DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

National Institute for Research on Safety and Quality (NIRSQ)

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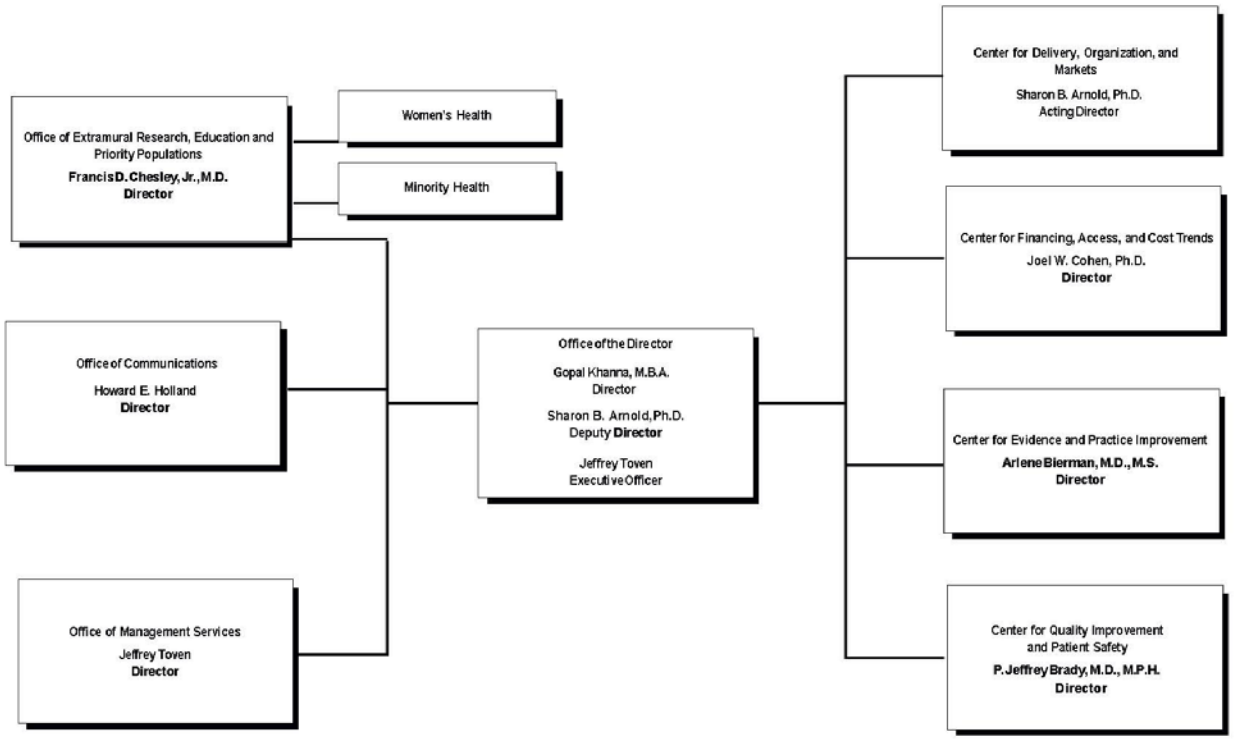

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE FOR RESEARCH ON SAFETY 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, $272,000,000: Provided, That section 947(c) of the PHS Act shall not apply in fiscal year 2018: 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 expended.

NATIONAL INSTITUTES OF HEALTH
National Institute for Research on Safety and Quality

Amounts Available for Obligation 1/ 2/
(Dollars in Thousands)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Appropriation	$ 333,554	$ 333,366	$ 272,000
Offsetting Collections from:			
Federal funds pursuant to Title IX of P.L. 102-410, (Section 947(c) PHS Act)			
HCQO	0	0	0
MEPS	0	0	0
Program Support	0	0	0
Subtotal, adjusted appropriation	$ 333,554	$ 333,366	$ 272,000
Unobligated Balance Lapsing	$ 446	0	0
Total obligations, AHRQ	$ 334,000	$ 333,366	
Total obligations, NIRSQ			$ 272,000

1/ Excludes funding from other HHS operating divisions provided through reimbursable agreements and mandatory financing from the Patient-Centered Outcomes Research Trust Fund (PCORTF).

2/ For this and all other tables, the FY 2016 and FY 2017 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2018 President's Budget consolidates AHRQ's activities into NIH, and the FY 2018 column represents the request for the National Institute for Research on Safety and Quality.

NATIONAL INSTITUTES OF HEALTH
National Institute for Research on Safety and Quality
Authorizing Legislation 1/ 2/

	FY 2017 Amount Authorized	FY 2017 Amount Appropriated in AHRQ	FY 2018 Amount Authorized	FY 2018 President's Budget
Research on Health Costs, Quality, and Outcomes:				
Secs. 301 & 926(a) PHSA.....	SSAN	$ 196,426	SSAN	$ 145,530
Research on Health Costs, Quality, and Outcomes:				
Part A of Title XI of the Social Security Act (SSA) Section 1142(i) 4/ 5/				
Budget Authority.....				
Medicare Trust Funds 5/ 6/				
Subtotal BA & MTF.....	Expired 7/		Expired 7/	
Medical Expenditure Panel Surveys:				
Sec. 947(c) PHSA.....	SSAN	$ 65,875	SSAN	$ 69,991
Program Support:				
Section 301 PHSA.....	Indefinite	$ 71,065	Indefinite	$ 56,479
Evaluation Funds:				
Section 947 (c) PHSA		$0		$0
Total appropriations, AHRQ 3/		$333,366		
Total appropriations, NIRSQ 2/, 3/				$272,000
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/ For this and all other tables, the FY 2016 and FY 2017 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2018 President's Budget consolidates AHRQ's activities into NIH, and the FY 2018 column represents the request for the National Institute for Research on Safety and Quality.
3/ Excludes mandatory financing from the PCORTF.
4/ 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.
5/ No specific amounts are authorized for years following FY 1994.
6/ 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%).
7/ Expired September 30, 2005.

Appropriation History Table
Agency for Healthcare Research and Quality (2009-2017) 1/, 2/
National Institute for Research on Safety and Quality (2018) 1/, 2/

	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriation	
AHRQ 2009					
Budget Authority……	$ -	$ 323,087,000	$ 90,598,000	$ -	
PHS Evaluation Funds……	$ 325,664,000	$ 51,913,000	$ 243,966,000	$ 372,053,000	
ARRA Funding P.L. 111-5……	$ -	$ -	$ -	$ 1,100,000,000	3/
Total……	$ 325,664,000	$ 375,000,000	$ 334,564,000	$ 1,472,053,000	
AHRQ 2010					
Budget Authority……					
PHS Evaluation Funds……	$ 372,053,000	$ 372,053,000	$ 372,053,000	$ 397,053,000	
ARRA Funding P.L. 111-5……					
Total……	$ 372,053,000	$ 372,053,000	$ 372,053,000	$ 397,053,000	
AHRQ 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	
AHRQ 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	
AHRQ 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	
AHRQ 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	
AHRQ 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	
AHRQ 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	
AHRQ 2017					
Budget Authority……	$ 280,240,000	$ 280,240,000	$ 324,000,000	$ -	
PHS Evaluation Funds……	$ 83,458,000	$ -	$ -	$ -	
Total……	$ 363,698,000	$ 280,240,000	$ 324,000,000	$ -	
NIRSQ 2018 2/					
Budget Authority……	$ 272,000,000	$ -	$ -	$ -	
PHS Evaluation Funds……	$ -	$ -	$ -	$ -	
Total……	$ 272,000,000	$ -	$ -	$ -	

1/ Excludes mandatory financing from the PCORTF.

