DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2017

Agency for Healthcare Research and Quality

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare
Research and Quality

5600 Fishers Lane
Rockville, MD 20857
www.ahrq.gov

I am pleased to present the FY 2017 Congressional Justification. This budget reverses the significant reductions to research activities in FY 2016 and makes investments in AHRQ's core mission areas of improving the quality and safety of health care; creating tools and resources to be used by health care providers; and developing measures and data that can track and improve performance of the health care system. As part of HHS, AHRQ works closely with other partners within HHS and externally to make sure that these goals are achieved.

In 1999, an Institute of Medicine report, "To Err is Human," documented serious patient safety problems in our health care system. In the intervening years, AHRQ has led the nation in responding to those issues and improving the safety of health care. Using AHRQ's research and how-to-tools, the U.S. health care system had 2.1 million fewer harms to patients, saved 87,000 lives, and avoided nearly $20 billion in wasteful spending from 2010 to 2014. The causes of this remarkable improvement are not fully understood, but are almost certainly related to CMS' Partnership for Patients initiative, which provided technical assistance and focused hospitals' attention on the problem. Crucially, this initiative relied heavily on evidence produced by AHRQ-funded research on how to make health care safer, on the tools and training developed by AHRQ to assure that the evidence is understood and used, and on data and measures developed by AHRQ to track and improve performance. The FY 2017 Congressional Justification provides $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.

AHRQ data helped to highlight a jump in hospitalizations among Medicare, Medicaid, and private pay patients for overuse of opioids. AHRQ showed that these hospitalization rates more than doubled between 1993 and 2012, when there were more than 700,000 Americans hospitalized for opioid overuse. This warning contributed to the Department's launch of a major multipronged initiative to reduce opioid abuse in 2015. As part of this effort, in December, 2015 AHRQ released a funding opportunity announcement with the goal of making medication assisted treatment for opioid use disorder more accessible to people in rural areas. The announcement, titled, "Increasing Access to Medication-Assisted Treatment in Rural Primary Care Practices" will fund demonstration projects that explore how to overcome barriers to implementing Medication-Assisted Treatment (MAT) for opioid use disorder in primary care practices in rural areas of the United States. Primary care practices offer an opportunity to expand access to evidence-based treatment for substance abuse disorders, particularly for those in rural areas which lack specialized treatment facilities. This initiative was developed in close coordination with SAMHSA, HRSA, and NIDA. We intend to fund up to three projects for 3 years, at $1 million per year for each project. The FY 2017 Congressional Justification continues this important work to address prescription drug and opioid misuse and abuse.

Finally, the FY 2017 Congressional Justification includes $9.0 million in research funding within the Health Services Research, Data and Dissemination portfolio 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 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.

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 measureable 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.

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

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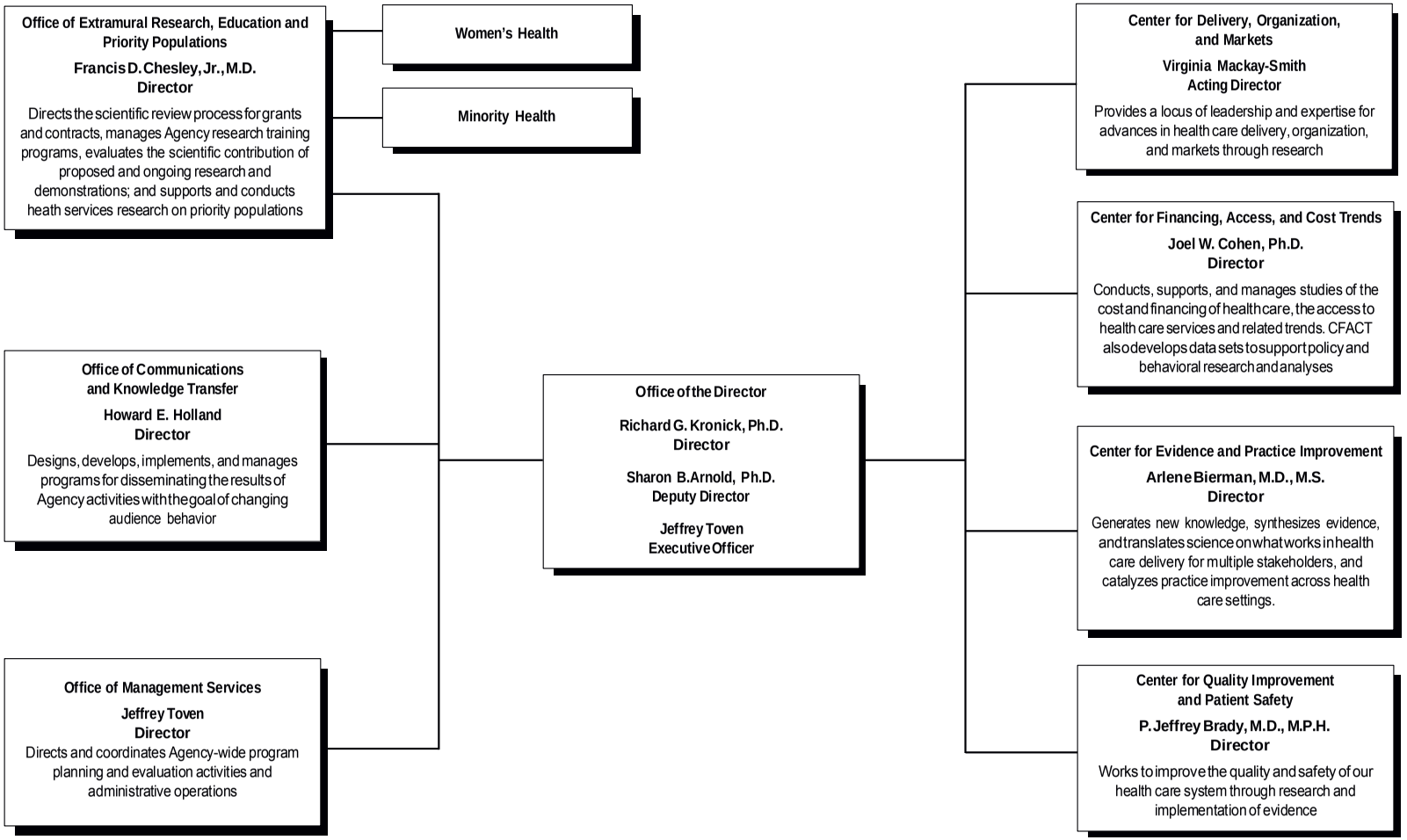
U.S. Department of Health and Human Services
Agency for Healthcare Research and Quality



AHRQ Pub. No. 15-M019
Revised September 2015

Performance Budget Overview

A. Introduction and Mission

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 2017 Congressional Justification supports this priority through both mandatory (funding through the Patient-Centered Outcomes Research Trust Fund (PCORTF)) and discretionary funds.

- The FY 2017 Congressional Justification provides $9.0 million within the Health Services Research, Data and Dissemination (HSR) portfolio for research that optimizes care for patients with Multiple Chronic Conditions (MCC). People with 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 MCCs by 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. 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 patient-centered and integrated care plans. 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. One of the goals of the MCC work is to identify and incorporate the elements needed to do care planning and management in Electronic Health Records (EHRs). The Office of the National Coordinator of Health IT (ONC) conducted outreach to delivery systems to identify where gaps remain regarding the tools health systems believe they need in order to achieve delivery system transformation. ONC determined that health IT-supported integrated care plans are a high priority for delivery systems. Following consultation with ONC, AHRQ will support work to develop the evidence around integrated care planning in an EHR within this MCC initiative.

- The FY 2017 Congressional Justification provides a total of $47.4 million in investigator-initiated grant funding within the HSR portfolio. It is anticipated that a significant portion of these grants will support AHRQ's priority to improve health care quality. New investigator-initiated research and training grants are essential to health services research – they ensure that both new ideas and new investigators are created each year. Investigator-initiated research grants allow extramural researchers to pursue the various

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.

research avenues that lead to successful yet unexpected discoveries. In this light, the investigator-initiated grant is seen as the most vital force driving health services research in this country.

- Finally, AHRQ will use mandatory funding in FY 2017 provided through the PCORTF to improve health care quality and patient health outcomes. On May 14, 2015 AHRQ awarded $112 million to seven grantees to work with thousands of primary care practitioners to strengthen their ability to continuously improve the quality of care they deliver and develop evidence about how to best integrate evidence-based patient centered outcomes research into practice. Aligned with the U.S. Department of Health and Human Services Million Hearts® campaign, this initiative, EvidenceNOW: Advancing Heart Health in Primary Care will focus on helping primary care practices use the latest evidence to improve the heart health of millions of Americans. This initiative establishes seven regional cooperatives composed of public and private partnerships and multidisciplinary teams of experts that will build a sustainable infrastructure of external quality improvement support for primary care. Each three-year project will recruit and engage 250-300 primary care practices and will provide a variety of quality improvement services typically not available to small independent primary care practices, including onsite practice facilitation and coaching, expert consultation, shared learning collaboratives, and electronic health record support. These efforts will be evaluated to determine best practices for improving use of evidence based practices in primary care to further quality improvement in the future. The cooperatives span 12 states, reaching Native Americans in Oklahoma, Hispanics in New Mexico and Colorado, medically underserved communities in New York City and the Chicago Tri-State region, and rural communities in the Pacific Northwest, Virginia, and North Carolina.

Priority 2: Make health care safer. This priority builds on AHRQ's current patient safety research. The FY 2017 level provides $76.0 million for the patient safety portfolio, including $8.7 million in new grant funding for the research portfolio.

- A total of $35.0 million is provided for general patient safety research focusing 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. This includes $10 million to support for patient safety learning laboratories, which utilize multidisciplinary teams to generate new ways of thinking about patient safety and simulate new approaches to improving patient safety.

- A total of $34 million will support research related to Healthcare-Associated Infections (HAIs). These funds will continue to advance the generation of new knowledge and promote the dissemination and implementation of proven methods for preventing HAIs. The HAI support includes a total of $11 million for three projects using AHRQ's Comprehensive Unit-based Safety Program (CUSP): CUSP for catheter-associated urinary tract infections (CAUTI) and central line-associated blood stream infections (CLABSI) in Intensive Care Units (ICUs); CUSP for Antibiotic Stewardship in Ambulatory and Long-Term Care Settings and Hospitals; and CUSP for Enhanced Recovery Protocol for Surgery. The CUSP for Antibiotic Stewardship project is designed to support the President's National Action Plan for Combating Antibiotic-Resistant Bacteria (CARB), and will extend the use of CUSP to promote the implementation of antibiotic stewardship

programs, which seek to reduce inappropriate antibiotic use, in ambulatory and long-term care settings as well as hospitals.

- Finally a total of $7.0 million is provided for AHRQ's Patient Safety Organization (PSO) program. These funds will be used to continue to support enhancements and new versions of data standards for patient safety reporting (Common Formats), standardization of processes for reporting patient safety events, analysis of events collected by Patient Safety Organizations, conformance with administrative requirements of the Patient Safety Act, and operation and continued refinement of the Quality and Safety Review System. As a result of these activities, providers will have the data and tools needed to strengthen patient safety culture in health care organization across the country, leading to safer care for patients.

Priority 3: Increase accessibility. This priority builds on the work AHRQ has done documenting the impact of insurance on health care utilization, costs, and health outcomes. AHRQ will continue to provide evidence on the effects of health insurance coverage expansions on the health and financial security of the uninsured, on health care providers, particularly those in the safety net, and on employer and employee decisions with respect to employer-sponsored insurance. The FY 2017 Congressional Justification includes $68.9 million for the Medical Expenditure Panel Survey (MEPS). MEPS, first funded in 1995, is the only national source for comprehensive annual data on how Americans use and pay for medical care and is used across the government, in academic research, and in the private sector to study and answer questions related to health care costs. In addition to collecting data that supports 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.

Priority 4: Improve health care affordability, efficiency and cost transparency. This priority focuses on producing evidence that supports efforts to pay providers, deliver care, and distribute information in ways that result in better care and wiser spending. The FY 2017 Congressional Justification continues funding within the HSR portfolio for several core measurement and data collection activities that directly impact this priority. 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; hold providers accountable under value purchasing initiatives; identify disparities in health status and use of health care by race or ethnicity, socioeconomic status, region, and other population characteristics; describe our experiences with the health care system; monitor trends in health status and health care delivery; identify health problems; support health services research; and provide information for making changes in public policies and programs. The Congressional Justification provides $17.1 million for continued funding of the AHRQ Quality Indicators (QI) program, Consumer Assessments of Healthcare Providers and Systems (CAHPS), National Quality and Disparities Reports, and the Healthcare Cost and Utilization Project (HCUP).

These priorities are reflected in AHRQ's Budget Summary Table provided below.

B. Overview of AHRQ Budget Request by Portfolio

AHRQ's FY 2017 Budget will continue to support both AHRQ's mission and our four priority areas of research. AHRQ's FY 2017 discretionary request totals $363.7 million, an increase of $29.7 million from the FY 2016 Enacted. Of the total discretionary request, $280.2 million is requested in Budget Authority funds and $83.5 million is requested in PHS Evaluation funds. AHRQ's total program level at the FY 2017 Request is $469.7 million, an increase of $41.2 million from the FY 2016 Enacted. The total program level includes $106.0 million in mandatory funds from the Patient-Centered Outcomes Research Trust Fund (PCORTF), an increase of $11.5 million from the prior year.

