DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

National Institute for Research on Safety and Quality (NIRSQ)

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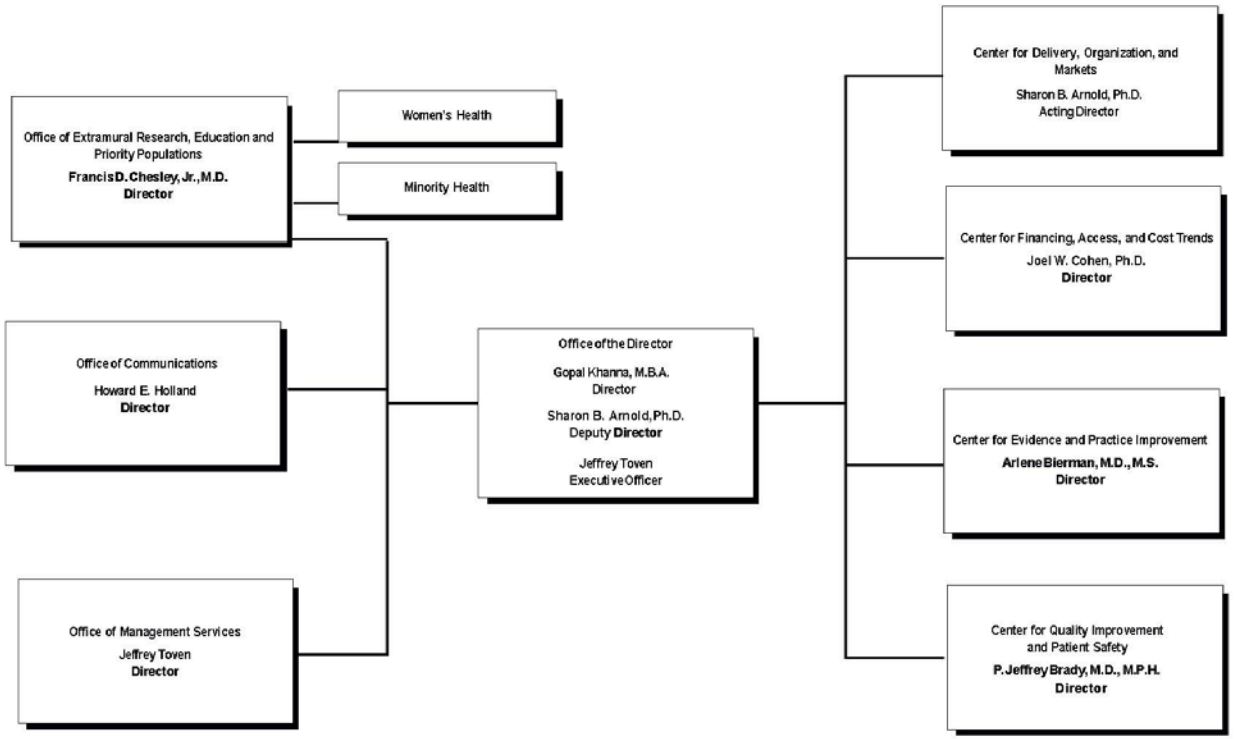

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For carrying out titles III and IX of the PHS Act, part A of title XI of the Social Security Act, and section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, $255,960,000: Provided, That section 947(c) of the PHS Act shall not apply in fiscal year 2019: 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.

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

	FY 2017 Final	FY 2018 Annualized CR	President's Budget
Appropriation	$ 324,000	$ 321,800	$ 255,960
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
Secretary's Transfer	-770		
Subtotal, adjusted appropriation	$ 323,230	$ 321,800	$ 255,960
Unobligated Balance Lapsing	$ 196	0	0
Total obligations, AHRQ	$ 323,034	$ 321,800	
Total obligations, NIRSQ			$ 255,960

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 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the request for the National Institute for Research on Safety and Quality.

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Mechanism Summary Table by Portfolio 1/ 2/

	FY 2017 Final		FY 2018 Annualized CR		FY 2019 President's Budget	
	No.	Dollars	No.	Dollars	No.	Dollars
RESEARCH GRANTS						
Non-Competing						
Patient Safety	68	31,048,921	50	21,665,772	62	24,685,612
Health Serv Res, Data & Diss	154	33,638,886	156	42,239,516	123	35,169,000
Health Information Technology	49	13,060,830	19	6,624,259	0	0
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	271	77,748,637	225	70,529,547	185	59,854,612
New & Competing						
Patient Safety	19	5,771,790	34	14,138,321	28	14,043,816
Health Serv Res, Data & Diss	76	18,924,927	25	9,888,484	0	0
Health Information Technology	8	1,438,670	16	7,776,826	0	0
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	103	26,135,387	74	31,803,631	28	14,043,816
RESEARCH GRANTS						
Patient Safety	87	36,820,711	84	35,804,093	90	38,729,428
Health Serv Res, Data & Diss	230	52,563,813	181	52,128,000	123	35,169,000
Health Information Technology	57	14,499,500	35	14,401,085	0	0
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	374	103,884,024	299	102,333,178	213	73,898,428
CONTRACTS/IAAs						
Patient Safety		33,190,289		33,994,907		31,069,572
Health Serv Res, Data & Diss		36,167,187		36,000,000		14,950,000
Health Information Technology		2,000,500		1,986,915		0
U.S. Preventive Services Task Force		11,332,000		11,570,000		7,400,000
Medical Expenditure Panel Survey		65,836,000		65,552,000		72,191,000
TOTAL CONTRACTS/IAAs		148,525,976		149,103,822		125,610,572
RESEARCH MANAGEMENT		70,820,000		70,363,000		56,451,000
GRAND TOTAL						
Patient Safety		70,011,000		69,799,000		69,799,000
Health Serv Res, Data & Diss		88,731,000		88,128,000		50,119,000
Health Information Technology		16,500,000		16,388,000		0
U.S. Preventive Services Task Force		11,332,000		11,570,000		7,400,000
Medical Expenditure Panel Survey		65,836,000		65,552,000		72,191,000
Research Management		70,820,000		70,363,000		56,451,000
GRAND TOTAL		323,230,000		321,800,000		255,960,000

1/ The FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

2/ Does not include mandatory funds from the PCORTF.

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Major Changes in the Fiscal Year 2019 President's Budget Request

The FY 2019 Budget proposes to consolidate the Agency for Healthcare Research and Quality's (AHRQ) highest priority activities in NIH in order to maximize efficiency of research. This narrative compares NIRSQ funding levels to levels previously funded within AHRQ. However, in addition to these quantifiable comparisons, additional efficiencies are anticipated as NIRSQ works to coordinate health services and patient safety research across NIH and leverage other NIH activities and resources.

Major changes by budget portfolio are briefly described below. NIRSQ's FY 2019 President's Budget discretionary request totals $256.0 million in budget authority, a decrease of $65.8 million from the FY 2018 Annualized CR level. NIRSQ's total program level at the FY 2019 President's Budget is $380.3 million, a decrease of $41.3 million from the FY 2018 Annualized CR level. The total program level includes $124.3 million in mandatory funds from the Patient-Centered Outcomes Research Trust Fund (PCORTF), an increase of $24.5 million from the prior year.

Patient Safety ($0.0 million; total $69.8 million): This research portfolio prevents, mitigates, and decreases patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients. NIRSQ will provide $69.8 million for this research portfolio, the same level as the prior year. Of this total, $35.8 million will support research grants and contracts to advance the generation of new knowledge and promote the application of proven methods for preventing Healthcare-Associated Infections (HAIs). Within this amount, $12 million will be invested in support of the national Combating Antibiotic-Resistant Bacteria enterprise.

Health Services Research, Data and Dissemination (HSR) (-$38.0 million; total $50.1 million): HSR funds foundational health services research through research grant support to the extramural community. NIRSQ will provide $35.2 million for non-competing research grant support. No funding for new research grants is provided. Health Services Research Contracts total $15.0 million, including $4.5 million in new support to accelerate evidence on preventing and treating opioid abuse in primary care.

Health Information Technology (-$16.4 million; total $0.0 million): The FY 2019 President's Budget ends dedicated funding for health information technology. Instead, health IT research will compete for related funding opportunities within patient safety and health services research to ensure the highest priority research is funded.

U.S. Preventive Services Task Force (-$4.2 million; total $7.4 million): 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. This program provides ongoing scientific, administrative, and dissemination support to assist the USPSTF in meeting its mission. A reduction of $4.2 million in FY 2019 will reduce the number of recommendations the USPSTF will make from an average of 12 recommendations per year to 6 recommendations in FY 2019.

Medical Expenditure Panel Survey (+$6.6 million; total $72.2 million): The Medical Expenditure Panel Survey (MEPS), is the only national source for comprehensive annual data on how Americans use and pay for medical care. The survey collects detailed information from families on access, use, expenses, insurance coverage and quality. The 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). An increase of $4.0 million over the FY 2018 Annualized CR level is required to provide ongoing support to the MEPS, allowing the survey to meet the precision levels of survey estimates, maximize survey response rates, and maintain the timeliness, quality and utility of data products specified for the survey in prior years. In addition, an increase of $1.8 million is provided to augment both the sample by 1,000 completed households (2,300 persons) and to redistribute the sample across states. This will allow MEPS to improve its national estimates and increase its capacity for making estimates of individual states and groups of states. An additional $0.4 million is provided to partner with other OPDIVs to develop two self-administered mental health questionnaires – one for adults and one for children-- that would address critical issues with mental health care, including access to care, barriers to care, experiences with care, and use of peer support, school-based services, community services, and other human services involved in mental health.

Research Management & Support (-$13.9 million; total $56.5 million)**:** RMS activities provide administrative, budgetary, logistical, and scientific support in the review, award, and monitoring of research grants, training awards, and research and development contracts. As the organization transitions to the NIH as an Institute, some programmatic activities will end. This reduction in scope will require a decrease of 32 FTEs in FY 2019 from the FY 2018 Annualized CR level.

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Summary of Changes 1/ 2/

2018 Annualized CR	
Total estimated budget authority	$ 321,800,000
(Obligations)	
2019 President's Budget 2/	$ 255,960,000
Total estimated budget authority	
(Obligations)	
Net Change	$ (65,840,000)

	FY 2018 Annualized CR FTE	FY 2018 Annualized CR	FY 2019 PB FTE	FY 2019 PB BA	FY 2019 +/- FY 2018 FTE	FY 2019 +/- FY 2018 BA
Increases:						
A. Built-in:						
1.						
2.						
Subtotal, Built-in Increases						
A. Program:						
1. Medical Expenditure Panel Survey	0	$ 65,552		$ 72,191		$ 6,639
2.						
Subtotal, Program Increases						
Total Increases	**0**	**$ 65,552**		**$ 72,191**		**$ 6,639**
Decreases:						
A. Built-in:						
1.						
2.						
Subtotal, Built-in Decreases						
A. Program:						
1. Health Services Research, Data and Dissemination		$ 88,128		$ 50,119		$ (38,009)
2. Health Information Technology		$ 16,388		$ -		$ (16,388)
3. U.S. Preventive Services Task Force		$ 11,570		$ 7,400		$ (4,170)
4. Research Management and Support (Program Support)	277	$ 70,363	245	$ 56,451	(32)	$ (13,912)
Subtotal, Program Decreases	**277**	**$ 186,449**	**245**	**$ 113,970**	**(32)**	**$ (72,479)**
Total Decreases	**277**	**$ 186,449**	**245**	**$ 113,970**	**$ (32)**	**$ (72,479)**
Net Change					**(32)**	**$ (65,840)**

1/ Excludes funding and FTE from other HHS operating divisions provided through reimbursable agreements and mandatory financing from the PCORTF. In FY 2018, 2 FTEs are funded through reimbursable agreements and 8 from the PCORTF. In FY 2019, 2 FTEs are expected to be funded through reimbrsable agreements and 8 from PRCOTF.

