DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2013

Agency for Healthcare Research and Quality

Justification of Estimates for Appropriations Committees

As the Director of the Agency for Healthcare Research and Quality (AHRQ), I am pleased to present the FY 2013 Congressional Justification. This budget request reflects an effort, amid uncertain economic uncertainty and fiscal constraint, to fulfill AHRQ's mission to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Our performance-based budget demonstrates our continued commitment to assuring the integrity of all programs so AHRQ can make a measurable difference in health care for all Americans. Quality, affordable health care for all Americans cannot occur without significant advances in the underlying evidence-based research that will enable better and more cost-effective treatments to be identified. Related projects that will be supported by AHRQ include: Patient-Centered Health Research; Value research; Prevention and Care Management research; Health Information Technology; investigator-initiated research; and Patient Safety research.

AHRQ's work to improve patient care continues through our investments in research to prevent healthcare-associated infections (HAIs). At any one time, 1 out of every 20 hospital patients has an HAI. HAIs are costly, deadly, and largely preventable. In 2009, there were approximately 41,000 cases of central line-associated bloodstream infection (CLABSI) in hospitals in the United States, leading to as many as 10,000 deaths, based on estimates from the Centers for Disease Control and Prevention. The average additional hospital cost for each case of CLABSI is over $16,500. The Keystone Project was an enormously successful AHRQ-funded initiative, which within 3 months reduced the rate of central line-related blood stream infections by two-thirds in more than 100 Michigan intensive care units (ICUs), and within 18 months saved more than 1,500 lives and nearly $200 million. The project was originally started by the Johns Hopkins University and the Michigan Health & Hospital Association to implement a Comprehensive Unit-based Safety Program (CUSP). CUSP 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 funding expanded CUSP to prevent CLABSI – a nationwide version of the Keystone Project – to encompass all 50 states, Puerto Rico, and the District of Columbia, and to extend the program's reach into hospital settings beyond the ICU. Interim results from 350 hospitals in the first two cohorts participating in the nationwide roll-out of CUSP for CLABSI are very encouraging. The average rate of CLABSI/1000 central line days decreased from 1.8 to 1.17 in the first four quarters, a drop of 35 percent. This drop translates into 430 CLABSIs prevented; and assuming a 25 percent mortality rate and an excess cost of $16,550 per CLABSI, as estimated by CDC, the observed rate decrease means ***108 deaths were prevented and over $7 million in excess costs were averted in one year***. CUSP has emerged as a recognized platform for the prevention of other infections, such as Catheter-Associated Urinary Tract Infections (CAUTI) and ventilator-associated pneumonia (VAP), and is also being adapted more broadly to address other patient safety events, such as those associated with surgical care. In FY 2013, following an approach similar to the successful implementation of CUSP for CLABSI, AHRQ will expand the nationwide implementation of CUSP for CAUTI and CUSP for safe surgery and will initiate the nationwide roll-out of CUSP for VAP. Results from pilot projects and from the nationwide CUSP for CLABSI show that CUSP has the potential to have a major impact in preventing various HAIs. In addition, these activities are contributing significantly to the attainment of the goals of the Partnership for Patients (PfP). Four of the nine hospital-acquired conditions (HACs) that the PfP seeks to reduce are HAIs – CLABSI, CAUTI, surgical site infections (SSI), and VAP – and AHRQ's CUSP implementation projects are thus integral components of the PfP's efforts to reduce these HACs.

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

Carolyn M. Clancy, M.D., Director
Agency for Healthcare Research and Quality

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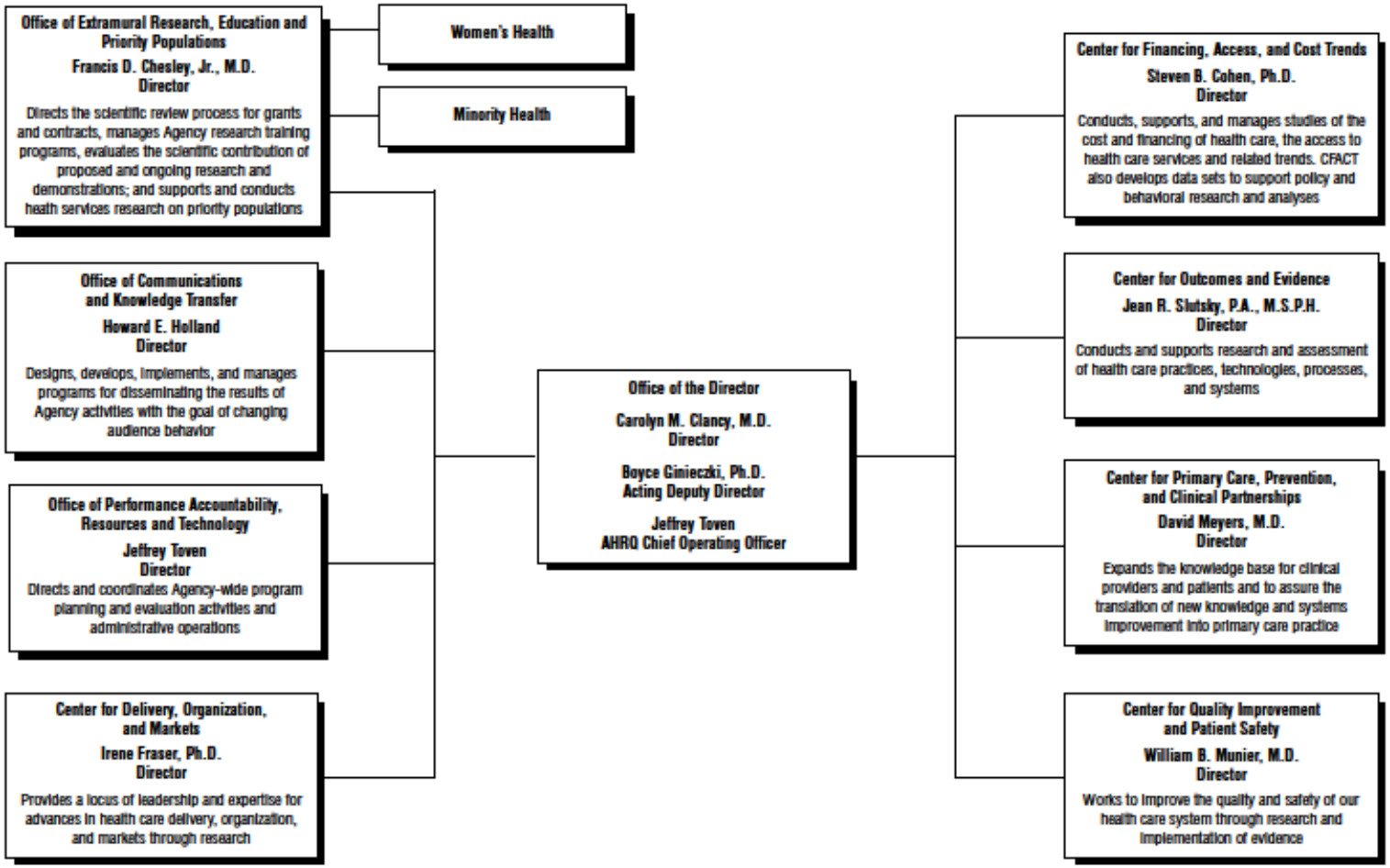
U.S. Department of Health and Human Services
Agency for Healthcare Research and Quality



AHRQ Pub. No. 11-M025
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May 2011

Performance Budget Overview

A. Introduction and Mission

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

HHS Organizational Focus

NIH
Biomedical research to prevent, diagnose and treat diseases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Overview of AHRQ Budget Request by Portfolio

AHRQ Budget Detail

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request Level	+/- over FY 2012 Enacted
Research on Health Costs, Quality, and Outcomes (HCQO):				
Patient-Centered Health Research	$29,000	$40,600	$72,400	$31,800
PCORTF Transfer (non-add)	*$8,000*	*$24,000*	*$62,400*	*$38,400*
Evaluation Funds	*$21,000*	*$16,600*	*$10,000*	*-$6,600*
Prevention/Care Management	27,904	27,904	27,904	$0
USPSTF - Prevention and Public Health Fund (non-add)	*7,000*	*7,000*	*7,000*	$0
Prevention Research - Prevention and Public Health Fund (non-add)	*5,000*	*5,000*	*5,000*	$0
Value	3,730	3,730	3,614	-$116
Health Information Technology	27,645	25,572	25,572	$0
Patient Safety	65,585	65,585	62,614	-$2,971
Crosscutting Activities Related to Quality, Effectiveness and Efficiency	111,789	108,377	88,931	-$19,446
HCQO, Total Program Level	**$265,653**	**$271,768**	**$281,035**	**$9,267**
HCQO, PHS Evaluation Funds	***$245,653***	***$235,768***	***$206,635***	***-$29,133***
Medical Expenditure Panel Surveys	**58,800**	**59,300**	**59,300**	**0**
Program Support	**67,600**	**73,985**	**68,422**	**-5,563**
Total Program Level	**392,053**	**405,053**	**408,757**	**$3,704**
PHS Evaluation Funds	372,053	369,053	334,357	-$34,696
Prevention and Public Health Fund	12,000	12,000	$12,000	$0
PCORTF Transfer	8,000	24,000	$62,400	$38,400

The AHRQ FY 2013 Request by Portfolio and Budget Activity

The FY 2013 Program Level Request for AHRQ is $408.757 million, an increase of $3.704 million or +0.9 percent from the FY 2012 Enacted level. In terms of PHS Evaluation Funds, AHRQ's request is $334.357 million, a decrease of $34.696 million or -9.4 percent below FY 2012. These funds will enable the health services research community to pursue a number of opportunities that will make a measurable difference in health care for all Americans.

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

- Patient-Centered Health Research (PCHR) is funded at $72.400 million, an increase of $31.800 million from the FY 2012 Enacted level. The total program level has two funding sources: PHS Evaluation funds totaling $10.000 million, a decrease of $6.600 million from FY 2012; and the Patient-Centered Outcomes Research Trust Fund (PCORTF) totaling $62.400 million, an increase of $38.400 million over FY 2012.
  - 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 incorporation of research findings, and to establish a process for receiving feedback on information disseminated. The activities undertaken using FY 2011 funds are provided on page 30. The planned activities for 2012 and 2013 are still under development.
  - The FY 2013 Request level for PHS Evaluation funds provides support for evidence generation ($6.723 million) and evidence synthesis ($2.127 million), and provides

funding for grant commitments for translation and dissemination ($0.250 million) and training and career development ($0.900 million). No funding is provided for horizon scanning, evidence gap identification, or the community forum.

- Prevention/Care Management Research is funded at $27.904 million, the same level of support as the prior year. The total program level has two funding sources: PHS Evaluation funds totaling $15.904 million, the same level of support as FY 2012; and Prevention and Public Health funds totaling $12.000 million.
  - Of the $12 million in FY 2013 Prevention and Public Health funds, $7.000 will be directed to the U.S. Preventive Services Task Force (USPSTF) and $5.000 million will provide for continuation support for the Research Centers for Excellence in Clinical Preventive Services first funded in FY 2011. Additional details on Prevention Fund activities are provided on page 81.
  - The FY 2013 Request level for PHS Evaluation funds is $15.904 million. These funds will provide $4.300 million in support for the US Preventive Services Task Force, for a total program level of $11.300 million. An additional $7.000 million is provided for research grants to improve primary care and clinical outcomes, and $4.404 million to support implementation activities to improve primary care.

- Value Research is funded at $3.614 million, a decrease of $0.116 million or -3.1 percent from the FY 2012 Enacted level. Research contract funds will support a comprehensive program that provides the measures, data, tools, and evidence needed to improve value, and partners with the field to turn this knowledge and tools into meaningful change. In 2013 AHRQ will focus on MONAHRQ 2.0 -- an award-winning web builder tool AHRQ designed to provide community leaders and consumers with timely local information about health and health care.

- Health Information Technology Research is funded at $25.572 million, the same level of support as the FY 2012 Enacted level. The FY 2013 Request level provides $6.676 million in new research grants for investigator-initiated health IT research and for research on consumer-focused uses of health IT and health care decision making. In order to support new research, the portfolio will curtail dissemination efforts. Coordinated efforts across the Department, including planned investments through ONC and the development of a single HHS-wide health IT-focused website, allow AHRQ to capitalize on new dissemination platforms and invest less in this activity.

- Patient Safety Research is funded at $62.614 million at the FY 2013 Request level, a decrease of $2.971 million or -4.5 percent from the FY 2012 Enacted level. Of this total, $34.000 million will be directed to research with a focus on prevention of Healthcare-Associated Infections (HAIs), the same level of support as the FY 2012 Enacted level. Additional support will be provided to continue the operation of the Patient Safety Organizations (PSO) program ($7.000 million) and Patient Safety Risks and Harms ($21.614 million, a decrease of $2.971 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.

- Crosscutting Activities Related to Quality, Effectiveness and Efficiency Research is funded at $88.931 million, a decrease of $19.446 million or -17.9 percent from the FY 2012 Enacted level. This decrease is directed to both research grants ($-14.800 million)

and research contracts ($-4.646 million). The FY 2013 Request level does provide $2.692 million for new grants, all of which will support new investigator-initiated research. At the Request level, total investigator-initiated research (continuing and new grants) totals $29.259 million, a decrease of $14.177 million from the FY 2012 Enacted level.

The Medical Expenditure Panel Survey (MEPS) will be funded at $59.300 million, the same level of support as the FY 2012 Enacted level. MEPS data have become the linchpin for economic models of health care use and expenditures. The data are key to estimating the impact of changes in financing, coverage and reimbursement policy on the U.S. healthcare system. No other surveys provide the foundation for estimating the impact of changes in national policy on various segments of the US population. This funding level will allow MEPS to operate at current levels.

Program Support (PS) will be funded at $68.422 million, a decrease of $5.563 million or -7.5 percent over the FY 2012 Enacted level. A total of $4.132 million of this reduction is associated with one-time expenditure in FY 2012 for tenant improvements associated with AHRQ's building move. AHRQ will implement several administrative efficiencies and prioritize operational functions for FY 2013 to offset the additional reduction.

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 and at AHRQ's total program level.

	FY 2011 Enacted	FY 2012 President's Budget	FY 2013 Request Level
FTEs – Total Program Level	308	320	328
FTEs – PHS Evaluation Funds	305	305	305

Note: This table does not include FTE funded through reimbursable funding.