AHRQ Budget Detail
(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 P.B. +/- FY 2016 Enacted
Research on Health Costs, Quality, and Outcomes (HCQO):				
Patient Safety	$76,584	$74,253	$75,977	+$1,724
Health Services Research, Data and Dissemination	$112,207	$89,398	$113,474	+$24,076
Budget Authority	*$112,207*	*$89,398*	*$30,016*	*-$59,382*
PHS Evaluation Funds	*$0*	*$0*	*$83,458*	*+$83,458*
Health Information Technology	$28,170	$21,500	$22,877	+$1,377
U.S. Preventive Services Task Force	$11,590	$11,649	$11,649	+$0
Subtotal HQCO	**$228,551**	**$196,800**	**$223,977**	**+$27,177**
HCQO, Budget Authority	*$228,551*	*$196,800*	*$140,519*	*-$56,281*
HCQO, PHS Evaluation Funds	*$0*	*$0*	*$83,458*	*+$83,458*
Medical Expenditure Panel Survey	**$65,447**	**$66,000**	**$68,877**	**+$2,877**
Program Support	**$69,700**	**$71,200**	**$70,844**	**-$356**
Total Budget Authority	**$363,698**	**$334,000**	**$280,240**	**-$53,760**
Total PHS Evaluation Funds	**$0**	**$0**	**$83,458**	**+83,458**
AHRQ Discretionary Request	**$363,698**	**$334,000**	**$363,698**	**+29,698**
PCORTF Transfer 1/	**$79,234**	**$94,464**	**$105,994**	**+$11,530**
Total Program Level	**$442,932**	**$428,464**	**$469,692**	**+$41,228**

1/ Mandatory Funds

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 Budget Authority, Reimbursable, and PCORTF funding.

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
FTEs – Budget Authority	**287**	**300**	**300**
FTEs – Reimbursable	**5**	**6**	**6**
FTEs – PCORTF	**10**	**25**	**25**

C. Overview of Performance

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 making investments in AHRQ's core mission areas of improving the quality and safety of health care; creating tools and resources to be used by health care providers; and developing measures and data that can track and improve performance of the health care system.

Throughout the fiscal year, portfolios and programs continue to report on key accomplishments. The Patient Safety program continues to expand patient safety initiatives to all settings, including hospital, ambulatory care and nursing home settings, among others. Also, it continues to work to reduce the rate of catheter-associated urinary tract infections (CAUTI) and increase the number of tools, evidence-based information, and products available for use by healthcare organizations, including a follow-up to reduce the rate of infections in intensive care units (ICUs). Two additional comprehensive unit-based program (CUSP) projects have been implemented to 1) foster the use of an Enhanced Recovery Protocol that can improve outcomes for surgical patients and 2) support the President's National Action Plan for Combating Antibiotic-Resistant Bacteria (CARB). AHRQ's Health IT program will continue investing in health IT to improve the quality, safety, effectiveness, and efficiency of US health care through support of new research grants. For example, the Health IT portfolio's Personal Health Information Management (PHIM) grants reported findings on understanding the unique information management needs and preferences of patients and their caregivers and how those may vary by condition, setting, health information management activity or age.

Health Services Research, Data and Dissemination projects support the measurement, data collection, and dissemination and translation activities of AHRQ-funded research, products, and tools. The number of organizations using the AHRQ QIs in their report on hospital and community level health care quality increased, and now include the Yale New Haven Health System, Cleveland Clinic, Partners for Kids and Nationwide Children's Hospital, Southeastern Med, Lee Memorial Health System, and McLaren Healthcare. In addition, the AHRQ CAHPS program advanced both the science around CAHPS as well as the release of surveys, supplemental items, and related educational materials. After seeking input from users and stakeholders, the CAHPS program released version 3.0 of the Clinician and Group Adult and Child Surveys. Significant changes included shortening the reference period to 6 months, creating a new composite measure for care coordination, and modifying two composite measures.

The Medical Expenditure Panel Survey (MEPS) data is used for economic models of health care use and expenditures. Increased operational efficiencies has resulted in a further reduction in FY2016 in the amount of time to produce the Insurance Component tables following data collection and a continued increase in the number of tables added annually to the MEPS table series.

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, the HHS Strategic Plan, HHS Strategic Reviews, the Summary of Performance and Financial Information, and the HHS Agency Financial Report.

All-Purpose Table 1/

(dollars in thousands)

Program	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
RESEARCH ON HEALTH COSTS, QUALITY AND OUTCOMES				
Patient Safety	**$76,584**	**$74,253**	**$75,977**	**+$1,724**
Health Services Research, Data and Dissemination	**$112,207**	**$89,398**	**$113,474**	**+$24,076**
Budget Authority	*$112,207*	*$89,398*	*$30,016*	*-$59,382*
PHS Evaluation Fund	*$0*	*$0*	*$83,458*	*+$83,458*
Health Information Technology	**$28,170**	**$21,500**	**$22,877**	**+$1,377**
U.S. Preventive Services Task Force	**$11,590**	**$11,649**	**$11,649**	**+0**
Budget Authority	**$228,551**	**$196,800**	**$140,519**	**-$56,281**
PHS Evaluation	**$0**	**$0**	**$83,458**	**+$83,458**
Subtotal, HCQO Program Level	**$228,551**	**$196,800**	**$223,977**	**+$27,177**
MEDICAL EXPENDITURE PANEL SURVEY				
Budget Authority	$65,447	$66,000	$68,877	+$2,877
PHS Evaluation	$0	$0	$0	+0
Subtotal, MEPS	**$65,447**	**$66,000**	**$68,877**	**+$2,877**
PROGRAM SUPPORT				
Budget Authority	$69,700	$71,200	$70,844	-$356
PHS Evaluation	$0	$0	$0	+0
Subtotal, Program Support	**$69,700**	**$71,200**	**$70,844**	**-$356**
SUBTOTAL				
Budget Authority	**$363,698**	**$334,000**	**$280,240**	**-$53,760**
PHS Evaluation	**$0**	**$0**	**$83,458**	**+$83,458**
Subtotal	**$363,698**	**$334,000**	**$363,698**	**+$29,698**
PCORTF Transfer 2/	$79,234	$94,464	$105,994	+$11,530
TOTAL PROGRAM LEVEL	**$442,932**	**$428,464**	**$469,692**	**+$41,228**
FTEs				
Budget Authority	**287**	**300**	**300**	**0**
PHS Evaluation	**0**	**0**	**0**	**0**
ACA Funds - PCORTF Transfer 2/	**10**	**25**	**25**	**0**
TOTAL PROGRAM LEVEL	**297**	**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 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	No.	Dollars	No.	Dollars	No.	Dollars
RESEARCH GRANTS						
Non-Competing						
Patient Safety	49	19,952	62	30,828	71	35,268
Health Serv Res, Data & Diss	88	22,544	68	27,139	99	39,639
Health Information Technology	52	17,578	24	11,901	29	14,479
U.S. Preventive Services Task Force	0	0	0	0	0	0
Medical Expenditure Panel Survey	0	0	0	0	0	0
Total Non-Competing	189	60,074	154	69,868	199	89,386
New & Competing						
Patient Safety	37	19,143	23	11,524	17	8,734
Health Serv Res, Data & Diss	104	30,484	66	26,259	34	13,759
Health Information Technology	24	6,595	14	7,099	11	5,521
U.S. Preventive Services Task Force	0	0	0	0	0	0
Medical Expenditure Panel Survey	0	0	0	0	0	0
Total New & Competing	165	56,222	103	44,882	62	28,014
RESEARCH GRANTS						
Patient Safety	86	39,095	85	42,352	88	44,002
Health Serv Res, Data & Diss	192	53,028	134	53,398	133	53,398
Health Information Technology	76	24,173	38	19,000	40	20,000
U.S. Preventive Services Task Force	0	0	0	0	0	0
Medical Expenditure Panel Survey	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	354	116,296	257	114,750	261	117,400
CONTRACTS/IAAs						
Patient Safety		37,489		31,901		31,975
Health Serv Res, Data & Diss		59,179		36,000		60,076
Health Information Technology		3,997		2,500		2,877
U.S. Preventive Services Task Force		11,590		11,649		11,649
Medical Expenditure Panel Survey		65,447		66,000		68,877
TOTAL CONTRACTS/IAAs		177,702		148,050		175,454
RESEARCH MANAGEMENT		69,700		71,200		70,844
GRAND TOTAL						
Patient Safety		76,584		74,253		75,977
Health Serv Res, Data & Diss		112,207		89,398		113,474
Health Information Technology		28,170		21,500		22,877
U.S. Preventive Services Task Force		11,590		11,649		11,649
Medical Expenditure Panel Survey		65,447		66,000		68,877
Research Management		69,700		71,200		70,844
GRAND TOTAL		363,698		334,000		363,698

1/ Does not include ACA funds from the PCORTF.

Budget Exhibits – Table of Contents

Budget Exhibits

Appropriation Language and Analysis

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, [**$334,000,000]** *$363,698,000, of which $83,458,000 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 [**2016]** *2017*: *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, 2017]** *expended*.

Appropriations Language Analysis

Language Provision	Explanation
of which $83,458,000 shall be from funds available under section 241 of the PHS Act:	Language modified so that $83,458,000 of the AHRQ appropriation comes from PHS Evaluation Funds.
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, 2017] ***expended***	Language modified to change the period of availability from two-year to no-year for FOIA fees, sale of data fees, and reimbursable agreements.

Amounts Available for Obligation 1/

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

Amounts Available for Obligation 1/

	2015 Actual 2/	FY 2016 Enacted	FY 2017 President's Budget
Appropriation:			
Annual	$363,364,000	$334,000,000	$280,240,000
Subtotal, adjusted appropriation	$363,364,000	$334,000,000	$280,240,000
Offsetting Collections from:			
Federal funds pursuant to Title IX of P.L. 102-410, (Section 947(c) PHS Act)			
HCQO	$0	$0	$83,458,000
MEPS	$0	$0	$0
Program Support	$0	$0	$0
Subtotal, adjusted appropriation	$0	$0	$83,458,000
Unobligated Balance Lapsing	$334,000	---	---
Total obligations	$363,698,000	$334,000,000	$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

2016 Total estimated budget authority	$334,000,000
(Obligations)	**($334,000,000)**
2017 Total estimated budget authority	$280,240,000
(Obligations)	**($280,240,000)**
Net change	-$53,760,000
(Obligations)	**-($53,760,000)**

Increases	2016 Estimate		Change from Base	
A. Program Support (Built-in)	(FTE)	Budget	(FTE)	Budget Authority
1. Salary and Benefits	300	48,182,000	0	+590,000
	(300)	(48,182,000)	(0)	(+590,000)
2. Equipment	0	1,542,000	0	+28,000
	(0)	(1,542,000)	(0)	(+28,000)
Subtotal, Built-in			**0**	**+618,000**
			(0)	**(+618,000)**
B. Program				
1. Patient Safety	0	74,253,000	0	+1,724,000
	(0)	(74,253,000)	(0)	(+1,724,000)
2. Health Information Technology	0	21,500,000	0	+1,377,000
	(0)	(21,500,000)	(0)	(+1,377,000)
3. Medical Expenditures Panel Survey	0	66,000,000	0	+2,877,000
	(0)	(66,000,000)	(0)	(+2,877,000)
Subtotal, Program			**0**	**+5,978,000**
			(0)	**(+5,978,000)**
Total Increases			**0**	**+6,596,000**
			(0)	**(+6,596,000)**

Summary of Changes Continued

Decreases		2016 Estimate		Change from Base
A. Program Support (Built-in)				
1. Rent savings from moving to 5600 Fishers Lane	0	4,140,000	0	-948,000
	(0)	(4,140,000)	(0)	-(948,000)
2. Non-pay costs.....	0	17,336,000	0	-26,000
	(0)	(17,336,000)	(0)	(26,000)
Subtotal, Built-in.....			**0**	**-974,000**
			(0)	**-(974,000)**
B. Program				
1. Health Services Research, Data and Dissemination.....	0	89,398,000	0	-59,382,000
	(0)	(89,398,000)	(0)	-(59,382,000)
Subtotal, Program.....			**0**	**-59,382,000**
			(0)	**-(59,382,000)**
Total Decreases.....			**0**	**(60,356,000)**
			(0)	**-(60,356,000)**
Net change, Budget Authority.....			**0**	**(53,760,000)**
Net change, Obligations.....			**(0)**	**-(53,760,000)**

Budget Authority by Activity 1/

(Dollars in thousands)

	FY 2015 Actual		FY 2016 Enacted		FY 2017 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
1. Research on Health Costs, Quality, & Outcomes BA	0	$228,551	0	$196,800	0	$140,519
PHS Evaluation	0	$0	0	$0	[0]	[$83,458]
Total Operational Level	0	$228,551	0	$196,800	0	$140,519
2. Medical Expenditures Panel Surveys BA	0	$65,447	0	$66,000	0	$68,877
PHS Evaluation	0	$0	0	$0	0	$0
Total Operational Level	0	$65,447	0	$66,000	0	$68,877
3. Program Support BA	287	$69,700	300	$71,200	300	$70,844
PHS Evaluation	0	$0	0	$0	0	$0
Total Operational Level	287	$69,700	300	$71,200	300	$70,844
Total, Budget Authority	287	$363,698	300	$334,000	300	$280,240
Total PHS Evaluation	0	0	0	0	[0]	[$83,458]
Total Operations	287	$363,698	300	$334,000	300	$280,240

