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Appendices to the Performance Plan

INTRODUCTION   The Agency for Health Care Policy and Research was reauthorized as the Agency for Healthcare Research and Quality (AHRQ) in December 1999 under P.L. 106-129, the Healthcare Research and Quality Act of 1999. AHRQ, a part of the U.S. Public Health Service within the Department of Health and Human Services, is the lead agency charged with supporting research designed to improve the quality of health care, reduce its cost, improve patient safety, address medical errors, and broaden access to essential services. AHRQ sponsors and conducts research that provides evidence-based information on health care outcomes; quality; and cost, use, and access. The information helps health care decisionmakers – patients and clinicians, health system leaders, and policymakers – make more informed decisions and improve the quality of health care services.

The AHRQ FY 2002 performance plan has the following format: Part 1 describes the Agency's mission, strategic goals, and programs and includes the basic frameworks that the Agency uses to accomplish its core business, and Part 2 then presents the Agency's six performance goals.

The structure of the performance goals and measures was modified in FY 2001 to reflect the two budget lines where the Agency's program activities are funded: 1) Research on health care outcomes; quality; and cost, use and access, and 2) the Medical Expenditure Panel Survey. The goals for the third budget lie, Program Support, focuses on internal management issues for contracts management and information system development. Although the measures continue to be important and remain in place for internal accountability in the Office of Management Operations Plan and performance plans for the managers and staff, they have been removed from the plan.

PART 1 – AGENCY CONTEXT FOR PERFORMANCE MEASUREMENT

1.1   Agency Vision, Mission, and Long-Term Goals

Vision   The vision of the Agency for Healthcare Research and Quality (AHRQ) is to foster health care research that helps the American health care system provide access to high quality, cost-effective services; be accountable and responsive to consumers and purchasers; and improve health status and quality of life.

Mission   The Agency's mission is to improve the outcomes and quality of health care services, reduce its costs, address patient safety, and broaden access to effective services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health system practices, including the prevention of diseases and other health conditions.

The Agency promotes health care quality improvement by conducting and supporting health services research that develops and presents scientific evidence regarding all aspects of health care. Health services research addresses issues of "organization, delivery, financing, utilization, patient and provider behavior, quality, outcomes, effectiveness and cost. It evaluates both clinical services and the system in which these services are provided. It provides information about the cost of care, as well as its effectiveness, outcomes, efficiency, and quality. It includes studies of the structure, process, and effects of health services for individuals and populations. It addresses both basic and applied research questions, including fundamental aspects of both individual and system behavior and the application of interventions in practice settings."[1]

Strategic Goals   AHRQ has identified three strategic goals, each of which will contribute to improving the quality of health care for all Americans.

AHRQ Goal 1. Support Improvements in Health Outcomes

AHRQ seeks to support research to understand and improve decision-making at all levels of the health care system, the outcomes of health care and, in particular, what works, for whom, when, and at what cost.

AHRQ Goal 2. Strengthen Quality Measurement and Improvement

AHRQ is interested in a broad array of research topics, including studies to develop valid and reliable measures of the process and outcomes of care, causation and prevention of errors in health care, strategies for incorporating measures of quality improvement into programs, and dissemination and implementation of validated quality improvement mechanisms.

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[1] Eisenberg JM. Health Services Research in a Market-Oriented Health Care System. *Health Affairs*, Vol. 17, No. 1:98-108, 1998.

AHRQ Goal 3. Identify Strategies To Improve Access, Foster Appropriate Use, and Reduce Unnecessary Expenditures

AHRQ will focus on whether particular approaches to health care delivery and financing, or characteristics of the health care market, alter behaviors in ways that improve access and promote cost-effective use of health care resources.

AHRQ Strategic Plan   The strategic plan will serve as the road map for AHRQ activities through 2002. The current plan was released in December 1998 after an extensive planning process and was made widely available for comment. In 2001, AHRQ will publish its second "Request for Ideas" (RFI) soliciting ideas from the Agency's customers and the general public for priorities in the context of planning for the new Strategic Plan.

AHRQ assesses the progress made toward achieving each of the goals as part of the annual planning and budget development process. These assessments are integral to AHRQ's compliance with the Government Performance and Results Act of 1993 and provide the backdrop against which the next year's activities are planned. The completion of the 1999 performance report provided valuable information to the Agency on progress toward strategic goals. Results have been used to gather new knowledge, improve research management, and strengthen dissemination activities.

1.2   Organization, Programs, Operations, and Strategies

AHRQ Organization   General program direction and strategic planning is accomplished through the collaboration of the Office of the Director (with its three administrative offices) and six Research Centers, which have programmatic responsibility for portions of the Agency's research portfolio. The Agency planning processes are linked to budget planning and performance management through GPRA.

Each Office and Center (O/C) have individual strategic and operations plans. The annual operations plans identify critical success factors that illustrate how each O/C contributes to AHRQ's achieving its strategic and annual performance plan goals, as well as internal O/C management goals. At the end of each year, the Office and Center Directors and their staffs review their accomplishments in relation to the annual operations plans and draft the next year's plans. The results of the reviews contribute significantly to the performance reports, which are influential in revising the operations plans.

As a result of the increased emphasis on strategic planning, evaluation activities have taken on greater focus. Evaluations are used to demonstrate the impact of Agency work on the health care system, to test and improve the usefulness and usability of Agency products, and to assess the effectiveness and efficiency of internal operations. The results of the evaluation studies are used to make planning, budget, and

operations decisions in subsequent years, as well as for GPRA reporting purposes.   Evaluations of significant AHRQ programs are reported on in Goal 4 of the Performance Report.

AHRQ Programs, Operations, and Strategies

The main focus of AHRQ research is on the delivery of health care and identifying ways to measure and improve it. The Agency's research portfolio consists of intramurally and extramurally funded work. Extramural research is the primary source of studies on outcomes and effectiveness.   AHRQ sponsored and conducted research measures the effectiveness of the services that deliver preventive, diagnostic, and therapeutic care, compares them with existing practice, and evaluates the ability of the health care system to deliver them effectively. The Agency's reauthorization led to an increased focus on patient safety and the reduction in medical errors, as well as research that will accelerate and magnify the impact of research on clinical practice and patient outcomes. Through the Translating Research Into Practice (TRIP) agenda, the Agency sponsors applied research to develop sustainable and replicable models and tools to improve the quality, outcomes, effectiveness, efficiency, and cost effectiveness of health care.

The Research Pipeline

New Knowledge on Priority Health Issues	New Tools and Talent for a New Century	Translating Research Into Practice
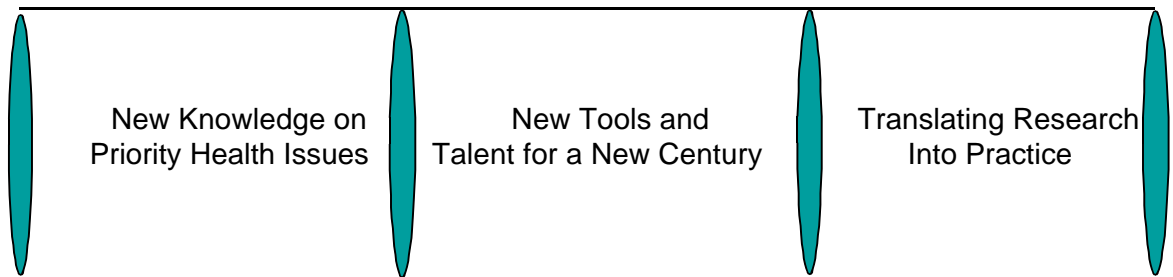
The AHRQ portfolio reflects a "pipeline" of activities that together build the infrastructure, tools, and knowledge for improvements in the American health care system. This pipeline begins with the funding of new research that answers important questions about what works in American health care (*New Knowledge on Priority Health Issues*).

The second section in the pipeline (*New Tools and Talent for a New Century*) is focused on more applied research and translates new knowledge into instruments for measurement, databases, informatics, and other applications that can be used to assess and improve care.

The final section of the pipeline is where the first two investments come together by closing the gap between what we know and what we do *(Translating Research Into Practice)*. AHRQ funds research and demonstrations to translate the knowledge and tools into measurable improvements in the care Americans receive.

AHRQ Audiences

Levels of Decisionmaking				
G O A L A R E A S		**Clinical Services**	**Health Systems**	**Public Policy**
	Outcomes			
	Quality			
	Access, Cost, & Use			

Agency activities begin and end with the end-users of Agency research. AHRQ customers require evidence-based information to inform health policy decisions. Health policy choices in this context represent three general levels of decisionmaking:

Clinical Policy Decisions – Information is used every day by clinicians, consumers, patients, and health care institutions to make choices about what works, for whom, when, and at what cost.

Health Care Organizations Policy Decisions – Health plan and system administrators, policymakers, and purchasers are confronted daily by choices on how to improve the health care system's ability to provide access to and deliver high-quality, high-value care.

Public Policy Decisions – Information is used by policymakers to expand their capability to monitor and evaluate the impact of system changes on outcomes, quality, access, cost, and use of health care and to devise policies designed to improve the performance of the system. These decisions include those made by Federal, State, and local policymakers and those that affect the entire population or certain segments of the public.
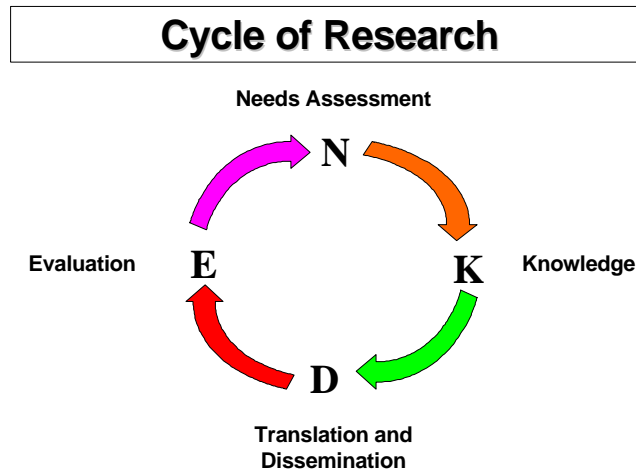
Cycle of Research

Needs Assessment

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                    N
          (Needs Assessment)