2/ For this and all other tables, the FY 2016 and FY 2017 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2018 President's Budget consolidates AHRQ's activities into NIH, and the FY 2018 column represents the request for the National Institute for Research on Safety and Quality.

3/ 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.

Justification of Budget Request

National Institute for Research on Safety and Quality

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

Budget Authority (BA)[1]:

	FY 2016 Actual	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
AHRQ Total[2]	$334,000,000	$333,366,000		
NIRSQ Total[2]:			$272,000,000	-$61,366,000
AHRQ FTEs[2]:	284	289		
NIRSQ FTEs[2]:			247	-42

[1]For this and all other tables, the FY 2016 and FY 2017 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2018 President's Budget consolidates AHRQ's activities into NIH, and the FY 2018 column represents the request for the National Institute for Research on Safety and Quality.
[2]Excludes mandatory financing and FTEs from the PCORTF.

Program funds are allocated as follows: Competitive Grants/Cooperative Agreements; Contracts; Direct Federal/Intramural and Other.

Director's Overview

The FY 2018 President's Budget transitions the highest priority activities of the former Agency for Healthcare Research and Quality (AHRQ) to an Institute at the National Institute of Health (NIH) – the National Institute for Research on Safety and Quality (NIRSQ). This proposed consolidation will allow for a more efficient, coordinated and seamless transfer of research efforts on the diagnosis, prevention, and cure of human diseases developed by NIH to the frontlines of care. The National Institute for Research on Safety and Quality's role in translating research outcomes into practice and our expertise in primary care will better ensure that NIH's investments in medical science are translated into knowledge and practical tools that can be adopted by physicians and other health care professionals to benefit patients. As part of this consolidation, NIH plans to convene a working group of its Advisory Committee to the Director that will consider the findings from a proposed trans-NIH review of health services and implementation research and make recommendations regarding overlap of activities and develop a gap analysis to identify the most compelling future opportunities for NIRSQ. This effort will include stakeholder outreach. As a result of this work, NIH will continue to consider ways to improve the efficiency and coordination of health services research across NIH.

As a relatively small organization – about 246 people and a proposed FY 2018 budget of $272 million – we have strategically maximized our investments to support clinicians and patients to improve quality and safety. In the context of a $3.2 trillion health care system, with 800,000 physicians, 5,000 hospitals, and millions of nurses, NIRSQ will partner with others by producing evidence-based research and tools and by working with Federal and non-Federal partners to make sure the evidence developed is easily applied and used in health care settings. Accelerating learning and innovation in health care delivery is also a priority for NIRSQ and many of the research-backed, practical tools we develop takes the "what" of scientific advances and translates it into the "how" for use by physicians and nurses to improve care. The FY 2018 President's Budget provides examples of how NIRSQ will build the bridge between research and practice.

Fundamental Research: Patient Safety. In FY 2018 NIRSQ will focus on patient safety research. Since 2000, with Congressional support, AHRQ has invested heavily in patient safety to assist doctors and nurses in their efforts to reduce or eliminate adverse events – such as drug interactions, surgical site or central line infections, and post-op thromboembolisms when they receive medical care in hospitals, physician offices, nursing homes, ambulatory surgery centers, and other settings. AHRQ's research and tools have contributed to significant reductions in hospital-acquired conditions, which patients develop while in the hospital being treated for something else. Hospital-acquired conditions have relatively high mortality risk and include central line-associated blood stream infections, ventilator-associated pneumonia, and post-operative venous thromboembolism. AHRQ's efforts contributed to a 21 percent reduction in hospital-acquired conditions, 125,000 lives saved, and $28 billion in savings since 2010[1]. Preventing central line-associated blood stream infections, the top-ranked mortality risk among all hospital-acquired conditions, has been a patient safety focus for AHRQ and will continue to be for NIRSQ. After AHRQ grantee Peter Pronovost, M.D., Ph.D., developed and tested a method called the Comprehensive Unit-based Safety Program, or CUSP, at The Johns Hopkins Hospital, he nearly eliminated central line-associated blood stream infections in the hospital's intensive care units over a 4-year period. With funding from AHRQ, he deployed CUSP, which combines clinical best practices with training in safety education, process improvement, and teamwork, to more than 1,100 intensive care units nationwide and reduced central line-associated blood stream infection rates by 41 percent. AHRQ's and other HHS investments have led to a reduction in central line-associated blood stream infections of 91 percent from 2010 to 2015 nationwide. Today, we are closer than ever to the time when hospital-acquired conditions become "never events" (that is, they should never occur when a patient is receiving medical care). NIRSQ will continue this critical work and will work with others across NIH to coordinate patient safety research and identify high priority areas for tools and research.

Fundamental Research Enhanced by Technical Advances: One of AHRQ's widely adopted projects began in 2004, when AHRQ awarded a grant to Sanjeev Arora, M.D, of the University of New Mexico's School of Medicine to establish the first clinic for the Extension for Community Healthcare Outcomes initiative (Project ECHO). This project opened the lines of communication between disease experts at an urban academic medical center and rural primary

[1] https://www.ahrq.gov/professionals/quality-patient-safety/pfp/2015-interim.html?utm_source=AHRQ&utm_medium=PR&utm_term=&utm_content=6&utm_campaign=AHRQ_NSOHAC_2016

care physicians to combat widespread untreated hepatitis C in New Mexico. Today, using a tele-consultation network, Project ECHO helps primary care doctors across the country effectively treat rural and underserved patients in their own communities. A 2011 New England Journal of Medicine article showed that patient care was equally good whether care was provided by specialists or by local primary care doctors using Project ECHO teleconsultation.

Following AHRQ's lead, additional payers and funders have adopted Project ECHO, including the Department of Defense for pain and opioid management and the Veterans Health Administration for diabetes, pain management, and hepatitis C. Several HHS agencies and private foundations have also supported the Project ECHO model for providing care in rural areas.

Since the initial program, Project ECHO has spread:

- Geographically—With 77 specialist hubs in 33 States
- Clinically—With 55-plus conditions, including obesity, chronic pain, diabetes, mental health disorders, substance abuse, and rheumatologic diseases

The substantial growth and interest led Congress to enact the "Expanding Capacity for Health Outcomes" or ECHO Act in December 2016.

NIRSQ will continue funding for Project ECHO to treat opioid abuse in rural communities. Primary care doctors and nurses on the frontlines of the opioid epidemic are receiving remote training and expert consultation on delivering medication-assisted treatment from specialists at an academic hub via Project ECHO. Additionally, NIRSQ will look across NIH for opportunities to leverage this type of infrastructure to further the reach of NIH's research findings.

