DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2014

Agency for Healthcare Research and Quality

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Agency for Healthcare
Research and Quality

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As the Director of the Agency for Healthcare Research and Quality (AHRQ), I am pleased to present the FY 2014 Congressional Justification. This budget request reflects an effort, amid economic uncertainty and fiscal constraints, to fulfill AHRQ's mission to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Our performance-based budget demonstrates our continued commitment to assuring the integrity of all programs so AHRQ can help the health care system make measurable differences in health care for all Americans.

All Americans will not have high-quality and affordable health care without the significant advances yielded by the AHRQ-supported evidence-based research that identifies better and more effective and cost-effective treatments and quality interventions. AHRQ supports this research through a variety of research programs, including: Patient-Centered Health Research; Value; Prevention and Care Management; Health Information Technology; Investigator-Initiated research projects; and Patient Safety.

The products of this research are making important contributions to our Nation's health care system. For example, AHRQ-funded research on stents that are placed in heart arteries when they are clogged found that patients who stopped taking a common anti-blood clotting drug at three months after surgery, were more likely to have problems such as heart attacks and blood clots – than patients who stayed on longer. This is critical information because most clinical practice guidelines only recommended staying on the anti-clotting medication for three months after surgery; the recommendations now have extended the time to stay on the medication.

AHRQ also helps providers and other health care stakeholders implement the findings of research. Twelve Nebraska critical access hospitals revised their protocol for preventing venous thromboembolism – blood clots that can break loose and cause strokes and other dangerous health care conditions – after their State Quality Improvement Organization, CIMRO, participated in a series of onsite learning sessions and technical assistance calls for implementing the AHRQ toolkit Preventing Hospital-Acquired Venous Thromboembolism: A Guide for Effective Quality Improvement.

Work funded by AHRQ also is making it easier and more efficient for state and local data organizations, regional reporting collaboratives, hospitals and hospital systems, and health plans to quickly and easily generate a health care reporting Website -- completely free of charge. MONAHRQ is a tool that responds to the needs of future public report sponsors by offering a way to build a public report Web site both inexpensively and quickly. It allows users to create a public reporting Web site using hospital discharge data, inpatient measures from CMS Hospital Compare, and/or HCAHPS survey measures. Six states (Hawaii, Indiana, Kentucky, Maine, Nevada, and Utah) now use MONAHRQ for reporting to the public on the status of health care in their State.

AHRQ also is continuing its efforts to improve the safety of health care. An important priority in this area continues through our investments in research to prevent healthcare-associated infections (HAIs). At any one time, 1 out of every 20 hospital patients has an HAI. HAIs are

costly, deadly, and largely preventable. In 2009, there were approximately 41,000 cases of central line-associated bloodstream infection (CLABSI) in hospitals in the United States, leading to as many as 10,000 deaths, based on estimates from the Centers for Disease Control and Prevention.

Through nationwide implementation of the AHRQ-supported Comprehensive Unit-based Safety Program (CUSP), an AHRQ project aimed at preventing central line-associated blood stream infections (CLABSIs) showed a 41 percent reduction in the rate of CLABSIs from 1.915 to 1.133 CLABSIs per 1,000 central line-days in the 18 months after implementation of CUSP. These results translate directly into benefits for patients— keeping them safer by preventing over 2,100 CLABSIs, saving more than 500 lives, and averting over $36 million in excess costs due to patient harm. The average additional hospital cost for each case of CLABSI is over $16,500.

In FY 2013, following an approach similar to the successful implementation of CUSP for CLABSI, AHRQ will expand the nationwide implementation of CUSP for other conditions, including catheter-associated urinary tract infection (CAUTI) and ventilator-associated pneumonia (VAP) as well as for safe surgery. Results from existing efforts show that CUSP has the potential to have a major impact in preventing various HAIs. In addition, these activities are contributing significantly to the attainment of the goals of the Partnership for Patients (PfP). Four of the nine hospital-acquired conditions (HACs) that the PfP seeks to reduce are HAIs – CLABSI, CAUTI, surgical site infections, and VAP – and AHRQ's CUSP implementation projects are thus integral components of the PfP's efforts to reduce these HACs.

AHRQ seeks to promote economy, efficiency, accountability, and integrity in the management of our research dollars to ensure that AHRQ is an effective steward of limited resources. With our continued investment in successful programs that develop useful knowledge and tools, I am confident that we will have more accomplishments to celebrate. The end result of our research will be measurable improvements in health care in America, gauged in terms of improved quality of life and patient outcomes, lives saved, and value gained for what we spend.

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Carolyn M. Clancy, M.D., Director

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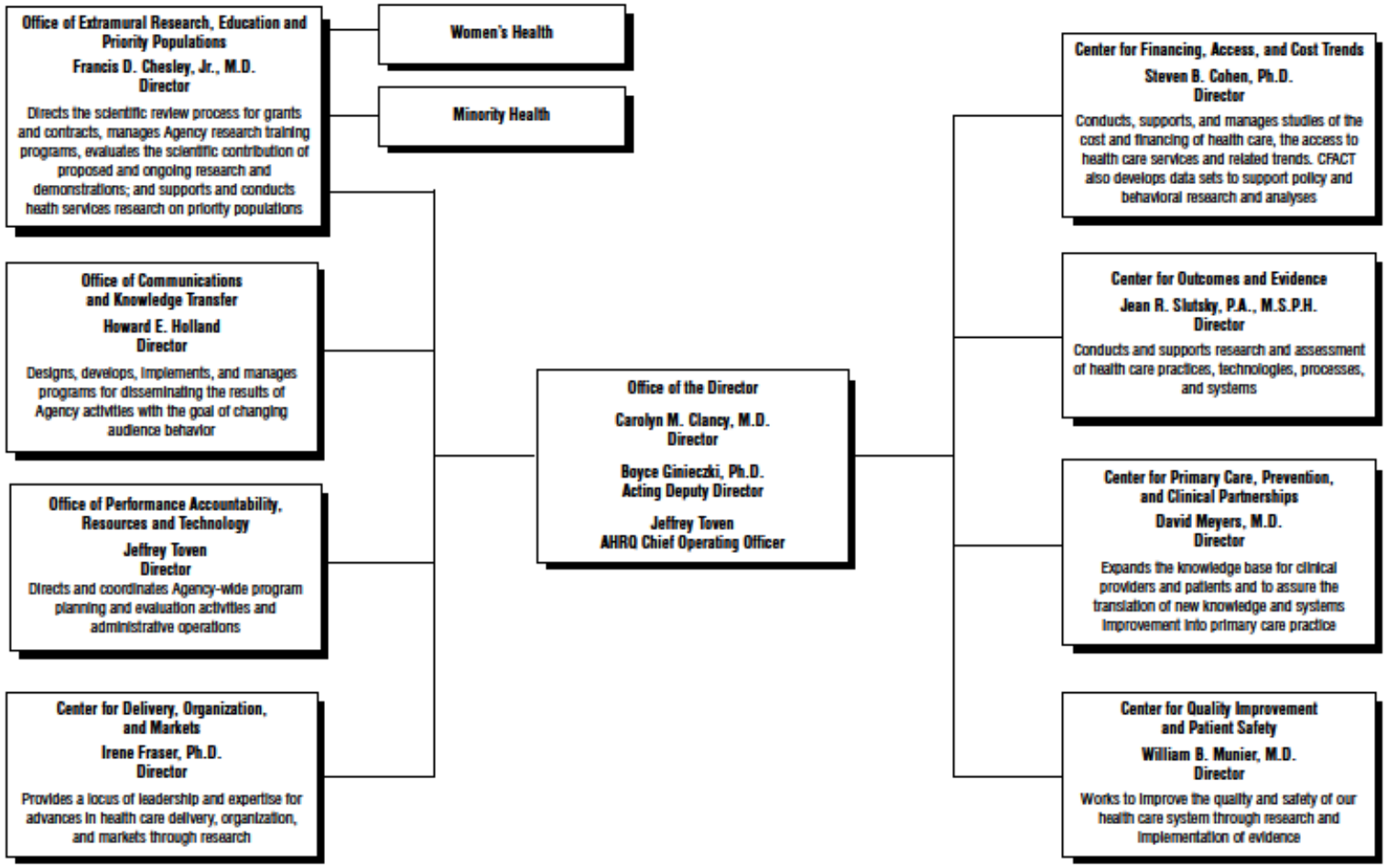
U.S. Department of Health and Human Services
Agency for Healthcare Research and Quality



AHRQ Pub. No. 11-M025
Replaces AHRQ Pub. No. 10-M048
May 2011

Performance Budget Overview

A. Introduction and Mission

As one of 12 agencies within the Department of Health and Human Services, the Agency for Healthcare Research and Quality (AHRQ) supports health services research initiatives that seek to improve the quality of health care in America. AHRQ's research role in the DHHS context is provided below:

HHS Organizational Focus

NIH
Biomedical research to prevent, diagnose and treat diseases

CDC
Population health and the role of community-based interventions to improve health

AHRQ
Long-term and system-wide improvement of health care quality and effectiveness

Vision
As a result of AHRQ's efforts, American health care will provide services of the highest quality, with the best possible outcomes, at the lowest cost.

Mission
AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. The Agency works to fulfill this mission through one overarching program: **health services research.** Health services research examines how people get access to health care, how much care costs, and what happens to patients as a result of the care they receive. The principal goals of health services research are to identify the most effective ways to organize, manage, finance, and deliver high quality care, reduce medical errors, and improve patient safety. AHRQ conducts and supports health services research, both within AHRQ as well as in leading academic institutions, hospitals, physicians' offices, health care systems, and many other settings across the country.

The AHRQ **research** mission is pursued by six research portfolios:

- Patient-Centered Health Research/Effective Health Care: Patient-centered health research improves health care quality by providing patients and physicians with state-of-the-science information on which medical treatments work best for a given condition.
- Prevention/Care Management Research: Prevention/Care Management research focuses on improving the quality, safety, efficiency, and effectiveness of the delivery

of evidence-based preventive services and chronic care management in ambulatory care settings.

- Value Research: Value research focuses on finding a way to achieve greater value in health care – reducing unnecessary costs and waste while maintaining or improving quality.
- Health Information Technology: Health IT research develops and disseminates evidence and evidence-based tools to inform policy and practice on how Health IT can improve the quality of American health care.
- Patient Safety: AHRQ's patient safety research priority is aimed at identifying risks and hazards that lead to medical errors and finding ways to prevent patient injury associated with delivery of health care.
- Research Innovation: Research Innovations includes investigator-initiated and targeted research grants and contracts that focus on health services research in the areas of quality, effectiveness and efficiency. Crosscutting Activities also includes additional research activities that support all of our research portfolios including data collection, measurement, dissemination and translation, and program evaluation.

Medical Expenditure Panel Survey

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

Program Support

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

AHRQ's Extramural Community

The extramural community is composed of non-Federal scientists at universities, medical centers, hospitals, purchasers, payers, policymakers, nursing homes, and research institutions throughout the country and abroad. With AHRQ support, these investigators and their institutions conduct the vast majority of research that leads to long-term and system-wide improvement of health care quality and effectiveness. In tandem with the conduct of research, the extramural community also contributes to training the next generation of researchers, enhancing the skills and abilities of established investigators, and renewing the infrastructure for AHRQ-sponsored research.

Peer Review Process

In accordance to the Public Health Service Act and the federal regulations governing "Scientific Peer Review of Research Grant Applications and Research and Development Contract Proposals" (42 CFR Part 52h), applications submitted to AHRQ are evaluated via AHRQ peer review process to ensure a fair, equitable, and unbiased evaluation of their scientific and technical merit. The initial peer review of grant applications involves an assessment conducted by panels of experts established according to scientific disciplines or

medical specialty areas. A Scientific Review Administrator (SRA) is the Designated Federal Official of the initial review group meeting. Her/his role is to make sure that each application receives a review that is thorough, competent and fair. Following the peer review meeting, the SRA prepares summary statements for all applications. The summary statement is an official feedback to the applicant conveying the issues, critiques, and/or comments that were raised during the review of his/her application. See http://www.ahrq.gov/fund/peerrev/peerproc.htm for more details.)

Research Grants and Contracts: AHRQ provides financial support in the form of grants, cooperative agreements, and research contracts. This assistance supports the advancement of the AHRQ mission to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. While AHRQ awards many grants specifically for research, we also provide grant opportunities that support research-related activities, including: fellowship and training, career development, and scientific conferences. We encourage both AHRQ–requested research and investigator-initiated research.

- **AHRQ-Requested Research.** AHRQ Portfolios regularly identify specific research areas and program priorities to carry out their missions. To encourage and stimulate research and the submission of research applications in these areas, many portfolios will issue funding opportunity announcements (FOAs) in the form of program announcements (PAs) and requests for applications (RFAs), or requests for proposals (RFPs). These FOAs may be issued to support research in an understudied area of research, to take advantage of current research opportunities, to address a high priority research program, or to meet additional needs in research training and infrastructure.

- **Investigator-initiated or Unsolicited Research.** AHRQ supports "investigator-initiated" research and training applications that do not fall within the scope of AHRQ-requested targeted announcements. These applications originate from stakeholder research idea or training needs, yet also address the research mission of the AHRQ and one or more of its portfolios.

Please note that all projects must be unique. By HHS policy, AHRQ cannot support a project already funded or pay for research that has already been done. Although applicants may not send the same application to more than one Public Health Service (PHS) agency at the same time, applicants can apply to an organization outside the PHS with the same application. If the project gets funded by another organization, however, it cannot be funded by AHRQ as well.

B. Overview of AHRQ Budget Request by Portfolio

AHRQ Budget Detail
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Research on Health Costs, Quality, and Outcomes (HCQO):				
Patient-Centered Health Research	$40,600	$77,342	$100,000	+$59,400
PCORTF Transfer (non-add)	*$24,000*	*$60,640*	*$100,000*	*+$76,000*
Evaluation Funds	*$16,600*	*$16,702*	*$0*	*-$16,600*
Prevention/Care Management	$27,904	$16,001	$20,704	-$7,200
USPSTF - Prevention and Public Health Fund (non-add) 1/	*$7,000*	*N/A*	*$0*	*-$7,000*
Prevention Research - Prevention and Public Health Fund (non-add) 1/	*$5,000*	*N/A*	*$0*	*-$5,000*
Value	$3,730	$3,753	$3,252	-$478
Health Information Technology	$25,572	$25,729	$25,572	$0
Patient Safety	$65,585	$65,986	$62,614	-$2,971
Research Innovations (Formerly Crosscutting Activities)	$108,377	$109,040	$88,931	-$19,446
HCQO, Total Program Level	**$271,768**	**$297,851**	**$301,073**	**+$29,305**
HCQO, PHS Evaluation Funds	***$235,768***	***$237,211***	***$201,073***	***-$34,695***
Medical Expenditure Panel Surveys	**$59,300**	**$59,663**	**$63,811**	**+$4,511**
Program Support	**$73,985**	**$74,438**	**$68,813**	**-$5,172**
Total Program Level	**$405,053**	**$431,952**	**$433,697**	**+$28,644**
PHS Evaluation Funds	$369,053	$371,312	$333,697	-$35,356
Prevention and Public Health Fund 1/	$12,000	*N/A*	$0	-$12,000
PCORTF Transfer	$24,000	$60,640	$100,000	+$76,000

1/ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

The AHRQ FY 2014 Request by Portfolio and Budget Activity

The FY 2014 total Program Level Request for AHRQ is $433.7 million, an increase of $28.6 million or +7.1 percent from the FY 2012 Actual level. In terms of PHS Evaluation Funds, AHRQ's request is $333.7 million, a decrease of $35.4 million or -9.6 percent below the FY 2012 Actual. These funds will enable the health services research community to pursue a number of opportunities that will make a measurable difference in health care for all Americans.

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

- Patient-Centered Health Research (PCHR) is funded at $100.0 million, an increase of $59.4 million from the FY 2012 level. This portfolio is funded in the entirety through the Patient-Centered Outcomes Research Trust Fund (PCORTF). PCORTF levels are mandatory funds appropriated to establish grants to train researchers, disseminate research findings of the Patient Centered Outcomes Research Institute (PCORI) and other government-funded research, assist with the incorporation of research findings, and establish a process for receiving feedback on information disseminated. The activities proposed using these funds for FYs 2011, 2012, and 2013 are provided beginning on page 34. The planned activities for FY 2014 are still under development.

- Prevention/Care Management Research is funded at $20.7 million, a decrease of $7.2 million from the FY 2012 Actual level. These funds will provide $11.3 million in support for the U.S. Preventive Services Task Force. The Task Force is an independent non-

governmental panel focused on evaluating risks and benefits of clinical preventive services, making recommendations about which services should be incorporated into primary medical care, and identifying research priorities. AHRQ provides scientific and administrative support to the Task Force, including topic selection, methods development, systematic evidence review, and dissemination. In FY 2014, AHRQ will continue to focus on enhancing the quality of scientific support provided, as well as continue efforts to improve public engagement and transparency.

- Value Research is funded at $3.3 million, a decrease of $0.5 million from the FY 2012 Actual level. Research contract funds will support a comprehensive program that provides the measures, data, tools, and evidence needed to improve value, and partners with the field to turn this knowledge and tools into meaningful change. At the FY 2014 Request level the Value portfolio will focus on continued uptake of AHRQ evidence and tools through dissemination via the Chartered Value Exchanges (CVE) Learning Network.

- Health Information Technology Research is funded at $25.6 million, the same level of support as the FY 2012 Actual level. The FY 2014 Request level provides $3.3 million in new research grants for foundational health IT research, providing a total of $20.0 million in research grant support. In addition, $6 million will support contract activities related to synthesizing and disseminating evidence on meaningful use of health IT and developing the tools and resources for various stakeholders to implement best practices.

- Patient Safety Research is funded at $62.6 million, a decrease of $3.0 million from the FY 2012 Actual level. Of this total, $34.0 million will be directed to research with a focus on prevention of Healthcare-Associated Infections (HAIs), the same level of support as FY 2012. Additional support will be provided to continue the operation of the Patient Safety Organizations (PSO) program ($7.0 million) and Patient Safety Risks and Harms ($21.6 million). These funds will focus on continued investments in research to identify and prevent risks and hazards, as well as efforts to translate promising safe practices identified through research into tools and resources that facilitate changes in practice, delivery, and communication patterns.

- Research Innovation is funded at $88.9 million, a decrease of $19.4 million from the FY 2012 Actual level. The FY 2014 Request level provides $8.9 million for new investigator-initiated grants. At the Request level, total investigator-initiated research totals $29.3 million, a decrease of $14.2 million from the FY 2012 Actual level. FY 2014 funding will also support measurement and data collection activities, including the Healthcare Cost and Utilization Project (HCUP), which among other purposes, supports the Partnership for Patients (PfP) initiative to track and reduce injuries a mother may suffer during childbirth and readmissions to community hospitals.

The Medical Expenditure Panel Survey (MEPS) will be funded at $63.8 million, an increase of $4.5 million from the FY 2012 Actual level. The increase will permit the MEPS Household Component to meet the precision levels of survey estimates, survey response rates and the timeliness of data products specified for the survey in prior years. Without this increment in funding, the sample size specifications for the survey would need to be reduced by over 8,000 persons, significantly limiting the survey's capacity to detect changes in health care use, medical expenditures and insurance coverage for important population subgroups, such as racial and ethnic minorities, persons with specific conditions, and the uninsured, during a time of significant changes in the financing and delivery of health care in the United States. 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. This funding level will allow MEPS to operate at current levels.

Program Support (PS) will be funded at $68.8 million, a decrease of $5.2 million from the FY 2012 level. A total of $4.1 million of this reduction is associated with a one-time expenditure in FY 2012 for tenant improvements associated with AHRQ's building move. Within this total, $0.874 million over FY 2012 is required for increased rent costs based on a renegotiated lease that begins in March 2013. The lease renegotiation is required as AHRQ must stay at our current location until our new space at the Parklawn Building is finished in early FY 2017. At that time AHRQ anticipates lower overall rent expenses. The Request level also provides a pay raise of 1.0 percent for civilian and commissioned corps staff beginning in January of 2014.