Evaluation   E          K   Knowledge

                    D

          Translation and
          Dissemination
```

Figure 1

AHRQ Cycle of Research

Producing meaningful contributions to the Nation and to research on health care requires continuous activity focused on iterative improvement in priority setting, on developing research initiatives, and on research products and processes. The following research cycle describes the processes AHRQ uses to conduct its ongoing activities in order to make the most productive use of its resources.

Needs Assessment. Agency activities begin and end with the end-users of Agency research. The research agenda is based on an assessment of gaps in the knowledge base and on the needs of patients, clinicians, institutions, plans, purchasers, and State and Federal policymakers for evidence-based information. Input gained during the needs assessments feeds directly into the research initiatives undertaken by the Agency, as well as the products developed from research findings to facilitate use in health care.

Knowledge Creation. AHRQ will support and conduct research to produce the next generation of knowledge needed to improve the health care system. Building on the last 10 years of investment in outcomes and health care research, AHRQ will focus on national priority areas for which much remains unknown.

Translation and Dissemination. Simply producing knowledge is not sufficient; findings must be useful and made widely available to practitioners, patients, and other decisionmakers. The Agency will systematically identify priority areas for improving care through integrating findings into practice and will determine the most effective ways of doing this. Additionally, AHRQ will continue to synthesize and translate knowledge into products and tools that support its customers in problem-solving and decision making. It will then actively disseminate the knowledge, products, and tools to appropriate audiences. Effective dissemination involves forming partnerships with other organizations and leveraging resources.

Evaluation. Knowledge development is a continuous process. It includes a feedback loop that depends on evaluation of the research's utility to the end user and impact on health care. In order to assess the ultimate outcomes of AHRQ research, the Agency will place increased emphasis on evaluation of the impact and usefulness of Agency-supported work in health care settings and policymaking. The evaluation activities will include a variety of projects, from smaller, short-term projects that assess process, outputs, and interim outcomes to larger, retrospective projects that assess the ultimate outcomes/impact of AHRQ activities on the health care system.

Priority Populations

Health services research has consistently documented the persistent, and at times great, disparities in health status and access to appropriate health care services for certain groups. The Agency's reauthorization legislation, P.L. 106-129, the Healthcare Research and Quality Act of 1999, mandated the creation of an Office of Priority Populations to continue to build the research and associated activities that AHRQ undertakes on health care for priority populations to eliminate disparities. These populations include racial and ethnic minorities, women, children (including adolescents), the elderly, people with special needs (disabilities, chronic illness, end-of-life issues), low income populations and those from inner-city and rural (including frontier) areas with health care delivery issues. In FY 2000, AHRQ developed the structure for the Agency's Office of Priority Populations Research (OPPR) to continue focusing on developing science-based information to address issues of access to care, outcomes, quality, and the cost and use of services for each of these priority populations. The OPPR leadership will be implemented in FY 2001.

Training

AHRQ assures a strong infrastructure for health services research through investments in training and the support of young investigators. Critical areas of emphasis include:
- bringing diversity to the health services research workforce by increasing the number of trained minority researchers;
- instituting training programs to build research capacity in states that have not traditionally been involved in health services research, but are interested in developing the needed infrastructure;
- training programs for junior-level researchers and mid-career scientists to emerging and innovative research methods; and
- training programs that build curricula and foster innovative training approaches.

1.3 Partnerships and Coordination

AHRQ is not able to accomplish its mission alone. Partnerships formed with the agencies within the Department of Health and Human Services, with other components of the Federal Government, with State and local governments, and with private-sector organizations play a critical role in enabling the Agency to achieve its goals.

Most of the Agency's partnerships are related to:

- ▸ the development of new research knowledge
    - – AHRQ co-funds individual research projects and sponsors joint research solicitations with agencies within HHS, such as NIH, CDC, and SAMHSA
    - – AHRQ co-funds research with academic institutions and foundations such as the David and Lucille Packard Foundation

- ▸ the development of tools, measures, and decision support mechanisms
    - – HRSA and AARP partnered with AHRQ to develop the Put Prevention into Practice Personal Health Guide for Adults Over 50, which was launched at the Healthy People 2010 conference on January 25, 2000.
    - – An increasing number of agencies (such as NIH, HCFA, and the VA) are working closely with AHRQ's Evidence-based Practice Centers to develop assessments of existing scientific evidence to guide their work.
    - – Evidence reports are being used to develop clinical practice guidelines by organizations such as the American Psychiatric Association, American Academy of Pediatrics, American College of Obstetrics and Gynecology, American Academy of Physicians, American Academy of Cardiology, American Heart Association, and the Consortium for Spinal Cord Medicine.
    - – The Healthcare Cost and Utilization Project (HCUP) is a long standing public-private partnership between AHRQ and 26 partner states to build a multi-state data system

- ▸ the translation of research into practice
    - – 14 companies/organizations (e.g. Midwest Business Group on Health, IBM, United Parcel Service, National Consumers League) have joined AHRQ in disseminating its Quality Navigational Tool designed to assist individuals to apply research findings on quality measures and make major decisions regarding health plans, doctors, treatments, hospitals, and long-term care.
    - – 14 organizations/companies have joined AHRQ in disseminating smoking cessation materials (e.g. American Cancer Society, American Academy of Pediatrics, Michigan Department of Community Health, Utah Tobacco Prevention and Control System)

1.4   Summary FY 2000 Performance Report: Accountability through Performance Measurement

AHRQ uses its strategic plan to integrate the Agency's planning processes with budget development and implementation, and performance management and evaluation. The current focus is to improve the linkage between the performance indicators and the office and center annual

operations plans, clarifying and strengthening Agency performance reporting systems, and documenting more thoroughly how the results of the performance plans are used in the management of the Agency.

One of the strengths of the performance plan is its alignment with the cycle of research (needs assessment, creation of new knowledge, translation and dissemination, and evaluation), and the strategic Agency plans for projects like the quality initiative, and the core Medical Expenditure Panel Survey (MEPS) activities. This alignment allows the Agency to more readily conduct gap analyses of where we are and where we want to be. The results of these analyses help AHRQ identify where to place further emphasis, where to continue on its current course, and/or where to discontinue an initiative. AHRQ investment in these core activities are rewarded by high rates of customer satisfaction and user input. For example, 90% of the users of MEPS data indicate they are highly satisfied, and the number of AHRQ grants funded in FY 2000 using MEPS data are twice the target goal. Additionally, the response to user requests are at and above target goals: requests received from policymakers, purchasers and plans for MEPS data tapes, analyses, and/or reports were responded to within promised time frames 95% of the time, with staff responding to 96% of all user requests for technical assistance within 4 working days. This is a reduction of a full day over last year's performance. In other goals, figures often exceed the target goals. As another example of its ongoing efforts to involve customers in the developmental stage, AHRQ has solicited and received extensive user contributions toward the development of the National Quality Report. Customer input has identified thousands of potential indicators of quality care. This extensive list of initial measures is currently under review for selection of a core set of broadly applicable quality measures.

Increasingly, within its annual operations plans, AHRQ is placing emphasis on (1) the translation and dissemination of research findings, which the Agency refers to as "Translation of Research Into Practice" or TRIP, and (2) the evaluation of research and products developed by the Agency that are in use in the health care system. These are two core activities that are critical to the AHRQ mission to use its investments in research to change health care and impact the well being of the American public. The benefits of AHRQ funding of TRIP grants is evidenced by the scope of funded projects which span conditions, populations and healthcare settings. Examples include: assessing a model for accelerating the use of evidence-based treatment guidelines for acute ischemic stroke; comparing usual care with interactive, multi-media computer based patient education to improve diabetes-related knowledge, attitudes, self-efficacy and compliance with self-care recommendations; comparing two methods of integrating services in a group practice plan serving a low-income minority Medicaid population; and focusing on improving asthma outcomes for poor, inner-city, minority children. The studies funded under the TRIP initiative also address five of the six priority conditions identified in the Department's Racial and Ethnic Disparities in Health strategy.

AHRQ has maintained the same structure, goals, and objectives for the FY 2002 performance plan. As Agency's programs move through the cycle of research, some of the specific measures used under any one goal change

from year to year to reflect the stage that the programs are in: process stage, output stage, or outcome stage. For instance, in the FY 1999 Plan, the Evidence-based Practice Centers (EPC) are represented with measures under Goal 3 representing translation and dissemination. In FY 2000 and FY 2001 they are represented under Goal 4 (evaluation) because the Agency will have moved on to assessing the actual use and impact of the EPC products in the health care system.

The performance measures provide the Agency the opportunity to be reflective of its efforts during the fiscal year, and assess which approaches have been the most productive in supporting its mission to support, conduct, and disseminate research that improve access to care and the outcomes, quality, cost, and utilization of health care services. The Performance Report for FY 2000 demonstrates the Agency has a high degree of success with its efforts to realize its goals and objectives. AHRQ has reported on 100% of the 53 measures contained in the Performance Report for FY 2000. Of these 53 objective performance measures, 98% (52 measures) of the target goals have been met or exceeded. The remaining measure is being reviewed to determine if the baseline target was overly optimistic. Thus, while the Agency's efforts to meet target goals have been very good, AHRQ continually reviews target goals to assess the need for reformulation.

A summary of AHRQ's annual performance plans' measures for FY 1999 - FY 2002 follows.

Summary of Performance Objectives

Budget Line 1:   Research on Health Costs, Quality, and Outcomes

Funding Levels:	FY 1999	$139,314,000 (Actual)
	FY 2000	$165,293,000 (Enacted)
	FY 2001	$226,446,000 (Appropriation)
	FY 2002	$255,145,000 (President's Budget)

> **GPRA Goal 1:   Establish research agenda based on users' needs.**

NOTE: B: is Budget; Page: will have entered a page number; CB is commitment base. Under Actual Performance column the corresponding page (p., pp.) #s of the GPRA report are noted.

Performance Objective	FY Targets	Actual Performance	Refer-ence

13

| Objective 1.1: Define direction of FY project funding priorities, in large part, by needs assessment activities. | 02:
 • Agency research agenda covering strategic goal areas for FY 2002 priorities (investigator-initiated research, national quality report, national disparities report) is documented by March 2002 based on consultations with various groups.

 01:
 • Agency research agenda covering strategic goal areas for FY 2001 priorities (patient safety and informatics) is documented based on consultations with various groups.

 00:
 • Agency research agenda covering the 3 strategic research goals and the new FY 2000 closing the gap initiatives are documented based on consultations with various groups.

 99:
 • Agency research agenda covering the 3 strategic research goals is developed in FY 99 and documented based on consultations with various groups. |

Completed.

Completed. P. 40 and Appendix 5. | CB

CB

B:3 |

GPRA Goal 2:   **Make significant contributions to the effective functioning of the U.S. health care system through the creation of new knowledge.**

Performance Objective	FY Targets	Actual Performance	Refer-ence
01 - 02 Objective 2.1: Determine annually the salient findings from research in each of the three areas (outcomes; quality; and cost, access, and use) and develop plan for next steps translation and dissemination.	02: • Produce an annual report on at least 18 science advances covering the three research goal areas (outcomes; quality; cost, access, and use). • For each finding, specific steps in translation and dissemination are identified and initiated. • Generate 2 - 3 synthesis reports on research findings and practical applications on Agency priority topics. 01: • Produce an annual report on at least 12 science advances covering the three research goal areas (outcomes; quality; cost, access, and use) • For each finding, specific steps in translation and dissemination are identified and initiated. • Generate 2 - 3 synthesis reports on research findings and practical applications on Agency priority topics.		CB CB
00 Objective 2.1: Determine annually the salient findings from research in each of the three areas (outcomes; quality; and cost, access, and use) and develop plan for next steps translation and dissemination.	00: • Annual report on science advances in three research goal areas. • At least four major findings in each area that have potential to save significant amounts of money, improve quality, save lives or prevent physical suffering, or change the organization and delivery of health care. • For each finding, specific steps in translation and dissemination are identified and initiated.	Completed. Completed. Completed.	CB
99 Objective 2.1: Determine the salient findings from research for three priority populations and develop plan for next steps in translation and dissemination.	99: • A report produced that synthesizes research on the major health concerns of at least three priority populations.	Completed. (Appendix 6).	

Objective 2:2: Achieve significant findings from AHRQ sponsored and conducted research.	02: • Findings from at least 20 AHRQ sponsored or conducted research are used by public and private partners to improve health care.		CB
	01: same as 00, except changed to 40 findings		CB
	00: • Findings from at least 25 AHRQ sponsored or conducted research are published in major peer reviewed professional publications (*New England Journal of Medicine, Journal of American Medical Association*, etc.); receive national press coverage; are used in Federal or State policymaking; are used by professional associations or health plans as the basis of strategies to achieve quality; or are used to establish coverage decisions by health care purchasers, managed care organizations, or insurers, including Medicare or Medicaid.	400% increase: 250 citations for AHRQ findings (20 listed). 32 examples of major media coverage; 7 examples of usage	CB
	99: Findings from at least 10 AHRQ sponsored or funded research are published in major peer reviewed professional publications (*New England Journal of Medicine, Journal of American Medical Association*, etc.); receive national press coverage; are used in Federal or State policymaking; are used by professional associations or health plans as the basis of strategies to achieve quality; or are used to establish coverage decisions by health care purchasers, managed care organizations, or insurers, including Medicare or Medicaid.	50 citations for AHRQ findings; 7 examples of major media coverage; 7 examples of usage.	

01 - 02 Objective 2.3: Initiate FY Research Initiatives	02: Funding of a minimum of 100 projects; 30% of these projects address priority populations. 01: Funding of a minimum of 60 projects in the following areas: • 40 projects in reducing medical errors and enhancing patient safety • 10 projects in informatics applications in health care • 10 projects in quality improvement through improvements in health care working conditions		B:64 B:31-35 B:33 B:36-37