Health Promotion: Help Physicians, Nurses and Other Health Professionals Improve Quality. In FY 2018 NIRSQ will continue AHRQ's focus on quality improvement. As AHRQ did in the past, NIRSQ will develop tools for doctors and nurses to improve safety, quality, and patient engagement in hospitals, physician offices, and nursing homes, and will now be better positioned to incorporate findings and lessons learned from across NIH.

AHRQ funded one of the Nation's leading tools for hospitals to reduce avoidable readmission rates, the RED (Re-Engineered Discharge) toolkit. Initially developed through research conducted by AHRQ grantee Brian Jack, M.D., of the Boston University Medical Center, the RED toolkit is a standardized approach to discharge planning that centers on the patient by making follow-up appointments with patients' primary care physician, identifying medications that patients should take, educating patients about their diagnosis, and assessing patients' understanding of their care. By ensuring hospital staff members take these steps with every patient, the RED toolkit improves patient preparedness for self-care and reduces readmissions. At Boston University Medical Center, patients whose care incorporated the RED protocol had almost one-third fewer return trips to the hospital (both readmissions and emergency department visits) within 30 days and an average of $400 lower costs. NIRSQ now offers a toolkit to help health providers apply RED and address language barriers and disparities in health care communication and trust. Scores of hospitals across the United States have received training to implement the RED toolkit. The Wisconsin Hospital Association used the RED toolkit and additional NIRSQ tools in an initiative that avoided 30-day readmissions for an estimated 3,556

patients. Their quality and safety efforts reduced readmissions by 22 percent in 18 months, saving approximately $34.1 million.

Building on AHRQ's work, NIRSQ will support doctors and nurses in using data to improve care delivery so their organizations can become learning health care systems. AHRQ's support led to doctors developing the ImproveCareNow Enhanced Registries Project, the world's largest registry for pediatric inflammatory bowel disease. The registry includes data on 45 percent of children in the United States with inflammatory bowel disease who receive care from pediatric gastroenterologists. The registry collects clinical data on medications, interventions, and patient outcomes and patient- and family-reported data on symptoms, medication side effects, outcomes, and the care experience. Using the registry data, physicians identified practice changes that resulted in dramatic improvements in children with the disease, including increased remission rates and improvements in growth and nutrition.

Develop Data to Track Changes in the Health Care System.
As policymakers work toward finding the best solutions for reforming health care, NIRSQ data initiatives will continue to help identify priorities for health care improvement and monitor trends over time. Analysis from the Healthcare Cost and Utilization Project (HCUP), which includes the largest collection of all-payer, encounter-level hospital care data in the United States, provided an early flag of rising opioid use and helped target local-level solutions by identifying variations in opioid-related hospitalization rates across and within States. State-specific opioid data from HCUP help show where the burdens on hospital care have grown the most. They also suggest which States are making the most headway when it comes to tackling the epidemic. HCUP analyses have also tracked trends in readmission rates by payer type; inpatient versus outpatient surgeries; and specific procedures such as double mastectomy. HCUP is developed through a Federal-State-industry partnership sponsored by NIRSQ.

NIRSQ's Medical Expenditure Panel Survey (MEPS)—a set of large-scale surveys of families and individuals, their medical providers, and employers across the United States – is used by legislative and executive branch agencies including the Government Accountability Office, the Congressional Research Service, the Congressional Budget Office, the Bureau of Economic Analysis, and the Department of Treasury in their analyses of health expenditures and health insurance. MEPS is the only national data source measuring how Americans use and pay for medical care, health insurance, and out-of-pocket spending. At the State level, Arkansas used MEPS to identify characteristics of people who would be best served by Medicaid and private insurance when that State implemented its "private option" Medicaid expansion through a Medicaid waiver. The State Health Access Data Assistance Center also recently used MEPS Insurance Component data—the only comprehensive source of State-level employer health insurance data—to develop State by State analyses of employment-based health insurance. NIRSQ's MEPS data show national growth in the share of employees enrolled in employment-based high-deductible plans, yet with variations across states ranging from under 25 percent in the lowest five States to over 52 percent in the five States with the highest share in high-deductible plans.

Overall IC Budget Policy:
The FY 2018 President's Budget Request is $272.000 million. NIRSQ's total program level at the FY 2018 Request is $378.5 million. The total program level includes $106.5 million in mandatory funds from the Patient-Centered Outcomes Research Trust Fund (PCORTF). The FY 2018 President's Budget funds selected activities that have a demonstrated record of effectiveness and make unique contributions to quality improvement and patient safety. Included in the President's Budget is $74.112 million to prevent, mitigate, and decrease patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients. The Budget will continue funding for the Medical Expenditure Panel Survey at $70 million, providing ongoing support to the MEPS allowing the survey 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. NIRSQ will continue to provide administrative support for the United States Preventive Services Task Force at $7.400 million, a reduction of $4.249 million below the FY 2017 continuing resolution level for AHRQ's support of the USPSTF. In addition, the President's Budget includes $5.0 million for a trans-NIH comprehensive review of health services and translation research to help minimize overlap and ensure coordination across NIH. Within Health Services Research, Data, and Dissemination, the FY 2018 President's Budget provides $43.919 million for investigator-initiated research and training grants, a reduction of $3.5 million below the FY 2017 continuing resolution level for AHRQ's support of these research grants. Also within Health Services Research, Data, and Dissemination, a total of $10 million continues for the Healthcare Cost and Utilization Project, $1 million for Evidence-Based Practice Centers, and $3.0 million to continue opioid treatment research grants. The FY 2018 President's Budget reduces or eliminates potentially overlapping or lower priority programs, including many activities in the Health Services Research, Data, and Dissemination portfolio, such as dissemination and implementation projects, the Consumer Assessment of Healthcare Providers and Systems surveys, quality measures development, measurement and data projects, and several contract-funded health services research projects. In addition, no funding is included for the research and dissemination activities of the Health Information Technology portfolio, which could potentially be funded within other portfolios, such as patient safety or health services research, or by other continuing programs.

Program Descriptions and AHRQ Accomplishments to Build On

Review of Health Services and Implementation Research: To maximize the effectiveness of the consolidation of AHRQ's activities in NIH, the FY 2018 President's Budget includes $5.0 million for a trans-NIH comprehensive review of health services and implementation research to help minimize overlap and ensure coordination across NIH. The purpose of this review will be to identify where there are gaps in the health services research; to determine which of those gaps should be filled by the other institutes and which should be filled by this new group; and to identify ways to improve the communication and adoption of NIH's health services research by other federal agencies and stakeholders. NIH may also use the results of this review to identify additional potential opportunities to improve efficiency and coordination of health services research.

Patient Safety Research: The objectives of this program are 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; improve teamwork and communication to improve organizational culture in support of patient safety; and maintain vigilance through adverse event reporting and surveillance in order to identify trends and prevent future patient harm.

NIRSQ will engage 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 NIRSQ 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. As a result of these cross-agency partnerships, AHRQ is conducting a follow-on CUSP project that NIRSQ will continue to fund to address persistently elevated rates of infections in ICUs. We expect these opportunities for more substantial collaboration to result in a greater combined impact.