Full Time Equivalents (FTEs)

The workforce at AHRQ includes talented scientific, programmatic, and administrative staff who works to fulfill AHRQ's mission. The table below summarizes current full- time equivalent (FTE) levels funded with PHS Evaluation Funds and at AHRQ's total program level. Please note, the total program level includes FTEs funded from other HHS operating divisions through reimbursable agreements as well as funding from the PCORTF.

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
FTEs – Total Program Level	308	320	323
FTEs – PHS Evaluation Funds	300	305	300

C. Overview of Performance

The AHRQ strategic plan goals of Safety/Quality, Effectiveness, and Efficiency continue to guide the overall management of the Agency. Through the development of a framework of Dashboard aims, the Agency is able to align the performance goals and targets with the HHS Strategic Plan goals and objectives. AHRQ's research portfolios support the following HHS Strategic Goals: Transform Health Care, Advance Scientific Knowledge and Innovation, Advance the Health, Safety, and Well-Being of the American People, Increase Efficiency, Transparency, and Accountability of HHS Programs, and Strengthen the Nation's Health and Human Services Infrastructure and Workforce.

Most recent key accomplishments include: 1) Medical Expenditure Panel Survey (MEPS) - accelerated the data release schedule for all the targeted MEPS public release files

scheduled for release during FY 2012: Insurance Component summary data tables for civilian data by private and state/local government sectors and census division; 2) Patient-Centered Health Research – continued to increase the number of products produced, including translational products and statistical briefs; 3) Value – developed and released version 4.0.1 of MONAHRQ (My Own Network Powered by AHRQ) that includes support for reporting estimated cost savings from reducing potentially available to hospitals; 4) Research Innovations - two CAHPS Surveys gained wider use: the CAHPS Home Health Survey and the CAHPS Clinician/Group Survey; and 5) Patient Safety – concluded a landmark 4-year project to promote the nationwide implementation of the Comprehensive Unit-based Safety Program to prevent central line-associated blood stream infections (CLABSI).

The portfolios and programs may experience challenges around data issues. As stakeholders' request for information continues, the challenge to reduce the time required to release evidence-based products and to meet accelerated data delivery schedules highlights the importance of gaining greater efficiencies with regards to data processing and preparation. Other data challenges include identifying relevant data sources to show the impact of AHRQ's research.

AHRQ continues to work to set performance goals and measures that are meaningful to the Agency and support the goals and objectives identified in the HHS Strategic Plan. Program staff worked closely to retire those measures which are no longer meaningful to the programs and which do not contribute to the Department's overall strategic plan.

Budget by Strategic Goal

(Dollars in Millions)

HHS Strategic Goals and Objectives	FY 2012	FY 2013 CR	FY 2014 Request
1 Transform Health Care	**194.826**	**196.018**	**168.339**
1.A Make coverage more secure			
1.B Improve health care quality and patient safety	165.524	166.536	139.515
1.C Emphasize primary & preventative care, link to prevention			
1.D Reduce the growth of health care cost while promoting high-value, effectivie care	3.730	3.753	3.252
1.E Ensure access to quality culturally competent care			
1.F Promote the adoption of health information technology	25.572	25.729	25.572
2 Advance Scientific Knowledge and Innovation 1/	**40.600**	**77.342**	**100.000**
2.A Accelerate the process of scientific discovery to improve patient care	40.600	77.342	100.000
2.B Foster innovation at HHS to create shared solutions			
2.C Invest in sciences to improve food & medical product			
2.D Increase understanding of what works in health & services			
3 Advance the Health, Safety, and Well-Being of the American People 2/	**27.904**	**16.001**	**20.704**
3.A Ensure the children & youth safety, well-being & health			
3.B Promote economic & social well-being			
3.C Improve services for people with disabilities and elderly			
3.D Promote prevention and wellness	27.904	16.001	20.704
3.E Reduce the occurrence of infectious diseases			
3.F Protect Americans' health and safety during emergencies			
4 Increase Efficiency, Transparency, and Accountability of HHS Programs	**96.723**	**97.315**	**98.784**
4.A Ensure program integrity and responsible stewardship of resources	28.714	28.890	22.668
4.B Fight fraud and work to eliminate improper payments			
4.C Use HHS data to improve the health and well-being of the American people	67.738	68.152	75.841
4.D Improve HHS environmental performance for sustainability	0.271	0.273	0.275
5 Strengthen the Nation's Health and Human Service Infrastructure and Workforce	**45.000**	**45.276**	**45.870**
5.A Invest in the HHS workforce to help meet America's health and human service needs today and tomorrow	45.000	45.276	45.870
5.B Invest in HHS workforce to meet the needs today &			
5.C Enhance ability of public health workforce to improve			
5.D Strengthen the Nation's human service workforce			
5.E Improve national, state & local surveillance capacity			
Total, Program Level	**405.053**	**431.952**	**433.697**

1/ The FY 2013 CR column includes the ACA - PCORTF Transfer in the amount of $60.640M.

2/ In the FY 2013 CR column the FY 2013 Prevention Fund resources are reflected in the Office of the Secretary

Discretionary All-Purpose Table 1/

(dollars in thousands)

PROGRAM	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
RESEARCH ON HEALTH COSTS,				
QUALITY AND OUTCOMES (NON-ADD)				
Patient-Centered Health Research	**$40,600**	**$77,342**	**$100,000**	+59,400
PHS Evaluation Fund	*16,600*	*16,702*	$0	*-16,600*
ACA Funds - PCORTF Transfer	*24,000*	*60,640*	*100,000*	*+76,000*
Preventive/Care Management	**27,904**	**16,001**	**20,704**	**-7,200**
PHS Evaluation Fund	*15,904*	*16,001*	*20,704*	+4,800
Prevention/Care Management - ACA Funds - Prevention and Public Health Fund 2/	*5,000*	*N/A*	$0	-5,000
USPSTF - ACA Funds - Prevention and Public Health Fund 2/	*7,000*	*N/A*	$0	-7,000
Value Research	**3,730**	**3,753**	**3,252**	**-478**
Health Information Technology	**25,572**	**25,729**	**25,572**	**-**
Patient Safety	**65,585**	**65,986**	**62,614**	**-2,971**
Research Innovations (formerly Crosscutting)	**108,377**	**109,040**	**88,931**	**-$19,446**
Budget Authority	$0	$0	$0	$0
PHS Evaluation	**235,768**	**237,211**	**201,073**	**-34,695**
ACA Funds - Prevention and Public Health Fund 2/	*12,000*	*N/A*	*0*	*-12,000*
ACA Funds - PCORTF Transfer	*24,000*	*60,640*	*100,000*	*+76,000*
Subtotal, HCQO Program Level	**$271,768**	**$297,851**	**$301,073**	**+29,305**
MEDICAL EXPENDITURES PANEL SURVEY				
Budget Authority	$0	$0	$0	$0
PHS Evaluation	59,300	59,663	63,811	*+4,511*
Subtotal, MEPS	**$59,300**	**$59,663**	**$63,811**	**+$4,511**
TOTAL PROGRAM SUPPORT				
Budget Authority	$0	$0	$0	$0
PHS Evaluation	73,985	74,438	68,813	*-5,172*
TOTAL, PROGRAM SUPPORT	**$73,985**	**$74,438**	**$68,813**	**-$5,172**
SUBTOTAL				
Budget Authority	**$0**	**$0**	**$0**	**$0**
PHS Evaluation	**$369,053**	**$371,312**	**$333,697**	**-$35,356**
ACA Funds - Prevention and Public Health Fund 2/	**$12,000**	**N/A**	**$0**	**-$12,000**
ACA Funds - PCORTF Transfer	**$24,000**	**$60,640**	**$100,000**	**+$76,000**
TOTAL PROGRAM LEVEL	**$405,053**	**$431,952**	**$433,697**	**$28,644**
FTEs				
Budget Authority	**0**	**0**	**0**	**0**
PHS Evaluation	**300**	**305**	**300**	**0**
ACA Funds - Prevention and Public Health Fund 2/	**0**	**0**	**0**	**0**
ACA Funds - PCORTF Transfer	**4**	**12**	**20**	**16**
TOTAL PROGRAM LEVEL	**304**	**317**	**320**	**16**

1/ Excludes funding and FTE from other HHS operatiang divisions provided through reimbursable agreements.
2/ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

AHRQ Detailed Mechanism Table 1/

PHS Evaluation Fund and Prevention and Public Health Fund
(Dollars in Thousands)

	FY 2012 Actual		FY 2013 CR		FY 2014 Request	
	No.	Dollars	No.	Dollars	No.	Dollars
RESEARCH GRANTS						
Non-Competing						
Patient-Centered Health Research	**19**	**5,840**	**22**	**4,034**	**0**	**0**
Prevention/Care Management	**10**	**7,399**	**4**	**1,311**	**10**	**4,800**
PHS Evaluation Fund	*7*	*3,007*	*4*	*1,311*	*10*	*4,800*
ACA - Prevention and Public Health Fund	*3*	*4,392*	*N/A*	*N/A*	*0*	*0*
Value	**0**	**0**	**0**	**0**	**0**	**0**
Health Information Technology	**27**	**7,613**	**34**	**12,300**	**37**	**16,710**
Patient Safety	**53**	**24,836**	**49**	**17,327**	**48**	**14,160**
Research Innovations	**112**	**35,100**	**109**	**34,157**	**81**	**27,299**
Medical Expenditure Panel Survey	**0**	**0**	**0**	**0**	**0**	**0**
Total Non-Competing	**221**	**80,788**	**218**	**69,129**	**176**	**62,969**
New & Competing						
Patient-Centered Health Research	**0**	**0**	**0**	**0**	**0**	**0**
Prevention/Care Management	**10**	**1,263**	**16**	**5,689**	**0**	**0**
PHS Evaluation Fund	*10*	*1,263*	*16*	*5,689*	*0*	*0*
ACA - Prevention and Public Health Fund	*0*	*0*	*N/A*	*N/A*	*0*	*0*
Value	**0**	**0**	**0**	**0**	**0**	**0**
Health Information Technology	**26**	**6,267**	**13**	**6,833**	**7**	**3,266**
Patient Safety	**32**	**7,146**	**29**	**9,772**	**39**	**11,126**
Research Innovations	**81**	**15,694**	**74**	**17,300**	**75**	**8,865**
Medical Expenditure Panel Survey	**0**	**0**	**0**	**0**	**0**	**0**
Total New & Competing	**149**	**30,370**	**132**	**39,594**	**121**	**23,257**
RESEARCH GRANTS						
Patient-Centered Health Research	**19**	**5,840**	**22**	**4,034**	**0**	**0**
Prevention/Care Management	**20**	**8,662**	**20**	**7,000**	**10**	**4,800**
PHS Evaluation Fund	*17*	*4,270*	*20*	*7,000*	*10*	*4,800*
ACA - Prevention and Public Health Fund	*3*	*4,392*	*N/A*	*N/A*	*0*	*0*
Value	**0**	**0**	**0**	**0**	**0**	**0**
Health Information Technology	**53**	**13,880**	**47**	**19,133**	**44**	**19,976**
Patient Safety	**85**	**31,982**	**78**	**27,099**	**87**	**25,286**
Research Innovations	**193**	**50,794**	**183**	**51,457**	**156**	**36,164**
Medical Expenditure Panel Survey	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL, RESEARCH GRANTS	**370**	**111,158**	**350**	**108,723**	**297**	**86,226**
PHS Evaluation Fund		*106,766*		*108,723*		*86,226*
ACA - Prevention and Public Health Fund		*4,392*		*N/A*		*0*

1/ Does not include ACA funds from the PCORTF.

AHRQ Detailed Mechanism Table Continued 1/

PHS Evaluation Fund and Prevention and Public Health Fund
(Dollars in Thousands)

	FY 2012 Actual		FY 2013 CR		FY 2014 Request	
	No.	Dollars	No.	Dollars	No.	Dollars
CONTRACTS/IAAs						
Patient-Centered Health Research..		**10,760**		**12,668**		**0**
Prevention/Care Management……..		**19,242**		**9,001**		**15,904**
PHS Evaluation Fund……		*11,634*		*9,001*		*15,904*
ACA - Prevention and Public Health Fund..		*7,608*		*N/A*		*0*
Value……		**3,730**		**3,753**		**3,252**
Health Information Technology ……		**11,692**		**6,596**		**5,596**
Patient Safety ……		**33,603**		**38,887**		**37,328**
Research Innovations……		**57,583**		**57,583**		**52,767**
Medical Expenditure Panel Survey..		**59,300**		**59,663**		**63,811**
TOTAL CONTRACTS/IAAs.....		**195,910**		**188,151**		**178,658**
PHS Evaluation Fund……		*188,302*		*188,151*		*178,658*
ACA - Prevention and Public Health Fund..		*7,608*		*N/A*		*0*
RESEARCH MANAGEMENT.....		**73,985**		**74,438**		**68,813**
PHS Evaluation Fund……		*73,985*		*74,438*		*68,813*
GRAND TOTAL						
Patient-Centered Health Research..		**16,600**		**16,702**		**0**
Prevention/Care Management……..		**27,904**		**16,001**		**20,704**
PHS Evaluation Fund……		*15,904*		*16,001*		*20,704*
ACA - Prevention and Public Health Fund..		*12,000*		*N/A*		*0*
Value……		**3,730**		**3,753**		**3,252**
Health Information Technology ……		**25,572**		**25,729**		**25,572**
Patient Safety ……		**65,585**		**65,986**		**62,614**
Research Innovations……		**108,377**		**109,040**		**88,931**
Medical Expenditure Panel Survey..		**59,300**		**59,663**		**63,811**
Research Management……..		**73,985**		**74,438**		**68,813**
GRAND TOTAL						
PHS Evaluation……		**369,053**		**371,312**		**333,697**
ACA - Prevention and Public Health Fund....		**12,000**		**N/A**		**0**
GRAND TOTAL.....		**381,053**		**371,312**		**333,697**

1/ Does not include ACA funds from the PCORTF.

Budget Exhibits – Table of Contents

Budget Exhibits

Appropriation Language

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

HEALTHCARE RESEARCH AND QUALITY

For carrying out titles III and IX of the PHS Act, part A of title XI of the Social Security Act, and section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, **[**$334,357,000**]** *$333,697,000* shall be available from amounts available under section 241 of the PHS Act, notwithstanding subsection 947(c) of such Act: *Provided*, 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.

Amounts Available for Obligation

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

Amounts Available for Obligation 1/

	2012 Actual 2/	FY 2013 CR 3/	FY 2014 PB
Appropriation:			
Annual	$0	$0	$0
Subtotal, adjusted appropriation	$0	$0	$0
Offsetting Collections from:			
Federal funds pursuant to Title IX of P.L. 102-410, (Section 947(c) PHS Act)			
HCQO	$235,768,000	$237,211,000	$201,073,000
MEPS	$59,300,000	$59,663,000	$63,811,000
Program Support	$73,985,000	$74,438,000	$68,813,000
Subtotal, adjusted appropriation	$369,053,000	$371,312,000	$333,697,000
Unobligated Balance Lapsing	-$2,931,666	---	---
Total obligations	$366,121,334	$371,312,000	$333,697,000

1/ Excludes funding from other HHS operating divisions provided through reimbursable agreements.
2/ Reflects actual obligations. Excludes obligations from other reimbursable funds.
3/ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Summary of Changes

Summary of Changes

2012 Total estimated budget authority	$0
(Obligations)	($369,053,000)
2014 Total estimated budget authority	
(Obligations)	($333,697,000)
Net change	
(Obligations)	-($35,356,000)

Increases	2012 Actual (FTE)	2012 Actual Budget Authority	Change from Base (FTE)	Change from Base Budget Authority
A. Built-in				
1. Military FY 2013 pay raise	--	--	--	--
	(--)	(44,860,000)	(--)	(+26,000)
2. GS FY 2013 pay raise	--	--	--	--
	(--)	(44,860,000)	(--)	(+163,000)
3. Military FY 2014 pay raise	--	--	--	--
	(--)	(44,860,000)	(--)	(+17,000)
4. GS FY 2014 pay raise	--	--	--	--
	(--)	(44,860,000)	(--)	(+490,000)
5. One More Day of Pay (FY 2013)	--	--	--	--
	(--)	(44,860,000)	(--)	(+166,000)
6. Annualization of FY 2013 New Hires	--	--	--	--
	(--)	(44,860,000)	(+5)	(+898,000)
7. Rental Payments to GSA	--	--	--	--
	(--)	(4,221,000)	(--)	(+874,000)
Subtotal, Built-in			**(+5)**	**(+2,634,000)**
B. Program				
1. Prevention/Care Management	--	--	--	--
	(--)	(15,904,000)	(--)	(+4,800,000)
2 MEPS	--	--	--	--
	(--)	(59,300,000)	(--)	(+4,511,000)
Subtotal, Program			**(0)**	**(+9,311,000)**
Total Increases			**(+5)**	**(+11,945,000)**

Summary of Changes Continued

	2012 Actual		Change from Base	
Decreases				
A. Built-in				
1. Reduction of 2014 FTEs.....	--	--	--	--
	(--)	(44,860,000)	(-5)	(-750,000)
2. Tenant Improvement Reduction.....	--	--	--	--
	(--)	(24,904,000)	(--)	(-4,132,000)
3. Absorption of the built-in increases.....	--	--	--	--
			(--)	(-2,634,000)
Subtotal, Built-in.....			**--**	**--**
			(-5)	**(-7,516,000)**
B. Program				
1. Patient-Centered Health Research.....	--	--	--	--
	(--)	(16,600,000)	(--)	(-16,600,000)
2. Value.....	--	--	--	--
	(--)	(3,730,000)	(--)	(-478,000)
3. Patient Safety.....	--	--	--	--
	(--)	(65,585,000)	(--)	(-2,971,000)
4. Research Innovations.....	--	--	--	--
	(--)	(108,377,000)	(--)	(-19,446,000)
5. Program Support.....				
	(--)	(73,985,000)	(--)	(-290,000)
Subtotal, Program.....	**--**	**--**	**--**	**--**
			(0)	**(-39,785,000)**
Total Decreases.....			**--**	**--**
			(-5)	**(-47,301,000)**
Net change, Budget Authority.....			**--**	**--**
Net change, Obligations.....			**(0)**	**(-35,356,000)**

Budget Authority by Activity 1/

(Dollars in thousands)

	FY 2012 Actual		FY 2013 CR		FY 2014 PB	
	FTE	Amount	FTE	Amount	FTE	Amount
1. Research on Health Costs,						
Quality, & Outcomes BA	---	0		0	---	0
PHS Evaluation	[0]	[$235,768]	[0]	[$237,211]	[0]	[$201,073]
Total Operational Level	0	235,768	0	237,211	0	201,073
2. Medical Expenditures Panel						
Surveys BA	---	---	---	---	---	---
PHS Evaluation	---	[59,300]	---	[59,663]	---	[63,811]
Total Operational Level	---	59,300	---	59,663	---	63,811
3. Program Support BA	---	---	---	---	---	---
PHS Evaluation	[300]	[73,985]	[305]	[74,438]	[300]	[68,813]
Total Operational Level	300	73,985	305	74,438	300	68,813
Total, Budget Authority	0	0	0	0	0	0
Total PHS Evaluation	[300]	[369,053]	[305]	[371,312]	[300]	[333,697]
Total Operations	300	$369,053	305	$371,312	300	$333,697

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

Authorizing Legislation 1/

Authorizing Legislation 1/

	FY 2012 Amount Authorized	FY 2012 Appropriation	2014 Amount Authorized	FY 2014 President's Budget
Research on Health Costs, Quality, and Outcomes:				
Secs. 301 & 926(a) PHSA.....	SSAN	$0	SSAN	$0
Research on Health Costs, Quality, and Outcomes:				
Part A of Title XI of the Social Security Act (SSA) Section 1142(i) 2/ 3/				
Budget Authority.....				
Medicare Trust Funds 4/ 3/				
Subtotal BA & MTF.....	Expired 5/		Expired 5/	
Program Support:				
Section 301 PHSA.....	Indefinite	$0	Indefinite	$0
Evaluation Funds:				
Section 947 (c) PHSA	Indefinite	$371,312,000	Indefinite	$333,697,000
Total appropriations.....		$371,312,000		$333,697,000
Total appropriation against definite authorizations.....	----	----	----	----

SSAN = Such Sums As Necessary

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

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

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

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

5/ Expired September 30, 2005.