00 Objective 2.3: Implement FY 2000 priority (1) "New Research on Priority Health Issues."	• Funding of a minimum of 10 projects that address gaps in knowledge about the priority problems faced by Medicare and Medicaid. • Funding of a minimum of 10 projects to address eliminating disparities in health care with particular emphasis on disparities that exist for racial and ethnic minorities.	43 projects funded More then 30 projects funded	B:19-20 B:50-51
99 Objective 2.3 Initiate FY 99 Research Initiatives	Funding of a minimum of 21 projects in: • consumers use of information on quality • strengthen value-based purchasing • measure national health care quality • vulnerable populations • translating research into practice Funding of a minimum of 17 projects in: • Outcomes for the elderly and chronically ill • Clinical preventive services • CERTS • Improving the quality of children's health	56 projects funded. 51 projects funded. Details on p. 47.	

<table>
<tr><td colspan="3">Goal 3:   Foster translation and dissemination of new knowledge into practice by developing and providing information, products, and tools on outcomes; quality; and access, cost, and use of care.</td></tr>
</table>

Performance Objective	FY Targets	Actual Performance	Refer-ence
01 - 02 Objective 3.1: Maximize dissemination of information, tools, and products developed from research results for use in practice settings. NOTE: in the FY 2001 plan, objective 3.1 and 3.2 have been consolidated.	**02:** • Number of state and local governments trained and/or receiving technical assistance through User Liaison Program (ULP). • At least 20 partnerships to disseminate and implement research findings are formed with public and private-sector organizations. • Synthesis of at least 5 grant portfolio areas on quality of care across Agency's goals for persons with chronic care needs produced and disseminated with particular focus on outreach to managed care executives. **01:** • At least 5 public-private partnerships are formed to implement research findings for decisionmakers. • Formation of a minimum of 10 partnerships to support dissemination of AHRQ products through intermediary organizations, such as health plans and professional organizations. • Number of hits on the Web site • Number of inquiries handled on web site • Number of Uploaded documents. • Number of State and local governments trained in the understanding and use of health services research findings through ULP Workshops .		CB CB CB for all web site mea-sures and ULP

00 & 99 Objective 3.1: Promote distribution of AHRQ publications, products, and tools through intermediary organizations.	00: Formation of a minimum of 5 partnerships to support dissemination of AHRQ products through intermediary organizations, such as health plans and professional organizations.	Over 30 public/private and public/public partnerships formed.	CB
	99: Formation of a minimum of 5 partnerships to support dissemination of AHRQ products through intermediary organizations, such as health plans and professional organizations.	Over 30 public/private and public/public partnerships formed	
01 - 02 Objective 3.2: Develop and facilitate the use of new tools, talent, products, and implementation methodologies stemming from research portfolio. (This is objective 3.3 in FY 99-00)	02: • Produce evidence summaries for use in Federal direct care providers' efforts to create guidelines. • Evidence-based practice centers (EPCs) will produce a minimum of 18 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality by improving practice. • Fund at least 10 projects in tool and data development.		CB CB CB
	01: • Produce evidence summaries for use in Federal direct care providers' efforts to create guidelines. • EPCs will produce a minimum of 12 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality by improving practice. • Support a minimum of 165 pre- and post-doctoral trainees. • Support up to 3 Minority Research Infrastructure Support Program IM-RISP) grants in order to develop the health services research capabilities of traditionally minority-serving institutions. • Support up to 6 Building Research Infrastructure and Capacity (BRIC) two-year planning grants in EPSCOR states and states which historically have received little or no research support from AHRQ. • Fund at least 10 projects in tool development.		CB

99 - 00 Objective 3.2: Maximize dissemination of information, tools, and products developed from research results for use in practice settings. (Becomes Objective 3/1 in FY 01.)	00:		
	• Number of hits on the Web site	18.8 million hits	B:57
	• Number of inquiries handled on web site.	3,500	B:57
	• Number of Uploaded documents	4,400	B:57
	• Reports from user surveys on how the information requested was used.	Completed	B:59
	• Number of State and local governments trained in the understanding and use of health services research findings through User Liaison Program (ULP) Workshops	State - 50 Local - 29	CB
	• + Meetings held.	17 meetings	CB
	• + Number of attendees	1196 attend.	CB
	• + States represented.	50 States + D.C.	CB
	• Reports from annual participants on how the information was used in decisionmaking.	Met	CB
	• Statistics on usage of National Guideline Clearinghouse including number of hits, requests, organizations, and total users.	Hits: 32,234,401 Requests: 18,207,430 Org's: 58,803 User sessions 1.5 million	B:24-25
	• Survey of a sample of NGC users to understand the impact of use on decisions and patient care.	902 respondents Evaluation to be completed in mid-year 2001	B25:
	• At least 10 purchasers/businesses use AHRQ findings to make decisions.	11 examples listed	

| Goal 3 continued:
Objective 3.2 | 99:
• Number of hits on the Web site
• Number of inquiries handled on web site.
• Number of Uploaded documents

• Number of State and local governments trained in the understanding and use of health services research findings through User Liaison Program (ULP) Workshops

• + Meetings held.
• + Number of attendees
• + States represented.

• Statistics on usage of National Guideline Clearinghouse including number of hits, requests, organizations, and total users.

• At least 5 purchasers/businesses use AHRQ findings to make decisions. | 15.5M
2,950
4,000

48 states; 4 territories; 30 county gov'ts; 9 city gov'ts

18
834
48

13,590,013

21 examples listed.

Further details, p 54 | |
| **Objective 3.3**   (This becomes objective 3.2 in FY 01. Objective 3.3 is discontinued in FY 01.)

99 - 00 Objective 3.3: Develop and facilitate the use of new tools, talent, products, and implementation methodologies stemming from research portfolio. | 00
• Demonstration of use of at least 3 AHRQ research findings in systematic efforts to Translate Research Into Practice.
• Funding of a minimum of 5 major projects that will develop products, tools, or methodologies for implementing research findings into practice in significant segments of the health care system (i.e., potential to be generalizable across health care systems, provider-types, or clinical areas.)
• At least 2 new tools, products, or methodologies become available from projects funded between FY 1993 and FY 1996.
• Support a five percent increase, at a minimum, in number of pre- and post-doctoral trainees. | Met

29 Projects funded

23 Listed

40% Increase (further details, P.89)) | |

Goal 3, continued: Objective 3.3	99 • Evidence-based Practice Centers (EPCs) produce a minimum of 12 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality by improving practice (i.e., practice guidelines, quality measures, and other quality improvement tools). At least four reports are being used by customers to develop practice guidelines or other interventions.	10 produced; 3 "in press"; 30 under development	
	• The AHRQ software product, CONQUEST 2.0 released in FY 1999 containing new measures, including measures for new conditions, and updated measures. Contract awarded to create web-based product for more timely updating of information contained within product.	Released March 1999; contract to be awarded 9/00	
	• Funding of a minimum of 5 major projects that will develop products, tools, or methodologies for implementing research findings into practice in significant segments of the health care system (i.e., potential to be generalizable across health care systems, provider-types, or clinical areas.)	13 examples provided	
	• At least two new tools, products, or methodologies become available from projects funded between FY 1993 and FY 1996	15 examples provided	
	• Support a minimum of 150 pre- and post-doctoral trainees.	167 trainees	
		Further details, p. 56	

| GPRA Goal 4: | Evaluate the effectiveness and impact of AHRQ research and associated activities. | | |

Performance Objective	FY Targets	Actual Performance	Refer-ence

01 - 02 Objective 4.1 Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care. NOTE: 99 - 00 Objectives 4.1 and 4.2 have been consolidated in the FY 01 plan.	02: Evaluate the impact of the CERTS program in disseminating information regarding therapeutics to at least 3 health care providers or others in order to improve practice. • Evaluation to determine whether AHRQ funded studies in methodological development have been effective in developing at least 3 new research techniques, whether the techniques are being implemented, and how these studies could be improved. • Evaluation of the outcomes of the pharmaceutical studies the Agency has funded to assess impact. • Interim assessment of the impact of the management system for tracking project profiles. • Qualitative review by experts of results of one major research initiative to assess quality and productivity and potential impact. • Evaluate private sector use of at least 5 AHRQ findings. • Identify at least 5 private sector uses of AHRQ findings, and describe any assessment of the impact on clinical practice and/or patient care. ***Evidence-based Practice Centers*** • Use of evidence reports and technology assessments to create quality improvement tools in at least 10 organizations. • For at least four evidence reports or technology assessments per year, work with partners to measure how the reports or assessments were used and what impact they had on clinical decision making and patient care. • Findings from at least 3 evidence reports or technology assessments will effect State or Federal health policy decisions. • Use of evidence reports or technology assessments and access to NGC site informed organizational decision making in at least 4 cases and resulted in changes in health care processes, quality, or health outcomes. 01: ***Evidence-based Practice Centers*** • Use of evidence reports and technology assessments to create quality improvement tools in at least 10 organizations. • For at least four evidence reports or technology assessments per year, work with partners to measure how the reports or assessments were used and what impact they had on clinical decision making and patient care. • Findings from at least 3 evidence reports or technology assessments will effect State or Federal health policy decisions.	CB CB CB

Goal 4 continued: **01 Objective 4.1** Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care. *Cont.*	• Findings from at least 3 evidence reports or technology assessments will effect State or Federal health policy decisions. • Use of evidence reports or technology assessments and access to NGC site informed organizational decisionmaking in at least 4 cases and resulted in changes in health care procedures or health outcomes.		CB
	Research • At least 3 examples of how research informed changes in policies or practices in other Federal agencies.		CB
	Quality Measures • Achievable Benchmarks of Care are used for quality improvement activities by Peer Review Organizations • Use of dental performance measures by dental service and insurance organizations. • HCUP quality indicators incorporated into efforts by hospital associations and hospitals to improve the quality of care.		CB
	National Guideline Clearinghouse • At least 10 users of the National Guideline Clearinghouse will use site to inform clinical care decisions • Guideline development or quality improvement efforts by users will be facilitated through use of NGC in at least 5 cases. • NGC information will be used to inform health policy decisions in at least 2 cases. • Improvements in clinical care will result from utilization of NGC information in at least 3 cases.		CB
	Training Programs Two thirds of former pre- and postdoctoral institutional award trainees are active in the conduct or administration of health services research.		CB

00 Objective 4.1 (& 4.2)*: Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care. * Objectives 4.1 and 4.2 were inadvertently the same. They have been consolidated to simplify the reporting.	00 • AHRQ's HCUP Quality Indicators(QI's) will be redesigned based on consultations with state policy makers, researchers, hospital associations, and others about their past use of the QI's. By the end of March 2001, a new set of quality indicators will be defined and feedback obtained from a new set of HCUP QI users. In addition, AHRQ will provide access to recent national-level QI information via both the Internet and through published reports, with special focus on disseminating information to hospital users and organizations with responsibility for hospital quality reporting. • Use of evidence reports and technology assessments to create quality improvement tools in at least 10 organizations. • For at least four evidence reports or technology assessments per year, work with partners to measure how the reports or assessments were used and what impact they had on clinical decisionmaking and patient care. • At least three examples of how research informed changes in policies or practices in other Federal agencies. • AHRQ will report on the extent to which CONQUEST assists those who are charged with carrying out quality measurement and improvement activities and the extent to which it helps further state-of-the-art in clinical performance measurement. • CAHPS® has assisted the Health Care Financing Administration (HCFA) in informing Medicare beneficiaries about their health care choices. The use and impact of this information is determined by surveying a sample of these beneficiaries. • At least one quality measure from Q-span (or instances where AHRQ research contributes to the development of measures) are used in the Health Plan Employer Data Information Set (HEDIS) by the National Committee for Quality Assurance (NCQA), measurement activities of the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), or other organizations monitoring health care quality.	HCUP QI's defined National-level QI information posted to Internet Sept 2000 16 examples listed 4 examples listed 4 examples listed Completed (details p. 102) Completed. Results to be published in July 2001 ABC System of performance profiling cited (details p. 103)	CB

Goal 4 continued: **99 Objective 4.1** Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care. *Cont.*	99 • An evaluation of the outcomes of outcomes research and the impact of AHRQ-supported outcomes and effectiveness research on clinical practice.	Completed	
	• An evaluation and synthesis of (1) primary care research supported by AHRQ and (2) an assessment of the current state of the science and future directions for primary care research.	Progress report (details p.64)	
	• AHRQ's state data strategy will be redesigned based on consultations with state policy makers, researchers, hospital associations, and others about their past use of data from the Healthcare Cost and Utilization Project (HCUP) as well as additional data needs.	Completed	
	• Results of the evaluation of the Consumer Assessment of Health Plan Study (CAHPS®) will be used to improve the usability and usefulness of the tool. Findings are expected to show whether (a) the survey-based information from CAHPS® helps consumers make better health care decisions, (b) the information increases consumer confidence when choosing health care plan, and (3) CAHPS® is used by public and private organizations.	Preliminary results.	
	• Evaluation studies on: (1) the quality and usefulness of the evidence reports and technology assessments produced by the Evidence-based Practice Centers and (2) the impact of the use of these products on the health care system will be developed and initiated in FY 1999.	Final report received in June 2000.	

| 01 - 02 Objective 4.2: Evaluate the impact of MEPS data and associated products on policymaking and research products. | 02
• Have a fully functional MEPS-based MEDSIM model to allow simulation of the potential impact of programmatic changes in health care financing and delivery Dec 2002.
• Produce baseline FY statistics on number of MEPS-based articles published in peer review journals.
• Conduct customer satisfaction survey for MEPS workshop participants to assess how MEPS data is being used to inform research and public policy.
• Develop marketing plan to promote the MEPS-IC data to state officials Dec 2002.
• At least 5 examples of how research using MEPS has been used to inform decisions by Federal, state and private sector policymakers.

01
• Use of MEPS data in AHRQ research applications will increase by 10 percent over number received in baseline period of 2000
• Feedback from MEPS workshop participants indicating that they were useful and timely.
• At least 5 examples of how research using MEPS has been used to inform decisions by Federal, state and private sector policymakers.

00
See above 4.1 for 00 | | CB

CB

CB

CB

CB

CB

CB

CB |
| 99: Objective 4.2: Evaluate major dissemination mechanisms. | • AHRQ Clearinghouse customer satisfaction rated at 98%.
• Customer satisfaction data on AHRQ consumer publications (useful/relevant) rated at 90%. | Met.
81.3% | CB |

Performance Objective	FY Targets	Actual Performance	Reference
