DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2015

Agency for Healthcare Research and Quality

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Agency for Healthcare
Research and Quality

540 Gaither Road
Rockville MD 20850
www.ahrq.gov

As the new Director of the Agency for Healthcare Research and Quality (AHRQ), I am very pleased to present the FY 2015 Congressional Justification. Although I have only been AHRQ's director for a few months, I have learned quickly about the commitment and dedication of the Agency's staff to improving health and health care in America, and the substantial progress we have made towards achieving those goals.

This budget, my first as Director of AHRQ, details the activities and effort needed to fulfill AHRQ's new mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work with the U.S. Department of Health and Human Services (HHS) and other partners to make sure that the evidence is understood and used. AHRQ is well known for our research and collaboration with our public- and private-sector partners to improve the quality and safety of health care in such critical areas as reducing health care-associated infections and other harms when patients receive health care services.

AHRQ has funded groundbreaking research developing and implementing methods of reducing hospital acquired infections, leading to a greater than 40% reduction in Central Line Associated Blood Stream Infections (CLABSIs) and, more recently, in a substantial reduction in Catheter Associated Urinary Tract Infections (CAUTIs). AHRQ was an early federal partner with CMS, and helped lay the groundwork for the Partnership for Patients. Working with other Federal agencies involved in improving patient safety, such as CMS, CDC, and FDA, AHRQ staff led analyses to produce estimates of achievable targets for reductions in rates of hospital-acquired conditions, and of the deaths that would be avoided and of the costs that could be saved through this effort. AHRQ funds relevant research, and develops and disseminates specific toolkits and methods, to improve patient safety and reduce readmissions, such as a new falls prevention toolkit, and a comprehensive quality program that has been successfully implemented to reduce several types of healthcare-associated infections.

I am very excited to build on the track record that AHRQ has in quality improvement and patient safety research, patient-centered outcomes research, and data analysis and evaluation. Our proposed new mission as well as four new priorities, which are described in detail in this Congressional Justification, responds to the evidence and information needs of our evolving health care system.

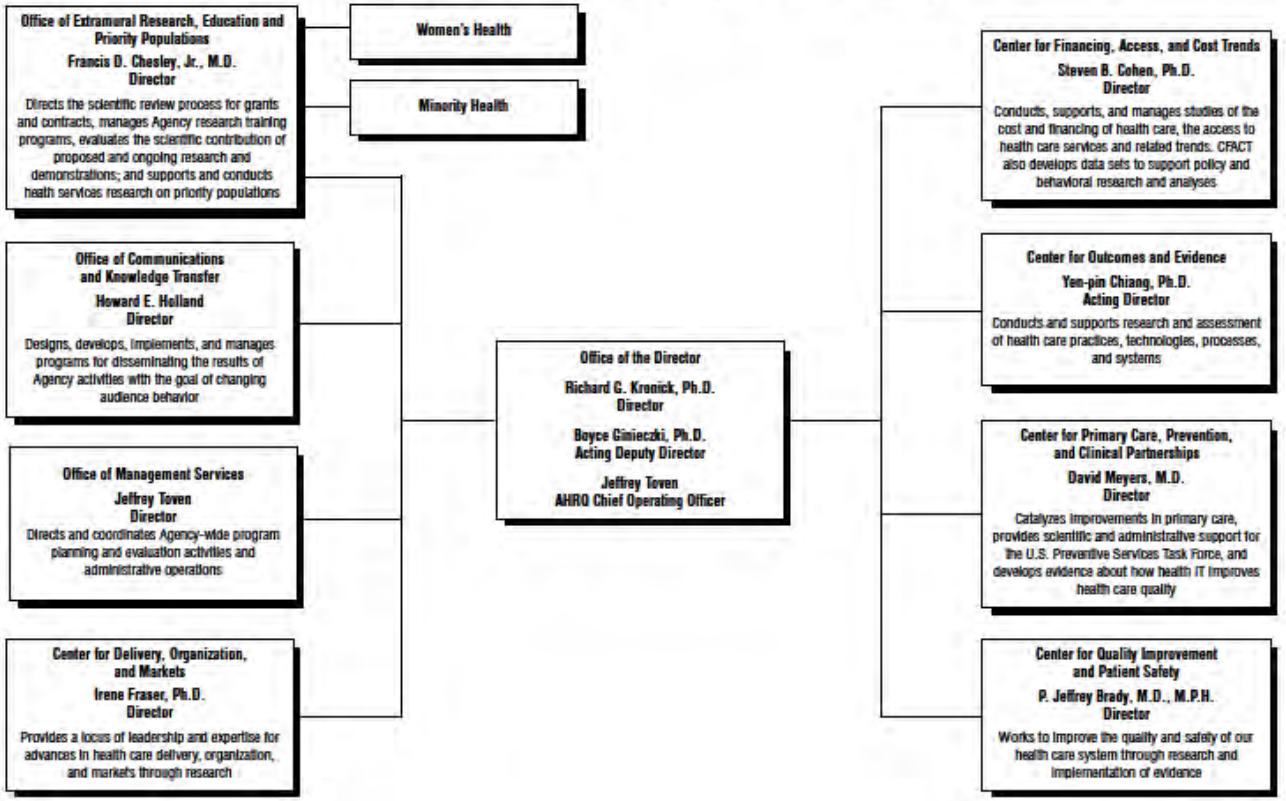
AHRQ seeks to promote economy, efficiency, accountability, and integrity in the management of our research dollars to ensure that AHRQ is an effective steward of limited resources. With our continued investment in successful programs that develop useful knowledge and tools, the end result of our research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

_____

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

Table of Contents

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



AHRQ Pub. No. 14-M005
Replaces AHRQ Pub. No. 13-M016
February 2014

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. AHRQ's research role in the HHS 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

The FY 2015 Congressional Justification introduces a new mission statement – a subtle revision from AHRQ's prior mission.

> **Prior Mission**: To improve the quality, safety, efficiency, and effectiveness of health care for all Americans.
>
> **New Mission**: To produce evidence to make health care safer, higher quality, more accessible, equitable and affordable, and to work with the U.S. Department of Health and Human Services (HHS) and other partners to make sure that the evidence is understood and used.

The new mission emphasizes that AHRQ's job is to produce evidence. It recognizes that AHRQ can't make health care safer or higher quality alone. Our role is to produce evidence and work with others to make sure that it's understood and used. Providing evidence to guide the work of key HHS initiatives is a role AHRQ is uniquely able to play. While the Centers for Medicare and Medicaid Services (CMS), the National Institute of Health (NIH), and the Center for Disease Control and Prevention (CDC) produce evidence on various aspects of health care, we are the only agency with the sole mission of producing evidence to improve the delivery of health care services and health outcomes.

To accompany this new mission, AHRQ proposes to emphasize 4 priorities for the next several years. These priorities are related directly to AHRQ's new mission.

Priority 1: Improve health care quality by accelerating implementation of Patient Centered Outcomes Research (PCOR). AHRQ will use our mandatory funding in FY 2015 provided through the Patient-Centered Outcomes Research Trust Fund (PCORTF) to improve health care quality and patient health outcomes. AHRQ is proposing to work with small- and medium-sized primary care practices to help ensure that these practices are able to improve health outcomes, initially focused on cardiovascular disease, and to improve the ability of these practices to adopt new PCOR evidence. This would be a "boots on the ground" effort to help small- and medium-sized practices that don't often have quality improvement methods in place like large health care systems. Please see page 83 for additional information.

Priority 2: Make health care safer. This priority builds on AHRQ's current patient safety research. The focus includes work on reducing healthcare-associated infections, accelerating safety improvements in hospitals, reducing harm in obstetric care, improving safety and reducing medical liability, testing safety toolkits and accelerating safety improvements in nursing homes. Many of the new patient safety efforts will begin in FY 2014. In addition, in FY 2015, AHRQ is proposing a new $15 million patient safety initiative -- *Extending Safety to Patients in All Settings*. Prior AHRQ investments in patient safety have supported research on safety in the inpatient hospital setting. Building on our many successes in the hospital settings, AHRQ will now focus on other settings of care, beginning with primary care and nursing home care safety in 2015 – two health care settings in which patient safety research has not been focused.

Priority 3: Increase accessibility. This priority recognizes that in a few years' time, there will be tens of millions of people who are currently uninsured who will be newly covered, as well as the likelihood that there will be millions of people who could be insured but who remain uninsured. We know from previous research, some of it funded by AHRQ, that increasing the level of insurance coverage is an effective method of improving health. Further, we know that more research is needed about how to expand coverage efficiently and sustainably, and how to ensure that newly insured people have access to needed care. AHRQ's focus will be to provide evidence to help the Secretary and other policymakers make better informed decisions by providing evidence on the effects of coverage expansion on uninsured people, on labor markets, and on employer and employee decisions regarding employer-sponsored insurance. We anticipate that these research topics will be proposed by investigator-initiated grantees through AHRQ's normal application and peer review process. In addition, the FY 2015 President's Budget provides $15.0 million in investigator-initiated grant funding within the Health Services Research, Data and Dissemination portfolio to support a new initiative focusing on health economics research. AHRQ is anticipating grant proposals in FY 2015 focused on increasing the efficiency, effectiveness, and value of the health care system. These grants could improve our understanding of the causes and consequences of lack of insurance, and of the effects of the health insurance expansion on access to care, utilization of health care, health care spending, and health outcomes, and the labor market.

Priority 4: Improve health care affordability, efficiency and cost transparency. AHRQ has historically funded research on affordability and efficiency (part of our previous mission) through the Health Services Research, Data and Dissemination and Value portfolios. This work will continue in FY 2014 and 2015, with an added focus on increasing price transparency. We will build on the relationships we have developed as part of the Hospital Cost and Utilization Project (HCUP), and build also on grants that the CMS provided to states to work with state data centers as part of improving rate review. We propose to work with state agencies that are engaged in increasing price transparency, providing technical assistance and development of reporting tools that facilitate the reporting of transparent information on prices. A second major initiative in this priority will invest in tools and methods to describe health care systems and their

performance. As has been much remarked, health care delivery is being transformed from a cottage industry, with many practitioners working relatively independently, into an industry increasingly characterized by more organized health care systems. However, our ability to describe these systems, to measure their performance, and to understand the characteristics of high performing systems is extremely limited. Limitations in the evidence here create severe limitations for systems engaged in quality improvement efforts. We propose to invest in research to remedy these deficiencies, with a focus on understanding the extent to which various systems incorporate Patient-Centered Outcomes Research into practice, and to disseminate information on the use of PCOR. Research in this area will be a mix of intramural work, investigator-initiated research and research contracts. Work related to this priority could also be funded in FY 2015 through the $15.0 million for health economics research in investigator-initiated grant funding within the Health Services Research, Data and Dissemination portfolio.

Research Portfolios

AHRQ's research will now fall under three research portfolios: Patient Safety, Health Information Technology, and Health Services Research, Data and Dissemination. This is a reduction in the number of portfolios from previous years. In 2015, AHRQ is ending three research portfolios (Prevention/Care Management, Patient-Centered Health Research, and Value). AHRQ's administrative support for the U.S. Preventive Services Task Force, which was catalogued under Prevention/Care Management, will continue as will our investments supported through mandatory funding from the Patient-Centered Outcomes Research Trust Fund. AHRQ's remaining three research portfolios cover:

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

- Health Services Research, Data and Dissemination: This portfolio uses research grants and contracts to conduct investigator-initiated and targeted research that focuses on quality, effectiveness and efficiency. This portfolio also supports measurement and data collection activities and dissemination and translation of research.

- Health Information Technology: 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.

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 health care 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 policymakers and non-Federal scientists at universities, medical centers, hospitals, purchasers, payers, 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. Along with conducting 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's 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. While AHRQ awards many grants specifically for research, we also provide grants 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 support research in an understudied area, take advantage of current research opportunities, address a high priority research program, or 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 ideas or training needs that address AHRQ's mission and one or more of its portfolios.

All AHRQ research projects must be unique. By HHS policy, AHRQ cannot support a project already funded or pay for research that has already been conducted. 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Request +/- FY 2014 Enacted
Research on Health Costs, Quality, and Outcomes (HCQO):				
Patient Safety	$66,584	$71,584	$72,614	+$1,030
Health Services Research, Data and Dissemination	$111,072	$111,072	$93,209	-$17,863
Health Information Technology	$25,572	$29,572	$23,465	-$6,107
Prevention/Care Management	$25,747	$22,904	$11,300	-$11,604
PHS Evaluation Funds	*$19,282*	*$15,904*	*$11,300*	*-$4,604*
USPSTF - Prevention and Public Health Fund	*$6,465*	*$7,000*	*$0*	*-$7,000*
Value	$3,730	$3,252	$0	-$3,252
Patient-Centered Health Research	$10,000	$0	$0	+$0
Subtotal HQCO	**$242,705**	**$238,384**	**$200,588**	**-$37,796**
HCQO, Prevention and Public Health Fund	***$6,465***	***$7,000***	***$0***	***-$7,000***
Medical Expenditure Panel Survey	**$60,700**	**$63,811**	**$63,811**	**+$0**
Program Support	**$68,422**	**$68,813**	**$69,700**	**+$887**
Total PHS Evaluation Funds	**$365,362**	**$364,008**	**$334,099**	**-$29,909**
Total Prevention and Public Health Fund	**$6,465**	**$7,000**	**$0**	**-$7,000**
PCORTF Transfer 1/	**$57,701**	**$92,800**	**$105,600**	**+$12,800**
Total Program Level	**$429,528**	**$463,808**	**$439,699**	**-$24,109**

1/ Mandatory Funds

The FY 2015 President's Budget Level for AHRQ is $334.1 million, a decrease of $29.9 million or -8.2 percent below the FY 2014 Enacted. In terms of program level, AHRQ's request is $439.7 million, a decrease of $24.1 million or -5.2 percent from the FY 2014 Enacted. Within Research on Health Costs, Quality and Outcomes, the research and specific funding changes for programs that fit within them are:

- Patient Safety Research is funded at $72.6 million at the FY 2015 President's Budget level, an increase of $1.0 million above the FY 2014 Enacted. This research portfolio houses AHRQ's new initiative -- Extending Safety to Patients in All Settings. The bulk of AHRQ's previous investments in patient safety have supported research on safety in the inpatient hospital setting. Building on our many successes in the hospital settings, AHRQ will now focus on other settings of care, beginning with primary care and nursing home care safety in FY 2015 – two health care settings in which patient safety research has not been focused. The total investment for this new initiative is $15.0 million. The Patient Safety budget also provides $34.0 million directed to research with a focus on prevention of Healthcare-

Associated Infections (HAIs), the same level of support as the FY 2014 Enacted. 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 ($16.6 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.

- Health Services Research, Data and Dissemination is funded at $93.2 million, a decrease of $17.9 million or -16.1 percent from the FY 2014 Enacted. At the FY 2015 President's Budget level, total investigator-initiated research (continuing and new grants) totals $40.0 million, a decrease of $5.9 million from the FY 2014 Enacted. The FY 2015 President's Budget level provides approximately $20.1 million for new grants, all of which will support new investigator-initiated research. Within the $20.1 million for new investigator-initiated research grants, $15.0 million will support a new initiative focusing on health economics research. AHRQ is anticipating grant proposals focused on increasing the efficiency, effectiveness, and value of the health care system. These grants could improve our understanding of the causes and consequences of lack of insurance, and of the effects of health insurance expansion on access to care, utilization of health care, health care spending, health outcomes, and the labor market.

