakers and Health Care Stakeholders	$2.107	$0.000	$0.000
Health IT Research Activities	**$29.572**	**$28.170**	**$22.877**

Overall Budget Policy:

Research Grants on Utilizing Health IT to Improve Quality: Since 2004, the Health IT portfolio has invested in a series of groundbreaking research grants to increase understanding of the ways health IT can be improve health care quality. Early efforts evaluated the facilitators and barriers to health IT adoption in rural America and the value of health IT implementation. Recent results from one AHRQ-funded grant showed that health IT improved cure rates for hepatitis C and reduced rural disparities[1]. In FY 2013, AHRQ funded a dozen rapid-cycle research projects that provided critical and timely evidence for the development of the final stage of the Meaningful Use incentive program. In 2014, Congress directed AHRQ to fund new research to fill the gaps in our knowledge of health IT safety. In 2015 and 2016, AHRQ intends to continue building the foundational evidence necessary to successfully leverage the significant investment in health IT to improve the quality, safety, effectiveness, and efficiency of US health care through support of new research grants.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level provides $20.0 million for this activity, a decrease of $4.7 million from the FY 2015 Enacted level. These funds will support $6.9 million in new investigator-initiated grants in FY 2016, an increase of $0.5 million from the prior year. The FY 2016 President's Budget level proposes allocating 87 percent of total portfolio funds to research grants. This budget reflects AHRQ's commitment to funding foundational health information technology research. This portfolio's grant investments have a history of conducting innovative and ground breaking research which presently informs and supports meaningful use, and will lead to future National achievements. Notable accomplishments include pioneering clinical decision support projects and rapid cycle evaluation of proposed stage 3 meaningful use objectives.

Synthesizing and Disseminating Evidence on the Meaningful Use of Health IT: As interest and investments in health IT have grown, so has the need for evidence and best practices in health IT. In addition to developing field-defining evidence reports on health IT, AHRQ has provided comprehensive and ready access to the research and experts funded by the portfolio through its National Resource Center for Health IT at healthit.ahrq.gov. AHRQ coordination with other Federal programs ensures that high profile research findings developed through its NRC are fed to healthit.gov, the HHS official website for health IT information. FY 2015 funding was directed to systematic reviews of the scientific literature, dissemination through the National Resource Center and other modes, and portfolio synthesis. FY 2016 funding will support portfolio activity monitoring and synthesis and continuing online dissemination.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level provides $2.9 million for this activity, a decrease of $0.6 million from the FY 2015 Enacted level. These funds will continue to support online dissemination as well as project monitoring and reporting. The

1 Arora S et al. Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers. N Engl J Med 2011; 364:2199-2207

portfolio is narrowing its activities to focus on evidence generation and dissemination, and eliminating support for systematic reviews.

Program Portrait: **A Robust Health Information Infrastructure**

AHRQ's research findings and expert analyses are an important contribution to the Nation's efforts to develop a Federal health IT strategy that improves health care quality. In April 2014, an AHRQ-funded report titled "A Robust Health Data Infrastructure" was published by HHS on healthit.gov. The report provided analysis of the current state of health data interoperability, and offered findings and recommendations, including specific suggestions on privacy and security approaches, Meaningful Use and certified EHR technology regulations and promotion of entrepreneurship in health care.

The National Coordinator for Health IT cited this report in its Ten Year Plan to promote interoperability of health IT, and asked for public feedback on the report and its findings. In May and June 2014 the Health IT Policy Committee and Health IT Standards Committee, both FACA committees, began to study the report and returned recommendations for action to ONC based on extensive input from innovators in the field of health IT. These recommendations are incorporated into the Federal Health IT Strategic Plan which defines our plan of action for the next five years. In summary, this AHRQ-funded report was a galvanizing initiator of policy and implementation direction in health IT for HHS and the Nation. This is a concrete example of how AHRQ-funded work supports the Nation's health IT initiatives.

The report can be found at:

http://healthit.gov/sites/default/files/ptp13-700hhs_white.pdf

Developing resources and tools for policy makers and health care stakeholders: In the past, AHRQ has provided resources for the Nation's healthcare stakeholders to promote the safe and effective use of health IT. A wide variety of implementation and evaluation tools are available through the AHRQ health IT portfolio. FY 2014 resources supported limited evaluation and refinement of existing tools, and FY 2015 did not provide funding for this activity.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level does not provide funding for this activity.

C. Mechanism Table

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Health Information Technology Portfolio
(Dollars in Thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	36	14,212	59	18,298	33	13,087
New & Competing……	24	10,243	15	6,383	17	6,889
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**60**	**24,455**	**74**	**24,681**	**50**	**19,976**
TOTAL CONTRACTS/IAAs.....		**5,117**		**3,489**		**2,901**
TOTAL.....		**29,572**		**28,170**		**22,877**

D. Funding History

Funding for the Health Information Technology program during the last 5 years has been as follows:

Year	Dollars
2011	$27,645,000
2012	$25,572,000
2013	$25,572,000
2014	$29,572,000
2015	$28,170,000

U.S. Preventive Services Task Force (USPSTF)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 P.B. +/- FY 2015 Enacted
TOTAL				
--BA	$0	$11,590,000	$11,649,000	$59,000
--PHS Eval	$ 4,300,000	$0	$0	$0
--Prev. & Public Hlth Fund 1/	$ 7,000,000	$0	$0	$0
Total Program Level	$ 11,300,000	$ 11,590,000	$ 11,649,000	$59,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2014 Authorization……..……..……..……..……..……..Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in prevention and evidence-based medicine whose mission is to improve the health of all Americans by making evidence-based recommendations about the effectiveness of clinical preventive services and health promotion. Since 1998, AHRQ has been authorized by Congress to provide ongoing scientific, administrative and dissemination support to assist the USPSTF in meeting its mission. AHRQ, the sole funding source of the USPSTF, has invested in ensuring that the USPSTF has the evidence it needs in order to make its recommendations, the ability to operate in an open, transparent, and efficient manner, and to clearly and effectively share its recommendations with the health care community and general public.

B. FY 2016 Justification by Activity Detail

U.S. Preventive Services Task Force
(in millions of dollars)

Research Activities	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
U.S. Preventive Services Task Force			
--PHS Evaluation Funds	$4.300	$0.000	$0.000
--Budget Authority	$0.000	$11.590	$11.649
--Prevention and Public Health Funds	$7.000	$0.000	$0.000
TOTAL, USPSTF	**$11.300**	**$11.590**	**$11.649**

Overall Budget Policy:

AHRQ is Congressionally mandated to convene and provide scientific, administrative and dissemination support to the U.S. Preventive Services Task Force (USPSTF), an independent panel of nationally renowned non-federal experts in prevention, primary care, and evidence-based medicine. The FY 2014 Enacted Level included $11.3 million to support the USPSTF which included $7.0 million from the Prevention and Public Health Fund. AHRQ provided ongoing support to the USPSTF by investing in: systematic evidence reviews and decision analysis studies; methods development; public engagement; transparency; communication; dissemination including website development; and, logistics support. AHRQ also invested in ways to enhance the implementation and use of USPSTF recommendations by developing continuing education modules based on USPSTF recommendations. In FY 2015, this funding level provides $11.6 million in Budget Authority to provide ongoing support to the USPSTF.

FY 2016 President's Budget Level Budget Policy: The FY 2016 President's Budget provides $11.7 million for this activity, an increase of $0.1 million from the FY 2015 Enacted level. With these funds AHRQ will continue to provide ongoing support to the USPSTF by investing in: systematic evidence reviews and decision analysis studies; methods development; public engagement; transparency; communication; dissemination including website development; and, logistics support.

Program Portrait: **The U.S. Preventive Services Task Force Updates its Recommendation on Screening for Hepatitis C Virus Infection in Adults**

"This may be the single most important development in the more than ten years that I have worked in hepatitis advocacy. With the release of the updated USPSTF hepatitis C screening recommendation, we have a tremendous opportunity to save lives by diagnosing the people who are most likely to have hepatitis C and linking them to care."

Martha Saly, Executive Director of National Viral Hepatitis Roundtable

In 2013, the U.S. Preventive Services Task Force released its updated recommendation on Screening for Hepatitis C Virus (HCV) Infection in Adults, one of 14 final recommendations it released in 2013. **The USPSTF now recommends screening for HCV infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.** The updated recommendation was based on new evidence, public comment, and close working partnerships within HHS.

In 2004, the USPSTF recommended against screening for HCV infection in adults not at increased risk of infection and found insufficient evidence to recommend for or against screening in adults at high risk. In 2013, the updated recommendation was based on two systematic evidence reviews commissioned by AHRQ through the Evidence-based Practice Center program. New evidence was available on the benefits of screening, based on the availability of new effective treatments for HCV.

In addition, in 2013, the USPSTF had expanded its efforts to increase transparency of its processes and opportunities for public comment. As a result, the draft recommendation on screening for HCV was posted for public comment from November 27, 2012 through December 24, 2012.

During public comment, the USPSTF and AHRQ actively engaged scientists at the CDC and the NIH and other federal and non-federal partners to review new evidence and discuss the implications of this evidence for screening and treatment.

As a result of its commitment to evidence, public engagement and scientific partnerships, the USPSTF carefully considered and ultimately revised its draft recommendation on HCV screening. The final recommendation on screening for HCV is consistent with CDC guidelines and aligned with the HHS Action Plan for the Prevention, Care and Treatment of viral hepatitis, communicating a consistent message to health care professionals and patients.