2/ FY 2018 column contains information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

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Budget Authority by Activity 1/ 2/
(Dollars in thousands)

	FY 2017 Final		FY 2018 Annualized CR		FY 2019 President's Budget 2/	
	FTE	Amount	FTE	Amount	FTE	Amount
Research on Health Costs, Quality and Outcomes		186,574		185,885		127,318
Medical Expenditure Panel Survey		65,836		65,552		72,191
Research Management and Support	280	70,820	277	70,363	245	56,451
TOTAL, AHRQ		323,230		321,800		
Total, NIRSQ						255,960

1/ Excludes funding and FTE from other HHS operating divisions provided through reimbursable agreements and mandatory financing from the PCORTF. In FY 2018, 2 FTEs are funded through reimbursable agreements and 8 from the PCORTF. In FY 2019, 2 FTEs are expected to be funded through reimbrsable agreements and 8 from PRCOTF.

2/ For this and all other tables, the FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the request for the National Institute for Research on Safety and Quality.

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Authorizing Legislation 1/ 2/

	FY 2018 Amount Authorized	FY 2018 Amount Appropriated	FY 2019 Amount Authorized	FY 2019 President's Budget
Research on Health Costs, Quality, and Outcomes:				
Secs. 301 & 926(a) PHSA.....	SSAN	$ 185,885	SSAN	$ 127,318
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	$ 65,552	SSAN	$ 72,191
Program Support:				
Section 301 PHSA.....	Indefinite	$ 70,363	Indefinite	$ 56,451
Evaluation Funds:				
Section 947 (c) PHSA		$0		$0
Total appropriations, AHRQ 3/		$321,800		
Total appropriations, NIRSQ 2/, 3/				$ 255,960
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 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 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.

Agency for Healthcare Research and Quality (2010-2018) 1/, 2/, 3/
National Institute for Research on Safety and Quality (2019) 1/, 2/
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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	$ 324,000,000
PHS Evaluation Funds……..	$ 83,458,000	$ -	$ -	$ -
Total……..	$ 363,698,000	$ 280,240,000	$ 324,000,000	$ 324,000,000
AHRQ 2018 3/				
Budget Authority……..	$ 272,000,000	$ 300,000,000	$ 324,000,000	$ 321,800,000
PHS Evaluation Funds……..		$ -	$ -	$ -
Total……..	$ 272,000,000	$ 300,000,000	$ 324,000,000	$ 321,800,000
NIRSQ 2019 2/				
Budget Authority……..	$ 255,960,000	$ -	$ -	$ -
PHS Evaluation Funds……..	$ -	$ -	$ -	$ -
Total……..	$ 255,960,000	$ -	$ -	$ -

1/ Excludes mandatory financing from the PCORTF.

2/ For this and all other tables, the FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the request for the National Institute for Research on Safety and Quality.

3/ FY 2018 columns represent annualized CR level.

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 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
AHRQ Total[2]	$324,000,000	$321,800,000		
NIRSQ Total[2]:			$255,960,000	-$65,840,000
AHRQ FTEs[2]:	282	279		
NIRSQ FTEs[2]:			247	-32

[1]For this and all other tables, the FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the request for the National Institute for Research on Safety and Quality.
[2]Excludes mandatory financing and FTEs from the PCORTF. Includes reimbursable FTE.

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

Director's Overview

The FY 2019 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). Further integration in NIH is anticipated in future years pending the results of an FY 2018 study whose findings will inform future consolidation efforts. 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 of Healthcare 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.

NIRSQ accelerates learning and innovation in health care delivery, building bridges between clinical research and health care practice. Through innovation, by creating research-backed, practical tools, and through harnessing the power of data, NIRSQ addresses the nation's most pressing health concerns and helps doctors, nurses, and health systems deliver safer, more effective, and higher value health care that saves lives.

Fundamental Principle – Patient Safety: Medical breakthroughs, increasing numbers of people living with multiple chronic conditions, and the shifting landscape of the health care delivery system all increase the challenges and complexities around providing safer care. Since 2000, with Congressional support, AHRQ has focused on assisting doctors and nurses in their efforts to keep patients safe when they receive medical care. AHRQ has invested in research to understand how health care systems can safely and reliably provide high-quality health care and has translated the resulting findings into practical tools and training ready for real-world implementation. We continue to develop new and innovative partnerships to ensure that more health systems, doctors, nurses, patients, and communities are using them. The potential benefit to American patients is extraordinarily high, as is the potential return on investment. AHRQ has made progress in health care safety at the front lines of care, taking stock of the best science and safe practices and giving providers the tools they need to implement changes to keep patients safe. For example, AHRQ's Comprehensive Unit-based Safety Program has been shown to substantially reduce healthcare-associated infections. Building on this successful foundation, AHRQ programs have reduced the rates of infections in long-term care facilities, improving safety for mechanically ventilated patients in intensive care units, and helping ambulatory surgery centers make care safer for their patients. AHRQ recognized that multiple perspectives are needed to develop solutions to complex challenges. Our Patient Safety Learning Laboratories take a systems engineering approach to allow researchers and health care professionals to identify and create practical solutions to patient safety problems. The learning laboratories involve cross-disciplinary teams to address the patient safety-related challenges providers face. As a result of these and other activities, AHRQ's National Scorecard on Rates of Hospital-Acquired Conditions shows that about 125,000 fewer patients died and more than $28 billion in health care costs was saved from 2010 through 2015 due to a 21 percent drop in hospital-acquired conditions. In total, hospital patients experienced more than 3 million fewer hospital-acquired conditions from 2010 through 2015.

Fundamental Competency – Health Services Research: In order to improve health, it is imperative that the health care delivery systems put people at the center of care. NIRSQ will continue to promote an approach to health services research called Person360 which asks researchers to place health care delivery in context with both the individual patient's social context and in relation to social and human services. NIRSQ will continue to fund critical research on how the health care delivery systems is organized and operates. We fund research on how to improve care delivery so that patients can benefit from new therapies and discoveries; we also facilitate the analysis of current patterns of care in current practice so that health outcomes can be improved. This kind of research has resulted in real impact on patients' lives: AHRQ research targeting care for pediatric inflammatory bowel disease allowed investigators to collect clinical data on medications, interventions, and patient outcomes and stimulated clinicians to develop and spread practice changes that resulted in dramatic improvement with the disease, including increased remission rates (from 58 to 81%) and improved growth rates (93% achieved satisfactory growth). This was accomplished without the development of any new medications or treatments, solely with a focus on better implementing existing knowledge. In FY 2019, NIRSQ will continue funding for all continuing investigator-initiated health services research, which creates a distributed portfolio in which researchers investigate a wide range of scientific questions. History strongly suggests that letting scientists drive the research topics is the most

productive route to findings that will eventually translate into research that improves the quality of health care. NIRSQ's current delivery system research investments include the foundational areas of health services research (including safety, quality, value, and access) as well as emerging areas and current topics (such as opioids, mental health, obesity, and health information technology). NIRSQ recognizes the value of engaging operational leadership, including chief executive officers and other members of the C-suite, in the development, conduct, and use of health services research. NIRSQ will continue to engage these organizational leaders to join clinical and research teams in efforts to shrink the time between research advances and implementation to create better patient outcomes. NIRSQ will engage health care operation leaders in research to improve safety and quality, and embed those results in how care is provided—all while continuing to engage patients as partners in this critical process.

Fundamental Capability – Data: The volume of health care data nationwide is astonishing and our grand challenge is developing data platforms to use this information to improve patient safety, health care quality, and value. NIRSQ is in the preeminent position to analyze this data with our two powerful data platforms—the Healthcare Cost and Utilization Project (HCUP) and Medical Expenditure Panel Survey (MEPS). HCUP is the Nation's most comprehensive source of hospital data and also includes information on inpatient care, hospital-based outpatient surgery, and emergency department visits. MEPS is the only national source of data measuring how Americans use and pay for medical care, examining health insurance, and out-of-pocket spending.

After hurricanes struck Texas and Florida, AHRQ used data from HCUP to explore how previous hurricane-related spikes in hospital care might inform responses to current or future disasters. This information was shared with our State partners for their use. Such predictive analytics have great promise to improve decision-making both within and outside of government. Since hurricane season returns each year, developing AHRQ's capacity to create analytic and predictive models of health care delivery is a critical investment in our national security.

AHRQ's data have also helped describe the impact the opioid crisis has had on states. HCUP data show that opioid-related hospital stays increased nationwide by 64 percent from 2005 to 2014 with rates increasing more than 70 percent in North Carolina, Oregon, South Dakota and Washington, for example, while declining in Illinois, Kansas, Louisiana and Maryland. And HCUP data helped regions across the United States understand the impact of opioid misuse in their states and communities and develop public health initiatives and treatment strategies based on that demographic data. For example, the HCUP platform showed that in 2014:

- Women in Colorado, North Carolina, and Oklahoma had a higher rate than men for opioid-related hospitalizations. In Pennsylvania, men had the highest rate.
- People aged 65 and older had the highest hospitalization rate for any age group in Colorado. The rate was highest in Oklahoma for people between age 45 and 64. In North Carolina and Pennsylvania, it was highest for those between age 22 and 44.

Enhancing these platforms by greatly expanding the public data they use gives Americans greater return on their investment in NIRSQ by adding to the types of data the Agency make available; increasing the number of users; and by diversifying the ways in which these data,

tools, and research can be applied to make the best health care decisions possible. All of these data efforts further NIRSQ's critical mission to improve safety, quality, and access to care.

Vision for the Future: NIRSQ remains fully aligned with the DHHS and its transformational strategies. Recognizing the dynamic shifts that are occurring across the health care delivery landscape and leveraging NIRSQ's work. NIH is prepared to lead the Department in meeting the enormous need for transformational strategies within health care organizations to move from 'volume' to 'value.' NIRSQ has adopted the conceptual and operational model of learning health delivery organizations, also referred to as learning health systems, as a way to unify its work. Health care delivery organizations are rich with data, and those data are the fuel that transforms a health care delivery organization into a learning health system. In learning health organizations, internal clinical data are systematically collected and analyzed (along with appropriate external data) to inform improvements in clinical practice. The ongoing use of data is an essential element of a health organization's efforts to continuously learn and improve. To better understand the performance of health care systems, AHRQ created the first Compendium of U.S. Health Systems, 2016, the Nation's first publicly available database that gives researchers, policymakers, and health care administrators a snapshot of the U.S. health systems. The online resource was developed by the agency's Comparative Health System Performance Initiative, a collaborative to examine systems' use of evidence-based medicine and explore factors that contribute to high performance. Moving forward, NIRSQ will use the concept of the learning health system as we partner with health care delivery organizations to prioritize health services research, translate findings into tools and trainings to keep patients safe and help doctors and nurses improve quality, and harness data to track changes and spur innovation in health care delivery. NIRSQ will also share these strategies across NIH and build upon existing work at NIH to increase the impact for the healthcare system.

Patient Safety Risks and Harms: Recent accomplishments build on past successes and focus on the continued expansion of projects that demonstrate impact in improving patient safety, including ongoing support for the dissemination and implementation of successful initiatives that seamlessly integrate the use of evidence-based resources in multiple settings such as TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety) and the Surveys on Patient Safety Culture. These projects address the challenges of healthcare teamwork, communication and coordination among provider teams. Better teamwork and the establishment of safety cultures in healthcare organizations are critically important to patient safety. Both of these topics are widely recognized as foundational bases on which patient safety can be improved.

Healthcare-Associated Infections (HAIs): In FY 2017, AHRQ released three new toolkits to prevent HAIs and improve patient safety. These are: 1. Toolkit To Reduce CAUTI and Other HAIs in Long-Term Care Facilities – the product of a CUSP project that reduced CAUTI rates by 54 percent in over 400 participating nursing homes; 2. Toolkit To Improve Safety in Ambulatory Surgery Centers – helps staff apply proven CUSP principles to reduce surgical site infections (SSI) and other complications; and 3. Toolkit to Improve Safety for Mechanically Ventilated Patients – enables ICU staff to apply CUSP principles to reduce complications in patients on ventilators, including ventilator-associated pneumonia (VAP).

Patient Safety Organizations (PSOs): Within the protected environment under the Patient Safety Act that affords privilege and confidentiality safeguards, PSOs have used AHRQ tools to expand their quality and safety improvement programs to nearly every State in the Nation. For example, the Tennessee Center for Patient Safety, a PSO whose parent organization is the Tennessee Hospital Education and Research Foundation, helped 120 member hospitals reduce safety events by more than 1,000 and readmissions by more than 1,500; this resulted in the hospitals saving $17 million between 2012 and 2014. Being able to freely share best practices and lessons learned among partner facilities has resulted in reductions of harms, including falls, infections, and vascular events that can cause significant morbidity and mortality in healthcare settings.