01 Objective 4.3 n/a **00 Objective 4.3:** Evaluate the impact of MEPS data and associated products on policymaking and research projects. **99: n/a**	• Use of MEPS data in 1% of research applications received by AHRQ. • Distribution of MEPS data sets to at least 2500 requestors. • At least 5 examples of how research using MEPS has been used to inform decisions by Federal, state, and private sector policymakers. • Feedback from recipients of MEPS data indicating that the data were timely, useful, and of high significance.	MEPS used in 31% of funded projects 5,700 data sets; 379 CD ROM's 15 examples given Met.	

GPRA Goal 5:	Support initiative to improve health care quality through leadership and research.

Performance Objective	FY Targets	Actual Performance	Refer-ence

00 - 02 Objective 5.1: Conduct research to help to measure the current status health of care quality in the Nation.	**02** • Integration of at least one private sector data source into the national quality report by 31 December 2002.		B:35-36
	01 • QI Taxonomy meeting held under the auspices of the QuIC.		CB
	• Number of grants and contracts funded in FY2001 that will help to fill gaps in the information available to assess the national quality of care, or will help to expand the use of current measures to provide a broader or richer picture of quality.		
	00 • Data sources identified that will contribute information as part of the mosaic picture of quality of care in the Nation.	Final recommend. March 2001	CB
	• Develop and begin to test some questions to be added to existing data collection activities to provide a better picture of quality.	Survey completed. Fielded during FY 2001	CB
	• Develop framework for National Healthcare Quality Report.	Final report 30 March 2001.	B:35
99 Objective 5.1: Provide leadership for the Executive Branch's Quality Interagency Coordination Task Force (QuIC)	• Provide leadership for the Executive Branch's Quality Interagency Coordination Task Force (QuIC).	Met: (details pp.110-111)	CB
	99 • Collaborative work groups are established under the QuIC under take projects with direct application to improving quality of care. • In addition to the work on specific projects chosen by the QuIC, communication is facilitated on common issues such as: 1) Implementation of the Bill of Rights and Responsibilities from the President's Commission on Consumer Protection and Quality in the Health Care Industry; And 2) organization or management strategies to improve quality of care.	Met.	

Goal 5 continued: **00 - 02 Objective 5.2:** Facilitate use of quality information to improve health care in the Nation	02 • Funding of at least 5 projects bringing healthcare information to the public in an understandable, user friendly manner which facilitates its use in decision making.		CB
	01 • Number of grants to improve patient safety. • Adoption of Agency sponsored research and tools developed by one or more users to facilitate consumers/purchaser/decision- maker use of information about quality		B:31-35
99 Objective 5.2: Conduct research to expand the tool box of measures and risk adjustment methods available help to measure the current status of quality in the nation.	00 • Development of at least one tool that can be used by large group purchasers in assisting their beneficiaries to choose the health care plan, provider, or hospital that best meets their needs.	3 examples given. Details pp. 112	CB
	99 • Inventory of measures and risk adjustment methods currently in use by Federal Agencies will be developed. • Assessment of measures and risk adjustment methods needed by Federal Agencies will be conducted.	Met. Met.	

00 - 02 Objective 5.3: Improve quality measurement	02 • Adoption of at least one quality measure to be developed from our vulnerable populations RFA by a national accrediting organization.		CB
	01 • Identification of collaborators for research projects on electronic medical records integrated with guidelines (e.g., from the Guideline Clearinghouse) or QI indicators (e.g., CONQUEST, QI Taxonomy project, HCUP measures).		CB
	• Adoption of Living With Illness children's health measure by NCQA.		CB
	00 • Sponsor research to fill existing gaps in quality measures in areas of high need.	Met. (Details p.112)	
99 Objective 5.3: Inform health care organizational leaders and others how to design quality into their systems	99 • Review research conducted that identifies appropriate ways of redesigning health care delivery systems to reduce errors.	Met.	
00: Discontinued **99 Objective 5.4:** Improve understanding of how to ensure that research affects clinical practice as appropriate	99 • Research on effective dissemination of information to decisions makers including patients, clinicians, organizational leaders, purchasers, and public policy makers conducted.	Met.	

Budget Line 2: **Medical Panel Expenditure Surveys**

Funding Levels:
FY 1999	$29,300,000 (Actual)
FY 2000	$36,000,000 (Enacted)
FY 2001	$40,850,000 (Appropriation)
FY 2002	$48,500,000 (President's Budget)

> **GPRA Goal 6:** **Collect current data and create data tapes and associated products on health care use and expenditure for use by public and private-sector decision makers and researchers. (Medical Expenditure Panel Surveys)**

Performance Objective	FY Targets	Actual Performance	Refer-ence
99 - 02 Objective 6.1: Release and disseminate MEPS data and information products in timely manner for use by researchers, policy makers, purchasers, and plans.	02 • Develop a method to facilitate users' custom cross tabulations of MEPS data. • Conduct six MEPS data user workshops. • Expand MEPS list-server participation by 20%. • Produce 4 Findings and at least one Chartbook. • Develop Frequently Asked Questions Section for MEPS web site.		CB

99 - 02 Objective 6.1: Release and disseminate MEPS data and information products in timely manner for use by researchers, policy makers, purchasers, and plans. *Cont.*	**01** • In FY2001, 1997 Use and Expenditures, 2000 Point-in-Time, and 1998 Health Insurance and Demographics MEPS public use data files will be released. • Response time for requests received for information, assistance or specific products is as promised 95 percent of time		CB CB
	00 • Core MEPS public use files (PUFs) available through Web site and CD-ROM within 9-18 months after data collection completed.	Available within 12 mos	CB

	• Specific products due in FY2000:
	  + 1999 point-in-time file
	  + 1997 expenditure data
	    available
	  + 1996 full panel file available
		Released:
		-July 2000
		-Available 1st quarter 2001
		-Jan 2000
			CB

	• Customer satisfaction data from use of MEPS tapes and products rated at least 90%.	Rated at 90%	CB
	• Response time for requests received from policymakers, purchasers and plans for MEPS data tapes, analyses, and/or reports responded to within promised time frames 95% of time.	96% within 4 days	CB
	99 • Core MEPS public use files (PUFs) available through Website and CD-ROM within 9-12 months after data collection completed.	Significant progress made. Delivered: March 1999	CB

	• Specific products due in FY 1999:
	  + 1997 point-in-time file.
	  + 1996 full-year expenditure file.
	  + 1996 full-year event, job, and
	    condition files.
		Dec. 1999
		Job and Condition Files delivered November 1999 and August 1999 respectively; event files will be available by March, 2000
			CB

Goal 6 continued: **Objective 6.1**	• Research findings and survey reports developed and disseminated for use by policy makers and researchers including *MEPS Research Findings, MEPS Highlights*, chart books, peer-reviewed journal articles, book published on contributions of expenditure surveys to policy making, publications oriented toward non-researchers.)	30+ publications related to MEPS	B:A5-A-6
	• Customer satisfaction data from use of MEPS tapes and products rated at 85%.	Ratings between 86-96%	CB
	• Requests received from policy makers, purchasers and plans for MEPS data tapes, analyses, and/or reports responded to within promised time frames 85% of the time.	Requests filled within 5 days uniformly. p.81	CB

Goal 6 continued:
 	
99 - 02 Objective 6.2: Facilitate use of MEPS data and associated products as tools by extramural researchers, policy makers, purchasers, and plans.
	02
	• Determine the feasibility of existing mechanisms to provide off-site access to confidential MEPS data.
	• Expand data center capacity by 10% over FY 01 level.
	
	01
	• Establish baseline for Data Center use capacity.
	
	00
	• Data centers operational
	  + # requests for use of the centers
	  + # user-days at the data centers
	  + # projects completed
	
	99
	• Inclusion of MEPS data in extramural research grants with AHRQ and other funders.
	
	• Plan for extramural researcher access to MEPS data fully implemented
		
		Deferred to Jan 2001 (Details p.116)
		
		Included in 20 applications, 5 funded.
		
		Met.
		Fully up Feb. 2000.
			CB
			CB
			
			CB
			
			CB

01 - 02 Objective 6.3: Modify MEPS to support annual reporting on quality, health care disparities, and research on long-term care in adults and children with special needs.	02 • Process and make available data to be included in the National Quality Report. • Begin data collection to support the disparities report Sept 2002. 01 • Data collection begins on the treatment of common clinical conditions over time for a nationally representative portion of the population in support of the National Healthcare Quality Report. • LTC Measures: 1. Have developed data use agreements (DUA) with HCFA to assess and begin data development related to the MDS. 2. Design MEPS over sample of adults with functional limitations and children with special needs. 3. Produce one report related to LTC. 4. Have developed IAA with NCHS for LTC frame development activities. 5. Submit at least one peer-reviewed publication in the area of LTC.		B:78 B:78 CB CB
00 Objective 6.3: Modify and enhance MEPS to enable reporting on the quality of health care in America as part of FY 2000 Priority (3), "New Tools for a New Century."	00: • The design decisions necessary for the expansion of MEPS databases in order to collect data that will support the National Healthcare Quality Report are completed by August 2000. The design decisions will be operationalized in the coming fiscal years.	Met. (Details pp. 117-119)	

99 Objective 6.3: Modify and enhance MEPS to enable reporting on the quality of health care in America.	99 • MEPS Household Survey: Interviews with 9,000 previously surveyed families to obtain calendar year 1998 health care data, and with 5,600 new families.	Met.	
	• MEPS Medical Provider Survey: Interviews with approximately 3,000 facilities, 12,000 office-based providers, 7,000 hospital-identified physicians, and more than 500 home health providers.	Met.	
	• MEPS Insurance Component (MEPS-IC): Interviews with more than 40,000 employers and 1,000 insurance carriers.	Met.	
	• MEPS data collection successfully moved to ongoing survey mode from data collection every ten years.	Met.	
		p. 82	

Budget Line 3:   **Program Support**

Funding Level: FY 1999 $2,341,000 (Actual)
                        FY 2000 $2,484,000 (Enacted
                        FY 2001 $2,500,000 (Appropriation)
                        FY 2002 $2,600,000 (President's Budget)

GPRA Goal 7:   **Support the overall direction and management of AHRQ**

Summary of Performance Objectives

Performance Objective	FY Targets	Actual Performance	Refer-ence
Objective 7.1 is mandatory (Capital Assets) but not applicable to AHRQ.			
00-99 Objective 7.2:Maintain acquisition performance management system to ensure: (1) timely completion of transactions, (2) vendor and customer satisfaction, and (3) efficient and effective use of resources.	01 DISCONTINUED 00 • Internal customer satisfaction rated at minimum of 4.5/5.	Rated 4.2 (Details p. 123)	CB
	• External customer satisfaction rated at 4.5/5.	Rated 4.6	CB
	• Customer satisfaction survey results assessed and used to implement changes to improve and enhance services.	Met. (Details p. 123)	CB
	99 • Internal customer satisfaction rated at minimum of 4.5/5. • External customer satisfaction rated at 4/5. • Customer satisfaction survey results assessed and used to implement changes to improve and enhance services.	4.4 4.0 Met. (Details p. 85)	CB

Goal 7 continued:	01 DISCONTINUED		
	00		
00-99 Objective 7.3. Continued enhancement and expansion of Agency Intranet site to ensure staff have immediate access to all current information.	• Customer satisfaction rated at minimum of 3.5/4.	3.2/5.0	CB
	• Demonstration through customer satisfaction surveys that the daily work of staff has been facilitated by the Intranet.	Met. (Details pp. 123-124)	CB
	• Assessment of customer satisfaction surveys and use of such surveys to implement changes to improve and enhance services as necessary.	Met. (Details p. 124)	CB
	99		
	• Customer satisfaction rated at minimum of 3.5/4.	3.1/4	
	• Customer satisfaction surveys assessed and used to implement changes to improve and enhance services as necessary.	Met	

Goal 7 continued:	02		CB
01-02 Objective 7.4. Establish and maintain a secure Agency computer network infrastructure.	• Perform initial tests, (periodically, beginning in 2nd quarter of FY 2002) to evaluate the preliminary policies and procedures.		
	01		
	• Preliminary policies and procedures for reducing security risks will be developed by the end of FY 2001.		CB
	• Initial criteria for reporting security incidents will be established by the end of CY 2001.		
	• Initial procedures for responding to security incidents will be established by the end of CY 2001.		
	• Implementation of a Secure Phase 1 LAN for analysis of intramural research and survey data will be completed by end of FY-01.		
	• Implementation of a Phase 1 firewall, intrusion detection and virus control system will be in place by end of CY 2001.		
	• Initial security awareness training will begin by end of CY 2001.		

PART 2 – PROGRAM PLANNING AND ASSESSMENT

**Introduction -- Structure of the AHRQ GPRA FY 2000 Performance Report and
FY 2001 Revised Performance Plan and FY 2002 Annual Performance Plan**

The AHRQ GPRA annual performance report and plans are aligned with the Agency's three budget lines:

   (1) Research on Health Care Costs, Quality, and Outcomes,
   (2) Medical Panel Expenditure Surveys, and
   (3) Program Support.

The first two budget lines are where Agency programs are funded. The cycle of research (see page 8), used to structure the first four goals, is the basic framework from the Agency's strategic plan that is used when designing and implementing research projects.

What the Indicators Address	GPRA Goal	FY 2002 Funding
Budget line 1: Research on Health Care Costs, Quality, and Outcomes		**Subtotal = $255,145,000**
Cycle of Research Phase 1: Needs Assessment	**GPRA Goal 1:** Establish Research Agenda Based on User's Needs	
Cycle of Research Phase 2: Knowledge Creation	**GPRA Goal 2:** Make significant contributions to the effective functioning of the US health care system through the creation of new knowledge.	
Cycle of Research Phase 3: Translation and Dissemination	**GPRA Goal 3:** Foster translation of new knowledge into practice by developing and providing information, products, and tools on outcomes, quality, access, cost and use of care.	
Cycle of Research Phase 4: Evaluation	**GPRA Goal 4:** Evaluate the effectiveness and impact of AHRQ research and associated activities.	
Lead role for quality initiative	**GPRA Goal 5:** Support Department-wide Initiative to Improve Health Care Quality through leadership and research.	
Budget line 2: Medical Panel Expenditure Surveys		**Subtotal = $48,500,000**

Core MEPS activities	**GPRA Goal 6:** Collect current data and create data tapes and associated products on health care use and expenditures for use by public and private-sector decision makers and researchers.	
Budget line 3: Program Support		**Subtotal = $2,600,000**
Agency management activities: contracts management and the AHRQ Intranet.	**Goal 7:** Support the overall direction and management of AHRQ	
		Total = $306,245,000

Performance Measures/Indicators

AHRQ uses a combination of process, output, and outcome indicators to present its performance information. **Process measures:** To monitor the establishment of major new initiatives or implementation of improvements in core activities where significant resources are involved or the potential for significance of the ultimate impact is high. **Output measures:** To record the results of research initiatives and dissemination activities essential to moving to the next step of implementation. **Outcome measures:** To show the impact (or potential for impact) in affecting the outcomes, quality, access, cost, or use of health care.

AHRQ Performance Indicators

Phase of initiative	Year One – research initiative starts	Years 3 - 5 – results received	Years 3 - 10 – results used in health care system
Indicator type	Process indicators	Output indicators	Outcome indicators
Indicator examples	Grants funded, creation of reports, partnerships formed	Publications, web site, dissemination, research findings, reports, products available for use in health care system	Results of evaluation studies, users stories, analysis of trend/other data

Crosswalk to the Budget Document

Where appropriate, the page numbers from the budget request are listed with the corresponding GPRA objective. In many cases the funding for activities, such as evaluation studies or dissemination activities, are captured in the base and there will not be a corresponding description in the text.

FY 2000 GPRA Performance Report Results Executive Summary

The mission of the Agency for Healthcare Research and Quality is to conduct and sponsor research that will help improve the outcomes and quality of health care, reduce costs, address patient safety and medical errors, and broaden access to effective services. AHRQ's ability to sustain a high level of performance during fiscal year 2000 is evidenced by how its research has been used to provide better health care and the impact it has had on the delivery of health care services.

In fiscal year 2000, AHRQ:

▸ Awarded 348 research grants (competing and non-competing), over 100 more than were awarded in the previous fiscal year.