C. Mechanism Tables for Prevention/Care Management

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
U.S Preventive Services Task Force Mechanism Table
(Dollars in Thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	7	1,325	0	0	0	0
New & Competing……	14	4,063	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**21**	**5,388**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**10,516**		**11,590**		**11,649**
TOTAL.....		**15,904**	0	**11,590**	**0**	**11,649**

NOTE: The FY 2014 Final column includes funding provided as part of the Prevention and Care Management Portfolio. This portfolio was eliminated in FY 2015 and now only reflects support for the Task Force. Of this total, $4.3 million in the contracts line directly supported the USPSTF in FY 2014. Combined with the $7.0 M in Prevention and Public Health Funding (see below), the total support for the USPSTF in FY 2014 was $11.3 million.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
ACA/PPHF - USPSTF
(Dollars in Thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**7,000**		**0**		**0**
RESEARCH MANAGEMENT……		**0**		**0**		**0**
TOTAL.....		**7,000**		**0**		**0**

D. Funding History

Funding (program level) for the USPSTF is provided below. Please note, prior to FY 2015, this portfolio was the Prevention/Care Management program and included research and work in addition to the USPSTF.

Year	Dollars
2011	$27,904,000
2012	$27,904,000
2013	$25,747,000
2014	$22,904,000
2015	$11,590,000

Key Performance Measures for HCQO by Portfolio

Portfolio: Patient Safety.

Measure	*Most Recent Result*	*FY 2015 Target*	*FY 2016 Target*	*FY 2016 +/- FY 2015*
1.3.38: Increase the number of users of research implementing AHRQ-supported research tools to improve patient safety culture *(Outcome)*	FY 2014: 1,851 users of research (Target Exceeded)	2,050 users of research	2,200 users of research	+150 users of research
1.3.39: Increase the number of patient safety events (e.g. medical errors) reported to the Network of Patient Safety Databases (NPSD) from baseline. *(Outcome)*	FY 2014: 27 DUAs between PSOs and the PSO PPC (Target Exceeded)	25,000 patient safety event reports transmitted by the PSO PPC to the NPSD	50,000 patient safety event reports transmitted by the PSO PPC to the NPSD	N/A
1.3.41: Increase the cumulative number of tools, evidence-based information, and products available in AHRQ's inventory of resources to improve patient safety and reduce the risk of patient harm. *(Outcome)*	FY 2014: 132 tools, evidence-based information & products (Target Exceeded)	147 tools, evidence-based information & products	162 tools, evidence-based information & products	+15 tools, evidence-based information & products
1.3.59 (Through FY 2015): Reduce the rate of CAUTI cases in hospitals (Outcome)	FY 2014: a) NHSN rate – Baseline: 2.539 CAUTI cases per 1,000 catheter days. Result: 2.153 CAUTI cases per 1,000 catheter days (–15.2%). b) Population rate – Baseline: 8.15 CAUTI cases per 10,000 patient days. Result: 6.40 CAUTI cases per 10,000 patient days (–21.5%). Target: Baseline –10% (i.e., Baseline minus 10%): a) NHSN rate: 2.285 CAUTI cases per 1,000 catheter days. b) Population rate: 7.335 CAUTI cases per 10,000 patient days (Target Exceeded in both NHSN and population rates)	FY 2015 Baseline –15% (i.e., FY 2015 Baseline minus 15%)	N/A	N/A
1.3.62 (Beginning in FY 2016): Reduce the rate of CAUTI cases in hospital intensive care units (ICUs) (Outcome)		Establish baseline – see narrative	N/A	N/A

AHRQ's Patient Safety Portfolio identifies risks and hazards associated with patient harm and facilitates change to reduce quality gaps associated with health care and their harmful impact on patients. AHRQ accomplishes this by funding research and implementation projects that: produce evidence to make health care safer, work within HHS and with other partners to ensure evidence is understood and used, promote improvement in health care delivery, and support local solutions and national goals.

The portfolio supports research and activities that are vital for understanding the factors that can contribute to patient safety events ("adverse events") in order to better understand risks to patients so that harm can be prevented. AHRQ provides tools, evidence-based information, and products to be used by health care providers and organizations to implement safety initiatives in all health care settings, including the hospital, ambulatory and long-term care facilities, and the home. The Patient Safety Portfolio disseminates useful tools, evidence-based information, and products to inform multiple stakeholders on how to implement initiatives to enhance patient safety and quality.

Historically, the Patient Safety Portfolio has concentrated most of its resources on evidence generation. While that activity continues to be important, increasingly, AHRQ is also supporting measurement/reporting and dissemination/implementation as the Agency focuses on making demonstrable improvements in patient safety. This reporting and implementation focus has the advantage of providing a natural feedback loop that can highlight areas in which new evidence is most needed to address real quality and safety problems encountered by providers and patients. At the same time, AHRQ appreciates a clear need to balance investments in measurement/reporting and dissemination/implementation with funding for more fundamental research in patient safety. This balance will support ongoing knowledge creation and a continuous cycle of improvement that encompasses both the discovery and application of safe health care practices.

1.3.38: Increase the number of users of research implementing AHRQ-supported research tools to improve patient safety culture

As an indicator of the number of users of research implementing AHRQ-supported tools to improve patient safety, the agency relies in part on the Surveys of Patient Safety Culture (SOPS). AHRQ developed the SOPS tools to support a culture of patient safety and quality improvement in the Nation's health care system. AHRQ SOPS can be used by hospitals, nursing homes, medical offices, and community pharmacies.

Each AHRQ patient safety culture survey has an accompanying toolkit that contains: survey forms, survey items and dimensions, survey user's guide, and a data entry and analysis tool. Health care organizations can use the SOPS to: raise staff awareness about patient safety, identify strengths and areas for improvement, examine trends in culture over time, and conduct internal and external benchmarking. SOPS can be used to assess the safety culture of individual units/departments or organizations as a whole.

Since the 2004 release of the hospital SOPS, thousands of health care organizations have implemented the surveys and downloaded SOPS tools from the AHRQ Web site. The interest in the SOPS resources has remained strong over the past 10 years as evidenced by electronic downloads, orders placed for various products, participation in webinars describing SOPS resources, and requests for technical assistance.

In response to requests, AHRQ established comparative databases as central repositories for survey data from health care organizations that have administered the SOPS. Upon meeting minimal eligibility requirements, health care organizations can voluntarily submit their survey data for aggregation and compare their safety culture survey results to others. In FY 2014, AHRQ moved to a bi-annual collection of survey data to enhance accuracy of the survey results and reduce the burden on organizations.

In FY 2014, over 1,851 users of research submitted data to the comparative databases, including 653 hospitals, 935 medical offices, and 263 nursing homes. In FY 2014, community pharmacies were able to submit data to a comparative database for the first time; the comparative database report will be issued in this fiscal year. In FY 2016, AHRQ is expecting that the number of hospitals, nursing homes, medical offices, and community pharmacies submitting data in the next fiscal years will continue to be greater than the number of users of research submitting data in previous years. However, AHRQ projects in FY 2017 that the increase of the users of research will begin to level off and the submissions to the comparative databases will remain in a steady state due to implementation of bi-annual collection of data.

1.3.39: Increase the number of patient safety events (e.g. medical errors) reported to the Network of Patient Safety Databases (NPSD) from baseline.

A critical component of the Patient Safety Portfolio is AHRQ's administration of the provisions of the Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act) and the related Patient Safety and Quality Improvement Final Rule (Patient Safety Rule) which support and stimulate the advancement of a culture of safety in health care organizations across the country, leading to provision of safer care to patients. The Patient Safety Act and Patient Safety Rule provide for the formation of patient safety organizations (PSOs) in order to provide protection (privilege) to health care providers throughout the country for quality and safety review activities, including patient safety event reporting and analysis. The uniform Federal protections that apply to a health care provider's relationship with a PSO are expected to remove significant barriers that can deter the participation of health care providers in patient safety and quality improvement initiatives, such as fear of legal liability or professional sanctions.

PSOs collect information from health care providers in a standardized manner that permits valid comparisons of similar cases among similar providers, to the extent practical and appropriate. Patient safety event information that is assembled and developed by providers for reporting to PSOs and the information received and analyzed by PSOs – called patient safety work product (PSWP) – is protected by the privilege and confidentiality protections of the Patient Safety Act and Patient Safety Rule. PSWP is used to conduct quality and patient safety activities, which may include identifying events, patterns of care, and unsafe conditions that increase risks and hazards to patients.

The Patient Safety Act authorizes AHRQ to facilitate the development of the Network of Patient Safety Databases (NPSD) to which PSOs can voluntarily contribute PSWP that is "non-identifiable", i.e., cannot be attributed to a specific institutional or individual provider, patient, or reporter. As data become available from PSOs, the NPSD will receive, analyze, and report on de-identified and aggregated patient safety event information. The NPSD will employ common definitions and reporting formats (Common Formats) that allow health care providers to collect and submit standardized information to PSOs regarding patient safety events. AHRQ will use

data collected from the NPSD to analyze national and regional quality and patient safety event statistics, including trends and patterns. The NPSD will facilitate the aggregation of sufficient volumes of patient safety event data to identify more rapidly the causes of risks and hazards associated with the delivery of health care services. The Patient Safety Act directs AHRQ to make the findings public through incorporation of non-identifiable data from the NPSD in its annual *National Healthcare Quality Report (NHQR*).