C. Overview of Performance

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

FY 2013 Budget by HHS Strategic Goal
(Dollars in Thousands)

OPDIV: Agency for Healthcare Research and Quality (AHRQ)

HHS Strategic Goals and Objectives	FY 2011	FY 2012 Enacted	FY 2013 Request
1 Strengthen Health Care	**196,924**	**189,364**	**166,351**
1.B Improve health care quality and patient safety	165,549	160,062	137,165
1.D Reduce growth of health care costs while promoting high-value, effectivie care	3,730	3,730	3,614
1.F Promote the adoption and meaningful use of health information technology	27,645	25,572	25,572
2 Advance Scientific Knowledge and Innovation	**29,000**	**40,600**	**72,880**
2.A Accelerate the process of scientific discovery to improve patient care	29,000	40,600	72,880
3 Advance the Health, Safety, and Well-Being of the American Peopoe	**27,904**	**27,904**	**27,904**
3.D Promote prevention and wellness	27,904	27,904	27,904
4 Increase Efficiency, Transparency, and Accountability of HHS Programs	**92,395**	**101,329**	**95,581**
4.A Ensure program integrity and responsible stewardship of resources	21,482	27,834	22,092
4.C Use HHS data to improve the health and well-being of the American people	70,625	73,200	73,200
4.D Improve HHS environmental, energy, and economic performance to promote sustainability	288	295	289
5 Strengthen the Nation's Health and Human Service Infrastructure and Workforce	**45,830**	**45,856**	**46,041**
5A Invest in the HHS workforce to help meet America's health and human service needs today and tomorrow	45,830	45,856	46,041
Total, Program Level	**392,053**	**405,053**	**408,757**

Throughout the fiscal year, portfolios and programs have reported on key accomplishments and also acknowledged challenges in supporting their goals. The accomplishments include: 1) Medical Expenditure Panel Survey (MEPS) - release of national and state level data on employer sponsored health offers and premiums which is used to determine tax credits for small employers providing coverage to their employees as part of the affordable care act; 2) Centers for Education and Research on Therapeutics (CERTs) - publication of a web toolkit to assist nurses in communicating effectively about the safe use of warfarin – a blood thinner; 3) Patient-Centered Health Research – release of over 50 stakeholder driven, user-focused, evidence-based products on the effectiveness, benefits, and harms of different treatment options; 4) Value – development and release of version 2.0 of MONAHRQ (My Own Network Powered by AHRQ) which also reports AHRQ Quality Indicators and composites, HCAHPS measures, and CMS' Hospital Compare inpatient safety, mortality, and readmissions

measures; and, 5) Patient Safety – expansion of the common clinical definitions and reporting formats (Common Formats) for standardized reporting of patient safety events to the nursing home setting (including skilled nursing facilities), and the launched of a page (http://www.ahrq.gov/qual/impptdis.htm) on the AHRQ Web site featuring links to AHRQ-funded resources that aim to reduce readmissions to the hospital by improving information flow during the hospital discharge process. These resources showcase the tangible benefits of AHRQ research and help hospitals nationwide that continue to seek effective ways of decreasing their preventable readmission rates.

During the fiscal year, portfolios and programs may experience challenges around data issues. As stakeholders' requests for information continues, the challenge to reduce the time required to release evidence-based products and to meet accelerated data delivery schedules highlights the importance of gaining greater efficiencies with regard to data processing and preparation. Another data challenge is identifying relevant data sources to show impact of AHRQ's research. As programs continue to disseminate research, the ability to show the impact of such research is a constant concern that the Agency is working to address.

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

Discretionary All-Purpose Table

(dollars in thousands)

PROGRAM	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
RESEARCH ON HEALTH COSTS,				
QUALITY AND OUTCOMES				
Patient-Centered Health Research	**$29,000**	**$40,600**	**$72,400**	+31,800
PHS Evaluation Fund	*21,000*	*16,600*	*10,000*	*-6,600*
ACA Funds - PCORTF Transfer	*8,000*	*24,000*	*62,400*	*+38,400*
Preventive/Care Management	**27,904**	**27,904**	**27,904**	**-**
PHS Evaluation Fund	*15,904*	*15,904*	*15,904*	-
Prevention Research - ACA Funds - Prevention and Public Health Fund	*5,000*	*5,000*	*5,000*	-
USPSTF - ACA Funds - Prevention and Public Health Fund	*7,000*	*7,000*	*7,000*	-
Value Research	**3,730**	**3,730**	**3,614**	**-116**
Health Information Technology	**27,645**	**25,572**	**25,572**	**-**
Patient Safety	**65,585**	**65,585**	**62,614**	**-2,971**
Crosscutting Projects that Support Quality, Effectiveness and Efficiency Research	**111,789**	**108,377**	**88,931**	**-$19,446**
Budget Authority	$0	$0	$0	$0
PHS Evaluation	**245,653**	**235,768**	**206,635**	**-29,133**
ACA Funds - Prevention and Public Health Fund	*12,000*	*12,000*	*12,000*	*0*
ACA Funds - PCORTF Transfer	*8,000*	*24,000*	*62,400*	*+38,400*
Subtotal, HCQO Program Level	**$265,653**	**$271,768**	**$281,035**	**+9,267**
MEDICAL EXPENDITURES PANEL SURVEY				
Budget Authority	$0	$0	$0	$0
PHS Evaluation	58,800	59,300	59,300	*0*
Subtotal, MEPS	**$58,800**	**$59,300**	**$59,300**	**$0**
PROGRAM SUPPORT				
Budget Authority	$0	$0	$0	-
PHS Evaluation	67,600	73,985	68,422	*-5,563*
Subtotal, Program Support	**$67,600**	**$73,985**	**$68,422**	**-$5,563**
SUBTOTAL				
Budget Authority	**$0**	**$0**	**$0**	**$0**
PHS Evaluation	**$372,053**	**$369,053**	**$334,357**	**-$34,696**
ACA Funds - Prevention and Public Health Fund	**$12,000**	**$12,000**	**$12,000**	**$0**
ACA Funds - PCORTF Transfer	**$8,000**	**$24,000**	**$62,400**	**+$38,400**
TOTAL PROGRAM LEVEL	**$392,053**	**$405,053**	**$408,757**	**+$3,704**
FTEs				
Budget Authority	**0**	**0**	**0**	**0**
PHS Evaluation	**305**	**305**	**305**	**0**
ACA Funds - Prevention and Public Health Fund	**3**	**3**	**3**	**0**
ACA Funds - PCORTF Transfer	**0**	**12**	**20**	**+8**
TOTAL PROGRAM LEVEL	**308**	**320**	**328**	**+8**

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

AHRQ Detailed Mechanism Table 1/

(Dollars in Thousands)

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request	
	No.	Dollars	No.	Dollars	No.	Dollars
RESEARCH GRANTS						
Non-Competing						
Patient-Centered Health Research.	**35**	**13,204**	**20**	**5,945**	**22**	**4,055**
Prevention/Care Management……	**13**	**3,632**	**13**	**7,586**	**9**	**5,760**
PHS Evaluation Fund……	*13*	*3,632*	*10*	*3,189*	*6*	*1,311*
ACA - Prevention and Public Health Fund..	*0*	*0*	*3*	*4,397*	*3*	*4,449*
Value……	**0**	**0**	**0**	**0**	**0**	**0**
Health Information Technology ….	**20**	**5,766**	**28**	**8,106**	**43**	**12,300**
Patient Safety ……	**41**	**21,730**	**50**	**24,695**	**39**	**16,668**
Crosscutting Activities……	**142**	**39,746**	**110**	**35,022**	**109**	**33,472**
Medical Expenditure Panel Survey	**0**	**0**	**0**	**0**	**0**	**0**
Total Non-Competing ……	**251**	**84,078**	**221**	**81,354**	**222**	**72,255**
New & Competing						
Patient-Centered Health Research.	**0**	**0**	**0**	**0**	**0**	**0**
Prevention/Care Management……	**10**	**7,382**	**6**	**1,311**	**20**	**5,689**
PHS Evaluation Fund……	*7*	*3,033*	*6*	*1,311*	*20*	*5,689*
ACA - Prevention and Public Health Fund..	*3*	*4,349*	*0*	*0*	*0*	*0*
Value……	**0**	**0**	**0**	**0**	**0**	**0**
Health Information Technology ….	**24**	**7,092**	**18**	**6,170**	**13**	**6,676**
Patient Safety ……	**22**	**8,348**	**17**	**5,900**	**16**	**6,400**
Crosscutting Activities……	**86**	**10,857**	**94**	**15,942**	**11**	**2,692**
Medical Expenditure Panel Survey	**0**	**0**	**0**	**0**	**0**	**0**
Total New & Competing ……	**142**	**33,679**	**135**	**29,323**	**60**	**21,457**
RESEARCH GRANTS						
Patient-Centered Health Research.	**35**	**13,204**	**20**	**5,945**	**22**	**4,055**
Prevention/Care Management……	**23**	**11,014**	**19**	**8,897**	**29**	**11,449**
PHS Evaluation Fund……	*20*	*6,665*	*16*	*4,500*	*26*	*7,000*
ACA - Prevention and Public Health Fund..	*3*	*4,349*	*3*	*4,397*	*3*	*4,449*
Value……	**0**	**0**	**0**	**0**	**0**	**0**
Health Information Technology ….	**44**	**12,858**	**46**	**14,276**	**56**	**18,976**
Patient Safety ……	**63**	**30,078**	**67**	**30,595**	**55**	**23,068**
Crosscutting Activities……	**228**	**50,603**	**204**	**50,964**	**120**	**36,164**
Medical Expenditure Panel Survey	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL, RESEARCH GRANTS	**393**	**117,757**	**356**	**110,677**	**282**	**93,712**
PHS Evaluation Fund……		*113,408*		*106,280*		*89,263*
ACA - Prevention and Public Health Fund..		*4,349*		*4,397*		*4,449*

1/ Does not include ACA funds from the PCORTF.

AHRQ Detailed Mechanism Table Continued 1/

(Dollars in Thousands)

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request	
	No.	Dollars	No.	Dollars	No.	Dollars
CONTRACTS/IAAs						
Patient-Centered Health Research..		**7,796**		**10,655**		**5,945**
Prevention/Care Management……		**16,501**		**18,623**		**16,071**
PHS Evaluation Fund……		*9,239*		*11,404*		*8,904*
ACA - Prevention and Public Health Fund..		*7,262*		*7,219*		*7,167*
Value……		**3,730**		**3,730**		**3,614**
Health Information Technology ……		**14,787**		**11,296**		**6,596**
Patient Safety ……		**35,507**		**34,990**		**39,546**
Crosscutting Activities……		**61,186**		**57,413**		**52,767**
Medical Expenditure Panel Survey..		**58,800**		**59,300**		**59,300**
TOTAL CONTRACTS/IAAs.....		**198,307**		**196,007**		**183,839**
PHS Evaluation Fund……		*191,045*		*188,788*		*176,672*
ACA - Prevention and Public Health Fund..		*7,262*		*7,219*		*7,167*
RESEARCH MANAGEMENT.....		**67,984**		**74,369**		**68,806**
PHS Evaluation Fund……		*67,600*		*73,985*		*68,422*
ACA - Prevention and Public Health Fund..		*384*		*384*		*384*
TOTAL RESEARCH MANAGEMENT..		**67,984**		**74,369**		**68,806**
GRAND TOTAL						
Patient-Centered Health Research..		**21,000**		**16,600**		**10,000**
PHS Evaluation Fund……		*21,000*		*16,600*		*10,000*
Prevention/Care Management……		**27,899**		**27,904**		**27,904**
PHS Evaluation Fund……		*15,904*		*15,904*		*15,904*
ACA - Prevention and Public Health Fund..		*11,995*		*12,000*		*12,000*
Value……		**3,730**		**3,730**		**3,614**
Health Information Technology ……		**27,645**		**25,572**		**25,572**
Patient Safety ……		**65,585**		**65,585**		**62,614**
Crosscutting Activities……		**111,789**		**108,377**		**88,931**
Medical Expenditure Panel Survey..		**58,800**		**59,300**		**59,300**
Research Management……..		**67,600**		**73,985**		**68,422**
GRAND TOTAL						
PHS Evaluation……		**372,053**		**369,053**		**334,357**
ACA - Prevention and Public Health Fund....		**11,995**		**12,000**		**12,000**
GRAND TOTAL……		**384,048**		**381,053**		**346,357**

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, **[**$369,053,000**]** *$334,357,000* 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, 2013**]** *expended.*

Language Analysis

Language Provision	Explanation
"…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, 2013] *expended*."	AHRQ recommends revising the language to provide availability of funding from a 2-year account to a no-year account. Use of a no-year account allows for planning of research projects that are longer term in nature -- generally lasting from 3 to 5 years -- to more efficiently implement these research activities.

Amounts Available for Obligation

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Amounts Available for Obligation 1/

	2011 Actual 2/	FY 2012 Enacted	FY 2013 PB
Appropriation:			
Annual.....	$0	$0	$0
Subtotal, adjusted appropriation.....	$0	$0	$0
Offsetting Collections from:			
Federal funds pursuant to Title IX of P.L. 102-410, (Section 947(c) PHS Act)			
HCQO.....	$245,653,000	$235,768,000	$206,635,000
MEPS.....	$58,800,000	$59,300,000	$59,300,000
Program Support.....	$67,600,000	$73,985,000	$68,422,000
Subtotal, adjusted appropriation.....	$372,053,000	$369,053,000	$334,357,000
Unobligated Balance Lapsing.....	-$1,151,000	---	---
Total obligations.....	$370,902,000	$369,053,000	$334,357,000

1/ Excludes funding from other HHS operating divisions provided through reimbursable agreements.
2/ Reflects actual obligations. Excludes obligations from other reimbursable funds.

Summary of Changes

2012 Total estimated budget authority ..... $ -0-
(Obligations) ..... ($369,053,000)

2013 Total estimated budget authority ..... $ -0-
(Obligations) ..... ($334,357,000)

Net change ..... $ -0-
(Obligations) ..... (-$ 34,696,000)

	2012 Estimate		Change from Base	
	(FTE)	Budget Authority	(FTE)	Budget Authority
Increases				
A. Built-in:				
1. Military Annualization of FY 2012 pay raise	--	--	--	--
	(--)	(46,352,000)	(--)	(+ 8,000)
2. GS January 2013 pay raise	--	--	--	--
	(--)	(46,352,000)	(--)	(+165,000)
3. One More Day of Pay	--	--	--	--
	(--)	(46,352,000)	(--)	(+169,000)
4. Rental Payments to GSA	--	--	--	--
	(--)	(4,335,000)	(--)	(+74,000)
5. Inflation Costs on Other Objects.....	--	--		
			(--)	(+369,000)
**Subtotal, Built-in ..... **			**--**	**--**
			(--)	**(+785,000)**
B. Program:				
**Subtotal, Program ..... **			**--**	**--**
			(+0)	**(+000,000)**
**Total Increases ..... **			**--**	**--**
			(+0)	**(+785,000)**

Summary of Changes Continued

	2012 Estimate		Change from Base	
	(FTE)	Budget Authority	(FTE)	Budget Authority
Decreases				
A. Built-in:				
Subtotal, Built-in			**--**	**--**
			(--)	**(-000,000)**
B. Program:				
HCQO				
1. Patient-Centered Health Research	--	--	--	--
	(--)	($16,600,000)	(--)	(-6,600,000)
2. Value	--	--	--	--
	(--)	($3,730,000)	(--)	(-116,000)
3. Patient Safety	--	--	--	--
	(--)	($65,585,000)	(--)	(-2,971,000)
4. Crosscutting Activities	--	--	--	--
	(--)	($108,377,000)	(--)	(-19,446,000)
5. Research Management	--	--	--	--
	(--)	($73,985,000)	(--)	(-6,348,000)
Subtotal, Program			**--**	**--**
			(--)	**(-35,481,000)**
Total Decreases			**--**	**--**
			(--)	**(-35,481,000)**
Net change, Budget Authority			**--**	**--**
Net change, Obligations			**(+0)**	**(-34,696,000)**

Budget Authority by Activity 1/

(Dollars in thousands)

	FY 2011 Actual		FY 2012 Enacted		FY 2013 PB	
	FTE	Amount	FTE	Amount	FTE	Amount
1. Research on Health Costs,						
Quality, & Outcomes BA	---	0		0	---	0
PHS Evaluation	[0]	[$245,653]	[0]	[$235,768]	[0]	[$206,635]
Total Operational Level	0	245,653	0	235,768	0	206,635
2. Medical Expenditures Panel						
Surveys BA	---	---	---	---	---	---
PHS Evaluation	---	[58,800]	---	[59,300]	---	[59,300]
Total Operational Level	---	58,800	---	59,300	---	59,300
3. Program Support BA	---	---	---	---	---	---
PHS Evaluation	[305]	[67,600]	[305]	[73,985]	[305]	[68,422]
Total Operational Level	305	67,600	305	73,985	305	68,422
Total, Budget Authority	0	0	0	0	0	0
Total PHS Evaluation	[305]	[372,053]	[305]	[369,053]	[305]	[334,357]
Total Operations	305	$372,053	305	$369,053	305	$334,357

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/

	2012 Amount Authorized	2012 Enacted	2013 Amount Authorized	FY 2013 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	$369,053	Indefinite	$334,357
Total appropriations.....		$369,053		$334,357
Total appropriation against definite authorizations.....	----	----	----	----

SSAN = Such Sums As Necessary

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

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

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

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

5/ Expired September 30, 2005.