Program Portrait: Comprehensive Unit-based Safety Program (CUSP) – Three projects:
1. CUSP for Persistently Elevated Catheter-Associated Urinary Tract Infections and Central Line-Associated Blood Stream Infections Rates in ICUs;
2. CUSP for Antibiotic Stewardship in Hospitals, Long-Term Care, and Ambulatory Care; and
3. CUSP for Enhanced Recovery After Surgery.

FY 2017 Level within AHRQ:	$ 12.3 million
FY 2018 Level within NIRSQ:	$ 10.6 million
Change:	$ -1.7 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 central line-associated blood stream infections in more than 1,000 ICUs that participated in AHRQ's nationwide CUSP for central line-associated blood stream infections implementation project. Subsequently, AHRQ expanded the application of CUSP to prevent other HAIs, including catheter-associated urinary tract infections in hospitals and long-term care facilities, surgical site infections and other surgical complications in inpatient and ambulatory surgery, and ventilator-associated events.

NIRSQ will provide $10.6 million for CUSP activities in FY 2018, a decrease of $1.7 million from what AHRQ funded the prior year. This decrease does not reflect a reduced commitment to CUSP implementation. Instead, the decrease is related to the fact that in FY 2017, the CUSP for ICU expansion project was initiated with attendant start-up costs, whereas in FY 2018, this project and the other two CUSP projects will be continued, with slightly lower continuation costs.

In FY 2018, NIRSQ will continue funding of the nationwide expansion of the CUSP project to reduce persistently elevated catheter-associated urinary tract infections and central line-associated blood stream infections rates in ICUs, an expansion that was initially funded in FY 2017. In addition, NIRSQ will support the further expansion of two CUSP projects that were initiated in FY 2016 to address two important challenges. The first issue is using CUSP to promote the implementation of antibiotic stewardship in diverse settings, with a focus on ambulatory and long-term care, as well as hospitals, where antibiotic stewardship is a more familiar concept. Antibiotic stewardship is designed to improve antibiotic use. Increasing the appropriateness of antibiotic use is an essential element in preserving the efficacy of existing and yet-to-be-developed antibiotics and reducing unnecessary risks to patients. Many providers have not yet established antibiotic stewardship programs.

Health Services Research, Data, and Dissemination (HSR): The objectives of this program are to identify the most effective ways to organize, manage, finance, and deliver high quality care 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 NIRSQ's ability to answer questions related to improving the quality of health care. In FY 2018, NIRSQ will support investigator-initiated health services research. New investigator-initiated research and training grants are essential to health services research – they ensure that innovative hypotheses and methodologies are generated as well as the nurture introduction of new investigators into the research pipeline. Investigator-initiated research grants also allow extramural researchers to pursue the various research avenues that lead to successful yet unexpected discoveries. In this light, the investigator-initiated grant is seen as the most vital mechanism for driving health services research in this country and is a funding priority for NIRSQ in FY 2018. In addition, NIRSQ will provides an array of extramural predoctoral and postdoctoral educational and career

development grants and opportunities in health services research to develop the next generation of health services researchers.

FY 2018 funding will also support evidence-based syntheses and measurement and data collection to help fulfill the mission of HSR. Funding is provided for the Evidence-Based Practice Center (EPC) program. The EPCs review all relevant scientific literature on a wide spectrum of clinical and health services topics to produce various types of evidence reports that are widely used by public and private health care organizations. These reports may be used for informing and developing coverage decisions, quality measures, educational materials and tools, clinical practice guidelines, and research agendas. The EPCs also conduct research on the methodology of evidence synthesis. Funding is also provided for the Healthcare Cost and Utilization Project (HCUP). Please see the program portrait on the following page.

Program Portrait: Healthcare Cost and Utilization Project (HCUP)

FY 2017 Level within AHRQ:	$9.7 million (comparable)
FY 2018 Level within NIRSQ:	$9.7 million
Change:	$0.0 million

HCUP is the Nation's most comprehensive source of hospital care data, including information on in-patient stays, ambulatory surgery and services visits, and emergency department encounters. HCUP enables researchers, insurers, policymakers and others to study health care delivery and patient outcomes over time, and at the national, regional, State, and community levels. HCUP is a family of databases, software tools and related products developed through a Federal-State-Industry partnership and sponsored by NIRSQ. HCUP databases are derived from administrative data and contain encounter-level, clinical and nonclinical information including all-listed diagnoses and procedures, discharge status, patient demographics, and charges for all patients, regardless of payer (e.g., Medicare, Medicaid, private insurance, uninsured), beginning in 1988. The critical data made available by this project enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to health care programs, and outcomes of treatments at the national, State, and local market levels. Like AHRQ, NIRSQ will produce HCUP Statistical Briefs – these briefs present simple, descriptive statistics on a variety of topics including specific medical conditions as well as hospital characteristics, utilization, quality, and cost. A recent statistical brief is provided below:

Emergency Department Visits Related to Suicidal Ideation, 2006-2013[2]
Suicide is a major public health concern that causes immeasurable pain and suffering to individuals, families, and communities nationwide. Suicide is the tenth leading cause of death overall and the second leading cause among Americans aged 10-44 years. In 2014, the suicide rate reached a 30-year high, accounting for nearly 43,000 deaths. Suicide is preventable, however. Suicidal thoughts or actions are signs of extreme distress, and require intervention. Emergency departments (EDs) have been identified as an important site of care to identify individuals at risk, to provide timely support and intervention, and to facilitate entry into more intensive treatment, if appropriate.

This Healthcare Cost and Utilization Project (HCUP) Statistical Brief presents information on ED visits related to suicidal ideation among adults aged 18 years or older in 2006, 2010, and 2013. Trends in the population-based rate of ED visits related to suicidal ideation are presented overall and by patient and hospital characteristics. Trends in the number of admissions to the same hospital are examined over time, as well as the cost and length of these inpatient stays.

HIGHLIGHTS:

* From 2006 to 2013, the rate of ED visits related to suicidal ideation among adults increased by 12 percent on average annually. By 2013, 1 percent of all adult ED visits involved suicidal ideation.

*In 2013, compared with other ED visits, those related to suicidal ideation were more likely to be among patients who were male, aged 18-64 years and uninsured or covered by Medicaid.

*In 2013, most suicidal ideation-related ED visits were admitted to the same hospital or transferred to another facility (72 percent).

*Among admissions to the same hospital, the average length of inpatient stay increased from 5.1 to 5.6 days from 2006 to 2013, and aggregate costs increased four-fold (from $600 million to $2.2 billion).

*Among suicidal ideation-related ED visits, 12 percent of patients had a co-occurring injury. Injuries were more common among females than among males.

*Three-quarters of ED visits with suicidal ideation had an associated diagnosis of mood disorders, 43 percent had a substance-related disorder, and 30 percent had an alcohol-related disorder.

[2] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb220-Suicidal-Ideation-ED-Visits.jsp

Health Information Technology: AHRQ's legislatively authorized role is to fund research on whether and how health IT improves healthcare quality. AHRQ-funded research has informed the programs and policies of the Office of the National Coordinator for Health IT (ONC), the Centers for Medicare and Medicaid Services (CMS), the Veteran's Administration, and other Federal entities. The FY 2018 President's Budget ends dedicated funding for health IT. Instead, health IT research will compete for funding opportunities within patient safety and health services research to ensure the highest priority research is funded. Please see the Programs Proposed for Elimination section of this chapter for more details.