AHRQ established the PSO Privacy Protection Center (PSO PPC) to receive data from PSOs, facilitate the use of the Common Formats, de-identify data in a standardized manner, validate the quality and accuracy of PSO data, provide technical assistance to PSOs and other users of the Common Formats, and transmit non-identifiable data to the NPSD. The Common Formats are intended to enhance the ability of health care providers and PSOs to report information that is standardized both clinically and electronically. The submission of AHRQ Common Formats data by health care providers to PSOs, and by PSOs to the PSO PPC for transmission to the NPSD, is entirely voluntary; AHRQ has no mechanism to compel either the timing, types of, or the volume of the Common Formats data submitted by PSOs.

The PSO PPC works with PSOs on submission of de-identified patient safety event information. In order to submit reports, a PSO must first have a data use agreement (DUA) with the PSO PPC. Once a DUA is established, the PSO PPC works with the PSO on data submission and de-identification. By the end of FY 2014, 27 out of 76 listed PSOs had established DUAs with the PSO PPC. While these DUAs grew in number in FY 2014, and some data were transmitted to the PSO PPC, none have been of sufficient quality and volume to ensure that data transmitted to the NPSD is both accurate and non-identifiable. In FY 2015, AHRQ expects an increase in volume of data submission to the PSO PPC and a concomitant increase in the quality of the data submitted. AHRQ's goal is to have a sufficient amount of patient safety event reports to transmit to the NPSD. The FY 2015 performance target is the transmission of 25,000 patient safety event reports to the NPSD by the end of FY 2015. The number of patient safety event reports transmitted by the PSO PPC to the NPSD is expected to increase to 50,000 in FY 2016.

1.3.41: Increase the cumulative number of tools, evidence-based information, and products available in AHRQ's inventory of resources to improve patient safety and reduce the risk of patient harm.

The ultimate goal of the Patient Safety Portfolio is to prevent harm and improve safety for patients. AHRQ accomplishes the goal by successful translation of patient safety research findings into safe practices. Since implementation is so important, the portfolio supports projects which establish strategies for overcoming barriers and obstacles in order to enhance the capability of health care providers and organizations to improve safety and quality. A major output of AHRQ's Patient Safety Portfolio is the development of tools, evidence-based information, and products that can be utilized by health care organizations to improve the care they deliver, and, specifically, patient safety.

In FY 2014, AHRQ has made available 132 tools, evidence-based information, and products such as: *AHRQ Web M&M (Morbidity and Mortality Rounds on the Web)* which is a free, peer-reviewed online journal and forum on patient safety and health care quality; the *Carbapenem-Resistant Enterobacteriaceae (CRE) Control and Prevention Toolkit* which assists hospitals in developing interventions to control CRE; *Improving Hospital Discharge Through Medication Reconciliation and Education* toolkit which focuses on a "discharge bundle" consisting of

medication reconciliation and patient-centered hospital discharge education**;** and *Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care* which assists hospital in overcoming the challenges associated with developing, implementing, and sustaining a fall prevention program. In the next fiscal years, AHRQ is supporting an expanding set of tools, evidence-based information, and resources as a result of ongoing investments to generate knowledge through research, including optimal ways to synthesize and disseminate new knowledge.

One ongoing investment is the *AHRQ Patient Safety Network (PSNet)* which is a national web-based resource featuring the latest news and essential resources on patient safety for health care organizations, providers, policymakers, researchers, and consumers. The *PSNet* offers weekly updates of patient safety literature, news, tools, and meetings; and a vast set of links to resources, tools, and information on patient safety. A critical *PSNet* resource are the "Patient Safety Primers" which define a topic, offer background information, and serve as a guide to key concepts in patient safety such as diagnostic errors, medication errors, safety culture, and teamwork training. Currently, AHRQ has 25 primers available on *PSNet* with at least 10 new primers planned to be released in FY 2015 and 10 new primers in FY 2016.

Another area of investment is the *Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®)* which is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and teamwork skills among health care providers. AHRQ and The Department of Defense (DoD) developed *TeamSTEPPS*® as a tool for institutions to improve collaboration and communication. This resource has ready-to-use materials and a training curriculum for health care organizations for successful integration of teamwork principles into all areas of their system. In the past several years, *TeamSTEPPS*® has been adapted from the initial hospital setting for use in primary care and long term care settings. Finally, AHRQ has been developing an online *TeamSTEPPS*® resource which can be used by both health care teams and individual providers.

AHRQ is expecting that the number of tools, evidence-based information, and products in AHRQ's inventory of patient safety resources will continue to increase with a projected cumulative number of 147 tools, evidence-based information, and resources in FY 2015 and 162 in FY 2016. In the next two fiscal years, AHRQ plans to develop new resources resulting from research in other areas such as AHRQ's healthcare-associated infections (HAIs) Program and the Patient Safety & Medical Liability Reform Research Activity.

1.3.59: Reduce the rate of CAUTI cases in hospitals [Through FY 2015]:

Another main focus of the Patient Safety Portfolio is the prevention and reduction of HAIs. AHRQ is working collaboratively with other HHS components to design and implement HAI initiatives to improve patient safety. In September 2012, AHRQ completed a project to promote the nationwide implementation of the Comprehensive Unit-based Safety Program (CUSP) for central line-associated blood stream infections (CLABSI), which has achieved remarkable success in reducing CLABSI cases and deaths from CLABSI and averting excess costs associated with CLABSI.

Building on the model of CUSP for CLABSI, AHRQ has been extending the application of CUSP to other HAIs. In FY 2011, AHRQ initiated the nationwide implementation of CUSP for catheter-associated urinary tract infections (CAUTI) in hospitals, which will be completed in the latter half of FY 2015. The HAI performance measure aims to assess progress in reducing the rate of

CAUTI in hospitals participating in the CUSP for CAUTI project. CAUTI rates are being measured in two ways: a) as CAUTI cases per 1,000 catheter days (NHSN rate), and b) as CAUTI cases per 10,000 patient days (population rate). This latter rate is important, because efforts are being made to reduce catheter days as a strategy to reduce CAUTI. Reducing catheter days, which is the denominator in the NHSN CAUTI rate, will have the effect of increasing that rate, whereas the population rate (CAUTI per 10,000 patient days) will not be affected by a decline in catheter days.

In FY 2014, AHRQ has expanded the reach of the CUSP for CAUTI project to additional States and hospital units and has been aiming for a 10 percent reduction from the contemporaneous FY 2014 baseline CAUTI rates of participating hospitals to date. Interim data reported in August 2014 indicate that the baseline rates in FY 2014 are: a) NHSN rate: 2.539 CAUTI cases per 1,000 catheter days; and b) Population rate: 8.15 CAUTI cases per 10,000 patient days. The results show that the NHSN CAUTI rate in the project has been reduced by 15.2 percent, and the population rate has been reduced by 21.5 percent (see table). Both of these results exceed the FY 2014 target of a 10 percent reduction. In FY 2015, the CUSP for CAUTI project will further expand its reach, and AHRQ will determine progress toward achieving a final 15 percent reduction from the then-contemporaneous baseline CAUTI rates of participating hospitals.

AHRQ's CUSP for CAUTI project is making a major contribution to attaining the HHS Agency Priority Goal, which aims to reduce the CAUTI Standardized Infection Ratio (observed CAUTI divided by expected CAUTI) by 10 percent by 2015. AHRQ is collaborating closely with CMS, CDC, and OASH in this concerted effort to reduce CAUTI. Over 1,500 hospital units are already participating in CUSP for CAUTI, and additional units are being enrolled in this project, which runs until August 2015. The reduction in CAUTI rates that the project aims to achieve will help reduce CAUTI nationwide, which will contribute to reaching the Agency Priority Goal.

1.3.62: Reduce the rate of CAUTI cases in hospital intensive care units (ICUs) [Beginning in FY 2016]

The reduction in CAUTI rates in the CUSP for CAUTI project, which interim data have shown to be in the range of 15 percent for the NHSN rate and about 20 percent for the population rate, is making a major contribution to attaining the HHS Agency Priority Goal, which aims to reduce CAUTI by 10 percent by the end of FY 2015. CUSP for CAUTI will be completed in the latter half of FY 2015, and thus the current HAI performance measure, which assesses progress in reducing the rate of CAUTI in hospitals participating in the CUSP for CAUTI project, will be applicable only through FY 2015. A new HAI performance measure is proposed for FY 2016.

The new performance measure is connected to an HAI project that will be conducted in FY 2016 as follow-on to the earlier CUSP projects. Interim data from CUSP for CAUTI have thus far consistently shown that hospital units other than intensive care units (ICUs) have achieved greater reductions in CAUTI rates than ICUs. For example, the August 2014 interim data report shows that non-ICUs have reduced CAUTI rates by 25 percent (NHSN rate), whereas ICUs have reduced CAUTI rates by 8 percent. It appears that this difference is related to the clinical culture of the ICU, including a tendency on the part of ICUs to maintain indwelling urinary catheters in their patients for relatively longer times than non-ICUs. In a similar vein, some hospitals in the CUSP for CLABSI project did not achieve the significant reductions in CLABSI rates that were attained by their peers. An HAI project in FY 2016 will enhance CUSP to bring down persistently elevated CAUTI and CLABSI rates in ICUs. The new performance measure will focus on CAUTI rates because the baseline rate for CAUTI is likely to be easier to estimate and more stable than

for CLABSI.