▸ Capitalized upon the research capacity of, and opportunities provided by, integrated delivery systems through the creation of an integrated delivery systems research network (IDSRN).

▸ Established the foundation for a new data center where approved users can work in a secured data center to gain access to a broader range of data from the Medical Expenditure Panel Survey (MEPS) than is available publicly.

▸ Awarded 80 training and career development awards.

▸ Saw continued growth in the number of health plans (now over 500) submitting data to its Consumer Assessment Health Plan (CAHPS), a survey and reporting program that helps employees choose among survey health plans.

▸ Established 19 primary care practice-based research networks (PBRNs).

▸ Reached 853 in the number of evidence-based clinical practice guidelines that can be accessed through its National Guideline Clearinghouse (NGC).

▸ Documented over 18,207,000 requests for National Guideline Clearinghouse (NGC) information during the course of over 1,665,000 visits to the NGC Web site from nearly 59,000 organizations.

▸ Developed a draft of a long-term care (LTC) research agenda for the agency and the Department that is driven by user input collected at AHRQ- sponsored expert and User Liaison meetings.

The above listing, however only begins to capture the nature of AHRQ research and the Agency's role within the federal health care infrastructure. As the only federal agency specifically charged with providing information to the people who make decisions about health care, the research AHRQ sponsors and conducts undergirds the work of several federal agency, such as FDA, NIH, CDC and SAMHSA and others. These agencies, and the decisionmakers who run them, are a key consumer group for AHRQ.

User Input
Key to the Agency's success in carrying out its mission is its user-driven agenda. AHRQ regularly requests input from its customers (public and private sector) through a variety of vehicles, including: the National Advisory Council, expert meetings, Federal Register notices, and public comments submitted through its Web site <www.ahrq.gov>.

This user-driven research agenda may be thought of as a three-part research pipeline which 1) supports new research on priority health care issues, 2) develops the tools and talent for knowledge creation and 3) translates research into practice.

New Research

The first pipeline segment is about fundamental research that address important questions about what worked in American health care. Further, it is about moving from using conventional practices in medicine (organizational and financial, as well as clinical) to using the most valid scientific information available. It is about outcomes, about links between processes and outcome, how to measure quality, and about health expenditures, among other topics.

It is knowledge creation in the most literal sense of that term.

In FY 2000, AHRQ provided $39.9 million to fund more than 120 new grants that were investigator initiated. The topics cover the gamut of health services research and allow AHRQ to fund important research which often may not fit within an RFA. The Agency funded an additional 106 small conference, conference and dissertation grants ($4.3 million). Some examples of these grants include the following:

- ▸ Develop measures of the activities of managed care organizations (MCOs) and collect data to create the largest dataset in the country with information relevant to understanding growth of MCOs. These data will then be used to evaluate the impact of MCO growth on costs, utilization, and patient outcomes, and the impact of legislation and regulations on MCO growth.

- ▸ Assess the reliability and efficacy of telemedicine for common, acute complaints of children presenting to the emergency department or primary care office setting.

- ▸ Identify reasons for variability in the interpretation of mammograms in various communities.

Developing Tools and Talent

The second segment of AHRQ's pipeline is about the instruments used and the people mobilized to translate this new knowledge into practice. Among AHRQ's "tool-chest" in this regard are CAHPS and its Computerized Needs-Oriented Quality Measurement Evaluation System (CONQUEST), the quality measures derived from the Healthcare Cost and Utilization Project (HCUP) and Q-SPAN, and the quality improvement tools created from use of Evidence Reports (ERs) and Technology Assessments (Tas). In the area of preventive care, AHRQ provides technical support for the U.S. Preventive Services Task Force (USPSTF), an independent panel of preventive health experts charged with evaluating the scientific evidence for the effectiveness of a range of clinical preventive services.

AHRQ has been very successful in its partnerships with a wide variety of Federal agencies, academic institutions and health care organizations. Decisionmakers use the evidence developed through AHRQ-sponsored research, and the tools developed from those findings, to help make informed decisions about what works, for whom, when and at what cost.

Among the most visible examples of AHRQ's partnerships are its Evidence- Based Practice Centers (EPCs). For the past four years, AHRQ has been a science partner with leading public and private research institutions nationwide in conducting scientific reviews and syntheses of scientific literature. Each EPC has a five year contract to review assigned specific topics in clinical care. Nominations for these topics are routinely solicited from professional organizations, delivery systems,

and others as well as accepted on an ongoing basis. Among the prime criteria for topic selection are whether these clinical care topics are common, expensive, and/or significant for medicare and medicaid populations (see www.ahrq.gov/clinic/epc.)

With regard to talent, in fiscal year 2000 AHRQ funds ($3.6 million) supported 218 scholars, a 25% increase over the number of pre- and postdoctoral trainees and fellows supported in FY 1999. In addition, fiscal year 2000 saw the launch of two career development programs, (the Independent Scientist Award (K02) and the Mentored Clinical Scientist Development (K08) programs), making it the first time the agency has invested in both intramural and extramural career development activities. These latter two programs supported an additional 16 scholars.   Along with the National Institutes of Health, AHRQ also expanded opportunities available under the National Research Service Award program to include sponsorship of individual pre-doctoral fellowships for underrepresented minority students.

Translating Research
The final pipeline segment brings together the investment to achieve measurable improvements in health care. It combines the knowledge from the first pipeline segment with the tools and talent developed in the second to close the gap between what we know and what we can do to improve health care quality.

During an initial round of Translating Research into Practice (TRIP) grants in fiscal year 1999, the Agency sponsored work on a wide range of topics. Through its Translating Research into Practice II (TRIP II) initiative, in fiscal year 2000 AHRQ funded a second round of grants ($5.7 million) that more than doubled the number of projects funded in the first round. TRIP II focuses on seven specific areas: the six found in the race and disparities initiative (infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV infection/AIDS, immunizations) and pediatric asthma. Each of these TRIP II grants requires partnerships among researchers, health care systems and organizations to evaluate strategies for improving the quality of care. The expectation of the Agency is that this strategy will result in more rapid uptake of research results by providing an incentive for health care organizations to evaluate alternative improvement strategies. To complement this initiative and further foster partnerships, in FY2000, AHRQ awarded planning grants ($2.0 million) to19 primary care practice-based research networks (PBRNs), groups of ambulatory practices devoted principally to the care of patients, affiliated with each other in order to investigate questions related to community-based practice. This funding supports the efforts of the PBRNs to design systems that will facilitate the translation of research into practice and to assess the impact of these systems on care delivered. In addition, AHRQ has partnered with nine Integrated Delivery System Networks (IDSRN) to link the nation's top researchers with the some of the country's largest health care systems. As a group, the networks provide health services to over 34 million Americans, including the privately insured, Medicare and Medicaid patients, and the uninsured. This new model of field-based research will enable AHRQ to accelerate the pace of its research on key concerns such as medical care quality and safety, access to services and costs.

Additionally, AHRQ oversees the Put Prevention Into Practice (PIPP) initiative, which serves as the implementation vehicle for USPSTF's age-specific and risk factor-specific recommendations on preventive care.

Evaluations
To understand and report on the impact of AHRQ programs on health care, additional emphasis is being placed on evaluation activities. As a result, AHRQ was able to report on process, output, and interim outcome goals for its major initiatives. The FY 2000 evaluation portfolio included a number of evaluations that assessed the impact of research products used to inform customers, measure quality,

and make policy decisions. For example:

Evaluations of existing programs which are helping to shape their future development:

▸   Evaluation of the National Guideline Clearinghouse

▸   Evaluation of Performance of the Medical Expenditure Panel Survey (MEPS)

▸   Evaluation of CONQUEST

▸   Development and Implementation of the Evidence-Based Practice Center (EPC) Program
Evaluations to assist in the design of new initiatives:

▸   Review of Existing Reporting Systems to Inform the Development of the National Quality Report

▸   Development of Priority Populations Report to Congress (Design Phase)

Evaluations in response to specific Congressional requests:

▸   Study of the Per-Patient Cost and Efficacy of Treatment for Temporomandibular Joint (TMJ) Disorders

▸   Vision Rehabilitation within Models of Care and Benefit Plans

Leadership on Health Care Quality
Shortly after the agency's renaming, it adopted a new slogan, "Quality Research for Quality Healthcare". This phrase underscores the agency's commitment to research on quality measurement as well as quality improvement.

In this area, over 80 AHRQ-funded investigators are now studying issues as far ranging as:

▸   Quality improvement in caring for newborns with jaundice.

▸   The comprehensiveness of prescription drug coverage as a measure of quality care among elderly beneficiaries with chronic health conditions.

▸   Identification of hospital-based quality improvement interventions that are most effective in increasing use of beta-blockers after acute myocardial infarction.

AHRQ has taken a lead role in the QuIC Task Force efforts to address medical errors and patient safety in the U.S.. Medical error and patient safety aren't well understood by most Americans. When the need for vital or risky health services occurs, patients want to believe that someone else has made sure the care they receive is safe. Sadly, every hour, 10 Americans die in a hospital due to avoidable errors; another 50 are disabled. As part of its efforts to improve patient safety and reduce medical errors, the QuIC Task Force has published *Five Steps to Safer Health Care*. The five steps were distilled from an earlier AHRQ publication, "20 Tips to Reduce Medical Errors."   Those evidence based recommendations provide patients with guidance on how to improve their safety and have been widely adopted across the government through the QuIC. As an example, the OPM has included them in this years health benefits brochure.

As lead agency of the QuIC, AHRQ coordinated publication of a landmark report, *Doing What*

Counts for Patient Safety–Federal Actions to Reduce Medical Errors and Their Impact, a response to the 1999 Institute of Medicine (IOM) report, *To Err is Human*.

As the Department's leader on healthcare quality, AHRQ has continued funding patient safety research. The agency awarded six grants ($2.1 million) covering topics as diverse as medical errors in primary care, use of decision support to reduce errors in emergency cardiac care, and development of a public-private patient safety consortium to study building a national evidence base for developing best practices for patient safety.

In collaboration with the National Center for Health Statistics and other agencies, AHRQ began the foundation work for the first annual report ever produced on U.S. healthcare quality, the National Quality Report (NQR). When completed, the NQR will show how the system is faring and where improvements may be needed.

Health Care Disparities
A similar agency effort is underway to produce a national disparity report. The National Disparities Report, targeted for release in 2003, will address prevailing disparities in health care delivery as it relates to racial and socioeconomic factors in the priority populations of rural, inner-city, low-income groups; minority groups; women; children; the elderly; and individuals with special health care needs. Life expectancy and overall health have improved for many Americans, but too many racial and ethnic minorities still suffer disproportionately from diabetes, cancer, and other diseases. We believe that through research partnerships, we can expand the magnitude of our efforts to ensure that all Americans receive high quality health care services. In FY 2000, AHRQ, in partnership with the Office of Research on Minority Health and the National Cancer Institute, funded ($4.8 million) a major new research initiative that will improve knowledge of the factors underlying ethnic and racial inequities in health care and help identify practical tools and strategies to eliminate such disparities, the EXCEED (Excellence Centers to Eliminate Ethnic/Racial Disparities) initiative. The studies also will help identify practical tools and strategies to eliminate these disparities. The themes of the projects include doctor-patient communication, racial health disparities in rural settings, under use of established and effective medical and surgical interventions, health issues of particular importance to elderly American Indians and Alaska Natives, health care access and quality for vulnerable African Americans, differences between white and minority elderly populations in health status, and factors that influence health care use and behavior.

MEPS
On the cost and utilization side, AHRQ conducts the Medical Expenditure Panel Survey (MEPS) that provides up-to-date, highly detailed information on how Americans as a whole, as well as different segments of the population, use and pay for health care. In fiscal year 2000, the impact of MEPS data and associated products on policymaking and research products was evaluated at a continuing high level, and the use of data and products from the MEPS databases increased dramatically. Users downloaded over 5,700 MEPS data files from the new MEPS Web-site, an additional 379 CD ROM's containing MEPS data were distributed through the AHRQ clearinghouse, and AHRQ responded to 670 user requests for technical assistance. The MEPS data was used to inform policy decisions in numerous public and private sector agencies around issues that included establishing a baseline measure for the Healthy People 2010 objective on oral health and preventive dental visits; comparing estimates of prices paid for drugs by elderly and non elderly persons with and without health insurance for prescribed medications; validating an actuarial model; helping to create a profile of the population living with chronic illness; estimating national health expenditure rates for the elderly; and informing estimates of out-of-pocket expenditures by individuals not covered by the government or their own insurance policy. Customer satisfaction was rated high (90%), and feedback from recipients of MEPS data indicated that the data were timely and useful.

The data currently collected from MEPS will support quality of health care research directed to the following broad areas: access to care, patient/customer satisfaction, health insurance coverage, health status, health services utilization and expenditures. By August 2000, design enhancement decisions to modify the MEPS to facilitate collecting data to inform the National Healthcare Quality report were completed. The planned MEPS healthcare quality enhancements call for a significant household survey sample expansion of individuals with certain illnesses of national interest in terms of patient satisfaction with care received, the quality of the care and the burden of disease. The intent of this planned enhancement was to permit more focused analyses of the quality of care received for these special populations. It was recommended that the following medical conditions be given special attention for implementing MEPS healthcare quality enhancements: Diabetes, Asthma, Hypertension, Stroke, Ischemic Heart Disease, Arthritis, and COPD . It should be noted that the selection of diabetes and ischemic heart disease as targeted conditions also cover two clinical areas that are the focus of the disparities agenda (i.e., diabetes, cardiovascular disease).

Conclusion

AHRQ's agenda has reflected, and continues to reflect, the most pressing issues in health care research. These issues have fueled the growth of outcome-centered research over the years. Building on the last 10 years of investment in outcomes and health care research, in fiscal year 2001 AHRQ will focus on national priority areas for which much remains unknown.