U.S. Preventive Services Task Force (USPSTF): The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of nationally-recognized experts in prevention and evidence-based medicine whose mission is to improve the health of all Americans through evidence-based recommendations regarding the effectiveness of clinical preventive services and health promotion to the general population. Since 1998, AHRQ has been authorized by Congress to provide ongoing scientific, administrative and dissemination support to assist the USPSTF in meeting its mission. In FY 2018 administrative support continues at NIRSQ.

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. 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.

Program Portrait: Medical Expenditure Panel Survey (MEPS)

FY 2017 Level within AHRQ:	$65.875 million
FY 2018 Level within NIRSQ:	$69.991 million
Change:	+$4.116 million

Medical Expenditure Panel Survey-Insurance Component Chartbook 2015[3].

Employer-sponsored insurance (ESI) is the primary source of health insurance coverage in the U.S for individuals under age 65. This chartbook presents national and state level estimates from the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) that highlight important characteristics of ESI for private-sector workers. The large sample size and high survey response rate of the MEPS-IC permit analyses of variations in ESI by firm size and across States that are not readily available from other sources. The chartbook covers the following 5 critical aspects of employer-sponsored health insurance: Insurance Offer Rates; Employee Eligibility and Enrollment Rates; Health Insurance Premiums; Employee and Employer Premium Contributions; and Employee Cost Sharing.

Key Findings:

• From 2014 to 2015, there was no significant change in the overall percentage of private-sector employees covered by a health insurance plan offered by their employers (47.8 percent in 2015). However, there was an increase in the number of enrollees from 55.8 million in 2014 to 57.3 million in 2015 as overall employment increased in this period.

• The percentage of employees working at establishments that offer insurance ("the offer rate") increased from 83.2 percent in 2014 to 83.8 percent in 2015. While the offer rate at large firms (with 100 or more employees) increased from 97.3 percent to 98.8 percent in this period, offer rates at small firms (with fewer than 50 employees) fell from 49.8 percent to 47.6 percent, continuing their long-term decline.

•Eligibility rates for employees at private-sector establishments that offer insurance were not significantly different between 2014 (75.4 percent) and 2015 (76.0 percent). Rates in both 2014 and 2015 were lower than eligibility rates from 2003 to 2013.

•Take-up rates declined from 76.7 percent in 2014 to 75.0 percent in 2015, returning to levels similar to those in 2013 (74.8 percent).

•The 2014 to 2015 growth rate for single premiums and employee-plus-one premiums (2.2 percent and 2.6 percent, respectively) were significantly lower than the 4.7 percent growth rates for both types of coverage from 2013 to 2014. The 2014 to 2015 growth rate for family premiums (4.0 percent) was similar to the growth rate for 2013 to 2014.

Research Management and Support (RMS): RMS (formerly known as Program Support) activities provide administrative, budgetary, logistical, and scientific support in the review, award, and monitoring of research grants, training awards, and research and development contracts. RMS functions also encompass strategic planning, coordination, and evaluation of the Institute's programs, regulatory compliance, international coordination, and liaison with other Federal agencies, Congress, and the public.

[3] https://meps.ahrq.gov/survey_comp/MEPSICChartbook.pdf

NATIONAL INSTITUTES OF HEALTH
National Institute for Research on Safety and Quality
Detail of Full Time Equivalents (FTE) 1/ 2/

	2016 Actual Civilian	2016 Actual Military	2016 Actual Total	2017 Est. Civilian	2017 Est. Military	2017 Est. Total	2018 Est. Civilian	2018 Est. Military	2018 Est. Total
Office of the Director (OD)									
Direct:	11	0	11	7	0	7	6	0	6
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	11	0	11	7	0	7	6	0	6
Office of Management Services (OMS)									
Direct:	56	0	56	59	0	59	59	0	59
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	56	0	56	59	0	59	59	0	59
Office of Extramural Research, Education, and Priority Populations (OEREP)									
Direct:	34	3	37	34	3	37	34	2	36
Reimbursable:	0	0	0	1	0	1	1	0	1
Total:	34	3	37	35	3	38	35	2	37
Center for Evidence and Practice Improvement (CEPI)									
Direct:	44	2	46	47	3	50	33	2	35
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	44	2	46	47	3	50	33	2	35
Center for Delivery, Organization and Markets (CDOM)									
Direct:	26	0	26	27	0	27	17	0	17
Reimbursable:	2	0	2	0	0	0	0	0	0
Total:	28	0	28	27	0	27	17	0	17
Center for Financing, Access, and Cost Trends (CFACT)									
Direct:	44	0	44	46	0	46	46	0	46
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	44	0	44	46	0	46	46	0	46
Center for Quality Improvement and Patient Safety (CQuIPS)									
Direct:	30	2	32	30	2	32	30	2	32
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	30	2	32	30	2	32	30	2	32
Office of Communications and Knowledge Transfer (OCKT)									
Direct:	30	0	30	30	0	30	15	0	15
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	30	0	30	30	0	30	15	0	15
AHRQ FTE Total	**277**	**7**	**284**	**281**	**8**	**289**			
NIRSQ FTE Total							**241**	**6**	**247**

Average GS Grade	
FY 2014	13.1
FY 2015	13.1
FY 2016	13.1
FY 2017	13.1
FY 2018	

1/ Excludes mandatory PCORTF FTE.

2/ For this and all other tables, the FY 2016 and FY 2017 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2018 President's Budget consolidates AHRQ's activities into NIH, and the FY 2018 column represents the request for the National Institute for Research on Safety and Quality.

NATIONAL INSTITUTES OF HEALTH
National Institute for Research on Safety and Quality
Detail of Positions 1/ 2/

	2016 Actual	2017 Annualized CR	2018 President's Budget
Executive level I	3	3	1
Executive level II	5	5	5
Executive level III	1	1	1
Executive level IV	3	3	3
Executive level V	0	0	0
Subtotal, AHRQ	12	12	
Total - Exec. Level Salaries, AHRQ	$ 1,465,077	$ 1,682,083	
Subtotal, NIRSQ			10
Total - Exec. Level Salaries, NIRSQ			$ 1,271,848
Total SES, AHRQ	3	3	
Total - ES Salary, AHRQ	$ 437,517	$ 523,219	
Total SES, NIRSQ			3
Total - ES Salary, NIRSQ			$ 533,422
GS-15	62	65	40
GS-14	72	73	59
GS-13	71	71	47
GS-12	15	13	11
GS-11	13	13	7
GS-10	0	0	0
GS-9	10	9	9
GS-8	2	1	0
GS-7	4	4	3
GS-6	3	3	2
GS-5	1	1	1
GS-4	2	3	2
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal , AHRQ	255	256	
Subtotal , NIRSQ			181
Average GS grade, AHRQ	13.1	13.1	
Average GS salary, AHRQ	$92,145	$94,796	
Average GS grade, NIRSQ			13.1
Average GS salary, NIRSQ			$96,645

1/ Excludes Special Experts, Serivces Fellows and Commissioned Officer positions.
Also excludes positions financed using mandatory financing from the PCORTF.
2/ For this and all other tables, the FY 2016 and FY 2017 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency.
The FY 2018 President's Budget consolidates AHRQ's activities into NIH, and the FY 2018 column represents the request for the National Institute for Research on Safety and Quality.