AHRQ Appropriations History

	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriation	
2004					
Budget Authority.....	$ -	$ -	$ -	$ -	
PHS Evaluation Funds.....	$ 279,000,000	$ 303,695,000	$ 303,695,000	$ 318,695,000	
Total.....	$ 279,000,000	$ 303,695,000	$ 303,695,000	$ 318,695,000	
2005					
Budget Authority.....	$ -	$ -	$ -	$ -	
PHS Evaluation Funds.....	$ 303,695,000	$ 303,695,000	$ 318,695,000	$ 318,695,000	
Total.....	$ 303,695,000	$ 303,695,000	$ 318,695,000	$ 318,695,000	
2006					
Budget Authority.....	$ -	$ 318,695,000	$ -	$ -	
PHS Evaluation Funds.....	$ 318,695,000	$ -	$ 323,695,000	$ 318,692,000	
Total.....	$ 318,695,000	$ 318,695,000	$ 323,695,000	$ 318,692,000	
2007					
Budget Authority.....	$ -	$ 318,692,000	$ 318,692,000	$ -	
PHS Evaluation Funds.....	$ 318,692,000	$ -	$ -	$ 318,983,000	
Total.....	$ 318,692,000	$ 318,692,000	$ 318,692,000	$ 318,983,000	
2008					
Budget Authority.....	$ -	$ 329,564,000	$ 329,564,000	$ -	
PHS Evaluation Funds.....	$ 329,564,000	$ -	$ -	$ 334,564,000	
Total.....	$ 329,564,000	$ 329,564,000	$ 329,564,000	$ 334,564,000	
2009					
Budget Authority.....	$ -	$ 323,087,000	$ 90,598,000	$ -	
PHS Evaluation Funds.....	$ 325,664,000	$ 51,913,000	$ 243,966,000	$ 372,053,000	
ARRA Funding P.L. 111-5.....	$ -	$ -	$ -	$ 1,100,000,000	1/
Total.....	$ 325,664,000	$ 375,000,000	$ 334,564,000	$ 1,472,053,000	
2010					
Budget Authority.....	$ -	$ -	$ -	$ -	
PHS Evaluation Funds.....	$ 372,053,000	$ 372,053,000	$ 372,053,000	$ 397,053,000	
Total.....	$ 372,053,000	$ 372,053,000	$ 372,053,000	$ 397,053,000	
2011					
Budget Authority.....	$ -	$ -	$ -	$ -	
PHS Evaluation Funds.....	$ 610,912,000	$ -	$ 397,053,000	$ 372,053,000	
Total.....	$ 610,912,000	$ -	$ 397,053,000	$ 372,053,000	
2012					
Budget Authority.....	$ -	$ -	$ -	$ -	
PHS Evaluation Funds.....	$ 366,397,000	$ 324,294,000	$ 372,053,000	$ 369,053,000	
Total.....	$ 366,397,000	$ 324,294,000	$ 372,053,000	$ 369,053,000	
2013					
Budget Authority.....	$ -	$ -	$ -	$ -	
PHS Evaluation Funds.....	$ 334,357,000	$ -	$ -	$ -	
Total.....	$ 334,357,000	$ -	$ -	$ -	

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

Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level in Last Year of Authorization	Appropriations in Last Year of Authorization	Appropriations in FY 2013
Research on Health Costs, Quality, and Outcomes……	FY 2005	Such Sums As Necessary	260,695,000	206,635,000

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

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
TOTAL			
--BA	$0	$0	$0
--PHS Eval	245,653,000	235,768,000	206,635,000
--Prev. & Public Hlth Fund	12,000,000	12,000,000	12,000,000
--PCORTF Transfer	8,000,000	24,000,000	62,400,000
Total Program Level	**$265,653,000**	**$271,768,000**	**$281,035,000**

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 2012 Authorization……..……....Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

Summary

AHRQ's Program Level for Research on Health Costs, Quality, and Outcomes (HCQO) in FY 2013 is $281.035 million, an increase of $9.267 million or +3.4 percent from the FY 2012 Enacted level. In terms of PHS Evaluation Funds, the request is $206.635 million, a decrease of $29.133 million or -12.4 percent from the FY 2012 Enacted level.

AHRQ Budget Detail
(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request Level	+/- over FY 2012 Enacted
Research on Health Costs, Quality, and Outcomes (HCQO):				
Patient-Centered Health Research	$29,000	$40,600	$72,400	$31,800
PCORTF Transfer (non-add)	*$8,000*	*$24,000*	*$62,400*	*$38,400*
Evaluation Funds	*$21,000*	*$16,600*	*$10,000*	*-$6,600*
Prevention/Care Management	27,904	27,904	27,904	$0
USPSTF - Prevention and Public Health Fund (non-add)	*7,000*	*7,000*	*7,000*	$0
Prevention Research - Prevention and Public Health Fund (non-add)	*5,000*	*5,000*	*5,000*	$0
Value	3,730	3,730	3,614	-$116
Health Information Technology	27,645	25,572	25,572	$0
Patient Safety	65,585	65,585	62,614	-$2,971
Crosscutting Activities Related to Quality, Effectiveness and Efficiency	111,789	108,377	88,931	-$19,446
HCQO, Total Program Level	**$265,653**	**$271,768**	**$281,035**	**$9,267**
HCQO, PHS Evaluation Funds	***$245,653***	***$235,768***	***$206,635***	***-$29,133***

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

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

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

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

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

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

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

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

***Program increases at FY 2013 Request Level*:**

HCQO: Patient-Centered Health Research (+$31. 800 million): The FY 2013 Request provides $72.400 million for the Patient-Centered Health Research (PCHR) portfolio, an increase of $31.800 million from the FY 2012 Enacted level. This increase is all attributable to mandatory funds transferred to AHRQ from the Patient-Centered Outcomes Research Trust Fund. As authorized in section 937 of the Public Health Service Act, AHRQ will disseminate research findings from the Patient-Centered Outcomes Research Institute and other government-funded comparative clinical effectiveness research and build research and data capacity for comparative clinical effectiveness research. Funds provided through PHS Evaluation Funds at the FY 2013 level totals $10.000 million, a decrease of $6.600 million from FY 2012. These funds will provide support for evidence synthesis ($2.127 million), evidence generation ($6.723 million), and provides funding for grant commitments for translation and dissemination ($0.250 million) and training and career development ($0.900 million). No funding is provided for horizon scanning, evidence gap identification, or the community forum.

Program decreases at FY 2013 Request Level:

HCQO: Value Research (-$0.116 million): The FY 2013 Request reduces the Value portfolio by $0.116 million or -3.1 percent from the FY 2012 Enacted level. This reduction is reflected in reduced research contract support.

HCQO: Patient Safety Research (-$2.971 million): The FY 2013 Request reduces the Patient Safety portfolio by $2.971 million or -4.5 percent from the FY 2012 Enacted level. This reduction is reflected in reduced research grant support.

HCQO: Crosscutting Activities Related to Quality, Effectiveness and Efficiency Research (-$19.446 million): The FY 2013 Request reduces the Crosscutting Activities portfolio by $19.446 million or -17.9 percent from the FY 2012 Enacted level. A total of $14.800 million is reduced from research grants and $4.646 million is reduced from research contracts.

5-Year Table Reflecting Dollars

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

Year	Dollars
2008	$216,884,000
2009	$251,631,000
2010	$276,153,000
2011	$265,653,000
2012	$271,768,000

Patient-Centered Health Research/Effective Health Care

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
TOTAL			
--BA	$0	$0	$0
--PHS Eval	21,000,000	16,600,000	10,000,000
--PCORTF Transfer	8,000,000	24,000,000	62,400,000
Total Program Level	$29,000,000	$40,600,000	$72,400,000

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

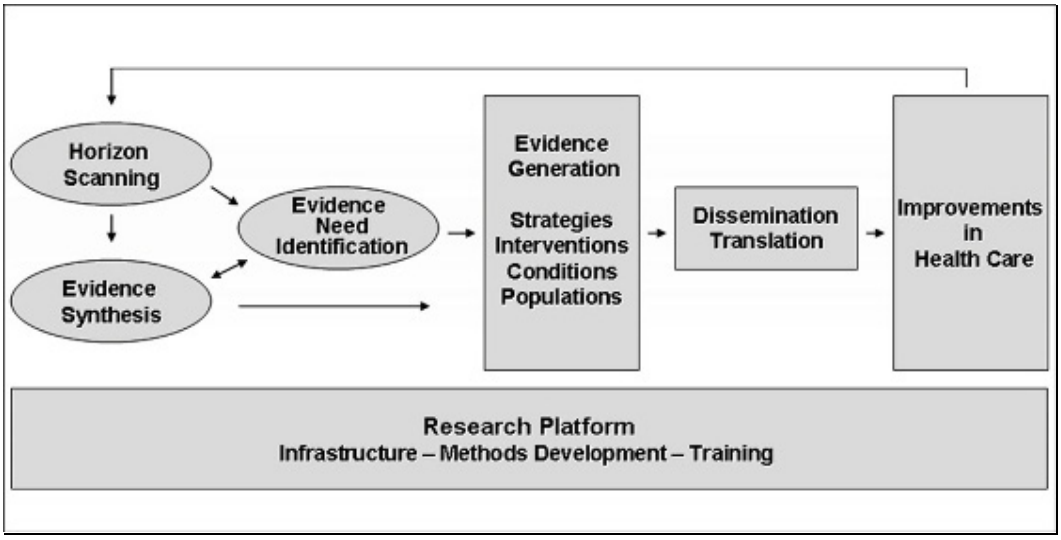
FY 2012 Authorization……..Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

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

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

AHRQ conceptualizes the process of generating patient-centered health research as shown on the following page. Stakeholder input occurs through all steps of this process to ensure the relevance of the research to decision makers. AHRQ actively involves stakeholders, including other HHS OPDIVs, in the patient-centered outcomes research process. This begins with the identification and prioritization of research questions. One example of how we have done this is by holding expert meetings on a given clinical topic. We invite stakeholder representatives from public and private payers, federal agencies, patient/consumer groups, foundations, product developers, and professional societies, in addition to clinical researchers. The goals of the meeting are to identify clinical problems for which new research will inform treatment decisions for patients and providers (especially beneficiaries of the Medicare and Medicaid programs) and to identify, in partnership with stakeholders, clinically-or policy-relevant research questions related to the topic.



This provides credibility and usability to our research, helps us avoid prioritizing topics that have no relevance to real-world issues, and reduces potential duplication. Additionally, we engage key stakeholder informants and technical experts (including HHS OPDIVs) to provide additional input to AHRQ in formulating key questions for both research reviews and new research. These key stakeholder informants and technical experts are invited to peer review draft reports. The draft key questions for reviews and draft research review reports are also posted on the Effective Health Care Web site (www.EffectiveHealthCare.ahrq.gov) for the public to review and provide comments. Finally, we have dedicated staff liaisons to HHS OPDIVs to ensure continual communication in this important area.

In addition to appropriated funds, this portfolio receives funding through the Patient-Centered Outcomes Research Trust Fund (PCORTF) established through the Affordable Care Act to build research capacity and to translate and disseminate comparative clinical effectiveness research. Investments in FY 2013 AHRQ core patient-centered health research activities will be made strategically in consideration of activities that are supported by the Patient-Centered Outcomes Research Trust Fund and to avoid duplication. For example, the FY 2013 AHRQ Budget does not invest in new training or dissemination activities since PCORTF resources will be used to support these activities within AHRQ.

B. FY 2013 Justification by Activity Detail

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

Research Activity	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Horizon Scanning (Contracts)	$0.000	$0.000	$0.000
Evidence Synthesis	2.127	9.700	2.127
Evidence Gap Identification	0.000	0.000	0.000
Evidence Generation	12.803	5.000	6.723
Translation and Dissemination	4.559	0.500	0.250
Training and Career Development	1.511	1.400	0.900
Community Forum (Stakeholder Engagement)	0.000	0.000	0.000
TOTAL, PCHR (PHS Evaluation Funds)	**$21.000**	**$16.600**	**$10.000**
PCORTF Allocation	8.000	24.000	62.400
TOTAL Program Level, PCHR	**$29.000**	**$40.600**	**$72.400**

Overall Budget Policy:

Horizon Scanning: Horizon scanning is the identification of current or emerging medical interventions available to diagnose, treat, or otherwise manage a particular condition. Horizon scanning activities are important for understanding the relevant healthcare context and landscape, as a basis for identifying and beginning to prioritize among research needs. AHRQ used FY 2009/ /2010 Recovery Act funding to establish an infrastructure to identify new and/or emerging issues for research review investments. This program is dedicated to tracking emerging technologies and investigating their contextual role in health care. In FY 2011 and FY 2012 there were no appropriated funds available to support this activity.

FY 2013 Request Budget Policy: The FY 2013 Request does not include funds for this activity.

Evidence Synthesis: Evidence synthesis focuses on the review and synthesis of current medical research, to provide rigorous evaluation of what is known on the basis of existing research about

the comparative effectiveness of alternative approaches to the given clinical problem. Evidence synthesis involves the distillation of a body of evidence generally comprised of multiple studies and often including a combination of trials and non-experimental studies, to provide the most relevant information possible for clinicians and other decision makers. AHRQ used FY 2009/2010 Recovery Act funding to increase support for research reviews. AHRQ also strategically built upon the existing strengths of the Evidence-based Practice Centers (EPCs), enhancing capacity at the EPCs to create a larger and stronger pool of expertise in systematic review and to advance the scientific methods of systematic review. In FY 2011 AHRQ provided $2.127 million to support a limited number of EPCS to update existing comparative effectiveness reviews as required in Section 1013 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and to do research on methods for conducting systematic review. The FY 2012 level includes $9.700 million to assess the science already available or in the pipeline on cutting edge issues identified through horizon scanning activities and context changing events, including but not limited to clinical, system level, organization and behavior changing events as they directly relate to patients in a reforming health system. These funds will support approximately 10 contract task orders.

FY 2013 Request Budget Policy: The FY 2013 Request provides $2.127 million for this activity, a decrease of $7.573 million from the FY 2012 Enacted level. These funds will support a limited number of EPCs to perform comparative effectiveness reviews and update existing comparative effectiveness reviews as required in Section 1013 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Evidence Gap Identification: Evidence gap identification is the identification of areas where new research conducted would contribute to bridging the gap between existing medical research and clinical practice. This effort produces recommendations that further consider the timing, value and feasibility of research that would fill these gaps and includes coordination with other funders as well researchers able to conduct needed research. FY 2009/2010 Recovery Act funding allowed AHRQ to put greater emphasis on the identification of evidence needs in the systematic review process. A process was developed that involves stakeholders, including clinicians, funding agencies, and researchers, considering gaps identified in systematic reviews. This activity helps shape research agendas for future research and identifies priorities for national investments in new research based on the findings. For example, the University of Minnesota Evidence-based Practice Center worked on a project to emphasize where gaps in evidence exist for patients who have sustained a hip fracture. They developed a report that includes information about where further information is needed and will describe, with input from stakeholders, the feasibility of conducting this research as well as the potential value of it. In FY 2011 and FY 2012 there were no appropriated funds available to support this activity.