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 2016 Amount Authorized	FY 2016 Appropriations Act	FY 2017 Amount Authorized	FY 2017 President's Budget
Research on Health Costs, Quality, and Outcomes:				
Secs. 301 & 926(a) PHSA.....	SSAN	$196,800,000	SSAN	$140,519,000
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	$66,000,000	SSAN	$68,877,000
Program Support:				
Section 301 PHSA.....	Indefinite	$71,200,000	Indefinite	$70,844,000
Evaluation Funds:				
Section 947 (c) PHSA	Indefinite	$0	Indefinite	$83,458,000
Total appropriations.....		$334,000,000		$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	
2009					
Budget Authority	$ -	$ 323,087,000	$ 90,598,000	$ -	
PHS Evaluation Funds	$ 325,664,000	$ 51,913,000	$ 243,966,000	$ 372,053,000	
Total	$ -	$ -	$ -	$ 1,100,000,000	1/
2010	$ 325,664,000	$ 375,000,000	$ 334,564,000	$ 1,472,053,000	
Budget Authority					
PHS Evaluation Funds	$ -	$ -	$ -	$ -	
ARRA Funding P.L. 111-5	$ 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	$ -	$ 236,001,000	$ 334,000,000	
PHS Evaluation Funds	$ 87,888,000	$ -	$ -	$ -	
Total	$ 363,698,000	$ -	$ 236,001,000	$ 334,000,000	
2017					
Budget Authority	$ 280,240,000	$ -	$ -	$ -	
PHS Evaluation Funds	$ 83,458,000	$ -	$ -	$ -	
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 2016
Research on Health Costs, Quality, and Outcomes……	FY 2005	Such Sums As Necessary	$260,695,000	$334,000,000

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

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 PB +/- FY 2016 Enacted
TOTAL				
--BA	$ 228,551,000	$ 196,800,000	$ 140,519,000	$ (56,281,000)
--PHS Eval	$ -	$ -	$ 83,458,000	$ 83,458,000
Total Program Level	$ 228,551,000	$ 196,800,000	$ 223,977,000	$ 27,177,000

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 2017 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 2017 Congressional Justification is $224.0 million, an increase of $27.2 million or +13.8 percent from the FY 2016 Enacted level. The details by research portfolio are provided below.

AHRQ Budget Detail
(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 P.B. +/- FY 2016 Enacted
Research on Health Costs, Quality, and Outcomes (HCQO):				
Patient Safety	$76,584	$74,253	$75,977	+$1,724
Health Services Research, Data and Dissemination	$112,207	$89,398	$113,474	+$24,076
Budget Authority	*$112,207*	*$89,398*	*$30,016*	*-$59,382*
PHS Evaluation Funds	*$0*	*$0*	*$83,458*	*+$83,458*
Health Information Technology	$28,170	$21,500	$22,877	+$1,377
U.S. Preventive Services Task Force	$11,590	$11,649	$11,649	+$0
Subtotal HQCO	**$228,551**	**$196,800**	**$223,977**	**+$27,177**
HCQO, Budget Authority	*$228,551*	*$196,800*	*$140,519*	*-$56,281*
HCQO, PHS Evaluation Funds	*$0*	*$0*	*$83,458*	*+$83,458*

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 implementation activities, 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 2017 President's Budget Level*:**

HCQO: Patient Safety Research (+$1.7 million): The FY 2017 President's Budget provides $76.0 million, an increase of $1.7 million from the prior year. FY 2017 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). Included in this total is $12.0 million in support of the Presidential-level initiative on Combating Antibiotic-Resistant Bacteria (CARB). A total of $7.0 million will be provided to continue the operation of the Patient Safety Organizations (PSO) program, an increase of $1.7 M from the prior year.

HCQO: Health Services Research, Data and Dissemination (+$24.1 million): The FY 2017 President's Budget level provides $113.5 million for the Health Services Research, Data and Dissemination (HSR) portfolio, an increase of $24.1 million from the FY 2016 Enacted. The FY 2017 President's Budget maintains grants support at $53.4 million, including $47.4 million for investigator-initiated research. Health Services Research Contracts increases by $18.9 million. Included in this increase is $9.0 million in new research contracts to optimize care for patients with Multiple Chronic Conditions. Other contract funding will support new evidence reviews; implementation and rapid-cycle research contracts; research related to paying for value; program evaluations; and contract funds to restore across the board reductions made in the prior year to core activities in data management and events management support. Measurement and Data

Collection activities increase $3.0 million over the prior year. This funding will allow for expansion of the CAHPS program to conduct some preliminary work related to incorporating patient narratives into CAHPS surveys and to develop approaches to disseminating narrative information. The increase will also support the production of the National Quality and Disparities Report (QDR). Dissemination and Implementation activities will increase by $3.0 million. These funds will help expand promotion of AHRQ resources to reduce healthcare-associated infections, tools to improve primary care, and in general, foster the adoption and use of evidence in health care decision making.

HCQO: Health Information Technology (+$1.3 million): The FY 2017 President's Budget provides $22.9 million for the Health Information Technology portfolio, an increase of $1.3 million from the FY 2016 Enacted level. The FY 2017 President's Budget provides $20.0 million in research grants support, an increase of $1.0 million from the FY 2016 Enacted level. A total of $2.9 million, an increase of $0.4 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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 PB +/- FY 2016 Enacted
TOTAL				
--BA	$ 76,584,000	$ 74,253,000	$ 75,977,000	$ 1,724,000
--PHS Eval	$ -	$ -	$ -	$ -

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2017 Authorization……..……..Expired.
Allocation Method……..……....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

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, Healthcare-Associated Infections (HAIs), and Patient Safety Organizations (PSOs). 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 Portfolio engages in key coordination activities which are informed by plans such as the National Action Plan to Prevent Health Care-Associated Infections and the National Action Plan for Adverse Drug Event Prevention. This coordination increases the effectiveness of the Portfolio and reduces fragmentation, overlap, and duplication with other agencies. In addition to the frameworks these plans provide, they also serve as nucleating agents that foster collaboration and partnerships. An example of one of these cross-agency partnerships is a follow-on CUSP project to address persistently elevated rates of infections in ICUs. We expect these opportunities for more substantial collaboration to result in a greater combined impact. Collaborative activities also extend to the assessment of our collective impact at the national level in the form of evaluative work such as the Department's Agency Priority Goals. Through this activity, AHRQ is engaged with other agencies in an ongoing, joint examination of progress towards addressing problems such as catheter-associated urinary tract infections (CAUTI). We are also looking ahead to shared tracking of the cross-Department implementation of antimicrobial stewardship activities. AHRQ's close relationship to the scientific evidence base—as both a producer and user of it—is fundamental to the Portfolio's, and the Department's, success with improving health care delivery.

B. FY 2017 Justification by Activity Detail

Patient Safety Research Activities
(in millions of dollars)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Patient Safety Risks and Harms	$35.584	$31.724	$34.977
Patient Safety Organizations (PSOs)	7.000	5.276	7.000
Healthcare-Associated Infections (HAIs)	34.000	37.253	34.000
Patient Safety Research Activities	**$76.584**	**$74.253**	**$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. The FY 2015 Enacted level directed $15.0 million to the new Patient Safety initiative --Extending Safety to Patients in All Settings, and $5.0 million was provided for additional Patient Safety Learning Laboratories for a total of $10.0 million in FY 2015. "Patient Safety Learning Laboratories" 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 2016 Enacted level directs $11 million to the new Patient Safety initiative to continue to extend safety to patients in All Settings and $10 million to Patient Safety Learning Laboratories. The FY 2016 Enacted level supports $20.4 million in continuing grants, $4.3 million in new grants, and $7 million in research contracts.

FY 2017 President's Budget Policy: The FY 2017 President's Budget provides $35.0 million for this activity, an increase of $3.3 million from the FY 2016 Enacted. This level of support will allow the patient safety research program to continue to fund new research for patient safety in all settings, building on the concerted efforts in FY 2015 and FY 2016 to further expand patient safety to all settings, including hospital, ambulatory care and nursing home settings among others.

The FY 2017 President's Budget provides $23.8 million to support patient safety research grants in all settings, including supporting grants for new FY 2016 patient safety program announcements for diagnostic safety in ambulatory settings, and making health care safer in ambulatory and long term care settings. Of that level, $21.5 million is provided for continuing grants, $2.4 million is provided for new grants, and $11.1 million in research contracts. Of

the$11.1 million allocated toward research contracts, $4.6 million is for ongoing contracts and $6.5 million is for new research contracts. This funding includes continued support of TeamSTEPPS training in multiple settings and the Surveys on Patient Safety Culture which also address multiple health care settings. These projects address the challenges of health care teamwork and coordination among provider teams as well as the establishment of cultures in health care organizations that are conducive to patient safety. Both of these issues are widely recognized as foundational bases on which patient safety can be improved.

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. The FY 2016 Enacted level reduces funding to $5.3 million. AHRQ is considering several options to operationalize this reduction.

FY 2017 President's Budget Policy: The FY President's Budget provides $7.0 million for this activity, an increase of $1.7 million over the FY 2016 Enacted level. These funds will be used to continue to support contracts for enhancements and new versions of the Common Formats, standardization of processes for reporting patient safety events, analysis of events collected by Patient Safety Organizations, conformance with administrative requirements of the Patient Safety Act, and operation of the Quality and Safety Review System.

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 2015, AHRQ has continued to work in close collaboration with HHS partners including CDC, CMS, NIH, and the Office of the Assistant Secretary for Health. In FY 2016, 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 2016, AHRQ's HAI budget of $37.3 million is supporting HAI-related grants in the amount of $17.2 million, 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), an evidence-based approach for preventing HAIs and other patient harms. In FY 2015, the HAI budget initiated funding for a follow-up project to AHRQ's nationwide CUSP implementation projects for preventing central line-associated blood stream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI), to reduce the toll in intensive care units (ICUs) that have persistently elevated rates of these infections. Expansion of this project to nationwide coverage will be initiated in FY 2017. In FY 2016, the HAI budget will initiate funding for two additional CUSP projects. One project, a follow-up to the current CUSP project for safe surgery in hospitals, will apply CUSP to foster the use of an Enhanced Recovery Protocol that can improve outcomes for surgical patients (see Program Portrait). A second CUSP project is designed to support the President's National Action Plan for Combating Antibiotic-Resistant Bacteria (CARB). This project will extend the use of CUSP to promote the implementation of antibiotic stewardship programs, which seek to reduce inappropriate antibiotic use, in ambulatory and long-term care settings as well as hospitals (see Program Portrait on page 26).

FY 2017 President's Budget Policy: The FY 2017 President's Budget provides $34.0 million for this activity, a decrease of $3.3 million from the FY 2016 Enacted level. 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 $20.1 million in HAI research grants and $13.9 million in HAI contracts. The grants will foster the generation of new knowledge about improved methods for preventing and reducing HAIs. In support of the national CARB enterprise, the grants will also further expand efforts to develop improved approaches to antibiotic stewardship, with a focus on ambulatory and long-term care settings, as well as hospitals. Of the contract amount, in support of CARB, $4.3 million will fund continued expansion of the CUSP project to promote the implementation of antibiotic stewardship programs in ambulatory and long-term care settings as well as hospitals (see Program Portrait). This CARB-related grant and contract funding, totaling $12.0 million in FY 2017, aligns with the National Action Plan for CARB, which calls on AHRQ to "sponsor research to develop improved methods and approaches for combating antibiotic resistance and conducting antibiotic stewardship activities in multiple healthcare settings, with a focus on long-term and ambulatory care settings,

Strengthening the Use of Evidence and Evaluation

Achievement of AHRQ's ultimate goal of improving patient safety and the health care delivery system relies on the Portfolio's ability to produce scientific evidence and to make sure that it is understood and used in the field. The Portfolio also proactively incorporates lessons learned from the evidence it produces. One example is AHRQ's work to enhance our ability to reliably measure the extent of harms in health care and use this information to guide efforts to improve patient safety. The Medicare Patient Safety Monitoring System (MPSMS) provides national estimates of the rate of hospital-acquired conditions (HACs), and AHRQ is actively engaged in a project to further refine this important capability. Output from MPSMS has been used both to confirm national progress in making health care safer and also to quantify the safety challenges that still remain. At the same time the Portfolio is focused on measuring and understanding patient harm based on high-quality data and evidence, innovative new interventions, identified by investigator-initiated grants and other projects, are developed and tested in progressively diverse settings in order to enable their wide-scale implementation. Efforts such as TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety), and the application of CUSP (Comprehensive Unit-based Safety Program), are successful initiatives that follow this productive formula.

as well as acute care hospitals." Expansion of CUSP will also be supported by $4.2 million in continued contract funding for the CUSP project to promote the use of an Enhanced Recovery Protocol for surgical patients (see Program Portrait on the following page). In addition, $2.5 million will support the initial expansion of the CUSP project on CAUTI and CLABSI in ICUs toward achieving nationwide coverage.