The FY 2016 HAI performance measure will assess progress toward reducing the rate of CAUTI in ICUs participating in the CUSP project. In FY 2016, an overall baseline rate of CAUTI will be derived from the baseline rates of all the ICUs then participating in the project. The FY 2016 baseline rate will provide an initial picture of the CAUTI rates in the ICUs. However, this rate will not be used to gauge progress in FY 2017 because ICUs will be recruited into the project on a rolling basis. Instead, a contemporaneous baseline CAUTI rate will be derived from all the ICUs participating in the project in FY 2017. The target for FY 2017 will be to reduce CAUTI rates in those ICUs by 10 percent. Experience in the project will allow the setting of additional targets for subsequent fiscal years.

Portfolio: Health Services Research, Data and Dissemination.

Measure	*Most Recent Result*	*FY 2015 Target*	*FY 2016 Target*	*FY 2016 +/- FY 2015*
1.3.22: Increase the number of additional organizations per year that use AHRQ Quality Indicators (AHRQ QIs) *(Output)*	FY 2014: 7 additional Organizations (Target Exceeded)	4 additional Organizations	4 additional Organizations	Maintain
1.3.23: Increase the number of consumers for whom Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data is collected *(Output)*	FY 2013: 143 Million (Target Not Met)	146 Million	147 Million	+1 Million
1.3.61: Increase the number of Host Users of the MONAHRQ software *(Output)*	FY 2014: 13 Host Users (Target Exceeded)	15 Host Users	17 Host Users	+2 Host Users

1.3.22: Increase the number of additional organizations per year that use AHRQ Quality Indicators (AHRQ QIs)

AHRQ has been a pioneer and technical leader in the development and public distribution of evidence-based quality measures. The AHRQ QIs are an important tool for measuring, tracking, monitoring, assessing and improving the quality of care.

Each year, AHRQ maintains and improves the specifications, methodology, and software for more than 100 QIs based on administrative data, and provides tools and technical support to QI users. The National Quality Forum has endorsed about half of them for use in public reporting. The QIs include four sets:

- Inpatient Quality Indicators (IQIs) - reflect the quality of care provided in hospitals.
- Patient Safety Indicators (PSIs) - reflect potentially avoidable complications or other adverse events during hospital care.
- Prevention Quality Indicators (PQIs) - consist of hospital admission rates for ambulatory care-sensitive conditions, and serves as a window on the health care of the community; and
- Pediatric Quality Indicators (PDIs) - apply PSIs, IQIs, and PQIs to the pediatric population.

A variety of stakeholders from across the spectrum of health care delivery including providers,

professional and hospital associations, accreditation organizations, employers and business groups, insurance companies, and state and federal governments use the AHRQ QIs in a variety of ways. The AHRQ QIs continue to be used as national benchmarks in the National Healthcare Quality and Disparity Reports. They are used broadly by healthcare organizations for internal quality improvement and by state and regional organizations for public reporting intended to inform patients seeking higher quality care and to drive providers to improve their performance, including in the form of pay-for-performance or insurance products which steer patients toward higher quality providers. Currently, thirty-two organizations utilize the AHRQ QIs to publicly report on hospital quality at the state level. The AHRQ QIs have also been used internationally by several countries, and the PSIs continue to be used by the Organization for Economic Cooperation and Development's (OECD) Health Care Quality Indicators. Project, an intergovernmental research institution with a membership of 30 developed market economy countries.

In 2014 several new organizations began using the AHRQ QIs in their reports on hospital and community level health care quality as well as their quality improvement initiatives. Of note are:

Texas Health Resources
http://www.texashealth.org/workfiles/THR%20System/Quality_Patient_Safety/PDF_Report_Files/09-24-2014_Patient_Safety.pdf

Texas Health Resources is one of the largest faith-based, nonprofit health systems in the United States. The health system includes 25 acute care and short-stay hospitals that are owned, operated, joint-ventured or affiliated with Texas Health Resources. Texas Health's new Quality and Safety Report (2014) is an effort to provide transparent, unbiased reporting of quality and safety performance at all of the health system's wholly-owned hospitals. AHRQ indicators published in this report include PSI 2, PSI 3, PSI 4, and PSI 16. Additional information available at: http://www.texashealth.org/body.cfm?id=1629&action=detail&ref=1784

Minnesota Department of Health: Minnesota Statewide Quality Reporting and Measurement System
http://www.health.state.mn.us/healthreform/measurement/proposedrule/propappx.pdf

Minnesota Statutes 62U.02 requires the Commissioner of Health to establish standards for measuring health outcomes and develop a standardized set of measures to assess the quality of health care services offered by health care providers. In addition, Minnesota Statutes 62U.02 requires the Commissioner of Health to issue annual public reports on provider quality using a subset of measures from the standardized set of measures. Beginning in 2014, select PSIs (4, 18, 19, 90) and PDIs (6, 7 and 19) were added to these reporting requirements.

West Jefferson Medical Center
http://www.wjmc.org/docs/WJMC-Secondary-Data-Profile-09-23-2013.pdf

West Jefferson Medical Center is a 435 bed not-for-profit hospital located in Marrero, Louisiana. As part of its Community Health Needs Assessment, the center reported indicators of potentially avoidable hospitalizations associated with the parish in which it is located, and compared those indicators with state-level indicators. AHRQ indicators in the assessment include PQI's 1-3, 5, and 7-16.

Upstate University Hospital
http://qoc.upstate.edu/

University Hospital in Syracuse is part of SUNY Upstate Medical University and is the only academic medical center in central New York. As a medical enterprise SUNY Upstate serves 1.8 million people, covering one-third of the state and University Hospital in Syracuse is the hub of SUNY Upstate clinical activities. Upstate Medical University reports a broad range of over 20 AHRQ Inpatient Quality Indicators (IQI's) and Patient Safety Indicators for both itself and a national average of over 100 academic medical centers.

Cook County HHS
http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf

The Cook County Health and Hospitals System (CCHHS) is the safety net for health care in Chicago and suburban Cook County. Its main hospital, the John H. Stroger, Jr. Hospital serves as the primary public provider of comprehensive medical services for the people of metropolitan Chicago. CCHHS recently conducted an assessment of patient safety at John H. Stroger, Jr. Hospital (September 2014) which included measures such as AHRQ PSI 90 as well as its component measures, PSI 4 - Death Among Surgical Inpatients, PSI 6 - Iatrogenic Pneumothorax, PSI 11 - Postoperative Respiratory Failure, PSI 12 -Postoperative PE/DVT, PSI 14 - Postoperative Wound Dehiscence, and PSI 15 -Accidental Puncture or Laceration.

The Network of Care
http://union.oh.networkofcare.org/ph/indicator.aspx?id=2041

Network of Care is a single place for consumers, caregivers and case managers to gain knowledge; quickly find and coordinate community services; store important information, and advocate to policymakers. As part of its Public Health Assessment and Wellness reporting, it reports rates of several AHRQ QIs: PQI 3 - diabetes long-term complications; PQI 5 - COPD or asthma in older adults; PQI 7 - hypertension; PQI 8 - congestive heart failure admission rate; PQI 10 - dehydration; PQI 11 - bacterial pneumonia; PQI 12 - UTI; PQI 15 – asthma in younger adults; PQI 16 - diabetes lower-extremity amputation; IQI 15 - AMI mortality; IQI 16 - heart failure mortality; IQI 20 - pneumonia mortality.

AHRQ anticipates continued success in at least 4 new organizations adopting the AHRQ Quality Indicators in its quality improvement and public reporting efforts.

1.3.23: Increase the number of consumers for whom Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data is collected:

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The CAHPS Program has not met the goal of 145 million users in FY 2013. We have seen a slower uptake of the CAHPS Survey for Patient Centered Medical Homes (PCMH) than was anticipated. Also, the Centers for Medicare and Medicaid Services (CMS) has delayed

implementation of some new CAHPS surveys (for Accountable Care Organizations and other settings, facilities) which has affected our ability to reach the target set for January 2015. We are hoping that implementation will begin soon and that we may be able to update use data for these surveys in June 2015.

By the end of 2015, participants in the Healthcare Marketplaces will have received their first CAHPS surveys through which they will be able to assess the quality of care they receive. As a result, we have set a target of 146 million Americans as our goal for 2015 and 147 million for 2016.

1.3.61: Increase the number of host users of the MONAHRQ software

Our continued support of MONAHRQ – free software that allows users to build Web sites for public reporting both quickly and inexpensively – is important given its direct link to both Departmental and ACA priorities. Public reporting to help consumers choose safer and higher quality providers has been a major strategy for the Department, and the ACA has heightened the importance of this strategy. In previous years, this program was funded in the Value Portfolio, but is moved to the Health Services Research Portfolio in FY 2015.

In FY 2014, MONAHRQ underwent a complete re-design, drawing on the science of public reporting, lessons learned and feedback from current MONAHRQ users, and evidence from AHRQ/CMS-funded grants on public reporting. The redesigned MONAHRQ software is streamlined and upgraded, making it much easier and faster for users to build their public reporting websites, as well as readily incorporating new MONAHRQ upgrades. In addition, the redesigned MONAHRQ software now: allows users to build separate Web sites for different audiences, such as consumers, providers, researchers, and policy-makers; incorporates new measures that AHRQ developed as part of its Quality Indicators program, as well as new measures from CMS' Hospital Compare; and includes an evaluation component for MONAHRQ users to get feedback on the usefulness of their MONAHRQ-generated websites. As a result of these and other improvements, more states have adopted MONAHRQ as their platform for mandated Public Reporting sites, and other organizations (both public and private sector) are using MONAHRQ for quality improvement, data quality control, and other healthcare reporting purposes.