- Health Information Technology Research is funded at $23.5 million, a decrease of $6.1 million from the FY 2014 Enacted. The FY 2015 Request level provides $1.7 million in new research grants for investigator-initiated health IT research, providing a total of $20.0 million in research grant support.

- Prevention/Care Management Research is funded at $11.3 million at the FY 2015 President's Budget level, a decrease of $11.6 million from the FY 2014 Enacted level. The entirety of this portfolio will now only support the U.S. Preventive Services Task Force (USPSTF), including their continuing work to increase transparency. The USPSTF is an independent, volunteer panel of national experts in prevention and evidence-based medicine whose mission is to improve the health of all Americans by making evidence-based recommendations about the effectiveness of clinical preventive services and health promotion. AHRQ support for research grants to improve clinical outcomes in primary care and contract support for implementation activities to improve primary care have been eliminated. In future budget requests, AHRQ will rename this portfolio "Ongoing Support of the U.S. Preventive Services Task Force."

- Value Research is no longer being funded by AHRQ at the FY 2015 President's Budget level - a decrease of $3.3 million from the FY 2014 Enacted. Although the mission of the Value Research portfolio is important, AHRQ will be able to support this type of research through the Health Services Research, Data, and Dissemination portfolio and therefore will not require a separate portfolio area. One program, MONAHRQ ($1.5 million), will be moved to the Health Services Research, Data and Dissemination portfolio to add to our data and measurement activities.

- Patient-Centered Health Research (PCHR) has not been funded by AHRQ since FY 2013 and this budget submission no longer includes discussion of this portfolio. All support for PCHR in AHRQ is funded through the Patient-Centered Outcomes Research Trust Fund (PCORTF). PCORTF resources 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, to assist with the adoption of research findings, and to establish a process for receiving feedback on information disseminated. Please see page 83 for additional information.

The Medical Expenditure Panel Survey (MEPS) will be funded at $63.8 million, the same level of support as the FY 2014 Enacted. 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 $69.7 million, an increase of $0.9 million or +1.3 percent over the FY 2014 Enacted. The entire increase is required for additional rental payments to GSA for two month's rent for the new Parklawn building in FY 2015 prior to our move in FY 2016. Under the new occupancy agreement, rent commences starting August 2015. AHRQ anticipates lower rent costs in FY 2016 following our relocation.

Full Time Equivalents (FTEs)

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

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
FTEs – PHS Evaluation Funds	299	300	300
FTEs – PCORTF	6	20	20
FTEs – Other Reimbursable Funds	6	6	6

C. Overview of Performance

AHRQ's new mission is supported by a research agenda that spans the areas of Patient Safety, Health IT, Health Services Research, Data and Dissemination, and the Medical Expenditure Panel Survey (MEPS). This research agenda also supports the following HHS Strategic Goals: Strengthen Health Care; Advance Scientific Knowledge and Innovation; Advance the Health, Safety, and Well-Being of the American People; and Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs.

Recent key accomplishments include: 1) Patient Safety – promoting the nationwide implementation of the Comprehensive Unit-based Safety Program to prevent central line-associated blood stream infections (CLABSI); 2) Health IT – developing and synthesizing the best evidence on how health IT can improve the quality of American health care, disseminating that evidence, and developing evidence-based tools for adoption and meaningful use of health IT; 3) Health Services Research, Data and Dissemination - identifying the most effective ways to organize, manage, finance, and deliver high quality care, reduce medical errors, and improve patient safety by conducting investigator-initiated and targeted research that focus on health services research in the areas of quality, effectiveness and efficiency through research grants and research contracts; 4) Medical Expenditure Panel Survey (MEPS) – providing annual estimates at the national level of the health care utilization, expenditures, sources of payment

and health insurance coverage of the U.S. population. Other accomplishments have included the development and release of version 4.0.1 of MONAHRQ. MONAHRQ is a free software tool that enables organizations to quickly generate a health care public reporting Website, using either their own inpatient discharge data or pre-calculated measures from CMS Hospital Compare. The latest version of this software tool includes a feature that allows for reporting estimated cost savings from reducing potentially avoidable hospitalizations. Also, two CAHPS Surveys gained wider use: the CAHPS Home Health Survey and the CAHPS Clinician/Group Survey.

Looking to the future, AHRQ will conduct research to improve safety in primary care practices and nursing homes. Also, AHRQ will continue 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 measures that are no longer meaningful to the programs and that do not contribute to the Department's overall strategic plan.

Discretionary All-Purpose Table 1/

(dollars in thousands)

Program	FY 2013 Actual	FY 2014 Enacted /2	FY 2015 President's Budget	FY 2015 +/- FY 2014
RESEARCH ON HEALTH COSTS, QUALITY AND OUTCOMES				
Patient Safety	**$66,584**	**$71,584**	**$72,614**	**+1,030**
Health Services Research, Data and Dissemination	**$111,072**	**$111,072**	**$93,209**	**-$17,863**
Health Information Technology	**$25,572**	**$29,572**	**$23,465**	**-$6,107**
Prevention/Care Management	**$25,747**	**$22,904**	**$11,300**	**-$11,604**
PHS Evaluation Fund	*$19,282*	*$15,904*	*$11,300*	*-$4,604*
USPSTF-ACA Funds - Prevention and Public Health Fu	*$6,465*	*$7,000*	*$0*	*-$7,000*
Value Research	**$3,730**	**$3,252**	**$0**	**-$3,252**
Patient-Centered Health Research	**$10,000**	**$0**	**$0**	**$0**
Budget Authority	**$0**	**$0**	**$0**	**$0**
PHS Evaluation	**$236,240**	**$231,384**	**$200,588**	**-$30,796**
ACA Funds - Prevention and Public Health Fund 3/	*$6,465*	*$7,000*	*$0*	*-$7,000*
Subtotal, HCQO Program Level	**$242,705**	**$238,384**	**$200,588**	**-$37,796**
MEDICAL EXPENDITURE PANEL SURVEY				
Budget Authority	$0	$0	$0	$0
PHS Evaluation	$60,700	$63,811	$63,811	$0
Subtotal, MEPS	**$60,700**	**$63,811**	**$63,811**	**$0**
PROGRAM SUPPORT				
Budget Authority	$0	$0	$0	$0
PHS Evaluation	$68,422	$68,813	$69,700	+$887
Subtotal, Program Support	**$68,422**	**$68,813**	**$69,700**	**+$887**
SUBTOTAL				
Budget Authority	**$0**	**$0**	**$0**	**$0**
PHS Evaluation	**$365,362**	**$364,008**	**$334,099**	**-$29,909**
ACA Funds - Prevention and Public Health Fund 3/	**$6,465**	**$7,000**	**$0**	**-$7,000**
Subtotal	**$371,827**	**$371,008**	**$334,099**	**-$36,909**
PCORTF Transfer 3/	$57,701	$92,800	$105,600	+$12,800
TOTAL PROGRAM LEVEL	**$429,528**	**$463,808**	**$439,699**	**-$24,109**
FTEs				
Budget Authority	**0**	**0**	**0**	**0**
PHS Evaluation	**299**	**300**	**300**	**0**
ACA Funds - Prevention and Public Health Fund 3/	**0**	**0**	**0**	**0**
ACA Funds - PCORTF Transfer 3/	**6**	**20**	**20**	**0**
TOTAL PROGRAM LEVEL	**305**	**320**	**320**	**0**

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

2/ Reflects FY 2014 Omnibus Appropriations Bill and PHS Evaluation and Prevention fund allocations as detailed in the bill.

3/ Mandatory funds.

AHRQ Detailed Mechanism Table 1/

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

	FY 2013 Actuals		FY 2014 Enacted		FY 2015 President's Budget	
	No.	Dollars	No.	Dollars	No.	Dollars
RESEARCH GRANTS						
Non-Competing						
Patient Safety	48	16,707	37	12,236	59	18,750
Health Serv Res, Data & Diss	106	34,259	91	28,230	82	26,824
Health Information Technology	39	11,687	36	14,368	45	18,298
Prevention/Care Management	9	5,897	7	1,325	0	0
PHS Evaluation Fund	*9*	*5,897*	*7*	*1,325*	*0*	*0*
ACA - Prevention and Public Health Fund	*0*	*0*	*0*	*0*	*0*	*0*
Value	0	0	0	0	0	0
Patient-Centered Health Research	12	3,834	0	0	0	0
Medical Expenditure Panel Survey	0	0	0	0	0	0
Total Non-Competing	214	72,385	171	56,159	186	63,872
New & Competing						
Patient Safety	26	10,281	56	18,050	32	13,490
Health Serv Res, Data & Diss	70	20,046	103	25,259	70	20,081
Health Information Technology	27	7,785	24	9,608	4	1,678
Prevention/Care Management	23	4,364	14	4,063	0	0
PHS Evaluation Fund	*23*	*4,364*	*14*	*4,063*	*0*	*0*
ACA - Prevention and Public Health Fund	*0*	*0*	*0*	*0*	*0*	*0*
Value	0	0	0	0	0	0
Patient-Centered Health Research	6	3,924	0	0	0	0
Medical Expenditure Panel Survey	0	0	0	0	0	0
Total New & Competing	152	46,400	197	56,980	106	35,249
RESEARCH GRANTS						
Patient Safety	74	26,988	93	30,286	91	32,240
Health Serv Res, Data & Diss	176	54,306	194	53,489	152	46,905
Health Information Technology	66	19,472	60	23,976	49	19,976
Prevention/Care Management	32	10,262	21	5,388	0	0
PHS Evaluation Fund	*32*	*10,261*	*21*	*5,388*	*0*	*0*
ACA - Prevention and Public Health Fund	*0*	*0*	*0*	*0*	*0*	*0*
Value	0	0	0	0	0	0
Patient-Centered Health Research	18	7,758	0	0	0	0
Medical Expenditure Panel Survey	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	366	118,785	368	113,139	292	99,121
PHS Evaluation Fund	*366*	*118,784*	*368*	*113,139*	*292*	*99,121*
ACA - Prevention and Public Health Fund		*0*		*0*		*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 2013 Actuals		FY 2014 Enacted		FY 2015 President's Budget	
	No.	Dollars	No.	Dollars	No.	Dollars
CONTRACTS/IAAs						
Patient Safety ……		**39,596**		**41,298**		**40,374**
Health Serv Res, Data & Diss …		**56,767**		**57,583**		**46,304**
Health Information Technology ……		**6,100**		**5,596**		**3,489**
Prevention/Care Management……		**15,486**		**17,516**		**11,300**
PHS Evaluation Fund……		*9,021*		*10,516*		*11,300*
ACA - Prevention and Public Health Fund..		*6,465*		*7,000*		*0*
Value……		**3,730**		**3,252**		**0**
Patient-Centered Health Research..		**2,242**		**0**		**0**
Medical Expenditure Panel Survey..		**60,700**		**63,811**		**63,811**
TOTAL CONTRACTS/IAAs.....		**184,622**		**189,056**		**165,278**
PHS Evaluation Fund……		*178,157*		*182,056*		*165,278*
ACA - Prevention and Public Health Fund..		*6,465*		*7,000*		*0*
RESEARCH MANAGEMENT.....		**68,422**		**68,813**		**69,700**
PHS Evaluation Fund……		*68,422*		*68,813*		*69,700*
GRAND TOTAL						
Patient Safety ……		**66,584**		**71,584**		**72,614**
Health Serv Res, Data & Diss ……		**111,072**		**111,072**		**93,209**
Health Information Technology ……		**25,572**		**29,572**		**23,465**
Prevention/Care Management……		**25,747**		**22,904**		**11,300**
PHS Evaluation Fund……		*19,282*		*15,904*		*11,300*
ACA - Prevention and Public Health Fund..		*6,465*		*7,000*		*0*
Value……		**3,730**		**3,252**		**0**
Patient-Centered Health Research..		**10,000**		**0**		**0**
Medical Expenditure Panel Survey..		**60,700**		**63,811**		**63,811**
Research Management……..		**68,422**		**68,813**		**69,700**
GRAND TOTAL						
PHS Evaluation……		**365,362**		**364,008**		**334,099**
ACA - Prevention and Public Health Fund....		**6,465**		**7,000**		**0**
GRAND TOTAL.....		**371,827**		**371,008**		**334,099**

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, **[**$364,008,000**]** *$334,099,000* 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 **[**September 30, 2015**]** *expended. (Department of Health and Human Services Appropriations Act, 2014).*

Amounts Available for Obligation

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

Amounts Available for Obligation 1/

	2013 Actual 2/	FY 2014 Enacted 3/	FY 2015 President's Budget
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	$236,193,000	$231,384,000	$200,588,000
MEPS	$60,700,000	$63,811,000	$63,811,000
Program Support	$68,257,000	$68,813,000	$69,700,000
Subtotal, adjusted appropriation	$365,150,000	$364,008,000	$334,099,000
Unobligated Balance Lapsing	$212,000	---	---
Total obligations	$365,362,000	$364,008,000	$334,099,000

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 2014 Prevention Fund resources are reflected in the Office of the Secretary.

Summary of Changes

Summary of Changes

2014 Total estimated budget authority	$0
(Obligations)	($364,008,000)
2015 Total estimated budget authority	
(Obligations)	($334,099,000)
Net change	
(Obligations)	-($29,909,000)

Increases	2014 Estimate (FTE)	Budget Authority	Change from Base (FTE)	Budget Authority
A. Program Support (Built-in)				
1. Salary and Benefits	--	--	--	--
	(--)	(45,870,000)	(--)	(+503,000)
2. Rental Payments to GSA	--	--	--	--
	(--)	(5,095,000)	(--)	(+1,051,000)
Subtotal, Built-in			**(0)**	**(+1,554,000)**
B. Program				
1. Patient Safety	--	--	--	--
	(--)	(71,584,000)	(--)	(+1,030,000)
Subtotal, Program			**(0)**	**(+1,030,000)**
Total Increases			**(0)**	**(+2,584,000)**
Decreases				
A. Program Support (Built-in)				
1. Absorption of the built-in increases	--	--	--	--
			(--)	(-667,000)
Subtotal, Built-in			**--**	**--**
			(0)	**(-667,000)**
B. Program				
1. Health Services Research, Data and Dissemination.	--	--	--	--
	(--)	(111,072,000)	(--)	(-17,863,000)
2. Health Information Technology				
	(--)	(29,572,000)	(--)	(-6,107,000)
3. Prevention Care/Management	--	--	--	--
	(--)	(15,904,000)	(--)	(-4,604,000)
4. Value	--	--	--	--
	(--)	(3,252,000)	(--)	(-3,252,000)
Subtotal, Program	**--**	**--**	**--**	**--**
			(0)	**(-31,826,000)**
Total Decreases			**--**	**--**
			(0)	**(-32,493,000)**
Net change, Budget Authority			**--**	**--**
Net change, Obligations			**(0)**	**(-29,909,000)**

Budget Authority by Activity

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

Budget Authority by Activity 1/
(Dollars in thousands)

	FY 2013 Actual		FY 2014 Base		FY 2014 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
1. Research on Health Costs, Quality, & Outcomes BA	---	0		0	---	0
PHS Evaluation	[0]	[$236,240]	[0]	[$231,384]	[0]	[$200,588]
Total Operational Level	0	236,240	0	231,384	0	200,588
2. Medical Expenditures Panel Surveys BA	---	---	---	---	---	---
PHS Evaluation	---	[60,700]	---	[63,811]	---	[63,811]
Total Operational Level	---	60,700	---	63,811	---	63,811
3. Program Support BA	---	---	---	---	---	---
PHS Evaluation	[299]	[68,422]	[300]	[68,813]	[300]	[69,700]
Total Operational Level	299	68,422	300	68,813	300	69,700
Total, Budget Authority	0	0	0	0	0	0
Total PHS Evaluation	[299]	[365,362]	[300]	[364,008]	[300]	[334,099]
Total Operations	299	$365,362	300	$364,008	300	$334,099

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

Authorizing Legislation 1/

	FY 2014 Amount Authorized	FY 2014 Appropriations Act	2015 Amount Authorized	FY 2015 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	$364,008,000	Indefinite	$334,099,000
Total appropriations.....		$364,008,000		$334,099,000
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

Appropriation History Table
Agency for Healthcare Research and Quality

	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriation	
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	$ 365,362,000	
Total	$ 334,357,000	$ -	$ 364,053,000	$ 365,362,000	
2014					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 333,697,000	$ -	$ 364,008,000	$ 364,008,000	
Total	$ 333,697,000	$ -	$ 364,008,000	$ 364,008,000	
2015					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 334,099,000	$ -	$ -	$ -	
Total	$ 334,099,000	$ -	$ -	$ -	

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

Appropriations Not Authorized by Law

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	Appropriations in FY 2014
Research on Health Costs, Quality, and Outcomes……	FY 2005	Such Sums As Necessary	260,695,000	364,008,000

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

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 Request +/- FY 2014 Enacted
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 236,240,000	$ 231,384,000	$ 200,588,000	-$30,796,000
--Prev. & Public Hlth Fund	$ 6,465,000	$ 7,000,000	$ -	-$7,000,000
Total Program Level	$ 242,705,000	$ 238,384,000	$ 200,588,000	-$37,796,000

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

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

Summary

AHRQ's Program Level for Research on Health Costs, Quality, and Outcomes (HCQO) at the FY 2015 President's Budget level is $200.6 million, a decrease of $37.8 million or -15.9 percent from the FY 2014 Enacted. AHRQ's entire request for HCQO is funded through PHS Evaluation Funds.