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 and combat antibiotic resistance. The combination of research and implementation in the HAI portfolio is the most effective way to ensure progress toward eventually eliminating the national problem of HAIs, which is the ultimate goal of the National Action Plan to Prevent HAIs, and toward overcoming the threat of antibiotic resistance, which is the goal of the National Action Plan for Combating Antibiotic-Resistant Bacteria.

C. Mechanism Table

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

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	49	19,952	62	30,828	71	35,268
New & Competing……	37	19,143	23	11,524	17	8,734
Supplemental	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	**86**	**39,095**	**85**	**42,352**	**88**	**44,002**
TOTAL CONTRACTS/IAAs		**37,489**		**31,901**		**31,975**
TOTAL		**76,584**		**74,253**		**75,977**

D. Funding History

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

Year	Dollars
2012	$65,585,000
2013	$66,584,000
2014	$71,584,000
2015	$76,584,000
2016	$74,253,000

Program Portrait: Comprehensive Unit-based Safety Program (CUSP) – three projects: 1. CUSP for CAUTI and CLABSI in ICUs; 2. CUSP for Antibiotic Stewardship in Ambulatory and Long-Term Care Settings + Hospitals; 3. CUSP for Enhanced Recovery Protocol for Surgery.

FY 2016 Level:	$ 8.4 million
FY 2017 Level:	$ 11.0 million
Change:	$ +2.6 million

The Comprehensive Unit-based Safety Program (CUSP), which was both developed and shown to be effective with AHRQ funding, involves improvement in safety culture, teamwork, and communication, together with a checklist of evidence-based safety practices. CUSP was highly effective in reducing CLABSI in the 1,100 ICUs that participated in AHRQ's nationwide CUSP for CLABSI implementation project. Subsequently, AHRQ expanded the application of CUSP to prevent other HAIs, including CAUTI in hospitals and long-term care facilities, surgical site infections (SSI) and other surgical complications in inpatient and ambulatory surgery, and ventilator-associated events. AHRQ provides $11.0 million for CUSP activities in FY 2017, a increase of $2.6 million from the prior year.

In FY 2017, AHRQ will initiate funding of the nationwide expansion of the CUSP project to reduce persistently elevated CAUTI and CLABSI rates in ICUs, which was first funded at the end of FY 2015. In addition, AHRQ will support the further expansion of two CUSP projects that will be initiated in FY 2016 to address two important problems. The first issue is closely tied to the national effort on Combating Antibiotic-Resistant Bacteria (CARB): using CUSP to promote the implementation of antibiotic stewardship programs in diverse settings, with a focus on ambulatory and long-term care, as well as hospitals. Antibiotic stewardship programs are designed to reduce inappropriate antibiotic use. Increasing the appropriateness of antibiotic use is an essential element in preserving the efficacy of existing and yet-to-be-developed antibiotics. Many providers have not yet established antibiotic stewardship programs. CUSP is a powerful behavior change vehicle, and increasing the implementation of antibiotic stewardship programs is basically a behavioral change. The novel extension of CUSP to promoting antibiotic stewardship has the potential to produce significant benefits to both patients and the health care system. A second important issue is improving the recovery of patients from surgery, including reduction in SSIs and other complications. An approach that has shown promising effectiveness is the Enhanced Recovery Protocol for surgery. This approach, which involves careful attention to the patient's nutritional and metabolic status and early post-operative mobilization, among other enhancements, improves various outcomes, including shortening the length of stay. In FY 2017, AHRQ will continue to expand the CUSP project that will be initiated in FY 2016 to apply CUSP for promoting the use of the Enhanced Recovery Protocol for surgical patients.

Health Services Research, Data and Dissemination

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 PB +/- FY 2016 Enacted
TOTAL				
--BA	$ 112,207,000	$ 89,398,000	$ 30,016,000	$ (59,382,000)
--PHS Eval	$ -		$ 83,458,000	$ 83,458,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2017 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. 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 focuses on the areas of quality, effectiveness and efficiency through grants and 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 Implementation of Research to help fulfill the mission of HSR.

B. FY 2017 Justification by Activity

Research Innovations
(in millions of dollars)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Health Services Research Grants *(Investigator-Initiated)*	$53.028 *($46.123)*	$53.398 *($47.398)*	$53.398 *($47.398)*
Health Services Contract/IAA Research	$27.035	$14.000	$32.869
Measurement and Data Collection	$19.156	$14.080	$17.132
Dissemination and Implementation	$12.988	$7.920	$10.075
Total, HSR	**$112.207**	**$89.398**	**$113.474**

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, efficiency, and 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 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 funding is seen as one of the most vital forces driving health services research in this country. The FY 2016 Enacted provides $53.4 million for this activity, an increase of $0.4 million from the FY 2015 level. The FY 2016 Enacted level would provide total support of $47.4 million in investigator-initiated grants, an increase of $3.4 million from the FY 2015 level.

Addressing Prescription Drug and Opioid Misuse and Abuse

The misuse and abuse of prescription drugs impacts the lives of millions of Americans across the country, and costs the American economy tens of billions of dollars in lost productivity and increased health care and criminal justice expenses. In 2009, total drug overdoses overtook every other cause of injury death in the United States, outnumbering fatalities from car crashes for the first time.

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 (MAT). To respond to this need, in FY 2016 AHRQ will award $3.0 million in new grants 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. An additional $1.0 million is provided to conduct a systematic evidence review on the implementation of what is known about the effects of alternative approaches to MAT on patient outcomes, and to identify where more research is needed.

The FY 2017 President's Budget provides $3.25 million in total funding for this initiative, providing $3.0 million for continuing research grants and $0.25 million in contract support for dissemination and technical assistance.

FY 2017 President's Budget Policy: The FY 2017 President's Budget level provides $53.4 million for research grants, the same level of support as the FY 2016 Enacted level.

Support for non-competing research grants, which are continuations of prior year awards, total $39.6 million, an increase of $12.8 million from the FY 2016 level. Included in our continuation support is $3.0 million related to addressing prescription drug and opioid misuse and abuse. Support for new research grants is $13.8 million at the FY 2017 President's Budget level, a decrease of $12.5 million from the FY 2016 level. Of the new research grant funding, the funds are provided as follows:

- $10.8 million is directed to new investigator-initiated research projects. In total, the FY 2017 President's Budget level supports of $47.4 million in investigator-initiated research grant funding, the same level of support as the FY 2016 Enacted level. The new investigator-initiated grants will focus on AHRQ's traditional mission of how to make health care safer and improve quality. Given budgetary constraints, 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.

- $3.0 million is directed to new grants for a re-competition of one of AHRQ's flagship programs -- the Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS supports and promotes the assessment of consumers' experiences with health care. The goals of the CAHPS program are twofold: develop standardized patient questionnaires that can be used to compare results across sponsors and over time; and generate tools and resources that sponsors can use to produce understandable and usable comparative information for both consumers and health care providers. Please see the text box on page 33 for additional information about this program.

Health Services Contract/IAA Research: Similar to support of research grants, funding of health services contracts and IAAs support health services research activities that impact quality, effectiveness and efficiency of health care. Included in Other Health Services Contract/IAA Research is support for evidence reviews, rapid cycle health services research activities, and other contracts to extramural recipients. One of AHRQ's most effective rapid cycle research contract mechanisms is ACTION III: Accelerating Change and Transformation in Organizations and Networks III. The ACTION III contractors include 13 large partnerships comprised of more than 300 research, provider, quality and other stakeholder organizations. Through ACTION III task orders, AHRQ supports and studies the development and testing of interventions designed to improve the quality and safety of care, and the dissemination and implementation of successful care delivery models in diverse care settings. The aim of these rapid cycle research contract mechanisms is to accelerate the diffusion of results into practice. AHRQ's highly successful patient safety CUSP activities use the ACTION contract mechanism. In addition to support of rapid cycle research, this line item 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 2015 AHRQ provided $27.0 million for this activity. The FY 2016 Enacted level provides $14.0 million for this activity, a decrease of $13.0 million. The decrease will require AHRQ to reduce or eliminate support for evidence reviews; implementation research and rapid-cycle research; program evaluations; and require across the board reductions to all other activities.

FY 2017 President's Budget Policy: The FY 2017 President's Budget provides $32.9 million for this activity, an increase of $18.9 million from the FY 2016 Enacted level. Of the increase requested for Health Services Contracts and IAAs:

- $9.0 million is directed to support the new research contracts focused on optimizing care for people with multiple chronic conditions (MCC). People with 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. We anticipate awarding, through a competitive process, one four-year contract in the amount of $9.0 million to optimize care for patients with MCC by 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. One of the goals of the MCC work is to identify and incorporate the elements needed to do care planning and management in Electronic Health Records (EHRs). The Office of the National Coordinator of Health IT (ONC) conducted outreach to delivery systems to identify where gaps remain regarding the tools health systems believe they need in order to achieve delivery system transformation. ONC determined that health IT-supported integrated care plans are a high priority for delivery systems. Following consultation with ONC, AHRQ will support work to develop the evidence around integrated care planning in an EHR within this MCC initiative.

- $8.3 million to fund new evidence reviews, implementation and rapid-cycle research, program evaluations, and funding to restore across the board reductions made in the prior year to data management and events management support.

- $1.3 million in research contracts related to 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. This research will 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 methods of enhancing value that might be used.

- $0.3 million is directed for dissemination and technical assistance support, in addition to the $3.0 million in continuing grants described above, for AHRQ's work on the Secretarial initiative to Address Prescription Drug and Opioid Misuse and Abuse.

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 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

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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.

analysis activities across the Agency. In FY 2015 AHRQ provided $19.2 million to support measurement and data collection activities including the following flagship projects: Healthcare Cost and Utilization Project (HCUP), Consumer Assessment of Healthcare Providers and Systems (CAHPS), AHRQ Quality Indicators (AHRQ QIs), the National Healthcare Disparities and Quality Reports (QDRs), MONAHRQ®, and the HIV Research Network (HIVRN). The FY 2016 Enacted level provides $14.1 million for this activity. This level of support will allow AHRQ to continue funding for Healthcare Cost and Utilization Project (HCUP), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and AHRQ Quality Indicators (AHRQ QIs). Due to the reduced funding level for this Health Services Research, Data and Dissemination, AHRQ will end support of MONAHRQ®, and the HIV Research Network (HIVRN). In addition, AHRQ will seek efficiencies in the production of the National Healthcare Disparities and Quality Reports (QDRs), which may include a reduction in the development of new chartbooks on special populations and changes in the frequency with which data is updated.

FY 2017 President's Budget Policy: The FY 2017 President's Budget provides $17.1 million for Measurement and Data Collection activities, an increase of $3.0 million over the prior year. This funding level will support measurement and data collection including support of the following flagship projects: Healthcare Cost and Utilization Project (HCUP), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and AHRQ Quality Indicators (AHRQ QIs). This funding will allow for expansion of the CAHPS program to conduct some preliminary work related to incorporating patient narratives into CAHPS surveys and to develop approaches to disseminating narrative information. The incorporation of patient narratives as a method for patients to provide feedback about their experience will enhance consumers' understanding of standardized measures of quality, better engage consumers in health care decision making, and more effectively convey patient experiences to providers in ways that are more actionable and supportive of quality improvement. The increase will also support a more robust production of the QDRs.

Dissemination and Implementation: AHRQ's dissemination and implementation activities foster the use of Agency-funded research, products, and tools to achieve measurable improvements in the health care 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 the dissemination of research findings and tools through tailored, hands-on technical assistance.

Support for Dissemination and Implementation activities was $13.0 million in at the FY 2015 Enacted level. The FY 2016 Enacted level provides $7.9 million, a decrease of $5.1 million. AHRQ will increase our efforts with other public- and private-sector organizations to leverage our resources in FY 2016. As a result of funding cuts, AHRQ will end support of the National Quality Measures Clearinghouse (NQMC). NQMC is a public resource for evidence-based quality measures and measure sets. Whether the NQMC website will still be available to users to browse measures included in the HHS Measures Inventory has not yet been decided. AHRQ will also end support of the Health Care Innovations Exchange. In addition, AHRQ will prioritize dissemination and implementation work critical activities including the development and distribution of materials to assist consumers and patients in shared decision making with their clinicians; encouraging the adoption of tools and proven models to enhance delivery systems,

and reduce health care-associated infections, such as those developed by the patient safety portfolio's Comprehensive Unit-based Safety (CUSP) Program.

FY 2017 President's Budget Policy: The FY 2017 President's Budget provides $10.1 million for this activity, an increase of $2.2 million over the FY 2016 Enacted. 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 the Agency's statistical briefs based on the Medical Expenditure Panel Survey (MEPS) and the Healthcare Cost and Utilization Project (HCUP). In addition, these funds will help expand promotion of AHRQ resources to reduce healthcare-associated infections, tools to improve primary care, and in general, foster the adoption and use of evidence in health care decision making. The Agency will also promote the state-based information and topic-specific chapters from the newly re-formatted and renamed National Quality and Disparities Report (**http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html**) and restore publication and on-line hosting of the State Snapshots (**http://nhqrnet.ahrq.gov/inhqrdr/state/select**).