In FY 2015, MONAHRQ will make another leap in expanding its usefulness by adding two entirely new sections for nursing home and physician reports to the software. In addition, by the end of FY 2015, MONAHRQ will add new consumer-friendly features supported by the redesign software platform, including further expansions of the measures reported and new educational features on how to use the MONAHRQ reports. The number of Host Users is expected to increase by two.

In FY 2016, the MONAHRQ measure will continue tracking the number of new MONAHRQ Host Users (states and other organizations using MONAHRQ to host a Web site for tracking and reporting provider performance) with the target increasing by two (a 13% increase).

Portfolio: Health Information Technology.

Measure	*Most Recent Result*	*FY 2015 Target*	*FY 2016 Target*	*FY 2016 +/- FY 2015*
1.3.60 Identify three key design principles that ca be used by health IT designers to improve Personal Health Information Management (PHIM) (Output)	FY 2013: Preliminary results will be posted on healthit.ahrq.gov and in Health IT's Annual report (under development). Target: Report preliminary results of grantees in Health IT's Annual Report (Target Met) FY 2013: Gathered first year reports from grantees. Target: Gather first year report from grantees (Target Met)	Continue gathering reports from grantees. Report preliminary results of grantees in Health IT's Annual Report and summarize any ongoing findings from PA-11-99 identifying key design principles for PHIM in preparation for final report in FY 2016.	Continue gathering reports from grantees. Report final findings of completed grants (first awarded in 2011) and preliminary results and findings from ongoing grants from PA-11-199 identifying key design principles for PHIM.	N/A

<u>1.3.60:</u> Identify three key design principles that can be used by health IT designers to improve Personal Health Information Management (PHIM)

The increased interest in and availability of consumer health information technology (IT) applications meant to assist consumers in managing their personal health information needs has rapidly increased over the past decade. Consumer empowerment through the adoption and meaningful use of health IT is also a fundamental strategy for HHS and the Office of the National Coordinator for Health IT. This policy imperative must be informed by relevant evidence in order to be successful. Individuals are the end users of consumer health IT; however, there is still a lack of basic research around these end users' personal health information management (PHIM) practices and needs and how these methods are influenced by a multitude of other contextual factors (e.g., care settings, demographics, motivations, user capabilities and limitations, informal care-giving networks, technology sophistication, and access to Internet) that, typically, represent

a mixture of facilitators or barriers to adequate PHIM. The potential of health IT to improve the quality of health care lies in providing information to people about their health in ways that are meaningful and useful to them. AHRQ's health IT portfolio will build the evidence on what works for people when they manage their health information.

Preliminary results are revealing key principles for useful health IT design. Innovative researchers are using consumer gaming devices to capture doctor's workflow, and are discovering what happens to clinical care when electronic health records "go down" temporarily. AHRQ's research is pushing the boundaries of our current standards and systems to better fit the needs of American patients and their doctors. Preliminary results will be posted on healthit.ahrq.gov, to be released in 2014.

Portfolio: U.S. Preventive Services Task Force

Measure	*Most Recent Result*	*FY 2015 Target*	*FY 2016 Target*	*FY 2016 +/- FY 2015*
2.3.7: Increase the percentage of older adults who receive appropriate clinical preventive services *(Output)*	FY 2014: Developed a prototype of a 38-item patient survey to collect data on 8 composite measures, each for men and women in four age ranges, of the receipt of high-priority clinical preventive services (CPS). (Target Met) FY 2014: Conducted a pilot study to test the feasibility of using EHRs to collect data on receipt of high-priority CPS. Rates for the all-or-none composite measures were extremely low, reflecting the challenge of capturing data on counseling and one-time services. However, the study demonstrated that the use of EHR data for quality reporting is feasible. (Target Met) FY 2014: Developed and released continuing medical education curriculum and modules for primary care clinicians regarding the delivery of appropriate clinical preventive services including a webinar (1.0 contact hour(s) of CE) to explain how advanced practice nurse educators can incorporate AHRQ's Electronic Preventive Services Selector into the educational process (Target Met) FY 2014: Received results from the Centers for Excellence in Clinical Preventive Services to further understand how to deliver high quality (safe, equitable) clinical preventive services. See multiple materials as well as bibliography of published studies at http://www.ahrq.gov/professionals/prevention-chronic-care/decision/research-centers/index.html. (Target met)	Validate final survey to collect data on the receipt of high-priority clinical preventive services among adults	National estimates of receipt of high-priority clinical preventive services from MEPS Final report on the evaluation of the impact of the USPSTF recommendations.	N/A

2.3.7: Increase the percentage of older adults who receive appropriate clinical preventive services

In FY 2014, a study by the Center for Advancing Equity in Clinical Preventive Services at the Feinberg School of Medicine, Northwestern University, Chicago, Illinois demonstrated that an intensive outreach program targeting vulnerable patients dramatically improved screening rates

for colorectal cancer. The researchers found that the intervention was very successful, with 82.2 percent of the patients in the intervention group completing the FOBT within six months of the screening due date vs. 37.3 percent of the patients in the usual care group. The study indicates that outreach programs run through community health centers may hold great promise in reducing preventable deaths due to colorectal cancer.

In FYs 2015 and 2016, the Agency for Healthcare Research and Quality (AHRQ) will provide ongoing scientific, administrative and dissemination support to the U.S. Preventive Services Task Force (USPSTF). Funding to support the USPSTF is anticipated to remain stable in FY 2015 and FY 2016. By supporting the work of the U.S. Preventive Services Task Force, AHRQ helps to identify appropriate clinical preventive services for adults as well as develop methods for understanding prevention in older adults. In FY 2015, AHRQ will fund an evaluation of the impact of the USPSTF recommendations on improving evidence-based preventive practices in primary care practices.

For several years, AHRQ has invested in creating a national measure of the receipt of appropriate clinical preventive services by older adults (measure 2.3.7). A necessary first step in creating quality improvement within health care is measurement and reporting. Without the ability to know where we are and the direction we are heading, it is difficult to improve quality. In FY 2015, AHRQ anticipates having a validated final survey to collect data on the receipt of appropriate clinical preventive services among older adults. The survey has been designed to be a self-administered questionnaire that will be included as part of the MEPS. In FY 2016, AHRQ anticipates having national estimates of receipt of high-priority clinical preventive services among to serve as a baseline for this performance measure.

Medical Expenditure Panel Survey (MEPS)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 P.B. +/- FY 2015 Enacted
TOTAL				
--BA	$0	$65,447,000	$ 68,877,000	$3,430,000
--PHS Eval	$ 63,811,000	$0	$0	+$0

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2014 Authorization……..……..……..……..Expired.
Allocation Method…….....……. Contracts and Other.

A. Program Overview

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

B. FY 2016 Justification by Activity Detail

Medical Expenditure Panel Survey by Activity
(in millions of dollars)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
MEPS Household Component	$41.611	$42.678	$43.678
MEPS Medical Provider Component	$12.200	$12.513	$14.513

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
MEPS Insurance Component	$10.000	$10.256	$10.678
TOTAL, MEPS	**$63.811**	**$65.447**	**$68.877**

Overall Budget Policy:

MEPS Household Component: The MEPS Household component collects data from a sample of families and individuals in communities across the United States, drawn from a nationally representative subsample of households that participated in the prior year's National Health Interview Survey (conducted by the National Center for Health Statistics). During the household interviews, MEPS collects detailed information for each person in the household on the following: demographic characteristics, health conditions, health status, use of medical services, expenses and source of payments, access to care, satisfaction with care, health insurance coverage, income, and employment. In FY 2013 and FY 2014, the Household Component of the MEPS maintained the precision levels of survey estimates, maintained survey response rates and improved the timeliness of the data.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level provides $43.7 million for this activity, an increase of $1.0 million from the FY 2015 Enacted level. This increase is associated with AHRQ's new initiative (see page 30) to optimize care for patients with multiple chronic conditions. These funds will permit the MEPS Household Component 1) to meet the precision levels of survey estimates, survey response rates and the timeliness, quality and utility of data products specified for the survey in prior years, and 2) to obtain new content in the survey for individuals with multiple chronic conditions (MCC) about their experience with care plans, care management, and care coordination, and their level of satisfaction with their care plan.

At present, there are no nationally representative data on how health care professionals are responding to initiatives related to transforming the healthcare delivery system and transforming the care of people with MCC, who are disproportionately represented among senior citizens and individuals with disabilities, and limited national data on the experience of people with MCC in receiving patient-centered, coordinated care. To address this gap, in 2016, AHRQ will invest in a targeted expansion of both the Household and Medical Provider Components of the MEPS. This will deepen our understanding of the degree to which the care of people with MCC is being coordinated and if and how engagement with new models of care, such as patient centered medical homes (PCMHs) and Accountable Care Organizations (ACOs), are associated with improvements in the quality, safety, and value of the care for people with MCC.

MEPS Medical Provider Component: The MEPS Medical Provider component is a survey of medical providers, including office-based doctors, hospitals and pharmacies that collect detailed data on the expenditures and sources of payment for the medical services provided to individuals sampled for the MEPS. This component of MEPS is necessary because households are often unable to accurately report payments made on their behalf for their medical care. In FY 2014 and FY 2015, the Medical Provider Component of the MEPS maintained its sample specifications.