FY 2013 Request Budget Policy: The FY 2013 Request does not include funds for this activity.

Evidence Generation: Evidence generation within the PCHR portfolio is the conduct of new research that compares the effectiveness of different health care interventions. It is essential to meeting the needs of clinical and health policy decision makers. FY 2009/2010 Recovery Act funding included both efforts to build the infrastructure for conducting studies that compare the effectiveness of different health care interventions, and underwriting rigorous research with dedicated study designs and data collection to definitively address knowledge gaps that could not otherwise be addressed. Projects in FY 2011 were aimed at addressing specific stakeholder-identified research gaps in serious mental illness and implantable cardioverter defibrillators. In FY 2012 AHRQ will invest $5.000 million in this activity. These funds will support $4.045 million in continuation costs of grants funded in prior years and $0.955 million in Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) Network research contracts.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $6.723 million for this activity, an increase of $1.723 million from the FY 2012 Enacted level. AHRQ will use Evidence Generation funds to support re-competition of the DEcIDE research contract ($3.818 million) and to fund continuation support of existing PCHR grants ($2.905 million). No new grants will be funded.

Translation and Dissemination: Dissemination and translation efforts ensure that knowledge synthesized or generated within the patient-centered health research program is available to decision makers to better inform their decisions. AHRQ produces summary guides for stakeholder groups, including the general public, patients, providers, payers, and policy-makers, with information tailored to their circumstances. AHRQ also supports innovative research on incorporating patient-centered health research findings into decision making. With FY 2009/2010 Recovery Act funding, AHRQ increased efforts in this area, expanding the number of clinician- and consumer-oriented summaries of findings produced by the Eisenberg Center. FY 2010 and 2011 funds were used to support continuing grants. The FY 2012 Enacted includes $0.500 million to support grant commitments funded in prior years.

FY 2013 Request Budget Policy: The FY 2013 Request provides $0.250 million for this activity, $0.250 million less than the FY 2012 Enacted level. AHRQ will use Translation and Dissemination funds to support grant commitments from prior years. No new grants will be funded. The FY 2013 Request takes into account anticipated funding for this research component through funds provided to AHRQ from the Patient-Centered Outcomes Research Trust Fund to disseminate research findings.

Training and Career Development: Research training and career development of researchers and clinicians will strengthen the research infrastructure and build capacity through ensuring a sufficient pool of research expertise for national efforts in research that compares the effectiveness of different health care interventions. With FY 2009/2010 Recovery Act funding, AHRQ provided institutional support to increase the intellectual and organizational capacity for larger scale research programs and allowed fellowship training opportunities. Through grant mechanisms, funding supported the career development of clinicians and research doctorates focusing their research on the synthesis, generation, and translation of new scientific evidence and analytic tools for patient-centered health research. FY 2011 and 2012 funds were used to support continuing grants.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $0.900 million for this activity, $0.500 million less than the FY 2012 Enacted level. AHRQ will use Training and Career Development funds to support grant commitments from prior years; no new grants will be funded. The FY 2013 Request takes into account anticipated funding for this research component through funds provided to AHRQ from the Patient-Centered Outcomes Research Trust Fund to support these activities.

Community Forum (Stakeholder Engagement): Stakeholder engagement means consistently and comprehensively involving stakeholders in all aspects of the Effective Health Care Program. AHRQ used FY 2009/2010 Recovery Act funding to establish and support a Community Forum on Effective Health Care to formally engage stakeholders in the entire Effective Health Care enterprise and to continue to open up and make the program inclusive and transparent. This initiative was built on a smaller initiative that has guided AHRQ's Effective Health Care Program until now and is an important component for a larger and more sustained national initiative in patient-centered health research, translation, and use. There were no FY 2011 or FY 2012 appropriated funds available to support these activities.

FY 2013 Request Budget Policy: The FY 2013 Request does not include funds for this activity.

C. Mechanism Table for Patient-Centered Health Research

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

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	35	13,204	20	5,945	22	4,055
New & Competing……	0	0	0	0	0	0
Supplemental	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	**35**	**13,204**	**20**	**5,945**	**22**	**4,055**
TOTAL CONTRACTS/IAAs		**7,796**		**10,655**		**5,945**
TOTAL		**21,000**		**16,600**		**10,000**

D. Funding History

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

Year	Dollars
2008	$ 30,000,000
2009	$ 50,000,000
2010	$ 21,000,000
2009/10 Recovery Act	$300,000,000
2011	$ 21,000,000
2011 ACA PCORTF Transfer	$ 8,000,000
2012	$ 16,600,000
2012 ACA PCORTF Transfer	$ 24,000,000

E. Patient-Centered Outcomes Research Trust Fund

Public Law 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). 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. Transferred funds will be distributed to the Secretary of HHS and

the Agency for Healthcare Research and Quality to carry out these activities.

As directed in the statute, AHRQ will use the funds to establish grants to train researchers, disseminate research findings of the Patient Centered Outcomes Research Institute and other government-funded research, and assist with the incorporation of research findings, and establish a process for receiving feedback on information disseminated. The activities AHRQ will support will continue to maintain the infrastructure to support research now and in the future, and will provide for a growing number of flexible, well-trained researchers to accommodate demands. Additionally, the investments will build on current AHRQ efforts and complement what is already being done, while also being distinct.

Projects funded with the PCORTF funding are chosen to be consistent and complementary with PCORI activities and needs. This is accomplished via the presence of AHRQ and NIH senior leaders as members of the PCORI Board of Governors and Methodology Committee. Additionally, AHRQ and NIH have regular consultations regarding this work and PCORI to ensure that activities funded using the PCORTF funding are unique and not duplicative. Finally, AHRQ is frequently collaborating with HHS Office of the Secretary on their PCORTF activities and this serves to make sure the projects are complementary of OS activities.

FY 2011 Activities

AHRQ proposed research grant and contract activities totaling $5.720 million of the $8.000 million available in FY 2011 through the Patient-Centered Outcomes Research Trust Fund (PCORTF). Most of these funds will be obligated in early FY 2012. AHRQ's investments are separated into 3 distinct areas: Training and Career Development, Dissemination and Implementation, and Administrative Costs.

Training and Career Development in Patient-Centered Outcomes Research ($2.000 million)

The Affordable Care Act provides additional opportunities to build capacity in patient-centered outcomes research (PCOR), specifically with regard to training in the methods used to conduct such research. In FY 2011, AHRQ proposed a $2.000 million grant initiative to fund two-year fellowships through institutional training programs for training in PCOR. A focus for these fellowships will be recruitment of trainees from diverse disciplines, including social and behavioral sciences, business, and engineering.

Dissemination and Implementation ($3.707 million)

In FY 2011 AHRQ proposed a variety of dissemination and implementation projects responsive to Section 937, Dissemination and Building Capacity for Research. These projects are funded using competitive research contracts and are focused on the following areas of PCOR research:

- Dissemination of patient-centered outcomes research to health professional student associations, such as the American Medical Students Association, the American Pharmacists Association Academy of Student Pharmacists, and others to evaluate students' understanding of the importance and clinical applicability of patient-centered outcomes research and shared decision making to their practice.

- Dissemination of patient-centered outcomes research to business leaders and their employees, as well as an evaluation of various dissemination methods of patient-centered outcomes research information to this population.

- Dissemination of patient-centered outcomes research via enhanced in-store promotion by expanding prior successes to promote patient-centered outcome research through PCOR-

focused public service announcements in grocery stores, specifically their in-store pharmacies, nationwide.

- Development of a patient-centered outcomes research methods symposium and publications to disseminate research findings relevant to comparative informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policymakers.

Administrative Costs ($0.013 million). In FY 2011 AHRQ required $0.013 million to begin implementation of these activities. FY 2011 support only includes salary and benefit costs. Additional administrative costs necessary for program management of funds, including travel costs for site visits, will be used in subsequent years.

FY 2012 and FY 2013 Activities

The planned activities for 2012 and 2013 are still under development. AHRQ is estimating the 12 FTE to support activities proposed in 2011 and 2012 and 20 total FTEs in FY 2013 (+8 FTE) at this time. These estimates could change depending on the type of activities proposed in FY 2012 and FY 2013.

Prevention/Care Management

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
TOTAL			
--BA	$0	$0	$0
--PHS Eval	15,904,000	15,904,000	15,904,000
--Prev. & Public Hlth Fund	12,000,000	12,000,000	12,000,000
Total Program Level	$27,904,000	$27,904,000	$27,904,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2012 Authorization……..……..Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

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

B. FY 2013 Justification by Activity Detail

Prevention/Care Management Activities
(in millions of dollars)

Research Activities	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
Research Grants to Improve Primary Care and Clinical Outcomes	$ 11.500	$ 9.000	$ 11.500
Prevention and Public Health Fund (non-add)	*4.500*	*4.500*	*4.500*
Clinical Decision-making for Preventive Services	11.500	12.000	11.500
Prevention and Public Health Fund (non-add)	*7.000*	*7.000*	*7.000*
USPSTF Support (non-add)	*11.300*	*11.300*	*11.300*
Implementation Activities to Improve Primary Care	4.904	6.904	4.904
Prevention and Public Health Fund (non-add)	*0.500*	*0.500*	0.500
Total, Prevention/Care Management	**$27.904**	**$27.904**	**$27.904**
Prevention and Public Health Fund (non-add)	***$12.000***	***$ 12.000***	***$12.000***

Overall Budget Policy:

Research Grants to Improve Primary Care and Clinical Outcomes: The Prevention/Care Management Portfolio fosters the generation of new knowledge about clinical preventive services and chronic conditions with a focus on the care of complex patients with multiple chronic conditions. Results from this research will provide the evidence needed to support clinical decision making by clinicians and patients, and transform the delivery of prevention and care management services to provide better access to care and make care more effective. The 2012 Enacted includes $7.586 million in non-competing grants, including three Centers for Excellence in Clinical Preventive Services funded through the Prevention and Public Health Fund. In FY 2012 AHRQ will also fund $1.311 million in new, investigator-initiated grants related to prevention and chronic care.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $11.500 million for this activity, an increase of $2.500 million over the FY 2012 Enacted level. These funds will continue support for 3 Research Centers for Excellence in Clinical Preventive Services ($4.449 million funded using the Prevention and Public Health Fund) as well as noncompeting support of $1.311 million in prior year grant investments. In addition, the portfolio will provide approximately $5.689 million in new research grants to support improving quality of care for people with multiple chronic conditions and to support new rapid cycle research grants to improve the delivery of primary care.

Clinical Decision-making for Preventive Services: To be of value, evidence from research on health services and health behaviors must be successfully integrated into patient care. The Prevention/Care Management Portfolio invests in the development of measures, tools, materials and technical assistance to support clinical decision-making for preventive services and to improve the delivery of evidence-based primary care. As part of this work, the Portfolio fulfills the Agency's Congressional mandate to convene and support the U.S. Preventive Services Task Force (USPSTF), an independent panel of nationally renowned non-federal experts in prevention, primary care, and evidence-based medicine. In FY 2010 and FY 2011, AHRQ assisted the USPSTF in increasing the transparency of its scientific and deliberative processes and in improving the communication of its recommendations. In FY 2012, work will focus on additional evidence reviews; methods development including modeling; management of public comment processes to enhance transparency; technical assistance in translation and dissemination of USPSTF recommendation statements; expanding outreach activities with stakeholders, including increasing efforts to engage content experts outside of primary care; and assisting organizations requesting support for the implementation of preventive services recommendations.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $11.500 million for this activity, a decrease of $0.500 million from the FY 2012 Enacted level. The decrease in funds for this activity will be re-allocated to provide fund additional new prevention/care management grants in FY 2013. This activity will provide $11.300 million in total to support the USPSTF ($7.000 M from the Prevention Fund and $4.300 M with PHS Evaluation Funds). At this funding level, the USPSTF will maintain the same workload as in FY 2012. AHRQ will assist the Task Force in maintaining the high level of transparency and improved communications as developed and initiated in prior fiscal years.

Implementation Activities to Improve Primary Care: The AHRQ Prevention/Care Management Portfolio supports the development of measures, tools, materials and technical assistance to facilitate health systems redesign in primary care settings. Within this field, the Portfolio focuses on health systems redesign, self management support, linking clinical practices with community resources; and, care coordination. FY 2012 funds will support contract research, technical

assistance, and tool and resource development in the areas of primary care redesign including the patient-centered medical home and team based care, the integration of mental health in primary care, self management support, linking clinical and community health systems, and care coordination. In addition, in FY 2012, AHRQ will fund a supplement in the journal *Annals of Family Medicine* to disseminate the findings from 14 grants funded in FY 2010 to enhance understanding of the transformation of primary care practices to patient-centered medical homes--the process, barriers and challenges, cost implications, and impacts to patients, providers, and staff.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $4.904 million for this activity, a decrease of $2.000 million from the FY 2012 Enacted level. The decrease in funds for this activity will be re-allocated to provide fund additional new prevention/care management grants in FY 2013 – a high priority of this portfolio. These funds will support ongoing contract research, technical assistance and tool and measurement development in the areas of the patient-centered medical home and the integration of mental health services in primary care. Funding is also provided for new work with a focus on care coordination within the patient-centered medical home. This activity also provides continuation support of the Support and Evaluation Center ($0.500 million) supporting the Research Centers for Excellence in Clinical Preventive Services funded using Prevention and Public Health Funds.

Program Portrait: **What is a Patient-Centered Medical Home? Why would a Patient Want to Visit?**

FY 2010: $4.0 million in two-year grants to study the transformation of primary care practices to patient-centered medical homes

FY 2011: $1.5 million in two-year cooperative agreements to catalyze state-level, multi-sector efforts to transform primary care practices and develop sustainable infrastructure for quality improvement in small independent primary care practices

FY 2012: $1.5 million in for the second year funding of the FY 2011 cooperative agreements

FY 2013: $1.0 million in a contract to support commissioned research on the patient-centered medical home.

AHRQ recognizes that revitalizing the Nation's primary care system is foundational to achieving high-quality, accessible, efficient health care for all Americans. The primary care medical home, also referred to as the patient-centered medical home (PCMH), advanced primary care, and the healthcare home, is a promising model for transforming the organization and delivery of primary care.