C. Mechanism Table

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

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	88	22,544	68	27,139	99	39,639
New & Competing……	104	30,484	66	26,259	34	13,759
Supplemental	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	**192**	**53,028**	**134**	**53,398**	**133**	**53,398**
TOTAL CONTRACTS/IAAs		**59,179**		**36,000**		**60,076**
TOTAL		**112,207**		**89,398**		**113,474**

D. Funding History

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

Year	Dollars
2012	$108,377,000
2013	$111,072,000
2014	$111,072,000
2015	$112,207,000
2016	$ 89,398,000

Research Highlight: CAHPS Program

FY 2016 Enacted: $4.5 million (grants and contracts)
FY 2017 President's Budget: $5.5 million (grants and contracts)

Through its Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program, AHRQ is advancing patient-centered care by providing patients with effective surveys and information to help them make better health care decisions. The CAHPS program develops standardized surveys that organizations can use to collect comparable information on patients' experience with care and produces tools and resources to support the dissemination and use of comparative survey results to inform the public and improve health care quality. The CAHPS surveys incorporate patient and stakeholder perspectives in the development process. They ask questions that patients identify as important and address issues for which patients are the best or only source of the information. Many organizations can develop and use CAHPS surveys, but AHRQ ensures that the surveys meet rigorous design principles before they can use the CAHPS trademark, in order to produce data that are objective, accurate, and reliable. Additionally, AHRQ develops and maintains guidance on survey format, developing an appropriate sample, and choosing the correct mode of administration for the survey. AHRQ also provides tools for analysis of CAHPS data.

The CAHPS surveys ask patients to detail their experiences with ambulatory care providers, such as physicians' offices; health plans; home health care agencies; and care delivered in institutional settings such as hospitals, dialysis centers, and nursing homes. CAHPS survey results are typically used to monitor and drive improvements in patient experience with care and to better inform consumers about health care providers in their area. Some organizations incorporate the survey results into programs that reward or recognize health care providers for providing high-quality care. The surveys are used in a variety of public and private programs including:

- The Centers for Medicare & Medicaid Services' (CMS) Hospital Value-Based Purchasing (Hospital VBP) program links a portion of inpatient prospective payment system (IPPS) hospital payment from CMS to performance on a set of quality measures. The Hospital CAHPS (HCAHPS) survey is the basis for the Patient and Caregiver Centered Experience of Care/Care Coordination (PEC/CC) domain, which accounts for 30% of a hospital's Total Performance Score (TPS) in FY 2015 and 25% of a hospital's TPS in 2016.

- CMS has implemented The Medicare CAHPS® a set of surveys sponsored by CMS that collect information from and provide findings to Medicare beneficiaries on the quality of health services provided through MA and Medicare and Part D programs. Health plans can use the survey findings for quality improvement. The surveys assess the experiences of beneficiaries who receive health care through the Medicare Fee-for-Service (FFS), MA and PDP programs. The Medicare CAHPS surveys produce comparable data on the patient's experience of care that allow objective and meaningful comparisons between MA and PDP contracts. The results from the Medicare CAHPS surveys are published in the Medicare & You handbook and on the Medicare Options Compare Web site (www.medicare.gov).

- The National Committee for Quality Assurance's (NCQA) Health Plan Healthcare Effectiveness Data and Information Set (HEDIS®) is the premier tool for monitoring the quality of care in health plans. The CAHPS 5.0H surveys are designed to capture accurate and reliable information from consumers about their experiences with health care. There are four versions that can be administered to adults and children in commercial and Medicaid plans. The surveys include a core set of questions, with some questions grouped to form composites, or summary results, of key areas of care and service. Health plans report survey results as part of HEDIS data collection. NCQA uses survey results in health plan performance reports, to inform accreditation decisions and to create national benchmarks for care.

The CAHPS Database is the repository for data from selected CAHPS surveys. The primary purpose of the CAHPS Database is to facilitate comparisons of CAHPS survey results by and among survey users.

For more information, please see: https://cahps.ahrq.gov/

Health Information Technology

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 PB +/- FY 2016 Enacted
TOTAL				
--BA	$ 28,170,000	$ 21,500,000	$ 22,877,000	$ 1,377,000
--PHS Eval	$ -	$ -	$ -	$ -

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2017 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 2017 Justification by Activity Detail

Health Information Technology Research Activities
(in millions of dollars)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Research Grants on Utilizing Health IT to Improve Quality	$24.173	$19.000	$20.000
Synthesizing and Disseminating Evidence on the Meaningful Use of Health IT	$3.997	$2.500	$2.877
Health IT Research Activities	**$28.170**	**$21.500**	**$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. In 2014 and 2015, Congress directed AHRQ to fund new research to fill the gaps in our knowledge of health IT safety. In 2016 and 2017, 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 2017 President's Budget Policy: The FY 2017 President's Budget provides $20.0 million for this activity. These funds will support $6.0 million in new investigator-initiated grants in FY 2017. The FY 2017 Budget 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. Notable achievements include development of national requirements for health IT used to care for children (please see the program portrait on the following page) and forward-looking analysis of the use of data for individual health.

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 at healthit.ahrq.gov. In coordination with other Federal programs, AHRQ also ensures that high profile research findings appear on healthit.gov, the HHS official website for health IT information. In FY 2016, AHRQ will maintain the U.S. Health Information Knowledgebase (USHIK), a publicly accessible, online registry of health care-related metadata, specifications, and standards. Through USHIK, users are able to navigate the technical requirements for AHRQ's Common Formats, specifications for quality measures in the EHR incentive program from CMS, and the functional requirements that comprise the Children's EHR Format, among others. AHRQ participates in the Federal Health IT Advisory Council, is represented on the Implementation, Usability and Safety Work Group of ONC's Health IT Policy Federal Advisory Committee, is a member of the Networking and Information Technology Research and Development (NITRD) Program, and participates in topic-specific working groups such as the AHRQ-ONC Safety Workgroup. These activities help to reduce fragmentation, unnecessary overlap, and duplication.

FY 2017 President's Budget Policy: The FY 2017 President's Budget provides $2.9 million for this activity, the same level of supports as the FY 2016 Enacted level. These funds will support portfolio activity monitoring and synthesis and continuing online dissemination. Ongoing website evaluations and updates are planned.

Program Portrait: **Health IT Improves Outcomes for Children with Asthma**

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 particular, research targeted at significant initiatives like adoption and meaningful use of health IT helps the Nation understand how to get better value from our efforts and investment. In September 2013, AHRQ funded projects that evaluated proposed objectives for the Medicare and Medicaid EHR Incentive Program, including patient access to their health data. One project at the Children's Hospital of Philadelphia evaluated the effect on outcomes for children with asthma.

Dr. Alexander Fiks and colleagues found that when patients and their families were given access to data on symptoms, medications, care plans and best practices, their health improved. The children experienced fewer asthma flare-ups, and parents missed fewer days of work. Over 90% of participants reported they were satisfied with the electronic application they used, and parents also reported improved satisfaction with care.

The widespread adoption of health IT in the past several years has made possible online access by patients to their health data. Research funded by AHRQ shows that this access can help us achieve healthier children and families.

Pediatrics. 2015 Apr;135(4):e965-73. doi: 10.1542/peds.2014-3167. Epub 2015 Mar 9.

C. Mechanism Table

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

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	52	17,578	24	11,901	29	14,479
New & Competing……	24	6,595	14	7,099	11	5,521
Supplemental	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	**76**	**24,173**	**38**	**19,000**	**40**	**20,000**
TOTAL CONTRACTS/IAAs		**3,997**		**2,500**		**2,877**
TOTAL		**28,170**		**21,500**		**22,877**

D. Funding History

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

Year	Dollars
2012	$25,572,000
2013	$25,572,000
2014	$29,572,000
2015	$28,170,000
2016	$21,500,000

U.S. Preventive Services Task Force (USPSTF)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 PB +/- FY 2016 Enacted
TOTAL				
--BA	$11,590,000	$11,649,000	$11,649,000	$0
--PHS Eval	$ -	$ -	$ -	$0
--Prev. & Public Hlth Fund 1/	$ -	$ -		$0
Total Program Level	$ 11,590,000	$ 11,649,000	$ 11,649,000	$0

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2017 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 2017 Justification by Activity Detail

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

Research Activities	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
USPSTF			
--Budget Authority	$11.590	$11.649	$11.649
--PHS Evaluation Funds	$ 0.000	$ 0.000	$ 0.000
TOTAL, USPSTF	**$11.590**	**$11.649**	**$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 2015 Enacted provided $11.6 million to support the USPSTF. 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 2016, this funding level provides $11.6 million to provide ongoing support to the USPSTF.

FY 2017 President's Budget Policy: The FY 2017 President's Budget provides $11.6 million for this activity, the same level of support as the FY 2016 Enacted. 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.

C. Mechanism Table for USPSTF

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

	FY 2015 Final		FY 2016 Enacted		FY 2017 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		**11,590**		**11,649**		**11,649**
TOTAL		**11,590**	0	**11,649**	**0**	**11,649**

D. Funding History

Funding 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. The other research has now ended or is included in other research portfolios. The funding provided below only includes support for the Task Force.

Year	Dollars
2012	$11,300,000
2013	$11,300,000
2014	$11,300,000
2015	$11,590,000
2016	$11,649,000

Leading in Science and Innovation*: Expand our ability to assess and use information about important differences among individuals to make recommendations about prevention and treatment.*

Program Portrait*:* ***Recommendation on Abnormal Blood Glucose and Type 2 Diabetes Mellitus Screening***

More than 29 million Americans have diabetes and another 86 million are at high risk for the disease. Uncontrolled diabetes is a leading cause of cardiovascular mortality and morbidity and may also result in other complications, such as vision loss, renal failure, and amputation.

Given the increasing prevalence of abnormal glucose metabolism in the U.S. population, the USPSTF sought to examine the benefits and harms of screening for impaired fasting glucose (IFG), and impaired response to oral glucose intake (impaired glucose tolerance [IGT]), and type 2 diabetes.

In October 2015, the U.S. Preventive Services Task Force released its updated recommendation on Abnormal Blood Glucose and Type 2 Diabetes Mellitus. The updated recommendation was based on new evidence, public comment, and close working partnerships within the DHHS.

In 2015, the USPSTF updated its recommendation to be:

- The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. **This is a grade B recommendation.**

Key Performance Measures for HCQO by Portfolio

Portfolio: Patient Safety.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
1.3.38 Increase the number of users of research using AHRQ-supported research tools to improve patient safety culture (Outcome)	FY 2015: 2106 users of research Target: 1350 users of research (Target Exceeded)	2200 users of research	2275 users of research	+75 users of research
1.3.39 Increase the number of patient safety events (e.g. medical errors) reported by Patient Safety Organizations (PSOs) to the Network of Patient Safety Databases (NPSD) (Outcome)	FY 2015: 26 DUAs between PSOs and the PSO PPC (Target Exceeded)	N/A	N/A	N/A
1.3.41 Increase the cumulative number of tools, evidence-based information, and products available in AHRQ's inventory of tools to improve patient safety and reduce the risk of patient harm. (Outcome)	FY 2015: 152 tools (Target Exceeded)	162 tools	177 tools	+15 tools
1.3.59 Reduce the rate of CAUTI cases (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%).	N/A	N/A	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
	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 Exceeded) (Pending)			
1.3.62 Reduce the rate of CAUTI cases in hospital intensive care units (ICUs) (Outcome)		Establish baseline	TBD	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 2015, over 2,106 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 was issued in this fiscal year with 255 community pharmacies reporting data.

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 Privacy Protection Center (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. While these DUAs grew in number in the past years, 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. Submission is voluntary, so there is no way for AHRQ to require the submission of data of higher volume and quality that is currently the case.

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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.

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In FY 2015, AHRQ has made available 152 tools, evidence-based information, and products including:

- 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 31 primers available on PSNet with a plan for more than five new primers to be released 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 in the coming years. 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). With these new additions, AHRQ expects to grow the patient safety tools, evidence-based information and products available in AHRQ's inventory of resources to 162 in FY 2016, and 177 in FY 2017.

1.3.59: Reduce the rate of CAUTI cases in hospitals

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 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 was completed in the latter half of FY 2015. This 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 expanded the reach of the CUSP for CAUTI project to additional States and hospital units and aimed for a 10 percent reduction from the contemporaneous FY 2014 baseline CAUTI rates of participating hospitals at that time. Interim data reported in August 2014 indicated that the NHSN CAUTI rate in the project was reduced by 15.2 percent, and the population rate was 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 further expanded its reach, and AHRQ will determine progress toward achieving a 15 percent reduction from the then-contemporaneous baseline CAUTI rates of participating hospitals.

The reduction in CAUTI rates in the CUSP for CAUTI project has made a major contribution to attaining the HHS Agency Priority Goal, which aimed to reduce CAUTI by 10 percent by the end of FY 2015. CUSP for CAUTI was completed in the latter half of FY 2015, making it necessary to establish a new HAI performance measure, #1.3.62, for FY 2016.