AHRQ Budget Detail

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 Request +/- FY 2014 Enacted
Research on Health Costs, Quality, and Outcomes (HCQO):				
Patient Safety	$66,584	$71,584	$72,614	+$1,030
Health Services Research, Data and Dissemination	$111,072	$111,072	$93,209	-$17,863
Health Information Technology	$25,572	$29,572	$23,465	-$6,107
Prevention/Care Management	$25,747	$22,904	$11,300	-$11,604
PHS Evaluation Funds	*$19,282*	*$15,904*	*$11,300*	*-$4,604*
USPSTF - Prevention and Public Health Fund	*$6,465*	*$7,000*	*$0*	*-$7,000*
Value	$3,730	$3,252	$0	-$3,252
Patient-Centered Health Research	$10,000	$0	$0	+$0
Subtotal HQCO	**$242,705**	**$238,384**	**$200,588**	**-$37,796**
HCQO, Prevention and Public Health Fund (PPHF)	***$6,465***	***$7,000***	***$0***	***-$7,000***

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

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

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

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

AHRQ has ended and/or revised three research portfolios:

- Prevention/Care Management Research: In prior years, this portfolio focused on improving the quality, safety, efficiency, and effectiveness of the delivery of evidence-based preventive services and chronic care management in ambulatory care settings. Beginning in FY 2015 this portfolio will only provide funding to support the U.S. Preventive Services Task Force (USPSTF). Beginning in FY 2016, AHRQ will rename this portfolio "Ongoing Support of the U.S. Preventive Services Task Force."

- Value Research: The FY 2015 Budget eliminates this portfolio. Although the research funded by this portfolio is important, AHRQ will be able to support this type of research through AHRQ's Health Services Research, Data and Dissemination portfolio.

- Patient-Centered Health Research/Effective Health Care: As of FY 2014, this portfolio is now funded only through the Patient-Centered Outcomes Research Trust Fund (PCORTF) – a mandatory trust fund. Please see the separate discussion about the PCORTF on page 83.

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

***Program increases at FY 2015 President's Budget level*:**

HCQO: Patient Safety Research (+$1.0 million): The FY 2015 President's Budget level provides $72.6 million for the Patient Safety portfolio, an increase of $1.0 million from the FY 2014 Enacted. Included in the President's Budget level is a $15.0 million new patient safety initiative – *Extending Safety to Patients in All Settings*. This initiative will begin a five year investment in building evidence, strategies, data, measures and tools to improve safety in a variety of settings, beginning with primary care practices and nursing homes in FY 2015. These are settings with high patient use, high potential for harm, and potential to learn from our work in the inpatient arena. They often have data systems linked to inpatient facilities, and patients often move from one of these settings to another. Finally, these are areas that can build on some investments AHRQ has already made. We expect to have early evidence, data and tools by the end of 2016.

Program decreases at FY 2015 President's Budget level:

HCQO: Health Services Research, Data and Dissemination (-$17.9 million): The FY 2015 President's Budget provides $93.2 million for the Health Services Research, Data and Dissemination portfolio, a decrease of $17.9 million from the FY 2014 Enacted level. The FY 2015 President's Budget provides approximately $20 million for new grants, all of which will support new investigator-initiated research. Within the $20 million for new investigator-initiated research grants, $15.0 million will support a new initiative focusing on health economic research. AHRQ is anticipating grant proposals focused on increasing the efficiency, effectiveness, and value of the health care system. These grants could improve our understanding of the causes and consequences of lack of insurance and of the effects of health insurance expansion on access to care, utilization of health care, health care spending, health outcomes, and the labor market.

HCQO: Health Information Technology Research (-$6.1 million) is funded at $23.5 million, a decrease of $6.1 million from the FY 2014 Enacted. The FY 2015 Request level provides $1.7 million in new research grants for investigator-initiated health IT research, providing a total of $20.0 million in research grant support.

HCQO: Prevention/Care Management (-$11.6 million): The FY 2015 President's Budget provides $11.3 million for the Prevention/Care Management portfolio, a decrease of $11.6 million from the FY 2014 Enacted level. The entirety of this portfolio will now only support the U.S. Preventive Services Task Force (USPSTF). AHRQ support for research grants to improve clinical outcomes in primary care and contract support for implementation activities to improve primary care have been eliminated.

HCQO: Value Research (-$3.3 million): The FY 2015 President's Budget eliminates this portfolio, a decrease of $3.3 million. A total of $1.5 million from this portfolio supports MONAHRQ. MONAHRQ will be moved to the Health Services Research, Data and Dissemination portfolio to add to our data and measurement activities in FY 2015.

5-Year Table Reflecting Dollars

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

Year	Dollars
2010	$276,153,000
2011	$257,653,000
2012	$247,768,000
2013	$242,705,000
2014	$238,384,000

Patient Safety

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 Request +/- FY 2014 Enacted
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 66,584,000	$ 71,584,000	$ 72,614,000	+$1,030,000

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

A. 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 2015 Justification by Activity Detail

Patient Safety Research Activities
(in millions of dollars)

	FY 2013 Final	FY 2014 Enacted Level	FY 2015 President's Budget
Patient Safety Risks and Harms *(NEW Initiative: Extending Safety to Patients in All Settings)*	$25.584 *($0.000)*	$30.584 *($0.000)*	$31.614 *($15.000)*
Patient Safety Organizations (PSOs)	7.000	7.000	7.000
Patient Safety and Medical Liability Reform	0.000	0.000	0.000
Healthcare-Associated Infections (HAIs)	34.000	34.000	34.000
Patient Safety Research Activities	**$66.584**	**$71.584**	**$72.614**

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 FYs 2013 and 2014 builds on past successes and focuses on the expansion of projects that have demonstrated impact in improving health care 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. This activity supported $6.1 million in new grants in 2013. The FY 2014 Enacted level provides $15.0 million in new research grant support.

FY 2015 President's Budget Policy: The FY 2015 President's Budget level provides $31.6 million for this activity, an increase of $1.0 million from the FY 2014 Enacted. A total of $15.0 million has been provided at this level to fund a new initiative in FY 2015 – *Extending Safety to Patients in All Settings*. (Additional information is provided below.) The remaining funds, $16.6 million, 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 $10.7 million. No new grant funding outside of the new initiative will be provided at the FY 2015 Request level. The program will invest approximately $5.9 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.

NEW - Extending Safety to Patients in All Settings: Fourteen years ago, the Institute of Medicine published a landmark study, *To Err Is Human*, estimating that as many as 98,000 patients each year die as a result of an inpatient hospital error. Subsequent research showed that many times more patients suffer a serious error. Since then, AHRQ has developed, piloted, and refined a robust portfolio of evidence and tools on ways to make inpatient care far safer, and has developed measures and data to track improvement. For example, with AHRQ support, Peter Pronovost and colleagues at Johns Hopkins University developed, piloted, tested, and refined a Comprehensive Unit-based Safety Program, including a checklist of evidence –based safety practices to reduce the incidence of central line-associated blood-stream infections. Widespread adoption and spread of this work through over 1,000 intensive care units has reduced the incidence of these by 41%. When the Department decided to launch a very ambitious multi-year Partnership for Patients to reduce the number of preventable inpatient errors by 40%, they turned to AHRQ for the measures, data, evidence and tools to make it happen. Early reports show considerable success.

Using Evidence and Innovation to Improve Performance

The new AHRQ Initiative aimed at extending patient safety improvements to all health care settings will support two associated activities in order to achieve its objective: (1) the application of existing evidence, and (2) the development of new evidence. Both of these linked activities will expand our understanding of threats to patient safety and produce new approaches that enable clinicians to protect patients from harm. More evidence is available and has been used to improve patient safety in hospitals. Drawing from past experience and success in generating hospital patient safety improvements, AHRQ's goal will be to identify, develop, and apply proven methods to keep patients safe in settings beyond the hospital.

But Americans experience harm in many settings, not just inpatient facilities. While inpatient care accounts for about 30% of all health care costs, in any given year only one in ten Americans has an inpatient stay. Patients can and do experience serious harm in many other settings - emergency departments, primary and specialty care clinics and practices, ambulatory surgery centers, observation units, nursing homes, assisted living facilities, and home care. Transitions from one of these settings to the next can provide even greater patient risk. Unfortunately, we have insufficient evidence on the full extent and nature of such harm, much less on how to prevent it. While it is critical that we continue our work to enhance inpatient safety, we also need to lay the foundation for similar improvements in other settings.

In 2015, AHRQ will launch a $15.0 million multi-year grant and contract initiative to build the evidence, strategies, and tools for reducing errors in all health care settings, moving step-wise out from hospital inpatient areas to other institutional settings and beyond, so that patients can expect safe care wherever they are. In so doing, we will also look to secure the critical transitions of care from one setting to another. Our experience to date suggests that a successful reduction of patient harm requires at least 6 things:

1. Development of strong evidence on what strategies can be successful
2. Creation of evidence-based tools to facilitate implementation of these strategies
3. Piloting, evaluation, testing, and refinement of these strategies and tools
4. Identification of enablers (e.g. aligned financial incentives, culture of safety, process redesign, strong IT systems)
5. Strong data and measures to track success
6. A strong, coordinated effort to bring about widespread successful use of the strategy

AHRQ's comparative advantage lies in the first five steps. AHRQ has a proven track record of mobilizing both researchers and innovators in the field, building and testing the evidence base and the implementation tools, and using credible data and measures to track performance. Our work on the inpatient side has enabled us to systematically identify, test, improve, and track what works best in providing safe care. We then partner with other entities (e.g. CMMI, QIOs, states, private payers) with the authority and leverage to bring about major implementation.

Over the next ten years, we will develop the evidence, data, measures, tools and strategies to bring safe care to all settings, starting in 2015 with a focus on two care sites, and then moving systematically through other sites. All work will include a focus on settings caring for underserved populations. Priority settings include:

- Primary care practices
- Specialty care practices
- Nursing homes
- Independent living and assisted living facilities
- Ambulatory surgery facilities
- Hospital outpatient departments
- Community mental health and substance abuse settings

- Home care
- Emergency departments
- Virtual care

In 2015 AHRQ will:

- Begin a five year investment in building evidence, strategies, data, measures and tools to improve safety in Primary Care Practices and Nursing Homes. These are settings with high patient use, high potential for harm, and potential to learn from our work in the inpatient arena. Patients often move from one of these settings to another, and efforts are underway to enhance linkages between these settings and inpatient care. Finally, these are areas that can build on some investments AHRQ already has made in the past few years. We expect to have early evidence, data and tools by the end of 2016.

- Continue to engage with national stakeholders and experts to prioritize work in the other settings. While the sequencing will depend in part on the product of this work, we anticipate prioritizing settings where: a) errors are most likely and most serious, b) data systems and strong measures already exist or can be built quickly, and c) preliminary evidence suggests that improvement strategies have a strong probability of success.

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. 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 has just released Common Formats for Surveillance—Hospital – which will eventually replace the Medicare Patient Safety Monitoring System (MPSMS), the surveillance system currently used in HHS to track the rate of adverse events nationally. Until now, Common Formats have been designed to support only traditional event reporting. Common Formats for Surveillance—Hospital are designed to provide, through retrospective review of medical records, information that is complementary to that derived from event reporting systems. These formats will facilitate improved detection of events as well as calculation of adverse event rates in populations reviewed. The National Quality Forum (NQF) is currently assisting in gathering and analyzing feedback on these new Common Formats. AHRQ is also developing Common Formats for health care settings beyond the acute care hospital. Finally, AHRQ continues to conduct compliance reviews authorized by the Patient Safety Act to ensure that PSOs are operating in

conformance with statute and regulations. AHRQ has funded the PSO program at $7.0 million in FYs 2013 and 2014.

FY 2015 President's Budget Policy: The FY 2015 President's Budget level provides $7.0 million for this activity, the same level of support as the FY 2014 Enacted 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 progress report for planning and demonstration grant results will be posted on the AHRQ website by Spring 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. The demonstration grants will end in June of 2014. Final data from the project will be compiled and analyzed and a comprehensive evaluation will be completed by late calendar 2014.

FY 2015 President's Budget Policy: The FY 2015 President's Budget level does not include funds for new projects in this area.

Healthcare-Associated Infections (HAIs) Research Activity: The Agency is working collaboratively with other HHS components to design and implement initiatives to reduce HAIs. In FY 2013, AHRQ continued to work in close collaboration with HHS partners including CDC, CMS, NIH, and the Office of the Assistant Secretary for Health. In FYs 2013 and 2014, AHRQ is building on past successes and extend these collaborative efforts to support a portfolio of grant- and contract-funded projects that will both buttress research to advance our knowledge about effective approaches for reducing HAIs and at the same time promote the implementation of proven methods for preventing HAIs. In FY 2013 and FY 2014, AHRQ's HAI budget of $34.0 million is supporting HAI-related grants in the amount of $15.0 million in FY 2013 and $9.9 million in FY 2014, 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. AHRQ's CUSP implementation projects are also 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.

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 2014 Level: $16.6 million
FY 2015 Level: $ 8.9 million
Change: -$ 7.7 million (Decrease due to CUSP for CAUTI/SSI completed in 2015)

The Keystone Project, which first deployed the Comprehensive Unit-based Safety Program (CUSP) in more than 100 Michigan intensive care units (ICUs), reduced the rate of central line-related blood stream infections by two-thirds within 3 months, and within 18 months, the Project saved more than 1,500 lives and nearly $200 million. The CUSP approach involves 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 2011, AHRQ funded further expansion of CUSP to prevent CLABSI to nationwide coverage. The over 1,000 ICUs that implemented CUSP reduced the rate of CLABSI by more than 41 percent in 18 months, thereby preventing over 2,100 CLABSIs, saving more than 500 lives, and averting over $36 million in excess costs.