AHRQ Appropriations History

	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriation	
2005					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 303,695,000	$ 303,695,000	$ 318,695,000	$ 318,695,000	
Total	$ 303,695,000	$ 303,695,000	$ 318,695,000	$ 318,695,000	
2006					
Budget Authority	$ -	$ 318,695,000	$ -	$ -	
PHS Evaluation Funds	$ 318,695,000	$ -	$ 323,695,000	$ 318,692,000	
Total	$ 318,695,000	$ 318,695,000	$ 323,695,000	$ 318,692,000	
2007					
Budget Authority	$ -	$ 318,692,000	$ 318,692,000	$ -	
PHS Evaluation Funds	$ 318,692,000	$ -	$ -	$ 318,983,000	
Total	$ 318,692,000	$ 318,692,000	$ 318,692,000	$ 318,983,000	
2008					
Budget Authority	$ -	$ 329,564,000	$ 329,564,000	$ -	
PHS Evaluation Funds	$ 329,564,000	$ -	$ -	$ 334,564,000	
Total	$ 329,564,000	$ 329,564,000	$ 329,564,000	$ 334,564,000	
2009					
Budget Authority	$ -	$ 323,087,000	$ 90,598,000	$ -	
PHS Evaluation Funds	$ 325,664,000	$ 51,913,000	$ 243,966,000	$ 372,053,000	
ARRA Funding P.L. 111-5	$ -	$ -	$ -	$ 1,100,000,000	1/
Total	$ 325,664,000	$ 375,000,000	$ 334,564,000	$ 1,472,053,000	
2010					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 372,053,000	$ 372,053,000	$ 372,053,000	$ 397,053,000	
Total	$ 372,053,000	$ 372,053,000	$ 372,053,000	$ 397,053,000	
2011					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 610,912,000	$ -	$ 397,053,000	$ 372,053,000	
Total	$ 610,912,000	$ -	$ 397,053,000	$ 372,053,000	
2012					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 366,397,000	$ 324,294,000	$ 372,053,000	$ 369,053,000	
Total	$ 366,397,000	$ 324,294,000	$ 372,053,000	$ 369,053,000	
2013					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 334,357,000	$ -	$ 364,053,000	$ 371,312,000	2/
Total	$ 334,357,000	$ -	$ 364,053,000	$ 371,312,000	
2014					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 333,697,000	$ -	$ -	$ -	
Total	$ 333,697,000	$ -	$ -	$ -	

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

2/ Reflects the Continuing Resolution Level through March 27, 2013.

Appropriations Not Authorized by Law

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level in Last Year of Authorization	Appropriations in Last Year of Authorization	FY 2013 CR
Research on Health Costs, Quality, and Outcomes……	FY 2005	Such Sums As Necessary	260,695,000	371,312,000

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

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 235,768,000	$ 237,211,000	$ 201,073,000	-$34,695,000
--Prev. & Public Hlth Fund	$ 12,000,000	N/A	$ -	-$12,000,000
--PCORTF Transfer	$ 24,000,000	$ 60,640,000	$ 100,000,000	+$76,000,000
Total Program Level	$ 271,768,000	$ 297,851,000	$ 301,073,000	+$ 29,305,000

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

FY 2013 Authorization……...Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

Summary

AHRQ's Program Level for Research on Health Costs, Quality, and Outcomes (HCQO) in FY 2014 is $301.1 million, an increase of $29.3 million or +10.8 percent from the FY 2012 Actual level. In terms of PHS Evaluation Funds, the request is $201.1 million, a decrease of $34.7 million or -14.7 percent from the FY 2012 Actual level.

AHRQ Budget Detail
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Research on Health Costs, Quality, and Outcomes (HCQO):				
Patient-Centered Health Research	$40,600	$77,342	$100,000	+$59,400
PCORTF Transfer (non-add)	*$24,000*	*$60,640*	*$100,000*	*+$76,000*
Evaluation Funds	*$16,600*	*$16,702*	*$0*	*-$16,600*
Prevention/Care Management	$27,904	$16,001	$20,704	-$7,200
USPSTF - Prevention and Public Health Fund (non-add) 1/	*$7,000*	*N/A*	*$0*	*-$7,000*
Prevention Research - Prevention and Public Health Fund (non-add) 1/	*$5,000*	*N/A*	*$0*	*-$5,000*
Value	$3,730	$3,753	$3,252	-$478
Health Information Technology	$25,572	$25,729	$25,572	$0
Patient Safety	$65,585	$65,986	$62,614	-$2,971
Research Innovations (Formerly Crosscutting Activities)	$108,377	$109,040	$88,931	-$19,446
HCQO, Total Program Level	**$271,768**	**$297,851**	**$301,073**	**+$29,305**
HCQO, PHS Evaluation Funds	***$235,768***	***$237,211***	***$201,073***	***-$34,695***

1/ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

The AHRQ **health services research** mission is pursued by six research portfolios within HCQO:

- Patient-Centered Health Research/Effective Health Care: Patient-centered health research improves health care quality by providing patients and physicians with state-of-the-science information on which medical treatments work best for a given condition.

- Prevention/Care Management Research: Prevention/Care Management research focuses on improving the quality, safety, efficiency, and effectiveness of the delivery of evidence-based preventive services and chronic care management in ambulatory care settings.

- Value Research: Value research focuses on finding a way to achieve greater value in health care – reducing unnecessary costs and waste while maintaining or improving quality.

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

- Patient Safety Research: AHRQ's patient safety research priority is aimed at identifying risks and hazards that lead to medical errors and finding ways to prevent patient injury associated with delivery of health care.

- Research Innovation: Unlike AHRQ's other portfolios, the activities in this portfolio provide the core infrastructure used by the other portfolios to do their work. Activities in this portfolio include data collection and measurement, dissemination and translation, and program evaluation. In addition, support is provided for investigator-initiated and targeted research grants and contracts that focus on health services research in the areas of quality, effectiveness and efficiency.

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

***Program Increases at FY 2014 President's Budget Level*:**

HCQO: Patient-Centered Health Research (+$59.400 million): The FY 2014 President's Budget provides $100.0 million for the Patient-Centered Health Research (PCHR) portfolio, an increase of $59.4 million from the FY 2012 Actual level. The entirety of the increase is attributable to mandatory funds transferred to AHRQ from the Patient-Centered Outcomes Research Trust Fund. As authorized in section 937 of the Public Health Service Act, AHRQ will disseminate research findings from the Patient-Centered Outcomes Research Institute and other government-funded comparative clinical effectiveness research and build research and data capacity for comparative clinical effectiveness research. There are no funds provided through PHS Evaluation Funds at the FY 2014 Request level, a decrease of -$16.6 million from FY 2012.

Program Decreases at FY 2014 President's Budget Level:

HCQO: Prevention/Care Management (-$7.200 million): The FY 2014 President's Budget funds the Prevention/Care Management portfolio at $20.7 million, a decrease of $7.2 million from the FY 2012 level. This reflects a decrease of $12.0 million from the Prevention and Public Health funds and an increase of $4.8 million from PHS Evaluation funds. The Prevention and Public Health funds will no longer support the Centers of Excellence in Clinical Preventive Services and the portfolio will support no new grants in FY 2014.

HCQO: Value Research (-$0.478 million): The FY 2014 Request level funds the Value portfolio at $3.3 million, a decrease of $0.48 million or -12.8 percent from the FY 2012 Actual level. This reduction is reflected in reduced research contract support.

HCQO: Patient Safety (-$2.971 million): The FY 2014 President's Budget funds the Patient Safety portfolio at $62.6 million, a decrease of $3.0 million or -4.5 percent from the FY 2012 Actual level. This reduction is reflected in reduced support for new patient safety research grants.

HCQO: Research Innovations (-$19.446 million): The FY 2014 President's Budget funds the Research Innovations portfolio at $88.9 million, a decrease of $19.4 million or -17.9 percent from the FY 2012 Actual level. At the FY 2014 President's Budget level, Research Innovations will support $29.3 million in investigator-initiated research, a decrease of -$14.2 million from the FY 2012 level.

5-Year Table Reflecting Dollars

Funding (program level) for the HCQO program during the last five years has been as follows below.

Year	Dollars
2009	$251,631,000
2010	$276,153,000
2011	$265,653,000
2012	$271,768,000
2013 CR	$297,851,000

Patient-Centered Health Research/Effective Health Care

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 16,600,000	$ 16,702,000	$ -	-$16,600,000
--PCORTF Transfer	$ 24,000,000	$ 60,640,000	$ 100,000,000	+$76,000,000
Total Program Level	$ 40,600,000	$ 77,342,000	$ 100,000,000	+$ 59,400,000

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

FY 2013 Authorization……Expired.

Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

The Patient-Centered Health Research/Effective Health Care portfolio conducts and supports patient-centered health research in response to Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. In addition, it builds research infrastructure and capacity, allowing future studies to address questions where data are currently not sufficient to provide guidance about competing alternatives and to improve the efficiency with which the research infrastructure is able to respond to pressing health care questions. Research activities are performed using rigorous scientific methods within a previously-established process that emphasizes stakeholder involvement and transparency, that was designed to prioritize among pressing health issues, and whose products are designed for maximum usefulness for health care decision makers. Translation and dissemination of research findings to diverse audiences is a priority for the portfolio.

Patient-Centered Health Research is designed to inform health-care decisions by providing evidence on the effectiveness, benefits, and risks of different treatment options. The evidence is generated from research studies that compare drugs, medical devices, tests, surgeries, or ways to deliver health care.

In addition to appropriated funds in prior years, this portfolio receives funding through the Patient-Centered Outcomes Research Trust Fund (PCORTF), established by the Affordable Care Act, transfers funding to AHRQ to build research capacity and to translate and disseminate comparative clinical effectiveness research. Investments in current AHRQ core patient-centered health research activities were made strategically in consideration of activities that are supported by the Patient-Centered Outcomes Research Trust Fund and to avoid duplication. AHRQ has not requested any appropriated funds for this portfolio in FY 2014 and will focus on projects associated with the PCORTF.

B. FY 2014 Justification by Activity Detail

Patient-Centered Health Research Activities
(in millions of dollars)

Research Activity	FY 2012 Actual	FY 2014 President's Budget	FY 2014 +/- FY 2012
Horizon Scanning (Contracts)	$0.000	$0.000	$0.000
Evidence Synthesis	9.700	0.000	-9.700
Evidence Gap Identification	0.000	0.000	0.000
Evidence Generation	5.000	0.000	-5.000
Translation and Dissemination	0.500	0.000	-0.500
Training and Career Development	1.400	0.000	-1.400
Community Forum (Stakeholder Engagement)	0.000	0.000	0.000
TOTAL, PCHR (PHS Evaluation Funds)	**$16.600**	**$0.000**	**-$16.600**
PCORTF Allocation	24.000	100.000	+76.000
TOTAL Program Level, PCHR	**$40.600**	**$100.000**	**+$59.400**

Overall Budget Policy:

Horizon Scanning: Horizon scanning is the identification of current or emerging medical interventions available to diagnose, treat, or otherwise manage a particular condition. Horizon scanning activities are important for understanding the relevant healthcare context and landscape, as a basis for identifying and beginning to prioritize among research needs. AHRQ used FY 2009/2010 Recovery Act funding to establish an infrastructure to identify new and/or emerging issues for research review investments. This program is dedicated to tracking emerging technologies and investigating their contextual role in health care. In FY 2012 there were no appropriated funds available to support this activity.

FY 2014 President's Budget Policy: The FY 2014 Request level does not include funds for this activity.

Evidence Synthesis: Evidence synthesis is the review and synthesis of current medical research, to provide rigorous and unbiased evaluation of what can be learned from existing research about the health outcomes and effectiveness of alternative approaches to a given clinical problem. Evidence synthesis involves the systematic distillation of a comprehensive body of evidence generally comprised of multiple studies and often including a combination of trials and non-experimental studies, to provide the most objective and relevant information possible for clinicians, patients, and other decision makers. AHRQ's Evidence-based Practice Center (EPC) Program has been performing high quality user driven systematic review since 1998. The EPC program has provided systematic reviews for NIH, FDA, CMS, other components of HHS, and other Federal agencies. The products that come out of the EPC program inform research funding decisions, product labeling, coverage decisions, clinical practice guidelines, quality measures and individual patient decision making. AHRQ used FY 2009/2010 Recovery Act funding to increase support for research reviews. AHRQ also strategically built upon the existing strengths of the Evidence-based Practice Centers (EPCs), enhancing capacity at the EPCs to create a larger and stronger pool of expertise in systematic review and to advance the scientific methods of systematic review, especially to focus on special populations, complex medical conditions and health care system improvements. The FY 2012 level included $9.700 million to assess the science already available or in the pipeline on cutting edge issues identified through horizon scanning activities and context changing events, including but not limited to clinical, system level, organization and behavior changing events as they directly relate to patients in a reforming health system.

FY 2014 President's Budget Policy: The FY 2014 Request level does not include funds for this activity.

Evidence Gap Identification: Evidence gap identification is the identification of areas where new research conducted would contribute to bridging the gap between existing medical research and clinical practice. This effort produces recommendations that further consider the timing, value and feasibility of research that would fill these gaps and includes coordination with other funders as well researchers able to conduct needed research. FY 2009/2010 Recovery Act funding allowed AHRQ to put greater emphasis on the identification of evidence needs in the systematic review process. A process was developed that involves stakeholders, including clinicians, funding agencies, and researchers, considering gaps identified in systematic reviews. This activity helps shape research agendas for future research and identifies priorities for national investments in new research based on the findings. For example, the University of Minnesota Evidence-based Practice Center worked on a project to emphasize where gaps in evidence exist for patients who have sustained a hip fracture. They developed a report that includes information about where further information is needed and will describe, with input from stakeholders, the feasibility of conducting this research as well as the potential value of it. In FY 2012 there were no appropriated funds available to support this activity.

FY 2014 President's Budget Policy: The FY 2014 Request level does not include funds for this activity.

Evidence Generation: Evidence generation within the PCHR portfolio is the conduct of new research that evaluates the outcomes and effectiveness of different health care interventions. It is essential to meeting the pragmatic needs of clinical and health policy decision makers. FY 2009/2010 Recovery Act funding included both efforts to build the re-usable infrastructure for conducting practical studies that compare the effectiveness of different health care interventions, and underwriting rigorous research with dedicated study designs and data collection to

definitively address knowledge gaps that could not otherwise be addressed. AHRQ's investment in new outcomes and effectiveness research is unique in its focus on stakeholder driven pragmatic research. The DEcIDE Network research contracts have conducted research that has served the needs of CMS, FDA, other components of HHS, and the private sector. This unique resource provides a platform for research that makes a difference for health care decision makers. In FY 2012 AHRQ invested $5.000 million in this activity. These funds supported $4.045 million in continuation costs of grants funded in prior years and $0.955 million in Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) Network research contracts.

FY 2014 President's Budget Policy: The FY 2014 Request level does not include funds for this activity.

Translation and Dissemination: Dissemination and translation efforts ensure that knowledge synthesized or generated within the patient-centered health research program is available to decision makers to better inform their decisions. AHRQ produces summary guides for stakeholder groups, including the general public, patients, providers, payers, and policy-makers, with information tailored to their circumstances. AHRQ also supports innovative research on incorporating patient-centered health research findings into decision making. With FY 2009/2010 Recovery Act funding, AHRQ increased efforts in this area, expanding the number of clinician- and consumer-oriented summaries of findings produced by the Eisenberg Center. The FY 2012 levels provided funding for existing grant commitments only – no new activities. This decision reflects the fact that funding for this research component is provided to AHRQ from the Patient-Centered Outcomes Research Trust Fund.

FY 2014 President's Budget Policy: The FY 2014 Request level does not include PHS Evaluation funds for this activity, however translation and dissemination activities are supported through the PCORTF.

Training and Career Development: Research training and career development of researchers and clinicians will strengthen the research infrastructure and build capacity through ensuring a sufficient pool of research expertise for national efforts in research that compares the effectiveness of different health care interventions. With FY 2009/2010 Recovery Act funding, AHRQ provided institutional support to increase the intellectual and organizational capacity for larger scale research programs and allowed fellowship training opportunities. Through grant mechanisms, funding supported the career development of clinicians and research doctorates focusing their research on the synthesis, generation, and translation of new scientific evidence and analytic tools for patient-centered health research. FY 2012 funds were used to support continuing grants. This decision took into account funding for this research component through funds provided to AHRQ from the Patient-Centered Outcomes Research Trust Fund.

FY 2014 President's Budget Policy: The FY 2014 Request level does not include PHS Evaluation funds for this activity, however research training activities are supported through the PCORTF.

Community Forum (Stakeholder Engagement): Stakeholder engagement means consistently and comprehensively involving stakeholders in all aspects of the Effective Health Care Program. AHRQ used FY 2009/2010 Recovery Act funding to establish and support a Community Forum on Effective Health Care to formally engage stakeholders in the entire Effective Health Care enterprise and to continue to open up and make the program inclusive and transparent. This initiative was built on a smaller initiative that has guided AHRQ's Effective Health Care Program

until now and is an important component for a larger and more sustained national initiative in patient-centered health research, translation, and use. There were no FY 2012 appropriated funds available to support these activities, however AHRQ incorporates stakeholder input into its other PCHR/EHC initiatives.

FY 2014 President's Budget Policy: The FY 2014 Request level does not include funds for this activity.

C. Mechanism Table for Patient-Centered Health Research

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Patient-Centered Health Research Mechanism Table
(Dollars in Thousands)

	FY 2012 Enacted		FY 2013 CR		FY 2014 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	19	5,840	22	4,034	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**19**	**5,840**	**22**	**4,034**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**10,760**		**12,668**		**0**
TOTAL.....		**16,600**		**16,702**		**0**

D. Funding History

Funding for the Patient-Centered Health Research program during the last five years has been as follows:

Year	Dollars
2009	$ 50,000,000
2010	$ 21,000,000
2009/10 Recovery Act	$300,000,000
2011	$ 21,000,000
2011 ACA PCORTF Transfer	$ 8,000,000
2012	$ 16,600,000
2012 ACA PCORTF Transfer	$ 24,000,000
2013 CR	$ 16,702,000
2013 ACA PCORTF Transfer	$ 60,640,000

E. Patient-Centered Outcomes Research Trust Fund

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

AHRQ utilizes PCORTF funds to establish grants to train researchers; disseminate research findings of PCORI and other government-funded research; assist with the incorporation of research findings; and establish a process for receiving feedback on information disseminated.

(Dollars in Millions)

APPROPRIATION PROGRAM	FY 2011	FY 2012	FY 2013 Estimate	FY 2014 Estimate
Agency for Healthcare Research and Quality: PCORTF				
Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)	$ 8.00	$ 24.00	$ 60.64	$100.00

Based on the estimated amount to be transferred to AHRQ from the PCORTF (see table above), AHRQ has initiated activities in the following 3 categories: Training and Career Development Training, Dissemination and Translation Research Activities, and Data Methods.

Training and Career Development

In FY 2012 and 2013, AHRQ has initiated research grants related to training and career development. These activities support opportunities in PCOR for individuals at different career stages, institutional training opportunities that focus on applied settings, and institutions that have not previously developed expertise in PCOR training:

- **Research Career Enhancement Awards (K18) for Established Investigators in Patient-Centered Outcomes Research.** This program seeks to accelerate the development of the research workforce at the Associate and Full Professor level capable of conducting PCOR.