Building on the work of a large and growing community, AHRQ defines a medical home not simply as a place but as a model of the organization of primary care that delivers care that is:

- Patient-centered
- Comprehensive
- Coordinated
- Accessible
- Continuously improved through a systems-based approach to quality and safety

To further work on the PCMH, AHRQ has created and hosted *The Federal PCMH Collaborative. The Collaborative* is designed to bring together Executive Branch employees in agencies or departments that are currently doing worked related to the PCMH in order to develop a common base of knowledge about the PCMH model through presentations by colleagues and by non-Federal experts and exchange of information. In addition, AHRQ has commissioned research in order to enhance understanding of the PCMH such as:

White Papers

- *Engaging Patients and Families in the Medical Home*
- *Integrating Mental Health and Substance Use Treatment in the Patient-Centered Medical Home*
- *The Roles of Patient-Centered Medical Homes and Accountable Care Organizations in Coordinating Patient Care*
- *Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions*
- *Building the Evidence Base for the Medical Home: What Sample and Sample Size Do Studies Need?*

Decisionmaker Briefs

- *Strategies to Put Patients at the Center of Primary Care*
- *Ensuring that Patient Centered Medical Homes Effectively Serve Patients with Complex Needs*
- *Improving Evaluations of the Medical Home*

Other Resources

- *Care Coordination Measures* Atlas
- *Developing and Running a Practice Facilitation Program for Primary Care Transformation: A How-To Guide*

C. Mechanism Tables for Prevention/Care Management

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

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	13	3,632	10	3,189	6	1,311
New & Competing……	7	3,033	6	1,311	20	5,689
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**20**	**6,665**	**16**	**4,500**	**26**	**7,000**
TOTAL CONTRACTS/IAAs.....		**9,239**		**11,404**		**8,904**
TOTAL.....		**15,904**		**15,904**		**15,904**

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

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	3	4,397	3	4,449
New & Competing……	3	4,349	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS...	**3**	**4,349**	**3**	**4,397**	**3**	**4,449**
TOTAL CONTRACTS/IAAs.....		**7,262**		**7,219**		**7,167**
RESEARCH MANAGEMENT……		**384**		**384**		**384**
TOTAL.....		**11,995**		**12,000**		**12,000**

D. Funding History

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

Year	Dollars
2008	$ 7,100,000
2009	$ 7,100,000
2010	$15,904,000
2011	$27,904,000
2012	$27,904,000

Value

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
TOTAL			
--BA	$0	$0	$0
--PHS Eval	3,730,000	3,730,000	3,614,000
Total Program Level	$3,730,000	$3,730,000	$3,614,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2012 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. The aim is to assist the Department in fulfilling its mission to help Americans receive high-quality, efficient, affordable care by creating a high-value system, in which providers produce greater value, consumers and payers choose value, and the payment system rewards value.

B. FY 2013 Justification by Activity Detail

Value Research Activities
(in millions of dollars)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
Value Research	**$3.730**	**$3.730**	**$3.614**

Overall Budget Policy:

Value Research: To improve value, we must be able to measure and track quality and cost, identify strategies to improve both, and partner with the field to implement what we know. The Value Portfolio seeks to move forward on all three fronts in an integrated way. First, the portfolio develops and expands measures, data and tools to support transparency, public reporting, payment initiatives, and quality improvement. While working with a modest budget, we've seen several major successes: In FY 2010 AHRQ launched a new tool that incorporates the Quality Indicators – My Own Network powered by AHRQ (MONAHRQ) – to give States, communities, and others the software they need to build their own Web sites for public reporting and quality improvement. By the end of FY 2011, five states (HI, IN, KY, ME, NV and UT) had launched Web sites using the tool, and many others were participating in a learning collaborative to plan for use

of the tool. With the release of MONAHRQ 2.0 in FY 2011, states are now able to report local data from Hospital Compare and CAHPS as well as the Quality Indicators, and new links to Quality Improvement Guides enable users to improve quality of care in diabetes and asthma care. In FYs 2012 and 2013, we will continue our enhancements to MONAHRQ, adding new Hospital Compare measures, additional Quality Improvement Guides, and additional 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 2011 we were able to disseminate to our stakeholders evidence and strategies through more than 20 venues (webinars, workshops, etc.). This included, for example, evidence on measuring hospital readmissions, a guide on considering methods for generating provider scores for public reporting, and on-line surveys developed for public report sponsors to receive feedback from visitors to their sites. Much of this material provided the core curriculum for various Learning Networks and achieved wide visibility across the country with employers, providers, consumers, and others seeking major improvements in value. A priority for AHRQ is to continue to build and disseminate the evidence base for value and efficiency, which we expect to disseminate through an additional 20 webinars and in-person workshops each year in FY 2012 and 2013.

A third component of the portfolio is partnering with providers, payers, communities and other stakeholders to use the measures, data and evidence to increase transparency through public reporting. Including the 5 states currently using MONAHRQ to produce public reports, AHRQ's Quality Indicators are used in public reports of provider performance in at least 23 states. Another strong partnership is with a Learning Network of 24 community quality collaboratives, known as Chartered Value Exchanges (CVEs). The CVEs take research findings on public reporting and implement them in their public reports of hospital and physicians across their respective communities and entire States. The uptake of evidence and best practices by the healthcare leaders participating in the Learning Network and other partnerships link directly to AHRQ performance measures that focus on dissemination and use of this evidence, 1.3.51 and 1.3.53.

FY 2013 President's Budget Policy: The FY 2013 President's Budget provides $3.614 million for the Value portfolio, $0.116 million less than the FY 2012 Enacted level. These funds will enable us to continue all current efforts, with a slight reduction in the number of evidence-based tools and the number of enhancements to MONAHRQ produced in FY 2013.

***Program Portrait*:** MONAHRQ 2.0

FY 2012 Level: $1.4 million
FY 2013 Level: $1.4 million
Change: $0.0 million

MONAHRQ is an award-winning web builder tool AHRQ designed to provide community leaders and consumers with timely local information about health and health care. In recent years, in talks with state data organizations, public health agencies, and others doing public reporting or local data analysis, a frequent lament we heard was that transparency is expensive and time consuming. Why should each of us have to spend eighteen months and $300,000 to design and mount a Web site, they asked?

In FY 2010, AHRQ responded to these needs by releasing MONAHRQ (My Own Network Powered by AHRQ), a Web-builder through which any coalition, community, hospital or state with access to hospital discharge data can quickly run that data through downloaded AHRQ software to create their own Web site. By January 2012, five states have created public Web sites using this tool, and many other organizations are exploring or using it internally. MONAHRQ versions 2.0 and 3.0 enhance the original application in several ways.

- MONAHRQ can now report CAHPS patient satisfaction measures and inpatient and outpatient measures from CMS Hospital Compare, so that a consumer looking for hospitals with good outcomes, good processes of care and positive patient experiences of care has one-stop shopping, and local policy-makers can put up a Web site even if they don't have access to local discharge data.

- MONAHRQ now embeds links to several Quality Improvement Guides for diabetes care, asthma care, readmissions, patient safety for providers, and patient safety for healthcare consumers. It enables community leaders and providers to not only diagnose problems, but implement solutions, through links to Quality Improvement Guides for diabetes and asthma care.

- MONAHRQ continues to incorporate new evidence on the science of public reporting, by offering more consumer-friendly reports and help information.

For FY 2012 and FY 2013, MONAHRQ will continue to expand its capabilities, focusing not only on expanding to report additional types of measures but on reporting in more effective, usable ways, such as through consumer-friendly composites and summaries.

C. Mechanism Table for the Value Portfolio

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

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS....	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**3,730**		**3,730**		**3,614**
TOTAL.....		**3,730**		**3,730**		**3,614**

D. Funding History

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

Year	Dollars
2008	$3,730,000
2009	$3,730,000
2010	$3,730,000
2011	$3,730,000
2012	$3,730,000

Health Information Technology

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
TOTAL			
--BA	$0	$0	$0
--PHS Eval	27,645,000	25,572,000	25,572,000
Total Program Level	$27,645,000	$25,572,000	$25,572,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2012 Authorization……..Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

The ultimate purpose of AHRQ's Health Information Technology (Health IT) portfolio is to demonstrate how Health IT can improve the quality of American health care. AHRQ's Health IT portfolio develops and synthesizes the best evidence on how health IT can improve the quality of American health care, disseminates that evidence, and develops evidence-based tools for adoption and meaningful use of health IT. By building and synthesizing the evidence-base and through the development of resources and tools, the portfolio has played a key role in the Nation's drive to adopt and meaningfully use health IT. AHRQ-funded research underlies much of the supporting evidence and best practices used in the implementation of the HITECH Act. In partnership with the Office of the National Coordinator for Health IT (ONC), AHRQ is implementing the HITECH-authorized Health IT Research Center. 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 ONC policy decisions. AHRQ's Health IT portfolio will continue to produce field-leading research and demonstration evaluations, summarized evidence synthesis, and user-driven tools and resources to inform future decisions about health IT by healthcare stakeholders and policymakers.

B. FY 2013 Justification by Activity Detail

Health Information Technology Research Activities
(in millions of dollars)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Research Grants on Utilizing Health IT to Improve Quality	$12.840	$14.276	$18.976
Synthesizing and Disseminating Evidence on the Meaningful Use of Health IT	$10.800	$7.450	$3.489
Developing Resources and Tools for Policymakers and Health Care Stakeholders	$4.005	$3.846	$3.107
Health IT Research Activities	**$27.645**	**$25.572**	**$25.572**

Overall Budget Policy:

Research Grants on Utilizing Health IT to Improve Quality: Since 2004, the Health IT portfolio has invested in a series of 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 2012 and 2013, AHRQ intends to resume building the foundational evidence necessary to successfully leverage the significant investment in health IT to improve the quality, safety, effectiveness, and efficiency of US health care through support of new research grants.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $18.976 million for this activity, $4.700 million more than the FY 2012 Enacted level. Of this total, $12.300 million will support continuing research grants and $6.676 million will support new research grants. A continued emphasis on new research grants is the portfolio's highest priority as the need for evidence on the use of health IT to deliver high-quality health care has grown dramatically with the widespread adoption of health IT.

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. In partnership with the Centers for Medicare and Medicaid Services, AHRQ has also provided specific outreach to State Medicaid programs. AHRQ coordination ensures that research findings and tools synthesized and developed through its NRC are fed to the Health IT Resource Center (HITRC), which supports the HITECH Regional Extension Centers. FY 2011 funding was directed to supporting the National Resource Center, demonstrations of scalable clinical decision support, and technical assistance for State Medicaid programs. FY 2012 funding will continue to focus on synthesis and dissemination through AHRQ's National Resource Center and demonstrations of scalable clinical decision support.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $3.489 million for this activity, $3.961 million less than the FY 2012 Enacted level. In order to support new research, the portfolio will curtail dissemination efforts. Coordinated efforts across the Department, including planned investments through ONC and the launch of www.healthit.gov, allow AHRQ to capitalize on new dissemination platforms and invest less in this activity. FY 2013 activities will focus on continued synthesis of AHRQ-funded research and dissemination to targeted audiences through AHRQ's National Resource Center and other projects.

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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: Workflow Assessment for Health IT Toolkit

FY 2012 Level: $0.00 million *
FY 2013 Level: $0.00 million *
Change: $0.0 million

Health IT systems sometimes do not achieve their full potential due to a lack of integration of the health IT into clinical workflow. For health IT to be effective, it needs to be integrated into the multiple levels of workflow that exist in ambulatory health care delivery. AHRQ developed a toolkit that health care organizations and decision makers can use to help them assess their workflows and determine when and how health IT may be used.

Through this toolkit, end users should obtain a better understanding of the impact of health IT on workflow in ambulatory care for each of the following stages of health IT implementation: (1) determining system requirements, (2) selecting a vendor, (3) preparing for implementation, or (4) using the system post implementation. They should also be able to effectively utilize the publicly available workflow tools and methods before, during, and after health IT implementation while recognizing commonly encountered issues in health IT implementation.

This toolkit is an illustrative example of an AHRQ developed evidence-based resource that can achieve widespread use through partnership between AHRQ and end users, particularly the Health IT Extension Program led by ONC.

* This toolkit was developed with funding from prior fiscal years but is now available for use. AHRQ provides technical assistance. You can find the toolkit at: http://healthit.ahrq.gov/workflow/

Developing resources and tools for policy makers and health care stakeholders: The urgent need for real tools and systems is growing dramatically as the HITECH Act and ARRA incentives are implemented nationwide. AHRQ continues to provide resources the Nation's healthcare stakeholders need for the safe and effective use of health IT. The Workflow Assessment for Health IT Toolkit described above and a wide variety of other tools are available through the AHRQ health IT portfolio. In FY 2010, the Health IT portfolio funded development and testing of a safety monitoring and reporting system for early identification and amelioration of health IT safety issues in collaboration with the FDA and ONC. Resources in FY 2012 will support evaluation and refinement of current tools.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $3.107 million for this activity, $0.739 million less than the FY 2012 Enacted level. In FY 2013 this activity will create needed resources to implement the best evidence and practices funded by AHRQ or related programs.

C. Mechanism Table

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

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	20	5,766	28	8,106	43	12,300
New & Competing……	24	7,092	18	6,170	13	6,676
Supplemental	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	**44**	**12,858**	**46**	**14,276**	**56**	**18,976**
TOTAL CONTRACTS/IAAs		**14,787**		**11,296**		**6,596**
TOTAL		**27,645**		**25,572**		**25,572**

D. Funding History

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

Year	Dollars
2008	$44,820,000
2009	$44,820,000
2010	$27,645,000
2011	$27,645,000
2012	$25,572,000

Patient Safety

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
TOTAL			
--BA	$0	$0	$0
--PHS Eval	65,585,000	65,585,000	62,614,000
Total Program Level	$65,585,000	$65,585,000	$62,614,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2012 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 2013 Justification by Activity Detail

Patient Safety Research Activities
(in millions of dollars)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Patient Safety Risks and Harms	$24.585	$24.585	$21.614
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	**$65.585**	**$65.585**	**$62.614**

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 FY 2011 and 2012 builds on

past successes and focuses on the expansion of projects that have demonstrated impact in improving healthcare safety, including ongoing support for the dissemination and implementation of successful initiatives that integrate the use of evidence-based resources such as TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) and the Surveys of Patient Safety Culture. In addition to ongoing support for successful projects which continue to advance quality improvements, further support for new discovery and development will identify and refine the opportunities on which to base wide-scale patient safety improvements in the future. This activity will support $3.400 million in new grants in FY 2012 -- $1.000 million related to healthcare simulation research, $1.000 million for Partnerships in Implementing Patient Safety II research grants, and $1.416 million new investigator-initiated patient safety grants.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $21.614 million for this activity, $2.971 million less than the FY 2012 Enacted level. These funds will continue to advance the discovery and application of knowledge that increases patient safety. Sustained investments in core general patient safety research grant programs include continuation grant support of $9.101 million. The FY 2013 Request level will provide $2.400 million in new research grants support -- $0.800 million related to healthcare simulation research grants, $0.800 million for Partnerships in Implementing Patient Safety II research grants, and $0.800 million new investigator-initiated patient safety grants. The program will invest approximately $10.113 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 teams as well the establishment of cultures in healthcare organizations that are conducive to patient safety. Both of these issues are widely recognized as foundational bases on which patient safety can be improved.

Patient Safety Organizations (PSOs): The Patient Safety Act (2005) provided needed 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 anticipated to support and spur advancement of a culture of safety in health care organizations across the country leading to provision of safer care to patients. AHRQ administers the provisions of the Patient Safety Act dealing with PSO operations. HHS issued regulations to implement the Patient Safety Act, which authorized the creation of PSOs. (The effective date of the regulation was January 19th, 2009.) AHRQ, in conjunction with the Office of the Secretary and the Office of Civil Rights, continues to make significant progress in administering the Patient Safety Act. In addition, AHRQ continues to develop 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 made available Version 1.1 of 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. AHRQ is also developing Common Formats for health care settings beyond the acute care hospital; most recently, AHRQ announced the availability of Skilled Nursing Facility Beta Common Formats in a Federal Register notice (March 7, 2011). AHRQ has funded the PSO program at $7.000 million in FY 2011 and 2012.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $7.000 million for this activity, the same level of support as the FY 2012 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 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 ($2.000 million). These grants were provided using multi-year funding in FY 2010. Therefore, no continuing research grants costs are required.

FY 2013 Request Budget Policy: The FY 2013 Request does not include funds for this activity.