1.3.62: Reduce the rate of CAUTI cases in hospital intensive care units (ICUs)

Beginning in FY 2016, a new performance measure was connected to an HAI project as follow-on to 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. It appears that this difference is related to the clinical culture of the ICU, where staff who are treating critically ill patients favor maintaining indwelling urinary catheters to closely monitor urine output for relatively longer times than in 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. The new HAI project will enhance CUSP to bring down persistently elevated CAUTI and CLABSI rates in ICUs. The new performance measure focuses 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 assesses 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. Given the lesser reductions in CAUTI rates that have been seen in ICUs in the nationwide CUSP for CAUTI project, the target for FY 2017 will have to be set on the basis of experience in the new project in FY 2016. It would appear that a target of approximately a 5 percent reduction may be reasonable, but this will have to be re-examined when data from the new project become available in FY 2016.

Portfolio: Health Services Research, Data and Dissemination

	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
1.3.22 Increase the number of additional organizations per year that use AHRQ Quality Indicators (AHRQ QIs) (Output)	FY 2015: 7 additional Organizations (Target Exceeded)	4 additional Organizations	4 additional organizations	+4 additional organizations
1.3.23 Increase the number of consumers for whom Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data is collected (Output)	FY 2015: 143 Million Target: 145 Million (Target Not Met)	147 Million	148 Million	+1 Million
1.3.61 Increase the number of Host Users of the MONAHRQ software (Output)	FY 2015: 15 Host Users (Target Met)	N/A	N/A	N/A

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 FY 2015, 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. To date, we have been able to verify the use of the QIs by 116 organizations. New organizations of note are:

Yale New Haven Health System

Yale New Haven Health System is a large organization with more than 18,000 employees and a medical staff of 6,060. The organization had 110,000 discharges in 2013, generated more than $3.3 billion in revenue and accumulated total assets of approximately $3.8 billion. One example of how YNHHS has used the QIs for improvement: YNHHS had an issue with ventilator associated pneumonia in surgical unit as identified through QIs – was able to decrease the prevalence and saved $200,000 in labor and $500,000 in non-labor costs including therapy.

Cleveland Clinic

Cleveland Clinic first began working with the AHRQ QIs in 2010, choosing to implement the Patient Safety Indicators (PSI) module at a very deep level. Cleveland Clinic's focus on the PSIs is directly because of federal payment programs and private payers that use these quality indicators in their reimbursement programs.

- On a daily basis, partnering with the coding department, the quality improvement team identifies each individual case that triggers a patient safety event as measured by one or more PSIs; these results are then aggregated into monthly management goals. One of Cleveland Clinic's enterprise (system wide) goals is to translate these results into quarterly scorecard reviews, whereby department chairs see their performance on PSIs to drive the focus of quality improvement activities.

- The latest month reporting places Cleveland Clinic in the top decile of performance for all of the PSIs. When Cleveland Clinic first implemented the PSIs, their scores were in the lowest quartile.

Partners for Kids and Nationwide Children's Hospital

Partners for Kids (PFK) is a pediatric ACO serving approximately 300,000 Medicaid-eligible children in Ohio. The PFK ACO was established in 1994 in partnership with the Nationwide Children's Hospital and community Pediatricians. A measure of the ACO's success is to improve value by reducing costs and improving the quality and outcomes of care.
A study assessed the value of care provided by PFK from 2008 through 2013 and the costs of care were compared to overall reported costs of Medicaid within Ohio. AHRQ's Pediatric Quality Indicators and other measures were used.

- Results of cost comparisons indicated that PFK had lower cost growth than Medicaid fee-for-service programs and Medicaid managed care plans. Costs per member per month for PFK grew at a rate of $2.40 per year. Managed care plans grew at a rate of $6.47 per year and Medicaid fee-for-service costs grew at a rate of $16.15 per year.

www.nationwidechildrens.org/news-room-articles/partners-for-kids-nationwide-childrens-hospital-demonstrate-cost-savings-and-quality-as-pediatric-aco?contentid=138372

Southeastern Med

Southeastern Med is community hospital located in southeastern Ohio. The organization was concerned about improper reporting of quality metrics and how the metrics were interpreted by others.

- Elements of the PSI (Patient Safety Indicators) score showed the organization was high in accidental punctures or lacerations.
- Using the results, the organization analyzed their data to obtain specific information on the specific indicator. The results identified an error in how the organization was coding the information.
- Southeastern Med implemented targeted education for coding staff and physicians to mitigate this issue.

http://www.healthcare-informatics.com/blogs/david-raths/ohio-hospitals-begin-apply-predictive-modeling-patient-safety-efforts

Lee Memorial Health System

Lee Memorial Health System was penalized for their rates of hospital-acquired conditions and infections. Through the use of the AHRQ QIs, the organization identified that PSI 12 related to Pulmonary Embolism or Deep Vein Thrombosis was one of the main drivers of the penalty and the most opportunity for improvement. Analysis identified the following causes:

- Not aware of the specific definition the government was using.
- Coding not looking at Orthopedic Cases.
- 'False Positives' error rates in coding/documentation.
- Routine scanning increased false positives for DVT.

The organization has implemented educational programs to educate providers on best practices around treatment, documentation and coding.
http://www.leememorial.org/boardofdirectors/pdf/packets/2015/021915Quality&SafetyandFullBoardElectronicPacket.pdf

McLaren Healthcare

McLaren Health Care (MHC) is a comprehensive system with operations in nearly 200 facilities serving 54 counties with a population in excess of 3.5 million lives throughout Michigan. McLaren is a non-profit health care system committed to quality, evidence-based patient care and cost efficiency. The healthcare system has started to calculate hospital performance scores for measures that make up the Patient Safety Indicators (PSI-90).

Additional information available at: http://mclarenmedstaff.blogspot.com/search?q=PSI

Southeastern Med

Southeastern Med is an acute health care center serving more than 4,000 inpatients and nearly 100,000 outpatients each year. Plus, more than 300 surgeries are performed here monthly. Southeastern Med has been focusing on quality measures with unexplainable outliers such as elements of the PSI (patient safety indicator). An example is that Southeastern was very high in accidental punctures or lacerations. With this newfound knowledge, they have provided additional training for Physicians and coding staff.

Additional information available at: http://www.healthcare-informatics.com/blogs/david-raths/ohio-hospitals-begin-apply-predictive-modeling-patient-safety-efforts

AHRQ does anticipate continued success in meeting our performance target of 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 will not meet the goal of 145 million users in FY 2015. 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 (ACO) and other settings, facilities) which has affected our ability to reach the target set for FY 2015. CMS plans to implement the ACO survey during November 2015 to February 2016; therefore, the CAHPS anticipates reporting an increase in the number of consumers for whom CAHPS survey data is collected in FY 2016. As a result, the numbers for FY 2015 remain at 143 million.

CMS has distributed the CAHPS Survey to participants in the Healthcare Marketplaces during FY 2015 and participants will be able to assess the quality of care they receive. As the result, the CAHPS anticipates achieving the target of 147 million for 2016 and 148 million for 2017.

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

MONAHRQ's free software 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 2015, MONAHRQ met the program's performance target of increasing the number of Host Users with publicly available MONAHRQ-generated websites by two:

- SunCoast Regional Health Information Organization http://www.floridahealthinformation.com/
- Maryland Health Care Commission https://www.marylandqmdc.org/

Also, the program continued to expand its usefulness by adding two entirely new sections for nursing home and physician reports to the software. In addition, in August 2015, MONAHRQ provided a completely new consumer-friendly version of the MONAHRQ website with features supported by the redesign software platform, including further expansions of the measures reports and information about making informed decisions about receiving health care.

Due to budget reductions in FY 2016, the MONAHRQ program will no longer be funded. FY 2015 will be the final year for reporting on the MONAHRQ measure.

Portfolio: Health IT

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
1.3.60 Identify key design principles that can be used by health IT designers to improve Personal Health Information Management (PHIM) (Output)	FY 2015: 3 preliminary findings for PHIM healthit.ahrq.gov (Target Met)	2 additional reports from PHIM grantees	3 additional reports from PHIM grantees	+1 additional report from PHIM grantees

1.3.60: 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 findings have begun to emerge regarding, for example, the unique personal health information management needs and preferences of patients and their caregivers and how those may vary by condition, setting, health information management activity[1], or age.[2] For example, one grantee[3] found that elderly patients and their caregivers have different perspectives regarding how they share health information. The grantee also found that preferences for controlling access to health information gradually change over time. As part of the grant, the project team has also developed an application (App) available from https://itunes.apple.com/us/app/infosage/id1000777716?mt=8. An article about this study is

1 https://healthit.ahrq.gov/events/national-web-conference-assessing-patient-health-information-needs-developing-consumer-hit-tools
2 http://www.ncbi.nlm.nih.gov/pubmed/26147401
3 https://healthit.ahrq.gov/ahrq-funded-projects/infosage-information-sharing-across-generation-and-environments

available from http://reut.rs/1dQuYVW. Another grantee[1] has found that use of health IT to communicate between patients and providers has both enhanced and complicated this process. In addition, this grantee has begun to uncover patient "types" regarding their needs for health IT solutions design to support patient self-management of their conditions. Findings from this project were presented at the American Medical Informatics Association 2015 Annual Symposium. A third grantee has begun developing methods[2] to understand how spaces influence how individuals manage their health information.

1 https://healthit.ahrq.gov/ahrq-funded-projects/patient-reminders-and-notifications
2 http://www.ncbi.nlm.nih.gov/pubmed/26173040

Portfolio: United States Preventive Services Task Force (USPSTF)

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
2.3.7 Increase the percentage of older adults who receive appropriate clinical preventive services (Output)	FY 2015: Piloted the use of a clinical preventive services composite measure within the MEPS survey. (Target met)	Develop national estimates of receipt of high-priority clinical preventive services from MEPS. Prepare final report on the evaluation of the implementation of the USPSTF recommendation in large integrated health systems and at the Veterans Administration.	Use MEPS data and data from the evaluation of the USPSTF's recommendations implementation project in order to identify specific preventive services that can be targeted for improvement. Identify preventive services for dissemination to clinical providers.	N/A

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

In FY 2016 and 2017, AHRQ will provide ongoing scientific, administrative and dissemination support to the USPSTF. Funding to support the USPSTF is anticipated to remain stable in FY 2016 and FY 2017. By supporting the work of the USPSTF, AHRQ helps to identify appropriate clinical preventive services for adults as well as develop methods for understanding prevention in older adults.

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 validated a 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 was 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.

In FY 2017, AHRQ anticipates being able to identify specific preventive services that can be targeted for improved dissemination to users. By supporting the dissemination of the USPSTF recommendations, AHRQ anticipates being able to improve communication to clinical providers to improve selected preventive services. The data from this measure can also identify gaps in the receipt of preventive services and therefore inform the Department's and the public health sector's prevention strategies.

Medical Expenditure Panel Survey (MEPS)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 PB +/- FY 2016 Enacted
TOTAL				
--BA	$65,447,000	$66,000,000	$68,877,000	$2,877,000
--PHS Eval	$ -	$ -	$ -	$ -

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2017 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 2017 Justification by Activity Detail

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

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
MEPS Household Component	$42.678	$43.231	$45.358
MEPS Medical Provider Component	$12.513	$12.513	$13.013
MEPS Insurance Component	$10.256	$10.256	$10.506
TOTAL, MEPS	**$65.447**	**$66.000**	**$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 2015 and FY 2016, 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 2017 President's Budget Policy: The FY 2017 President's Budget provides $45.4 million for this activity, an increase of $2.1 million from the prior year. These funds will permit the MEPS Household Component 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.

At this level of support, AHRQ will provide funding to support 14,500 households necessary to meet steady state precision levels in survey estimates. The 2017 MEPS Household Component will also be directly affected by a major sample redesign of the National Health Interview Survey (NHIS) that serves as the sampling frame for MEPS. This redesign will result in a much wider geographical dispersion of the MEPS sampled households relative to prior years. The specified level of funding for the survey accounts for the additional complexities and travel costs involved in fielding a sample of 14,500 households over more dispersed set of geographical locations than in prior years. The funding will permit the survey to maintain its capacity to detect changes in health care use, medical expenditures and insurance coverage for important population subgroups, such as racial and ethnic minorities, persons with specific conditions.

MEPS Medical Provider Component: The MEPS Medical Provider component is a survey of medical providers, including office-based doctors, hospitals and pharmacies that collects 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 2015 and FY 2016, the Medical Provider Component of the MEPS maintained its sample specifications.

FY 2017 President's Budget Policy: The FY 2017 President's Budget provides $13.0 million for this activity, an increase of $0.5 million from the FY 2016 Enacted level. These funds will permit the MEPS Medical Provider Component to maintain existing survey capacity at its current level.

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. In FY 2015 and 2016, the MEPS Insurance Component maintained the precision levels of survey estimates for all 50 states and the District of Columbia, maintained survey response rates, and adhered to data release schedules.

FY 2017 President's Budget Policy: The FY 2017 President's Budget provides $10.5 million for this activity, an increase of $0.2 million from the FY 2016 Enacted level. These funds will permit the MEPS Insurance Component to maintain existing survey capacity at its current level.

Strengthening the Use of Evidence and Evaluation: MEPS has a long history of sharing its research findings and products with other agencies within HHS, in addition to the federal sector at large. 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 Congressional Budget Office, Congressional Research Service, 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.

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 private insurance coverage through the state's Marketplace.