- **Pathway to Independence in Patient-Centered Outcomes Research.** The Pathway to Independence Award is designed to facilitate the transition of postdoctoral candidates from mentored to independent research positions.

- **Infrastructure Development Program in Patient-Centered Outcomes Research.** This initiative will support the development of PCOR capacity among institutions that have basic health services research capacity, but need focused support to develop capacity to conduct and implement PCOR.

- **Institutional Mentored Career Development Award Program in PCOR (K12).** This program will provide grants to institutions to combine teaching and practical opportunities to focus on the generation, adoption and spread of new scientific evidence.

- **Researcher Training and Workforce Development in Methods and Standards for Conducting Patient-Centered Outcomes Research Studies.** This project will fund institutions to provide one of three independent training topics to individual researchers. CER/PCOR training topics may focus on recognized research standards in CER/PCOR; instruction on innovative methods for conducting CER/PCOR; or a mentorship rotation at an organization that funds PCOR and/or include senior investigators within the respective research networks.

- **Individual Mentored Career Development Award Program in PCOR.** This program provides support for intensive research career development for individual investigators in academic or applied settings, leading to research independence in the field of PCOR.

Dissemination and Translation Research Activities

In FY 2012 and 2013, AHRQ has initiated research contracts and grants focused on dissemination and translation research activities. These investments are studying the most efficient and successful mechanisms to translate, disseminate, and implement PCOR findings from AHRQ, NIH, PCORI and other funding institutions.

- **John M. Eisenberg Clinical Decisions and Communications Science Center.** The Eisenberg Center translates comparative effectiveness reviews and research reports created by the Effective Health Care Program into short, easy-to-read summaries and tools that can be used by consumers, clinicians and policymakers.

- **Dissemination and Implementation of PCOR Findings to Clinicians.** This grant funding opportunity focuses on utilizing the existing infrastructure of professional societies to disseminate and implement Patient-Centered Outcomes Research findings.

- **Educating the Educators - Developing Patient-Centered Outcomes Research Tools for the People Who Educate Consumers, Patients, and Caregivers.** This project seeks to create tools and materials to educate health educators across several disciplines (Certified Health Education Specialists, Nurse Practitioners, Nurses, Physician Assistants, and Medical Assistants) about patient-centered outcomes research.

- **"Value of Using Medical Evidence" – A Paid Multi-Media Campaign.** This campaign will utilize traditional print, broadcast, and web based media to help educate health care consumers about the value of using medical evidence and scientific research in health care decision-making.

- **Integrating Patient-Centered Outcomes Research into Clinical Decision Support Systems – an Environmental Scan.** The purpose of this project is to further detail and describe the landscape for clinical decision support and PCOR. Information gathered from this project will inform future investments to incorporate comparative clinical effectiveness information into health information technologies, such as clinical decision support.

- **Methods Center in Decision and Simulation Modeling.** This contract creates a decision modeling methods center that will develop methods guidance on modeling alongside systematic reviews, (e.g. structuring decision models, model validation, communication of results) and to conduct research on modeling methodology in areas where knowledge gaps exist.

- **Implementation of a Systematic Review Data Repository Collaborative (SRDRC)**. The project facilitates further development of an open-access data system and systematic review infrastructure.

- **Developing and Evaluating Methods for Record Linkage and Reducing Bias in Clinical Patient Registries.** This methods project will improve validity of registry studies through three related methods projects. The project will be implemented within an existing clinical area of the DEcIDE program.

- **Methods for Dissemination and Translation.** This project solicits innovative proposals to develop and test methods for translating and disseminating PCOR findings to hard-to-reach audiences, including patients with low health literacy, disadvantaged populations, isolated clinicians, and other decision makers who may not have been reached by more traditional translation and dissemination efforts.

- **Horizon Scanning System: Dissemination of Information on Emerging Interventions.** The project facilitates a process for discovering and disseminating information to the public about emerging medical interventions with a strong likelihood of having significant impact in the near future.

- **The Evidence-based Practice Centers – Evidence Synthesis and Translation program**. EPCs develop, coordinate, and conduct systematic evidence reviews and updates on health care interventions, including items, services, and care delivery systems, to synthesize and disseminate the evidence of effectiveness of these interventions. The review methods are designed to reduce bias and allow research investigators to incorporate large amounts of information from different sources, while focusing on objective analysis and interpretation.

- **National Initiative (Publicity Center) Contract-Option Year.** This program enhances national partnership development activities including dissemination, implementation and adoption of the use of PCOR/CER among various stakeholders.

- **Regional Partnership Development Offices- Option Year** .This project develops partnerships with State and/or regional organizations to cultivate the use of Effective Health Care Products when making decisions.

- **Evaluation of AHRQ Comparative Effectiveness Research Dissemination Efforts.** This evaluation examines the impact of the AHRQ's dissemination contracts on the uptake of AHRQ's CER as part of the EHC program to inform future dissemination efforts.

- **Continuing Education of Comparative Effectiveness Research.** This contract will provide for numerous additional PCOR-based CME/CE modules over 5 years, including, evaluation of the initiatives' effectiveness.

- **Electronic Data Methods (EDM) Forum: Second Phase (Post-ARRA OS Collaboration).** The Electronic Data Methods (EDM) Forum facilitates collaboration between 11 ARRA-funded grants funded through the PROSPECT, Distributed Research Network, and Enhanced Registry for Quality Improvement and CER programs. This phase of EDM Forum expands its interactions to other electronic data infrastructure projects that are conducting PCOR and CER, QI, and using HIT to support routine clinical care.

- **Registry of Patient Registries (RoPR).** This funding will conduct ongoing maintenance and continued development of RoPR, a database developed under ARRA to combine multiple patient registries in order to be used for PCOR.

- **Closing the Gap in Disparities with Patient-Centered Outcomes Research**. This program aims to identify effective ways to disseminate and translate PCOR findings to reduce health care differences across diverse populations with a particular focus on minority populations in under-resourced healthcare settings.

- **BEST to Primary Care: Bringing Evidence to Stakeholders for Translation to Primary Care.** This project provides the best evidence to primary care by disseminating systematic reviews, consumer guides, and new PCOR research findings to primary care settings.

- **Disseminating Patient Centered Outcomes Research to Improve Healthcare Systems.** This program supports multi-site, multi-region, multi-stakeholder dissemination and implementation of PCOR delivery system evidence.

- **Deliberative Approaches for Patient Involvement in Implementing Evidence-based Health Care Projects**. This project evaluates an aspect of deliberative methods used to gather input from patients on a complex topics related to the implementation of evidence-based health-care decision making.

- **Understanding Caregivers' Needs for Patient-Centered Outcomes Research.** This project defines the informational needs of caregivers, explores the potential of PCOR to meet these needs, and provides recommendations for creating audience specific tools and innovative strategies for dissemination and implementation of PCOR findings to caregivers.

- **Understanding how Policymakers use Patient-Centered Outcomes Research to Make Decisions.** This project seeks to understand how policymakers use patient centered outcomes research for policy decisions and how to improve dissemination techniques to this population.

- **AHRQ Publication Clearinghouse – Contract Modification.** The publications clearinghouse facilitates the distribution of AHRQ of materials created on the basis of Agency-funded research. Additional funds are utilized to cover additional expenses associated with PCOR dissemination.

- **Communication Support – Contract Modification.** For editorial, web, and related assistance related to PCOR.

Data Methods

In FY 2013 AHRQ has initiated research contracts and grants related to data methods research activities:

- **Patient-Generated Health Outcomes Data and Clinical Decision Support Using Smart Device Technology.** This project examines the feasibility of using patient-generated outcomes data collected from home medical devices, mobile communication platforms, and other smart devices to improve clinical decision making and create a registry of patient-generated health outcomes.

- **Enhancing Comparative Effectiveness Research Data.** This project builds upon AHRQ's substantial investment in CER data infrastructure programs, initially funded by the American Reinvestment and Recovery Act (ARRA), the Clinical and Health Outcomes Initiative in Comparative Effectiveness (CHOICE) and Prospective Outcomes Systems using Patient-specific Electronic data to Compare Tests and therapies (PROSPECT) grant programs. The grants will fund 3 to 4 one-year pilot projects to maintain and enhance longitudinal data collection via new data linkages and data elements that were collected under ARRA, in prospectively collected datasets; to develop user groups to evaluate data resources; and to demonstrate the value of data infrastructure to the end user.

- **Methods Guidance to Improve the Dissemination and Implementation of Systematic Reviews.** This project will develop detailed guidance on how reviewers should handle certain methodological challenges that may affect the credibility and utility of systematic reviews for end users. Topics will address variations in methodological approaches currently found among AHRQ systematic reviews.

Administrative Costs

AHRQ provides administrative support for the implementation of PCORTF activities. For FYs 2012-2013, AHRQ will support 12 FTEs, training requirements, contract costs associated with nine Special Emphasis Panel peer review meetings, and travel costs related to site visits. AHRQ anticipates supporting 20 FTE in FY 2014 for implementation of PCORTF activities.

Prevention/Care Management

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 15,904,000	$ 16,001,000	$ 20,704,000	+$4,800,000
--Prev. & Public Hlth Fund 1/	$ 12,000,000	N/A	$ -	-$12,000,000
Total Program Level	$ 27,904,000	$ 16,001,000	$ 20,704,000	-$7,200,000

1/ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2013 Authorization……Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

The foundation of a healthy democracy is a healthy, productive populace. Preventing disease and helping patients maximize health and function over the life span are two essential activities of a well-functioning health care system. High-quality, accessible, effective primary care, which encompasses a continuum of care from prevention through the management of complex chronic conditions, is an essential component of a health care system that improves and sustains the health of the American public. This portfolio works to improve the delivery of primary care services to meet the needs of the American population for high-quality, safe, effective, and efficient clinical prevention and chronic disease care. To accomplish this work, the Prevention/Care Management Portfolio supports health services and behavioral research, facilitates the translation of evidence into effective primary care practice, and maximizes the investment of Federal resources through a commitment to collaborative partnerships with Federal partners and other stakeholders committed to improving the health of the Nation.

B. FY 2014 Justification by Activity Detail

Prevention/Care Management Activities
(in millions of dollars)

Research Activities	FY 2012 Actual	FY 2014 President's Budget	FY 2014 +/- FY 2012
Research Grants to Improve Primary Care and Clinical Outcomes	$ 9.000	$ 4.800	-$ 4.200
Prevention and Public Health Fund (non-add)	*4.500*	*0.000*	*-4.500*
Clinical Decision-making for Preventive Services	12.000	11.500	-0.500
Prevention and Public Health Fund (non-add)	*7.000*	*0.000*	*-7.000*
USPSTF Support (non-add)	*11.300*	*11.300*	*0.000*
Implementation Activities to Improve Primary Care	6.904	4.404	-2.500
Prevention and Public Health Fund (non-add)	*0.500*	*0.000*	*-0.500*
Total PL, Prevention/Care Management	**$27.904**	**$20.704**	**-$7.200**
Prevention and Public Health Fund (non-add)	***$ 12.000***	***$0.000***	***-$12.000***

Overall Budget Policy:

Research Grants to Improve Primary Care and Clinical Outcomes: The Prevention/Care Management Portfolio fosters the generation of new knowledge about clinical preventive services and chronic conditions with a focus on the care of complex patients with multiple chronic conditions. Results from this research will provide the evidence needed to support clinical decision making by clinicians and patients, and transform the delivery of prevention and chronic care services to provide better access to care and make care more effective. The 2012 Enacted level included $7.6 million in non-competing grants, including three Centers for Excellence in Clinical Preventive Services funded through the Prevention and Public Health Fund. In FY 2012 AHRQ also funded $1.3 million in new, investigator-initiated grants related to prevention and chronic care.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $4.8 million for this activity to support continuation costs of grants funded in prior years, a decrease of $4.2 million from the FY 2012 Actual level. The Request eliminates $4.5 million in grant funding from the Prevention and Public Health Fund to support three Centers for Excellence in Clinical Preventive Services. In addition, the FY 2014 Request level eliminates all new research grant funds to support rapid cycle research related to prevention and chronic care.

Clinical Decision-making for Preventive Services: To be of value, evidence from research on health services and health behaviors must be successfully integrated into patient care. The Prevention/Care Management Portfolio invests in the development of measures, tools, materials and technical assistance to support clinical decision-making for preventive services and to improve the delivery of evidence-based primary care. As part of this work, the Portfolio fulfills the Agency's Congressional mandate to convene and support the U.S. Preventive Services Task Force (USPSTF), an independent panel of nationally renowned non-federal experts in prevention, primary care, and evidence-based medicine. The FY 2012 level included $11.3 million to support the USPSTF, including $7.0 million from the Prevention and Public Health Fund.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $11.5 million for this activity, a decrease of $0.5 million from the FY 2012 Actual level. There are no funds provided from the Prevention and Public Health Fund, a decrease of $7.0 million. In FY 2014 AHRQ will fund the USPSTF at $11.3 million, the same level of support as the FY 2012 Actual level. With these funds, AHRQ will provide ongoing support to the USPSTF in the following areas: administration; topic selection (i.e., topic nomination development, refinement, prioritizing and horizon scanning for new topics); methods development; systematic evidence review; public engagement; transparency; communication; and dissemination, including website development.

Program Portrait: **Follow-up - Optimizing Care for People with Multiple Chronic Conditions: AHRQ's Multiple Chronic Conditions Research Network**

FY 2010: $18.0 million through the Office of the Secretary's ARRA funds in two-year grants to use existing data to conduct comparative effectiveness research for patients with MCC, and to create new datasets or methods for improved examination of care for patients with MCC.

FY 2013 and FY 2014: $1.0 million in grants related to multiple chronic conditions

More than a quarter of all Americans—and two out of three older Americans—are estimated to have at least two chronic physical or behavioral health problems. Treatment for people living with these multiple chronic conditions (MCC) currently accounts for an estimated 66% of the Nation's health care costs. As the U.S. population ages, the number of patients with MCC continues to grow. This mounting challenge has become a major public health issue that is linked to suboptimal health outcomes and rising health care costs.

AHRQ's MCC Research Network aims to improve understanding about interventions that provide the greatest benefit to MCC patients, the safety and effectiveness of interventions to improve health outcomes for patients with MCC, and interventions that may need to be modified for specific patient populations. Over time, this foundational research can begin to help our country meet the needs of Americans living with MCC.

In December 2010, HHS issued its new "Strategic Framework on Multiple Chronic Conditions," designed to further research that will address the challenges of MCC. AHRQ's efforts directly help to implement a key goal of the HHS Strategic Framework: to increase clinical, community, and patient-centered health research on MCC.

The MCC Research Network includes 18 original grants funded in 2008 (two of which received additional funding in 2009), 27 grants funded in 2010 under the American Recovery and Reinvestment Act of 2009, and a Learning Network and Technical Assistance Center designed to support the overall effort. Collectively, the AHRQ MCC Research Network works to advance the field of MCC research, provide needed guidance for clinicians and patients, and advise policymakers about improved methods to measure and promote quality care for complex patients.

Please visit www.ahrq.gov/research/mccrn.htm to learn more about AHRQ's MCC Research Network

Implementation Activities to Improve Primary Care: The AHRQ Prevention/Care Management Portfolio supports the development of measures, tools, materials and technical assistance to facilitate the improvement of primary care services. Within this field, the Portfolio focuses on health systems redesign, self management support, linking clinical practices with community resources, and care coordination. FY 2012 funds provide ongoing support for contract research, technical assistance, and tool and resource development in areas of primary care redesign including the patient-centered medical home and team based care, the integration of behavioral health in primary care, and care coordination. In addition, AHRQ will invest in targeted initiatives to enhance quality in primary care, with a focus on tools and resources to support primary care quality improvement. Specific investments will include advancing the

effectiveness of practice facilitation building on AHRQ's earlier work catalyzing state-level primary care improvement coalitions.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $4.4 million for this activity, a decrease of $2.5 million from the FY 2012 Actual level. This level of support eliminates $0.5 million from the Prevention and Public Health Fund to support and evaluate the Centers for Excellence in Clinical Preventive Services. The FY 2014 Request provides funds to support investments in contract research, technical assistance, and tool and resource development in areas of primary care redesign.

C. Mechanism Tables for Prevention/Care Management

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Prevention/Care Management Mechanism Table
(Dollars in Thousands)

	FY 2012 Enacted		FY 2013 CR		FY 2014 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	7	3,007	4	1,311	10	4,800
New & Competing……	10	1,263	16	5,689	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**17**	**4,270**	**20**	**7,000**	**10**	**4,800**
TOTAL CONTRACTS/IAAs.....		**11,634**		**9,001**		**15,904**
TOTAL.....		**15,904**		**16,001**		**20,704**

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
ACA - Prevention/Care Management
(Dollars in Thousands)

	FY 2012 Enacted		FY 2013 CR 1/		FY 2014 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	3	4,392	N/A	N/A	0	0
New & Competing……	0	0	N/A	N/A	0	0
Supplemental.....	0	0	N/A	N/A	0	0
TOTAL, RESEARCH GRANTS...	**3**	**4,392**	**N/A**	**N/A**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**7,608**		**N/A**		**0**
RESEARCH MANAGEMENT……		**0**		**N/A**		**0**
TOTAL.....		**12,000**		**N/A**		**0**

1/ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

D. Funding History

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

Year	Dollars
2009	$ 7,100,000
2010	$15,904,000
2011	$27,904,000
2012	$27,904,000
2013 CR	$16,001,000

Value

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 3,730,000	$ 3,753,000	$ 3,252,000	-$478,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2013 Authorization……..Expired.
Allocation Method……..Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

The cost of health care has been growing at an unsustainable rate, even as quality and safety challenges continue. Finding a way to achieve greater value in health care – reducing unnecessary costs and waste while maintaining or improving quality – along with increased transparency of provider performance information, are critical national needs. These needs can only be met through a coordinated state and regional approach. Quality and affordability improvement happen one region at a time, and require alignment of public and private stakeholders. AHRQ's Value portfolio aims to meet these needs by producing the measures, data, tools, evidence and strategies that health care organizations, systems, insurers, purchasers, and policymakers need to improve the value, affordability and transparency of health care. The aim is to assist the Department in fulfilling its mission to help Americans receive high-quality, efficient, affordable care by creating a high-value system, in which providers produce greater value, consumers and payers choose value, and the payment system rewards value.

B. FY 2014 Justification by Activity Detail

Value Research Activities
(in millions of dollars)

	FY 2012 Actual	FY 2014 President's Budget	FY 2014 +/- FY 2012
Value Research	**$3.730**	**$3.252**	**-$0.478**

Overall Budget Policy:

Value Research: To improve value, we must be able to measure and track quality and cost, identify strategies to improve both, and partner with the field to implement what we know. The Value Portfolio seeks to move forward on all three fronts in an integrated way. First, the portfolio develops and expands measures, data and tools to support transparency, public reporting, payment initiatives, and quality improvement. While working with a modest budget, we've seen several major successes: AHRQ developed My Own Network powered by AHRQ (MONAHRQ), a tool that gives States, communities, and others the software they need to build their own Web

sites for public reporting and quality improvement. By FY 2012, six states (HI, IN, KY, ME, NV and UT) have launched Web sites using the tool, and many others will participate in a User's Group in FY 2013 to prepare for use of the tool. The most recent release of MONAHRQ 2.0 allows states to report local data from Hospital Compare and CAHPS measures as well as the Quality Indicators. In addition to Quality Improvement Guides on diabetes and asthma, MONAHRQ includes new Quality Improvement links to guides on reducing readmissions and improving care across settings. In FY 2014, we will continue our enhancements to MONAHRQ, adding new Hospital Compare measures, more Quality Improvement Guides, and greater capacity to report other information and data needed by state and local policy-makers in order to improve public reporting and the quality and value of care.