In FY 2011, AHRQ initiated the nationwide implementation of CUSP for CAUTI in hospitals. In FY 2012, AHRQ continued to expand application of the CUSP approach to reduce Surgical Site Infections in inpatient and ambulatory settings. In FY 2013, AHRQ continued the national implementation of CUSP for CAUTI in inpatient settings and initiated a parallel initiative for long-term care settings, and also expanded a pilot project of CUSP for VAP to initial nationwide implementation. In FY 2014, AHRQ plans to support the continued implementation of the aforementioned projects. In FY 2015, CUSP for CAUTI and CUSP for SSI in the hospital setting will have been completed; AHRQ will continue the projects of CUSP for SSI/Safe Surgery in the ambulatory setting, for CAUTI in long-term care, and for VAP in hospitals. The following summarizes planned funding in FY 2015 to address these important program objectives.

	CUSP Total	CAUTI-LTC	Safe Surgery-Amb	VAP
FY 2015	**$8.9 M**	3.9 M	2.5 M	2.5 M

FY 2015 President's Budget Policy: The FY 2015 President's Budget level provides $34.0 million for this activity, the same level of support as the FY 2014 Enacted level. These funds will continue to advance the generation of new knowledge and promote the application of proven methods for preventing HAIs. The investments to be made will include $13.9 million in HAI research grants and $20.1 million in HAI contracts. The grants will support the development of new knowledge about improved methods for preventing and reducing HAIs. Of the contract amount, $8.9 million will support the ongoing extension of the nationwide implementation of CUSP (see Program Portrait) both to reduce additional HAIs and to address additional settings. CUSP projects include: $3.9 million for CUSP for CAUTI in long term care facilities, $2.5 million to prevent surgical site infections (SSIs) and other surgical complications in ambulatory surgical settings, and $2.5 million to continue the expansion of CUSP for ventilator-associated pneumonia (VAP) from a field test in FY 2012/2013 to full 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, AHRQ's CUSP for CAUTI project in hospitals is making a major contribution to attaining the HHS Agency Priority Goal, which aims to reduce the CAUTI Standardized Infection Ratio (observed CAUTI divided by expected CAUTI) by 10% by 2015. AHRQ is collaborating closely with CMS, CDC, and OASH in this concerted effort to reduce CAUTI. Over 1,000 hospital units are already participating in the CUSP for CAUTI project, and additional units are being enrolled in this project, which runs until August 2015. The reduction in CAUTI rates that the project aims to achieve will help reduce CAUTI nationwide, which will contribute to reaching the agency priority goal.

C. Mechanism Table

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

	FY 2013 Actual		FY 2014 Enacted		FY 2015 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	48	16,707	37	12,236	59	18,750
New & Competing……	26	10,281	56	18,050	32	13,490
Supplemental	0	0	0	0		
TOTAL, RESEARCH GRANTS	**74**	**26,988**	**93**	**30,286**	**91**	**32,240**
TOTAL CONTRACTS/IAAs		**39,596**		**41,298**		40,374
TOTAL		**66,584**		**71,584**		**72,614**

D. Funding History

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

Year	Dollars
2010	$90,585,000
2011	$65,585,000
2012	$65,585,000
2013	$66,584,000
2014	$71,584,000

Health Services Research, Data and Dissemination

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 Request +/- FY 2014 Enacted
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 111,072,000	$ 111,072,000	$ 93,209,000	-$17,863,000

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

A. Portfolio Overview

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

B. FY 2015 Justification by Activity

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

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Health Services Research Grants	$54.305	$53.489	$46.905
(Investigator-Initiated)	*(46.698)*	*(45.882)*	*(40.000)*
Health Services Contract/IAA Research	$22.972	$23.788	$16.687
Measurement and Data Collection	$15.665	$15.665	$17.054
Dissemination and Translation	$18.130	$18.130	$12.563
Total, Crosscutting Activities	**$111.072**	**$111.072**	**$93.209**

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, appropriateness of health care services. Investigator-initiated research is particularly important. New

investigator-initiated research and training grants are essential to health services research – they ensure that an adequate number of both new ideas and new investigators are created each year. Investigator-initiated research grants allow extramural researchers to pursue the various research avenues that lead to successful yet unexpected discoveries. In this light, the investigator-initiated grant is seen as the most vital force driving health services research in this country. The FY 2013 level provided $54.3 million for Health Services Research Grants, with $46.7 million supporting investigator-initiated research. Support for new research grants totaled $20.0 million with the entirety directed to 70 investigator-initiated research projects. The FY 2014 Enacted level provides $53.5 million Health Services Research Grants. Support for non-competing research grants totals $28.2 million and support for new research grants is $25.3 million. The new research grant funding is directed to an estimated 103 investigator-initiated research projects.

FY 2015 President's Budget Policy: The FY 2015 President's Budget provides $46.9 million for this activity, a decrease of $6.6 million from the FY 2014 Enacted level. The FY 2015 President's Budget level would provide a total (noncompeting and new) support of $40.0 million in investigator-initiated grants, a decrease of $5.9 million from the FY 2014 Enacted level. Support for non-competing research grants totals $26.8 million, a decrease of $1.4 million from the FY 2014 level. Support for new research grants is approximately $20.1 million, a decrease of $5.2 million from the FY 2014 level. The new research grant funding is all directed to an estimated 70 investigator-initiated research projects. Within the $20.1 million for new investigator-initiated research grants, $15.0 million will support a new initiative focusing on health economics research. AHRQ is anticipating grant proposals focused on increasing the efficiency, effectiveness, and value of the health care system. These grants could improve our understanding of the causes and consequences of lack of insurance and of the effects of health insurance expansion on access to care, utilization of health care, health care spending, health outcomes, and the labor market. This new initiative is in support of AHRQ's new mission and priorities.

Health Services Contract/IAA Research: Health Services Contract/IAA Research Activities support health services research activities that impact quality, affordability, effectiveness and efficiency of health care. In FY 2013 AHRQ provided $23.0 million for this activity. This level of funding is increased slightly to $23.8 million in FY 2014. Included in Other Health Services Research is contract support for health services research activities, including support of rapid cycle research contract mechanisms to accelerate the diffusion of results into practice. AHRQ uses a variety of networks to accomplish this research. Each network has a different focus.

- Accelerating Change and Transformation in Organizations and Networks (ACTION) - ACTION is a model of field-based research designed to promote innovation in health care delivery by accelerating the diffusion of research into practice. The ACTION II network includes 17 large partnerships and more than 350 collaborating organizations that provide health care to an estimated 50 percent of the U.S. population.

- Primary Care Practice-Based Research Networks (PBRNs) – PBRNs are groups of primary care clinicians and practices working together to answer community-based health care questions and translate findings into practice. PBRNs engage clinicians in quality improvement activities and evidence–based culture in primary care practice to improve the health of all Americans.

- Evidence-based Practice Centers (EPCs) – EPCs review all relevant scientific literature on clinical, behavioral, and organization and financing topics to produce evidence reports

and technology assessments. These reports are used for informing and developing coverage decisions, quality measures, educational materials and tools, guidelines, and research agendas. The EPCs also conduct research on methodology of systematic review.

In addition to rapid cycle research, in FY 2013 and FY 2014, funding was provided to a variety of contracts that support administrative activities that are related to research including support for grant review, ethics reviews, data management, data security and research evaluation activities.

FY 2015 President's Budget Policy: The FY 2015 President's Budget level provides $16.7 million for this activity, a decrease of $7.1 million from the FY 2014 Enacted level. These funds will allow for AHRQ to continue support for contracts and IAAs related health services research, including work related to quality, affordability, effectiveness, efficiency and value of health care system. AHRQ also anticipates funding new contracts related to AHRQ's proposed fourth priority to improve health care affordability, efficiency, and cost transparency. At the FY 2015 President's Budget level some areas of research contract support will be reduced including rapid cycle research, evaluation activities, data management and events management.

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 FYs 2013 and 2014 AHRQ is supporting 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 2015 President's Budget Policy: The FY 2015 President's Budget level provides $17.1 million for this activity, an increase of $1.5 million from the FY 2014 Enacted level. The entirety of the increase is related to the move of MONAHRQ® from the Value portfolio to this activity. MONAHRQ® is a desktop software tool that enables organizations - such as state and local data organizations, regional reporting collaboratives, hospitals and hospital systems, and health plans - to quickly and easily generate a health care reporting Website. Our continued support of MONAHRQ is important given its direct link to both Departmental and ACA priorities. Public reporting to help consumers choose safer and higher quality providers has been a major strategy for the Department, and the ACA has heightened the importance of this strategy.

Dissemination and Translation: AHRQ's dissemination and implementation activities foster the use of Agency-funded research, products, and tools to achieve measurable improvements in the health care services patients receive. AHRQ research, products, and tools are used by a wide range of audiences, including individual clinicians; hospitals, health systems, and other providers; patients and families; payers, purchasers, and health plans; and Federal, state, and local policymakers. AHRQ's dissemination and implementation activities are based on assessments of these audiences' needs and how best to foster use of Agency products and

tools, plus sustained work with key stakeholders to develop ongoing dissemination partnerships. In addition, AHRQ sponsors knowledge transfer activities designed to assist users through learning networks and tailored, hands-on technical assistance.

Support for Dissemination and Translation activities was $18.1 million in FY 2013 and 2014. These funds supported critical dissemination and implementation activities, including the development and distribution of materials to assist consumers and patients in shared decision making with their clinicians; adoption of tools to enhance delivery systems and reduce health care-associated infections, such as AHRQ's Comprehensive Unit-based Safety (CUSP) Program; support for learning networks for state Medicaid Medical Directors and others; assistance to providers to use findings from AHRQ's Evidence-based Practice Program; support of 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 will be used to maintain AHRQ's electronic dissemination activities and website.

FY 2015 President's Budget Policy: The FY 2015 President's Budget level provides $12.6 million for this activity, a decrease of $5.6 million from the FY 2014 Enacted 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 2015. As a result, we will maintain support for the AHRQ projects funded in FY 2014, 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). In addition, these funds will continue support of the National Quality Measures Clearinghouse (NQMC) and companion National Guideline Clearinghouse (NGC). Additional information on these clearinghouses is provided on the following page.

Program Portrait: National Guideline Clearinghouse/National Quality Measures Clearinghouse

FY 2014 Level: $4.3 million
FY 2015 Level: $4.3 million
Change: $0.0 million

The National Guideline Clearinghouse™ (NGC) and the National Quality Measures Clearinghouse™ (NQMC) are databases containing structured summaries of public and private sector evidence-based clinical practice guidelines and health care quality measures, respectively, and made freely available on the Web at www.guideline.gov and www.qualitymeasures.ahrq.gov. The content of both resources are used by clinicians, guideline or quality measure developers, health plans, hospitals and health systems, state and federal agencies, policymakers, researchers, and others to help inform decisions about and improve the quality of patient care.

Approximately 500,000 users visit NGC and NQMC each month searching over 4,000 guidelines and measures to find those of interest.

Available to the public since January 1999, an independent evaluation of NGC in 2011 found NGC to be the 'go to place' to find clinical practice guidelines making it a flagship tool supporting health care decision making. The evidence-based clinical practice guidelines in NGC meet criteria that were established at the outset of the project, in FY 1997. In FY 2013, NGC revised its inclusion criteria for evidence as the result of the 2011 Institute of Medicine's (IOM) "Clinical Practice Guidelines We Can Trust" report, thereby raising the bar for inclusion. Also, the guidelines that address patients with Multiple Chronic Conditions (MCC) will be made easily identifiable for users.

In FY 2001, wanting to leverage its technical investments in NGC and offer a robust resource for finding health care quality measures, AHRQ added the companion resource, NQMC. Available to the public since January 2003, NQMC includes measures and measure sets that meet criteria and a framework which have evolved over time as the field of health care quality measurement has evolved. NGC and NQMC show connections between guidelines and measures, when possible.

In FY 2014, NGC and NQMC continued to create new and updated summaries of guidelines and measures, respectively, keeping the content up-to-date. FY 2015 funds will continue this work.

Also, in FY 2014, NGC began implementing its revised criteria for guideline inclusion and started work to designate for each guideline its adherence to the IOM standards of guideline trustworthiness, using a phased approach; the intent of this work is to facilitate identification of trustworthy guidelines as recommended by the IOM. FY 2015 funds will continue to support this phased implementation effort.

In addition, in FY 2014, NQMC began exploring how to modify the NQMC inclusion criterion regarding evidence to align with NGC's revised evidence criterion. FY 2015 funds will support finalizing revised NQMC criteria, thereby raising the bar for inclusion, and starting the implementation of those criteria, using a phased approach.

C. Mechanism Table

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

	FY 2013 Actual		FY 2014 Enacted		FY 2015 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	106	34,259	91	28,230	82	26,824
New & Competing……	70	20,046	103	25,259	70	20,081
Supplemental	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	**176**	**54,305**	**194**	**53,489**	**152**	**46,905**
TOTAL CONTRACTS/IAAs	0	**56,767**		**57,583**		46,304
TOTAL		**111,072**		**111,072**		**93,209**

D. Funding History

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

Year	Dollars
2010	$111,789,000
2011	$111,789,000
2012	$108,377,000
2013	$111,072,000
2014	$111,072,000

Health Information Technology

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 Request +/- FY 2014 Enacted
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 25,572,000	$ 29,572,000	$ 23,465,000	-$6,107,000

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

A. Portfolio Overview

The 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 and disseminates that evidence. By building and synthesizing the evidence-base, 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 healthcare quality, whereas ONC is responsible for implementation of the HITECH Act and for cross-Departmental coordination of health IT implementation 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 healthcare stakeholders and policymakers.

B. FY 2015 Justification by Activity Detail

Health Information Technology Research Activities
(in millions of dollars)

	FY 2013 Final	FY 2014 Enacted Level	FY 2015 President's Budget
Research Grants on Utilizing Health IT to Improve Quality	$19.472	$23.976	$19.976
Synthesizing and Disseminating Evidence on the Meaningful Use of Health IT	$3.489	$3.489	$3.489
Developing Resources and Tools for Policymakers and Health Care Stakeholders	$2.611	$2.107	$0.000
Health IT Research Activities	**$25.572**	**$29.572**	**$23.465**

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 2010, Congress halted new research investments through the portfolio's appropriations in recognition of a large, one-time research investment made possible through ARRA. In FY 2011, AHRQ finalized a multiyear research initiative focused on quality improvement in primary care that addressed medication management, patient-centered care, and clinical decision support. In 2013 and 2014, AHRQ is building the foundational evidence necessary to successfully leverage the significant investment in health IT to improve the quality, safety, effectiveness, and efficiency of US health care through support of new research grants. In addition, in FY 2014 AHRQ will fund several new research projects that aim to fill gaps in our knowledge about the safety of health IT tools, systems and practices, and to address recommendations from the Institute of Medicine.

FY 2015 President's Budget Policy: The FY 2015 President's Budget level provides $20.0 million for this activity, $4.0 million less than the FY 2014 Enacted level. Included in this level is $1.7 million to support 4 new investigator-initiated grants in FY 2015. The FY 2015 Request level proposes allocating 85 percent of total portfolio funds to research grants. This budget reflects AHRQ's commitment to funding foundational health information technology research. This portfolio's grant investments have a history of conducting innovative and ground breaking research which presently informs and supports Meaningful Use, and will lead to future National achievements. Notable achievements include the first State and regional demonstrations for health information exchange in 2004 and pioneering clinical decision support projects in 2008.