Reducing Fragmentation, Overlap, and Duplication: The set of households selected for the MEPS Household Component is a subsample of those participating in the National Health Interview Survey (NHIS), an ongoing annual household survey on health conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. In addition to the cost savings achieved by eliminating the need to independently list and screen households, selecting a subsample of NHIS participants has resulted in an enhancement in analytical capacity of the resultant MEPS survey data. Use of the NHIS data in concert with the data collected for the MEPS provides an additional capacity for longitudinal analyses not otherwise available. Furthermore, the large number and dispersion of the primary sampling units in MEPS has resulted in improvements in precision over prior expenditure survey designs.

The MEPS design has also helped reduce the likelihood of several agencies in HHS from conducting independent surveys that overlapped in content with MEPS to obtain the necessary information for subpopulations within their purview. For example, rather than conducting an independent survey to obtain nationally representative on cancer survivors experiences with healthcare, the National Cancer Institute at NIH sponsored a *Experiences with Cancer* Supplement as a component of the MEPS.

C. Mechanism Table for MEPS

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

	FY 2015 Final		FY 2016 Enacted		FY 2017 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		**65,447**		**66,000**		**68,877**
TOTAL		**65,447**		**66,000**		**68,877**

Program Portrait: **Research Using MEPS Data**

"If Rollbacks Go Forward, Up To 14 Million Children Could Become Ineligible For Public Or Subsidized Coverage By 2019"

By Julie L. Hudson, Steven C. Hill, and Thomas M. Selden at the Agency for Healthcare Research and Quality (AHRQ).

This study investigated the potential health insurance options available to low-income children in the future if two changes were to happen: The Children's Health Insurance Program (CHIP) is not renewed after fiscal year 2017; and the Affordable Care Act's (ACA) maintenance-of-effort requirements are allowed to expire after 2019, thereby authorizing states to roll back Medicaid- and CHIP-eligibility thresholds. The authors examined data for the years 2005-10 from the Medical Expenditure Panel Survey, which is sponsored by AHRQ. Based on these data and a simulation model, they found that 10.9 million children in the United States would lose eligibility for the separate CHIP if the program's funding was allowed to expire in 2017. If the ACA maintenance-of-effort requirements end in 2019, the authors found that an additional seven million children who were eligible for Medicaid, but lived in families with incomes above the statutory minimum thresholds, would lose eligibility for Medicaid. Among the 17.9 million children losing eligibility for public coverage, the authors simulate 4.0 million would be eligible for Marketplace subsidies. However, the remaining fourteen million children would not be eligible for Marketplace subsidies. "While not all states are likely to reduce eligibility to federal Medicaid statutory minimums, these estimates highlight the fact that many children who do lose public coverage eligibility will not become eligible for subsidized Marketplace coverage." "The study highlights the potential impacts on children's pathways to affordable coverage if CHIP funding is not renewed in 2017 and again after 2019 as ACA maintenance-of-effort requirements expire."

D. Performance Summary and Key Measures

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
1.3.16 Maintain the number of months to produce the Insurance Component tables following data collection (MEPS-IC) (Output)	FY 2015: 6.5 months (Target Met)	6 months	6 months	0
1.3.19 Increase the number of tables per year added to the MEPS table series (Output)	FY 2015: 7912 total tables in MEPS table series (Target Exceeded)	8162 total tables in MEPS table series	8412 total tables in MEPS table series	+250 MEPS table series
1.3.21 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 (MEPS-HC) (Output)	FY 2015: 9.5 months (Target Met)	9.5 months	9 months	-0.5 months
1.3.49 Decrease the average number of field staff hours required to collect data per respondent household for the MEPS (Efficiency)	FY 2015: 12.5 hours (Target Exceeded)	13.5 hours	13.5	0

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 2016 through FY 2017. Further reducing the target time is not feasible because the proration and poststratification processes are dependent upon the timing and availability of key IRS data that are appended to the survey frame. Data trends from 1996 through 2014 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 1,321 tables. For the Insurance Component there are a total of 2,079 national level tables and 4,512 state and metro area tables. The total number of tables available to the user population is currently 7,912.

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 conducting research and informing policy. Currently data are available in tabular format for the years 1996 – 2014. This represents nineteen 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; and 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 2015. We are on target to also meet the data release schedule for the MEPS public use files scheduled for release during FY 2016. The release date for public use file (point-in-time) will be reduced another two weeks moving from FY 2015 to FY 2016. The earlier release date for the point-in-time file will be maintained for FY 2017. Additionally, the following files will be released a month earlier as compared to FY 2016: jobs file; home health event file; other medical expense file; dental visit file; medical provider visit file; outpatient department visit file; emergency room visit file; hospital stays file; prescribed drug event file; and full year consolidated file.

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 are 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 data collection. 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, recent MEPS questionnaire redesign efforts will be ongoing through FY 2017 in order to address content modifications and administration 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 (FY 2015 actual 12.5 hours) and this will be maintained through FY 2017.

E. Funding History

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

Year	Dollars
2012	$59,300,000
2013	$60,700,000
2014	$63,811,000
2015	$65,447,000
2016	$66,000,000

Program Support

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 PB +/- FY 2016 Enacted
TOTAL				
--BA	$69,700,000	$71,200,000	$70,844,000	-$356,000
--PHS Eval	$ -	$ -	$ -	+$0
FTEs (Total Program Level)	297	325	325	0
FTEs (Budget Authority)	287	300	300	0
FTE (Other Reimbursable Funds)	5	6	6	0
Estimated FTEs (PCORTF)	10	25	25	0

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2017 Authorization……..……..……..Expired.
Allocation Method…….....……..……Other.

A. Program Overview

This budget activity supports the strategic direction and overall management of the AHRQ, including funds for salaries and benefits of 300 FTEs (Budget Authority). 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 the AHRQ's mission.

B. FY 2017 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 2017 President's Budget Policy: The FY 2017 President's Budget level for Program Support is $70.8 million, a decrease of $0.4 million from the FY 2016 Enacted level. The decrease is related to one-time costs provided in FY 2016 related to AHRQ's move to 5600 Fisher's Lane. The FY 2017 President's Budget does provide an additional $0.59 million for the estimated FY 2017 pay raise.

Program Support provides funds for AHRQ's PHS Evaluation Fund FTEs. In FY 2017 AHRQ is supporting 300 FTEs, the same level of support as the FY 2016 Enacted level. As shown in the table on the prior page, AHRQ has 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 mandatory funds. The estimate for the PCORTF is preliminary and will be finalized once activities are decided for FY 2017.

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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Patient Safety	18,156	18,548	18,370
Health Services Research, Data, and Dissemination	26,602	27,408	28,198
Health Information Technology	6,678	5,585	5,531
USPSTF	2,748	2,844	2,817
Medical Expenditure Panel Survey	15,516	16,815	15,928
Total, Program Support	69,700	71,200	70,844

Demonstrating Efficiencies: The President's Management Agenda seeks to improve the efficiency and effectiveness of Government through increased efficacy of citizen and business facing services. One area where more work remains is how the Federal Government interacts with contractors to pay invoices. The Federal Government is the largest single purchaser of goods and services in the United States, processing over 19 million invoices each year. Approximately 40% of these invoices are processed using electronic invoicing with the remaining using a mix of electronic and manual processes that provide little visibility to businesses and can result in tax dollars being used for late payment fees rather than to support critical agency missions. Electronic invoicing can further these goals while also reducing administrative burden and costs to taxpayers. OMB Memorandum M-15-19 directs agencies, by the end of FY 2018, to transition to electronic invoicing for appropriate Federal procurements.

AHRQ has developed an electronic routing and approval tool for use for our invoices and may transition to an HHS-wide e-invoicing tool in the future. This tool is being piloted in FY 2016. We expect this tool to increase timeliness of invoice review and decrease interest charges.

C. Mechanism Table

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

	FY 2015 Final		FY 2016 Enacted		FY 2017 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……		**69,700**		**71,200**		**70,844**
TOTAL		**69,700**		**71,200**		**70,844**

D. Funding History

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

Year	Dollars
2012	$73,985,000
2013	$68,422,000
2014	$68,813,000
2015	$69,700,000
2016	$71,200,000

Supplementary Tables – Table of Contents

Supplementary Tables

Budget Authority by Object Class – Reimbursable

(DOLLARS IN THOUSANDS)

Object Class	FY 2016 Enacted	FY 2017 Budget	FY 2017 +/- FY 2016
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		**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	22,089,000	+22,089,000
Interest and Dividends (43.0)	0	0	0
Subtotal Non-Pay Costs	**0**	**83,458,000**	**+83,458,000**
Total, Reimbursable Obligations	**0**	**83,458,000**	**+83,458,000**

Budget Authority by Object Class – Direct

(DOLLARS IN THOUSANDS)

Object Class	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Direct Obligations:			
Personnel Compensation:			
Full-time Permanent (11.1)	$32,799,000	$33,223,000	+424,000
Other than Full-Time Permanent (11.3)	3,408,000	3,453,000	+45,000
Other Personnel Comp. (11.5/11.8)	584,000	592,000	+8,000
Military Personnel (11.7)	810,000	824,000	+14,000
Subtotal, personnel compensation	**37,601,000**	**38,092,000**	**+491,000**
Civilian Personnel Benefits (12.1)	10,064,000	10,155,000	+91,000
Military Personnel Benefits (12.2)	517,000	525,000	**+8,000**
Subtotal Pay Costs	**48,182,000**	**48,772,000**	**+590,000**
Travel (21.0)	351,000	351,000	0
Transportation of Things (22.0)	54,000	55,000	+1,000
Rental Payments to GSA (23.1)	4,140,000	3,192,000	-948,000
Communications, Utilities, and Misc. Charg. (23.3)	972,000	989,000	+17,000
Printing and Reproduction (24.0)	250,000	250,000	0
Other Contractual Services:			0
Other Services (25.2)	14,630,000	14,567,000	-63,000
Purchases from Govt. Accts. (25.3)	20,112,000	20,112,000	0
Research & Development Contracts (25..5)	127,938,000	91,811,911	-36,126,089
Operation and Maintenance of Equipment (25.7)	679,000	691,000	+12,000
Subtotal Other Contractual Services	**163,359,000**	**127,181,911**	**(36,177,089)**
Supplies and Materials (26.0)	400,000	407,000	+7,000
Equipment (31.0)	1,542,000	1,570,000	+28,000
Grants, Subsidies, and Contributions (41.0)	114,750,000	97,472,089	-17,277,911
Interest and Dividends (43.0)	0	0	0
Subtotal Non-Pay Costs	**285,818,000**	**231,468,000**	**-54,350,000**
Total, Direct Obligations	**334,000,000**	**280,240,000**	**-53,760,000**

Salaries and Expenses

(Dollars in Thousands)

Object Class	FY 2016 Enacted	FY 2017 Budget	FY 2017 +/- FY 2016
Personnel Compensation:			
Full-time Permanent (11.1).....	32,799,000	33,223,000	+424,000
Other than Full-Time Permanent (11.3).....	3,408,000	3,453,000	+45,000
Other Personnel Comp. (11.5/11.8).....	584,000	592,000	+8,000
Military Personnel (11.7).....	810,000	824,000	+14,000
**Subtotal, personnel compensation.....	**37,601,000**	**38,092,000**	**+491,000**
Civilian Personnel Benefits (12.1).....	10,064,000	10,155,000	+91,000
Military Personnel Benefits (12.2).....	517,000	525,000	+8,000
**Subtotal, Pay Costs.....	**48,182,000**	**48,772,000**	**+590,000**
Travel (21.0).....	351,000	351,000	0
Transportation of Things (22.0).....	54,000	55,000	+1,000
Communications, Utilities, and Misc. Charg. (23.3).....	972,000	989,000	+17,000
Printing and Reproduction (24.0).....	250,000	250,000	0
Other Contractual Services:			
Other Services (25.2).....	14,630,000	14,567,000	-63,000
Operations and maintenance of equipment (25.7).....	679,000	691,000	+12,000
**Subtotal Other Contractual Services.....	**15,309,000**	**15,258,000**	**-51,000**
Supplies and Materials (26.0).....	400,000	407,000	+7,000
**Subtotal Non-Pay Costs.....	**17,336,000**	**17,310,000**	**-26,000**
**Total, Salaries & Expenses.....	**65,518,000**	**66,082,000**	**+564,000**
Rental Payments to GSA (23.1).....	4,140,000	3,192,000	-948,000
**Total FTEs.....	**300**	**300**	**0**

Detail of Full-Time Equivalent Employment (FTE)

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

	2015 Actual Civilian	2015 Actual Military	2015 Actual Total	2016 Est. Civilian	2016 Est. Military	2016 Est. Total	2017 Est. Civilian	2017 Est. Military	2017. Est. Total
Office of the Director (OD)	18	0	18	18	0	18	18	0	18
Office of Management Services (OMS)	52	0	52	52	0	52	52	0	52
Office of Extramural Research, Education, and Priority Populations (OEREPP)	37	3	40	39	3	42	39	3	42
Center for Evidence and Practice Improvement (CEPI)	42	2	44	48	2	50	48	2	50
Center for Delivery, Organization and Markets (CDOM)	23	0	23	23	0	23	23	0	23
Center for Financing, Access, and Cost Trends (CFACT)	41	0	41	41	0	41	41	0	41
Center for Quality Improvement and Patient Safety (CQuIPS)	34	1	35	34	2	36	34	2	36
Office of Communications and Knowledge Transfer (OCKT)	34	0	34	38	0	38	38	0	38
AHRQ FTE Total	**281**	**6**	**287**	**293**	**7**	**300**	**293**	**7**	**300**

Average GS Grade	
2013	13.1
2014	13.1
2015	13.1
2016	13.1
2017	13.1

1/ Excludes PCORTF FTE.