While measures and data can be useful for identifying problems and tracking change, providers, payers and others need evidence on what strategies can work to improve performance and increase transparency. In FY 2012, we were able to disseminate to our stakeholders evidence and strategies through more than 20 venues (webinars, workshops, etc.). This included, for example, evidence on how to publicly report cost data to consumers, and strategies for reducing costs and improving quality by redesigning hospital and physician care. These and other topics provided the core curriculum for various Learning Networks and achieved wide visibility across the country with health plans, employers, providers, consumers, and others seeking major improvements in value. A priority for AHRQ is to continue to build and disseminate the evidence base for value and efficiency, which we expect to disseminate through an additional 15 webinars and in-person workshops in FY 2014. Performance measure 1.3.51 links directly to these dissemination efforts.

A third component of the portfolio is partnering with providers, payers, communities and other stakeholders to use the measures, data and evidence to increase transparency through public reporting. Including the 6 states currently using MONAHRQ to produce public reports, AHRQ's Quality Indicators are used in public reports of provider performance in at least 23 states. Another strong partnership is with a Learning Network of 24 community quality collaboratives, known as Chartered Value Exchanges (CVEs). The CVEs – comprised of 615 leading purchasers, patients/consumer organizations, health plans, and providers – take research findings on public reporting for consumers, private reporting for physicians, payment reform and quality improvement and implement them across their respective communities and entire States. AHRQ's work with the CVEs is directly aligned with Affordable Care Act (ACA) provisions as well as key principles of the National Quality Strategy (See Program Portrait). The CVEs take research findings on public reporting and implement them in their public reports of hospital and physicians across their respective communities and entire States. A March 2012 article in *Health Affairs* (G. Young, March 2012) documents the success of some of the CVEs in producing multi-payer public reports that allow consumers to find performance information about a variety of providers (regardless of health plan) on one Web site.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $3.3 million for this activity, a decrease of $0.4 million from the FY 2012 Actual. The Request will allow for continued improvements to the MONAHRQ tool, AHRQ measures, and data, as well as continued uptake of AHRQ evidence and tools through dissemination via the CVE Learning Network and potentially through grants to CVEs and other regional quality collaboratives.

Program Portrait: **Chartered Value Exchange (CVE) Learning Network**

FY 2012 Level: $1.07 million
FY 2014 Level: $1.07 million
Change: $0.0 million

The creation of Chartered Value Exchanges (CVEs) was based on the principle that all health care is "local." National goals and common standards are important, but real improvement needs to take place in local settings where the various stakeholders know and work with one another. The CVE Learning Network brings together 24 CVEs – or community quality collaboratives – from across the country. In aggregate, these collaborative members involve more than 600 healthcare leaders and represent more than 124 million lives, more than one-third of the U.S. population. The CVEs are multi-stakeholder collaboratives – comprised of purchasers, consumer organizations, health plans, and providers – with a mission of quality improvement and transparency through public reporting.

AHRQ's work with the CVEs is directly aligned with Affordable Care Act (ACA) provisions as well as key principles of the National Quality Strategy. AHRQ disseminates evidence and best practices to the CVEs on key ACA strategies including health insurance exchanges, payment reform, Accountable Care Organizations and Primary Care Medical Homes, and increased transparency of both quality and costs of health care through pubic reporting. Another priority of AHRQ's CVE Learning Network is aimed at achieving four key National Quality Strategy principles – 1. aligning efforts of public and private sectors; 2. driving quality improvement by disseminating evidence about what works; 3. promoting consistent national standards while maintaining support for local, community and state-level activities; and 4. providing patients, providers and payers with clear information they need to make choices. Through AHRQ's CVE Learning Network, members learn from each other and from experts about these strategies, sharing experiences and best practices.

CVE members rely on AHRQ to provide the evidence and latest research to guide their efforts. One example is AHRQ-funded work by researcher Judith Hibbard to examine how to effectively present cost and quality information in a public report for consumers. AHRQ convened two Webinars to share Dr. Hibbard's findings both with CVE members and also for over 70 CMS and other federal colleagues working on public reporting. In response to the Learning Network's outreach to CVEs about this research, we received this response from a CVE Project Director in Virginia:

"…Knowing what consumers want and how to present information effectively is critical to our work. Given our size, we'd never be able to go beyond periodic focus groups. AHRQ is leading the way and I honestly do not know who would do it if not you."
(Virginia CVE Project Director)

The successes of CVEs are documented in a March 2012 *Health Affairs* article by Gary Young. The author credits CVEs with fostering relationships among diverse stakeholders in the health care system, noting: "The development of such relationships potentially has benefits that extend beyond [public] reporting to other activities that can improve the quality and efficiency of the US health care system."

CVE successes also are due in part to ongoing collaboration with CMS. In addition to those mentioned above, the CVE program has partnered with CMS in co-hosting a nationwide forum of quality improvement and transparency. Six CVEs are partnering with their State Health Insurance Exchanges, another 4 are exploring opportunities for partnering with exchanges, and four CVEs have been certified as "Qualified Entities" by CMS.

C. Mechanism Table for the Value Portfolio

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

	FY 2012 Enacted		FY 2013 CR		FY 2014 Request	
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.....		**3,730**		**3,753**		**3,252**
TOTAL.....		**3,730**		**3,753**		**3,252**

D. Funding History

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

Year	Dollars
2009	$3,730,000
2010	$3,730,000
2011	$3,730,000
2012	$3,730,000
2013 CR	$3,753,000

Health Information Technology

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 25,572,000	$ 25,729,000	$ 25,572,000	$0

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2013
Authorization……..……..……..……..Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

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

The portfolio operates in coordination with other Federal health IT programs. AHRQ's legislatively authorized role is to fund research on whether and how health IT improves health care quality, whereas ONC is responsible for implementation of the HITECH Act and for cross-Departmental coordination of health IT standards and activities. AHRQ programs help create the evidence base that informs policy decisions of others. AHRQ's Health IT portfolio will continue to produce field-leading research and summarized evidence synthesis to inform future decisions about health IT by health care stakeholders and policymakers.

B. FY 2014 Justification by Activity Detail

Health Information Technology Research Activities
(in millions of dollars)

	FY 2012 Actual	FY2014 President's Budget	FY 2014 +/- FY 2012
Research Grants on Utilizing Health IT to Improve Quality	$14.276	$19.976	+$5.700
Synthesizing and Disseminating Evidence on the Meaningful Use of Health IT	$7.450	$3.489	-$3.961
Developing Resources and Tools for Policymakers and Health Care Stakeholders	$3.846	$2.107	-$1.739
Health IT Research Activities	**$25.572**	**$25.572**	**$0.000**

Overall Budget Policy:

Research Grants on Utilizing Health IT to Improve Quality: Since 2004, the Health IT portfolio has invested in a series of groundbreaking research grants to increase our understanding of the ways health IT can be utilized to improve health care quality. Early efforts evaluated the facilitators and barriers to health IT adoption in rural America and the value of health IT implementation. Recent results from one AHRQ-funded grant showed that telemedicine improved the cure rate for hepatitis C and reduced disparities.[1] In FY 2012 AHRQ continued building the foundational evidence to improve the quality, safety, effectiveness, and efficiency of US health care through support of new research grants.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $20.0 million for this activity, $5.7 million more than the FY 2012 Actual level. These funds will support $3.3 million in new investigator-initiated grants in FY 2014. The FY 2014 Request level proposes allocating 78 percent of total portfolio funds to research grants. This budget reflects AHRQ's commitment to funding foundational health information technology research. This portfolio's grant investments have a history of conducting innovative and ground breaking research which presently informs and supports meaningful use of health IT, and will lead to future National achievements. Notable achievements include the first State and regional demonstrations for health information exchange and pioneering clinical decision support projects.

Synthesizing and Disseminating Evidence on the Meaningful Use of Health IT: As interest and investments in health IT have grown, so has the need for best evidence and practices in health IT. In addition to developing field-defining evidence reports on health IT, AHRQ's National Resource Center for Health IT (NRC) has provided broad and ready access to the research and experts funded by the portfolio. AHRQ coordination with other Federal programs ensures that research findings and tools synthesized and developed through its NRC are fed to the Health IT Resource Center (HITRC), which supports the HITECH Regional Extension Centers. FY 2012 funding was directed to supporting the National Resource Center and demonstrations of scalable clinical decision support.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $3.5 million for this activity, a decrease of $4.0 million from the FY 2012 Actual level. In order to support new research, the portfolio will curtail dissemination efforts. Coordinated efforts across the Department, including planned investments through ONC and the launch of www.healthit.gov, allow AHRQ to capitalize on new dissemination platforms and to invest less in this activity. FY 2014 funds will be used to maintain current tools, which are used extensively by implementers of health IT.

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

Program Portrait: Research Grants to Understand Consumer and Clinician Information Needs in the Context of Health IT

FY 2012 Level: $5.00 million
FY 2014 Level: $5.00 million
Change: $0.0 million

Health IT has fundamentally changed how information flows through the healthcare system. The information needs of healthcare consumers and clinicians have also shifted, and a clear understanding of those new needs is essential to improving the quality of American healthcare.

The increased interest in and availability of consumer health IT applications has rapidly increased over the past decade, and will continue to grow explosively. Many other industries have greatly benefited from design principles that take into account user needs. Individuals are the end users of consumer health IT, but there is still a lack of basic research around these end users' personal health information management practices.

Similarly, while health IT has shown the potential to assist and support health care teams to improve the quality of care, many health care organizations continue to struggle with the implementation and adoption of health IT. This stems from a variety of contextual factors (e.g., workflow integration, usability of the health IT applications, provider dynamics). To better understand provider needs, basic research is needed on how clinical work is actually done and how it could be done in the context of robust health information systems and tools.

To develop this needed knowledge, AHRQ funded two funding opportunities that separately address consumers' and clinicians' needs. When results are available, they will inform private sector development of health IT and stakeholder policy decisions.

These funding opportunities are an illustrative example of the unique role AHRQ plays to develop the knowledge that underlies wise use of health IT for its true purpose, to improve healthcare quality.

Developing resources and tools for policy makers and health care stakeholders: AHRQ has provided resources for the Nation's healthcare stakeholders to promote the safe and effective use of health IT. A wide variety of implementation and evaluation tools are available through the AHRQ health IT portfolio.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $2.1 million for this activity, $1.7 million less than the FY 2012 Actual level. Investments by ONC and other Federal programs have reduced the need for tool development by AHRQ. These funds will be used to maintain current tools, which are used extensively by implementers of health IT.

C. Mechanism Table

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

	FY 2012 Enacted		FY 2013 CR		FY 2014 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	27	7,613	34	12,300	37	16,710
New & Competing……	26	6,267	13	6,833	7	3,266
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**53**	**13,880**	**47**	**19,133**	**44**	**19,976**
TOTAL CONTRACTS/IAAs.....		**11,692**		**6,596**		**5,596**
TOTAL.....		**25,572**		**25,729**		**25,572**

D. Funding History

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

Year	Dollars
2009	$44,820,000
2010	$27,645,000
2011	$27,645,000
2012	$25,572,000
2013 CR	$25,729,000

Patient Safety

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 65,585,000	$ 65,986,000	$ 62,614,000	-$2,971,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2013 Authorization……..……..Expired.
Allocation Method……....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Program Description and Accomplishments

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

B. FY 2014 Justification by Activity Detail

Patient Safety Research Activities
(in millions of dollars)

	FY 2012 Actual	FY 2014 President's Budget	FY 2014 +/- FY 2012
Patient Safety Risks and Harms	$24.585	$21.614	-$2.971
Patient Safety Organizations (PSOs)	7.000	7.000	0.000
Patient Safety and Medical Liability Reform	0.000	0.000	0.000
Healthcare-Associated Infections (HAIs)	34.000	34.000	34.000
Patient Safety Research Activities	**$65.585**	**$62.614**	**-$2.971**

Overall Budget Policy:

Patient Safety Risks and Harms: The Patient Safety Research Program focuses on the risks and harms inherent in the delivery of health care for a variety of conditions in all health care settings, including the hospital, ambulatory and long-term care facilities, and the home. These activities are vital for understanding the factors that can contribute to patient safety events ("adverse events"), and how to prevent them. Research funded in FY 2012 builds on past successes and focuses on the expansion of projects that have demonstrated impact in improving healthcare safety, including ongoing support for the dissemination and implementation of successful initiatives that integrate the use of evidence-based resources such as TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) and the Surveys of Patient Safety Culture. In FY 2012, AHRQ supported the expansion of TeamSTEPPS into primary care settings, and development of a Survey of Patient Safety Culture for community pharmacies. In addition to ongoing support for successful projects which continue to advance quality improvements, further support for new discovery and development will identify and refine the opportunities on which to base wide-scale patient safety improvements in the future.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $21.6 million for this activity, a decrease of $3.0 million from the FY 2012 Actual level. These funds will continue to advance the discovery and application of knowledge that increases patient safety. Sustained investments in core general patient safety research grant programs include continuation grant support of $5.8 million. The FY 2014 Request level will provide $6.8 million in new research grants support: $1.0 million related to healthcare simulation research grants, $1.0 million new investigator-initiated patient safety grants, $1.0 million in PIPS II grants, and $3.8 million in new general patient safety research grant funding opportunities. The program will invest approximately $8.9 million in research contracts that support patient safety improvements in healthcare, including continued support of TeamSTEPPS® and the Surveys of Patient Safety Culture. These projects address the challenges of healthcare teamwork and coordination among provider terms as well the establishment of cultures in healthcare organizations that are conducive to patient safety. Both of these issues are widely recognized as foundational bases on which patient safety can be improved.

Patient Safety Organizations (PSOs): The Patient Safety Act (2005) provides protection (privilege) to providers throughout the country for quality and safety review activities.
The Act promotes increased patient safety event reporting and analysis, as adverse event information reported to a Patient Safety Organization (PSO) is protected from disclosure in medical malpractice cases. This legislation is supporting and stimulating advancement of a culture of safety in health care organizations across the country leading to provision of safer care to patients. AHRQ administers the provisions of the Patient Safety Act dealing with PSO operations. HHS issued regulations to implement the Patient Safety Act, which authorized the creation of PSOs. (The effective date of the regulation was January 19th, 2009.) AHRQ, in conjunction with the Office of the Secretary and the Office of Civil Rights, continues to make significant progress in administering the Patient Safety Act. In addition, AHRQ continues to expand the development of common definitions and reporting formats (Common Formats) to describe patient safety events. Standardization of quality and safety reporting was authorized by the Patient Safety Act, and promulgation of these Common Formats fosters accelerated learning and allows for the aggregation and analysis of events collected by Patient Safety Organizations and annual national reporting on patient safety. AHRQ has updated the Common Formats for acute care hospitals that include technical specifications for electronic implementation of the Common Formats by PSOs and vendors of patient safety event reporting software. Hospital

Version 1.2 was released on April 4th, 2012. AHRQ is also developing Common Formats for health care settings beyond the acute care hospital; most recently, AHRQ announced the availability of Skilled Nursing Facility Beta Common Formats in a Federal Register notice. AHRQ funded the PSO program at $7.0 million in FY 2012.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $7.0 million for this activity, the same level of support as the FY 2012 Actual level. These funds will be used to facilitate receipt of data from PSOs and prepare the data for transfer to the Network of Patient Safety Databases and further analysis. In addition, the funds will support continued development of AHRQ's Common Formats.

Patient Safety and Medical Liability Reform Research Activity: Patient Safety and Medical Liability Reform research focuses on the following goals: (1) putting patient safety first and working to reduce preventable injuries; (2) fostering better communication between doctors and their patients; (3) ensuring that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and (4) reducing liability premiums. Demonstration and planning grants funded in FY 2010 ($23.0 million) are addressing medical liability reform models (e.g., health courts, safe harbors for evidence-based practices) and/or some of the limitations of the current medical liability system – cost, patient safety, and administrative burden. In addition to the grants funded in FY 2010, there was also a competitively bid evaluation contract ($2.0 million). These grants were provided using multi-year funding in FY 2010. All planning grants are now completed and have submitted their final reports. A summary of their results will be posted on the AHRQ website in Spring 2013. The demonstration grants are scheduled to end in June of 2013. Final data from the project will be compiled and analyzed and a comprehensive evaluation will be completed by early 2014. AHRQ demonstration funding allowed a number of existing, smaller-scale projects to expand to additional sites, and enabled other grantees to refine and enhance ongoing activities. As the demonstration grants enter their final year, many encouraging results are emerging from these projects.

FY 2014 President's Budget Policy: The FY 2014 Request level does not include funds for new projects in this area.

Healthcare-Associated Infections (HAIs) Research Activity: The Agency is working collaboratively with other HHS components to design and implement initiatives to reduce HAIs. In FY 2012 AHRQ built on past successes and extended these collaborative efforts to support a portfolio of grant- and contract-funded projects that advanced our knowledge about effective approaches for reducing HAIs and at the same time promoted the implementation of proven methods for preventing HAIs. In FY 2012, AHRQ's HAI budget of $34 million per annum is supporting HAI-related grants ($18.1 million in FY 2012), and the remaining funds are supporting HAI-related contracts. These grants and contracts will investigate methods of controlling HAIs in diverse healthcare settings and will address the major types of HAIs. In addition, contracts funded by the HAI budget will accelerate the nationwide implementation of the Comprehensive Unit-based Safety Program (CUSP – see Program Portrait on the following page), an evidence-based approach, to reduce the toll from several forms of HAI. In FY 2011, AHRQ also launched an initiative to develop a synthesis of results from research projects initially funded by AHRQ in the core period 2007-2010. This synthesis project, ending in FY 2014, will identifying HAI prevention approaches that are ready for implementation as well as gaps in the HAI science base that can be filled by new research.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $34.0 million for this activity, the same level of support as the FY 2012 Actual. These funds will continue to advance the generation of new knowledge and promote the application of proven methods for preventing HAIs. The investments to be made will include $12.6 million in HAI research grants and $21.4 million in HAI contracts. The grants will extend current research with a focus on multiple healthcare settings, including hospitals, ambulatory care settings, and long-term care facilities, and on linkages between these settings to improve the prevention and management of HAIs. Of the contract amount, $14.5 million will support the ongoing expansion of the nationwide implementation of CUSP (see Program Portrait on the following page) to reduce HAIs. CUSP projects include: $5.0 million for CUSP for CAUTI in hospitals, $2.0 million for CUSP for CAUTI in long term care facilities, $2.8 million to support the ongoing expansion of CUSP to prevent surgical site infections (SSI) and other surgical complications, $2.7 million to prevent SSIs in ambulatory care, and $2.0 million to expand CUSP for ventilator-associated pneumonia (VAP) from a field test in FY 2012/2013 to the initial phase of nationwide implementation. For the CUSP investments, the emphasis on the implementation is consistent with AHRQ's unique role in accelerating the widespread adoption of evidence-based approaches to prevent HAIs. The combination of research and implementation projects is the most effective way to ensure progress toward virtually eliminating the national scourge of HAIs, which is also the ultimate goal of the HHS National Action Plan to Prevent HAIs. In addition, these activities are contributing significantly to the attainment of the goals of the Partnership for Patients (PfP). Four of the nine specific hospital-acquired conditions (HACs) that the PfP seeks to reduce are HAIs – CLABSI, CAUTI, SSI, and VAP – and AHRQ's CUSP implementation projects are thus integral components of the PfP's efforts to reduce these HACs.

C. Mechanism Table

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

	FY 2012 Enacted		FY 2013 CR		FY 2014 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	53	24,836	49	17,327	48	14,160
New & Competing……	32	7,146	29	9,772	39	11,126
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**85**	**31,982**	**78**	**27,099**	**87**	**25,286**
TOTAL CONTRACTS/IAAs.....		**33,603**		**38,887**		**37,328**
TOTAL.....		**65,585**		**65,986**		**62,614**

D. Funding History

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

Year	Dollars
2009	$48,889,000
2010	$90,585,000
2011	$65,585,000
2012	$65,585,000
2013 CR	$65,986,000

Program Portrait: Comprehensive Unit-based Safety Program (CUSP) to prevent Healthcare-Associated Infections: Central Line-Associated Blood Stream Infections (CLABSI), Catheter-Associated Urinary Tract Infections (CAUTI), Surgical Site Infections (SSI), and Ventilator-Associated Pneumonia (VAP)

FY 2012 Level: $10.000 million
FY 2014 Level: $14.456 million
Change: +$2.130 million

The Keystone Project, which first deployed the Comprehensive Unit-based Safety Program (CUSP) on a large scale in more than 100 Michigan intensive care units, was a hugely successful initiative. Within 3 months, Keystone reduced the rate of central line-associated blood stream infections (CLABSI) by two-thirds, and within 18 months, the Project saved more than 1,500 lives and nearly $200 million. The project was originally started as a partnership of the Johns Hopkins University and the Michigan Health & Hospital Association. The CUSP approach involves using a checklist of evidence-based safety practices; staff training and other tools for preventing infections that can be implemented in hospital units; standard and consistent measurement of infection rates; and tools to improve teamwork among doctors, nurses, and hospital leaders.