FY 2019 Budget Policy: The FY 2019 President's Budget for Patient Safety research is $69.8 million, the same level of support as under the FY 2018 Annualized CR level. With FY 2019 resources, NIRSQ will continue to fund new research for patient safety in all settings, building on the concerted efforts in prior years to further expand patient safety research in settings outside of the hospital, including ambulatory care and nursing home settings among others. NIRSQ has been a leader in laying the foundation for moving research into practice in the area of diagnostic safety. In 2015, the National Academy of Medicine published a report finding that the issue of diagnostic safety has not received the same attention as other patient safety harms. The report called on HHS to develop and fund a coordinated research agenda to better understand and improve diagnosis in healthcare. NIRSQ will continue to make progress in understanding these errors by funding grants to understand both the incidence and contributing factors to diagnostic errors as well as strategies and interventions to improve diagnostic safety.

Within the overall patient safety budget, FY 2019 funds totaling $35.8 million will support research grants and contracts to advance the generation of new knowledge and promote the application of proven methods for preventing Healthcare-Associated Infections (HAIs). Within

this amount, $12 million will be invested in support of the national Combating Antibiotic-Resistant Bacteria enterprise. NIRSQ will fund research grants and implementation projects to further expand efforts to develop and apply improved approaches for combating antibiotic resistance, including efforts in antibiotic stewardship, with a focus on ambulatory and long-term care settings, as well as hospitals. In FY 2019, the Safety Program for Improving Antibiotic Use, which is applying CUSP to promote implementation of antibiotic stewardship, will continue to expand its reach beyond earlier cohorts of hospitals and long-term care facilities to address antibiotic stewardship in ambulatory settings. NIRSQ will also continue to expand the CUSP projects aimed at reducing rates of central line-associated blood stream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) in intensive care units (ICUs) with elevated levels of these infections, and enhancing care and recovery of surgical patients (see Program Portrait on the following page). The evidence and products of the CUSP projects are shared with other HHS OPDIVs. CDC and CMS staff serve on the Technical Expert Panels of these projects and are involved in the development and dissemination of toolkits that are produced by the projects.

Finally, NIRSQ will provide $4.8 million to continue conformance with administrative requirements of the Patient Safety Act (2005). The Patient Safety Act (2005) provides protection (legal privilege) to health care providers throughout the country for quality and safety improvement activities. The Act promotes increased voluntary patient safety event reporting and analysis, as patient safety work product reported to a PSO is protected from disclosure in medical malpractice cases. HHS issued regulations to implement the Patient Safety Act, which authorized the creation of PSOs, and NIRSQ administers the provisions of the Patient Safety Act dealing with PSO operations. In FY 2019 NIRSQ will support the aggregation of national PSO data, including receipt of data from PSOs, preparation of this data for transfer to the Network of Patient Safety Databases (NPSD), and preparation for analysis of national data at the NPSD.

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 Infection Rates in ICUs;
2. CUSP for Antibiotic Stewardship in Hospitals, Long-Term Care, and Ambulatory Care; and
3. CUSP for Improving Surgical Care and Recovery

FY 2018 Level:	$10.6 million
FY 2019 Level:	$10.6 million
Change:	$ 0.0 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 2019, the same level of funding as in AHRQ in FY 2018. In FY 2019, NIRSQ will continue funding the nationwide expansion of the CUSP project to reduce persistently elevated catheter-associated urinary tract infection 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. In FY 2019, the CUSP for antibiotic stewardship project will continue to expand its reach beyond earlier cohorts in hospitals and long-term care facilities to encompass ambulatory care, a setting in which antibiotic stewardship has not been widely adopted.

A second important issue is improving the recovery of patients from surgery, including reduction in surgical site infections (SSIs) and other complications. An approach that has shown promising effectiveness is an 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. The first cohort of the AHRQ Safety Program for Improving Surgical Care and Recovery, which is applying CUSP for promoting enhanced recovery for surgical patients, is addressing colorectal surgery, and orthopedic surgery is planned to be the next focus area. FY 2019 funds will support continued expansion of this project, which is planning to initiate two additional cohorts focused on gynecology and emergency general surgery.

Like previous CUSP projects, each of these three projects is developing a toolkit to assist participating hospitals and units in implementing safety and practice improvements. As the projects progress, the toolkits will be refined on the basis of participants' experience. At the conclusion of the projects, the final toolkits will be posted on the NIRSQ website to enable units and hospitals that did not participate in the projects to adopt the effective methods used in the projects and thereby benefit their patients. The availability of the toolkits on the NIRSQ website thus extends the impact of the CUSP projects beyond their duration. This toolkit development, refinement, and posting process is a standard feature of NIRSQ's CUSP projects.

Mechanism Table:

NIRSQ 1/
Patient Safety
(Dollars in Thousands)

	FY 2017 Final		FY 2018 Annualized CR		FY 2019 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	68	31,049	50	21,666	62	24,685
New & Competing……	19	6,037	34	14,138	28	14,044
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**87**	**37,086**	**84**	**35,804**	**90**	**38,729**
TOTAL CONTRACTS/IAAs.....		**32,925**		**33,995**		**31,070**
TOTAL.....		**70,011**		**69,799**		**69,799**

1/ The FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

5-Year Funding History:

FY 2015:	$76,584,000
FY 2016:	$74,253,000
FY 2017:	$70,011,000
FY 2018 Annualized CR:	$69,799,000
FY 2019 President's Budget:	$69,799,000

HCQO: Health Services Research, Data and Dissemination				
	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$ 88,731,000	$ 88,128,000	$ 50,119,000	$ (38,009,000)

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

FY 2019 Authorization……..……..……Expired.
Allocation Method……....Competitive Grant/Cooperative Agreement, Contracts, and Other.

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. Investigator-initiated research and training grants are essential to health services research – they ensure that innovative hypotheses and methodologies are generated as well as nurture the 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.

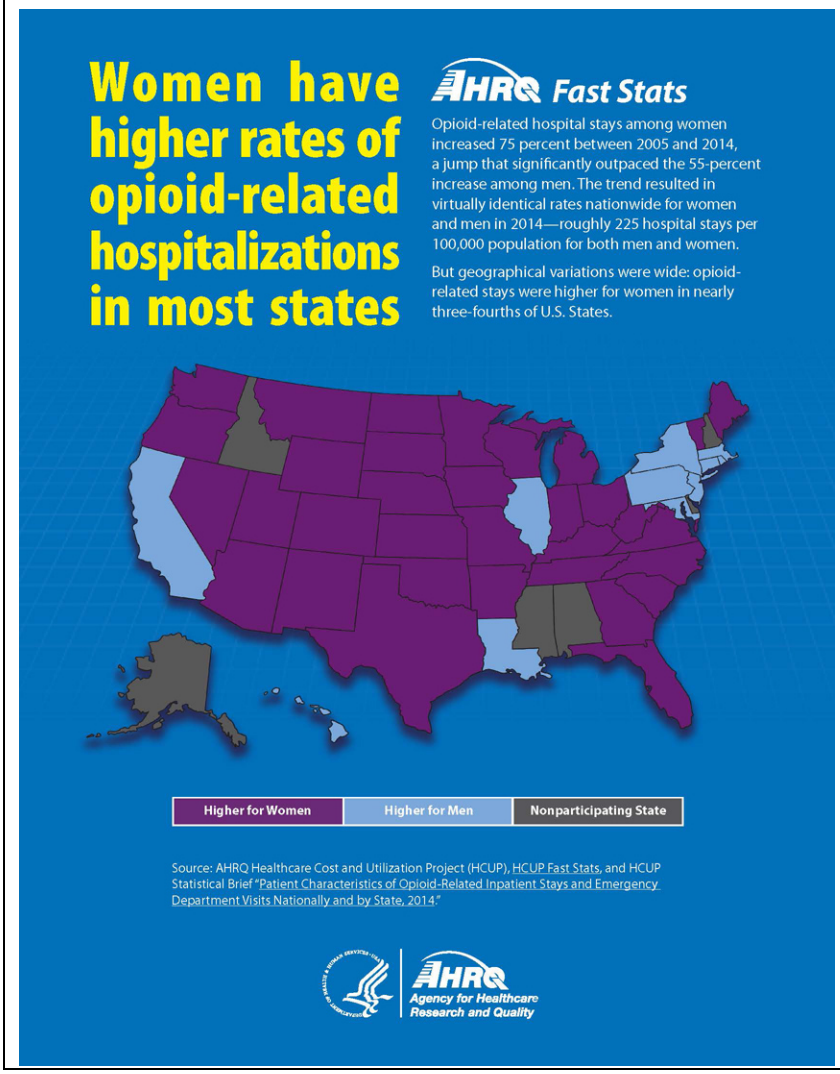
In addition to grants, contract funding supports evidence-based syntheses and measurement and data collection to help fulfill the mission of HSR. Funding is provided for the Evidence-Based Practice Center (EPC) program. The EPCs review all relevant scientific literature on a wide spectrum of clinical 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 for additional information on the program.

Program Portrait: Healthcare Cost and Utilization Project (HCUP)

FY 2019 Level	$9.7 million
FY 2018 Annualized CR Level	$9.7 million
Change:	$0.0 million

HCUP is the Nation's most comprehensive source of hospital care data, including all-payer 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. This program develops HCUP Statistical Briefs – these briefs present engaging, descriptive statistics on a variety of topics including specific medical conditions as well as hospital characteristics, utilization, quality, and cost.

Data from HCUP have been used to document dramatic increases in inpatient hospitalizations and emergency department (ED) visits related to opioid use. AHRQ is publishing a series of Statistical Briefs that provide descriptive information on opioid-related hospital use by State and select patient subgroups. A recent report showed that females and patients aged 65 years and older had the greatest increases in the rate of opioid-related inpatient stays between 2005 and 2014 (see below). Please the HCUP website for more information.



FY 2019 Budget Policy: The FY 2019 President's Budget for HSR is $50.1 million, a decrease of $38.0 million from the FY 2018 Annualized CR level. The FY 2019 President's Budget provides continuation support for investigator-initiated research and training grant support at $35.2 million, a decrease of $17.0 million from the prior year. No funding is provided for new investigator-initiated research grants. A total of $15.0 million is provided for research contracts, a decrease of $21.0 million from the prior year. The reduction of HSR funding in the FY 2019 President's Budget is proposed as NIRSQ will re-focus support to only the highest priority research programs. This reduction requires elimination of Quality Indicators, Consumer Assessment of Healthcare Provider and Systems (continuation grants and contracts), data analytics support, and all dissemination and implementation contracts. FY 2019 funding provides contract support for evidence syntheses through the Evidence-based Practice Centers ($0.8 million) and HCUP ($9.7 million). NIRSQ will use $0.050 million within the base funds for HCUP to conduct a data brief on childhood obesity. In addition, $4.5 million in new research contract funds are provided to accelerate evidence on preventing and treating opioid abuse in primary care. Details about NIRSQ's new research to address the opioid is provided below.

Accelerating Evidence on Preventing and Treating Opioid Abuse in Primary Care (+$4.5 million)

Problem: The Department is providing national leadership and targeting its efforts to address the nation's opioid crisis. Two million American have a prescription opioid abuse and 591,000 suffer from heroin-use disorder. Health care delivery systems, in particular primary care practices, have a critical role to play in preventing opioid abuse through implementing safe and **effective management of pain** and by **expanding access to opioid abuse treatment and recovery services**.

Solution: NIRSQ is uniquely positioned to accelerate the implementation of new evidence on the prevention and treatment of opioid abuse and to increase the capacity of primary care to respond to the opioid epidemic.

NIRSQ will build on a set of research grants exploring overcoming barriers to implementation of Medication-Assisted Treatment (MAT) in rural primary care practices. In FY 2018, the AHRQ-funded demonstration research projects will be completed. While expanding access to this evidence-based therapy in underserved communities, these grants are discovering and testing solutions to overcoming known barriers to implementation of MAT in primary care and creating training and implementation resources to support future efforts to expand access to MAT. The proposed investment will build on this work by accelerating the uptake of these tested solutions, training and implementation resources.