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 2010, AHRQ continued to work in close collaboration with HHS partners including CDC, CMS, NIH, and the Office of the Assistant Secretary for Health. In FY 2011 and 2012, AHRQ will build on past successes and extend these collaborative efforts to support a portfolio of grant- and contract-funded projects that will both buttress research to advance our knowledge about effective approaches for reducing HAIs and at the same time promote the implementation of proven methods for preventing HAIs. In FY 2011 and FY 2012, about half of AHRQ's HAI budget of $34 million per annum supported HAI-related grants ($17.158 million in FY 2011 and $17.525 million in FY 2012), and about half the funds will support HAI-related contracts. These grants and contracts will investigate methods of controlling HAIs in diverse healthcare settings and will address the major types of HAIs. In addition, contracts funded by the HAI budget will accelerate the nationwide implementation of the Comprehensive Unit-based Safety Program (CUSP – see Program Portrait on the following page), an evidence-based approach, to reduce the toll from several forms of HAI. In FY 2011, AHRQ will also launch an initiative to develop a synthesis of results from research projects initially funded by AHRQ in the period 2007-2010. This effort will identify HAI prevention approaches that are ready for implementation as well as gaps in the HAI science base that can be filled by new research.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $34.000 million for this activity, the same level of support as the FY 2012 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 $11.567 million in HAI research grants and $22.433 million in HAI contracts. The grants will extend current research with a focus on multiple healthcare settings, including hospitals, ambulatory care settings, and long-term care facilities, and on linkages between these settings to improve the prevention and management of HAIs. Of the contract amount, $6.000 million will support the ongoing expansion of the nationwide implementation of CUSP (see Program Portrait) to reduce catheter-associated urinary tract infections (CAUTI), $6.000 million will support the ongoing expansion of CUSP to prevent surgical site infections (SSI) and other surgical complications, and $2.000 million will expand CUSP for ventilator-associated pneumonia (VAP) from a field test in FY 2011/2012 to the initial phase of nationwide implementation. In the CUSP investments, the emphasis on implementation is consistent with AHRQ's unique role in accelerating the widespread adoption of evidence-based approaches to prevent HAIs. The combination of research and implementation projects is the most effective way to ensure progress toward eliminating the national scourge of HAIs. In

addition, these activities are contributing significantly to the attainment of the goals of the Partnership for Patients (PfP). Four of the nine hospital-acquired conditions (HACs) that the PfP seeks to reduce are HAIs – CLABSI, CAUTI, 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 2012 Level: $10 million
FY 2013 Level: $14 million
Change: +$4 million

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

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

Interim results from 350 hospitals in the first two cohorts participating in the nationwide roll-out of CUSP for CLABSI are very encouraging. The average rate of CLABSI/1000 central line days decreased from 1.8 to 1.17 in the first four quarters, a drop of 35 percent. This drop translates into 430 CLABSIs prevented; and assuming a 25 percent mortality rate and an excess cost of $16,550 per CLABSI, as estimated by CDC, the observed rate decrease means 108 deaths were prevented and over $7 million in excess costs were averted in one year.

In FY 2009, AHRQ also funded a demonstration project of the CUSP approach for prevention of CAUTI. In FY 2011 and 2012, following an approach similar to the successful implementation of CUSP for CLABSI, AHRQ supported several phases of the nationwide implementation of CUSP for CAUTI. AHRQ also supported a pilot test of CUSP for safe surgery in FY 2011 and the initial phase of nationwide implementation in FY 2012. In addition, AHRQ funded an 18-month field test of CUSP for VAP in two states in FY 2011 as a precursor to nationwide implementation beginning in FY 2013.

In FY 2013, AHRQ plans to expand the nationwide roll-out of CUSP for CAUTI and CUSP for safe surgery, and will initiate the nationwide implementation of CUSP for VAP. The following allocation will be used in FY 2013 to address these important program objectives:

	CUSP Total	CAUTI	Safe Surgery	VAP
FY 2013	**$14M**	6M	6M	2M

CUSP has emerged as a recognized platform for the prevention of HAIs. Results from pilot projects and from the nationwide CUSP for CLABSI show that CUSP has the potential to have a major impact in preventing various HAIs.

C. Mechanism Table

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

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	41	21,730	50	24,695	39	16,668
New & Competing……	22	8,348	17	5,900	16	6,400
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS....	**63**	**30,078**	**67**	**30,595**	**55**	**23,068**
TOTAL CONTRACTS/IAAs.....		**35,507**		**34,990**		**39,546**
TOTAL.....		**65,585**		**65,585**		**62,614**

D. Funding History

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

Year	Dollars
2008	$34,114,000
2009	$48,889,000
2010	$90,585,000
2011	$65,585,000
2012	$65,585,000

Crosscutting Activities Related to Quality, Effectiveness, and Efficiency Research

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
TOTAL			
--BA	$0	$0	$0
--PHS Eval	111,789,000	108,377,000	88,931,000
Total Program Level	$111,789,000	$108,377,000	$88,931,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2012 Authorization……..……..Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

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

B. FY 2013 Justification by Activity

Crosscutting Activities Related to Quality, Effectiveness, and Efficiency
(in millions of dollars)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Health Services Research Grants	$50.603	$50.964	$36.164
(Investigator-Initiated)	*(42.940)*	*(43.436)*	(29.259)
Measurement and Data Collection	$15.665	$15.665	$15.517
Dissemination and Translation	$19.120	$18.130	$15.942
Other Health Services Research Activities	$26.401	$23.618	$21.308
Total, Crosscutting Activities	**$111.789**	**$108.377**	**$88.931**

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. These grants represent the Agency's investment for future advances upon which the applied research of the future will be built. The topics addressed by unsolicited investigator-initiated research proposals reflect timely issues and ideas from the top health services researchers. In FY 2011, AHRQ provided $39.746 million in non-competing research grant support for prior year investigator-initiated grants as well as non-competing grant support for the Consumer Assessment of Healthcare Provides and Systems (CAHPS). The FY 2011 Enacted level provided $10.857 million in new research grants, including $3.736 million for new Centers for Education & Research on Therapeutics (CERTs) grants. The CERTs program is a 10 year old, national initiative to conduct research and provide education that advances the optimal use of therapeutics (i.e., drugs, medical devices, and biological products), improve patient health outcomes, and improve the quality of health care while reducing its costs. The FY 2012 Enacted provided $35.022 million for non-competing research grant support for prior year and $15.942 million in new grant support. The new research grant funding supports both targeted and investigator-initiated research projects. A total of $3.000 million will be provided for a re-competition of the CAHPS® grants which end in FY 2011. The CAHPS® program develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. Since CAHPS® surveys assess care from the consumer's point of view in many settings (e.g., hospitals, health plans, nursing homes, home health, etc.) these data will serve as an important metric through which DHHS can measure the impact of the Affordable Care Act on the American people. A total of $43.436 million is directed to investigator-initiated research grants in total.

FY 2013 Request Budget Policy: The FY 2013 Request provides $36.164 million for this activity, $14.800 million less than the FY 2012 Enacted level. Support for non-competing research grants totals $33.472 million, a decrease of $1.550 million from the FY 2012 level. Support for new research grants is $2.692 million, a decrease of $13.250 million from the FY 2012 level. The new research grant funding is all directed to investigator-initiated research projects. The Request would provide a total (noncompeting and new) support of $29.259 million in investigator-initiated grants. This is a decrease of $14.177 million from the FY 2011 Enacted level.

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 health status of the population and of important subgroups; identify disparities in health status and use of health care by race or ethnicity, socioeconomic status, region, and other population characteristics; describe our experiences with the health care system; monitor trends in health status and health care delivery; identify health problems; support health services research; and provide information for making changes in public policies and programs. AHRQ's Measurement and Data Collection Activity coordinates AHRQ data collection, measurement and analysis activities across the Agency. In FY 2011 and 2012 AHRQ will support data and measurement activities at approximately $15.5 million including support for the following flagship data 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). In addition to continuing activities, beginning in FY 2012 with a re-competition of the QI contract, AHRQ will plan for and execute several new activities to move the AHRQ Quality Indicators to the International Classification of Disease (ICD) 10 coding system by the HHS deadline of October 1, 2013.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $15.517 million for this activity, $0.148 million less than the FY 2012 Enacted level. This level of support will continue to support measurement and data collection activities including support of the following programs: 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). Additional details about the HIVRN are provided in the text box below.

Program Portrait: HIV Research Network (HIVRN)

FY 2012 Level: $1.413 million
FY 2013 Level: $1.413 million
Change: $0 million

Over one million people are estimated to be living with HIV infection in the United States, with an annual incidence of approximately 56,000 new infections. Over the past decade, changes in the clinical treatment of HIV infection have occurred rapidly; new antiretroviral medications have been developed, and treatment guidelines have evolved. In addition, the epidemiology of HIV infection has changed, with increasing proportions of patients from minority or disadvantaged segments of society, and with many patients presenting with significant comorbidity, including mental illness and substance abuse. This complex and changing environment poses challenges for delivering medical care to persons with HIV infection. The extent and rapidity of change in treatment of HIV infection requires a mechanism for continual monitoring of HIV service delivery over time and the use of longitudinal data to track changes in delivery of care, disparities in receipt of care, and outcomes of care across time.

The goal of the HIV Research Network (HIVRN) is to obtain and disseminate timely information on the provision of HIV-related medical care. The HIVRN is a consortium of 22 sites, in different regions of the U.S., that provide primary medical care to HIV patients, abstract data from patients' medical records, and submit these data to a data coordination center, which amalgamates them into a uniform database. The HIVRN has been collecting data since 2000 and, as of 2009, has data on 42,049 adult HIV patients, 53% of whom have longitudinal data for 3-10 years. Currently, data from 2010 have been received, cleaned, and added to the database, which now spans 2000-2010. Data from CY 2011 is due in September, 2012. No other current U.S. study has assembled such a large and diverse cohort. In addition, longitudinal data for several hundred pediatric patients are available. HIVRN has provided critical information on the treatment of HIV infection, such as:

- Using data from 2006, HIVRN investigators estimated the mean annual total expenditures for HIV-related medical care to be $19,912. Expenditures increased as immune status worsened, ranging from$16,614 for patients with median CD4 count >500 cells/mm^3 to $40,678 for those with median CD4 count < 50 cells/mm^3. This is the most recent and comprehensive estimate of direct HIV-related medical care costs.

- Rapid linking of HIV-infected patients with medical care is essential. However, 43% of HIVRN patients had CD4 counts < 200 cells/mm^3, indicating delayed entry into care. Patients who had delayed entry also had higher cumulative medical care costs than those who entered care earlier in the disease course: Among those in care for 7 years, late presenters' cumulative costs were $49,105 higher than costs for early presenters. These results suggest that rapid linkage into HIV medical care may be effective.

- Gender and racial/ethnic disparities in receipt of highly active antiretroviral therapy (HAART) have been noted in several studies conducted early in the HAART era. Analyses of HIVRN data in progress show that the proportion of patients receiving HAART has increased between 2002 (60%) and 2008 (81%). Although increases occurred for all gender and race/ethnicity subgroups, the proportion on HAART in 2008 remained lower for women than men (77% versus 82%) and lower for African-American than for white patients (79% versus 81%), suggesting persistent disparities.

Dissemination and Translation: The mission of our Dissemination and Translation activities is to translate, disseminate, and implement research findings that improve health care outcomes. Simply producing knowledge is not enough. Findings must be presented in ways that are useful and made widely available to clinicians, patients, health care managers, and other decision-

makers. AHRQ synthesizes and translates knowledge into products and tools that help our customers solve problems and make decisions. We are proactive in our dissemination of the knowledge, products, and tools to appropriate audiences, and we form partnerships with other organizations to leverage our resources. Support for Dissemination and Translation activities was $19.120 million in FY 2011. Dissemination and translation activities focus on continued support of the National Quality Measures Clearinghouse (NQMC) and its companion the National Guideline Clearinghouse (NGC); contract support for the AHRQ Publications Clearinghouse; continued support for the Centers for Education & Research on Therapeutics (CERTs) program; continued support for the Healthcare Cost and Utilization Project (HCUP); continued support for all CAHPS® activities, including Hospital CAHPS®; continued support for the National Healthcare Quality Report and National Healthcare Disparities Report; the electronic dissemination program; and knowledge transfer activities that focus on the AHRQ Quality Indicators, numerous consumer materials, and many other products as well as support for learning networks for Quality Improvement Organizations (QIOs) and the Medicaid Medical Directors. The FY 2012 Enacted provided $18.130 million for this activity.

FY 2013 Request Budget Policy: The FY 2013 Request provides $15.942 million for this activity, $2.188 million less than the FY 2012 Enacted level. This decrease was a result of re-prioritization of research activities in the portfolio. AHRQ will increase our partnerships with other organizations to leverage our resources in FY 2013. As a result, we will continue support for the AHRQ projects discussed in FY 2012, but will re-scale to accommodate the decreased funding. These funds will continue key dissemination and translational activities, including continued support of the National Quality Measures Clearinghouse (NQMC) and its companion the National Guideline Clearinghouse (NGC); support for the AHRQ Publications Clearinghouse; continued translation and dissemination support for the National Healthcare Quality Report and National Healthcare Disparities Report; the electronic dissemination program; and knowledge transfer activities that focus on the AHRQ Quality Indicators, consumer materials and products; and support for learning networks for Quality Improvement Organizations (QIOs) and the Medicaid Medical Directors.

Other Health Services Research Activities: Other Health Services Research Activities provides support to crosscutting research activities that impact quality, effectiveness and efficiency of health care. In FY 2012 AHRQ provided $23.618 million for this activity. Included in Other Health Services Research is support for rapid cycle research (accelerating the diffusion of research into practice) activities. Rapid Cycle Research is funded through the following AHRQ networks: Accelerating Change and Transformation in Organizations and Networks (ACTION), Primary Care Practice-Based Research Networks (PBRNs), Evidence-based Practice Centers (EPCs), and Developing Evidence to Inform Decisions about Effectiveness (DeCIDE Network). These rapid cycle research activities are found both in Crosscutting Activities and within our research portfolios – depending on the topic. An example of this rapid cycle research across the portfolios is the use of EPCs to develop a series of reports on “Closing the Quality Gap: Revisiting the State of the Science.” These reports focus on improving the quality of health care through critical assessment of relevant evidence for selected settings, interventions, and clinical conditions. This series aims to assemble the evidence about effective strategies to close the "quality gap"—the difference between what is expected to work well for patients based on known evidence, and what actually happens in day-to-day clinical practice across populations of patients. For every patient who receives optimal care, the evidence suggests that on average another patient does not. This series not only expands the topic terrain beyond that covered in the initial collection developed in 2004-2007, but also marshals the knowledge of eight EPCs with the goal of applying and advancing the state of the science for improving the health care system for the benefit of all patients. This report will inform HHS and AHRQ’s current work on aligning and coordinating quality activities. In addition to rapid cycle research, in FY 2011 and FY 2012 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 events management support. Contract support was also provided for evaluation activities, and inter-agency agreements with other Federal partners.

FY 2013 Request Budget Policy: The FY 2013 Request provides $21.308 million for this activity, $2.310 million less than the FY 2012 Enacted level. This level will allow for AHRQ to continue support for AHRQ's rapid cycle research networks. Continuation funding is also provided for a variety of contracts that support administrative activities that are related to research, including grant review, ethics review, events management, data management, data security, and inter-agency agreements with other Federal partners.