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 synthesized and developed through its NRC are fed to HealthIT.gov, which supports the Administration's health IT initiatives. FY 2014 funding was directed to supporting the National Resource Center and demonstrations of scalable clinical decision support.

FY 2015 President's Budget Policy: The FY 2015 President's Budget level provides $3.5 million for this activity, the same as the FY 2014 Enacted level. FY 2015 funding will continue to focus on synthesis and dissemination through AHRQ's National Resource Center and evidence synthesis through AHRQ's Evidence Based Practice Center program.

---

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: Health IT Hazard Manager

In 2010 AHRQ's Health IT Portfolio began development of a tool that health care providers could use to prospectively identify, categorize, track and ameliorate health IT related hazards. Health IT hazard control is especially complex because even modest-sized care delivery organizations (CDOs) typically use many software applications from different vendors, make hundreds of configuration decisions for many applications, develop interfaces between many pairs of applications, and may develop custom code for some applications. The complexity of health IT—and of the other health care systems with which it interacts—requires that IT vendors and CDOs identify and control thousands of hazards throughout the health IT life cycle, from design and implementation through maintenance and upgrading.

Because most, if not all, CDOs rarely disclose information about health IT related hazards, there is a large gap in the understanding of how these hazards are discovered, what caused them, and how they were mitigated. The Hazard Manager was centered on a common vocabulary and framework so the reported information to vendors and other CDOs potentially using similar vendor products is standardized. For the purpose of this project, a Patient Safety Organization (PSO) hosted the Hazard Manager software, and CDOs participating in the beta test submitted detailed reports about the types of hazards discovered (real and potential) as well as the characteristics surrounding hazards (vendor, type of product, harm potential), and plans for hazard correction. These reports were then aggregated based on attribute types and shared with vendors and other CDOs.

The Health IT Hazard Manager is currently used by PSOs focused on health IT, and is identified as a leading innovation by the Federal Health IT Patient Safety Action and Surveillance Plan. AHRQ is currently further distributing the Hazard Manager to additional PSOs so they can collect health IT related hazard data and share this aggregated information with AHRQ in addition to the Common Formats. Ultimately, this should shed more light on when and how a health IT hazard was identified, what might have been a catalyst for a particular hazard, whether it impacted patient care, and how it was resolved.

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. Resources in FY 2014 will support limited evaluation and refinement of current tools.

FY 2015 President's Budget Policy: The FY 2015 President's Budget level does not provide funding for this activity.

C. Mechanism Table

Health Information Technology Portfolio
(Dollars in Thousands)

	FY 2013 Actual		FY 2014 Enacted		FY 2015 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	39	11,687	36	14,368	45	18,298
New & Competing……	27	7,785	24	9,608	4	1,678
Supplemental.....	0	0	0	0		
TOTAL, RESEARCH GRANTS....	**66**	**19,472**	**60**	**23,976**	**49**	**19,976**
TOTAL CONTRACTS/IAAs.....		**6,100**		**5,596**		3,489
TOTAL.....		**25,572**		**29,572**	**49**	**23,465**

D. Funding History

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

Year	Dollars
2010	$27,645,000
2011	$27,645,000
2012	$25,572,000
2013	$25,572,000
2014	$29,572,000

Prevention/Care Management

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 Request +/- FY 2014 Enacted
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 19,282,000	$ 15,904,000	$ 11,300,000	-$4,604,000
--Prev. & Public Hlth Fund	$ 6,465,000	$ 7,000,000	$ -	-$7,000,000
Total Program Level	$ 25,747,000	$ 22,904,000	$ 11,300,000	-$11,604,000

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

A. Portfolio Overview

In FY 2015, AHRQ is planning a restructuring of its support for primary care research so that it will meet the requirement set out in the Agency's authorization which requires AHRQ to "serve as the principal source of funding for primary care practice research in the Department of Health and Human Services" and also provides the most return for limited funds. In FY 2015, AHRQ will end its support for "Research Grants to Improve Clinical Outcomes in Primary Care" and "Implementation Activities to Improve Primary Care". As a result of these changes, beginning in 2015, the Prevention/Care Management portfolio will include funding only to support the U.S. Preventive Services Task Force, and in 2016, the portfolio name will be changed to "Ongoing Scientific, Administrative and Dissemination Support of the U.S. Preventive Services Task Force."

B. FY 2015 Justification by Activity Detail

Prevention/Care Management Activities
(in millions of dollars)

Research Activities	FY 2013 Final	FY 2014 Enacted Level	FY 2015 President's Budget
Research Grants to Improve Clinical Outcomes in Primary Care	$9.947	5.385	$0.000
Clinical Decision-making for Preventive Services *Prevention and Public Health Fund (non-add)* *USPSTF Support (non-add)*	11.500 *6.465* *11.500*	11.300 *7.000* *11.300*	11.300 *0.000* *11.300*
Implementation Activities to Improve Primary Care	4.300	6.219	0.000
Total, Prevention/Care Management	**$25.747**	**$22.904**	**$11.300**
Prevention and Public Health Fund (non-add)	***$6.465***	***$7.000***	***$0***

Overall Budget Policy:

Research Grants to Improve Clinical Outcomes in Primary Care: 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 2013 Operating Level included $5.9 million in non-competing grants, including three Centers for Excellence in Clinical Preventive Services. In FY 2013, AHRQ funded $4.3 million in new grants and rapid cycle research grants. These grants study the economic impact of primary care practice transformation to new models of care such as the Patient-Centered Medical Home, evaluate tools on self management support developed for primary care clinicians, and will evaluate possible Stage 3 meaningful use objectives in primary care practices for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Funding in FY 2014 totals $5.4 million for this activity with approximately $1.3 million in continuing grants and $4.1 million in new grants. All new grants in FY 2014 will be one year investments. The grants will focus on the development of methods to enhance the study of people with multiple chronic conditions (MCC), and on understanding how to optimize the health of people with MCC using existing data sets.

FY 2015 President's Budget Policy: The FY 2015 President's Budget level does not include funding for this activity. Please note that AHRQ can still support investigator-initiated research in these topic areas within our Health Services Research, Data and Dissemination portfolio.

Clinical Decision-making for Preventive Services: AHRQ is Congressionally mandated to convene and provide scientific, administrative and dissemination 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 2013 Operating Level included $11.5 to support the USPSTF which includes $6.5 million from the Prevention and Public Health Fund. AHRQ will continue to provide ongoing support to the USPSTF by investing in: systematic evidence reviews and decision analysis studies, public engagement; transparency; communication; dissemination including website development; and, logistics support. AHRQ also invested in ways to enhance the implementation and use of USPSTF recommendations by developing continuing education modules based on USPSTF recommendations. In FY 2014, this funding level includes $4.3 million in PHS Evaluation Funds and $7.0 million in Prevention and Public Health Funds to provide ongoing support to the USPSTF.

FY 2015 President's Budget Policy: The FY 2015 President's Budget level provides $11.3 million for this activity, the same level of support as the FY 2014 Enacted, but all in PHS Evaluation funding. With these funds AHRQ will continue to provide ongoing support to the USPSTF by investing in: systematic evidence reviews and decision analysis studies, public engagement; transparency; communication; dissemination including website development; and, logistics support.

Program Portrait: **The U.S. Preventive Services Task Force**

FY 2014: $11.3 million
FY 2015: $11.3 million
Change: $ 0.000

"It is a fact that many medical interventions can cause both harm and benefit. It is only through understanding these interventions that we can hope to maximize benefit and minimize the harm. There is tremendous value in having a group with scientific expertise and no emotional or financial conflict of interest review the scientific data and make recommendations. The U.S. Preventive Services Task Force has set the bar high in being reasonable, courageous, and logical in its work."

Otis Webb Brawley, MD
Chief Medical Officer and Executive V.P.
American Cancer Society

The US Preventive Services Task Force is an independent, volunteer panel of national experts in prevention and evidence-based medicine whose mission is to improve the health of all Americans by making evidence-based recommendations about the effectiveness of clinical preventive services and health promotion. Since 1998, AHRQ has been authorized by Congress to provide ongoing scientific, administrative and dissemination support to assist the USPSTF in meeting its mission. AHRQ, the sole funding source of the Task Force, has invested significantly in ensuring that the USPSTF has the evidence it needs in order to make its recommendations. In FY 2012 and again in FY 2013, AHRQ commissioned 15 systematic evidence reviews on topics prioritized by the USPSTF which will lead to updated and new recommendations in the years to come.

Since 2010, with additional support from the Prevention and Public Health Fund, AHRQ has supported the USPSTF in expanding its efforts to engage stakeholders and the public in every step of its recommendation-making process to ensure that its approach is open, credible, independent and unbiased. The public, including scientists, health professionals, business and industry, health advocates, families and individuals, can:

- Nominate new members to serve on the Task Force
- Nominate new topics for Task Force consideration or share evidence about an existing topic
- Provide comments on all draft research plans
- Provide comments on draft evidence reports
- Provide comments on all draft recommendation statements.

The Task Force with support from AHRQ produced a series of materials explaining its mission, composition, and process, including an introductory slide show "USPSTF 101" and two short videos. These materials complement the comprehensive USPSTF procedure manual that remains available to the public on the USPSTF website. As one activity in its ongoing efforts to help primary care clinicians learn about its recommendations and put them into practice, AHRQ helped the USPSTF partner with Medscape/WebMD to produce and distribute a 30-minute, free, continuing education video.

Finally, AHRQ provides the USPSTF with dissemination support which enables it to produce plain language fact sheets for all of its draft and final recommendations, designed to help Americans understand what each recommendation means for them. These fact sheets highlight that evidence-based recommendation are only one part of informed decision making and encourage people to consider the Task Force recommendation within the context of their own health status, their own values and preferences for health and health care, and alongside advice from a trusted health care professional. The fact sheets contain links to resources for learning more about each topic and encourage people to have informed discussions about clinical preventive

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. The investments made in FY 2013 target initiatives to enhance quality in primary care, with a focus on tools and resources to support primary care transformation and redesign. Specific investments include advancing the development of practice facilitation as a quality improvement strategy, building on AHRQ's earlier work catalyzing state-level primary care improvement coalitions. Investments also provide ongoing support for research, measurement and dissemination in areas of primary care redesign. In FY 2014, AHRQ will expand its work on integrating behavioral health into primary care, and understanding how new models of primary care affect the delivery of services, the primary care workforce and the financing of primary care. AHRQ also will continue to support the development of a national survey to collect data on the receipt of appropriate clinical preventive services among adults.

FY 2015 President's Budget Policy: The FY 2015 President's Budget level does not include funding for this activity. Please note that the AHRQ can still support investigator-initiated research in these topic areas within its Health Services Research, Data and Dissemination portfolio.

C. Mechanism Tables for Prevention/Care Management

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

	FY 2013 Actual		FY 2014 Enacted		FY 2015 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	9	5,897	7	1,325	0	0
New & Competing……	23	4,364	14	4,063	0	0
Supplemental.....	0	0	0	0	0	
TOTAL, RESEARCH GRANTS....	**32**	**10,261**	**21**	**5,388**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**9,021**		**10,516**		11,300
TOTAL.....		**19,282**		**15,904**	**0**	**11,300**

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

	FY 2013 Actual		FY 2014 Enacted		FY 2015 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS....	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**6,465**		**7,000**		**0**
RESEARCH MANAGEMENT……		**0**		**0**		**0**
TOTAL.....		**6,465**		**7,000**	**0**	**0**

D. Funding History

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

Year	Dollars
2010	$15,904,000
2011	$27,904,000
2012	$27,904,000
2013	$25,747,000
2014	$22,904,000

Value

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 Request +/- FY 2014 Enacted
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 3,730,000	$ 3,252,000	$ -	-$3,252,000

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

A. Portfolio Overview

The 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. 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.

Although the mission of the Value Research portfolio is valuable, AHRQ will be able to support investigator-initiated research in these topic areas within our Health Services Research, Data and Dissemination portfolio, so is no longer funding this portfolio in FY 2015.

B. FY 2015 Justification by Activity Detail

Value Research Activities
(in millions of dollars)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Value Research	**$3.730**	**$3.252**	**$0.000**

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, AHRQ has 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 2013, eight states (AZ, HI, IN, KY, ME, NV, UT, VA) had launched Web sites using the tool, and by FY 2014, two additional states (OK, WA) have launched sites, with others preparing for use of the tool. The most recent release of MONAHRQ 4.1 added a path for ED data so that states can now generate reports on ED utilization, including ED visits that result in admission to the hospital. It also includes additional Hospital Compare measures, and raises the visibility of cost-related reports for consumers and others using the site. 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 2013, we disseminated to our stakeholders evidence and strategies through more than 20 venues (webinars, workshops, etc.). This included, for example, a series of webinars on alternative approaches to measuring costs as well as virtual forums on interventions to reduce readmissions and selecting and reporting measures for “shoppable” procedures (e.g., knee or hip replacement). These and other topics provided the core curriculum for various Learning Networks and achieve wide visibility across the country with health plans, employers, providers, consumers, and others seeking major improvements in value. 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. One particularly strong partnership has been with a Learning Network of 24 community quality collaboratives, known as Chartered Value Exchanges (CVEs). The CVEs have taken research findings on public reporting and implemented them in their public reports of hospital and physician practices across their respective communities and entire States. In FY 2013, we continued to disseminate through the Learning Network new research on public reporting that CVEs can implement in their public reports. We will conclude our support of the CVEs and related value work in FY 2014, and in FY 2015 we will re-invest these funds in other AHRQ priorities.

FY 2015 President’s Budget Policy: The FY 2015 President’s Budget eliminates support for this portfolio, a decrease of $3.3 million from the FY 2014 Enacted level. Although the mission of the Value Research portfolio is valuable, AHRQ will support value research elsewhere, and therefore does not require a separate portfolio area. A total of $1.5 million from this portfolio currently supports MONAHRQ. AHRQ proposes moving MONAHRQ to the data and measurement activities within Health Services Research, Data and Dissemination portfolio. Our continued

support of MONAHRQ is important given its direct link to both Departmental and ACA priorities. Public reporting to help consumers choose safer and higher quality providers has been a major strategy for the Department, and the ACA has heightened the importance of this strategy. States are major actors in public reporting, and certainly major agents for implementing the ACA. MONAHRQ is a free software product that enables states to quickly and easily generate a free, evidence-based public reporting web site. Ten states are already relying on MONAHRQ, and other states are planning to follow suit. AHRQ, in close consultation with CMS, current and potential state MONAHRQ hosts, and end users, will accelerate the evolution of MONAHRQ to incorporate more best practices in public reporting and to include data on new settings of care.