The investment will leverage the work of the AHRQ-convened Academy for Integrating Behavioral Health and Primary Care (The Academy). The Academy offers resources to advance the integration of behavioral health and primary care and fosters a collaborative environment for dialogue, discussion, and sharing of experience among those working in the field. This multi-year effort created a platform and tools for small, independent primary care practices to increase their capacity to deliver high-quality prevention and treatment programs for substance abuse disorders.

Specifically, NIRSQ will:

- Develop new tools and training to assist primary care practices in implementing the CDC's guidelines on opioid prescribing practices, and disseminate them through the Academy.
- In coordination with HRSA and SAMHSA, expand the national primary care integration implementation learning community to include HRSA's Federally Qualified Health Centers and SAMHSA's opioid use disorder grantees focused on treatment.
- Support faculty --experts in the prevention and treatment of substance abuse-- to provide practical guidance to members of the learning community in adapting the tools and resources for their local communities.
- Revise AHRQ's train-the-trainer (practice facilitation) primary care materials to incorporate solutions, tools and trainings on effective pain management and expanding access to treatment and recovery services for opioid abuse .

NIRSQ anticipates investing $4.5 million in a 3-year non-severable contract. This initiative leverages NIRSQ's leadership in the field of developing learning health care delivery systems. It will result in evidenced-based implementation tools for primary care clinicians and practical support for a primary care practices working to improve. NIRSQ will invest approximately 10% of funds in a formative evaluation of this effort to continue to learn how to support primary care practices and improve the quality of substance abuse prevention and treatment.

Through this 3-year investment NIRSQ anticipates reaching over 1,000 primary care practices. Depending on the size of the primary care practice, this project has the potential to touch millions of Americans by expanding access to opioid abuse treatment to tens of thousands of Americans while preventing the development of opioid abuse in thousands more.

Mechanism Table:

NIRSQ 1/
Health Services Research, Data and Dissemination
(Dollars in Thousands)

	FY 2017 Final		FY 2018 Annualized CR		FY 2019 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	154	33,780	156	42,240	123	35,169
New & Competing……	76	18,784	25	9,888	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**230**	**52,564**	**181**	**52,128**	**123**	**35,169**
TOTAL CONTRACTS/IAAs.....		**36,167**		**36,000**		**14,950**
TOTAL.....		**88,731**		**88,128**		**50,119**

1/ The FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

5-Year Funding History:

FY 2015:	$112,207,000
FY 2016:	$ 89,398,000
FY 2017:	$ 88,731,000
FY 2018 Annualized CR:	$ 88,128,000
FY 2019 President's Budget:	$ 50,119,000

HCQO: U.S. Preventive Services Task Force				
	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$ 11,332,000	$ 11,570,000	$ 7,400,000	$ (4,170,000)

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

FY 2019 Authorization……..……..……Expired.
Allocation Method…….... Contracts, and Other.

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. The Task Force makes evidence-based recommendations about clinical preventive services to improve the health of all Americans (e.g., by improving quality of life and prolonging life). 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, and now NIRSQ, is the sole funding source of the USPSTF. NIRSQ supports the USPSTF by ensuring that it has: the evidence it needs in order to make its recommendations; the ability to operate in an open, transparent, and efficient manner; and the ability to clearly and effectively share its recommendations with the health care community and general public.

Major FY 2017 accomplishments for the USPSTF include:

- Maintained recommendation statements for 84 preventive service topics with 132 specific recommendation grades. Many recommendation statements include multiple recommendation grades for different populations.
- Received 18 nominations for new topics and 3 nominations to reconsider or update existing topics.
- Posted 13 draft research plans for public comments.
- Posted 12 draft recommendation statements for public comments.
- Posted 15 draft evidence reports for public comments.
- Published 12 final recommendation statements in a peer-reviewed journal.

To do its work, the Task Force uses a four-step process:

1. **Step 1: Topic Nomination.** Anyone can nominate a new topic or an update to an existing topic at any time, via the Task Force Web site.
2. **Step 2: Draft and Final Research Plans.** The Task Force develops a draft research plan for the topic, which is posted on the Task Force Web site for a 4-week public comment period. The Task Force reviews and considers all comments as it finalizes the research plan.
3. **Step 3: Draft Evidence Review and Draft Recommendation Statement.** The Task Force reviews all available evidence on the topic from studies published in peer-reviewed scientific journals. The evidence is summarized in the draft evidence review and used to develop the draft recommendation statement. These draft materials are posted on the Task Force Web site for a 4-week public comment period.

4. **Step 4: Final Evidence Review and Final Recommendation Statement.** The Task Force considers all comments on the draft evidence review and recommendation statement as it finalizes the recommendation statement.

FY 2019 Budget Policy: The FY 2019 President's Budget for the USPSTF is $7.4 million, a decrease of $4.2 million from the FY 2018 Annualized CR level. With these funds NIRSQ will continue to maintain support for the Task Force, but at a reduced scope (including scientific, methodological, and dissemination support). The FY 2019 President's Budget will allow the USPSTF to make recommendations on approximately 6 topics, 6 fewer than the historical average for the Task Force.

Program Portrait: Recommendation on Screening for Obesity in Children and Adolescents

Childhood obesity is a priority identified by the U.S. Department of Health and Human Services (HHS). Approximately 1 in 3 children and adolescents are currently overweight or have obesity. Childhood and adolescent obesity can cause problems such as asthma, higher blood pressure, sleep apnea, or being bullied. It also may lead to health problems in adulthood, including obesity and related issues, such as diabetes and cardiovascular disease.

Given the importance, prevalence, and negative health effects of child and adolescent obesity, the USPSTF sought to see whether screening for obesity in children and adolescents can be beneficial or harmful for children's health and well-being. The USPSTF found that screening (with body mass index) can identify children who have obesity. It also found that programs that promote changes in behavior can help children and adolescents reduce their weight and improve their health.

Based on this evidence, the USPSTF recommends that clinicians screen children and adolescents 6 years and older for obesity. It also recommends that clinicians offer or refer them to comprehensive behavioral interventions that promote weight management. Parents often do not know when their children have obesity, so screening is an important tool to help improve children's health.

The Task Force recognizes that the medical community must work alongside families, communities, governments, and the public health system in addressing America's childhood obesity epidemic. The Task Force's role is to synthesize high quality evidence and communicate and disseminate the best evidence-based recommendations available to the primary care community. The Task Force's recommendations encourage clinicians to identify children with obesity as early as possible so clinicians can help them manage their weight and improve their overall health. This recommendation also supports the HHS' Secretary's goal to fight and reduce childhood obesity.

The USPSTF recommendation was published in the *Journal of the American Medical Association* in June 2017. It received a lot of national attention with 14,659 total page views on the *JAMA* website and 224 media pieces. For example, it received coverage from media outlets including *Reuters, The Los Angeles Times, Medscape, MedPage Today, and CBS This Morning.*

Mechanism Table:

NIRSQ 1/
U.S. Preventive Services Task Force
(Dollars in Thousands)

	FY 2017 Final		FY 2018 Annualized CR		FY 2019 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.....		**11,332**		**11,570**		**7,400**
TOTAL.....		**11,332**	0	**11,570**	**0**	**7,400**

1/ The FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

5-Year Funding History:

FY 2015:	$11,590,000
FY 2016:	$11,649,000
FY 2017:	$11,332,000
FY 2018 Annualized CR:	$11,570,000
FY 2019 President's Budget:	$ 7,400,000

Medical Expenditure Panel Survey				
	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$ 65,836,000	$ 65,552,000	$ 72,191,000	$ 6,639,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2019 Authorization……..……..……..……Expired.
Allocation Method……..... Contracts and Other.

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 survey 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.

MEPS data continue to be essential for the evaluation of health policies and analysis of the effects 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 gross domestic product
- MEPS HC and MPC data are used by the Congressional Budget Office, Congressional Research Service, the Treasury and others to inform high level inquiries related to healthcare expenditures, insurance coverage and sources of payment
- MEPS is used extensively to inform policymakers with respect to the Children's Health Insurance Program and its reauthorization
- MEPS is used extensively by the GAO in its studies of the U.S. healthcare system and subsequent reports as requested by the Senate Committee on Health, Education, Labor and Pensions
- MEPS is used by CMS to inform the National Health Expenditure Accounts

MEPS is used extensively by the health services research community as the primary source of high quality national data for studies related to healthcare expenditures and out-of-pocket costs and examinations of expenditures related to many types of health conditions.

FY 2019 Budget Policy: The FY 2019 President's Budget level for the MEPS is $72.2 million, an increase of $6.6 million from the FY 2018 Annualized CR level. A total of $70.0 million is required for base funding. Base funding will allow NIRSQ to continue to provide ongoing support to the MEPS, allowing the survey to maintain the precision levels of survey estimates, maximize survey response rates, and the timeliness, quality and utility of data products specified for the survey in prior years. In addition, this funding level allows MEPS to maintain childhood obesity funding at the FY 2018 level of $0.05 million. An additional $2.2 million will be directed to expanding the capacity of the MEPS to address HHS priorities. Additional details are provided below.

Expanding the Capacity of the MEPS for New HHS Priorities ($2.2 million):

Problem: This proposal expands the capacity of the Medical Expenditure Panel Survey to provide data and analysis to respond to NIRSQ and HHS priorities. These enhancements include additional sample and enhanced data collection on mental health.

Solution:
There are two components of the initiative:

1) By both augmenting the sample by 1,000 completed households (2,300 persons) and by redistributing sample across states, MEPS will improve its national estimates and increase our capacity for making estimates of individual states and groups of states particularly rural states and those with relatively small populations. An additional 1,000 completed household interviews could be used to produce improvements in precision of State level estimates for about 36 States and D.C. (i.e. all except the 7 largest and 7 smallest States). This augmentation will also enhance the ability of MEPS to support analyses of key population subgroups, such as persons with specific conditions, those at particular income levels or age groups, as well as analyses by insurance status. In the implementation of this investment, MEPS will engage with organizations with interest and expertise in state health matters, such as the State Health Access Data Assistance Center (SHADAC), the National Governors Association (NGA), the National Council of State Legislators (NCSL), and National Association of Counties (NACo) to assist with dissemination activities. The enhanced data will also be disseminated through the program's existing extensive network of users, which includes numerous universities, research organizations, and national, state, and local agencies and organizations. ($1.8 million in FY 2019 with outyear costs of $1.1 million in FY 2020 and $0.590 million in FY 2021.)

2) For this component NIRSQ would partner with other OPDIVs to develop 2 self-administered mental health questionnaires (SAQ)– one for adults and one for children--that would address critical issues with mental health care, including access to care, barriers to care, experiences with care, and use of peer support, school-based services, community services , and other human services involved in mental health. These questionnaires would contain about 60 additional questions that would be answered by the person (or their parent). This SAQ will substantially improve our ability to analyze the impacts of mental health policies and treatment on the effectiveness and

consequences of care, which will lead to a better understanding of the impacts of the current mental health care system on patients and, in turn, enhance our ability to predict the effects of changes in policy and treatment on patient outcomes across a number of important dimensions. ($0.4 million in one-time costs)

These initiatives will provide increased capacity to examine medical care access, use, spending and health outcomes both across states and for population subgroups, which will enhance researchers' and policymakers' ability to bring comprehensive data to bear on policy questions related to each of those priority issues. These enhancements to MEPS will make it an even more powerful tool for state and federal policy and decision makers. For example, they will improve the utility of the MEPS for examinations of medical care utilization and expenditures across states, allowing more precise comparisons across more states and regions, and provide a more solid basis for predicting the impact of state level policy changes on programs such as Medicaid and CHIP, as well as states' mental health care systems. Improvements to these programs will have a positive impact on system efficiency and outcomes, which can lessen burden on providers and increase the quality of care for patients.