National Institute for Research on Safety and Quality

FY 2018 Congressional Justification

Programs Proposed for Elimination

Health Information Technology Research Portfolio

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act.

Budget Authority (BA)[1]:

	FY 2016 Actual	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
BA	$21,500,000	$21,459,129	$0	-$21,459,129

[1]For this and all other tables, the FY 2016 and FY 2017 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2018 President's Budget consolidates AHRQ's activities into NIH, and the FY 2018 column represents the request for the National Institute for Research on Safety and Quality.

Program funds are allocated as follows: Competitive Grants/Cooperative Agreements; Contracts; and Other.

Program Description and Accomplishments

The purpose of the Health Information Technology (Health IT) portfolio is to show how health IT can improve the quality of American health care. The portfolio develops and synthesizes evidence on how health IT can improve the quality of American health care, disseminates that evidence, and develops evidence-based tools for the effective use of health IT. The portfolio has played a key role in the Nation's drive to accelerate the use of safe, effective, patient-centered health IT innovations.

In FY 2016, the Health IT portfolio within AHRQ funded $19.0 million in research grants to increase understanding of the ways health IT can improve health care quality. Early research efforts built the evidence base regarding facilitators and barriers to health IT adoption and the value of health IT implementation. Recent years' research grants included a focus on understanding how health IT can make care safer and how to ensure health IT safety and usability. Additionally, the Health IT portfolio supported the development and evaluation of health IT innovations ranging from mobile health applications to patient portals. In addition, $2.5 million in contract funds were used to support the synthesis and dissemination of health IT evidence.

At the FY 2017 Annualized CR level, AHRQ's Health IT portfolio continued $19.0 million in grant funding to focus on supporting patient engagement. Another initiative for 2017 is exploring how health IT can improve health care quality and outcomes by enabling more effective population health management and patient-centered care delivery and coordination; these grants will focus on applying data to facilitate bringing research evidence seamlessly into clinical practice to support shared decision making by patients and clinicians.

Funding History within AHRQ

Fiscal Year	Amount
FY 2014	$29,572,000
FY 2015	$28,170,000
FY 2016	$21,500,000
FY 2017 CR	$21,459,129
FY 2018	$0

Budget Request

The FY 2018 Budget does not consolidate this activity of AHRQ's in NIH. The FY 2018 Budget Request is $0.0 million, a decrease of $21.459 million from AHRQ's FY 2017 Annualized CR. The goal of the reorganization is to focus resources on the highest priority research, reorganize federal activities in a more effective manner, and provide increased coordination on health services research activities and patient safety. The FY 2018 President's Budget ends dedicated funding for health IT. Instead, health IT research will compete for funding opportunities within patient safety and health services research to ensure the highest priority research is funded.

NATIONAL INSTITUTES OF HEALTH

Niational Institute for Research on Safety and Quality

FTEs Funded by the Affordable Care Act

(Dollars in Thousands)

Program	Section	FY 2010			FY 2011			FY 2012			FY 2013			FY 2014		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
Prevention and Public Health Fund	4002															
AHRQ Mandatory		$ -	0	0	$ 384	3	0	$ -	0	0	$ -	0	0	$ -	0	0
NIRSQ Mandatory																
Patient-Centered Outcomes Research Trust Fund	6301															
AHRQ Mandatory		$ -	0	0	$ 13	0	0	$ 366	4	0	$ 633	6	0	$ 1,505	13	0
NIRSQ Mandatory																

1/ In FY 2018, AHRQ is consolidated into NIH as the National Institute for Research on Safety and Quality.

Program	Section	FY 2015			FY 2016			FY 2017 Est			FY 2018 Est 1/		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
Prevention and Public Health Fund	4002												
AHRQ Mandatory		$ -	0	0	$ -	0	0	$ -	0	0	$ -	0	0
NIRSQ Mandatory											$ -	0	0
Patient-Centered Outcomes Research Trust Fund	6301												
AHRQ Mandatory		$ 1,644	10	0	$ 1,430	10	0	$ 1,200	8	0	$ -	0	0
NIRSQ Mandatory											$ 2,405	13	0

1/ In FY 2018, AHRQ is consolidated into NIH as the National Institute for Research on Safety and Quality.

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National Institute for Research on Safety and Quality

Key Outputs and Outcomes Tables

Measure	**Year and Most Recent Result /** **Target for Recent Result /** **(Summary of Result)**	**AHRQ** **FY 2017 Target**	**NIRSQ** **FY 2018 Target 1/**	**FY 2018 Target** **+/-FY 2017 Target**
1.3.38 Increase the number of users of research using AHRQ-supported research tools to improve patient safety culture (Outcome)	FY 2016: 2726 users of research Target: 2200 users of research (Target Exceeded)	2850 users of research	2850 users of research	Maintain
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 2016: 167 tools Target: 162 tools (Target Exceeded)	177 tools	187 tools	+10 tools
1.3.62 Reduce the rate of CAUTI cases in hospital intensive care units (ICUS) (Outcome)	FY 2016 Result: Target: Establish baseline	Reduce from baseline	Reduce from baseline	N/A

1/ In FY 2018, AHRQ is consolidated into NIH as the National Institute for Research on Safety and Quality.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	AHRQ FY 2017 Target	NIRSQ FY 2018 Target 1/	FY 2018 Target +/-FY 2017 Target
2.3.7 Increase the percentage of older adults who receive appropriate clinical preventive services (Output)	FY 2016: Two reports on the evaluation of the implementation of the USPSTF recommendations: - Final Report for Veterans Health Administration - Report for Large Health Systems Target: Prepare final report on the evaluation of the implementation of the USPSTF recommendation in large integrated health systems and at the Veterans Administration. (Target Met) FY 2016/FY 2017: Began analysis of pilot data to assess whether it can be used to develop a clinical preventive services composite measure within the MEPS survey Target: Develop national estimates of receipt of high-priority clinical preventive services from MEPS Survey results found that 8 percent of adults (35+) received all of the high priority, appropriate clinical preventive services (95% confidence interval: 6.5% to 9.5%). (Target Met)	Analyzed MEPS pilot data to determine if the data can be used to provide national estimates of receipt of high-priority clinical preventive services. Pilot data was found to be reliable and valid to provide national estimates of receipt of high-priority clinical preventive services. Survey results found that 8 percent of adults (35+) received all of the high priority, appropriate clinical preventive services (95% confidence interval: 6.5% to 9.5%). Analyses are underway to identify specific preventive services that can be targeted for improvement.	Collect Preventive Services Self-Administered Questionnaire data again in FY2018. Results will be available in 2020. Continue analyses to identify specific preventive services that can be targeted for improvement.	N/A

1/ In FY 2018, AHRQ is consolidated into NIH as the National Institute for Research on Safety and Quality.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	AHRQ FY 2017 Target	NIRSQ FY 2018 Target 1/	FY 2018 Target +/-FY 2017 Target
1.3.16 Maintain the number of months to produce the Insurance Component tables following data collection (MEPS-IC) (Output)	FY 2016: 6 months Target: 6 months (Target Met)	6 months	6 months	Maintain
1.3.19 Increase the number of tables per year added to the MEPS table series (Output)	FY 2016: 8359 total tables in MEPS table series Target: 8162 total tables in MEPS table series (Target Exceeded)	8609 total tables in MEPS table series	8859 tables in MEPS table series	+160 total tables in 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 2016: 9 months Target: 9.5 months (Target Exceeded)	9 months	9 months	Maintain
1.3.49 Decrease the average number of field staff hours required to collect data per respondent household for the MEPS (Efficiency)	FY 2016: 12.61 hours Target: 13.5 hours (Target Exceeded)	13.5 hours	13.5 hours	Maintain

1/ In FY 2018, AHRQ is consolidated into NIH as the National Institute for Research on Safety and Quality.