FY 2016 President's Budget Policy: The FY 2016 Presidents Budget level provides $14.5 million for this activity, an increase of $2.0 million from the FY 2015 Enacted. This increase is provided

to support increased provider data collection to implement AHRQ's new initiative (see page 30) to optimize care for patients with MCC. This increase for the MCC initiative will deepen our understanding of the degree to which the care of people with multiple chronic conditions is being coordinated. These funds will permit the MEPS Medical Provider Component 1) to maintain existing survey capacity for collecting detailed data on the expenditures and sources of payment for the medical services provided to individuals sampled for the MEPS at its current level; and 2) to obtain new information on important features of the staffing, organization, use of care plans, care management, care coordination and financing of a sample of the medical providers providing care to a representative sample of individuals with multiple chronic conditions. This work will include collection of additional information from people with MCC about their experience with care plans, care management, and care coordination and collection of new information from the medical teams caring for these individuals about their use of care plans, care management, care coordination, and current practice arrangements. This project will result in nationally representative data in the 2016 MEPS for individuals with multiple chronic conditions regarding the presence of care plans for treatment of individuals with MCCs and the level of care coordination they receive; nationally representative linked medical provider data to the MEPS 2016 Household Survey with content on the provision of care plans to MCC patients, status of physician membership in an ACO, whether they are certified as a primary care medical home, their use of HIT, and related provider practice, organization and specialty characteristics; and analytic data files to determine whether patients with well-established medical care plans, who also who report greater satisfaction with their care, are associated with less frequent use of emergency rooms, lower overall utilization of health care services and lower medical expenditures, and whether there is any change over time as a consequence of greater adoption of this protocol. The data will facilitate assessments of the extent to which system changes and policies as adopted by medical providers have impacts on the health care utilization and expenditures, the health status, patient safety and health outcomes of individuals with MCCs.

MEPS Insurance Component (IC): The MEPS Insurance component is a survey of private business establishments and governments designed to obtain information on health insurance availability and coverage derived from employers in the U.S. The sample for this survey is selected from the Census Bureau's Business Register for private employers and Census of Governments for public employers. The IC is an annual survey designed to provide both nationally and state representative data on the types of health insurance plans offered by employers, enrollment in plans by employees, the amounts paid by both employers and employees for those plans, and the characteristics of the employers. The FY 2010 Appropriation level allowed for data on employer sponsored health insurance to be collected in order to support both national and separate estimates for all 50 States and the District of Columbia. In FY 2014 and 2015, the MEPS Insurance Component maintained the precision levels of survey estimates, maintained survey response rates and adhered to data release schedules.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level provides $10.7 million for this activity, an increase of $0.4 million from the FY 2015 Enacted level. These funds will permit the MEPS Insurance Component to maintain existing survey capacity at its current level.

Program Portrait: Use of MEPS Data

FY 2015 Enacted:	$65.4 million
FY 2016 President's Budget:	$68.9 million
Change:	$ 3.4 million

MEPS data have become the linchpin for economic models of health care use and expenditures. The data are key to estimating the impact of changes in financing, coverage and reimbursement policy on the U.S. healthcare system. No other surveys provide the foundation for estimating the impact of changes in national policy on various segments of the US population. These data continue to be key for the evaluation of health reform policies and analyzing the effect of tax code changes on health expenditures and tax revenue. Key data uses include:

- MEPS IC data are used by the Bureau of Economic Analysis in computing the nation's GDP.
- MEPS HC and MPC data are used by CBO, CRS, the Council of Economic Advisors, the Treasury and others to inform inquiries related to expenditures, insurance coverage and sources of payment.
- MEPS was used extensively to inform Congressional inquiries concerning the State Children's Health Insurance Program and its reauthorization.
- MEPS was extensively used by GAO to study access to care for Medicaid beneficiaries in a report requested by the Senate Committee on Health, Education, Labor and Pensions.
- MEPS is being used by CMS to inform the National Health Expenditure Accounts and for projects supporting the financial management of the planned health exchange markets.
- MEPS was being used by ASPE to estimate the impact of Medicaid Eligibility Changes under the Affordable Care Act with respect to Federal Medical Assistance Percentages (FMAP).
- MEPS was used extensively by the GAO to determine trends in employee compensation.
- MEPS is used extensively to examine the effects of chronic conditions on the levels and persistence of medical expenditures.
- MEPS is used by Treasury to determine the amount of the small employer health insurance tax credit that is a component of the Affordable Care Act.

This year, applied research based upon MEPS led to the formulation and adoption of two CHIP policy recommendations by the Medicaid and CHIP Payment Advisory Commission (MACPAC):

- Eliminate CHIP premiums for children in families under 150 percent of the Federal Poverty Line (FPL).
- Reauthorize CHIP in 2015.

In addition, MEPS data and analyses were used by the state of Arkansas in the development of their innovative plan to use the Medicaid expansion program to implement a premium assistance model, called the Health Care Independence Program (HCIP). This program provides expansion eligible individuals' access to insurance coverage through the state's Marketplace.

C. Mechanism Table for MEPS

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

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**63,811**		**65,447**		**68,877**
TOTAL.....		**63,811**		**65,447**		**68,877**

D. Performance Summary and Key Measures

Measure	***Most Recent Result***	***FY 2015 Target***	***FY 2016 Target***	***FY 2016 +/- FY 2015***
1.3.16: MEPS-IC: The number of months required to make insurance component tables available following data collection *(Output)*	FY 2014: 6 months (Target Met)	6 months	6 months	Maintain
1.3.19: Increase the number of tables per year added to the MEPS table series *(Output)*	FY 2014: 7317 total tables in MEPS table series (Target Exceeded)	7567 total tables in MEPS table series	7817 total tables in MEPS table series	+250
1.3.21: MEPS-HC: Decrease the number of months required to produce MEPS data files (i.e. point-in-time, utilization and expenditure files) for public dissemination following data collection. *(Output)*	FY 2014: 9.5 months (Target Met)	9.5 months	9 months	-0.5
1.3.49: Decrease the average number of field staff hours required to collect data per respondent household for the MEPS *(Efficiency)*	FY 2014: 13.5 hours (Baseline)	13.5 hours	13.5 hours	Maintain

The Medical Expenditure Panel Survey (MEPS) data have become the linchpin for economic models of health care use and expenditures. The data are key to estimating the impact of changes in financing, coverage and reimbursement policy on the U.S. healthcare system. No other surveys provide the foundation for estimating the impact of changes in national policy on various segments of the US population. These data continue to be key for the evaluation of health reform policies and analyzing the effect of tax code changes on health expenditures and tax revenue.

1.3.16: Maintain the number of months to produce the Insurance Component tables following data collection (MEPS-IC)

The MEPS-IC measures the extent, cost, and coverage of employer-sponsored health insurance on an annual basis. These statistics are produced at the National, State, and sub-State (metropolitan area) level for private industry. Statistics are also produced for State and Local governments. Special request data runs, for estimates not available in the published tables, are made for Federal and State agencies as requested.

The MEPS-IC provides annual National and State estimates of aggregate spending on employer-sponsored health insurance for the National Health Expenditure Accounts (NHEA) that are maintained by CMS and for the Gross Domestic Product (GDP) produced by Bureau of Economic Analysis (BEA). In support of the Affordable Care Act, MEPS-IC State-level premium estimates are the basis for determining the average premium limits for the federal tax credit available to small businesses that provide health insurance to their employees. MEPS-IC estimates are used extensively for additional analyses related to the ACA by federal agencies including:

- Congressional Budget Office (CBO);
- Congressional Research Service (CRS);
- Department of Treasury;
- The U.S. Congress Joint Committee on Taxation (JCT);
- The Council of Economic Advisors, White House;
- Department of Health and Human Services (HHS), including
- Assistant Secretary for Planning and Evaluation (ASPE)
- Centers for Medicare & Medicaid Services (CMS)

Schedules for data release will be maintained for FY 2015 through FY 2016. Data trends from 1996 through 2013 are mapped using the MEPSnet/IC interactive search tool. In addition, special runs are often made for federal and state agencies that track data trends of interest across years.

1.3.19: Increase the number of tables included in the MEPS Tables Compendia.

The MEPS Tables Compendia is scheduled to be expanded a minimum of 250 tables per year. Currently the Household Component offers a total of 1,236 tables. Household Component table additions are scheduled for May, July, and August of 2015. For the Insurance Component there are a total of 1,931 national level tables and 4,219 state and metro area tables. More tables are scheduled for July of 2015 at the national, state and metro area levels. The total number of tables available to the user population is 7,386. The performance measure has been changed from one table series (made up of many tables) per year to an addition of at least 250 tables per

year. This change better reflects the level of effort and resources committed to increasing the utility of the MEPS Tables Compendia for the user population.

The MEPS Tables Compendia is a source of important data that is easily accessed by users. Expanding the content and coverage of these tables furthers the utility of the data for all. Currently data is available in tabular format for the years 1996 – 2013. This represents eighteen years of data for both the Household and Insurance Components, enabling the user to follow trends on a variety of topics.

1.3.21: MEPS-HC: Decrease the number of months required to produce MEPS data files (i.e. point-in-time, utilization and expenditure files) for public dissemination following data collection.

In coordination with the MEPS Household Component contractor the Center for Financing, Access and Cost Trends (CFACT) senior leadership have met on a continuing basis to establish a strategy to address an accelerated delivery schedule. The following steps have and will continue to be taken in an effort to release public use files at an earlier date: 1) data editing now takes place in waves (batch processing) rather than data processing taking place all at once at the completion of date collection. 2) processing of multiple data sets now takes place concurrently rather than consecutively, thus multiple processes take place at any given point in time. 3) duplicative processes have either been eliminated or combined with similar processes. 4) review time of intermediate steps was reduced. 5) the contractor has eliminated a number of edits or streamlined such processes where they were determined to provide minimal benefit in relation to the resources utilized. 6) contractor editing staff have been cross-trained in order to more efficiently distribute work assignments.