Mechanism Table:

NIRSQ 1/
MEPS Mechanism Table
(Dollars in Thousands)

	FY 2017 Final		FY 2018 Annualized CR		FY 2019 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.....		**65,836**		**65,552**		**72,191**
TOTAL.....		**65,836**		**65,552**		**72,191**

1/ The FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

5-Year Funding History:

FY 2015:	$65,447,000
FY 2016:	$66,000,000
FY 2017:	$65,836,000
FY 2018 Annualized CR:	$65,552,000
FY 2019 President's Budget:	$72,191,000

Program Portrait: Medical Expenditure Panel Survey (MEPS)

FY 2018 Level: $65.6 million
FY 2019 Level: $72.2 million
Change: +$6.6 million

The MEPS Household Component (HC) collects nationally representative information on demographic characteristics, socioeconomic status, health insurance status, access to care, health status, chronic conditions and use of health care services that can be used to examine a broad range of important health economic issues. The Medical Provider Component (MPC) greatly enhances the analytic breadth of the MEPS HC by providing information on expenditures for health care services. Following are key findings from recent research that uses the MEPS HC to examine various aspects of health care expenditures in the US civilian non-institutionalized population. Specifically, this research examines the concentration of total health care expenditures, the amounts individuals paid out-of-pocket for health care services and the effects of obesity on individuals' total health care expenditures.

Key Findings

Concentration of Total Health Care Expenditures:

- In 2014, the top one percent of persons ranked by their health care expenditures accounted for 22.8 percent of total health care expenditures, while the bottom 50 percent accounted for only 2.8 percent.
- About three-quarters of adults in the top 10 percent of spending ranked by their health care expenditures in 2014 had two or more select chronic conditions while 60.0 percent of the adults in the bottom 50 percent of spending had none of the selected conditions.
- These results can inform efforts to improve health care delivery, focusing on individuals with the greatest health needs and resource use.

Out of Pocket Spending:

- Among those using medical care in 2014, mean per person out-of-pocket expenditures for the U.S. civilian noninstitutionalized adult population who had multiple chronic conditions were more than double for those adults who had no or one chronic condition.
- The percentage of people with out-of-pocket expenses over $2,000 increased with age from 3.5 percent for children 18 or younger to 17.3 percent for people aged 65 or older in 2014.
- These results identify populations that are more likely to be vulnerable to higher out of pocket spending.

Effects of Obesity on Total Expenditures for Youth and Adults:

- Among children ages 11-17, obesity raises annual medical care costs by $1,354 (in 2013 dollars) or 159%. Severe obesity raises costs by $2,628 or 310%.
- From 2001 to 2013, the annual direct cost of youth obesity averaged $9.33 billion, and reached $13.37 billion in 2013. Across all years, the cost was borne almost entirely by third party payers.
- In the USA, adult obesity raised annual medical care costs by $3,429 per obese individual, for a nationwide total of $342.2 billion (year 2013 values).
- The share of total health care spending of noninstitutionalized adults that is devoted to treating obesity related illness has risen from 20.6 percent in 2005 to 27.5 percent in 2010 to 28.2 percent in 2013.
- Expenditures have a J-shape over Body Mass Index (BMI), i.e., expenditures fall with BMI for adults who are underweight and healthy weight (BMI $\leq$18.5 and 18.5 < BMI <25), are relatively constant with BMI in the overweight range (25 $\leq$ BMI < 30), and then increase, rising most rapidly in the highest obese class ($\geq$40 BMI).
- Medical care expenditures are higher, and rise more steeply with BMI among adults with diabetes than among those without diabetes.
- The savings from a given percent reduction in BMI are greater the heavier the obese adult, and are greater for those with diabetes than for those without diabetes.
- These results may be useful to policymakers to predict costs of obesity and to payers considering how to target efforts to reduce obesity.

Research Management and Support				
	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$ 70,820,000	$ 70,363,000	$ 56,451,000	$ (13,912,000)
FTE	282	279	247	-32

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2019
Authorization……..……..……Expired.
Allocation Method……..…….... Other.

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.

FY 2019 Budget Policy: The FY 2019 President's Budget level for Research Management and Support (RMS) is $56.5 million, a decrease of $13.9 million from the FY 2018 Annualized CR level. In FY 2019, the reorganization transitioned AHRQ activities to the NIH as an Institute and ended some programmatic activities. This reduction in scope necessitated a decrease of 32 FTEs funded with discretionary accounts in the FY 2019 President's Budget. The FY 2019 President's Budget for Research Management and Support provides necessary one-time support related to close-out activities for research that is ending and workforce reduction expenses, as well as ongoing research management costs related to moving AHRQ's activities to the National Institute of Health (NIH).

In FY 2019 NIRSQ is supporting 245 FTEs with discretionary funds requested for NIRSQ, a decrease of 32 FTEs from the FY 2018 Annualized CR level. As shown below, AHRQ does have additional FTEs supported with other funding sources, including an estimated 2 FTE from other reimbursable funding and an estimated 8 FTEs supported by the Patient-Centered Outcomes Research Trust Fund. The estimate for the PCORTF is preliminary and will be finalized once activities are decided for FY 2019.

	FY 2017 Final	**FY 2018 Annualized CR**	**FY 2019 President's Budget**
FTEs – Budget Authority	280	277	245
FTEs – PCORTF	8	8	8
FTEs – Other Reimbursable	2	2	2

Mechanism Table:

NIRSQ 1/
Research Management and Support (Program Support)
(Dollars in Thousands)

	FY 2017 Final		FY 2018 Annualized CR		FY 2019 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……		**70,820**		**70,363**		**56,451**
TOTAL.....		**70,820**		**70,363**		**56,451**

1/ The FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

5-Year Funding History:

FY 2015:	$69,700,000
FY 2016:	$71,200,000
FY 2017:	$70,820,000
FY 2018 Annualized CR:	$70,363,000
FY 2019 President's Budget:	$56,541,000

Per

NATIONAL INSTITUTES OF HEALTH
National Institute for Research on Safety and Quality
Budget Authority by Object 1/ 2/

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Personnel compensation:				
Full-time permanent (11.1)	30,198,735	33,121,990	29,233,082	(3,888,908)
Other than full-time permanent (11.3)	3,843,816	3,441,560	1,018,093	(2,423,467)
Other personnel compensation (11.5)	1,075,051			-
Military personnel (11.7)	854,606	820,985	708,565	(112,420)
Special personnel services payments (11.8)	6,552			-
Subtotal personnel compensation	**35,978,760**	**37,384,535**	**30,959,740**	**(6,424,795)**
Civilian benefits (12.1)	10,726,083	10,260,249	9,513,591	(746,658)
Military benefits (12.2)	452,571	529,020	314,266	(214,754)
Benefits to former personnel (13.0)			1,401,256	1,401,256
Total Pay Costs	**47,157,414**	**48,173,804**	**42,188,853**	**(5,984,951)**
				-
Travel and transportation of persons (21.0)	250,469	338,364	250,000	(88,364)
Transportation of things (22.0)	38,500	52,056	7,000	(45,056)
Rental payments to GSA (23.1)	3,035,784	3,990,960	2,800,000	(1,190,960)
Rental payments to Others (23.2)				-
Communication, utilities, and misc. charges (23.3)	138,638	937,008	400,000	(537,008)
Printing and reproduction (24.0)	76,802	241,000	50,000	(191,000)
				-
Other Contractual Services:				-
Advisory and assistance services (25.1)				-
Other services (25.2)	10,864,412	14,103,164	10,079,137	(4,024,027)
Purchase of goods and services from government accounts (25.3)	22,350,371	19,387,968	10,380,866	- (9,007,102)
Operation and maintenance of facilities (25.4)				-
Research and Development Contracts (25.5)	133,715,790	129,715,854	115,229,585	(14,486,269)
Medical care (25.6)				-
Operation and maintenance of equipment (25.7)	719,449	654,556	340,000	(314,556)
Subsistence and support of persons (25.8)				-
Subtotal Other Contractual Services	**167,650,022**	**163,861,542**	**136,029,588**	**(27,831,954)**
				-
Supplies and materials (26.0)	125,200	385,600	136,010	(249,590)
Equipment (31.0)	749,386	1,486,488	200,000	(1,286,488)
Land and Structures (32.0)				-
Investments and Loans (33.0)				-
Grants, subsidies, and contributions (41.0)	104,007,785	102,333,178	73,898,549	(28,434,629)
Interest and dividends (43.0)				-
Refunds (44.0)				-
Total Non-Pay Costs	**276,072,586**	**273,626,196**	**213,771,147**	**(59,855,049)**
				-
Total Budget Authority by Object Class	**323,230,000**	**321,800,000**	**255,960,000**	**(65,840,000)**

1/ The FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

2/ Does not include mandatory financing from the PCORTF.

NATIONAL INSTITUTES OF HEALTH
National Institute for Research on Safety and Quality
Salaries and Expenses 1/ 2/

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Personnel compensation:				
Full-time permanent (11.1)	30,198,735	33,121,990	29,233,082	(3,888,908)
Other than full-time permanent (11.3)	3,843,816	3,441,560	1,018,093	(2,423,467)
Other personnel compensation (11.5)	1,075,051			-
Military personnel (11.7)	854,606	820,985	708,565	(112,420)
Special personnel services payments (11.8)				-
Subtotal personnel compensation	**35,972,208**	**37,384,535**	**30,959,740**	(6,424,795)
Civilian benefits (12.1)	10,726,083	10,260,249	9,513,591	(746,658)
Military benefits (12.2)	452,571	529,020	314,266	(214,754)
Benefits to former personnel (13.0)			1,401,256	1,401,256
Total Pay Costs	**47,150,862**	**48,173,804**	**42,188,853**	(5,984,951)
				-
Travel and transportation of persons (21.0)	250,469	338,364	250,000	(88,364)
Transportation of things (22.0)	38,500	52,056	7,000	(45,056)
Rental payments to GSA (23.1)	3,035,784	3,990,960	2,800,000	(1,190,960)
Communication, utilities, and misc. charges (23.3)	138,638	937,008	400,000	(537,008)
Printing and reproduction (24.0)	76,802	241,000	50,000	(191,000)
				-
Other Contractual Services:				-
Advisory and assistance services (25.1)	10,864,412	14,103,164	10,079,137	(4,024,027)
Operation and maintenance of equipment (25.7)	719,449	654,556	340,000	(314,556)
Subsistence and support of persons (25.8)				-
Subtotal Other Contractual Services	**11,583,861**	**14,757,720**	**10,419,137**	(4,338,583)
				-
Supplies and materials (26.0)	125,200	385,600	136,010	(249,590)
Total Non-Pay Costs	**15,249,254**	**20,702,708**	**14,062,147**	(6,640,561)
				-
Total Salary and Expense, AHRQ	**62,400,116**	**68,876,512**		
Total Salary and Expense, NIRSQ			**56,251,000**	(12,625,512)
Direct FTE, AHRQ 3/	280	277		
Direct FTE, NIRSQ 3/			245	

1/ The FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

2/ Does not include mandatory financing from the PCORTF.

3/ Excludes 8 mandatory PCORTF funded FTE and 2 reimbursable FTE.