C. Mechanism Table

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

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	142	39,746	110	35,022	109	33,472
New & Competing……	86	10,857	94	15,942	11	2,692
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS....	**228**	**50,603**	**204**	**50,964**	**120**	**36,164**
TOTAL CONTRACTS/IAAs.....		**61,186**		**57,413**		**52,767**
TOTAL.....		**111,789**		**108,377**		**88,931**

D. Funding History

Funding for the Crosscutting Activities Related to Quality, Effectiveness, and Efficiency Research program during the last five years has been as follows:

Year	Dollars
2008	$ 97,120,000
2009	$ 97,092,000
2010	$111,789,000
2011	$111,789,000
2012	$108,377,000

Key Performance Measures for HCQO by Portfolio

AHRQ's Research on Health Costs, Quality, and Outcomes is supported by a dynamic research agenda and performance measures captured in its portfolios of work. The portfolios are supported by evidence-based research in the areas of effective health care; delivery of primary care services; reduction of unnecessary costs while maintaining or improving quality; development and dissemination of Health IT tools; and, prevention, mitigation, and reduction of the number of medical errors, patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients. The key performance measures capture the Agency's research efforts as it continues to produce new knowledge, synthesize and disseminate this knowledge, and help consumers, clinicians, policymakers and other stakeholders to implement and use this evidence-based information to ultimately improve health outcomes.

The Agency's research is cited in published journal articles and on AHRQ's website, and the products are requested from consumers, clinicians, and policymakers. Product distribution is handled by placement of orders received by the Publication Clearinghouse; however, recent trends show that the distribution of Effective Health Care (EHC) products have increased substantially through venues such as conference exhibits. Such venues provide additional outlets for disseminating evidence-based information and tools and reduce the requests for mail-order distributions (as collected in measure 1.3.25). Stakeholder and public input continue to play a valuable role in AHRQ's research, product development, and availability. Depending on the project, the number of EHC products (measure 4.4.5) varies as research requests can focus on narrowly defined topics having faster production times or on large complex projects that are extremely labor-intensive requiring longer periods to produce. Currently, over 90% of the Medicaid Medical Directors Learning Network members, a key stakeholder group comprised of clinical leaders of the State Medicaid programs, report using available EHC products (measure 1.3.26). AHRQ will continue to develop new methods for capturing and reporting on stakeholder use of its products.

AHRQ's research also supports clinical decision-making for preventive services and implementation of activities to improve primary care and clinical outcomes (measure 2.3.7). Evidence reports generated on understanding prevention in older adults will be used to support the development of a set of composite measures of appropriate clinical preventive services for older adults. By increasing the synthesis and dissemination of measures, datasets, upgrades, and reports (measures 1.3.50 and 1.3.51), AHRQ provides stakeholders with tools to reduce unnecessary costs and waste while maintaining or improving quality to achieve greater value in health care. The Health IT portfolio serves numerous stakeholders, including health care organizations planning, implementing, and evaluating health IT, health services researchers, policymakers and other decision-makers. The portfolio achieves these goals through funding research grants and contracts, synthesizing findings, and developing and disseminating findings and tools.

As an indicator of the number of healthcare organizations using AHRQ-supported tools to improve patient safety and reduce the risk of patient harm (measure 1.3.41), the Agency relies in part on the Hospital Survey of Patient Safety. Interests 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. An expanding set of evidence-based tools to improve patient safety and reduce the risk of patient harm (measure 1.3.41) is available as a result of ongoing investments to generate knowledge through research, including optimal ways to synthesize and disseminate new knowledge. Lastly, as long-standing mature

performance measures approach target saturation, new measures will be introduced to support current research efforts.

Portfolio: Patient-Centered Health Research

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
1.3.25: Increase the dissemination of Effective Health Care (EHC) Program products to clinicians, consumers, and policymakers to promote the communication of evidence.	FY 2011: 834 Orders Target: 1030 Orders (Target Not Met)	900 Orders	900 Orders	Maintain
1.3.26: Increase the percentage of stakeholders who report they use Effective Health Care (EHC) Program products as a resource.	FY 2011: 92.5 % of stakeholders Target: 24% of stakeholders (Target Exceeded)	94 % of stakeholders	95 % of stakeholders	+1% of stakeholders
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.	FY 2011: 60 citations of EHC products Target: Establish Targets (Target Met)	63 citations of EHC products	66 citations of EHC products	+3 citations of EHC products
4.4.5: Increase the number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers.	FY 2011: 68 EHC products Target: 65 EHC products (Target Exceeded)	26 EHC products	65 EHC products	+39 EHC products

Portfolio: Prevention and Care Management

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
2.3.7: Increase the percentage of older adults who receive appropriate clinical preventive services.	FY 2011: Evidence Reports: 1) Review on common syndromes in older adults related to prevention; and 2) Review on values of older adults related to the benefits and harms of preventive service. Target: Final evidence reports on understanding prevention in older adults: focusing on patient values and one on geriatric syndromes Findings from the grant program, Optimizing Prevention and Healthcare Management in Complex Patients (Target Exceeded)	Expert panel meetings on developing and testing candidate measure set of composite measures of appropriate clinical preventive services for older adults Two methodological papers on understanding prevention in older adults Expert panel meeting on methods related to prevention in older adults	Final candidate set of composite measures of appropriate clinical preventive services for older adults Preliminary findings from 3 Research Centers for Excellence in Clinical Preventive Services Final report on Understanding Prevention in Older Adults	N/A

Portfolio: Value

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
1.3.50: SYNTHESIS: Increase the cumulative number of AHRQ measures, tools, upgrades, and syntheses available on healthcare value.	FY 2011: 127 Target: 127 (Target Met)	138	142	+4
1.3.51: DISSEMINATION: Increase the cumulative number of measures, datasets, tools, articles, analyses, reports, and evaluations on healthcare value that are disseminated.	FY 2011: 41 Target: 40 (Target Exceeded)	61	81	+20
1.3.53: Increase the cumulative number of AHRQ measures and tools used in national, state, or community public report cards.	FY 2011: 23 Target: 22 (Target Exceeded)	23	24	+1

Portfolio: Health IT

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
1.3.48: Decrease average cost per grantee for development and publication of annual performance reports and final reporting products.	FY 2011: $4,251 /grantee Target: $5,451 (Target Exceeded)	$4,026 /grantee	$3,886 /grantee	-$140 /grantee

Portfolio: Patient Safety

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
1.3.38: Increase the number of U.S. healthcare organizations per year using AHRQ-supported tools to improve patient safety culture.	FY 2011: 1032 Research users Target: 900 Research users (Target Exceeded)	1200 Research users	1300 Research users	+100 Research users
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.	FY 2011: Software implementation in progress Target: Establish Baseline (Active)	Establish out-year targets	NPSD Operational	N/A

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
1.3.40: Maintain Patient Safety Organizations (PSOs) listed by DHHS Secretary.	FY 2011: 80 listed PSOs Target: 85 listed PSOs (Target Not Met)	85 listed PSOs	85 listed PSOs	Maintain
1.3.41: Increase the 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.	FY 2010: 86 tools (Target Met) Target: 86 tools (Target Met)	98 tools	104 tools	+6 tools

Portfolio: Crosscutting Activities Related to Quality, Effectiveness and Efficiency Research

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
1.3.22: Increase the number of additional organizations per year that use Healthcare Cost and Utilization Project (HCUP) databases, products, or tools in health care quality improvement efforts.	FY 2011: 5 Organizations Target: 5 Organizations (Target Met)	7 Organizations	4 Organizations	-3 Organizations
1.3.23: Increase the number of consumers who have access to customer satisfaction data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to make health care choices.	FY 2010: 142 Million Target: 145 Million (Target Not Met but Improved)	144 Million	144 Million	Maintain
4.4.4: Decrease the cost per capita of hospital admissions for upper gastro-intestinal bleeding among patients aged 65 to 84.	FY 2011: $79.5 per capita Target: $83.81 per capita (Target Exceeded)	$81.3 per capita	$78.86 per capita	-$2.44 per capita

Medical Expenditure Panel Survey (MEPS)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
TOTAL			
--BA	$0	$0	$0
--PHS Eval	58,800,000	59,300,000	59,300,000
Total Program Level	**$58,800,000**	**$59,300,000**	**$59,300,000**

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2012 Authorization……..……..…….Expired.
Allocation Method…….....…… Contracts, and Other.

A. Program Overview

The Medical Expenditure Panel Survey (MEPS), first funded in 1995, is the only national source for comprehensive annual data on how Americans use and pay for medical care. The survey collects detailed information from families on access, use, expenses, insurance coverage and quality. Data are disseminated to the public through printed and Web-based tabulations, microdata files and research reports/journal articles. Data from the MEPS have become a linchpin for public and private economic models projecting health care expenditures and utilization. The MEPS is designed to provide annual estimates at the national level of the health care utilization, expenditures, sources of payment and health insurance coverage of the U.S. civilian non-institutionalized population. The 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 2013 Justification by Activity Detail

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

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
MEPS Household Component	$36.800	$37.100	$37.100
MEPS Medical Provider Component	$12.000	$12.200	$12.200
MEPS Insurance Component	$10.000	$10.000	$10.000
TOTAL, MEPS	**$58.800**	**$59.300**	**$59.300**

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 2011 and FY 2012, the Household Component of the MEPS maintained the precision levels of survey estimates, maintained survey response rates and improved the timeliness of the data.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $37.100 million for this activity, which is the same amount as the FY 2012 Enacted level. In FY 2013 the Household Component of the MEPS will continue to operate at its current level.

Program Portrait: Use of MEPS Data
FY 2011 Level: $59.3 million
FY 2013 Level: $59.3 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 Treasury and others to inform inquiries related to expenditures, insurance coverage and sources of payment.
- MEPS was used extensively to inform Congressional inquiries concerning the State Children's Health Insurance Program and its reauthorization.
- MEPS was used extensively by the GAO to determine trends in employee compensation.
- MEPS is used extensively to examine the effects of chronic conditions on the levels and persistence of medical expenditures.
- MEPS was used by the Treasury to determine the amount of the small employer health insurance tax credit that was a component of the Affordable Care Act.

MEPS Medical Provider Component: The MEPS Medical Provider component is a survey of medical providers, including office-based doctors, hospitals and pharmacies that collects detailed data on the expenditures and sources of payment for the medical services provided to individuals sampled for the MEPS. This component of MEPS is necessary because households are often unable to accurately report payments made on their behalf for their medical care. In FY 2011 and FY 2012, the Medical Provider Component of the MEPS maintained its sample specifications.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $12.200 million for this activity which is the same amount as the FY 2012 Enacted level. In FY 2013 the Medical Provider Component of the MEPS will continue to operate at its current level.

MEPS Insurance Component (IC): The MEPS Insurance component is a survey of private business establishments and governments designed to obtain information on health insurance availability and coverage derived from employers in the U.S. The sample for this survey is selected from the Census Bureau's Business Register for private employers and Census of Governments for public employers. The IC is an annual survey designed to provide both nationally and state representative data on the types of health insurance plans offered by employers, enrollment in plans by employees, the amounts paid by both employers and employees for those plans, and the characteristics of the employers. The FY 2010 Appropriation level allowed for data on employer sponsored health insurance to be collected in order to support both national and separate estimates for all 50 States and the District of Columbia. In FY 2011 and 2012, the MEPS Insurance Component maintained the precision levels of survey estimates, maintained survey response rates and adhered to data release schedules.

FY 2013 Request Budget Policy: The FY 2013 Request level provides $10.000 million for this activity, which is the same amount as than the FY 2012 Enacted level. In FY 2013 the Insurance Component of the MEPS will continue to operate at its current level.

C. Mechanism Table for MEPS

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

MEPS Mechanism Table

(Dollars in Thousands)

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs		**58,800**		**59,300**		**59,300**
TOTAL		**58,800**		**59,300**		**59,300**

D. Performance Summary and Key Measures

Each component of the Medical Expenditure Panel Survey (MEPS) maintained the precision levels of survey estimates and survey response rates. The program continues its goal to produce the same amount of data within the same time frame. With increasing costs associated with data collection, analysis, production, and dissemination, MEPS will maintain efficiencies as it continues to provide comprehensive annual data on how Americans use and pay for medical care.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
1.3.16: Maintain MEPS-IC: Maintain the number of months to produce the Insurance Component tables following data collection.	FY 2011: 6 months Target: 6 months (Target Met)	6 months	6 months	Maintain
1.3.19: Increase the number of topical areas tables included in the MEPS Tables Compendia.	FY 2011: Total Utilization and Mean Expenses per Event by Type of Ambulatory Health Care Service (topical areas table added) Target: 1 topical areas table (Target Met)	1 topical areas table	1 topical areas table	Maintain
1.3.21: MEPS-HC: Decrease the number of months required to produce MEPS Household Survey data files (i.e. point-in-time, utilization and expenditure files) for public dissemination following data collection	FY 2011: 10 months Target: 10 months (Target Met)	10 months	10 months	Maintain

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
1.3.49: Decrease the average number of field staff hours required to collect data per respondent household for the MEPS (at level funding).	FY 2011: 11.7 hours Target: 12.7 (Target Exceeded)	11.7 hours	11.7 hours	Maintain

E. Funding History

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

Year	Dollars
2008	$55,300,000
2009	$55,300,000
2010	$58,800,000
2011	$58,800,000
2012	$59,300,000

Program Support

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
TOTAL			
--BA	$0	$0	$0
--PHS Eval	67,600,000	73,985,000	68,422,000
Total Program Level	**$67,600,000**	**$73,985,000**	**$68,422,000**
FTEs (PHS Evaluation Funds)	305	305	305
FTEs (Prev. & Public Hlth Fund)	3	3	3
Estimated FTEs (PCORTF)	0	12	20

Note: The FTE levels above do not include FTEs supported from other reimbursable activities.

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2012 Authorization……..Expired.
Allocation Method…….....……..…….Other.

A. Program Overview

This budget activity supports the strategic direction and overall management of the AHRQ, including funds for salaries and benefits of 305 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 the AHRQ's mission.

B. FY 2013 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 2013 Request Budget Policy: Program Support (PS) will be funded at $68.422 million, a decrease of $5.563 million or -7.5 percent from the FY 2012 Enacted level. The bulk of the decrease is associated with a one-time allocation of $4.132 million in FY 2012 related to tenant improvement costs for a relocation of the AHRQ building.

Program Support provides funds for AHRQ's PHS Evaluation Fund FTEs. In FY 2013 AHRQ is supporting 305 FTEs, the same level as FY 2012. As shown in the table on page 68, AHRQ does have additional FTEs supported with other funding sources, including 3 FTEs included in the FY 2013 Request funded by the Prevention and Public Health Fund 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 2012 and FY 2013.

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 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Patient-centered Health Research	4,056	4,162	2,573
Prevention/Care Management	3,380	3,988	4,092
Value Research	676	935	930
Health Information Technology	5,408	6,412	6,579
Patient Safety	18,252	16,445	16,110
Crosscutting Activities	23,660	27,174	22,881
Medical Expenditure Panel Survey	12,168	14,869	15,257
Total, Program Support	67,600	73,985	68,422

AHRQ's FY 2013 Request level includes funding to support the President's information technology initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process.