C. Mechanism Table for the Value Portfolio

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

	FY 2013 Actual		FY 2014 Enacted		FY 2015 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....	0	0	0	0	0	
TOTAL, RESEARCH GRANTS....	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**3,730**		**3,252**		0
TOTAL.....		**3,730**		**3,252**	**0**	**0**

D. Funding History

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

Year	Dollars
2010	$3,730,000
2011	$3,730,000
2012	$3,730,000
2013	$3,730,000
2014	$3,252,000

Patient-Centered Health Research/Effective Health Care

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 Request +/- FY 2014 Enacted
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 10,000,000	$ -	$ -	$0
--PCORTF Transfer	$ 57,701,415	$ 92,800,000	$ 105,600,000	+$12,800,000
Total Program Level	$ 67,701,415	$ 92,800,000	$ 105,600,000	+$12,800,000

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

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

A. Portfolio Overview

The Patient-Centered Health Research/Effective Health Care portfolio was initially developed to conduct and support patient-centered health research in response to Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. 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 and synthesized from research studies that critically assess the effectiveness of drugs, medical devices, tests, surgeries, or ways to deliver health care and their impact on patient health outcomes. As of FY 2013, this portfolio is now funded only through the Patient-Centered Outcomes Research Trust Fund (PCORTF) – a mandatory trust fund established through the Affordable Care Act to build research capacity and to translate and disseminate comparative clinical effectiveness research.

B. FY 2015 Justification by Activity Detail

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

Research Activity	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget Level
Patient-Centered Health Research: PHS Evaluation Funds	$10.000	$0.000	$0.000
PCORTF Allocation (Mandatory Funds)	57.701	92.800	105.600
TOTAL Program Level, PCHR	**$67.701**	**$92.800**	**$105.600**

Overall Budget Policy:

As of the FY 2013, AHRQ no longer provides any PHS Evaluation funds to support Patient-Centered Health Research. AHRQ support of patient-centered outcomes research (PCOR) is now funded only through the Patient-Centered Outcomes Research Trust Fund (PCORTF) – a mandatory trust fund established through the Affordable Care Act to build research capacity and to translate and disseminate comparative clinical effectiveness research.

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

Please see the tab at the end of the Congressional Justification for additional information.

C. Mechanism Table for Patient-Centered Health Research

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

	FY 2013 Actual		FY 2014 Enacted		FY 2015 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	12	3,834	0	0	0	0
New & Competing……	6	3,924	0	0	0	0
Supplemental	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	**18**	**7,758**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs		**2,242**		**0**		0
TOTAL		**10,000**		**0**	**0**	**0**

D. Funding History

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

Year	Dollars
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	$ 24,001,473
2013	$ 10,000,000
2013 ACA PCORTF Transfer	$ 57,701,415
2014	$ 0
2014 ACA PCORTF Transfer	$ 92,800,000

Key Performance Measures for HCQO by Portfolio

Portfolio: Patient Safety.

Measure	*Most Recent Result*	*FY 2014 Target*	*FY 2015 Target*	*FY 2015 +/- FY 2014*
1.3.38: Increase the number of users of research using AHRQ-supported research tools to improve patient safety culture *(Output)*	FY 2013: 1627 users of research (Target Exceeded)	1350 users of research	1750 users of research	+400
1.3.39: Increase the number of patient safety events (e.g. medical errors) reported by Patient Safety Organizations (PSOs) to the Network of Patient Safety Databases (NPSD). (Output)	FY 2013: 20 Data Use Agreements (DUAs) between PSOs and the PSO Privacy Protection Center (PSO PPC) (Target Met)	25 DUAs between PSOs and the PSO PPC	25,000 patient safety event reports transmitted by the PSO PPC to the NPSD	N/A
1.3.41: Increase the cumulative number of tools, evidence-based information, and products available in AHRQ's inventory of tools to improve patient safety and reduce the risk of patient harm. *(Output)*	FY 2013: 117 tools (Target Exceeded)	116 tools	130 tools	+14
1.3.59: Reduce the rate of CAUTI cases *(Outcome)*	FY 2013: 1.) 2.55 CAUTI cases per 1,000 catheter days 2.) 7.97 CAUTI cases per 10,000 patient days (2013 Baselines) (Target Met)	10% reduction in rates of CAUTI from 2014 baselines	15% reduction in rates of CAUTI from 2015 baselines	–5%

AHRQ's Patient Safety Portfolio seeks to prevent, mitigate, and decrease the number of medical errors, patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients. In addition, the portfolio supports research and activities focused on the measurement and reporting of adverse events and surveillance in order to better understand risks to patients so that harm can be prevented. AHRQ provides tools and products used by providers and organizations to implement safety initiatives. The Patient Safety Portfolio disseminates useful tools, evidence-based information, and products to inform multiple stakeholders implement initiatives to enhance patient safety and quality. AHRQ's Patient Safety

Portfolio 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.

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

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

As an indicator of the number of users of research using AHRQ-supported tools to improve patient safety, the agency relies in part on the Hospital Survey of Patient Safety (HSOPS). Some organizations that use the survey voluntarily submit their data to a comparative database for aggregation. In FY 2013, there were over 1,627 users of research, including 653 hospitals, 934 medical offices, and 40 nursing homes. In addition, AHRQ also supports surveys for nursing homes and ambulatory outpatient medical offices. Finally, interest in other AHRQ tools and resources has also remained strong, based on for example, on-going participation in webinars describing resources, electronic downloads, and orders placed for various products. AHRQ anticipates that the number of hospitals and other healthcare providers submitting data in the next fiscal years will be greater than the number of users of research submitting data in FY 2013.

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

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

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

may include identifying events, patterns of care, and unsafe conditions that increase risks and hazards to patients.

The Patient Safety Act authorizes AHRQ to facilitate the development of the Network of Patient Safety Databases (NPSD) to which PSOs can voluntarily contribute "non-identifiable" PSWP, i.e., cannot be attributed to a specific institutional or individual provider, patient, or reporter. As data become available from PSOs, the NPSD will receive, analyze, and report on de-identified and aggregated patient safety event information. The NPSD will employ common definitions and reporting formats (Common Formats) that allow healthcare providers to collect and submit standardized information to PSOs regarding patient safety events. AHRQ will use data collected from the NPSD to analyze national and regional quality and patient safety event statistics, including trends and patterns. The NPSD will facilitate the aggregation of sufficient volumes of patient safety event data to identify more rapidly the causes of risks and hazards associated with the delivery of healthcare services. The Patient Safety Act directs AHRQ to make the findings public through incorporation of non-identifiable data from the NPSD in its annual *National Healthcare Quality Report (NHQR*).

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

The PSO PPC works with PSOs on submission of de-identified patient safety event information. In order to submit reports, a PSO must first have a data use agreement (DUA) with the PSO PPC. Once a DUA is established, the PSO PPC works with the PSO on data submission and de-identification. By the end of FY 2013, 20 out of 76 listed PSOs had established DUAs with the PSO PPC.

While these DUAs grew in number in FY 2013, and some data were transmitted to the PSO PPC, none have been of sufficient quality and volume to ensure that data transmitted to the NPSD is both accurate and non-identifiable. In FY 2014, AHRQ expects a significant increase in volume of data submission to the PSO PPC and a concomitant increase in the quality of the data submitted. In FY 2014, the PSO Program will continue to work with the PSO PPC to increase the number to 25 PSOs that have DUAs established with the PSO PPC. In the next fiscal year, AHRQ's goal is to have the NPSD become "operational", i.e., the PSO PPC will have a sufficient amount of patient safety event reports to transmit to the NPSD. The FY 2015 performance target is the transmission of 25,000 patient safety event reports to the NPSD by the end of FY 2015.

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.

A major output of AHRQ's Patient Safety Portfolio is 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. AHRQ has provided tools and products such as: *Advancing Pharmacy Health Literacy Practices Through Quality Improvement: Curricular Modules for Faculty; Common Formats (for reporting patient safety events); Comprehensive Unit-based Safety Program (CUSP);Guide to Patient and Family Engagement in Hospital Quality and Safety; TeamSTEPPS tools, including TeamSTEPPS Limited English Proficiency module; and Universal ICU Decolonization: An Enhanced Protocol.*

1.3.59: Reduce the rate of CAUTI cases

Another main focus of the Patient Safety Portfolio is the prevention and reduction of healthcare-associated infections (HAIs). AHRQ is working collaboratively with other HHS components to design and implement HAI initiatives to improve patient safety. In September 2012, AHRQ completed a project to promote the nationwide implementation of the Comprehensive Unit-based Safety Program (CUSP) for central line-associated blood stream infections (CLABSI), which has achieved remarkable success in reducing CLABSI cases and deaths from CLABSI and averting excess costs associated with CLABSI. Building on the model of CUSP for CLABSI, AHRQ has been extending the application of CUSP to other HAIs. In FY 2011, AHRQ initiated the nationwide implementation of CUSP for catheter-associated urinary tract infections (CAUTI), which will be completed in the latter half of FY 2015. The HAI performance measure will assess progress in reducing the rate of CAUTI in hospitals participating in the CUSP for CAUTI project. In FY 2013, AHRQ determined the baseline CAUTI rate at the 4-year project's midpoint. CAUTI rates are being measured in two ways: 1) as CAUTI cases per 1,000 catheter days, and 2) as CAUTI cases per 10,000 patient days (population rate). The baseline rates in FY 2013 were: 1) 2.55 CAUTI cases per 1,000 catheter days; and 2) 7.97 CAUTI cases per 10,000 patient days. This latter rate is important, because efforts are being made to reduce catheter days as a strategy to reduce CAUTI. Reducing catheter days, which is the denominator in the first CAUTI rate, will have the effect of increasing that rate, whereas the population rate (CAUTI per 10,000 patient days) will not be affected by a decline in catheter days.

In FY 2014, AHRQ is expanding the reach of the CUSP for CAUTI project to additional States and hospital units. In FY 2014, AHRQ is working toward a 10% reduction from the then-contemporaneous baseline CAUTI rates of participating hospitals to date. In FY 2015, the CUSP for CAUTI project will further expand its reach, and AHRQ will determine progress toward a 15% reduction from the then-contemporaneous baseline CAUTI rates of participating hospitals.

AHRQ's CUSP for CAUTI project is making a major contribution to attaining the HHS Agency Priority Goal, which aims to reduce the CAUTI Standardized Infection Ratio (observed CAUTI divided by expected CAUTI) by 10% by 2015. AHRQ is collaborating closely with CMS, CDC, and OASH in this concerted effort to reduce CAUTI. Over 1,000 hospital units are already participating in the CUSP for CAUTI project, and additional units are being enrolled in this project, which runs until August 2015. The reduction in CAUTI rates that the project aims to achieve – 10% in 2014 and 15% in 2015 – will help reduce CAUTI nationwide, which will contribute to reaching the agency priority goal.

Portfolio: Health Services Research, Data and Dissemination.

Measure	*Most Recent Result*	*FY 2014 Target*	*FY 2015 Target*	*FY 2015 +/- FY 2014*
1.3.22: Increase the number of additional organizations per year that use AHRQ Quality Indicators (AHRQ QIs) *(Output)*	FY 2013: 5 Organizations (Target Exceeded)	+4 Organizations	+4 Organizations	+4 additional Organizations
1.3.23: Increase the number of consumers for whom Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data is collected *(Output)*	FY 2013: 143 Million (Target Not Met)	145 Million	146 Million	+1 Million
1.3.61: Increase the number of Host Users of the MONAHRQ software *(Output)*	FY 2013: Baseline of 8	+2 Host Users	+2 Host Users	+2 additional Host Users

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

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

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. The QIs include four sets:

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

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

In addition, three new organizations began using the AHRQ QIs in a publicly available report on quality, bringing the total number of states using the AHRQ QIs in this manner to thirty-two states (and represents more than two thirds of the American population, patients or consumers can access public reports using the AHRQ Quality Indicators when selecting a hospital.):

- The Georgia Hospital Association reported AHRQ QIs in its Consumer Guide on Health. https://www.gha.org/Consumer Guide on Health

- The South Carolina Business Coalition on Health are reporting several AHRQ QIs. http://www.myschospital.org http://www.scbch.org/

- South Dakota Association of Healthcare Organizations have established the South Dakota Quality Indicator Program which is reporting on several AHRQ http://www.sdhospitalquality.org

Two additional organizations are using the AHRQ QIs in their quality improvement initiatives:

- Froedtert & The Medical College of Wisconsin is an academic medical center that participated in reducing Patient Safety Indicator Pressure Ulcer Rate (PSI #3) rates over a period of two years. Froedtert focused on PSI #3 reduction by creating a Skin Care Counts Campaign that rolled out AHRQ Patient Safety by unit every six weeks over a two year period. The campaign received administrative support from both nursing and physician leadership with education at all levels. A formal review of Stage III & IV hospital acquired pressure ulcers occurs at the monthly multidisciplinary Pressure Ulcer Steering committee meetings. Froedtert was able to impact hospital costs associated with pressure ulcer.

- University of Arkansas for Medical Sciences (UAMS) Medical Center in Little Rock, Ark, is the only academic medical center and level 1 trauma center in the state. UAMS used the AHRQ Quality Indicators Patient Safety Indicator Death among Surgical Inpatients with Serious Treatable Conditions (PSI #4) in a quality improvement project. UAMS decreased the rate for PSI #4 from 131.87 per 1000 cases in quarter 3, 2009 to 58.14 per 1000 cases in quarter 1, 2011. This impact was also reflected in University Health Center Consortium's (UHC) expected mortality for the PSI #4 patient population at Arkansas, which doubled between the pre- and post-intervention periods. UAMS also improved the PSI #4 UHC length of stay observed to expected ratio from 1.07 to 1.02, and the direct cost observed to expected ratio from 1.51 to 1.17.

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

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

By the end of 2015, participants in the Healthcare Marketplaces will have received their first CAHPS surveys through which they will be able to assess the quality of care they receive. As a result, we feel that at least 146 million Americans is an appropriate goal for 2015.

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

Our continued support of MONAHRQ – free software that allows users to build Web sites for public reporting both quickly and inexpensively – is important given its direct link to both Departmental and ACA priorities. Public reporting to help consumers choose safer and higher quality providers has been a major strategy for the Department, and the ACA has heightened the importance of this strategy. In FY 2014 and previous years, this program was funded in the Value Portfolio, but is moved to the Health Services Research Portfolio in FY 2015. By FY 2015, MONAHRQ will undergo a complete re-design, drawing on the lessons learned and feedback from current users as well as evidence from AHRQ/CMS-funded grants on public reporting. The redesigned MONAHRQ product will allow users to build separate Web sites for different audiences, such as consumers and physicians, and will incorporate new measures that AHRQ is currently developing as part of its Quality Indicators program, as well as new measures from CMS' Hospital Compare and Physician Compare sites. The new MONAHRQ measure #1.3.61 tracks the number of new MONAHRQ Host Users (organizations using MONAHRQ to host a Web site for tracking and reporting provider performance) with the target of increasing by 2 host users in FY 2015.

Portfolio: Health Information Technology.

Measure	*Most Recent Result*	*FY 2014 Target*	*FY 2015 Target*	*FY 2015 +/- FY 2014*
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 2013: Gathered first year reports from grantees Preliminary results will be posted on healthit.ahrq.gov and in Health IT's Annual Report (Target Met)	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.	Continue gathering reports from grantees. Report preliminary results of grantees in Health IT's Annual Report and summarize any ongoing findings from PA-11-99 identifying key design principles for PHIM in preparation for final report in FY 2016.	N/A

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

The increased interest in and availability of consumer health information technology (IT) applications meant to assist consumers in managing their personal health information needs has rapidly increased over the past decade. Individuals are the end users of consumer health IT; however, there is still a lack of basic research around these end users' personal health information management (PHIM) practices and needs and how these methods are influenced by a multitude of other contextual factors (e.g., care settings, demographics, motivations, user capabilities and limitations, informal care-giving networks, technology sophistication, and access to Internet) that, typically, represent a mixture of facilitators or barriers to adequate PHIM. The potential of health IT to improve the quality of health care lies in providing information to people about their health in ways that are meaningful and useful to them. AHRQ's health IT portfolio will build the evidence on what works for people when they manage their health information.