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

	2017 Actual Civilian	2017 Actual Military	2017 Actual Total	2018 Est. Civilian	2018 Est. Military	2018 Est. Total	2019 Est. Civilian	2019 Est. Military	2019 Est. Total
Office of the Director (OD)									
Direct:	7	0	7	7	0	7	6	0	6
Reimbursable:	0		0	0	0	0	0	0	0
Total:	7	0	7	7	0	7	6	0	6
Office of Management Services (OMS)									
Direct:	59	0	59	58	0	58	58	0	58
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	59	0	59	58	0	58	58	0	58
Office of Extramural Research, Education, and Priority Populations (OEREP)									
Direct:	33	2	35	32	2	34	32	2	34
Reimbursable:	1	0	1	1	0	1	1	0	1
Total:	34	2	36	33	2	35	33	2	35
Center for Evidence and Practice Improvement (CEPI)									
Direct:	42	3	45	42	3	45	35	2	37
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	42	3	45	42	3	45	35	2	37
Center for Delivery, Organization and Markets (CDOM)									
Direct:	28	0	28	27	0	27	17	0	17
Reimbursable:	1	0	1	1	0	1	1	0	1
Total:	29	0	29	28	0	28	18	0	18
Center for Financing, Access, and Cost Trends (CFACT)									
Direct:	44	0	44	44	0	44	44	0	44
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	44	0	44	44	0	44	44	0	44
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
	30	2	32	30	2	32	30	2	32
Office of Communications and Knowledge Transfer (OCKT)									
Direct:	30	0	30	30	0	30	17	0	17
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	30	0	30	30	0	30	17	0	17
AHRQ FTE Total	275	7	282	272	7	279			
NIRSQ FTE Total							241	6	247

Average GS Grade	
FY 2015	13.1
FY 2016	13.1
FY 2017	13.1
FY 2018	13.1
FY 2019	13.1

1/ Excludes 8 mandatory PCORTF FTE for FY 2018 and FY 2019. Includes reimbursable FTE.
2/ For this and all other tables, the FY 2017 and FY 20187 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 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/

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Executive level I	3	3	3
Executive level II	6	5	5
Executive level III			
Executive level IV			
Executive level V			
Subtotal Executive Level Positions	9	8	8
Total - Exec. Level Salaries	$ 1,843,132	$ 1,852,652	$ 1,889,437
Total SES, AHRQ	4	4	
Total - ES Salary, AHRQ	$ 767,993	$ 825,675	
Total SES, NIRSQ			4
Total - ES Salary, NIRSQ			$ 829,597
GS-15	63	63	40
GS-14	69	67	59
GS-13	70	70	47
GS-12	13	13	11
GS-11	12	12	10
GS-10	0	0	0
GS-9	10	9	9
GS-8	0	0	0
GS-7	2	2	2
GS-6	2	2	2
GS-5	1	1	1
GS-4	1	0	0
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal	243	239	181
Total - GS Salary			
Average ES level			
Average ES salary			
Average GS grade, AHRQ	13.1	13.1	
Average GS salary, AHRQ	$ 94,796	$ 96,970	
Average GS grade, NIRSQ			13.1
Average GS salary, NIRSQ			$ 97,431

1/ Excludes Special Experts, Serivces Fellows and Commissioned Officer positions. Also excludes positions financed using mandatory financing from the PCORTF.

2/ The FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

National Institute for Research on Safety and Quality

FY 2019 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 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$16,500,000	$16,388,000	$0	-$16,388,000

[1]For this and all other tables, the FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 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 2017, the Health IT portfolio within AHRQ funded $14.0 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. Research in 2017 explored 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. 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 2018 Annualized CR level, AHRQ's Health IT portfolio continues total funding of $16.4 million.

Funding History within AHRQ

Fiscal Year	Amount
FY 2015	$28,170,000
FY 2016	$21,500,000
FY 2017	$16,500,000
FY 2018 Annualized CR	$16,388,000
FY 2019 President's Budget	$0

Budget Request

The FY 2019 Budget does not consolidate this activity of AHRQ's in NIH. The FY 2019 Budget Request is $0.0 million, a decrease of $16.4 million from AHRQ's FY 2018 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 2019 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.

FTEs Funded by P.L. 111-56 (CR) and Any Supplementals
NATIONAL INSTITUTES OF HEALTH
FTEs Funded by the Affordable Care Act 1/
(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	$ -	0	0	$ 366	4	0	$ 633	6	0	$ 1,505	13	0
NIRSQ Mandatory																

Program	Section	FY 2015			FY 2016			FY 2017			FY 2018			FY 2019		
		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	$ -	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	$ 1,387	8	0	$ 1,500	8	0	$ -	0	0
NIRSQ Mandatory														$ 1,500	8	0

1/ The FY 2017 and FY 2018 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

NATIONAL INSTITUTES OF HEALTH

National Institute for Research on Safety and Quality

Key Outputs and Outcomes Tables

Patient Safety Research Portfolio:

Measure	**Year and Most Recent Result /** **Target for Recent Result /** **(Summary of Result)**	**AHRQ FY 2018 Target 1/**	**NIRSQ FY 2019 Target 1/**	**FY 2019 Target** **+/-FY 2018 Target**
1.3.38 Increase the number of users of research using AHRQ-supported research tools to improve patient safety culture (Outcome)	FY 2017: 2672 users of research Target: 2850 users of research (Target Not Met)	2850 users of research	2850 users of research	Maintain
1.3.41 Increase the cumulative number of evidence-based resources and tools available to improve the quality of health care and reduce the risk of patient harm. (Outcome)	FY 2017: 180 tools Target: 177 tools (Target Exceeded)	187 tools	200 tools	+13 tools
1.3.62 Reduce the rate of CAUTI cases in hospital intensive care units (ICUs)	FY 2017: 1.60 CAUTI/1,000 catheter days: Baseline NHSN Rate 10.26 CAUTI/10,000 patient days - Baseline Population Rate	5.00% reduction from FY 2018 Baseline NHSN and Population Rates	5.00% reduction from FY 2019 Baseline NHSN and Population Rates	Maintain

1/ The FY 2018 column contain information for the Agency for Healthcare Research and Quality and is provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

The Patient Safety Portfolio identifies risks and hazards associated with patient harm and facilitates change to reduce quality gaps associated with healthcare and their harmful impact on patients. AHRQ accomplishes this mission 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 healthcare delivery, and support local solutions and national goals.

The Patient Safety 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. Projects within the portfolio 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.

AHRQ conducts and funds applied research to assess the nature and extent of risks to patient safety and quality shortfalls; identifies contributing factors; and generates knowledge on how to improve patient safety and implement proven practices. In addition, the Patient Safety Portfolio promotes the wide-scale implementation of proven methods for improving use of this knowledge to accelerate improvements in patient safety and quality of healthcare.

AHRQ develops and supports resources and tools 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 and facilitates the use of these resources and tools to inform multiple stakeholders and their efforts 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, the Agency is also supporting measurement and reporting on adverse events. The Patient Safety Portfolio leverages partnerships and resources in order to disseminate and implement safe practices. Together these activities provide a natural feedback loop that can highlight and fill gaps in which new evidence is most needed to address real quality and safety problems encountered by providers and patients.

At the same time, the Patient Safety Portfolio appreciates a clear need to balance investments in measurement and reporting, with those in dissemination and implementation, and also with more fundamental research in patient safety. This balance supports ongoing knowledge creation and a continuous cycle of improvement that encompasses both the discovery and application of safe healthcare practices.

The FY 2017 Patient Safety Portfolio accomplishments build on past successes and focus on the continued expansion of projects that demonstrate impact in improving patient safety, including ongoing support for the dissemination and implementation of successful initiatives that seamlessly integrate the use of evidence-based resources in multiple settings such as TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety) and the Surveys on Patient Safety Culture (SOPS). These projects address the challenges of healthcare teamwork, communication and coordination among provider teams. Better teamwork and the

establishment of safety cultures in healthcare organizations are critically important to patient safety. Both of these topics are widely recognized as foundational bases on which patient safety can be improved.

Expanding on and leveraging existing work, the Patient Safety Portfolio will continue to fund new research for patient safety in all settings, building on the concerted efforts in prior years to further expand patient safety research in settings outside of the hospital, including ambulatory care and nursing home settings among others. AHRQ has been a leader in laying the foundation for moving research into practice in the area of diagnostic safety. In 2015, the National Academy of Medicine published a report finding that the issue of diagnostic safety has not received the same level of attention as other patient safety harms. The report called on HHS to develop and fund a coordinated research agenda to better understand and improve diagnosis in healthcare. The Agency continues to make progress in understanding these errors by funding grants to understand both the incidence and contributing factors to diagnostic errors as well as strategies and interventions to improve diagnostic safety.

AHRQ conducts research on identifying gaps, developing strategies to improve safety and quality, and disseminating evidence on the frequency and prevention of safety incidents. The funding for the Patient Safety Portfolio supports continued progress in preventing patient harm and enhancing the safety of healthcare for all Americans. In addition, the budget allows for the continued investment in the highest priority research in NIRSQ and ensuring that the research is applied by other Federal agencies and stakeholders.

Many public and private healthcare organizations across the country rely on the evidence base developed by the Patient Safety Portfolio to provide the strategies and tools needed to minimize risks and harms to patients. In the coming years, the Agency may face challenges in conducting research on reducing patient harm, acquiring relevant data to assess adverse events, and providing unique contributions to quality improvement and patient safety.

1.3.38: Increase the number of users of research implementing AHRQ-supported patient safety culture surveys

As an indicator of the number of users of research, the Agency relies in part on SOPS. AHRQ developed SOPS to support a culture of patient safety and quality improvement in the Nation's health care system. The safety culture surveys and related resources can be used by hospitals, nursing homes, medical offices, and community pharmacies. Each SOPS survey has an accompanying toolkit that contains: survey forms, survey items and dimensions, survey user's guide, and a data entry and analysis tool.

Healthcare organizations can use SOPS to: raise staff awareness about patient safety, examine trends in culture over time, conduct internal and external benchmarking, and identify strengths and areas for improvement. SOPS can be used to assess the safety culture of individual units and 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 and the related resources from the AHRQ Web

site. The interest in the resources has remained strong over the past 13 years as evidenced by electronic downloads, orders placed for various products, participation in SOPS Webinars, and requests for technical assistance.

In response to requests from SOPS users and patient safety researchers, AHRQ established comparative databases as central repositories for survey data from healthcare organizations that have administered the SOPS. Upon meeting minimal eligibility requirements, healthcare 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 2017, the submissions to the comparative databases were provided by 2,672 users of research, including: 680 hospitals; 1,528 medical offices; 290 nursing homes; and 255 community pharmacies. This number does not reflect users of the Ambulatory Surgery Center SOPS since there is not currently a comparative database for this particular SOPS survey. In FY 2018 and 2019, the Agency projects that the users of the comparative databases will remain in a steady state due to a levelling off of comparative database activities. The number of SOPS users, who submit results to the comparative databases, is only a portion of the total number of users.

1.3.41: Increase the cumulative number of evidence-based resources and tools available to improve the quality of health care and reduce the risk of patient harm.

A major output of the Patient Safety Portfolio is the availability of evidence-based resources and tools that can be utilized by healthcare organizations to improve the care they deliver, and, specifically, patient safety. An expanding set of evidence-based tools is available as a result of ongoing investments to generate knowledge through research and synthesize and disseminate this new knowledge in the optimal format to facilitate its application.

The Agency has provided resources and tools such as:

- AHRQ Patient Safety Network (AHRQ PSNet) & Web M&M (Morbidity and Mortality Rounds on the Web);
- AHRQ's Safety Program for Nursing Homes: On-Time Pressure Ulcer Prevention;
- Common Formats (standardized specifications for reporting patient safety events);
- Guide for Developing a Community-Based Patient Safety Advisory Council;
- Guide for Improving Patient Safety in Long- Term Care Facilities;
- Guide to Patient and Family Engagement in Hospital Quality and Safety;
- Improving Patient Flow and Reducing Emergency Department Crowding: A Guide for Hospitals;
- Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation;
- Nursing Home Antimicrobial Stewardship Modules;
- Preventing Hospital-Acquired Venous Thromboembolism: A Guide for Effective Quality Improvement
- Re-Engineered Discharge (RED) Toolkit; and
- Toolkit for Improving Perinatal Safety.

The Patient Safety Portfolio is projecting that the number of evidence-based resources and tools will continue to increase with a projected cumulative number of 200 in FY 2019.

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

A performance measure has been developed in connection with an HAI project as follow-on to earlier CUSP projects. Data from the CUSP for CAUTI project have 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 current HAI project is adapting CUSP to bring down persistently elevated CAUTI and CLABSI rates in ICUs. The 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.

In FY 2019, NIRSQ will continue the expansion of the CUSP project for reducing CAUTI and CLABSI rates in ICUs with persistently elevated rates of these infections. This expansion from four regions of the country to nationwide coverage was funded with FY 2017 funds and began at the beginning of FY 2018. The FY 2019 HAI performance measure assesses progress toward reducing the rate of CAUTI in ICUs participating in the CUSP project.

In FY 2017, there was a sufficient number of ICUs participating in the project to allow the derivation of two overall baseline rates of CAUTI from the baseline rates of all the then-participating ICUs. The first baseline rate is the National Healthcare Safety Network (NHSN) rate. This rate is defined as the number of CAUTI cases per 1,000 catheter days. An important approach for reducing CAUTI cases is to reduce the use of catheters and thus the number of catheter days. However, to the extent that this effort succeeds, it lowers the denominator in the NHSN rate and thereby appears to raise the CAUTI rate. A second rate has therefore been used: the population rate, defined as the number of CAUTI cases per 10,000 patient days. The denominator of this rate is not affected by a reduction in the number of catheter days.