C. Mechanism Table

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

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs		**0**		**0**		**0**
RESEARCH MANAGEMENT……		**67,600**		**73,985**		**68,422**
TOTAL		**0**		**0**		**0**

D. Funding History

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

Year	Dollars
2008	$62,380,000
2009	$65,122,000
2010	$67,600,000
2011	$67,600,000
2012	$73,985,000

Supplementary Tables – Table of Contents

Supplementary Tables

Budget Authority by Object Class – Reimbursable 1/

	2012 Enacted	2013 PB	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	30,096,000	30,325,000	+229,000
Other than full-time permanent (11.3)	4,148,000	4,179,000	+31,000
Other personnel compensation (11.5)	1,116,000	1,124,000	+8,000
Military Personnel (11.7)	1,119,000	1,127,000	+8,000
Subtotal personnel compensation	**36,479,000**	**36,755,000**	**+276,000**
Civilian Personnel Benefits (12.1)	9,267,000	9,337,000	+70,000
Military Personnel Benefits (12.2)	606,000	610,000	+4,000
Benefits to Former Personnel (13.0)	0	0	-0
Total Pay Costs	**46,352,000**	**46,702,000**	**+350,000**
Travel and transportation of persons (21.0)	430,000	430,000	-0
Transportation of Things	52,000	53,000	+1,000
Rental payments to GSA (23.1)	4,335,000	4,409,000	+74,000
Communications, utilities, & misc charges (23.3)	914,000	933,000	+19,000
Printing and reproduction (24.0)	806,000	806,000	-0
Other Contractual Services:			
Other services (25.2)	18,563,000	12,500,000	-6,063,000
Purchases of goods & services from government accounts (25.3)	19,384,000	19,384,000	0
Research and Development Contracts (25.5)	169,404,000	157,288,000	12,116,000
Operation and maintenance of equipment (25.7)	706,000	721,000	+15,000
Subtotal Other Contractual Services	**208,057,000**	**189,893,000**	**-18,164,000**
Supplies and materials (26.0)	377,000	386,000	+9,000
Equipment (31.0)	1,450,000	1,482,000	+32,000
Grants, subsidies, and contributions (41.0)	106,280,000	89,263,000	-17,017,000
Total Non-Pay Costs	**322,701,000**	**287,655,000**	**-35,046,000**
Total obligations by object class	**369,053,000**	**334,357,000**	**-34,696,000**

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

Budget Authority by Object Class - ACA: Prevention and Public Health Funds

	2012 Enacted	2013 PB	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	147,000	147,000	-0
Other than full-time permanent (11.3)	146,000	146,000	-0
Other personnel compensation (11.5)	9,000	9,000	-0
Military Personnel (11.7)	0	0	-0
Subtotal personnel compensation	**302,000**	**302,000**	**-0**
Civilian Personnel Benefits (12.1)	82,000	82,000	-0
Military Personnel Benefits (12.2)	0	0	-0
Benefits to Former Personnel (13.0)	0	0	-0
Total Pay Costs	**384,000**	**384,000**	**-0**
Travel and transportation of persons (21.0)	0	0	-0
Transportation of Things	0	0	-0
Rental payments to GSA (23.1)	0	0	-0
Communications, utilities, & misc charges (23.3)	0	0	-0
Printing and reproduction (24.0)	0	0	-0
Other Contractual Services:			
Other services (25.2)	0	0	-0
Purchases of goods & services from government accounts (25.3)	0		0
Research and Development Contracts (25.5)	7,267,000	7,267,000	0
Operation and maintenance of equipment (25.7)	0	0	-0
Subtotal Other Contractual Services	**7,267,000**	**7,267,000**	**-0**
Supplies and materials (26.0)	0	0	-0
Equipment (31.0)	0	0	-0
Grants, subsidies, and contributions (41.0)	4,349,000	4,349,000	-0
Total Non-Pay Costs	**11,616,000**	**11,616,000**	**-0**
Total obligations by object class	**12,000,000**	**12,000,000**	**-0**

Salaries and Expenses

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY Salaries and Expenses 1/ 2/ Total Appropriation			
Object Class	FY 2012 Enacted	FY 2013 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$30,096,000	$30,325,000	+$229,000
Other than full-time permanent (11.3)	$4,148,000	$4,179,000	+$31,000
Other personnel compensation (11.5)	$1,116,000	$1,124,000	+$8,000
Military Personnel (11.7)	$1,119,000	$1,127,000	+$8,000
Civilian Personnel Benefits (12.1)	$9,267,000	$9,337,000	+$70,000
Military Personnel Benefits (12.2)	$606,000	$610,000	+$4,000
Benefits to Former Employees (13.1)	$0	$0	$0
Pay Costs	**$46,352,000**	**$46,702,000**	**+$350,000**
Travel (21.0)	**$430,000**	**$430,000**	**-$0**
Transportation of Things (22.0)	**$52,000**	**$53,000**	**+$1,000**
Rental payments to others (23.2)	**$0**	**$0**	**-$0**
Communications, utilities, and miscellaneous charges (23.3)	**$914,000**	**$933,000**	**+$19,000**
Printing and reproduction	**$806,000**	**$806,000**	**-$0**
Other Contractual Services:			
Other services (25.2)	$18,563,000	$12,500,000	-$6,063,000
Operations and maintenance of equipment (25.7)	$706,000	$721,000	+$15,000
Subtotal Other Contractual Services	**$19,269,000**	**$13,221,000**	**-$6,048,000**
Supplies and materials (26.0)	**$377,000**	**$386,000**	**+$9,000**
Non-Pay Costs	**$21,848,000**	**$15,829,000**	**-$6,019,000**
Total Salaries and Expenses	**$68,200,000**	**$62,531,000**	**-$5,669,000**

1/ Annual Appropriation only. Excludes mandatory funding from PPHF and PCORTF and excludes other reimbursable estimates that are included in the Budget Appendix.

2/ Excludes Rent and Equipment.

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

	2011 Actual Civilian	2011 Acutal Military	2011 Actual Total	2012 Est. Civilian	2012 Est. Military	2012 Est. Total	2013 Est. Civilian	2013 Est. Military	2013 Est. Total
Office of the Director (OD)	24	0	24	24	0	24	24	0	24
Office of Performance Accountability, Resources and Technology (OPART)	52	0	52	52	0	52	52	0	52
Office of Extramural Research, Education, and Priority Populations (OEREPP)	44	3	47	44	3	47	44	3	47
Center for Primary Care, Prevention, and Clinical Partnerships (CP3)	24	0	24	24	0	24	24	0	24
Center for Outcomes and Evidence (COE)	34	5	39	34	5	39	34	5	39
Center for Delivery, Organization and Markets (CDOM)	25	0	25	25	0	25	25	0	25
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)	28	2	30	28	2	30	28	2	30
Office of Communications and Knowledge Transfer (OCKT)	39	0	39	39	0	39	39	0	39
AHRQ FTE Total	**313**	**10**	**323**	**313**	**10**	**323**	**313**	**10**	**323**
Recovery Act FTE	0	0	0	0	0	0	0	0	0
	313	**10**	**323**	**313**	**10**	**323**	**313**	**10**	**323**

Average GS Grade	
2009	12.8
2010	12.8
2011	12.8
2012	12.8
2013	12.8

1/ Excludes PCORTF FTE.

Detail of Positions 1/

	2011 Actual	2012 Enacted	2013 Request
Executive Level I	4	4	4
Executive Level II	0	0	0
Executive Level III	2	4	4
Executive Level IV	1	1	1
Executive Level V	1	0	0
Subtotal	8	9	9
Total Executive Level Salaries	$1,396,932	$1,604,241	$1,612,262
Total - SES	5	4	4
Total - SES Salaries	$ 881,055	$ 760,723	$ 764,527
GS-15	61	64	64
GS-14	74	79	79
GS-13	60	60	60
GS-12	27	31	31
GS-11	14	13	13
GS-10	2	2	2
GS-9	17	18	18
GS-8	2	3	3
GS-7	8	6	6
GS-6	1	1	1
GS-5	2	2	2
GS-4	0	0	0
GS-3	0	0	0
GS-2	0	1	1
GS-1	0	0	0
Subtotal	268	280	280
Average GS grade	12.8	12.8	12.8
Average GS salary	$92,341	$92,341	$92,803

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

Physicians' Comparability Allowance (PCA) Worksheet

		PY 2011 (Actual)	CY 2012 (Estimates)	BY 2013* (Estimates)
1) Number of Physicians Receiving PCAs		18	18	18
2) Number of Physicians with One-Year PCA Agreements		0	0	0
3) Number of Physicians with Multi-Year PCA Agreements		18	18	18
4) Average Annual PCA Physician Pay (without PCA payment)		137,182.16	137,182.16	141,297.28
5) Average Annual PCA Payment		23,833.33	23,833.33	23,833.33
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	0	0	0
	Category II Research Position	17	17	17
	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 2013 data will be approved during the FY 2014 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).

For any category of medical officer, the hiring process can take up to five (5) months (HHS-AHRQ-2010-0012) if not longer. 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.

SENATE REPORT NO. 112-84

Building the Next Generation of Researchers

1. SENATE (Rept. 112- 84) p. 127

The Committee is deeply concerned about declines in the number of, and funding for, training grants for the next generation of researchers. The Committee urges AHRQ to provide greater support to pre- and post-doctoral training grants and fellowships to ensure America stays competitive in the global research market.

Action Taken or to be Taken

AHRQ provides support for training the next generation of researchers through several venues. Since 1993 AHRQ has received one percent of the National Research Service Award (NRSA) award funds to support institutional training and individual fellowships. This has translated into approximately $7.6 million in annual funds from 2005 to approximately $7.8 million annually since 2008. In the two most recent National Research Council's quadrennial evaluations of the NRSA program (2005 and 2009) recommendations were made that the NRSA investment in AHRQ training programs should be expanded.

In FY 2012 AHRQ has allocated $500,000 to support dissertation training grants and $1.0 million to support individual career development grants. AHRQ will also support training at the institutional level 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.

Nurse Staffing Ratios

2. SENATE (Rept. 112- 84) p.128

The Committee notes that minimum nurse staffing standards have been found to increase patients' satisfaction with the care they receive and increase the number of nurses who serve at the bedside. The Committee encourages AHRQ to study the impact that nurse-to-patient ratios, in conjunction with the organizational setting, have on the quality of care and patient outcomes. AHRQ is also encouraged to recommend further

integration of these ratios into quality measurement and quality improvement activities.

Action Taken or to be Taken

AHRQ has interest in nurse staffing, quality of care and patient outcomes, evidenced most clearly in past funding of workforce grants and systematic evidence reviews, which include several on nurse staffing. AHRQ is interested in promoting research along this line of inquiry further, within current funding opportunities. AHRQ staff have ongoing communications with national nursing organizations and Federal colleagues related to potential projects. AHRQ continues to encourage nurse scientists to apply for grant funding under existing mechanisms. AHRQ currently funds nurse-centric grants with small and large grant mechanisms, dissertation and training grants. Sample topics for these grants include nurse practitioner organizational climate, nurse staffing policies, and staff nurse care coordination.

Rehabilitation Research

3. SENATE (Rept. 112-84) p.128

The Committee is aware that rehabilitation interventions offer potential solutions to many health policy issues regarding cost-effective interventions that improve the health of citizens and contribute to a higher quality healthcare delivery system. The Committee encourages AHRQ to seek opportunities to collaborate with CMS and the National Center for Medical Rehabilitation Research [NCMRR] within the Eunice Kennedy Shriver National Institute for Child Health and Human Development [NICHD]. The Committee believes such a partnership should advance potential opportunities to conduct comparative investigations of rehabilitation interventions with other healthcare treatment approaches.

Action Taken or to be Taken:

AHRQ agrees that partnerships between the CMS and NIH around meaningful scientific research are important to studying rehabilitation alongside other treatment interventions. AHRQ has undertaken several studies that are important in this area including holding a stakeholder driven research issues exploration forum on cerebral palsy and research reviews and new research on topic areas such as autism spectrum disorders, ADHD, and juvenile arthritis. AHRQ will continue to engage with CMS, NIH and other relevant agencies as it shapes its research agenda in this important area.

Scientific Freedom in Contracted Research

4. SENATE (Rept. 112-84) p.128

The Committee understands that AHRQ continues to increase its use of contracts for conducting research and that in a number of circumstances the principal investigator is not allowed to publish scientific findings in peer-reviewed journals in a reasonable time due to contract clause limitations. The Committee is concerned that such contractual prior restraint clauses on the publication of research may inadvertently stifle scientific freedom and hinder the dissemination of findings that can inform health policymaking. The Committee directs AHRQ to review its policies to ensure researchers have the opportunity to publish research findings in scientific peer-reviewed journals without unreasonable restrictions to allow greater review and input from the scientific community.

Action Taken or to be Taken:

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

Prevention and Public Health Fund

The FY 2013 Budget includes $12.000 million in support through the Prevention and Public Health Fund. These funds will provide support two Prevention/Care Management projects: Prevention Research and the U.S. Preventive Services Task Force (USPSTF).

Prevention Research ($5.000 million): Funds would continue support of $5.000 million for prevention research projects begun in FY 2011. In FY 2011 and FY 2012 AHRQ invested $5.000 million from the Prevention & Public Health Fund to support the first year of funding for three P01 grants to establish Centers for Excellence in Clinical Preventive Services and to fund the Support and Evaluation Program for the Centers for Excellence in Clinical Preventive Services for one year (contract). The FY 2013 Request provides continuation of grant funding—year 3 of 5 years— of approximately $4.5 million. In addition, AHRQ will exercise an option in the existing task order to fund the Support and Evaluation Program for $0.500 million.

These Centers are designed to expand and sustain the necessary capacity to prevent disease, detect it early and manage conditions before they become severe. States and communities are also funded to acquire the resources they need to promote healthy living. Consistent with the National Prevention Strategy of the U.S. Department of Health and Human Services, AHRQ planned a significant research effort to establish the Research Centers for Excellence in Clinical Preventive Services that are located in Chicago, Chapel Hill, North Carolina, and Aurora, Colorado. The centers will serve to advance the national research agenda in clinical preventive services in three specific areas:

- Health equity—to learn more about how to reduce disparities in the use of clinical preventives services.
- Patient safety—to better the understanding of risks and harms associated with clinical preventives services.
- Health systems implementation—to study how primary care practices, public health resources and the larger health care system can improve the delivery of evidence-based clinical preventive services.

Each center will conduct research projects, including pilot and exploratory projects affecting children, the elderly, minorities, those with disabilities and those who receive health care in rural and inner city settings.

The centers will be located at the following institutions:

- Northwestern University, Chicago ($1.4 million per year): The Center for Advancing Equity in Clinical Preventive Services will develop and test interventions to achieve equity in clinical preventive services by focusing on health literacy, health communication, quality improvement methods and health information technology.

- University of North Carolina (UNC) at Chapel Hill ($1.5 million per year): The UNC Research Center for Excellence in Clinical Preventive Services will focus on research to improve patient safety and reduce potential harms to patients by improving the appropriate

use of clinical preventive services in primary health care practices.

- University of Colorado, Anschutz Medical Campus ($1.5 million per year): The Center for Excellence in Research in Implementation Science and Prevention will involve primary care and public health experts to conduct research on how to increase use of preventive health services within primary health care settings while meeting national public health goals.

In addition, Abt Associates, Cambridge, Mass., has received an award to help coordinate and evaluate the research being conducted at the three centers ($0.5 million).

USPSTF ($7.000 million): As described in Section 4003 (3) of the Affordable Care Act (ACA), AHRQ provides ongoing scientific, technical, administrative and logistical support to the U.S. Preventive Services Task Force. The U.S. Preventive Services Task Force (USPSTF or Task Force) is the leading independent panel of private-sector experts in prevention and primary care. For FY 2013, the Request includes $7.000 million from the Prevention and Public Health Fund to support the Task Force. Appropriated funds will be used to support a Scientific Resource Center, a preventive medicine residency rotation program, 3 in-person meetings, staff support at the FY 2011 level of approximately $400,000, and ongoing communication and stakeholder activities. In FY 2013, this work will be accomplished through existing task orders. These funds would supplement ongoing activities funded with appropriated dollars (see below).

	AHRQ Base Budget	**Prevention & Public Health Fund**
FY 2011	$ 4.3 M	$7.0 M
FY 2012	$ 4.3 M	$7.0 M
FY 2013	$ 4.3 M	$7.0 M