We have achieved the data release schedule for all the targeted MEPS public release files scheduled for release during FY 2014. We are on target to also meet the data release schedule for the MEPS public use files scheduled for release during FY 2015. The release date for public use file (point-in-time) will be reduced another two weeks moving from FY 2015 to FY 2016.

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

1.3.49: Decrease the average number of field staff hours required to collect data per respondent household for the MEPS (at level funding).

The purpose of this measure is to improve the efficiency of the data collection. In FY 2013 there was a slight increase to 12.26 hours from FY 2012 of 11.7 hours. Field staff (interviewers) continue to be challenged with the dual missions of persuading eligible participants to take part in the MEPS survey while maintaining the desired level of data quality. Given the anticipated changes in health insurance coverage as a consequence of the Affordable Care Act, MEPS questionnaire redesign efforts will be ongoing from FY 2014 through FY 2015 in order to address content modifications and content complexity. For FY 2014, the average number of field staff hours required to collect data per respondent household for the MEPS underwent review and was re-baselined in light of these modifications. The new baseline for data collection is 13.5 hours (actual 13.47 hours) and this will be maintained through FY 2016.

E. Funding History

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

Year	Dollars
2011	$58,800,000
2012	$59,300,000
2013	$60,700,000
2014	$63,811,000
2015	$65,447,000

Program Support

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 P.B. +/- FY 2015 Enacted
TOTAL				
--BA	$0	$69,700,000	$72,044,000	$2,344,000
--PHS Eval	$ 68,813,000	$0	$0	+$0
FTEs (Discretionary Funds)	294	300	300	0
FTE (Other Reimbursable Funds)	7	6	6	0
Estimated FTEs (PCORTF)	13	25	25	0

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2014 Authorization……..……..……..Expired.
Allocation Method…….....……..…….Other.

A. Program Overview

This budget activity supports the strategic direction and overall management of AHRQ, including funds for salaries and benefits of 300 full time equivalents (FTEs). The principles which guide the Agency's management structure include:

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

B. FY 2016 Justification

Overall Budget Policy:

Program Support: Program support activities for AHRQ include operational and intramural support costs such as salaries and benefits, rent, supplies, travel, transportation, communications, printing and other reproduction costs, contractual services, taps and assessments, supplies, equipment, and furniture. Most AHRQ staff divide their time between multiple portfolios, which is why AHRQ's staff and overhead costs are shown centralized in Program Support, instead of within the relevant research portfolio or MEPS.

FY 2016 President's Budget Policy: The FY 2016 President's Budget level for Program Support will be funded at $72.0 million, an increase of $2.3 million or +3.4 percent from the FY 2015 Enacted level. Of the total increase, $1.5 million is associated with our physical relocation to 5600 Fisher's Lane. A total of $0.7 million is required to support pay increases and $0.1 million is provided for inflationary increases for operating expenses.

Program Support provides funds for AHRQ's PHS Evaluation Fund FTEs. In FY 2016 AHRQ is supporting 300 FTEs, the same level of support as the FY 2015 Enacted level. As shown in the table on the prior page, AHRQ does have additional FTEs supported with other funding sources, including approximately 6 FTE from other reimbursable funding and an estimated 25 FTEs supported by the Patient-Centered Outcomes Research Trust Fund.

As requested, AHRQ has estimated Program Support costs by portfolio (see below). However, as shown in the organizational chart at the beginning of the budget, AHRQ is organized by Offices and Centers. Each Center may have more than one portfolio housed within that structure. This is a purposeful design to allow cross-Center collaboration and expertise for a research topic. FTEs are allocated by Office/Center, but provided in the table below as a rough estimate of portfolio requirements.

Estimated Program Support Costs by Portfolio
(in thousands of dollars)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Patient Safety	16,300	18,156	18,768
Health Services Research, Data, and Dissemination	25,293	26,602	27,733
Health Information Technology	6,734	6,678	5,651
USPSTF	5,215	2,748	2,878
Value	741	-	-
Medical Expenditure Panel Survey	14,530	15,516	17,014
Total, Program Support	68,813	69,700	72,044

C. Mechanism Table

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Program Support
(Dollars in Thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**0**		**0**		**0**
RESEARCH MANAGEMENT……		**68,813**		**69,700**		**72,044**
TOTAL.....		**68,813**		**69,700**		**72,044**

D. Funding History

Funding for the Program Support budget activity during the last five years is provided below.

Year	Dollars
2011	$67,600,000
2012	$73,985,000
2013	$68,422,000
2014	$68,813,000
2015	$69,700,000

Supplementary Tables – Table of Contents

Supplementary Tables

Budget Authority by Object Class....73
Salaries and Expenses....75
Detail of Full-Time Equivalent Employment (FTE)....76
Detail of Positions....77
Physician Comparability Allowance Worksheet....78
FTEs Funded by the Affordable Care Act....79

Budget Authority by Object Class – Reimbursable 1/

(DOLLARS IN THOUSANDS)

Object Class	FY 2015 Enacted	FY 2016 Budget	FY 2016 +/- FY 2015
Reimbursable			
Personnel Compensation:			
Full-time Permanent (11.1)	$0	$0	$0
Other than Full-Time Permanent (11.3)	0	0	0
Other Personnel Comp. (11.5/11.8)	0	0	0
Military Personnel (11.7)	0	0	0
Subtotal, personnel compensation	**0**	**0**	**0**
Civilian Personnel Benefits (12.1)	0	0	0
Military Personnel Benefits (12.2)	0	0	0
Subtotal Pay Costs	**0**	**0**	**0**
Travel (21.0)	0	0	0
Transportation of Things (22.0)	0	0	0
Rental Payments to GSA (23.1)	0	0	0
Communications, Utilities, and Misc. Charg. (23.3)	0	0	0
Printing and Reproduction (24.0)	0	0	0
Other Contractual Services:			
Other Services (25.2)	0	0	0
Purchases from Govt. Accts. (25.3)	0	0	0
Research & Development Contracts (25..5)	0	61,369,000	+61,369,000
Operation and Maintenance of Equipment (25.7)	0	0	0
Subtotal Other Contractual Services	**0**	**61,369,000**	**+61,369,000**
Supplies and Materials (26.0)	0	0	0
Equipment (31.0)	0	0	0
Grants, Subsidies, and Contributions (41.0)	0	26,519,000	+26,519,000
Interest and Dividends (43.0)	0	0	0
Subtotal Non-Pay Costs	**0**	**87,888,000**	**+87,888,000**
Total, Reimbursable Obligations	**0**	**87,888,000**	**+87,888,000**

Budget Authority by Object Class – Direct 1/

(DOLLARS IN THOUSANDS)

Object Class	FY 2015 Enacted	FY 2016 Budget	FY 2016 +/- FY 2015
Direct Obligations:			
Personnel Compensation:			
Full-time Permanent (11.1)	$32,250,000	$32,799,000	+549,000
Other than Full-Time Permanent (11.3)	3,359,000	3,408,000	+49,000
Other Personnel Comp. (11.5/11.8)	573,000	584,000	+11,000
Military Personnel (11.7)	801,000	810,000	+9,000
Subtotal, personnel compensation	**36,983,000**	**37,601,000**	**+618,000**
Civilian Personnel Benefits (12.1)	9,927,000	10,064,000	+137,000
Military Personnel Benefits (12.2)	511,000	517,000	+6,000
Subtotal Pay Costs	**47,421,000**	**48,182,000**	**+761,000**
Travel (21.0)	351,000	358,000	+7,000
Transportation of Things (22.0)	53,000	54,000	+1,000
Rental Payments to GSA (23.1)	5,146,000	4,984,000	-162,000
Communications, Utilities, and Misc. Charg. (23.3)	952,000	972,000	+20,000
Printing and Reproduction (24.0)	781,000	797,000	+16,000
Other Contractual Services:			
Other Services (25.2)	12,415,000	14,075,000	+1,660,000
Purchases from Govt. Accts. (25.3)	19,384,000	20,112,000	+728,000
Research & Development Contracts (25..5)	161,700,000	97,692,000	-64,008,000
Operation and Maintenance of Equipment (25.7)	679,000	679,000	0
Subtotal Other Contractual Services	**194,178,000**	**132,558,000**	**(61,620,000)**
Supplies and Materials (26.0)	392,000	400,000	+8,000
Equipment (31.0)	1,510,000	1,542,000	+32,000
Grants, Subsidies, and Contributions (41.0)	112,914,000	85,963,000	-26,951,000
Interest and Dividends (43.0)	0	0	0
Subtotal Non-Pay Costs	**316,277,000**	**227,628,000**	**-88,649,000**
Total, Direct Obligations	**363,698,000**	**275,810,000**	**-87,888,000**

Salaries and Expenses

SALARIES AND EXPENSES

TOTAL APPROPRIATION

(Dollars in Thousands)