In FY 2017, as shown in the table, the NHSN rate was 1.60 CAUTI/1,000 catheter days (1,190 CAUTI cases/742,297 catheter days). The population rate was 10.26 CAUTI/10,000 patient days (1,189 CAUTI cases/1,158,974 patient days).

The FY 2017 baseline rate provides an initial picture of the CAUTI rates in the ICUs. However, this rate will not be used to gauge progress in FY 2018 or FY 2019 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 2018 and FY 2019. Given the virtual absence of reductions in CAUTI rates observed in ICUs in the nationwide CUSP for CAUTI project, the targets for FY 2018 and in FY 2019 will have to be set on the basis of experience in the new project in the first part of FY 2018. The targets will have to be set quite

conservatively in light of the fact that the participating ICUs have been chosen because they are among the lower-performing units in terms of reducing their rate of CAUTI (and/or CLABSI).

Health Services Research, Data and Dissemination Research Portfolio:

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	AHRQ FY 2018 Target 1/	NIRSQ FY 2019 Target 1/	FY 2019 Target +/-FY 2018 Target
2.3.8 Increase the availability of electronic clinical decision support tools related to safe pain management and opioid prescribing (Output)	FY 2018: Result Expected Sep 30, 2018 Target: Develop at least one new electronic clinical decision support tool related to safe pain management and opioid prescribing (In Progress)	Develop at least one new electronic clinical decision support tool related to safe pain management and opioid prescribing	Test, revise, and disseminate at least one new electronic clinical decision tool related to safe pain management and opioid prescribing Partner with stakeholders to identify additional evidence-based electronic clinical decision tools related to safe pain management and opioid prescribing and make them publicly available	N/A

1/ The FY 2018 column contain information for the Agency for Healthcare Research and Quality and is provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

Addressing the nation's opioid epidemic is an ongoing focus of AHRQ's Health Services Research, Data, and Dissemination portfolio. In FY 2017, AHRQ contributed to all five pillars of the Department of Health and Human Services comprehensive opioids strategy. Our work included practical health services research, data explorations, and public dissemination. Our dissemination activates included producing systematic evidence reviews on non-opioid pain management and the use of naloxone by emergency medical service personnel and publishing a collection of over 250 field-tested tools to support the delivery of Medication Assisted Treatment (MAT) in primary care settings. Using AHRQ data platforms, AHRQ produced a series of analysis documenting trends in health care utilization fueled by the opioid epidemic at state and national levels and which uncovered the diverse ways in which the crisis is manifesting itself across the country. In FY 2017, AHRQ also continued to support both investigator-initiated health services research on the prevention and treatment of opioid addiction by health care

delivery organizations and targeted health services research expanding access to MAT in rural communities through primary care.

In FY 2017, AHRQ initiated a new initiative to ensure that health care professionals have access to evidence supporting safe pain management and opioid prescribing at the point of care through electronic clinical decision support (CDS). This effort is part of AHRQ's overall CDS initiative, funded by resources from the Patient-Centered Outcomes Research Trust Fund, to advance evidence into practice through CDS and to make CDS more shareable, standards-based, and publicly-available. The infrastructure for developing and sharing these CDS tools is called CDS Connect (https://cds.ahrq.gov).

In FY 2018, new CDS will be developed in the clinical domain of safe pain management and opioid prescribing. The CDS will include shareable, interoperable specifications for integration into electronic health records as well as implementation guidance. The CDS will be developed with input from a CDS Connect work group consisting of stakeholders from multiple perspectives, including patients, providers, health IT developers, and others.

In FY 2018 and continuing in FY 2019, the CDS for safe pain management and opioid prescribing will be tested, revised, and disseminated through the CDS Connect platform. All resources developed within the project will be publicly-available. In addition, AHRQ plans to work with stakeholders to disseminate other safe pain management and opioid prescribing CDS tools and resources developed elsewhere. For example, CDC and ONC continue to develop opioid-related CDS that may be suitable for dissemination through CDS Connect.

U.S. Preventive Services Task Force (USPSTF) Portfolio:

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	AHRQ FY 2018 Target 1/	NIRSQ FY 2019 Target 1/	FY 2019 Target +/-FY 2018 Target
2.3.7 Increase the percentage of older adults who receive appropriate clinical preventive services (Output)	FY 2017: Pilot data was found to be reliable and valid to provide national estimates of receipts 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. Target: Analyzed MEPS pilot data to determine if the data can be used to provide national estimates of receipt of high-priority clinical preventive services.	Prepare for and collect PSAQ data again in FY 2018. Continue analyses to identify specific preventive services that can be targets for improvement.	Continue PSAQ data collection through 2019. The panel design of the survey features several rounds of interviewing covering two full calendar years. Data should be available in 2020.	N/A

1/ The FY 2018 column contain information for the Agency for Healthcare Research and Quality and is provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

2.3.7: Increase the percentage of adults who receive appropriate clinical preventive services
In FY 2018, the Agency for Healthcare Research and Quality (AHRQ) will continue to provide ongoing scientific, administrative and dissemination support to the U.S. Preventive Services Task Force (USPSTF). The Task Force makes evidence-based recommendations about clinical preventive services to improve the health of all Americans (e.g., by improving quality of life and prolonging life). By supporting the work of the USPSTF, AHRQ helps to identify appropriate clinical preventive services for adults, disseminate clinical preventive services recommendations, and develop methods for understanding prevention in adults.

For several years, AHRQ has invested in creating a national measure of the receipt of appropriate clinical preventive services by 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. This measure will allow AHRQ to assess where improvements are needed most in the uptake of clinical preventive services. It will help AHRQ support the USPSTF by targeting its recommendations and dissemination efforts to the populations and preventive services of greatest need. Thus, making sure the right people get the right clinical preventive services, in the right interval.

AHRQ now has a validated final survey to collect data on the receipt of appropriate clinical preventive services among adults (the Preventive Services Self-Administered Questionnaire (PSAQ) in the Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS)). The survey was fielded in a pilot test in 2015. It is a self-administered questionnaire that will be included as part of the standard MEPS starting in 2018. In FY 2017, AHRQ developed a baseline for national estimates of receipt of high-priority clinical preventive services among adults for this performance measure. Survey results found that eight percent of adults (35+) received all of the high priority, appropriate clinical preventive services (95% Confidence Interval: 6.5% to 9.5%).

In FY 2018, 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 the uptake of 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.

In FY 2018 and FY 2019, AHRQ will administer the PSAQ again. The panel design of the survey, which features several rounds of interviewing covering two full calendar years, makes it possible to determine how changes in respondents' health status, income, employment, eligibility for public and private insurance coverage, use of services, and payment for care are related. Once data is collected, it is reviewed for accuracy and prepared to release to the public. NIRSQ expects to report on the percentage of older adults who receive appropriate clinical preventive services for the first time in 2020 and every other year thereafter. Additional years of data will allow for AHRQ to track and compare receipt of high priority, appropriate clinical preventive services over time.

Medical Expenditure Panel Survey (MEPS):

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	AHRQ FY 2018 Target 1/	NIRSQ FY 2019 Target 1/	FY 2019 Target +/-FY 2018 Target
1.3.16 Maintain the number of months to produce the Insurance Component tables following data collection (MEPS-IC) (Output)	FY 2017: 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 2017: 9040 total tables in MEPS table series Target: 8609 total tables in MEPS table series (Target Exceeded)	9540 total tables in MEPS table series	9790 total tables in MEPS table series	+250 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 2017: 9 months Target: 9 months (Target Met)	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 2017: 12.61 hours Target: 12.61 hours (Target Exceeded)	13.5 hours	13.5 hours	Maintain

1/ The FY 2018 column contain information for the Agency for Healthcare Research and Quality and is provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

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). 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 health care reform 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 2018 through FY 2019. Further reducing the target time is not feasible because the proration and post-stratification processes are dependent upon the timing and availability of key IRS data that are appended to the survey frame. Data trends from 1996 through 2016 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 1,422 tables. For the Insurance Component there are a total of 2,494 national level tables and 5,124 state and metro area tables. The total number of tables available to the user population is currently 9,040.

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 – 2016. This represents twenty 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 the delivery schedule. The following steps have and will continue to be taken in an effort to release public use files as early as possible: 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 2017. We are on target to also meet the data release schedule for the MEPS public use files scheduled for release during FY 2018. The release date for public use files (jobs, home health, other medical expense, dental visits, medical provider visits, outpatient department visits, emergency room visits, hospital stays, prescribed drugs, and full year consolidated) will be maintained moving from FY 2017 to FY 2018. The current release dates for all public use files will be maintained for FY 2019.

The 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. MEPS questionnaire redesign efforts will be ongoing from FY 2017 through FY 2018 in order to address content modifications and content complexity. The baseline for data collection is 13.5 hours (FY 2017 actual 12.61 hours) and this will be maintained through FY 2019.

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

Unique Identifier	**Change Type**	**Prior Content in FY 2018 CJ**	**Change**	**Reason for Change**	**HHS** Performance Plan (APP/R) Measure
1.3.19	Revise FY 2018 targets	9199 total tables in MEPS table series	9540 total tables in MEPS table series	New data indicates FY 2018 target can be adjusted upwards	No
1.3.19	Revise FY 2019 targets	9449 total tables in MEPS table series	9790 total tables in MEPS table series	New data indicates FY 2018 target can be adjusted upwards	No
1.3.41	Modify measure language	Increase the cumulative number of evidence-based resources and tools available in the inventory of AHRQ supported tools to improve patient safety and reduce the risk of patient harm	Increase the cumulative number of evidence-based resources and tools available to improve the quality of health care and reduce the risk of patient harm	Modification of measure language supports Strategic Plan Objective 1.2	No
2.3.7	Add additional target for FY 2018	Collect PSAQ data again in FY 2018	Prepare for and collect PSAQ data again in FY 2018. Continue analyses to identify specific preventive services that can be targets for improvement.	Additional years of data will allow for AHRQ to track and compare receipt of high priority, appropriate clinical preventive services over time.	No
2.3.8	New	N/A	Increase the availability of electronic clinical decision support tools related to safe pain management and opioid prescribing	New measure supports AHRQ's opioid research and is approved as a measure in 2018-2022 HHS Strategic Plan	Yes

1/ The FY 2018 column contain information for the Agency for Healthcare Research and Quality and is provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the requests for the National Institute for Research on Safety and Quality.

Physicians' Comparability Allowance (PCA)

1) Department and component:

Agency for Healthcare Research and Quality/National Institute for Research on Safety and Quality 1/

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

Most, if not all of the research positions at the Agency 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 the mission of improving health care for all Americans. Since the Agency has not employed other incentive mechanisms for the 602 series (for example, Title 38), it is imperative that we offer PCA to entice physicians to accept and remain at the Agency. 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.

3-4) Please complete the table below with details of the PCA agreement for the following years:

	AHRQ 2017 Final	AHRQ FY 2018 Annualized CR	NIRSQ FY 2019 President's Budget
3a) Number of Physicians Receiving PCAs	20	20	19
3b) Number of Physicians with One-Year PCA Agreements	0	0	0
3c) Number of Physicians with Multi-Year PCA Agreements	20	20	19
4a) Average Annual PCA Physician Pay (without PCA payment)	149,311	153,919	153,378
4b) Average Annual PCA Payment	$24,350	24,050	23,737

1/ For this and all other tables, the FY 2017 and FY 2018 column contains information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2019 President's Budget consolidates AHRQ's activities into NIH, and the FY 2019 column represents the request for the National Institute for Research on Safety and Quality.