Detail of Positions 1/

Detail of Positions 1/

	2015 Actual	2016 Base	2017 Budget
Executive Level I	4	4	4
Executive Level II	2	2	2
Executive Level III	3	3	3
Executive Level IV	5	5	5
Executive Level V	0	0	0
Subtotal	14	14	14
Total Executive Level Salaries	$2,293,938	$2,362,756	$2,504,522
Total - SES	3	3	3
Total - SES Salaries	$ 525,890	$541,667	$574,167
GS-15	60	63	63
GS-14	76	97	97
GS-13	68	73	73
GS-12	20	21	21
GS-11	11	26	26
GS-10	1	2	2
GS-9	12	11	11
GS-8	2	1	1
GS-7	6	7	7
GS-6	6	3	3
GS-5	4	1	1
GS-4	2	1	1
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal	268	306	306
Average GS grade	13.1	13.1	13.1
Average GS salary	$90,823	$93,548	$99,161

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

Physician's Comparability Allowance Worksheet

		FY 2015 (Actual)	FY 2016 (Estimates)	FY 2017* (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)		$ 143,678	$145,115	$146,566
5) Average Annual PCA Payment		$ 24,409	$24,409	$24,409
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.

7) 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

8) 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.

9) 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).

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.

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

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

N/A

FTEs Funded by the Affordable Care Act

(Dollars in Thousands)

Program	Section(s)	FY 2013			FY 2014			FY 2015			FY 2016			FY 2017		
		$	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	633	6	0	1,505	13	0	1,644	10	0	4,110	25	0	4,113	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.

Please visit AHRQ's website for fact sheets and listings of all grantees funded through the PCORTF (http://www.ahrq.gov/funding/training-grants/pcor/index.html). Below are a few summaries of ongoing projects funded in FY 2016.

Supporting Decisions With Patient-Centered Outcomes Research (PCOR)

On September 1, 2015 AHRQ formally awarded funding to Dartmouth College, National Bureau of Economic Research, and RAND to serve as Centers of Excellence to study how high-performing health care systems promote evidence-based practices in delivering care. This project is funded at $52 million over five years. AHRQ also will award a contract for a coordinating center to facilitate collaboration among the three centers and to develop a national compendium of health care system performance across the United States. For more information: http://www.ahrq.gov/news/newsroom/press-releases/2015/pcorawards.html

In May, 2015 AHRQ awarded 7 large grants to establish EvidenceNOW, a $112 million initiative aligned with Million Hearts that will provide practice support to over 5,000 primary care physicians with the goal of improving the heart health of millions of patients and improving the capacity of the practices to incorporate new evidence into practice. All seven cooperatives are now recruiting practices with the goal of engaging 1,500 practices this fall. AHRQ has convened a departmental steering committee, including CMS, NIH, HRSA, CDC, IHS, SAMHSA, ACL, ONC, and ASPE to provide scientific guidance and ensure alignment and coordination (www.ahrq.gov/evidenceNOW.html).

In July, AHRQ published a notice of intent to publish funding opportunity announcements related to a new initiative to disseminate and implement patient-centered outcomes research (PCOR) findings through clinical decision support (CDS). The funding opportunity announcements are:

- PCOR CDS Learning Network – A cooperative agreement to create a community of stakeholders aimed at increasing the use of PCOR in clinical practice through CDS and moving the field of CDS forward. Applications were due 11/13/15.

- Extending ("taking to scale") CDS. Demonstration and dissemination grants to extend well-established, PCOR-based CDS beyond the initial setting or institution in which the CDS was developed. This funding opportunity is anticipated in Spring, 2016.

- Developing CDS. Demonstration and dissemination grants to develop new PCOR-based CDS and demonstrate its effectiveness to improve care in clinical practice. This funding opportunity is anticipated in Spring, 2016

Significant Items

FY 2016 SENATE REPORT NO. 114-74

Items

Central-Line Associated Blood Stream infection (CLABSI)

1. **SENATE (Rept. 114-74)**

The Committee notes that while much research on preventing CLASBI has been dedicated to the exploration of proper line insertion techniques and line management, little attention has been given to the relationship between the connectors utilized in central lines and rates of infection. The Committee urges AHRQ to examine whether neutral fluid displacement needleless connectors have the potential to reduce the incidence of CLABSI as compared to positive fluid displacement needleless connectors. AHRQ is encouraged to provide a best practice recommendation for the use of such connectors in hospital settings

Action Taken or to be Taken

AHRQ plans to examine evidence regarding the potential of neutral fluid displacement needleless connectors to reduce the incidence of CLABSI as compared to positive fluid displacement needleless connectors and will consider this question in the context of best practice for CLABSI prevention

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

2. **SENATE (Rept. 114-74**)

The CAHPS program supports and promotes the assessment of consumers' experiences with healthcare. Patient experience data in maternity care is currently not regularly and systematically collected. The Committee urges AHRQ to expand its current set of surveys and develop a CAHPS survey for maternity care.

Action Taken or to be Taken

AHRQ recognizes the importance of and interest in an experience of care survey for maternity care. The Agency is exploring possible activities to expand our knowledge of patient experience in this area that will be most efficient and cost-effective, and builds on existing work.

FY 2016 SENATE REPORT NO. 114-74

Healthcare-Associated Infections

3. SENATE (Rept. 114-74)

Within the Patient Safety portfolio, the Committee provides $34,000,000, the same level as in fiscal year 2015, for healthcare-associated infection activities. Within this funding level, the Committee includes $10,000,000 for activities as part of the CARB initiative. These funds will support the development and expansion of antibiotic stewardship programs specifically focused on ambulatory and long-term care settings. In addition, the Committee directs AHRQ to collaborate with NIH, BARDA, CDC, FDA, VA, DOD, and USDA to leverage existing resources to increase capacities for research aimed at developing therapeutic treatments, reducing antibiotic use and resistance in animals and humans, and implementing effective infection control policies.

Action Taken or to be Taken

AHRQ is working collaboratively with HHS and other Federal agencies to prevent healthcare-associated infections (HAIs) and combat antibiotic resistance. As part of coordinated activities to help attain the goals of the National Action Plan for Combating Antibiotic-Resistant Bacteria (CARB), AHRQ is supporting research and implementation projects to develop and expand antibiotic stewardship in ambulatory and long-term care settings, as well as in hospitals, and to develop improved methods for preventing HAIs. The FY 2017 Congressional Justification provides $12.0 million for CARB, an increase of $2.0 million from the prior year.

AHRQ will continue to collaborate with other agencies and engage in activities to further these aims, such as issuing a Special Emphasis Notice inviting applications for research on antibiotic stewardship with an emphasis on ambulatory and long-term care, working with CDC to plan and conduct a meeting of experts and stakeholders to consider knowledge gaps for the prevention of antibiotic-resistant HAIs, and collaborating with CDC, CMS, and NIH to increase the implementation of antibiotic stewardship programs.

Immunotherapy and Asthma

4. SENATE (Rept. 114-74)

The Committee is pleased that AHRQ has joined NIH in co-sponsoring a workshop on immunotherapy effectiveness. The Committee requests an update from AHRQ in the fiscal year 2017 CJ on research that will be undertaken pursuant to the workshop with the goal of identifying patient, healthcare provider, and systems barriers to initiation and adherence to allergy immunotherapy and developing interventions to address these problems. This report should include information on planned AHRQ initiatives pertaining to the utilization of allergy immunotherapy to reduce the prevalence of asthma.

Action Taken or to be Taken

As a follow-up to the June 2015 AHRQ- and NIAID-sponsored workshop on improving the treatment for allergic rhinoconjunctivitis and asthma through allergen immunotherapy, workgroups are developing protocols for addressing five major research gaps. Four of five research gaps were identified by the 2013 AHRQ report on effectiveness of immunotherapy:

1) Sublingual Immunotherapy (SLIT) versus Subcutaneous Immunotherapy (SCIT);
2) Mono-versus Multi-Allergen Immunotherapy;
3) Immunotherapy's Impact on the Progression of Childhood Asthma/Allergy; and
4) Dosing Strategies and Duration of Immunotherapy Treatment.

The fifth area is Immunotherapy Utilization, and includes questions such as: a) What is the percentage of children, adolescents, and adults in the Unites States for whom allergen immunotherapy is indicated by the current guidelines?; b) Of those for whom allergen immunotherapy is indicated, what percentage did not initiate immunotherapy and for what reasons, and what percentage did not adhere to immunotherapy and for what reasons?; and c) Of those for whom allergen immunotherapy is not indicated, what percentage initiated immunotherapy and for what reasons? AHRQ is working with NIAID to incorporate the protocols designed by the five workgroups into manuscript format for publication so that these protocols are available to researchers applying for research funding.

In addition, AHRQ is in the process of collaborating with NHLBI to conduct a systematic review covering the safety of SCIT administered in the home for asthma, the efficacy and safety of the newly approved tablet form of SLIT for the treatment of asthma, and a literature update (post-2013 AHRQ report) on the efficacy of SCIT in the treatment of asthma. NHLBI plans to use this systematic review to inform any subsequent asthma guidelines.

Malnutrition

5. **SENATE (Rept. 114-74)**

The Committee is aware that several studies suggest that malnourished hospitalized patients have a significantly higher incidence of infection, are at increased risk of mortality, have longer median lengths of stay, and are more likely to be readmitted. The Committee requests that AHRQ assess the prevalence of malnutrition in U.S. hospitals and report back to the Committee in its fiscal year 2017 CJ.

Action Taken or to be Taken

On December 15, AHRQ staff met with representatives from Baxter and the American Society for Parenteral and Enteral Nutrition (ASPEN) to discuss the issue of malnutrition in U.S. hospitals. As a result, AHRQ is conducting further analysis on this issue using data derived from its Healthcare Cost and Utilization Project (HCUP). The Agency will continue to work with ASPEN, and others to assess the prevalence of malnutrition in our nation's hospitals.

Training Grants

6. SENATE (Rept. 114-74)

The Committee appreciates AHRQ's commitment to providing research training and career development grants for young investigators. AHRQ is urged to maintain a strong training and career development pipeline for talented researchers.

Action Taken or to be Taken

AHRQ is committed to fostering the next generation of health services researchers and provides a variety of funding opportunities designed to support and enhance the education and career development of young investigators. AHRQ's training opportunities are designed to prepare researchers to address the vast changes occurring in health care delivery. In FY 2016, AHRQ will continue to support dissertation grants, mentored career development awards, and pre- and post-doctoral fellowships under the National Research Service Award program.

FY 2016 CONFERENCE REPORT NO. 114-39

Combating Antibiotic-Resistant Bacteria (CARB)

1. CONFERENCE (Rept. 114-39)

The agreement recognizes the importance of developing scientific based approaches related to CARB. The AHRQ is directed to work closely with BARDA, CDC, and NIAID and coordinate with other government-wide agencies like the Departments of Defense, Agriculture, and Veterans Affairs, to leverage resources toward this end. These activities should have coordinated goals and measurable objectives to best leverage the funds provided. The agreement requests an update in the fiscal year 2017 budget request on the planned activity.

Action Taken or to be Taken Under the umbrella of the National Action Plan for CARB, HHS agencies, including AHRQ, BARDA, CDC, and NIAID are working collaboratively to combat antibiotic resistance. A major theme of AHRQ's effort is supporting research to develop improved methods for combating antibiotic resistance and promoting their widespread implementation. The Plan outlines coordinated goals and measurable objectives for these activities, and AHRQ has reported on progress toward the attainment of milestones specified in the Plan. The FY 2017 Congressional Justification provides $12.0 million for CARB, an increase of $2.0 million from the prior year. An update on AHRQ's activities is provided in the patient safety section of the FY 2017 Congressional Justification beginning on page 21.

Medication Assisted Treatment (MAT)

2. **CONFERENCE (Rept. 114-39)**

The agreement requests an update in the fiscal year 2017 budget request on activity AHRQ supports related to MAT.

Action Taken or to be Taken

In December of 2015, AHRQ commissioned a report that will provide an overview of key issues on medication-assisted treatment (MAT) models of care and implementation strategies in primary care settings, including rural settings. Through a systematic literature search and key informant interviews, the report will describe the available evidence base, including various models of MAT, its components, and implementation strategies; and describe the context related to MAT such as regulatory, resource, financing, and workforce issues . AHRQ also published a funding opportunity announcement soliciting research proposals to implement MAT for opioid use disorder in primary care practices in rural areas of the United States. In addition to expanding access to this evidence-based therapy in underserved communities, these research studies will discover and test solutions to overcoming known barriers to implementation of MAT in primary care and create training and implementation resources to support future efforts to expand access to MAT. AHRQ expects to award up to three 3-year research grants under this initiative by the end of FY 2016.