Object Class	FY 2015 Enacted	FY 2016 Budget	FY 2016 +/- FY 2015
Personnel Compensation:			
Full-time Permanent (11.1)	$32,250,000	$32,799,000	+549,000
Other than Full-Time Permanent (11.3)	3,359,000	3,408,000	+49,000
Other Personnel Comp. (11.5/11.8)	573,000	584,000	+11,000
Military Personnel (11.7)	801,000	810,000	+9,000
Subtotal, personnel compensation	**36,983,000**	**37,601,000**	**+618,000**
Civilian Personnel Benefits (12.1)	9,927,000	10,064,000	+137,000
Military Personnel Benefits (12.2)	511,000	517,000	+6,000
Subtotal, Pay Costs	**47,421,000**	**48,182,000**	**+761,000**
Travel (21.0)	351,000	358,000	+7,000
Transportation of Things (22.0)	53,000	54,000	+1,000
Communications, Utilities, and Misc. Charg. (23.3)	952,000	972,000	+20,000
Printing and Reproduction (24.0)	781,000	797,000	+16,000
Other Contractual Services:			
Other Services (25.2)	12,415,000	14,075,000	+3,319,335
Purchases from Govt. Accts. (25.3)	0	0	+0
Operations and maintenance of equipment (25.7)	679,000	679,000	+665
Subtotal Other Contractual Services	**13,094,000**	**14,754,000**	**+3,320,000**
Supplies and Materials (26.0)	392,000	400,000	+8,000
Subtotal Non-Pay Costs	**15,623,000**	**17,335,000**	**+3,372,000**
Total, Salaries & Expenses	**63,044,000**	**65,517,000**	**+4,133,000**
Rental Payments to GSA (23.2)	5,146,000	4,984,000	-324,000
Total FTEs	300	300	0

Detail of Full-Time Equivalent Employment (FTE)

Detail of Full-Time Equivalent Employment (FTE) 1/

	2014 Actual Civilian	2014 Actual Military	2014 Actual Total	2015 Est. Civilian	2015 Est. Military	2015 Est. Total	2016 Est. Civilian	2016 Est. Military	2016 Est. Total
Office of the Director (OD)	20	0	20	20	0	20	20	0	20
Office of Management Services (OMS)	52	0	52	52	0	52	52	0	52
Office of Extramural Research, Education, and Priority Populations (OEREPP)	38	3	41	39	2	41	39	2	41
Center for Evidence and Practice Improvement (CEPI)	50	3	53	51	2	53	51	2	53
Center for Delivery, Organization and Markets (CDOM)	32	0	32	32	0	32	32	0	32
Center for Financing, Access, and Cost Trends (CFACT)	44	0	44	44	0	44	44	0	44
Center for Quality Improvement and Patient Safety (CQuIPS)	24	2	26	24	2	26	24	2	26
Office of Communications and Knowledge Transfer (OCKT)	43	0	43	43	0	43	43	0	43
AHRQ FTE Total	**303**	**8**	**311**	**305**	**6**	**311**	**305**	**6**	**311**

Average GS Grade	
2012	12.8
2013	13.1
2014	13.1
2015	13.1
2016	13.1

1/ Excludes PCORTF FTE.

Detail of Positions 1/

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Detail of Positions 1/

	2014 Actual	2015 Base	2016 Budget
Executive Level I	3	3	3
Executive Level II	0	0	0
Executive Level III	6	6	6
Executive Level IV	1	1	1
Executive Level V	0	0	0
Subtotal	10	10	10
Total Executive Level Salaries	$1,708,096	$1,922,480	$1,941,705
Total - SES	3	3	3
Total - SES Salaries	$ 847,887	$ 530,601	$535,907
GS-15	60	63	63
GS-14	88	97	97
GS-13	65	73	73
GS-12	22	21	21
GS-11	14	26	26
GS-10	2	2	2
GS-9	10	11	11
GS-8	1	1	1
GS-7	6	7	7
GS-6	2	3	3
GS-5	2	1	1
GS-4	1	1	1
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal	273	306	306
Average GS grade	13.1	13.1	13.1
Average GS salary	$89,924	$90,823	$91,731

1/ Excludes Special Experts, Services Fellows and Commissioned Officer positions.

Physician's Comparability Allowance Worksheet

		FY 2014 (Actual)	FY 2015 (Estimates)	FY 2016* (Estimates)
1) Number of Physicians Receiving PCAs		22	22	22
2) Number of Physicians with One-Year PCA Agreements		0	0	0
3) Number of Physicians with Multi-Year PCA Agreements		22	22	22
4) Average Annual PCA Physician Pay (without PCA payment)		$ 139,578	$140,974	$ 142,383
5) Average Annual PCA Payment		$ 22,955	$ 22,955	$ 22,955
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	0	0	0
	Category II Research Position	21	21	21
	Category III Occupational Health	0	0	0
	Category IV-A Disability Evaluation	0	0	0
	Category IV-B Health and Medical Admin.	1	1	1

*FY 2016 data will be approved during the FY 2017 Budget cycle.

- If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

N/A

- Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

Maximum annual PCA for category II and IV-B is $30,000 this amount is only attainable by GS-15 Medical Officers on multi-year contracts eligible for mission specific pay.

- Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

Most, if not all of the research positions at AHRQ are in occupations that are in great demand, commanding competitive salaries in an extremely competitive hiring environment. This includes the 602 (medical Officer) series which is critical to advancing AHRQ's mission of improving health care for all Americans. Since the Agency has not employed other incentives mechanisms for the 602 series (for example, Title 38 pay), it is imperative that we offer PCA to entice physicians to accept and remain at AHRQ. In the absence of PCA, we would be unable to compete with other Federal entities within HHS and other sectors of the Federal government which offer supplemental compensation (in addition to base pay) to individuals in the 602 series.

- Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

PCA contracts are used as a tool to alleviate recruitment problems and attract top private sector physicians into public sector positions. These recruitments give AHRQ a well-rounded and highly knowledgeable staff.

FTEs Funded by the Affordable Care Act

FTE Funded by the Affordable Care Act
Agency for Healthcare Research and Quality
(Dollars in Thousands)

Program	Section(s)	FY 2012			FY 2013			FY 2014			FY 2015			FY 2016		
		$	FTEs	CEs	$	FTEs	CEs	$	FTEs	CEs	$	FTEs	CEs	$	FTEs	CEs
New programs authorized and funded by PPACA																
Prevention and Public Health Fund	4002	-	0	0		N/A	0	N/A	N/A	0	0	0	0	0	0	0
Patient-Centered Outcomes Research Trust Fund	6301	366	4	0	633	6	0	1,505	13	0	1,900	25	0	1,900	25	0

Patient-Centered Outcomes Research Trust Fund (PCORTF)

The Patient Protection and Affordable Care Act (P.L. 111-148) established the Patient-Centered Outcomes Research Trust Fund (PCORTF). Beginning in FY 2011, a total of 20 percent of the funds appropriated or credited to the PCORTF will be transferred each year to the Department of Health and Human Services (HHS) – of the HHS total, 80 percent is transferred to AHRQ and 20 percent to the Office of the Secretary. As authorized in section 937 of the Public Health Service Act, HHS will disseminate research findings from the Patient-Centered Outcomes Research Institute and other government-funded comparative clinical effectiveness research and build research and data capacity for comparative clinical effectiveness research.

AHRQ uses its allocation to disseminate and implement PCOR research findings; obtain stakeholder feedback on the value of the information to be disseminated and subsequent dissemination efforts; assist users of Health IT to incorporate PCOR research findings into clinical practice; and provide training and career development for researchers and institutions in methods to conduct comparative effectiveness research. The Office of the Secretary allocation focuses on building data capacity for PCOR, in order to develop and maintain a comprehensive, interoperable data network to collect, link, and analyze data on outcomes and effectiveness from multiple sources, including electronic health records. AHRQ consults with PCORI, NIH, and other components of HHS to ensure that AHRQ activities are unique and not duplicative.

AHRQ is developing a website to display all funded PCORTF projects through AHRQ's allocation. It is currently being tested and should be available by March, 2015. The website will provide fact sheets for each project and provide listings of all grantees funded through the PCORTF. Below is a description of one large project that AHRQ is pursuing in FY 2015:

Supporting Decisions With Patient-Centered Outcomes Research (PCOR)

Broad adoption of health Information Technology (IT) and its meaningful use is a hallmark Administration initiative. Eligible hospitals and doctors have earned over $20 billion in incentive payments to date, and now the majority of health care is delivered in the Nation using certified electronic health record technology. A defining feature of health IT is clinical decision support, which improves clinical care by making evidence and best practices available and actionable at the point of care. These resources are a valuable tool for clinicians and patients.

The time to leverage the new health IT infrastructure to disseminate PCOR findings is now. The ACA directs AHRQ to assist health IT users to incorporate patient centered outcomes research findings into clinical decision support (CDS), and to receive feedback on the value of the assistance. CDS is a key component of HITECH Act-authorized health IT initiatives, and has been a subject of significant investment by AHRQ, ONC and HHS over the past decade. The stage is being set for stage 3 of meaningful use, which prominently features CDS use to improve outcomes.

In collaboration with ONC and others, AHRQ will launch a coordinated initiative to leverage the National investment in health IT to disseminate PCOR findings through CDS. Components of the initiative will include: (1) creation of a publicly available database of PCOR findings; (2) development of resources for CDS implementation based on PCOR findings, including coded clinical knowledge and implementation guides; (3) building web services to deliver CDS

resources to key stakeholders; (4) engaging stakeholders for feedback and future direction; and (5) evaluation of the overall initiative. This initiative has been developed in close coordination with staff from the Office of the National Coordinator for Health IT and the Assistant Secretary for Planning and Evaluation, and is both complementary and synergistic with other PCORTF initiatives and broader Administration initiatives such as the Meaningful Use Incentive Program and certification of EHR technology.