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

Portfolio: Prevention and Care Management.

Measure	*Most Recent Result*	*FY 2014 Target*	*FY 2015 Target*	*FY 2015 +/- FY 2014*
2.3.7: Increase the percentage of older adults who receive appropriate clinical preventive services. *(Outcome)*	FY 2013: Created composite measures using sets of clinical preventive services which vary by sex and age groups. (In Progress) FY 2013: Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services (Target Met) FY 2013: Selected findings from Research Centers for Excellence: 1) multifaceted intervention to improve adherence to colorectal cancer screening among patients cared for in a community health center; 2) developed a cardiovascular prevention registry; and 3) developed a taxonomy with 4 domains of harm from screening: physical effects, psychological effects, financial strain, and opportunity costs. (Target Met)	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. Results from Centers for Excellence in Clinical Preventive Services that further understanding of how to deliver high quality (safe, equitable) clinical preventive services.	Validated final survey to collect data on the receipt of appropriate clinical preventive services among adults and national estimates of receipt of high-priority clinical preventive services	N/A

In FY 2015, the Agency for Healthcare Research and Quality (AHRQ) will provide ongoing scientific, administrative and dissemination support to the U.S. Preventive Services Task Force (USPSTF). By supporting the work of the U.S. Preventive Services Task Force, AHRQ helps to identify appropriate clinical preventive services for adults as well as develop methods for understanding prevention in older adults.

For several years, AHRQ has invested in creating a national measure of the receipt of appropriate clinical preventive services by older adults (measure 2.3.7). A necessary first step in creating quality improvement within health care is measurement and reporting. Without the ability to know where we are and the direction we are heading, it is difficult to improve quality. In FY 2015, AHRQ anticipates having a validated final survey to collect data on the receipt of appropriate clinical preventive services among adults and national estimates of receipt of high-priority clinical preventive services.

Portfolio: Value.

Measure	*Most Recent Result*	*FY 2014 Target*	*FY 2015 Target*	*FY 2015 +/- FY 2014*
1.3.50: SYNTHESIS_Increase the cumulative number of AHRQ measures, tools, upgrades, and syntheses available on healthcare value. *(Output)*	FY 2013: 142 (Target Met)	146	N/A	N/A
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 2013: 81 (Target Met)	96	N/A	N/A
1.3.53: Increase the cumulative number of AHRQ measures and tools used in national, state, or community public report cards. *(Output)*	FY 2013: 27 (Target Met)	28	N/A	N/A

In the first half of FY 2014, we will continue to disseminate AHRQ data, measures, tools and evidence-based reports primarily through the CVE Learning Network for purposes of quality improvement and enhanced public reports on provider performance, accomplishing our targets for 1.3.51 and 1.3.53. However, since the CVE Learning Network will end in April of 2014, and has been a key initiative contributing results to measures 1.3.51 and 1.3.53, we will retire these measures for FY 2015.

We also plan to retire measure 1.3.50 for FY 2015 given it has been used to track Value Portfolio work, and the Portfolio will end in FY 2014. However, since the MONAHRQ project will continue beyond FY 2014 in the Health Services Research, Data, and Dissemination portfolio, we have created a new measure for MONAHRQ in FY2015. Please see the MONAHRQ measure in that section.

Portfolio: Patient-Centered Health Research (1/)

Measure	*Most Recent Result*	*FY 2014 Target*	*FY 2015 Target*	*FY 2015 +/- FY 2014*
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 2013: 992 Orders (Target Exceeded)	900 Orders	N/A	N/A
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 2013: 341 direct and indirect citations of EHC products (Target Exceeded)	186 citations of EHC products	N/A	N/A
4.4.5: Increase the number of Effective Health Care (EHC) products available for use by clinicians, consumers, and policymakers. *(Output)*	FY 2013: 108 EHC products (Target Exceeded)	35 EHC products	N/A	N/A

1/ As of FY 2014, PCHR portfolio activities will no longer be funded by discretionary funding.

The activities of the PCHR Portfolio support comparative effectiveness research in response to section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. In FY2013, the PCHR Portfolio continued to be a leader in providing objective evidence-based information and tools to consumers, clinicians and policymakers. In FY 2013 alone, the PCHR Portfolio produced 108 products. This includes Systematic Reviews, Summary Guides and Translational Products, and Original Research Reports funded by both portfolio appropriations. This increase in program products is mirrored in the number of citations of program products that are cited directly and indirectly by clinical practice guidelines, consensus statements, or quality measures. At the end of FY 2013, there were 341 direct and indirect citations, a 100% increase over the previous fiscal year. This is a direct reflection how the PCHR program serves to inform health care decision-making. Starting in FY 2014, this portfolio will no longer be supported by discretionary funding. Consequently, there are no out year targets for this portfolio in FY 2015. Support for programmatic activities related to research translation and dissemination of patient-centered outcomes will be supported via the Patient-Centered Outcomes Research Trust Fund (PCORTF).

Planned investments for FY 2015 and beyond will expand beyond the current PCHR activities and as such, new and/or updated performance measures may need to be developed and baselines for these measures will need to be developed. In FY 2014, AHRQ will develop or revise measures to ensure that the resulting measure(s) will be comprehensive of AHRQ PCORTF investments.

Medical Expenditure Panel Survey (MEPS)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 Request +/- FY 2014 Enacted
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 60,700,000	$ 63,811,000	$ 63,811,000	+$0

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

A. Program Overview

The Medical Expenditure Panel Survey (MEPS), first funded in 1995, is the only national source for comprehensive annual data on how Americans use and pay for medical care. The survey collects detailed information from families on access, use, expenses, insurance coverage and quality. Data are disseminated to the public through printed and Web-based tabulations, microdata files and research reports/journal articles. Data from the MEPS have become a linchpin for public and private economic models projecting health care expenditures and utilization. The MEPS is designed to provide annual estimates at the national level of the health care utilization, expenditures, sources of payment and health insurance coverage of the U.S. civilian non-institutionalized population. Given the level of detail on health care expenditures and utilization obtained from the MEPS, the data is also used annually to assist Federal employees with their health insurance coverage choices that are part of the Federal Employee Health Benefits (FEHB) Program. MEPS data is used to calculate expenses associated with various health plans. (Please see: https://www.checkbook.org/) 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 2015 Justification by Activity Detail

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

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
MEPS Household Component	$38.500	$41.611	$41.611
MEPS Medical Provider Component	$12.200	$12.200	$12.200
MEPS Insurance Component	$10.000	$10.000	$10.000
TOTAL, MEPS	**$60.700**	**$63.811**	**$63.811**

Overall Budget Policy:

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

FY 2015 President's Budget Policy: The FY 2015 President's Budget level provides $41.6 million for this activity, the same level of support as the FY 2014 Enacted. 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. 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.

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 2013 and FY 2014, the Medical Provider Component of the MEPS maintained its sample specifications.

FY 2015 President's Budget Policy: The FY 2015 President's Budget provides $12.2 million for this activity, which is the same as the FY 2014 Enacted level. These funds will permit the MEPS Medical Provider Component to maintain existing survey capacity at its current level.

MEPS Insurance Component (IC): The MEPS Insurance component is a survey of private business establishments and governments designed to obtain information on health insurance availability and coverage derived from employers in the U.S. The sample for this survey is selected from the Census Bureau's Business Register for private employers and Census of Governments for public employers. The IC is an annual survey designed to provide both

nationally and state representative data on the types of health insurance plans offered by employers, enrollment in plans by employees, the amounts paid by both employers and employees for those plans, and the characteristics of the employers. 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 FYs 2013 and 2014, the MEPS Insurance Component maintained the precision levels of survey estimates, maintained survey response rates and adhered to data release schedules.

FY 2015 President's Budget Policy: The FY 2015 President's Budget level provides $10.0 million for this activity, which is the same as the FY 2014 Enacted. These funds will permit the MEPS Insurance Component to maintain existing survey capacity at its current level.

Program Portrait: Use of MEPS Data

FY 2014 Level: $63.8 million
FY 2015 Level: $63.8 million

Change: $0.0 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 is used by Treasury to determine the amount of the small employer health insurance tax credit that is a component of the Affordable Care Act.
- MEPS was used extensively to inform Congressional inquiries concerning the State Children's Health Insurance Program and its reauthorization.
- 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 and the Office of the Secretary to estimate the impact of Medicaid Eligibility Changes under the Affordable Care Act with respect to Federal Medical Assistance Percentages (FMAP).
- MEPS data on health care quality, access, and health insurance coverage is used extensively in the Department's two annual reports to Congress, the National Healthcare Quality Report and the National Healthcare Disparities Report.
- MEPS is used extensively to examine the effects of chronic conditions on the levels and persistence of medical expenditures.
- MEPS has been used in Congressional testimony on the impact of health insurance coverage rate increases on small businesses.
- MEPS was used extensively by the GAO to determine trends in employee compensation.
- 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 data have been used by CDC and other agencies to evaluate the cost of common conditions including arthritis, injuries, diabetes, obesity, and cancer.

C. Mechanism Table for MEPS

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

	FY 2013 Actual		FY 2014 Enacted		FY 2015 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**60,700**		**63,811**		**63,811**
TOTAL.....		**60,700**		**63,811**		**63,811**

D. Performance Summary and Key Measures

Measure	*Most Recent Result*	*FY 2014 Target*	*FY 2015 Target*	*FY 2015 +/- FY 2014*
1.3.16: MEPS-IC: The number of months required to make insurance component tables available following data collection *(Output)*	FY 2013: 6 months (Target Met)	6 months	6 months	Maintain
1.3.19: Increase the number of tables per year added to the MEPS table series *(Output)*	FY 2013: 6,855 tables added to MEPS table series (Target Exceeded)	7,105 total tables in MEPS table series	7,355 total tables in MEPS table series	+250 tables
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 2013: 10 months (Target Met)	9.5 months	9.5 months	Maintain
1.3.49: Decrease the average number of field staff hours required to collect data per respondent household for the MEPS *(Efficiency)*	FY 2013: 12.26 hours (Target Not Met)	Re-baseline	Establish out-year targets	N/A

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

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

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

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

Schedules for data release will be maintained for FY 2014 through FY 2015. Data trends from 1996 through 2012 are mapped using the MEPSnet/IC interactive search tool. In addition, special runs are often made for federal and state agencies that track data trends of interest across years.

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

The MEPS Tables Compendia is scheduled to be expanded a minimum of 250 tables per year. Currently the Household Component offers a total of 1,146 tables, with 91 added during FY 2013. For the Insurance Component there are a total of 1,783 National level tables (86 added in FY 2013) and 3,926 state and metro area tables (297 added in FY 2013). The total number of tables available to the user population is 6,855. The performance measure has been changed from one table series (made up of many tables) per year to an addition of at least 250 tables per year. This change better reflects the level of effort and resources committed to increasing the utility of the MEPS Tables Compendia for the user population.

The MEPS Tables Compendia is a source of important data that is easily accessed by users. Expanding the content and coverage of these tables furthers the utility of the data for all. Currently data is available in tabular format for the years 1996 – 2012. This represents seventeen years of data for both the Household and Insurance Components, enabling the user to follow trends on a variety of topics.

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

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

We have achieved the data release schedule for all the targeted MEPS public release files scheduled for release during FY 2013. We are on target to also meet the accelerated data release schedule for the MEPS public use files scheduled for release during FY 2014.

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

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

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

E. Funding History

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

Year	Dollars
2010	$58,800,000
2011	$58,800,000
2012	$59,300,000
2013	$60,700,000
2014	$63,811,000

Program Support

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 Request +/- FY 2014 Enacted
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	$ 68,422,000	$ 68,813,000	$ 69,700,000	+$887,000
FTEs (Total Program Level)	311	326	326	0
FTEs (PHS Evaluation Funds)	299	300	300	0
Estimated FTEs (PCORTF)	6	20	20	0
FTE (Other Reimbursable Funds)	6	6	6	0

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 2015 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 2015 President's Budget Policy: Program Support (PS) will be funded at $69.7 million, an increase of $0.9 million or +1.3 percent over the FY 2014 Enacted. Of the total increase, $1.1 million is required for rental payments to GSA. This increase reflects the addition of two month's rent and other move-related expenses for the new Parklawn building in FY 2015 prior to our

move in FY 2016. Under the new occupancy agreement, rent commences starting August 2015. AHRQ anticipates lower rent costs in FY 2016 following our relocation. A total increase of $0.5 million is required for salaries and benefits. A total of $0.7 million in Program Support cost increases will be absorbed through cost savings in FY 2015.

Program Support provides funds for AHRQ's PHS Evaluation Fund FTEs. In FY 2015 AHRQ is supporting 300 FTEs, the same level of support as the FY 2014 Enacted. As shown in the table on page 69, AHRQ does have additional FTEs supported with other funding sources, including approximately 6 FTE from other reimbursable funding and 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 and FY 2015.

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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Patient-Centered Health Research	2,304	-	-
Prevention/Care Management	4,443	5,379	1,135
Value Research	859	845	-
Health Information Technology	5,892	6,643	6,751
Patient Safety	15,343	16,266	20,492
HSR, Data and Dissemination	25,594	23,103	24,475
Medical Expenditure Panel Survey	13,987	16,577	16,847
Total, Program Support	68,422	68,813	69,700

C. Mechanism Table

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

	FY 2013 Actual		FY 2014 Enacted		FY 2015 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs		**0**		**0**		0
RESEARCH MANAGEMENT……		**68,422**		**68,813**		**69,700**
TOTAL		**68,422**		**68,813**	**0**	**69,700**

D. Funding History

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

Year	Dollars
2010	$67,600,000
2011	$67,600,000
2012	$73,985,000
2013	$68,422,000
2014	$68,813,000

Supplementary Tables – Table of Contents

Supplementary Tables

Budget Authority by Object Class – Reimbursable 1/

	FY 2014 Enacted	2015 Budget	FY 2015 +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1)	30,737,000	31,078,000	+341,000
Other than full-time permanent (11.3)	3,468,000	3,502,000	+34,000
Other personnel compensation (11.5)	557,000	563,000	+6,000
Military Personnel (11.7)	920,000	930,000	+10,000
Subtotal personnel compensation	**35,682,000**	**36,073,000**	**+391,000**
Civilian Personnel Benefits (12.1)	9,603,000	9,708,000	+105,000
Military Personnel Benefits (12.2)	585,000	593,000	+8,000
Benefits to Former Personnel (13.0)	0	0	0
Total Pay Costs	**45,870,000**	**46,374,000**	**+504,000**
Travel and transportation of persons (21.0)	351,000	351,000	-0
Transportation of Things	53,000	53,000	-0
Rental payments to GSA (23.1)	5,095,000	6,146,000	+1,051,000
Communications, utilities, & misc charges (23.3)	934,000	952,000	+18,000
Printing and reproduction (24.0)	781,000	781,000	-0
Other Contractual Services:			
Other services (25.2)	13,184,000	12,462,000	-722,000
Purchases of goods & services from government accounts (25.3)	19,384,000	19,384,000	-0
Research and Development Contracts (25.5)	162,672,000	145,894,000	-16,778,000
Operation and maintenance of equipment (25.7)	679,000	679,000	-0
Subtotal Other Contractual Services	**195,919,000**	**178,419,000**	**-17,500,000**
Supplies and materials (26.0)	384,000	392,000	+8,000
Equipment (31.0)	1,482,000	1,510,000	+28,000
Grants, subsidies, and contributions (41.0)	113,139,000	99,121,000	-14,018,000
Total Non-Pay Costs	**318,138,000**	**287,725,000**	**-30,413,000**
Total obligations by object class	**364,008,000**	**334,099,000**	**-29,909,000**

1/ Annual Appropriation only. This table excludes other reimbursable estimates that are included in the Budget Appendix. Also, mandatory funds are excluded.