In FY 2008, AHRQ funded an expansion of this project to 10 states and in FY 2010 and FY 2011, AHRQ funded further expansion of CUSP to prevent CLABSI – a nationwide version of the Keystone Project – to encompass all 50 states, Puerto Rico, and the District of Columbia, and to extend the program's reach into hospital settings beyond the ICU.

Data for this implementation study were collected from 44 States, DC and Puerto Rico; with a total of 1,142 participating ICUs. The CUSP for CLABSI research team estimates that this sample includes 27 percent of hospitals that have adult intensive care units in the United States. Final results from this project show a 41 percent reduction in the rate of CLABSIs in the 18 months after implementation of CUSP, thereby preventing over 2,100 CLABSIs, saving more than 500 lives, and averting over $36 million in excess costs.

In FY 2012, AHRQ continued to expand application of the CUSP approach to reduce Surgical Site Infections (SSI) in inpatient and ambulatory setting and will continue the national implementation of CUSP for CAUTI in inpatient settings and also initiate a parallel initiative for Long-Term Care settings. In FY 2014, AHRQ plans to support the continued implementation of the aforementioned projects. The following summarizes planned funding in FY 2014 to address these important program objectives.

	CUSP Total	CAUTI	SSI	VAP
FY 2014	**$14.456M**	7.000M	5.456M	2.000M

Research Innovation

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 108,377,000	$ 109,040,000	$ 88,931,000	-$19,446,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2013 Authorization……..…….Expired.
Allocation Method……....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

Unlike AHRQ's other research portfolios, Research Innovation (formerly Crosscutting Activities Related to Quality, Effectiveness and Efficiency) funds projects that support all of HCQO's research portfolios. Research Innovations conducts investigator-initiated and targeted research that focus on health services research in the areas of quality, effectiveness and efficiency. Creation of new knowledge is critical to AHRQ's ability to answer questions related to improving the quality of health care. This portfolio also supports Measurement and Data Collection Activities, Dissemination and Translation of Research, and Other Health Services Research conducted through research contracts and IAAs.

B. FY 2014 Justification by Activity

Research Innovation
(in millions of dollars)

	FY 2012 Actual	FY 2014 President's Budget	FY 2014 +/- FY 2012
Health Services Research Grants	$50.794	$36.164	-$14.630
(Investigator-Initiated)	*($43.436)*	*($29.259)*	*-($14.177)*
Measurement and Data Collection	$15.665	$15.517	-$0.148
Dissemination and Translation	$18.300	$15.942	-$2.358
Other Health Services Research Activities	$23.618	$21.308	-$2.310
Total, Crosscutting Activities	**$108.377**	**$88.931**	**-$19.446**

Overall Budget Policy:

Health Services Research Grants: Health Services Research grants, both targeted and investigator-initiated, focus on research in the areas of quality, effectiveness and efficiency. These activities are vital for understanding the quality, effectiveness, efficiency, and appropriateness of health care services. Investigator-initiated research is particularly important. New investigator-initiated research and training grants are essential to health services research – they ensure that an adequate number of both new ideas and new investigators are created each year. These grants represent the Agency's investment for future advances upon which the

applied research of the future will be built. The topics addressed by unsolicited investigator-initiated research proposals reflect timely issues and ideas from the top health services researchers. The FY 2012 Actual level provided $35.1 million for non-competing research grant support for prior year grants and $15.7 million in new grant support. The new research grant funding supported both targeted and investigator-initiated research projects. A total of $3.0 million was provided for a re-competition of the CAHPS® grants which ended in FY 2011. The CAHPS® program develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. Since CAHPS® surveys assess care from the consumer's point of view in many settings (e.g., hospitals, health plans, nursing homes, home health, etc.) these data will serve as an important metric through which HHS can measure the impact of the Affordable Care Act on the American people. A total of $43.4 million was directed to investigator-initiated research in FY 2012.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $36.2 million for this activity, a decrease of $14.6 million from the FY 2012 Actual level. This request provides support for non-competing research grants totaling $27.3 million. Support for new research grants is $8.9 million at the FY 2014 President's Budget level. The Request would provide support of $29.3 million in investigator-initiated grants, a decrease of $14.2 million from FY 2012.

Measurement and Data Collection: Monitoring the health of the American people is an essential step in making sound health policy and setting research and program priorities. Data collection and measurement activities allow us to document the quality and cost of health care; track changes in quality or cost at the national, state, or community level; identify disparities in health status and use of health care by race or ethnicity, socioeconomic status, region, and other population characteristics; describe our experiences with the health care system; monitor trends in health status and health care delivery; identify health problems; support health services research; and provide information for making changes in public policies and programs. AHRQ's Measurement and Data Collection Activity coordinates AHRQ data collection, measurement and analysis activities across the Agency. In FY 2012 AHRQ supported data and measurement activities at approximately $15.7 million including support for the following flagship projects: Healthcare Cost and Utilization Project (HCUP), AHRQ Quality Indicators (AHRQ QIs), the Survey Users Network, the National Healthcare Disparities and Quality Reports (NHDR/QR), and the HIV Research Network (HIVRN).

FY 2014 President's Budget Policy: The FY 2014 Request level provides $15.5 million for this activity, a decrease of $0.2 million from the FY 2012 Actual level. This level of support will continue to support measurement and data collection activities including support of the following programs: HCUP, AHRQ QIs, the Survey Users Network, NHDR/QR, and the HIVRN. Specific investments in FY 2014 will allow HCUP to support the HHS Partnership for Patients (PfP) initiative to track and reduce severe tearing and injury a mother may suffer during delivery. HCUP data provide national estimates for two Quality Indicators (QIs) that measure this kind of potential trauma occurring to mothers while giving birth to their babies. HCUP also contributes to the national benchmark for readmissions to US community hospitals, so that clinicians and policy makers can accurately measure improvements in the rate of readmissions for patients as interventions are implemented under the Partnership for Patients. Additional information about HCUP and the AHRQ QIs is provided in the program portrait on the following page.

Program Portrait: AHRQ Quality Indictors

FY 2012 Level: $3.1 million
FY 2014 Level: $3.3 million
Change: +$0.2 million

Total national hospital costs associated with potentially avoidable hospitalizations (as measured with the AHRQ Prevention Quality Indicators) was estimated recently (2008) as $26.4 billion.[1] Progress in improving the quality and safety of Americans' health care is clearly needed, and it requires the ability to measure gaps in order to improve performance. In addition, patients want the capacity to choose higher-quality hospitals based on evidence-based measures and solid data.

AHRQ has been a pioneer and technical leader in the development and public distribution of health care quality indicators (QIs). The AHRQ QIs are an important tool for measuring, tracking, monitoring, assessing and improving the quality of care. AHRQ maintains the specifications and software for more than 100 QIs based on administrative data, and provides annual updates, tools and technical support to QI users. The National Quality Forum has endorsed about half of them for use in public reporting. In twenty-six states, representing two-thirds of the American population, patients or consumers can access public reports using the AHRQ Quality Indicators when selecting a hospital. The QIs include four sets:

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

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

Example
Pressure ulcers have been increasing in health care facilities and reduction has become a focus of national quality improvement efforts.[2] Each year more than 2.5 million people in the United States develop pressure ulcers at an estimated cost of $9.1 billion to $11.6 billion.[3] Pressure ulcers are largely preventable, yet cause patients considerable harm, including in some cases sepsis and mortality. In 2010, the University of Alabama Birmingham (UAB) Hospital began a major effort to reduce the incidence of pressure ulcers, relying on extensive use of AHRQ's Patient Safety Indicator Pressure Ulcer Rate (PSI #3) as a quality improvement tool. UAB Hospital's approach includes staff education on causes and prevention of pressure ulcers, hospital-wide data collection and trending, implementation of a Pressure Ulcer Team, providing nursing experts and leadership for pressure ulcer prevention, and posting monthly and quarterly graphs on all nursing units. These sustained efforts reduced UAB Hospital-acquired pressure ulcers by 87%, from 33 cases to 8 cases, at an estimated cost per case ranging from $20,900 to $151,700 per pressure ulcer.[3] The UAB Hospital is a member of the University Health Consortium (UHC) which supports its members' use of the AHRQ QIs.

[1]Source: http://www.hpcnef.org/about/news/northeast-florida-hospitals-health-departments-look-to-health-planning-council-to-serve-as-experts/ (Accessed 5/21/2012); Health Planning Council of Northeast Florida website: http://www.hpcnef.org/
[2]Institute for Healthcare Improvement (IHI) Prevent Pressure Ulcers website: http://www.ihi.org/explore/PressureUlcers/Pages/default.aspx (Accessed 5/22/2012)
[3]*Preventing Pressure Ulcers in Hospitals: A Toolkit for Improving Quality of Care*. AHRQ Publication No. 11-0053-EF, April 2011. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/ltc/pressureulcertoolkit/

Program Portrait: The Healthcare Cost and Utilization Project (HCUP)

FY 2012 Level: $5.8 million
FY 2014 Level: $5.8 million
Change: $0.0 million

Inpatient hospital costs represent the largest component of health care expenditures in the U.S.[1] In 2010, there were over 39 million inpatient stays in U.S. community hospitals which cost about $360 billion in the aggregate. Over the same time period, there were over 128 million emergency department visits in those hospitals.

HCUP, the largest collection of all-payer, longitudinal hospital care databases in the U.S., with encounter-level information beginning in 1988, provides a unique data resource to enable the study of health care delivery at the discharge, physician, market, and state levels. Currently 97% of all U.S. hospital discharge records are in HCUP with 46 states participating. Over 60% of all emergency department (ED) records are also included with 29 states participating. Ambulatory surgery data are included from 30 states. 2011 data are currently being produced.

HCUP's large databases allow study of rare conditions and uncommon procedures. HCUP also provides information on readmissions for all payers and age groups. In fact, HCUP is the only national all-payer data source on charges and costs, including the uninsured. HCUP is able to make these valuable contributions because it leverages investments in data made by states as the foundation to build nationwide databases and comparable state-wide databases for policy analyses, research, and trends.

Recent Findings from HCUP:

- Between 1997 and 2009, the aggregate cost of stays for non-elderly patients (up 4.4 percent annually) grew more quickly than the cost of stays for elderly patients (up 3.1 percent annually).
- The rate of obstetric trauma (injury to the mother during the birth process) was highest for Asian/Pacific Islanders and lowest for African-Americans, although rates of obstetric trauma decreased in general between 2000 to 2009.
- One in eight surgical hospitalizations resulted in a readmission within 30 days across all payer and age groups, compared to one in five non-surgical hospitalizations.
- In 2009, there were 336,600 hospitalizations that involved C. difficile infections—an intestinal infection associated with antibiotic use. Rates in the Northeast were highest (138 per 100,000 population) while rates in the West were lowest (89 per 100,000).
- On average, 4,600 new patients per day were treated in U.S. for septicemia. It was the most expensive reason for hospitalization in 2009—totaling nearly $15.4 billion in aggregate hospital costs. In 2009, 16 percent of inpatients with septicemia died—more than 8 times higher than other stays. This was unchanged from 2000.

[1] *Hartman, M, Martin A, McDonnell P, Catlin A. National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998. Health Affairs. 28(1): 246-261, January 2009.*

Dissemination and Translation: AHRQ's dissemination and implementation activities foster the use of Agency-funded research, products, and tools to achieve measurable improvements in the health care services patients receive. AHRQ research, products, and tools are used by a wide range of audiences, including individual clinicians; hospitals, health systems, and other providers; patients and families; payers, purchasers, and health plans; and Federal, state, and local policymakers. AHRQ's dissemination and implementation activities are based on assessments of these audiences' needs and how best to foster use of Agency products and tools, plus sustained work with key stakeholders to develop ongoing dissemination partnerships. In addition, AHRQ sponsors knowledge transfer activities designed to assist users through learning networks and tailored, hands-on technical assistance. Support for Dissemination and Translation activities was $18.3 million in FY 2012. These funds provided critical dissemination and implementation activities, including the development and distribution of materials to assist

consumers and patients in shared decision making with their clinicians; adoption of tools to enhance delivery systems and reduce healthcare-associated infections, such as AHRQ's Comprehensive Unit-based Safety (CUSP) Program; support for learning networks for state Medicaid Medical Directors and others; assistance to providers to use findings from AHRQ's Evidence-based Practice Program, the National Quality Measures Clearinghouse (NQMC) and companion National Guideline Clearinghouse (NGC); and promotion of AHRQ's Congressionally mandated National Healthcare Quality Report and National Healthcare Disparities Report. In addition, funds were used to maintain AHRQ's electronic dissemination activities and website.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $15.9 million for this activity, a decrease of $2.4 million from the FY 2012 Actual level. This decrease was a result of a re-prioritization of research activities in this portfolio. AHRQ will increase our efforts with other public- and private-sector organizations to leverage our resources in FY 2014. As a result, we will maintain support for the AHRQ projects funded in FY 2012, but will re-scale to accommodate the decreased funding. These funds will build on the dissemination and implementation activities described above, as well as AHRQ's investments in health information technology and data products and tools, such as AHRQ's Quality and Patient Safety Indicators. These funds will also facilitate the promotion and use of the Agency's data and measurement resources, including the Healthcare Cost and Utilization Project (HCUP) and Medical Expenditure Panel Survey (MEPS). Finally, these funds will help as AHRQ supports transforming the organization and delivery of primary care through the Patient Centered Medical Home and other models.

Other Health Services Research Activities: Other Health Services Research Activities provides support to crosscutting research activities that impact quality, effectiveness and efficiency of health care. In FY 2012, AHRQ provided $23.6 million for this activity. Included in Other Health Services Research is support for rapid cycle research (accelerating the diffusion of research into practice) activities. Rapid Cycle Research is funded through the following AHRQ networks: Accelerating Change and Transformation in Organizations and Networks (ACTION), Primary Care Practice-Based Research Networks (PBRNs), Evidence-based Practice Centers (EPCs), and Developing Evidence to Inform Decisions about Effectiveness (DeCIDE Network). These rapid cycle research activities are found both in Research Innovations and within our research portfolios – depending on the topic. An example of this rapid cycle research across the portfolios is the use of EPCs to develop a series of reports on "Closing the Quality Gap: Revisiting the State of the Science." These reports focus on improving the quality of health care through critical assessment of relevant evidence for selected settings, interventions, and clinical conditions. This series aims to assemble the evidence about effective strategies to close the "quality gap"—the difference between what is expected to work well for patients based on known evidence, and what actually happens in day-to-day clinical practice across populations of patients. For every patient who receives optimal care, the evidence suggests that on average another patient does not. This series not only expands the topic terrain beyond that covered in the initial collection developed in 2004-2007, but also marshals the knowledge of eight EPCs with the goal of applying and advancing the state of the science for improving the health care system for the benefit of all patients. This report will inform HHS and AHRQ's current work on aligning and coordinating quality activities.

FY 2014 President's Budget Policy: The FY 2014 Request level provides $21.3 million for this activity, a decrease of $2.3 million from the FY 2012 Actual level. This level will allow for AHRQ to continue support for AHRQ's rapid cycle research networks. Continuation funding is also provided for a variety of contracts that support administrative activities that are related to research, including grant review, ethics review, events management, data management, data

security, and inter-agency agreements with other Federal partners. A total of $0.75 million is provided for support of the National Quality Strategy (NQS). The funds will be spent to support implementation of the NQS in each agency of HHS and to support the work of the federal-wide Interagency Working Group on Health Care Quality as mandated by the Affordable Care Act. Specific implementation activities within the Department include measure streamlining and alignment across programs within agencies and across agencies and alignment of agency initiatives with the NQS priorities. Finally, a total of $0.75 million is provided for new evaluation activities within Research Innovations. The evaluation topic will be decided upon by Senior Leadership at the beginning of the fiscal year based on crosscutting evaluation needs identified by all research portfolios.

C. Mechanism Table

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Research Innovations (Formerly Crosscutting Activities) Mechanism Table

(Dollars in Thousands)

	FY 2012 Enacted		FY 2013 CR		FY 2014 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	112	35,100	109	34,157	81	27,299
New & Competing……	81	15,694	74	17,300	75	8,865
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**193**	**50,794**	**183**	**51,457**	**156**	**36,164**
TOTAL CONTRACTS/IAAs.....		**57,583**		**57,583**		**52,767**
TOTAL.....		**108,377**		**109,040**		**88,931**

D. Funding History

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

Year	Dollars
2009	$ 97,092,000
2010	$111,789,000
2011	$111,789,000
2012	$108,377,000
2013 CR	$109,040,000

Key Performance Measures for HCQO by Portfolio

Portfolio: **Patient-Centered Health Research**

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
1.3.25: Increase the dissemination of Effective Health Care (EHC) Program products to clinicians, consumers, and policymakers to promote the communication of evidence. *(Output)*	FY 2012: 1219 Orders (Target Exceeded)	900 Orders	900 Orders	Maintain
1.3.55: Increase the use of Effective Health Care (EHC) Program Products in evidence -based clinical practice guidelines, quality measures and measure sets in EHC priority areas to enhance decision making. *(Output)*	FY 2012: 170 direct and indirect citations of EHC products. (Target Exceeded)	66 citations of EHC products	186 citations of EHC products	+120 citations of EHC products
4.4.5: Increase the number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers. *(Output)*	FY 2012: 128 EHC products (Target Exceeded)	26 EHC products	35 EHC products	+9 EHC products

#1.3.25: The intended users and stakeholders of its PCHR research and translational products include patients, clinicians, health system leaders, guideline and measure developers, policymakers, and researchers. An underlying assumption is that decision-making and healthcare outcomes can only improve if research findings are successfully disseminated to and used by all stakeholders. This measure institutes a number of approaches to disseminate the products of its research efforts. One mechanism includes the Agency's Publications Clearinghouse, which underpins the current measure. This measure attempts to access the effectiveness of dissemination of EHC Program Products through this channel.

Over the past 4 years the number of major orders has been variable. This is due, in part, to varying budget for the work, the type and life-cycle of products available, and the ongoing work to promote the EHC products using various dissemination mechanisms of the Agency and others. Therefore, there may be a reduction in major orders over time due to EHC product distribution via alternate mechanism, including conference exhibits, in-store displays, and contractors charged with dissemination of EHC products, as well as new outreach efforts. As these distribution efforts are projected to increase substantially and are expected to have a much more immediate and broader reach of the potential targeted audience, the individual major orders received by the publication clearinghouse may indeed fluctuate or decrease.

#1.3.55: This cumulative measure seeks to assess the degree to which AHRQ's evidence reviews and original research are utilized in the development of clinical practice guidelines undertaken by the clinical professional societies and provider communities. The use of EHC publications directly in guidelines and quality measures development, or indirectly via the

contribution to research and evaluation effort that lead to guidelines and quality measures activities both reflect how the EHC program serves to inform health care decision-making. As such, we conduct a citation analysis in the National Guidelines Clearinghouse where eligible works from Evidence-based Practice Center (EPC) reports and DEcIDE (Developing Evidence to Inform Decisions about Effectiveness network) publications are referenced either directly or indirectly in the development of clinical practice guidelines, consensus statements, or quality measures.