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year. (Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)

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

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

SIGNIFICANT ITEMS FOR AHRQ IN THE HOUSE, SENATE, AND CONFERENCE REPORTS[1]

FY 2018 SENATE REPORT 115-000

Items

Diagnostic Quality and Safety

1. **SENATE (Rept. 115-000)**

- The Committee is concerned about the lack of dedicated research into improving how we diagnose medical conditions, especially given the magnitude of the public health burden of diagnostic failures that lead to patient harm. According to the 2015 report, "Improving Diagnosis in Healthcare", from the National Academy of Sciences, Engineering, and Medicine [NASEMJ, diagnostic errors have been a "blind spot" for healthcare delivery and improving diagnosis is a pressing "moral, professional, and public health imperative." The Committee requests that AHRQ convene a cross-agency working group that will propose a strategy to enhance scientific research to improve diagnosis in healthcare, as outlined in the 2015 NASEM report. This should include a review of current research, as well as consideration of opportunities for public-private partnerships and the development of centers of excellence to propel research forward to improve diagnostic quality and safety while reducing healthcare costs. The Committee requests this information be provided in the fiscal year 2019 CJ.

Action Taken or to be Taken:

AHRQ agrees with the Committee that research into diagnostic safety is a priority given the lack of attention this area of research has gotten compared to research focused on patient safety related to treatment decisions. In 2015, the National Academy of Medicine published a report finding that the issue of diagnostic safety has not received the same attention as other patient safety harms. The report called on HHS to develop and fund a coordinated research agenda to better understand and improve diagnosis in healthcare. NIRSQ will continue to make progress in understanding these errors by funding grants to understand both the incidence and contributing factors to diagnostic errors as well as strategies and interventions to improve diagnostic safety. In recognition of this important area of research, AHRQ currently has two program announcements to fund research on diagnostic safety, but the funding for this research competes with other equally important patient safety priorities at AHRQ. Based on a preliminary scan of diagnostic safety research funded by federal agencies in 2016, AHRQ understands that less than 1% of federal health care research spending has been dedicated to diagnostic safety research and supports the recommendations in the NAM report, “Improving Diagnosis in Healthcare” to provide dedicated funding for research on the diagnostic process and diagnostic errors. AHRQ has begun preliminary work to convene a cross-agency workgroup that will propose a strategy to enhance scientific research to improve diagnostic safety, including consideration of opportunities

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

for public private partnerships and the creation of centers of excellence in diagnostic safety. Should additional funding be made available, AHRQ stands ready to implement the strategy proposed by the cross-agency workgroup.

Evidence-based Practice

2. **SENATE (Rept. 115-000)**

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The Committee encourages AHRQ to include in its research portfolio a focus on disabilities and chronic conditions, including disability as a health disparity. The Committee encourages AHRQ to use all three levels of evidence stratification and assessment recognized by the U.S. Preventative Services Task Force and recognize that the absence of randomized controlled trials does not equate to the absence of evidence. Similarly, the Committee encourages AHRQ to recognize that the inability to draw conclusions about the comparative effectiveness of a treatment does not mean the treatment is ineffective.

Action Taken or to be Taken:

AHRQ has a major focus on providing patient-centered care to improve quality and outcomes. AHRQ recognizes the importance of this research for persons with disabilities and chronic conditions. This priority area is highlighted in our funding announcements, including disability as a disparity. Evidence of AHRQ's commitment to improving research in these populations is apparent in a Special Emphasis Notice for grants to Optimizing Care for People Living with Multiple Chronic conditions through the Development of Enhanced Care Planning and a recent report on Improving Cultural competence to Reduce Health Disparities, which included interventions to reduce disparities for persons with disabilities.

AHRQ agrees that the absence of randomized controlled trials does not equate to the absence of evidence. The AHRQ Evidence-based Practice Center (EPC) Program Methods Guide specifically considers non-randomized studies and has developed several papers describing the role of non-randomized studies, particularly when searching for harms. The AHRQ EPC Methods Guide on Grading the Strength of a Body of Evidence describes the approach to summarizing evidence according to high, moderate, low, or insufficient evidence. AHRQ also agrees that the inability to draw conclusions does not mean a treatment is ineffective. The Methods guide paper specifically describes the definition of insufficient as the inability to estimate the effect and that there is no confidence regarding whether the effect of one intervention is superior, inferior, or equivalent to another.

Health Services Research

3. **SENATE (Rept. 115-000)**

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Health services research provides decisionmakers critical information to improve health care quality, increase efficiency, and inform personal health care choices. The Committee does not support the administration's proposal to consolidate AHRQ into the NIH and instead continues to

fund the agency as an independent operating division within the Department. However, the Committee is concerned that AHRQ and the other Federal agencies conducting health services research do not sufficiently coordinate their efforts to optimize Federal investments in this science. The recommendation includes $1,000,000 for AHRQ to contract with an independent entity to study health services research supported by Federal agencies since fiscal year 2012. This study should identify research gaps and areas for consolidation, as well as propose strategies for better coordination of the Federal health services research enterprise. The Committee requests a report on the findings of this study to the Committee not later than 180 days after the enactment of this act.

Action Taken or to be Taken:

AHRQ supports the Committee's concern to better coordinate efforts with our Federal partners to optimize investments in health services research. In order to better coordinate this important research, AHRQ is following the Committee's guidance to fund a study to identify research gaps and possible areas of consolidation. AHRQ has begun planning for a contract to carry out an analysis of health services research supported by Federal agencies since 2012. AHRQ intends this study to assess the current state of HSR funding, identify research gaps, and propose strategies for better coordination of Federal HSR enterprise. AHRQ is currently drafting the scope of work and assessing available contract mechanisms to expeditiously meet the requirements of this analysis. AHRQ intends to execute this contract as soon as possible following confirmation of final budget and parameters.

Investigator-initiated Research

4. **SENATE (Rept. 115-000)**

The Committee reiterates its strong support for investigator-initiated research and believes this research should not target any specific area of health services research but should reflect the best unsolicited ideas from the research community. The Committee is aware that enhanced utilization of independent academic medical centers could lead to innovative and pragmatic solutions that improve clinical practices.

Action Taken or to be Taken:

AHRQ appreciates the Committee's strong support for investigator-initiated research. This type of non-targeted research is the foundation for generating many health services research discoveries. NIRSQ plans to continue support funding investigator-initiated research grants that are innovative and show promise in contributing to the evidence-base for improving safety and quality of clinical care. The Agency has consulted with the independent academic medical center community about potential opportunities for partnerships to improve clinical practices. NIRSQ plans to continue to work with independent academic medical centers where there are opportunities for mutual collaborations.

U.S. Preventive Task Force [USPSTF]

5. SENATE (Rept. 115-000)

The Committee notes the USPSTF's inclusion of additional stakeholders and physician experts during its recent process for drafting the updated prostate cancer screening recommendation. However, the Committee remains concerned about the lack of transparency in the process and directs the USPSTF to include a description of comments received on the draft recommendation statement and relevant recommendations of other Federal agencies and organizations in any final recommendation.

Action Taken or to be Taken

The USPSTF started posting its draft recommendation statements online for public comment in October 2009. A number of steps have been instituted to make the process transparent. Each draft recommendation is open for public comment for four weeks, and the deadline is always clearly noted on the USPSTF website and promoted in the media when the draft is posted. Those who submit comments receive acknowledgement that the comments have been transmitted.

The USPSTF receives comments from clinicians, including specialists; patients and health care consumers; the medical product manufacturing industry; federal agencies; professional organizations; and others. The USPSTF notifies these groups to ensure that they are aware of the opportunities to comment.

The final version of each recommendation contains a section titled "**Response to Public Comment**," wherein the USPSTF summarizes the themes of the public comments received and the USPSTF responses to them. It also summarizes the changes made based on feedback received during the public comment period. Feedback from the public comments is integral to the USPSTF recommendation statement development process.

As part of the USPSTF's review of the evidence, it examines other organization's recommendations (e.g., American College of Obstetricians and Gynecologists, American Cancer Society) and their relevant scientific publications. These recommendations from other organizations and Federal agencies are reviewed and evaluated in comparison with the USPSTF's own evidence review and recommendation. Furthermore, in each of its recommendation statements, the USPSTF includes a section called "**Recommendations of Others**" in order to provide the public with a full understanding of the current existing recommendations for that particular topic.

The USPSTF is committed to the transparency of its recommendation development process. Since October 2009, in its final recommendations, the USPSTF has included a summary of the public comments received and the changes made in response to them. In addition, it has included a summary of relevant recommendations of other Federal agencies and organizations. In the future, the USPSTF will continue to use these methods promoting the transparency of its work.

Significant Items -- HOUSE REPORT 115-000

Duplicative Activity

1. **HOUSE (Rept. 115-000)**

The Committee notes that the findings from research conducted and supported by AHRQ provide evidence to improve the quality, safety, accessibility, and affordability of health care. It is in the Nation's interest to ensure this work is being supported and managed effectively and efficiently, and in a way that avoids unnecessary duplication with other Federal agencies and/or the private sector. The Committee directs AHRQ to enter into an agreement with the National Academy of Public Administration to conduct a study and make recommendations for how the Federal government should best manage this important research, including the optimal organizational location and means of avoiding unnecessary overlap with other stakeholders.

Action Taken or to be Taken

AHRQ supports the Committee's concern to better coordinate efforts with our Federal partners to optimize investments in health services research. In order to better coordinate this important research, AHRQ is following the Committee's guidance to fund a study to identify research gaps and possible areas of consolidation. AHRQ has begun planning for a contract to carry out an analysis of health services research supported by Federal agencies since 2012. AHRQ intends this study to assess the current state of HSR funding, identify research gaps, and propose strategies for better coordination of Federal HSR enterprise. AHRQ is currently drafting the scope of work and assessing available contract mechanisms to expeditiously meet the requirements of this analysis. AHRQ intends to execute this contract as soon as possible following confirmation of final budget and parameters.

Patient Reported Outcomes in Children

2. **HOUSE (Rept.115-000)**

Patient-reported outcomes play a major role in assessing the type and quality of care being received by patients. While patient-reported outcome measures are being advanced as an important component of clinical decision- making, there is little evidence to guide pediatric providers with respect to implementation and application of these measures, particularly as children move from early childhood through adolescence and to adulthood. The Committee requests that AHRQ report back on the state of patient reported outcomes in children with kidney disease and how the agency intends to advance the scientific application of these measures toward improving health outcomes in kidney patients as they mature from newborns to young adults in the fiscal year 2019 Congressional Justification.

Action Taken or to be Taken:

AHRQ conducts reviews of the literature in partnership with organizations who have the content expertise to identify the questions to be addressed with a review of the literature and the interest and ability to use the AHRQ product. AHRQ does not currently have funding to conduct a systematic evidence review on patient-reported outcomes in children with kidney disease, and will reach out to the HHS-wide Kidney Interagency Coordinating Committee to determine their interest in partnering with and supporting a systematic evidence review which AHRQ could conduct through its Evidence-based Practice Center program. AHRQ also has an active grant announcement "Implementation and Evaluation of New Health Information Technology (IT) Strategies for Collecting and Using Patient-Reported Outcome (PRO) Measures" which seeks to invest in innovative collaborative investigations to understand how new health IT strategies can increase the utilization of PROs. Potentially grants funded through this announcement could advance the use of PROs and improve health outcomes in pediatric kidney patients.

Bibliography of Peer Reviewed Tick-Borne Diseases Literature

3. **HOUSE (Rept. 115-000)**

The Committee encourages AHRQ to assemble a bibliography of peer-reviewed tick-borne diseases literature, appropriately organized for use by the scientific community, treating physicians, and the public. The bibliography should include literature relating to possible mechanisms of persistent infection with Borrelia burgdorferi or other types of Borrelia.

Action Taken or to be Taken

AHRQ conducts reviews of the literature in partnership with organizations who have the content expertise to identify the questions to be addressed with a review of the literature and the interest and ability to use the AHRQ product. AHRQ does not currently have funding to conduct a systematic evidence review on tick-borne diseases, but reached out to CDC, NIH/NIAID, and OASH to determine their interest in partnering with and funding a systematic evidence review which AHRQ could conduct through its Evidence-based Practice Center program. Through the 21st Century Cures Act, a Tick-Borne Diseases Working Group was established will develop a summary of ongoing federally funded tick-borne disease research, recent advances, and federal activities, including research, services, and programs focused on causes, prevention, treatment, surveillance, diagnosis, diagnostics, duration of illness, and interventions. The Working Group will be conducting literature reviews as part of this effort, but it does not have sufficient funding to support comprehensive reviews in all of these areas. AHRQ will continue to follow-up with Working Group members about opportunities for complementary efforts.