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

	FY 2014 Enacted	2015 Budget	FY 2015 +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1)	30,737,000	31,078,000	+341,000
Other than full-time permanent (11.3)	3,468,000	3,502,000	+34,000
Other personnel compensation (11.5)	557,000	563,000	+6,000
Military Personnel (11.7)	920,000	930,000	+10,000
Subtotal personnel compensation	**35,682,000**	**36,073,000**	**+391,000**
Civilian Personnel Benefits (12.1)	9,603,000	9,708,000	+105,000
Military Personnel Benefits (12.2)	585,000	593,000	+8,000
Benefits to Former Personnel (13.0)	0	0	0
Total Pay Costs	**45,870,000**	**46,374,000**	**+504,000**
Travel and transportation of persons (21.0)	351,000	351,000	-0
Transportation of Things	53,000	53,000	-0
Communications, utilities, & misc charges (23.3)	934,000	952,000	+18,000
Printing and reproduction (24.0)	781,000	781,000	-0
Other Contractual Services:			
Other services (25.2)	13,184,000	12,462,000	-722,000
Operation and maintenance of equipment (25.7)	679,000	679,000	0
Subtotal Other Contractual Services	**13,863,000**	**13,141,000**	**-722,000**
Supplies and materials (26.0)	**384,000**	**392,000**	**+8,000**
Non-Pay Costs	**16,366,000**	**15,670,000**	**-696,000**
Total Salaries and Expenses	**62,236,000**	**62,044,000**	**-192,000**
Total FTEs	**300**	**300**	**0**

1/ Annual Appropriation only. This table excludes other reimbursable estimates that are included in the Budget Appendix. Also, mandatory funds are excluded.

Detail of Full-Time Equivalent Employment (FTE)

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

	2013 Actual Civilian	2013 Actual Military	2013 Actual Total	2014 Est. Civilian	2014 Est. Military	2014 Est. Total	2015 Est. Civilian	2015 Est. Military	2015 Est. Total
Office of the Director (OD)	22	0	22	21	0	21	21	0	21
Office of Management Services (OMS)	51	0	51	51	0	51	51	0	51
Office of Extramural Research, Education, and Priority Populations (OEREPP)	39	3	42	39	3	42	39	3	42
Center for Primary Care, Prevention, and Clinical Partnerships (CP3)	21	1	22	21	1	22	21	1	22
Center for Outcomes and Evidence (COE)	29	3	32	29	3	32	29	3	32
Center for Delivery, Organization and Markets (CDOM)	29	0	29	29	0	29	29	0	29
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)	23	2	25	23	2	25	23	2	25
Office of Communications and Knowledge Transfer (OCKT)	39	0	39	42	0	42	42	0	42
AHRQ FTE Total	**296**	**9**	**305**	**298**	**9**	**307**	**298**	**9**	**307**

Average GS Grade	
2011	12.8
2012	12.8
2013	13.1
2014	13.1
2015	13.1

1/ Excludes PCORTF FTE.

Detail of Positions 1/

	2013 Actual	2014 Base	2015 Budget
Executive Level I	4	3	3
Executive Level II	0	0	0
Executive Level III	5	5	5
Executive Level IV	1	1	1
Executive Level V	0	0	0
Subtotal	10	9	9
Total Executive Level Salaries	$1,688,326	$1,525,312	$1,540,565
Total - SES	4	4	3
Total - SES Salaries	$ 760,086	$ 640,784	$ 554,965
GS-15	58	58	58
GS-14	89	92	92
GS-13	58	61	61
GS-12	32	38	38
GS-11	14	15	15
GS-10	2	2	2
GS-9	11	10	10
GS-8	4	3	3
GS-7	6	6	6
GS-6	2	1	1
GS-5	2	2	2
GS-4	0	1	1
GS-3	1	1	1
GS-2	0	0	0
GS-1	0	0	0
Subtotal	279	290	290
Average GS grade	13.1	13.1	13.1
Average GS salary	$89,033	$89,924	$90,823

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 2015 Budget request. Termination of the funding provided through PHS Evaluation funds allows AHRQ to redirect $14.9 million. Following the table is a brief summary of each program and the rationale for its elimination.

Program	FY 2015 President's Budget Level
Value Portfolio	-$ 3.3 million
Prevention and Care Management Portfolio	-$11.6 million

Rationale

- Value Research is no longer being funded by AHRQ at the FY 2015 President's Budget level. Although the mission of the Value Research portfolio is important, AHRQ will be able to support this type of research within its Health Services Research, Data, and Dissemination portfolio. One program, MONAHRQ ($1.5 million), will be moved to the Health Services Research, Data and Dissemination portfolio to add to our data and measurement activities.

- Prevention/Care Management Research is funded at $11.3 million at the FY 2015 President's Budget level, a decrease of $11.6 million from the FY 2014 Enacted level. The entirety of this portfolio will now only support the U.S. Preventive Services Task Force (USPSTF), including their continuing work to increase transparency. AHRQ support for research grants to improve clinical outcomes in primary care and contract support for implementation activities to improve primary care have been eliminated. In future budget requests, AHRQ will rename this portfolio "Ongoing Support of the U.S. Preventive Services Task Force."

Physician's Comparability Allowance Worksheet

		FY 2013 (Actual)	FY 2014 (Estimate)	FY 2015* (Estimate)
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)		$ 138,318	$ 139,356	$ 140,749
5) Average Annual PCA Payment		$ 22,818	$ 22,818	$ 22,818
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	0	0	0
	Category II Research Position	21	21	21
	Category III Occupational Health	0	0	0
	Category IV-A Disability Evaluation	0	0	0
	Category IV-B Health and Medical Admin.	1	1	1

*FY 2014 data will be approved during the FY 2015 Budget cycle.

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

N/A

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

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

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

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

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

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

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

N/A

FTEs Funded by the Affordable Care Act

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

Program	Section(s)	FY 2011			FY 2012			FY 2013			FY 2014			FY 2015		
		$	FTEs	CEs	$	FTEs	CEs	$	FTEs	CEs	$	FTEs	CEs	$	FTEs	CEs
New programs authorized and funded by PPACA																
Prevention and Public Health Fund	4002	384	3	0	-	0	0	N/A	N/A	0	0	0	0	0	0	0
Patient-Centered Outcomes Research Trust Fund	6301	-	0	0	366	4	0	633	6	0	1,450	20	0	1,450	20	0

Significant Items in Appropriations Committee Reports

FY 2014 Senate Report 113-71

1. In its report on the fiscal year (FY) 2014 budget for the Department of Health and Human Services, the Senate Committee on Appropriations stated the following:

SENATE (REPORT NO. 113-71) p. 120

The Committee strongly supports AHRQ's unique mission within the Department to fund health services research that improves patient safety and promotes the delivery of high-quality healthcare. Whereas NIH conducts biomedical research to prevent, diagnose, and treat diseases, and CDC focuses on population health and community-based interventions, only AHRQ supports research that identifies the most effective clinical and system-level interventions, prevents medical errors, and promotes the wide-scale adoption of proven safety and quality practices throughout the healthcare system. The Committee recognizes the Comprehensive Unit-based Safety Program [CUSP] as an example of successful AHRQ-funded research aimed at preventing healthcare-associated infections [HAIs]. Within 3 months of being implemented in Michigan hospitals, this program reduced the rate of central line-related blood stream infections by two-thirds in more than 100 intensive care units, and within 18 months saved more than 1,500 lives and nearly $200,000,000. The Committee supports AHRQ's efforts in fiscal year 2014 to expand the implementation of CUSP to include other healthcare settings and other HAIs.

The following report has been prepared by the Agency for Healthcare Research and Quality, Department of Health and Human Services, in response to this request:

AHRQ is expanding its successful efforts to accelerate the implementation of proven methods to reduce HAIs not only in hospitals but also in ambulatory care and long-term care settings. Building on the success of its nationwide project that used the Comprehensive Unit-based Safety Program (CUSP) to reduce central line-associated bloodstream infections, AHRQ will continue to apply CUSP to prevent other HAIs. In FY 2014, five projects will implement CUSP to address catheter-associated urinary tract infections (CAUTI) in hospitals and in long-term care/nursing homes, surgical site infections (SSI) and other surgical complications in inpatient and ambulatory surgery, and ventilator-associated pneumonia (VAP) and other complications associated with mechanical ventilation in hospitals.

2. In its report on the fiscal year (FY) 2014 budget for the Department of Health and Human Services, the Senate Committee on Appropriations stated the following:

SENATE (REPORT NO. 113-71) p. 121

Health IT Safety.--The Committee is aware that the 2011 IOM report, `Health IT and Patient Safety: Building Safer Systems for Better Care,' found large gaps in our knowledge of how health IT impacts overall patient safety. Despite the clear potential for health IT to improve overall healthcare quality, patients can be harmed if IT systems fail, are poorly designed, or provide bad information. The Committee recommendation

includes $4,000,000 for AHRQ to research safe health IT practices specifically related to the design, implementation, usability, and safe use of these systems. The Committee hopes that this investment will generate new evidence on safe health IT practices that would ultimately be used by ONC, FDA, CMS, and others to inform certification and other policy interventions.

The following report has been prepared by the Agency for Healthcare Research and Quality, Department of Health and Human Services, in response to this request:

The safe use of health IT systems is fundamental to their ability to improve health care quality. AHRQ's health IT portfolio has supported preliminary efforts to improve health IT safety through resources such as the Computerized Provider Order Entry evaluation tool used by the Leapfrog Group in their annual hospital survey and the Health IT Hazard Manager project, which is currently used by leading Patient Safety Organizations in their safety improvement work. However, the Committee correctly recognizes that many important gaps in our knowledge remain unaddressed. In anticipation of implementing the Committee's recommendation from early 2013, AHRQ staff have analyzed the IOM and other relevant reports and coordinated with HHS partners including ONC, CMS, FDA and others to prepare funding opportunities for the requested research, and will deploy those opportunities if funding becomes available. In response to the 2014 Omnibus appropriation which provided funding for health IT safety research, AHRQ has published two special emphasis notices for large research grants and exploratory/developmental research grants focused on the design, implementation, usability and safe use of health IT. These funding opportunities were developed in close coordination with ONC and the evidence generated is expected to inform their relevant programs.

3. In its report on the fiscal year (FY) 2014 budget for the Department of Health and Human Services, the Senate Committee on Appropriations stated the following:

SENATE (REPORT NO. 113-71) p. 122

Training Grants- The Committee continues to be concerned by the reduction in training grants for health services researchers. The Committee requests an update from AHRQ in next year's budget justification outlining the recent status of `K' and `T' awards and other training activities.

The following report has been prepared by the Agency for Healthcare Research and Quality, Department of Health and Human Services, in response to this request:

AHRQ provides support for training the next generation of researchers through the National Research Service Award (NRSA) program, which provides support for pre- and post-doctoral trainees. New five-year T32 grant awards were made in FY 2013. Additionally, AHRQ will support training 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 effectiveness. AHRQ is funding career development awards (K grants) in comparative effectiveness research training.

SPECIAL REPORTS REQUIRED BY THE APPROPRIATIONS COMMITTEE

4. In its report on the fiscal year (FY) 2014 budget for the Department of Health and Human Services, the Senate Committee on Appropriations stated the following:

SENATE (REPORT NO. 113-71) p. 121

> Coordination of Health Services Research-The Committee is concernment that the various Federal agencies conducting health services research do not sufficiently coordinate their efforts to optimize Federal investments in patient safety, especially regarding HAIs. As the lead agency for health services research, the Committee requests that AHRQ examine health services research efforts in patient safety (including HAIs) supported by Federal agencies since fiscal year 2010. In particular, AHRQ should identify research gaps, areas that could be consolidated, and emerging research priorities, and propose strategies for better coordination among Federal agencies. The Committee requests that AHRQ report on its findings no later than 1 year after the enactment of this act.
>
> The following report has been prepared by the Agency for Healthcare Research and Quality, Department of Health and Human Services, in response to this request:
>
> AHRQ will conduct a report in close consultation with other Federal agencies involved in health services research on patient safety, especially regarding HAIs, including CDC, NIH, CMS, and OASH. AHRQ will work with these agencies to address the major coordination issues and identify research gaps, emerging research priorities, and opportunities to further strengthen the coordination of effort that is occurring in the framework of the HHS HAI National Action Plan (NAP). Results from the Longitudinal Program Evaluation of the NAP, which AHRQ funds and oversees, will help inform the development of the coordination report required by the Committee.

Patient-Centered Outcomes Research Trust Fund (PCORTF)

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

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

AHRQ is developing a website to display all funded PCORTF projects. It is expected to be available in Spring, 2014. The website will provide fact sheets for each project and provide listings of all grantees funded through the PCORTF. Below is a description of one large project that AHRQ is pursuing in FY 2014:

Focusing on the ABCS: Accelerating the Dissemination and Implementation of PCOR Findings into Primary Care Practice

With the funds transferred from the PCORTF in FY 2014, AHRQ will award 3-year competitive grants to no more than 8 regional cooperatives that will disseminate PCOR evidence directly to primary care practices and support them in implementing clinical and organizational evidence in practice. Each regional cooperative will bring together and actively involve state and local primary care professional societies and primary care departments of one or more health professional schools to collaborate with other partners such as public health agencies, and Medicare Quality Improvement Organizations (QIOs), etc. The cooperatives will improve patient health through focusing on improving implementation of the Million Hearts™ campaign ABCS (**a**spirin use among people with heart disease, **b**lood pressure control, high blood **c**holesterol control, and **s**moking cessation advice and support.) to reach the Million Hearts goal to prevent one million heart attacks and strokes by 2017. Working directly with primary care practices, the cooperatives will use evidence-based quality improvement techniques that may include practice assessment, benchmarking and feedback, expert consultation, local peer learning, clinical decision support, and practice facilitation (a type of organizational coaching).

The external evaluation of this initiative will examine improvements in patient health outcomes and delivery of the ABCS and whether and how quality improvement techniques allow for rapid and sustainable dissemination and implementation of PCOR evidence, including building capacity for evidence use by primary care practices.

The long-term goal of the initiative is to learn if and how quality improvement techniques can build the capacity of primary care practices to implement PCOR findings. The initiative will develop and test models for working directly with primary care practices to disseminate and implement the important findings of the nation's PCOR investments. If the initiative increases delivery of the ABCS from current levels to 80%, we expect that an additional 900,000 Americans would have their blood pressure under control, 700,000 would have their cholesterol under control, 1,000,000 would be provided support for quitting smoking, and 200,000 people at high-risk for heart attacks would begin taking aspirin daily[1.]

1 These illustrative estimates are based on the following assumptions: 2000 small to medium sized US primary care practices with 6000 primary care professionals serve an estimated 9 million US adults. 31% of US adults have high blood pressure, 17% have high blood cholesterol, 20% smoke, and 7% have ischemic heart disease. Of these, currently approximately 46% have their blood pressure controlled, 33% have their cholesterol controlled, 23% have received advice and support to quit smoking, and 47% are taking daily aspirin to reduce the risk of heart attacks.