Summary of Proposed Changes in Performance Measures
AHRQ/NIRSQ 1/

Unique Identifier	Change Type	Original in FY 2016 CJ	Proposed Change	Reason for Change	HHS Performance Plan (APP/R) Measure
1.3.36	Retire	Increase the number of consumers for whom Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data is collected.	Retire measure at the end of FY 2017.	This measure will be retired at the end of FY 2017 due to elimination of funding.	Yes
1.3.60	Retire	Identify key design principles that can be used by health IT designers to improve Personal Health Information Management (PHIM).	Retire measure at the end of FY 2017.	This measure will be retired at the end of FY 2017 due to elimination of funding.	Yes

1/ In FY 2018, AHRQ is consolidated into NIH as the National Institute for Research on Safety and Quality.

Physicians' Comparability Allowance (PCA) Worksheet
National Institute for Research on Safety and Quality

		NIRSQ FY 2018 President's Budget 1/
1) Number of Physicians Receiving PCAs		16
2) Number of Physicians with One-Year PCA Agreements		0
3) Number of Physicians with Multi-Year PCA Agreements		16
4) Average Annual PCA Physician Pay (without PCA payment)		149,607
5) Average Annual PCA Payment		24,263
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	
	Category II Research Position	15
	Category III Occupational Health	
	Category IV-A Disability Evaluation	
	Category IV-B Health and Medical Admin.	1

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 NIRSQ 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 NIRSQ's mission of making health care safer, higher quality, more accessible, equitable, and affordable, and to work to ensure that the evidence is understood and used. Since the Institute 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 NIRSQ. 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 NIRSQ a well rounded and highly knowledgeable staff.

1/ In FY 2018, AHRQ is consolidated into NIH as the National Institute for Research on Safety and Quality.

SIGNIFICANT ITEMS FOR AHRQ IN THE HOUSE, SENATE, AND CONFERENCE REPORTS[4]

FY 2017 SENATE REPORT 114-274

Items

Effective Healthcare Program

1. **SENATE (Rept. 114-274)**

The Committee is aware of AHRQ's interest in expanding the areas of focus for the Horizon Scanning System. The Committee believes it is equally important for AHRQ to improve the utility of the system by streamlining the processes by which it collects information and improving the manner and timeliness that this information is made available to the public. Therefore, the Committee requests a report from AHRQ within 90 days of enactment regarding how it can better accomplish these objectives.

Action Taken or to be Taken:

The Horizon Scanning System was a five year project that is now ended due to finite AHRQ resources. The project tracked new innovations in health care and flagged innovations with potential high impact for helping to improve patient outcomes. The project succeeded in tracking over 500 innovations at any given time and updating the information every two months. Health systems used the outputs of the horizon scanning system to predict issues for coverage of new technologies, establish and price health plans, contract with health care providers, and promote innovation. From this experience, we have the knowledge to streamline the processes for collecting the information and creating an online searchable database. AHRQ would welcome the opportunity to submit a plan to accomplish this should funding become available.

Antimicrobial Stewardship

2. **SENATE (Rept. 114-274)**

The Committee supports AHRQ's efforts to develop, improve, and disseminate antimicrobial stewardship interventions to combat the ongoing and serious threat of antimicrobial resistance. AHRQ is directed to work closely with CDC, NIH, and other Federal agencies to coordinate efforts to improve the use of antibiotics in humans across hospital and community settings.

[4] Since the Budget does not fund AHRQ, the responses for AHRQ are included here, as NIRSQ is absorbing the activities of AHRQ.

SENATE REPORT 114-274

Action Taken or to be Taken:

AHRQ is conducting a major project to promote the implementation of antibiotic stewardship programs by applying AHRQ's Comprehensive Unit-based Safety Program (CUSP). This 5-year nationwide project will accelerate adoption of antibiotic stewardship programs in all healthcare settings: hospitals, long-term care, and ambulatory care. AHRQ is coordinating its efforts with CMS and CDC in carrying out the project, and the stewardship interventions in the project will be consistent with CDC's Core Elements of Antibiotic Stewardship in the various settings. In addition, AHRQ is collaborating with NIH, CDC, CMS, and other Federal agencies in the HHS Agency Priority Goal for Combating Antibiotic-Resistant Bacteria (CARB), which aims to increase significantly the percent of hospitals that have antibiotic stewardship programs that incorporate all the core elements. AHRQ's CUSP for Antibiotic Stewardship project will make a major contribution to attaining this goal.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

3. **SENATE (Rept. 114-274)**

The Committee notes that CAHPS surveys are important tools for patients to make more informed decisions about their medical care and for providers and insurers to inform quality improvement initiatives and incentives. Patient experience data in maternity care is currently not regularly and systematically collected. Therefore, 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 appreciates the Committee's support of the CAHPS survey. Some patient experience of maternity care (i.e., inpatient) is collected by CMS through the HCAHPS (Hospital CAHPS) survey, which identifies maternity, medical, and surgical services lines of care. AHRQ agrees that maternity care is an important issue. Please note, the CAHPS survey is proposed for elimination in NIRSQ's FY 2018 President's Budget to help focus resources on the highest priority research and reorganize federal activities in a more effective manner.

SENATE REPORT 114-274

Healthcare-Associated Infections

4. **SENATE (Rept. 114-274)**

Within the Patient Safety portfolio, the Committee provides $37,253,000, the same level as in fiscal year 2016, 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 promoting the expansion of antibiotic stewardship programs in ambulatory and long-term care settings, as well as in hospitals, through its 5-year nationwide CUSP for Antibiotic Stewardship project, which AHRQ is coordinating with CDC and CMS. On the research front, AHRQ and CDC have collaborated in co-hosting a meeting of experts to identify knowledge gaps for the prevention of antibiotic-resistant healthcare-associated infections, which will help inform these agencies' research efforts. AHRQ is participating in the activities of the Presidential Advisory Council on CARB, together with NIH, BARDA, CDC, FDA, DOD, and USDA, and AHRQ has discussed its research innovations with the Council. AHRQ is also coordinating its activities with NIH, CDC, and CMS in collaborative activities which aim to increase the percent of hospitals that have antibiotic stewardship programs that incorporate all the CDC core elements of such programs.