2.1 Budget line 1 -- Research on Health Care Costs, Quality, and Outcomes

Funding Levels:	FY 1999	$139,314,000 (Actual)
	FY 2000	$165,293,000 (Enacted)
	FY 2001	$226,446,000 (Appropriation)
	FY 2002	$255,145,000 (President's Budget)

This budget line represents the bulk of the Agency's research (extramural and intramural) portfolio. Dissemination and evaluation activities as well as the Agency's lead role in the Quality Interagency Coordination Task Force (QuIC) are also included. The first five of the annual performance plan's six goals are used to track Agency performance in these areas.

GPRA GOAL 1:   Establish Research Needs Based on User's Needs.   (HCQO)

Strategy   **Cycle of Research Phase 1:   Needs Assessment**

In the field of health services research, the user of the information plays a critical role. If health services research is to improve the quality of health care, it must provide answers to the questions and issues that represent the barriers to improvement. AHRQ emphasizes open communication with users

of its research to ensure that it is addressing important questions. Through continued emphasis on the first phase of the cycle of research, needs assessment, AHRQ will continue to assure that the Agency's research *begins and ends with the user*.

Types of Indicators: Output

Use of Results by   Input received on specific topic areas and health care issues are used
AHRQ: in the Agency's program and budget development activities. The
                             result is inclusion of many identified research areas that will assist
                             users.

Data Issues: To provide context for reviewing the advice received from users, and
                             to determine the initiation of research, AHRQ reviews major articles in
                             the research literature pertaining to a particular subject area. This
                             allows the Agency to assess where the user input fits into the current
                             body of research and how best to proceed.   Through a 1999 study
                             conducted by the Lewin Group, we learned that user input loses much
                             of its critical meaning when aggregated. The Agency has created a
                             data management system that will electronically store the source
                             document and have word search capability so that staff can identify
                             relevant documents and access them efficiently from their desk top
                             computers when performing program and budget development
                             activities. Additionally, to ensure that the input from users is
                             incorporated into Agency activities, a number of check points have
                             been integrated into the planning processes where user input is
                             explicitly identified and assessed in relation to the proposed activities.

GPRA Goal 1 – FY 2000 Results

Objective 1.1:   Define direction of FY 2000 project funding priorities, in large part, by needs
                     assessment activities.

1st Indicator: Agency research agenda covering three strategic research goals and the
                             new FY 2000 "Closing the Gap" initiatives are documented based on
                             consultations with various groups.

Results: AHRQ strategic research goals include supporting improvements in health
                     outcomes, strengthening quality measurement and improvement, and identifying
                     strategies to improve access, foster appropriate use, and reduce unncecessary
                     expenditures. Three of the Agency's FY 2000 initiatives that focused on "Closing the
                     Gap" between the knowledge resulting from funded research and the translation of
                     research findings into practices that improve the health care Americans receive are:

   Long-Term Care

In FY 2000, AHRQ held three meetings to obtain user input, developed the draft of a long-term care (LTC) research agenda and associated work plan for the Agency and the Department, prepared a report on the first expert meeting, and increased AHRQ-financed LTC research activities.

The draft plan is based on feedback collected at two expert meetings and one User Liaison Meeting sponsored by AHRQ in FY 2000. The overall goal of AHRQ is to foster research on the LTC population that answers priority research and policy questions. Major goals identified by the users were to: 1) evaluate the quality of the overall system of care (including transitions in care) for persons requiring LTC, in both the community and residential settings, 2) monitor the variation in LTC programs and assess implications for access, outcomes of care and quality of life outcomes and 3) monitor the financial implications of the high cost of LTC care for consumers and payers. To accomplish these goals, the Agency developed in FY 2000 a multi-year work plan that focused initially on the development of an integrated data system that in time would support the research agenda. This plan will be publicly available by January 2001.

Translating Research Into Practice II

An implicit premise underlying the establishment of AHRQ was that supporting studies using data from typical practice settings would be relevant to clinical practice and that the results would be translated into practice rapidly. In short, studies assessing the impact of clinical care on outcomes or end results would be expeditiously translated into improved outcomes. In 1998 AHRQ conducted an internal evaluation (*The Outcome of Outcomes Research at AHCPR)* to assess the impact of the first decade of its outcomes research program, and found that while some findings had resulted in improved patient outcomes, particularly for Medicare beneficiaries, many studies had not achieved the highest level of impact. At the same time, systematic reviews of the impact of research on clinical practice reported that knowledge of "what works" was necessary but not sufficient to effect change. Improved practice and outcomes also required incentives for change and a supportive practice environment.

In 1999 and 2000, Agency staff consulted with external stakeholders to obtain feedback on the critical question of how the Agency could support research that would accelerate the translation of research into practice. Consistent themes from these consultations included:

- ▸ Many stakeholders, including those attempting to improve outcomes and quality in their institutions, perceive that outcomes research must include an explicit focus on evaluating alternative strategies for translating research findings into practice.
- ▸ Increased demands for accountability from purchasers have stimulated enormous interest within health care delivery organizations to create change.
- ▸ Published articles do not include sufficient details to help those attempting to replicate successful results to do so easily. For example, chart review forms and precise measure specifications are frequently not included in peer-reviewed articles.
- ▸ There is far too little evidence about *how* research can be translated into improved quality and outcomes, and almost no information on the sustainability of improvements.

Based on this input, in FY 2000 AHRQ developed a research initiative (Translating

Research Into Practice II or TRIP II) with the dual goals of promoting sustainable improvements in the quality and outcomes of healthcare. Extending investments in FY 1999 that evaluated strategies for translating research into practice under ideal conditions, and addressing stackholders' concerns, the TRIP II initiative explicitly required partnerships between researchers and health care organizations to encourage collaboration at all phases of the research, with the expectation that this strategy would result in more rapid uptake of research results. Rather than providing direct support for improvement programs, AHRQ's support would provide an incentive for health care organizations to evaluate alternative improvement strategies. The initiative further specified that an important objective was to produce tools for improvement that could be made available for broad use through an electronic clearinghouse or toolbox, and that a program evaluation would focus explicitly on the sustainability of observed improvements in practice and outcomes.

Patient Safety Initiative

The Congress has instructed AHRQ to support the development of guidance on the collection of uniform data related to patient safety. AHRQ has initiated this work with an evaluation of existing state reporting systems which will be released in early February 2001. In addition, in FY 2000, AHRQ funded the following six new research projects designed to improve patient safety by identifying and preventing avoidable system errors:

Characterizing Medical Error: A Primary Care Study. Principal investigator: Steven H. Woolf, M.D., Virginia Commonwealth University, Richmond, VA.
This study seeks a new perspective on the definition of medical error by gathering the input of primary care patients and their providers. In-depth interviews will be conducted with approximately 45 primary care patients from Virginia and Ohio from various demographic groups. Their perspective will be contrasted with that of 10-20 primary care physicians, who will participate in a telephone interview that explores their experience with errors and seeks their reaction to the patient's comments. The study seeks to find out what constitutes a medical error and the experiences the victims of error consider most common and most serious.

TIPI Systems to Reduce Errors in Emergency Cardiac Care. Principal investigator: Harry P. Selker, M.D., New England Medical Center, Boston, MA.
This project addresses the problem of medical errors in emergency department triage and treatment of acute cardiac ischemia by introducing a time-insensitive predictive instrument to provide concurrent, real-time decision support using tested and statistically based information. The intervention will be introduced in a stepwise fashion, and a before-after time-series design will be used to measure its impact.

Improving Safety by computerizing Outpatient Prescribing. Principal investigator: David W. Bates, M.D., M.Sc., Brigham and Women's Hospital, Boston, MA.
This project will study the impact of electronic medical records and computerized medication prescribing on adverse drug events (ADE) in outpatient clinics associated with Partners HealthCare System and the Regenstrief Institute at Indiana University. The study has three primary goals. The first is to develop improved methods for ADE detection by the use of an automated ADE monitor. The second goal is to study the impact of electronic prescribing on preventable ADE rates in the outpatient setting by examining whether a basic electronic prescribing system can influence the prescribing process. Finally, the applicants plan to disseminate the knowledge gained in ADE monitoring and

prevention and potential cost savings to encourage other institutions.

Teamwork and Error in Neonatal Intensive Care. Principal investigator: Eric J. Thomas, University of Texas Medical School, Houston, TX.
This project will assess team-related, error-management behavior in the hospital neonatal intensive care unit (NICU). It will adapt the aviation model of teamwork and medical error management to NICU teams by conducting focus groups with NICU personnel and analyzing videotapes for a prospective cohort of preterm infants recorded during two critical periods: initial resuscitation and the first 90 minutes of admission to the NICU. The data derived from focus group sessions and videotape analysis, along with data from previous work, will aid in the design of an intervention to improve these behaviors and address elements of the organizational and professional culture that influence the frequency of error.

Brief Risky High Benefit Procedures: Best Practice Model. Principal investigator: Colin F. MacKenzie, R. Adams Cowley Shock Trauma Center, University of Maryland, Baltimore, MD.
This project will study and evaluate the procedure of chest tube thoracostomy insertion at the Maryland Shock Trauma Center using video and audio recordings to demonstrate how medical errors can be reduced through the use of a practice guideline. The goals are to create a best practice model for chest tube insertion; examine diagnostic procedures, indications, and techniques under elective versus emergency conditions; and develop a best practice training guideline to reduce complications from chest thoracostomy insertion and improve patient safety.

Developing Best practices for Patient Safety. Principal investigator: Mark B. McClellan, Stanford University, Stanford, CA. Total projected funding:
This project will develop a public-private patient safety consortium between leading national organizations and 14 northern California hospitals serving diverse populations. The goals of this consortium will be to conduct a collaborative study to build the national evidence base for measuring and predicting patient safety performance and to develop cost-effective strategies for improving safety practices in hospitals. The study will analyze data from event reporting systems using internal hospital surveys and a new database on medication safety procedures and a new instrument to be used is the patient safety culture survey.

Visit AHRQ's Web site at http://www.ahrq.gov/qual/errorsix.htm for more information on patient safety.

GPRA Goal 1 – FY 2001 and 2002 Indicators

Goal 1 Objectives	FY 2001 Indicator	FY 2002 Indicator

Objective 1.1: Define direction of FY project funding priorities, in large part, by needs assessment activities.	Agency research agenda in strategic goal areas for FY 2001 priorities (patient safety and informatics) is documented based on consultations with various groups. Baseline: First reports produced in FY 99. Budget: Commitment Base	Agency research agenda for the FY 02 priorities (investigator-initiated research, national quality report, national disparities report) is documented based on consultation with various groups.

GPRA GOAL 2:	Make significant contributions to the effective functioning of the U.S. health care system through the *creation* of new knowledge. (HCQO)

Strategy Cycle of Research Phase 2: Knowledge Creation

There are many gaps in knowledge in all areas of health care. New questions emerge as new technologies are developed, the population's demographics change, areas of inquiry previously under-emphasized take on greater importance, and research previously undertaken identifies further areas that need attention. Therefore, AHRQ will continue to focus on creating new knowledge through its peer reviewed extramural and intramural research and assessing the findings that result from completed projects.

Type of Indicators: Process and Output

Use of Results by AHRQ AHRQ uses three approaches to illustrate how it addresses its core activity of creating new knowledge. First, the Agency documents science advances that have resulted from its investment of funds, staff, and other resources. This enables the Agency to do the following:

♦ identify and highlight significant research findings from research funded or sponsored by AHRQ;
♦ focus its translation and dissemination activities to maximize the potential use of critical findings in the health care system;
♦ annually assess progress toward filling the gap between what we know and what we need to know about health care.

Second, AHRQ documents coverage in major journals and/or evidence of use of research findings. Coverage by popular and professional media is highly competitive. AHRQ's receiving coverage is an initial indication that its investment in research has the potential for significant impact when disseminated and implemented widely. The actual use of the finding by purchasers, professional associations, managed care organizations, and/or

insurers also signals that the new knowledge has the potential to make a difference. The ultimate outcome or impact will be evaluated after the finding has been implemented over a period of time.

Third, the statistics on number of grants funded and dollars invested in particular areas are used to determine whether the AHRQ portfolio has a significant body of work underway to begin to inform the field. They are also used in gauging the investment in these areas vs. other programs as AHRQ allocates its resources.

Data Issues: AHRQ knows it cannot collect 100% of the available data on the publication and use of its research findings. Collecting data and/or anecdotes on the use of research results or tools is largely done through searches of the literature, media outlets, and Internet listings and tracking by project officers in consultation with grantees. Underscoring the commitment of the Agency to document and understand the use of its research, staff from the AHRQ Office of Health Care Information, Division of User Liaison and Research Translation have as a particular focus the tracking of documented evidence of the use. The information is captured through regular communications with partners, researchers, associations, and Federal, State, and local governments. Anecdotal information is used only when it can be verified with the actual user. Documentation of the use is sought whenever possible. AHRQ continues to look for ways to introduce efficiencies in this labor-intensive effort.

GPRA Goal 2 – FY 2000 Results

Objective 2.1: **Determine annually the salient findings from research in each of the three areas (outcomes; quality; and cost, access, and use) and develop plan for next steps translation and dissemination.**

1st Indicator: Annual report on science advances in three research goal areas.

At least four major findings in each area that have potential to save significant amounts of money, improve quality, save lives or prevent physical suffering, or change the organization and delivery of health care.