As guidelines and measures are either created or revised, there will be inclusion of evidence-based materials, including products produced by the EHC. This includes both new and existing materials. Therefore as the number of products and topics available increase, so will the number of citations in guidelines and quality measures.

#4.4.5: Evidence synthesis is one of the primary activities of AHRQ's PCHR portfolio. One way in which the agency seeks to achieve this mission is by making products available to clinicians, consumers, and policymakers. This output measure seeks to assess the number products that are produced.

The number of products each year indicates a strong positive correlation between funding level and evidence –based EHC program products. There has also been an increase in the types of products produced, including translational products and statistical briefs. There is often a lag in the release of final projects which may lead to a misinterpretation of the data as there is no direct fiscal year to number of projects comparison.

Portfolio: Prevention and Care Management

Measure	*Most Recent Result*	*FY 2012 Target*	*FY 2014 Target*	*FY 2014 +/- FY 2012*
2.3.7: Increase the percentage of older adults who receive appropriate clinical preventive services. *(Outcome)*	FY 2012: Held expert panel meeting to enhance understanding of prevention for older adults and to inform the processes of the USPSTF in making recommendations for older adults. (Target Met) FY 2012: Published two papers related to prevention in older adults: 1) Reconsidering the Approach to Prevention Recommendations for Older Adults (Ann Intern Med 2010:153:809-814) 2) Individualizing Cancer Screening in Older Adults: A Narrative Review and Framework for Future Research (J Gen Intern Med 2012; 25 Sep) (Target Met) FY 2012: Met with National Steering Committee (NSC) to determine criteria for creating a composite measure(s) of receipt of appropriate clinical preventive services for older adults. (Target Met)	Expert panel meeting on methods related to prevention in older adults Two methodological papers on understanding prevention in older adults Expert panel meetings on methods for developing a composite measure(s) of receipt of CPS and for determining high value, appropriate CPS for older adults.	Obtain baseline data from a small pilot study on percentage of older adults who receive appropriate clinical preventive services (CPS), and complete prototype survey to collect data on receipt of appropriate CPS. Release continuing medical education curriculum and modules for primary care clinicians regarding the delivery of appropriate clinical preventive services.	N/A

#2.3.7: AHRQ's objective is to create composite measures for the appropriate use of clinical preventive services for older adults, and to use of these measures to improve the delivery of appropriate preventive services. AHRQ anticipates that the composite measures will be based on USPSTF A, B, and possibly D recommendations, and may address what care should be delivered to older adults as well as what care/treatment should not be provided. In FY 2012, AHRQ convened a National Steering Committee representing key stakeholder groups including: clinicians; consumers; businesses/purchasers; insurers; public health and integrated health systems. Members brought expertise in preventive service delivery/quality improvement; older adult health; quality measurement; composite measures; and, analysis of EHR data. The goal was to engage the stakeholders (as represented by the NSC) in the measure development and consensus process in a way that promotes their organization's ownership and use of the measure for quality improvement in addition to producing the specifications and analytic plan for a composite measure(s). The work of the committee was designed to complement and collaborate with existing efforts by the National Priorities Partnership, National Commission on Prevention Priorities, and CDC, and is occurring within the context of the National Quality Strategy and National Prevention Strategy. In FY 2012, AHRQ, with support from the NSC, determined high priority, appropriate services for men and women and by different age groups. AHRQ also developed a methodological approach for creating the composite measures.

In addition, in FY 2012, AHRQ convened an expert panel to enhance understanding of prevention in older adults and to inform the processes of the USPSTF in making recommendations for older adults. The expert panel meeting resulted in a white paper, *Consideration of Heterogeneity of Treatment Effects and Clinically Determined Subgroups in Preventive Service Recommendations in Older Adults*.

In FY 2014, AHRQ will finalize specifications for composite measures at the national, health-plan, provider, and/or patient level based on existing data sources, but also for anticipating future data sources such as electronic health records (EHRs). In FY 2014, AHRQ will develop a prototype survey with the goal of creating a module that could be incorporated into the Medical Expenditure Panel Survey (MEPS) in FY 2015 and develop baseline data for this measure in future years.

Portfolio: Value

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
1.3.50: SYNTHESIS_Increase the cumulative number of AHRQ measures, tools, upgrades, and syntheses available on healthcare value. (Output)	FY 2012: 138 (Target Met)	138	146	+8
1.3.51: DISSEMINATION_Increase the cumulative number of measures, datasets, tools, articles, analyses, reports, and evaluations on healthcare value that are disseminated. (Output)	FY 2012: 61 (Target Met)	61	96	+35
1.3.53: Increase the cumulative number of AHRQ measures and tools used in national, state, or community public report cards. (Output)	FY 2012: 26 (Target Exceeded)	23	28	+5

#1.3.50 and #1.3.53: The Value Portfolio develops and expands measures, data and tools to support transparency, public reporting, payment initiatives, and quality improvement. In FY 2012, we produced a total of 11 new developments or enhancements to existing quality measures and data tools, such as HCUPnet's new readmissions statistics feature, particularly timely given the ACA's emphasis on reducing readmissions. Public report cards drawing on enhanced AHRQ quality measures increased to 26 in FY 2012. AHRQ's free public reporting tool, MONAHRQ, was also upgraded to version 4. 0.1 in FY 2012. This new version includes support for reporting estimated cost savings from reducing potentially available hospital states using the newly updated AHRQ QI Cost Calculator.

#1.3.51: This measure tracks our progress on another critical component of the portfolio – partnering with providers, payers, communities and other stakeholders on the ground to use the measures, data and evidence to bring about change. Through our partnership with 24 community quality collaboratives, known as Chartered Value Exchanges (CVEs), as well as other partnerships, we disseminated 20 AHRQ evidence-based tools and research products in FY 2012, including findings from AHRQ-supported public reporting research (JH Hibbard, et al, *Health Affairs*, March 2012). We will continue to make investments in these partnerships in FY 2014, and expect to disseminate an additional 35 research tools and products.

Portfolio: Health Information Technology

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
1.3.60: Identify three key design principles that can be used by health IT designers to improve Personal Health Information Management (PHIM) *(Output)*	FY 2012: Awarded research grants to identify key design principles. (Target Met)	Award research grants to identify key design principles	Gather second year report from grantees. Report preliminary results of grantees in Health IT's Annual Report and summarize any early findings from PA-11-99 identifying key design principles for PHIM.	N/A

Health care is undergoing an information revolution with the widespread adoption of electronic health records. The increased interest in and availability of consumer health information technology (IT) applications meant to assist consumers in managing their personal health information needs has rapidly increased over the past decade. However, making health information digital is not enough. Many other industries have greatly benefited from design principles that take into account user needs and context, which can help designers improve the utility of information management tools among a heterogeneous population of users. Individuals are the end users of consumer health IT; however, there is still a lack of basic research around these end users' personal health information management (PHIM) practices and needs and how these methods are influenced by a multitude of other contextual factors (e.g., care settings, demographics, motivations, user capabilities and limitations, informal care-giving networks, technology sophistication, and access to Internet) that, typically, represent a mixture of facilitators or barriers to adequate PHIM. The potential of health IT to improve the quality of health care lies in providing information to people about their health in ways that are meaningful and useful to them. AHRQ's health IT portfolio will build the evidence on what works for people when they manage their health information.

This initiative looks to bridge the chasm that currently exists between consumer health IT designers and the users themselves, by bolstering basic research to better understand users' PHIM practices, needs, and goals as they are intrinsically shaped by an array of contextual factors.

Research projects that are to be funded under this initiative will address one or more of the following:

1. The needs and preferences of diverse user groups in different contexts;
2. User goals, activities, and personal health information management practices;
3. User capacities (e.g., cognitive, physical, health literacy);
4. User motivation (including beliefs and preferences); and
5. Identifying “expert” user groups (e.g., frequent health care consumers and their caregivers) and studying them as models

In FY 2012, AHRQ’s Health IT portfolio awarded research grants to identify key design principles that can be used by health IT designers to improve personal health information management. Over the five-year lifespan of these projects, researchers will regularly report the results of their ongoing efforts. AHRQ will annually publicly report the status and ongoing findings of these projects, and by the end of the project period synthesize findings across all projects. These findings will be of great value to private sector innovators and policymakers who seek to improve the quality of healthcare through improved patient engagement.

Portfolio: Patient Safety

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
1.3.38: Increase the number of users of research using AHRQ-supported research tools to improve patient safety culture *(Outcome)*	FY 2012: 1128 users of research (Target Exceeded)	1032 users of research	1400 users of research	+368
1.3.39: Increase the number of patient safety events (e.g. medical errors) reported to the Network of Patient Safety Databases (NPSD) from baseline. *(Outcome)*	FY 2012: Software implementation in progress (Target Not Met)	NPSD operational	Baseline + 10% Event reports	N/A
1.3.41: Increase the cumulative number of tools, evidence-based information, and products available in AHRQ's inventory of tools to improve patient safety and reduce the risk of patient harm. *(Outcome)*	FY 2012: 106 tools (Target Exceeded)	104 tools	116 tools	+12
1.3.59: 10% reduction in the rate of CAUTI cases *(Outcome)*	Established Measure #1.3.59	Establish HAI Measure	Baseline – 10%	-10%

#1.3.38: AHRQ used information from its Hospital Survey of Patient Safety Culture (HSOPS) as an indicator for changes within health care organizations to improve the safety of care for patients. As health care organizations continually strive to improve, there is growing recognition of the importance of establishing a culture of patient safety. Achieving a culture of patient safety requires an understanding of the values, beliefs, and norms about what is important in an organization and what attitudes and behaviors related to patient safety are supported, rewarded, and expected. Recognizing the need for a measurement tool to assess the culture of patient safety in health care organizations, AHRQ funded and supervised development of patient safety culture assessment tools for hospitals, nursing homes, and ambulatory outpatient medical offices. The AHRQ tools facilitate health care organizations in the evaluation of how well they had established a culture of safety in their institutions. Additional background information on the safety culture tools is available on the AHRQ Web site at: http://www.ahrq.gov/qual/patientsafetyculture/.

#1.3.39: In the area of reporting, AHRQ coordinated the development of Common Formats for reporting patient safety events to Patient Safety Organizations (PSOs). The term "Common Formats" refers to the common definitions and reporting formats that allow health care providers to collect and submit standardized information regarding patient safety events. The Common Formats allows for the aggregation of sufficient data to identify and address underlying causal factors of patient safety problems. In collaboration with an interagency Federal Patient Safety Workgroup, the National Quality Forum and the public, AHRQ has developed Common Formats for two settings of care — acute care hospitals and skilled nursing facilities. The most important

use of the Common Formats is to support local quality improvement activities to provide immediate feedback by enhancing the ability of health care providers to report information that is standardized both clinically and electronically.

Patient safety events can be reported to the Network of Patient Safety Databases (NPSD). AHRQ will use data collected from the NPSD to analyze national and regional patient safety event statistics, including trends and patterns. Findings are to be made public and included in AHRQ's annual *National Healthcare Quality Report*. This measure indicates the level of PSO activity in collecting patient safety event data from healthcare providers using the Common Formats. As reporting to the NPSD is voluntary, the number of events reported does not necessarily translate into an occurrence rate of patient safety events in healthcare.

#1.3.41: AHRQ evaluated the major output of AHRQ's Patient Safety Portfolio through the assessment of the availability of tools, evidence-based information, and products 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, including optimal ways to synthesize and disseminate new knowledge.

#1.3.59: Prevention of healthcare-associated infections (HAIs) is a major focus of the Patient Safety Portfolio. In September 2012, AHRQ completed a project to promote the nationwide implementation of CUSP for CLABSI, which has achieved remarkable success in reducing CLABSI cases and deaths from CLABSI and averting excess costs associated with CLABSI. Building on the model of CUSP for CLABSI, AHRQ has been extending the application of CUSP to other HAIs. In FY 2011, AHRQ initiated the nationwide implementation of CUSP for catheter-associated urinary tract infections (CAUTI), which will be completed in the latter half of FY 2014. The FY 2014 HAI performance measure will assess progress in reducing the rate of CAUTI in hospitals participating in the CUSP for CAUTI project.

Portfolio: Research Innovations

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
1.3.22: Increase the number of additional organizations per year that use Healthcare Cost and Utilization Project (HCUP) databases, products, or tools in health care quality improvement efforts. *(Output)*	FY 2012: 8 Organizations (Target Exceeded)	7 Organizations	4 Organizations	-3 organizations
1.3.23: Increase the number of consumers who have access to customer satisfaction data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to make health care choices. *(Output)*	FY 2012: 143 Million (Target Not Met)	144 Million	146 Million	+2 million

HCUP

#1.3.22: In 2012, organizations from across the spectrum of health care delivery, including providers, professional and hospital associations, accreditation organizations, employers and business groups, insurance companies, and state and federal governments, began to use AHRQ's HCUP databases, products, and tools to make quality improvements in health care. These include:

- Connecticut Hospital Association
- HealthCare21 Business Coalition
- Hawaii Health Information Corporation
- South Carolina Hospital Association
- South Dakota Association of Healthcare Organizations
- Arkansas Department of Health
- Anderson Regional Medical Center
- University of California Irvine Medical Center

AHRQ anticipates several additional organizations, including state-based organizations, to utilize its HCUP products in future public reports and quality improvement initiatives.

CAHPS

#1.3.23: In FY 2012, two CAHPS Surveys gained wider use: the CAHPS Home Health Survey and the CAHPS Clinician/Group Survey.

CAHPS Home Health Survey. The Centers for Medicaid and Medicare Services (CMS) began requiring annual submission of CAHPS Home Health Care Survey data from Medicare-certified Home Health Agencies (HHAs) in 2009. These data are now being publically reported on CMS's *Home Healthcare Compare* website. HHAs that choose not to submit these data will not receive the Annual Payment Update (APU) from CMS. As of the beginning of FY 2013, there are 11,633 HHAs who provide services to more than 3,659,000 million Medicare beneficiaries.

CAHPS Clinician/Group Survey: PCMH Version. For the past two years, the CAHPS team has collaborated with the National Committee for Quality Assurance (NCQA) to develop a version of the CAHPS Clinician/Group Survey (CG CAHPS) for use in medical practices that function as Patient-Centered Medical Homes (PCMHs). Though the CAHPS team is still testing some aspects of the survey, NCQA is currently requiring survey results from medical practices who seek recognition as PCMHs.

Both these surveys will likely increase the number of CAHPS survey users, and thus the number of CAHPS survey data users, in the near future.

Looking forward, CMS plans to develop several new patient experience surveys in the coming years and will work with the CAHPS Team to obtain the CAHPS® trademark. These surveys include:

- Clinician Group CAHPS for Accountable Care Organizations
- CAHPS Survey for the Emergency Department
- CAHPS for Hospice
- CAHPS for Outpatient Surgical Centers
- CAHPS Survey for Healthcare Exchanges

Also, the CAHPS team is also working with researchers at Harvard Medical School to develop versions of Hospital CAHPS for pediatric hospitals and for adolescent care.

Medical Expenditure Panel Survey (MEPS)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 59,300,000	$ 59,663,000	$ 63,811,000	+$4,511,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2013 Authorization……..Expired.
Allocation Method…….... Contracts and Other.

A. Program Overview

The Medical Expenditure Panel Survey (MEPS), first funded in 1995, is the only national source for comprehensive annual data on how Americans use and pay for medical care. The survey collects detailed information from families on access, use, expenses, insurance coverage and quality. Data are disseminated to the public through printed and Web-based tabulations, microdata files and research reports/journal articles. Data from the MEPS have become a linchpin for public and private economic models projecting health care expenditures and utilization. These data are essential for the evaluation of health reform policies and analyzing the effect of tax code changes on health expenditures and tax revenue. Recently released national and state level data from MEPS on employer sponsored health offers and premiums is being used to determine tax credits for small employers providing coverage to their employees as part of the affordable care act.

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 MEPS consists of a family of interrelated surveys, which include a Household Component (HC), a Medical Provider Component (MPC), and an Insurance Component (IC). In addition to collecting data that support annual estimates for a variety of measures related to health insurance coverage, healthcare use and expenditures, MEPS provides estimates of measures related to health status, demographic characteristics, employment, access to health care and health care quality. The survey also supports estimates for individuals, families and population subgroups of interest. The data collected in this ongoing longitudinal study also permit studies of the determinants of insurance take-up, use of services and expenditures as well as changes in the provision of health care in relation to social and demographic factors such as employment and income; the health status and satisfaction with care of individuals and families; and the health needs of specific population groups such as racial and ethnic minorities, the elderly and children.

B. FY 2014 Justification by Activity Detail

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

	FY 2012 Actual	FY 2014 President's Budget	FY 2014 +/- FY 2012
MEPS Household Component	$37.100	$41.611	+$4.511
MEPS Medical Provider Component	$12.200	$12.200	$0.000
MEPS Insurance Component	$10.000	$10.000	$0.000
TOTAL, MEPS	**$59.300**	**$63.811**	**+$4.511**

Overall Budget Policy:

MEPS Household Component: The MEPS Household component collects data from a sample of families and individuals in communities across the United States, drawn from a nationally representative subsample of households that participated in the prior year's National Health Interview Survey (conducted by the National Center for Health Statistics). During the household interviews, MEPS collects detailed information for each person in the household on the following: demographic characteristics, health conditions, health status, use of medical services, expenses and source of payments, access to care, satisfaction with care, health insurance coverage, income, and employment. In FY 2012, the Household Component of the MEPS maintained the precision levels of survey estimates, maintained survey response rates and improved the timeliness of the data.

FY 2014 Request Budget Policy: The FY 2014 Request level provides $41.6 million for this activity, an increase of $4.5 million over the FY 2012 level. These funds will permit the MEPS Household Component to meet the precision levels of survey estimates, survey response rates and the timeliness of data products specified for the survey in prior years. Without this increment in funding, the sample size specifications for the survey would need to be reduced by over 8,000 persons, significantly limiting the survey's capacity to detect changes in health care use, medical expenditures, and insurance coverage for important population subgroups, such as racial and ethnic minorities, persons with specific conditions, and the uninsured, during a time of significant changes in the financing and delivery of health care in the United States. The specified budget request will also support the necessary survey staffing levels to maintain the attributes of survey products in terms of quality, precision, and utility of resultant data products.

Program Portrait: Use of MEPS Data
FY 2012 Level: $59.3 million
FY 2014 Level: $63.8 million
Change: +$4.5 million

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

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

MEPS Medical Provider Component: The MEPS Medical Provider component is a survey of medical providers, including office-based doctors, hospitals and pharmacies that collect detailed data on the expenditures and sources of payment for the medical services provided to individuals sampled for the MEPS. This component of MEPS is necessary because households are often unable to accurately report payments made on their behalf for their medical care. In FY 2012, the Medical Provider Component of the MEPS maintained its sample specifications.

FY 2014 Request Budget Policy: The FY 2014 Request level provides $12.2 million for this activity, which is the same as the FY 2012 Actual. These funds will permit the MEPS Medical Provider Component to maintain existing survey capacity at its current level.

MEPS Insurance Component (IC): The MEPS Insurance component is a survey of private business establishments and governments designed to obtain information on health insurance availability and coverage derived from employers in the U.S. The sample for this survey is selected from the Census Bureau's Business Register for private employers and Census of Governments for public employers. The IC is an annual survey designed to provide both nationally and state representative data on the types of health insurance plans offered by employers, enrollment in plans by employees, the amounts paid by both employers and employees for those plans, and the characteristics of the employers. The FY 2010 Appropriation

level allowed for data on employer sponsored health insurance to be collected in order to support both national and separate estimates for all 50 States and the District of Columbia. In FY 2012, the MEPS Insurance Component maintained the precision levels of survey estimates, maintained survey response rates and adhered to data release schedules.

FY 2014 Request Budget Policy: The FY 2014 Request level provides $10.0 million for this activity, which is the same as the FY 2012 Actual. These funds will permit the MEPS Insurance Component to maintain existing survey capacity at its current level.