U.S. Preventative Task Force [USPSTF]

5. **SENATE (Rept. 114-274)**

The Committee strongly urges the Secretary to ensure greater transparency and inclusion of appropriate physician experts in the development of USPSTF recommendations. The Committee is concerned about the lack of communication with relevant stakeholders and inconsistency with recommendations by other Federal agencies or organizations. Therefore, the Committee emphasizes the need for the USPSTF to conduct outreach to relevant stakeholders, including

provider groups, practicing specialists that treat the specific disease or condition under review, and relevant patient and disease advocacy organization before voting on a draft recommendation statement. To promote greater transparency, the Committee urges that any final recommendation statement include a description of comments received on the draft recommendation statement and relevant recommendations of other Federal agencies and organizations.

Action Taken or to be Taken

AHRQ is committed to the Committee's request to promote greater transparency of the recommendations of the U.S. Preventive Services Task Force (USPSTF or Task Force) and the inclusion of appropriate topic experts, including physician experts in the development of USPSTF recommendations.

All of the Task Force's recommendations are informed by topic experts, including provider groups, disease-specific experts, and practicing specialists that treat the specific disease or condition under review, such as radiologists, oncologists, cardiologists, and surgeons. For all topics, experts review and provide input at critical points in the recommendations development process. For example, experts provide guidance on key questions, populations of concern, and the research approach for the evidence reviews; help develop the evidence review; and provide peer review. This type of expert engagement happens prior to the Task Force voting on a grade for the draft recommendation.

In addition, for all topics, the Task Force invites comments from the public on draft materials at least three times throughout the recommendations' development process. Each public comment opportunity is publicized on the Task Force's website and promoted through its many communication vehicles. This comment period remains open for four weeks; anyone—including additional specialists, advocacy organizations, and others—can comment by visiting the Opportunities for Public Comment page on the USPSTF's website. The "Response to Public Comment" section of the final recommendation statement summarizes the themes of the public comments and details any changes that were made to the recommendation as a result.

The Task Force partners with relevant stakeholders—including specialists, patient and disease advocacy groups, and Federal agencies—throughout the recommendation development process**.** At the start of each topic, the Task Force alerts national primary care, specialty, patient, advocacy, and other stakeholder organizations with interest in and relevance to the topic and invites them to submit feedback on its work during the public comment periods. At each additional stage in the development of a recommendation, stakeholders are notified of progress and public comment opportunities through the Task Force's 42,000+ member email list. As a result of this comprehensive outreach, the USPSTF receives thousands of comments each year, all of which are carefully reviewed and considered. In addition, the Task Force has formal

partnerships with 17 organizations that represent primary care clinicians, patients and disease advocates, and other stakeholders. Partners contribute their expertise, communicate about Task Force's work to their constituents, and help put the recommendations into practice. A complete list of partners is available on the Our Partners page on the Task Force's Web site.

All final recommendation statements include a section covering relevant recommendations of other organizations and Federal agencies**.** The Task Force routinely examines recommendations from other organizations (e.g., American College of Obstetricians and Gynecologists, American Cancer Society) as part of its review of the evidence. It also communicates and partners with 12 Federal agencies and institutions, which keep the Task Force informed of major Federal initiatives that may produce new evidence. A complete list of the Task Force's Federal partners is available on the Our Partners page of its Web site.

At times, there are differences between the Task Force's evidence-based recommendations and those prepared by other organizations. These differences can often be attributed to differences in processes and procedures for developing recommendations. The Task Force uses independent systematic evidence reviews, as recommended by the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (formerly known as the Institute of Medicine). The standards for guideline development are described on the USPSTF Web site. The Task Force makes recommendations only for those populations without signs or symptoms of disease and in U.S. primary care settings. Nevertheless, the Task Force includes a section in each recommendation statement titled "Recommendations of Others," which summarizes topic recommendations from other professional societies, advocacy organizations, and Federal agencies (where applicable). This section serves to promote greater transparency and help educate the public and clinicians about the work of relevant external stakeholders.

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Duplicative Activity

1. **HOUSE (Rept. 114-699)**

The Committee notes that over time other HHS agencies have expanded into AHRQ's mission area. Therefore, AHRQ's mission and areas of research are duplicated in other HHS agencies. For example, NIH estimates that in fiscal year 2017 it will spend almost $1,500,000,000 on health services research, about five times AHRQs total budget request. CDC, like AHRQ, conducts Prevention Research and Care Management activities. The Office of National Coordinator for Health Information Technology (ONC) and CMS are both supporting Health IT activity. The Committee directs the Secretary to work with all other HHS OpDivs to determine where they have activities that overlap with AHRQ in an effort to consolidate, reduce duplication, and reduce overlap of mission areas across the OpDivs. The review should include a plan to streamline all OpDiv mission focus areas to improve the effectiveness, consolidate operations, and reduce duplicative and related overheard costs to taxpayers.

Action Taken or to be Taken

HHS supports the Committee's concern to consolidate, reduce duplication, and reduce overlap of mission among HHS OpDivs. To help focus resources on the highest priority research and reorganize federal activities in a more effective manner, the FY 2018 Budget consolidates AHRQ into NIH as the as the National Institute for Research on Safety and Quality. This Institute will lead a review of health services research at NIH to promote strategic coordination of health services research and to identify ways to improve the communication and adoption of NIH's health services research by other federal agencies and stakeholders.

AHRQ and its successor agency also play an important, complementary role to the biomedical discovery activities at NIH. This role is recognized in the proposal to consolidate AHRQ into NIH as the National Institute for Research on Safety and Quality in FY 2018 President's Budget. NIRSQ will invest in research on health care systems that supports the transfer of knowledge on the diagnosis, prevention, and cure of human diseases developed by NIH, other Federal agencies, and public- and private-sector organizations to the frontlines of care. Investments by NIRSQ will help ensure that NIH investments in medical science are translated into practical tools and knowledge that can be adopted by clinicians to benefit the American people. NIRSQ will synthesize the findings from related studies on a clinical topic area to help clinicians, health systems, and policymakers to know what constitutes best practices.

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NIRSQ will work closely with other HHS agencies and other government agencies, including CDC, CMS, and the Department of Veteran's affairs to ensure our work is complementary and not duplicative.

Tick-borne Diseases

2. **HOUSE (Rept.114-699)**

The Committee encourages AHRQ to determine when the last time a bibliography of peer-reviewed tick-borne diseases literature was last completed and to work with CDC and NIH to determine how best to develop a tool for use by the scientific community, treating physicians, and the public. The review should also evaluate the science related to persistent infection with borrelia burgdorferi or other types of borrelia.

Action Taken or to be Taken:

In 2012, AHRQ received a nomination to review information on chronic Lyme disease, and at that time, AHRQ conducted a review of existing guidelines and determined that there was consistency across recommendation and concluded that a complete systematic evidence review would not change practice.

AHRQ does not currently have funding to conduct a systematic evidence review on tick-borne diseases. However, AHRQ staff will reach out to CDC and NIH/NIAID to determine their interest in supporting a systematic evidence review which NIRSQ could conduct through its Evidence-based Practice Center program, and in developing tools based on this review.