Results: AHRQ investments in effective strategies for translation and dissemination have been successful, and are evidenced by the following examples:

Heart Disease-
"Emergency Room Assessment of Sestamibi for Evaluation of Chest Pain:

The ERASE Chest Pain Trial" - Selker.

The ERASE Chest Pain clinical trial has shown that patients who receive the sestamibi scan as part of their ED care were significantly more likely to be discharged safely and directly home from the ED. This represents a 20% reduction in unnecessary admission rates for patients without true acute cardiac ischemia, possibly avoiding approximately 240,000 unnecessary hospitalizations per year.

Translation and Dissemination - activities have included announcement at the annual American Heart Association meeting, a publication in preparation, an AHRQ press release, and presentation at the National Heart Attack Alert Program meeting.

Depression-

Depression PORT intervention tool: "Improving Depression Outcomes in Primary Care: A User's Guide to Implementing the *Partners in Care* Approach"

The quality-improvement toolkit is a collection of components that provide information and specific materials needed to understand and implement the *Partners in Care* approach to improving care for depression. The components are comprised of introductory materials, training manuals, materials for primary care physicians and nurses, quick reference cards, a range of therapy manuals, materials for patients, and videotapes. All of these materials can be used by various provider and service plans to improve depressed patient outcomes. Impact analysis after one year disseminating a QI program for depression in primary care practices found that the QI interventions improved use of medications and psychotherapy, reduced symptoms, increased employment retention of depressed MCO patients, and that medical visits did not increase overall.

Translation and Dissemination - AHRQ is marketing via Web site notices and letters to professional organization members the "tool" kit for purchase directly from RAND as a total package or in pieces.   In addition, the findings from a study using the tool was published in a peer-review journal: Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial [published erratum appears in *JAMA* 2000 Jun 28;283(24):3204] *JAMA* 2000 Jan 12;283(2):212-20.

Low Birthweight Babies-

Robert L. Goldenberg, M.D., University of Alabama, "Low Birthweight in Minority and High-Risk Women"

One of the results of the Low Birthweight PORT was the identification of effective strategies for the management of Group B strep neonatal infections. This past year, an article was published documenting a decrease in group B strep neonatal infections in a population-based surveillance in 8 states following dissemination of CDC recommendations. If projected nationally, 3900 infections and 200 deaths would be prevented.

Translation and Dissemination - publication in *The New England Journal of Medicine.*

Stroke-

David B. Matchar, M.D., Duke University, "Secondary and Tertiary Prevention

of Stroke Patient Outcomes Research Team"

The Stroke PORT released its phase I final report in June 2000. The investigators of the research team found that anticoagulation with warfarin though an effective therapy in preventing stroke related to atrial fibrillation is underprescribed by the clinical community. One particularly significant contribution of the Stroke PORT final report is the inclusion of programming codes, input data and algorithms used in a stroke policy model that can be utilized in clinical policy decision-making to estimate the impacts of different stroke prevention/treatment and quality improvement efforts.

Translation and Dissemination -The release and publication of the complete documentation specifications for the stroke policy model represent the first ever effort in facilitating and encouraging the use of the model in other studies of stroke interventions by the greater research and clinical policy making communities. To further disseminate this policy tool, we are currently exploring steps needed to develop a more user-friendly interface for the stroke policy model to be accessible via the Internet.

Schizophrenia-

Anthony F. Lehman, M.D., University of Maryland, "Schizophrenia Patient Outcomes Research Team"

Translation and Dissemination - Through a study of the State Mental Health Agencies (SMHAs), it was determined that at least seven states have adopted the Treatment Recommendations developed through the PORT as official state policy for the treatment of persons with schizophrenia.

2nd Indicator: At least four major findings in each area that have potential to save significant amounts of money, improve quality, save lives or prevent physical suffering, or change the organization and delivery of health care.

Results: The following are published examples of AHRQ-sponsored studies that have the potential to impact the outcomes, quality and cost, access and use of healthcare:

Quality of Care

"New Imaging Test Helps ER Doctors Separate Out Faster Patients in Danger of Heart Attack," Harry Selker and others. Presented at the 72nd annual meeting of the American Heart Association, November 10, 1999.

"The Impact of Disseminating Quality Improvement Programs for Depression in Managed Care: A Randomized Controlled Trial," Kenneth Wells and others, *Journal of the American Medical* Association, January 11, 2000.

"Lack of Progress as a Reason for Cesarean," Deidre Spelliscy and others, *Obstetrics and Gynecology*, April 1, 2000.

"Many Heart Attack Patients Present Without Chest Pain," John Canto and others, *Journal of the American Medical Association*, June 28, 2000.

Outcomes of Care

"Out-of-Hospital Pediatric Endotracheal Intubation -- The Effect on Survival

and Neurological Outcome: A Controlled Clinical Trial," Marianne Gausche and others, *Journal of the American Medical Association*, February 8, 2000.

"Comparison of Treatment Recommendations by Urologists and Radiation Oncologists for Men with Clinically Localized Prostate Cancer," Michael Barry and others, *Journal of the American Medical Association*, June 28, 2000.

"A Randomized Controlled Clinical Trial of Methods to Encourage the Use of Antenatal Corticosteroid Therapy for Fetal Maturation," Laura Leviton and Robert Goldenberg, *Journal of the American Medical Association*, January 5, 1999.

"Teaching Versus Non-Teaching Hospitals: Mortality and Quality of Care for Medicare Patients with Acute Myocardial Infarction," Jeroan Allison and others, *Journal of the American Medical Association*, September 12, 2000.

Access, Use And Costs of Care

"Organization and Financial Characteristics of Health Plans: Are They Related to Primary Care Performance?"Dana Gelb Safran and others, *Archives of Internal Medicine*, January 9, 2000.

"The Value of Medical Testing Before Cataract Surgery," Oliver Schein and others, *New England Journal of Medicine*, January 20, 2000.

"Relation of Race and Sex to the Use of Reperfusion Therapy in Medicare Beneficiaries with Acute Myocardial Infarction," John Canto and others, *New England Journal of Medicine*, April 13, 2000.

"Expenditures for Physician Services Under Alternative Models of Managed Care," Jose Escarce and others, *Medical Care Research and Review*, June 1, 2000.

3rd Indicator: For each finding, specific steps in translation and dissemination are identified and initiated.

Results: AHRQ employs a range of strategies to disseminate extramural and intramural study findings through publications in the peer reviewed journals, as well as AHRQ generated and disseminated reports, statistics, software products, and patient and consumer education materials. Depending on subject and target audiences, the following are specific strategies AHRQ uses to publicize and disseminate new information:

- *Research Activities*, a monthly periodical, summarizes AHRQ studies and announces all of the Agency's public information. It has about 50,000 subscribers from the research, policy, practitioner and other communities. *Research Activities* is also available on-line through AHRQ's Web site.

- *AHRQ Electronic Newsletter*, an on-line newsletter, publishes short notices about on-going Agency-sponsored studies. The subscription list for this new information vehicle is 5,000 and growing.

- **Media Outreach** is a core Agency strategy for marketing AHRQ-related information through press releases to mass media, including the trade press, and other specialized press, such as minority, business and consumer media. These releases can range from HHS- or AHRQ-letterhead press releases on issues of broad interest, to shorter "Research Bulletins" and other types of news announcements for more limited markets. In addition, AHRQ organizes and publicizes press conferences and briefings; establishes individual contact with reporters to alert them to the initiation, progress and findings of important studies; work with other Federal agencies and private-sector interest groups to produce video and audio news releases. Another approach by AHRQ is to send brief news announcements to editors of publications that target members of professional societies and trade associations.

- **Web Media** is the AHRQ's most rapidly expanding strategy for disseminating information to professional and consumer audiences. The Agency encourages use of online news services such as Web MD and ReutersHealth. For health information that is timely and immediately newsworthy, the Agency has arranged on-line Web chats by Agency staff, grantees and other Agency related experts. In addition, AHRQ has contacted the Web site editors of other Federal agencies, State agencies, professional societies, and other entities, such as health advocacy groups, to request they announce AHRQ health information on their sites and/or link to the Agency's site. In addition to these and other proactive tactics, AHRQ includes press releases and other public information on the AHRQ Web site and periodically highlights particular information in the "Spotlight" section of the Agency's home page.

- **Targeted Mailings** occur regularly. AHRQ routinely mails new AHRQ-sponsored publications and reports, press releases, and other new information to selected key audiences.

- **Exhibits** at over 20 meetings of professional societies and trade associations annually provide AHRQ the opportunity for personal interation with end-users of the Agency's tools and products such as HCUPnet and CONQUEST software.

- **AHRQ InstantFAX** is a fax-on-demand system used by AHRQ to provide the public with quick access to documents such as research requests, evidence report summaries and press releases.

- **Special Outreach to Capital Hill** is accomplished through our legislative liaisons who distribute selected and requested information to key Hill members.

Objective 2:2:   **Achieve significant findings from AHRQ sponsored and conducted research.**

1st Indicator: Findings from at least 25 AHRQ sponsored or funded research are

published in major peer reviewed professional publications (*New England Journal of Medicine, Journal of American Medical Association*, etc.); receive national press coverage; are used in Federal or State policymaking; are used by professional associations or health plans as the basis of strategies to achieve quality; or are used to establish coverage decisions by health care purchasers, managed care organizations, or insurers, including Medicare or Medicaid.

Baseline: 50 citations in peer reviewed publications, 7 examples of major media, 7 examples of usage.

Results: There are 250 publications in the outstanding peer-reviewed publications of AHRQ-sponsored and funded research. This represents a 400% increase over baseline. There are 32 examples of featured coverage in major media, and 6 examples of usage of AHRQ findings.

AHRQ sponsored a report completed by the National Academy of State Health Policy published in December 2000 that evaluated state-based patient safety reporting systems. This report is currently being used by Capitol Hill staff in developing a patient safety reporting bill.   A companion document written specifically for state health policymakers, was published in April 2001.

Below are highlights of published findings, media coverage and additional examples of usage of AHRQ-sponsored research:

AHRQ-Sponsored Research:

AHRQ-Sponsored Research	Description
American Association of Retired Persons (AARP) Chartbook *and* MEPS-IC	The American Association of Retired Persons (AARP) used Medical Expenditure Panel Survey (MEPS) data for its publication, *Reforming the Health Care System: State Profiles 1999.* Specifically, AARP used MEPS data from 40 states on family health insurance coverage (total premium cost, and employee contribution). This information was in the AARP Chartbook section, *Expenditures and Financing.* The AARP Chartbook received substantial press coverage.
PPIP Child Health Guides	Omni Women's Health in Fresno, California, distributes these guides to patients who are about to become mothers

USPSTF	In April 2000, the *American Family Physician* began publishing a monthly series of case studies based on the 1996 recommendations of the U.S. Preventive Services Task Force (USPSTF). The purpose of the studies is to help family physicians become more knowledgeable about ways to incorporate evidence-based preventive care into every encounter with their patients. These case-based, clinical prevention scenarios provide the supporting evidence and practical information needed to implement preventive services in the office. The case studies will address new recommendations from the third USPSTF, which is currently reviewing the 1996 recommendations, as they are released.
Brauer C, Morrison RS, Silverzweig SB, et al. The cause of delirium in patients with hip fracture.	Published: *Arch Intern Med* 2000 June 26; 160(12):1856-1860. [Grant No. U18 HS09459-0]
Morrison RS, Siu AL. Survival in end-state dementia following acute illness.	Published: *JAMA* 2000 July 5:284(1):47-52. [Grant No. U18 HS09459-0]
Rogowski J, Karoly L Health insurance and retirement behavior: evidence from the health and retirement survey.	Published: *J Health Econ* 2000 July; 19(4):529-539. [Grant No. 1-R01-HS-07048]
Moran WP, Cohen SJ, Preisser JS, et al. Factors influencing use of the prostate-specific antigen screening test in primary care.	Published: *Am J Manag Care* 2000 Mar; 6(3):315-324. [Grant No. HS06992]
Williams JW Jr., Mulrow CD, Chiquette E, et al. A systematic review of newer pharmacotherapies for depression in adults: evidence report summary.	Published: *Ann Intern Med*; 2000 May 2; 132(9):743-756]
Prosser LA, Stinnett AA, Goldman PA, et al. Cost-effectiveness of cholesterol-lowering therapies according to selected patient characteristics.	Published: *Ann Intern Med* 2000 May 16; 132(10):769-779. [Grant No. R01 HS06258]
Legnini MW, Rosenberg LE, Perry MJ, et al. Where does performance measurement go from here?	Press Release Date: May 8, 2000 Published: *Health Aff (Millwood)* 2000 May-June; 19(3):173-177. [Small Business Innovative Research Contract No. 290-98-0024]

Weinick RM, Cohen JW. Leveling the playing field: managed care enrollment and hospital use, 1987-1996.	1) Press Release Date: May 8, 2000 2) Published: *Health Aff (Millwood)* 2000 May/June, 19(3):178-184. [Authors are AHRQ researchers]
Schoonmaker MM, Bernhardt BA, Holtzman NA. Factors influencing health insurers' decisions to cover new genetic technologies.	Published: *Int J Tech Ass Health Care* 2000 Winter; 16(1):178-189. [Grant No. R02 HS508461]
Lydon-Rochelle M, Holt VL, Martin DP, et al. Association between method of delivery and maternal rehospitalization.	Published: *JAMA* 2000 May 10; 283(18):2411-2416. [Grant No. 5 T32 HS00034]
Fiscella K, Franks P, Gold MR, et al. Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care.	Published: *JAMA* 2000 May 17; 283(19):2579-2584. [Grant No. R01 09963-0l; fourth author is AHRQ's Carolyn M. Clancy]
Probst JC, Samuels ME, Hussey JR, et al. Economic impact of hospital closure on small rural counties, 1984-1988: demonstration of a comparative analysis approach.	Published: *J Rural Health*, 1999 Fall; 15(4):375-390. [Grant No. R01 HS07252]
Morales LS, Reise SP, Hays RD. Evaluating the equivalence of health care ratings by whites and Hispanics.	Published: *Med Care*, 2000 May; 38(5):517-527. [Grant No. U18 HS09204]
Canto JG, Every NR, Magid DJ, et al. Relation between the volume of primary angioplasty procedures and survival after acute myocardial infarction.	Published: *N Engl J Med* 2000 May 25; 342(21):1573-1580. [Grant No. HS08843]
Morse SV, Haywood JL, Goldenberg RL, et al. Estimation of neonatal outcome and perinatal therapy use.	1) Press Release: May 24, 2000 2) Published: *Pediatrics* 2000 May; 105(5):1046-1050. [PORT on Low Birthweight, Contract No. 290-92-0055]
Barry, et al., "Comparison of Treatment Recommendations by Urologists and Radiation Oncologists for Men with Clinically Localized Prostate Cancer"	1) Press Release Date: June 27, 2000 2) Published: June 28, 2000 issue of the *Journal of the American Medical Association.*
Escarce, et al., "Expenditures for Physician Services under Alternative Models of Managed Care"	1) Press Release: June 1, 2000 2) Published: June 2000 issue of *Medical Care Research and Review.*

Gifford, et al., "Lack of Progress in Labor as a Reason for Cesarean"	1) Press Release: March 31, 2000 2) Published: April 2000 issue of Obstetrics and Gynecology,
Allison, et al., "Teaching versus Non-Teaching Hospitals: Mortality and Quality of Care for Medicare Patients with Acute Myocardial Infarction"	1) JAMA has produced a video news release on this study. The VNR will be on Galaxy Transponder14, C-band on Tuesday, September 12, from 9 to 9:30 a.m., and on Telstar 6,Transponder 4, C-band from 2 to 2:30 p.m. EDT. 2) Press Release: September 12, 2000 3) Published: September 13, 2000, issue of JAMA