C. Mechanism Table for MEPS

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

MEPS Mechanism Table

(Dollars in Thousands)

	FY 2012 Enacted		FY 2013 CR		FY 2014 Request	
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.....		**59,300**		**59,663**		**63,811**
TOTAL.....		**59,300**		**59,663**		**63,811**

D. Performance Summary and Key Measures

Measure	*Most Recent Result*	*FY 2012 Target*	*FY 2014 Target*	*FY 2014 +/- FY 2012*
1.3.16: MEPS-IC: The number of months required to make insurance component tables available following data collection *(Output)*	FY 2012: 6 months (Target Met)	6 months	6 months	Maintain
1.3.19: Increase the number of topical areas tables included in the MEPS Tables Compendia. *(Output)*	FY 2012: 1 topical areas table (Target Met)	1 topical areas table	1 topical areas table	Maintain
1.3.21: MEPS-HC: Decrease the number of months required to produce MEPS data files (i.e. point-in-time, utilization and expenditure files) for public dissemination following data collection. *(Output))*	FY 2012: 10 months (Target Met)	10 months	9.5 months	-0.5 months
1.3.49: Decrease the average number of field staff hours required to collect data per respondent household for the MEPS. *(Efficiency)*	FY 2012: 11.7 hours (Target Met)	11.7 hours	11.7 hours	Maintain

#1.3.16: 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.

Dating from 2007 (baseline) through 2012 the Insurance Component tables have been posted six months after data collection. This schedule for data release will be maintained for FY 2014. The MEPS-IC produces over 400 tables of estimates annually and posts these data on the MEPS website. Data trends from 1996 through 2011 are mapped using the MEPSnet/IC interactive search tool.

#1.3.19: The MEPS Tables Compendia is a source of important data that is easily accessed by users. Expanding the content and coverage of these tables furthers the utility of the data for all. Currently data is available in tabular format for the years 1996 – 2011. This represents sixteen years of data for both the Household and Insurance Components, enabling the user to follow trends on a variety of topics. Currently there are eight topic areas on the Household Component and eleven topic and nine subtopic areas on the Insurance Component. In addition, specific large State and metro area expenditure and coverage estimates have been produced, further increasing the utility of MEPS within existing program costs. The MEPS data table series is scheduled to be expanded a minimum of one topical table series per year.

The following data was added to the Compendia: FY 2008 – prescribed drug tables; FY 2009 – updated and expanded state-level estimate tables; FY 2010 - variables from the diabetes care supplement; FY 2011 - expenditures per event by service type; and FY 2012 - Insurance

Component summary data tables for civilian data by private and state/local government sectors and census division. For FY 2014, the MEPS new table series will consist of Pooled Expenditures by Conditions.

#1.3.21: Moving from 2006 (baseline) to 2012 the number of months to public release of data from end of data collection has been reduced from 12 months to 10 months. We have achieved the accelerated data release schedule for all the targeted MEPS public release files scheduled for release during FY 2012. We are targeting a two week reduction for FY 2014 for the point-in-time file relative to our time for data release accomplished in FY 2012. Further acceleration is targeted for the current MEPS Household Component solicitation, with data delivery taking place in FY 2014 through FY 2018.

#1.3.49: The purpose of this measure is to improve the efficiency of the data collection. In FY 2007, a baseline of 14.2 field staff hours was established for data collection. Collection times were reduced to 11.7 field staff hours in 2012. This improvement was associated with an increase in the respondent remuneration for the MEPS Household Component. The increased respondent remuneration helped promote greater cooperation from the respondent thus necessitating fewer contacts and interviewers (time/hours) to complete a case. For FY 2014 this decrease in the average number of field staff hours required to collect data per respondent household for the MEPS will be maintained.

E. Funding History

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

Year	Dollars
2009	$55,300,000
2010	$58,800,000
2011	$58,800,000
2012	$59,300,000
2013 CR	$59,663,000

Program Support

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
TOTAL				
--BA	0	0	0	0
--PHS Eval	$ 73,985,000	$ 74,438,000	$ 68,813,000	-$5,172,000
FTEs (Total Program Level)	308	320	323	15
FTEs (PHS Evaluation Funds)	300	305	300	0
FTE (Other Reimbursable Funds)	4	3	3	-1
Estimated FTEs (PCORTF)	4	12	20	+16

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2013 Authorization……..Expired.
Allocation Method……..Other.

A. Program Overview

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

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

B. FY 2014 Justification

Overall Budget Policy:

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

FY 2014 Request Budget Policy: The FY 2014 Request level for Program Support (PS) will be funded at $68.8 million, a decrease of $5.2 million or -7.0 percent from the FY 2012 level. A total of $4.1 million of this reduction is associated with a one-time expenditure in FY 2012 for tenant improvements associated with AHRQ's building move. Within the PS total, $0.9 million over FY 2012 is required for increased rent costs based on a renegotiated lease that begins in March 2013. The lease renegotiation is required as AHRQ must stay at our current location until our

new space at the Parklawn Building is finished in early FY 2017. At that time AHRQ anticipates lower overall rent expenses. The Request level also provides a pay raise of 1.0 percent for civilian and commissioned corps staff beginning in January of 2014.

Program Support provides funds for AHRQ's PHS Evaluation Fund FTEs. In FY 2014 AHRQ is supporting 300 FTEs, the same level as FY 2012. AHRQ does have additional FTEs supported with other funding sources, including an estimated 20 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 2014.

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

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

	FY 2012 Actual	FY 2013 CR	FY 2014 Pres. Budget
Patient-centered Health Research	4,162	2,799	-
Prevention/Care Management	3,988	4,452	3,717
Value Research	935	1,012	882
Health Information Technology	6,412	7,158	6,937
Patient Safety	16,445	17,526	16,985
Crosscutting Activities	27,174	24,892	21,720
Medical Expenditure Panel Survey	14,869	16,599	18,572
Total, Program Support	73,985	74,438	68,813

C. Mechanism Table

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

	FY 2012 Enacted		FY 2013 CR		FY 2014 Request	
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……		**73,985**		**74,438**		**68,813**
TOTAL.....		**73,985**		**74,438**		**68,813**

D. Funding History

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

Year	Dollars
2009	$65,122,000
2010	$67,600,000
2011	$67,600,000
2012	$73,985,000
2013 CR	$74,438,000

Supplementary Tables – Table of Contents

Supplementary Tables

Budget Authority by Object Class – Reimbursable 1/

Budget Authority by Object 1/

	FY 2012 Actual	2014 Budget	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	29,394,000	30,057,000	+663,000
Other than full-time permanent (11.3)	3,881,000	3,968,000	+87,000
Other personnel compensation (11.5)	864,000	883,000	+19,000
Military Personnel (11.7)	861,000	880,000	+19,000
Subtotal personnel compensation	**35,000,000**	**35,788,000**	**+788,000**
Civilian Personnel Benefits (12.1)	9,196,000	9,403,000	+207,000
Military Personnel Benefits (12.2)	664,000	679,000	+15,000
Benefits to Former Personnel (13.0)	0	0	0
Total Pay Costs	**44,860,000**	**45,870,000**	**+1,010,000**
Travel and transportation of persons (21.0)	389,000	351,000	-38,000
Transportation of Things	13,000	53,000	+40,000
Rental payments to GSA (23.1)	4,221,000	5,095,000	+874,000
Communications, utilities, & misc charges (23.3)	765,000	934,000	+169,000
Printing and reproduction (24.0)	852,000	781,000	-71,000
Other Contractual Services:			
Other services (25.2)	14,400,000	13,184,000	-1,216,000
Purchases of goods & services from government accounts (25.3)	19,309,000	19,384,000	+75,000
Research and Development Contracts (25.5)	172,715,000	159,274,000	-13,441,000
Operation and maintenance of equipment (25.7)	649,000	679,000	+30,000
Subtotal Other Contractual Services	**207,073,000**	**192,521,000**	**-14,552,000**
Supplies and materials (26.0)	266,000	384,000	+118,000
Equipment (31.0)	916,000	1,482,000	+566,000
Grants, subsidies, and contributions (41.0)	106,766,000	86,226,000	-20,540,000
Total Non-Pay Costs	**321,261,000**	**287,827,000**	**-33,434,000**
Total obligations by object class	**366,121,000**	**333,697,000**	**-32,424,000**

1/ Annual Appropriation only. This table excludes other reimbursable estimates that are included in the Budget Appendix.

Salaries and Expenses

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
SALARIES AND EXPENSES 1/
TOTAL APPROPRIATION

	FY 2012 Actual	2014 Budget	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	29,394,000	30,057,000	+663,000
Other than full-time permanent (11.3)	3,881,000	3,968,000	+87,000
Other personnel compensation (11.5)	864,000	883,000	+19,000
Military Personnel (11.7)	861,000	880,000	+19,000
Subtotal personnel compensation	**35,000,000**	**35,788,000**	**+788,000**
Civilian Personnel Benefits (12.1)	9,196,000	9,403,000	+207,000
Military Personnel Benefits (12.2)	664,000	679,000	+15,000
Benefits to Former Personnel (13.0)	0	0	0
Total Pay Costs	**44,860,000**	**45,870,000**	**+1,010,000**
Travel and transportation of persons (21.0)	389,000	351,000	-38,000
Transportation of Things	13,000	53,000	+40,000
Communications, utilities, & misc charges (23.3)	765,000	934,000	+169,000
Printing and reproduction (24.0)	852,000	781,000	-71,000
Other Contractual Services:			
Other services (25.2)	14,400,000	13,184,000	-1,216,000
Operation and maintenance of equipment (25.7)	649,000	679,000	30,000)
Subtotal Other Contractual Services	**15,049,000**	**13,863,000**	**-1,186,000**
Supplies and materials (26.0)	**266,000**	**384,000**	**+118,000**
Non-Pay Costs	**17,334,000**	**16,366,000**	**-968,000**
Total Salaries and Expenses	**62,194,000**	**62,236,000**	**+42,000**
Total FTEs	**300**	**300**	**0**

1/ Annual Appropriation only. This table excludes other reimbursable estimates that are included in the Budget Appendix.

Detail of Full-Time Equivalent Employment (FTE)

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

	2012 Actual Civilian	2012 Actual Military	2012 Actual Total	2013 Est. Civilian	2013 Est. Military	2013 Est. Total	2014 Est. Civilian	2014 Est. Military	2014 Est. Total
Office of the Director (OD)	21	0	21	21	0	21	21	0	21
Office of Performance Accountability, Resources and Technology (OPART)	50	0	50	51	0	51	51	0	51
Office of Extramural Research, Education, and Priority Populations (OEREPP)	38	3	41	38	3	41	38	3	41
Center for Primary Care, Prevention, and Clinical Partnerships (CP3)	25	1	26	26	1	27	26	1	27
Center for Outcomes and Evidence (COE)	26	3	29	27	3	30	24	3	27
Center for Delivery, Organization and Markets (CDOM)	26	0	26	26	0	26	24	0	24
Center for Financing, Access, and Cost Trends (CFACT)	43	0	43	43	0	43	43	0	43
Center for Quality Improvement and Patient Safety (CQuIPS)	26	2	28	26	2	28	26	2	28
Office of Communications and Knowledge Transfer (OCKT)	40	0	40	41	0	41	41	0	41
AHRQ FTE Total	**295**	**9**	**304**	**299**	**9**	**308**	**294**	**9**	**303**

Average GS Grade	
2010	12.8
2011	12.8
2012	12.8
2013	12.8
2014	12.8

1/ Excludes PCORTF FTE.

Detail of Positions 1/

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Detail of Positions 1/

	2012 Actual	2013 CR	2014 Request
Executive Level I	4	4	4
Executive Level II	1	1	1
Executive Level III	3	3	3
Executive Level IV	1	1	1
Executive Level V	0	0	0
Subtotal	9	9	9
Total Executive Level Salaries	$1,593,208	$1,597,191	$1,613,163
Total - SES	4	4	4
Total - SES Salaries	$ 734,255	$ 734,622	$ 734,622
GS-15	58	61	61
GS-14	83	85	85
GS-13	57	61	59
GS-12	33	34	31
GS-11	13	17	16
GS-10	2	2	2
GS-9	13	16	16
GS-8	3	3	3
GS-7	7	10	10
GS-6	1	2	2
GS-5	2	2	2
GS-4	0	0	0
GS-3	1	1	1
GS-2	0	0	0
GS-1	0	0	0
Subtotal	273	294	288
Average GS grade	12.8	12.8	12.8
Average GS salary	$92,341	$96,958	$97,928

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

Programs Proposed for Elimination

The following table shows the program proposed for elimination or consolidation in the President's FY 2014 Budget request. Termination of the funding provided through PHS Evaluation funds allows AHRQ to redirect $16.6 million. Following the table is a brief summary of each program and the rationale for its elimination.

Program	FY 2013 CR Level (PHS Evaluation Funds in Millions)
Patient-Centered Health Research Portfolio	$16.6

Rationale

Patient-Centered Health Research Portfolio (-$16.6 million)

Patient-centered health research improves health care quality by providing patients and physicians with state-of-the-science information on which medical treatments work best for a given condition. In FY 2012 this research was funded using both PHS Evaluation Funds and mandatory funding through the Patient-Centered Outcomes Research Trust Fund (PCORTF).

The PHS Evaluation funding provided a wide range of research activities including evidence synthesis, evidence gap identification, and evidence generation. This funding has been eliminated assuming this overarching research is being conducted through the Patient-Centered Outcomes Research Institute (PCORI). AHRQ will instead focus on using PCORTF funds appropriated to establish grants to train researchers, disseminate research findings of PCORI and other government-funded research, assist with the incorporation of research findings, and establish a process for receiving feedback on information disseminated.

Physicians' Comparability Allowance (PCA) Worksheet

		FY 2012 (Actual)	FY 2013 (Estimates)	FY 2014* (Estimates)
1) Number of Physicians Receiving PCAs		22	22	22
2) Number of Physicians with One-Year PCA Agreements		0	0	0
3) Number of Physicians with Multi-Year PCA Agreements		22	22	22
4) Average Annual PCA Physician Pay (without PCA payment)		137,231.45	137,780.38	139,709.31
5) Average Annual PCA Payment		22,727.26	22,818.17	23,137.63
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	0	0	0
	Category II Research Position	21	21	21
	Category III Occupational Health	0	0	0
	Category IV-A Disability Evaluation	0	0	0
	Category IV-B Health and Medical Admin.	1	1	1

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

N/A

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

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

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

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

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

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

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

SENATE REPORT NO. 112-176

Broadening the Evidence Base

1. SENATE (Rept. 112- 176) p. 118

AHRQ's research portfolio focuses predominantly on patient safety and healthcare quality. The Committee urges AHRQ to develop a more balanced research agenda, supporting all aspects of healthcare research outlined in its statutory mission, including: the cost and utilization of, and access to, healthcare; and the ways in which healthcare services are organized, delivered, and financed.

Action Taken or to be Taken

AHRQ understands the necessity of a balanced research agenda that supports the entirety of AHRQ's mission including research on the cost and utilization of, and access to, health care as well as the ways in which healthcare services are organized, delivered and financed. AHRQ supports this broader mission through the agency's investment in investigator-initiated research grants. In FY 2012, the agency funded $43.436 million in research grants within our Research Innovations portfolio. The topics addressed by unsolicited investigator-initiated research proposals reflect timely issues and ideas from the top health services researchers and address this broader mission. We have provided a few examples of funded grants in FY 2012 that address topics that support AHRQ's broader mission. They include: Intended and Unintended Consequences of Nonpayment for Preventable Complications, The Long Term Impact of Medicaid in Childhood on Health and Socio-Economic Status, Access to Care in Asian Americans: Assessing Determinants of Usual Source of Care, Racial/Ethnic Disparities In Mental Health Service and Medical Care Expenditures, The Effect of Specialty Tier Placement on Enrollment and Utilization in the Medicare Prescription Drug Benefit Program (Part D), Evaluation of a Standard Acquisition Charge Model for Kidney Paired Donation, Study of a State-Level Model for Transitioning Nursing Home Residents to the Community, Evaluating Sequential Strategies to Reduce Readmission in a Diverse Population, Reducing Hospital Readmission Among Medical Patients with Depressive Symptoms, and Understanding Variation in the Use of Critical Care Services.

Maternal-Fetal Medicine

2. SENATE (Rept. 112- 176)p. 119

The practice of maternal-fetal medicine has made great strides. The Committee encourages AHRQ, in collaboration with NICHD, to conduct clinical comparative effectiveness research to guide best practices and clinical management. Special emphasis should be placed on the use of progesterone, when to use it and in whom, as well as on research that will provide guidance on optimal timing of delivery for maternal and fetal conditions.

Action Taken or to be Taken

AHRQ agrees that the practice of maternal-fetal medicine has made great strides. AHRQ has undertaken several studies that are important in this area including conducting stakeholder driven reviews of existing research on issues pertaining to maternal-fetal medicine. AHRQ recently published a comprehensive review of the science titled "Progestogens for Prevention of Preterm Birth" in collaboration with NICHD. This study has been translated into a guide for clinicians and a guide for patients (in both English and Spanish) and all of the products can be found at: http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1239

Medication Therapy Management

3. SENATE (Rept. 112- 176) p. 119

The Committee recognizes the importance of medication therapy management [MTM] as a critical component of primary care services. In order to further integrate MTM services into primary care, the Committee encourages AHRQ to perform a systematic review that includes: the breadth and context of MTM services, a synthesis of what is currently known about the comparative effectiveness of MTM programs and program components, and a delineation of the gaps in the existing evidence base.

Action Taken or to be Taken

AHRQ agrees that Medication Therapy Management (MTM) has an important role in primary care services. AHRQ has commissioned research on MTM and created a toolkit on MTM. Below is a link to the MTM toolkit.

http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=27

There are 3 published manuscripts that came from the AHRQ funded MTM study.
http://www.ncbi.nlm.nih.gov/pubmed/23023840
http://www.ncbi.nlm.nih.gov/pubmed/22823552
http://www.ncbi.nlm.nih.gov/pubmed/21249958

Additionally, AHRQ recently published a comprehensive review of the science titled "Closing the Quality Gap Series: Comparative Effectiveness of Medication Adherence Interventions" which can be found at: http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=764&pageaction=displayproduct

Scientific Freedom in Contracted Research

4. SENATE (Rept. 112- 176) p. 119

The Committee continues to be concerned that contractual prior restraint clauses on the publication of research may inadvertently stifle scientific freedom and hinder the dissemination of findings that can inform health policymaking. The Committee urges AHRQ to ensure that researchers have the opportunity to publish research findings in peer-reviewed journals without unreasonable restrictions to allow greater review and input from the scientific community.

Action Taken or to be Taken

AHRQ values and believes in academic freedom and the integrity of the research process. AHRQ policy is intended to balance academic freedom with requirements related confidentiality and quality required by section 934(c) of the Public Health Service Act (PHS Act) (42 U.S.C. § 299c-3(c)) and requirements to assure statistics and analyses developed with Agency support are of high quality, comprehensive, timely, and adequately analyzed as required by section 933(b)(1) of the PHS Act (42 U.S.C. § 299c-2(b)(1)). We reviewed our policy and we are not aware of any instance where publication has been prevented or delayed unreasonably.

Training Grants

5. SENATE (Rept. 112- 176) p. 119

The Committee is concerned about declines in the number of, and funding for, training grants for the next generation of researchers. Within the Crosscutting Activities portfolio, the Committee provides $2,250,000 for new, competing pre- and post-doctoral training grants. The comparable funding level for fiscal year 2012 is $1,500,000. The administration request did not include funding for new training grants.

Action Taken or to be Taken

AHRQ provides support for training the next generation of researchers through several the National Research Service Award (NRSA) program, which provides support for pre- and post-doctoral trainees. Additionally, AHRQ will support training at of the next generation of researchers with funds allocated through Section 6301(b)) of the Patient Protection and Affordable Care Act, Public Law 111-148 (the “Affordable Care Act”), which enacted Section 937(e) of the Public Health Services Act authorizing AHRQ to establish a grant program that provides for the training of researchers in comparative clinical effectiveness research.