Khandker, et al., "A Decision Model and Cost-Effectiveness Analysis of Colorectal Cancer Screening and Surveillance Guidelines for Average-Risk Adults"	1) Press Release: September 8, 2000 2) Published: Summer 2000 issue of the quarterly International Journal of Technology Assessment in Heath Care
Basu and Cooper, Out-of-Area Travel from Rural and Urban Counties: A Study of Ambulatory Care-Sensitive Hospitalizations for New York State Residents"	1) Press Release: August 3, 2000 2) Published: Spring 2000 issue of the *Journal of Rural Health* (Volume 16, issue no. 2).

AHRQ-sponsored research findings have been featured in coverage by an extensive number of major media representatives. The following highlight a sample of the media coverage of the Agency's research succcesses:

National summit on medical errors and patient safety research. 9/11/00.
- CNN
- Fox News
- WebMD

Teaching versus non-teaching hospitals: Mortality and quality of care for Medicare patients with acute myocardial infarction. (Allison/Kiefe) 9/12/00.
- Today in New York (WNBC-TV CH4), New York City
- News at 10 (KTLA-TV CH 5), Los Angeles
- Prime Time Report (News Channel 8 Cable), Washington, DC

Medication errors in nursing homes. 8/1/00.
- Washington Post
- Boston Globe
- Older Americans Report

Patterns of breast cancer treatment in older women: Patient preference and clinical and physician influences. (Madelblatt). 7/31/00.
- New York Times News Wire
- Atlanta Constitution
- WebMD

PHS smoking cessation guideline. 6/27/00.
- ABC's World News Tonight
- USA Today
- Washington Post Health Section

Prevalence, clinical characteristics, and mortality among patients with acute myocardial infarction presenting without chest pain. (Canto) 6/27/00.
- NBC Network news
- Prime Time Report, News Channel 8 Cable, Washington
- News Morning Drive Time, WCBS-AM 880 Radio, New York

Comparison of treatment recommendations by urologists and radiation oncologists for men with clinically localized prostate cancer. (Barry). 6/27/00.
- 11 News This Morning. KHOU-TV, CBS, Houston
- 7 News at 4:00, WHDH-TV, CH 7, NBC, Boston
- Washington Post

Expenditures for physician services under alternative models of managed care. (Escarce). 6/1/00.
- Health Plan and Provider Report
- Managed Care Week
- Medical Economics

Relationship of race and sex to the use of reperfusion therapy in Medicare beneficiaries with acute myocardial infarction. (Canto/Kiefe), 4/12/00.
- USA Today
- Washington Post
- Atlanta Constitution

Lack of progress in labor as a reason for Cesarean. (Keeler). 3/31/00.
- Washington Post Health Section
- JAMA
- Obstetrics and Gynecology

The value of medical testing before cataract surgery. (Schein). 1/20/00.
- WNBC-TV, New York
- KPRC-TV, Houston
- WMAQ-AM Radio, Chicago

The impact of disseminating quality improvement programs for depression in managed care: A randomized controlled trial. (Wells). 1/11/00.
- CNN
- WABC-TV, New York
- Dr. Dean Edell's syndicated radio program.

Organization and financial characteristics of health plans: Are they related to primary care performance? (Safran). 1/9/00.
- New England Cable
- Boston Herald
- Internal Medicine News

Hospitalizations in the United States, 1997. (Elixhauser). 6/21/00.
- Wichita Eagle

- AHA News (print and online)
- Managed Care Week

Leveling the playing field: Managed care enrollment and hospital use: 1987-1996. (Weinick). 5/8/00
- Hospitals and Health Networks
- Managed Care Outlook
- American Family Physician

Role and dollars and value. (Clancy et al.). 3/6/00.
- Drug Topics
- Managed Healthcare News
- Managed Care: A Guide for Physicians

Annual report on the patterns of health care utilization by children and adolescents. (Simpson and Elixhauser). 1/10/00.
- New York Times
- Hospitals and Health Networks
- American Health Line

AHRQ's 20 tips on medical errors. 4/4/00.
- Fox 5 News @ 10, WTTG-TV CH 5, Washington, D.C.
- UPN Nine News, WWOR-TV, New York
- Washington Post Health Section

PPIP guide, *Staying Healthy at 50+*. 1/27/00.
- Washington Post Health Section
- New York Times
- Kansas City Star

Antibiotic treatment of children with acute otitis media EPC report. 8/9/00.
- WUSA-TV, Washington
- New York Times
- ReutersHealth.com

Drug treatment and alternative therapies for stable angina EPC report. 2/1/00.
- Internal Medicine News
- American Family Physician
- American Journal of Health-System Pharmacy

Updated HCUPnet. 3/6/00.
- American Medical News
- Investors' Business Daily
- Insurance Advocate

NGC triples number of guidelines. 3/1/00.
- Modern Healthcare
- American Medical News
- American Family Physician

AHRQ maintains an Impact Case Studies Notebook that details the use and impact Agency research has for purchasers and users. The case studies

notebook contain 55 impact studies; below are excerpts from the Inpact Case Studies Notebook:

Topic: *Lucian Leape Study on Medical Errors*

<u>Massachusetts General</u>
<u>AMA's National Patient Safety Foundation</u>
<u>Joint Commission on Accreditation of Healthcare Organizations</u>

AHRQ-supported research found that many adverse drug events are preventable if appropriate systems, such as computerized monitoring programs, are in place in hospitals to assure accuracy. As a result of this research:

Hospitals, ranging from the 700-bed Massachusetts General Hospital in Boston, where the study was conducted, to 60-bed rural community hospitals, are redesigning their information systems to prevent errors from occurring.

AHRQ supported "Enhancing Patient Safety and Reducing Errors in Health Care," a national level conference which served as the springboard for the National Patient Safety Foundation (NPSF). The NPSF was launched in 1997 by the American Medical Association and a broad consortium of partners to investigate and reduce medical errors and promote drug safety.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) revised its policy on reporting medical errors largely as a result of AHRQ's research. Now, instead of placing an accredited hospital that reports a serious mistake on accreditation watch, thereby alerting the public to a possible downgrade of its standing, the hospital is now given time to investigate the root causes of the mistake and take corrective action.

Topic: *HCUPnet*

Vincent Mor, Ph.D.
Professor & Director
Center for Gerontology & Health Care Research
Chair, Department of Community Health
Brown University School of Medicine

"I use the HCUP data in a course I teach on working with, and analyzing large scale data bases. I use these data sets because I want to teach the students about nesting, creating aggregated variables and ultimately rudimentary ideas about hierarchical models. For this reason, I need the "raw" data. However, I was very impressed with this system [HCUPnet] because it is great at getting students to consider the viability of their questions before struggling with formatting the data. I will definitely require students to use this form of asking questions about the data in the class from now on. In a very few minutes, I was able to generate data on the rate of hospital death by age and sex among all cancer admissions and whether those rates varied as a function of ownership and payer source. This is a great tool to permit interactive learning right in the class."

Topic: NGC

Jeff Stockard, D.Ph.
Associate Pharmacy Director

TennCare

"I have been using the [AHRQ] site since last March, but only recently have I discovered the awesome power in the guideline.gov site. Within the TennCare program, we are quickly closing our behavioral formulary with stricter Pas and the guidelines have been immensely helpful. Thanks for a great site."

Objective 2.3:   **Implement FY 2000 priority (1) "New Research on Priority Health Issues"**

This objective represents the Agency's commitment to a certain level of effort that is necessary for the research initiative to succeed. The basic premise is that without a significant investment in research initiatives, there won't be enough new knowledge produced to improve the health care system.

1st Indicator: Funding of a minimum of 10 projects that address gaps in knowledge about the priority problems faced by Medicare and Medicaid.

Results: A total of 43 projects were funded by AHRQ to address the gaps in knowledge about Medicare and Medicaid issues. While a complete list is available through the Agency, the following is a sample of the funded projects:

Medicare

Brown, Arleen P. University of California, Los Angeles
Unmet Need in Medicare Beneficiaries with Diabetes

Safran, Dana G. New England Medical Center Hospitals, Inc.
Primary Care Performance & Outcomes in Medicare

Birkmeyer, John D. Dartmouth College
Benefits of Regionalizing Surgery for Medicare

Mueller, Keith J. University of Nebraska Medical Center
Rural Response to Medicare+Choice: Change and its Impact

Melnick, Glenn A. Rand Corporation
Medicare Managed Care: Selection/Competition/Quality

Lynn, Dorcas J. Rand Corporation
A Detailed Profile of the End-of-Life Care in Medicare

Ellis, Randall P. Boston University
Health Plan Responses to Medicare HMO Premium Payments

Anderson, Wayne L. University of North Carolina
Effects of State Home Medicare Maximization Plans

Brown, Jason D. Stanford University
Risk Section and Medicare HMOs

Uhrig, Jennifer D. Pennsylvania State University

Beneficiary Use of Quality Reports for Medicare Plans

Silverman, Elaine M. Dartmouth College
For-Profit Hospital Ownership and Medicare Spending

Harris-Kojetin, Lauren D. Research Triangle Institute
Helping Elders Include Quality in Health Plan Choice

Watson, Nancy M. University of Rochester, Rochester NY
AHCPR UI Guidelines: Application in Nursing Homes

Medicaid

Waitkin, Howard B. University of New Mexico

Multi-Method Assessment of Medicaid Managed care

Jordan, Neil. University of Minnesota

Effect of Medicaid Drug Copayments on Outcomes and Costs

Mitchell, Janet B. Center for Health Economics Res

Medicaid vs. Premium Subsidy: Oregon's CHIP Alternatives

Shenkman, Elizabeth A. University of Florida, Gainesville Fl*Quality of*

Care For Children With Special Needs in Managed Care

Swigonski, Nancy L. Indiana University, Indianapolis, IN
*Health Care Access Quality and Insurance for Children with Special
Needs (CSHCN)*

Vargas, Perla
Arkansas Children's Hospital, Little Rock AR
Developing an Asthma Management Model For Head Start Children

Richardson, Douglas. Beth Israel Deaconess Medical Center, Inc.

Unstudied Infants: Low Risk Babies in a High Risk Place

Cooper, William P. Vanderbilt University

TennCare Gaps for Children: Asthma Clinical Outcomes

Carino, Tanisha V. Johns Hopkins University

The Role of a Regular Source of Care for At-Risk Youth

2nd Indicator: Funding of a minimum of 10 projects to address eliminating disparities in health care with particular emphasis on disparities that exist for racial and ethnic minorities.

Results: In FY 2000, AHRQ funded over 30 projects on health disparities. The AHRQ director, John M. Eisenberg, M.D, says "Life expectancy and overall health have improved for many Americans, but too many racial and ethnic minorities still suffer disproportionately from diabetes, cancer, and other diseases". "Through research partnerships, we can expand the magnitude of our efforts to ensure that all Americans receive high quality health care services." In FY 2000, AHRQ, in partnership with the Office of Research on Minority Health and the National Cancer Institute, funded a major new research initiative that will improve knowledge of the factors underlying ethnic and racial inequities

in health care, the EXCEED (Excellence Centers to Eliminate Ethnic/Racial Disparities) initiative. The studies also will help identify practical tools and strategies to eliminate these disparities. Each project, outlined below, consists of a group of four to seven studies organized around a central theme:

- **Racial and Ethnic Variation in Medical Interactions.** Principal investigator: Carol M. Ashton, M.D., M.P.H. Baylor College of Medicine, Houston, TX.

  The researchers will assess the extent to which problems in doctor-patient communication contribute to racial and ethnic disparities in health care use. Six projects and three cores will be used to achieve four major objectives: improving our understanding of the etiologies of disparities, identifying interventions that can reduce disparities, disseminating information to patients, communities and health care providers, and building capacity for future minority health services research.

- **Overcoming Racial Health Disparities.** Principal investigator: Timothy S. Carey, M.D., M.P.H. University of North Carolina, Chapel Hill, NC.

  These researchers will establish a center of excellence on overcoming racial health disparities in African American adults, particularly in rural settings. They will collaborate with two historically black colleges and universities during the project.

- **Improving the Delivery of Effective Care to Minorities.** Principal investigator: Mark R. Chassin, M.D., M.P.P., M.P.H. Mount Sinai School of Medicine, New York, NY.

  The goal of this research project is to measure the underuse in Harlem of selected medical and surgical interventions that are known to be effective. The researchers will assess the reasons for the underuse and develop, implement, and evaluate ways to eliminate the underuse when appropriate.

- **Understanding and Reducing Native Elder Health Disparities.** Principal investigator: Spero M. Manson, Ph.D. University of Colorado Health Sciences Center, Denver, CO.

  Four health issues of particular importance to elderly American Indians and Alaska Natives will be addressed. They are: the quality of care for diabetes, the delivery of clinical preventive services (such as immunizations for influenza and pneumonia), cancer screening, and smoking cessation.

- **Access and Quality of Care for Vulnerable Black Populations.** Principal investigator: Robert M. Mayberry, M.S., M.P.H., Ph.D. Morehouse School of Medicine, Atlanta, GA.

  The researchers will explore ways to improve health care access and quality for vulnerable African Americans, particularly adults who are chronically ill and low-income children. Their goal is to identify opportunities to intervene and effective interventions to address disparities in access and quality.

- **Health Disparities in Minority Adult Americans.** Principal investigator: Edmund M. Ricci, Ph.D. University of Pittsburgh, Pittsburgh, PA.

  The goal of this project is to address differences between white and minority elderly populations in health status and the use of health services. It combines community linkages with academic resources to focus on health care for African Americans through effective communication and culturally sensitive health care.

- **UCLA/DREW/RAND Program to Address Disparities in Health.** Principal investigator: Martin F. Shapiro, M.D., Ph.D. University of California, Los Angeles, CA.

  In this collaborative project, researchers from the University of California, Los Angeles, Drew University, and RAND, will establish a multidisciplinary program to address racial and ethnic disparities in health. Their goal is to enhance understanding of the factors that influence health care use and behavior. They will use an integrated model to identify the principal factors responsible for disparities and test randomized interventions to address those factors. A major goal is to increase the capacity for health services research on health disparities.

- **Understanding and Eliminating Health Disparities in Blacks.** Principal investigator: Barbara Tilley, M.S., Ph.D. Medical University of South Carolina, Charleston, SC.

  The goal of this project is to identify solutions to known disparities in health status between African Americans and whites living in South Carolina, including those in rural areas. The researchers will focus on interventions related to providers and provider/patient interactions.

- **Promoting Effective Communication and Decision Making For Diverse Populations.** Principal investigator: Eugene A. Washington, M.D., M.Sc. University of California, San Francisco, CA.

  The researchers will assess ways to promote effective communication and decisionmaking in diverse populations. They hypothesize that racial and ethnic disparities in health may be related to less effective communication and decisionmaking skills in minorities compared with whites, which may lead to differences in the technical process of care that affect outcomes.

In addition to the EXCEED grants, AHRQ has funded studies that target specific areas of health disparities. Examples of these funded projects are:

-A Regional, Community-Health Center PBRN

    George S. Rust

-Interaction Technology for PBRNs and Communities

    John H. Wasson

-Time to Neonatal and Postneonatal Death U.S. 1985-1995

    Amanda J. Liddle

-Racism, Racial Identity and Blood Pressure

Lucie L Ferguson

-Developing an APRN Research Network

Margaret Grey

-Patient-Defined Culturally Sensitive Health Care-Part II

Carolyn M Tucker

-Racial And Ethnic Variation In Medical Interactions

Carolyn M Ashton

-Diabetes Education Multimedia for Vulnerable Populations

Ben S. Gerber

-Effect Of Navajo Interpreters On Diabetes Outcomes

Melvina McCabe

-An Inner-City Primary Care Research Network

David Lanier

-A Community Health Center/IHs/Tribal Pbrn

Robert L. Williams

GPRA Goal 2 – FY 2001 and 2002 Indicators

Objective	FY 2001 Indicator	FY 2002 Indicator

| Objective 2.1: Determine annually the salient findings from research in each of the three areas (outcomes; quality; and cost, access, and use) and develop plan for next steps translation and dissemination. | -- Produce an annual report on at least 12 science advances covering the three research goal areas (outcomes; quality; cost, access and use).

* For each finding, specific steps in translation and dissemination are identified and initiated.

-- Generate 2 - 3 synthesis reports on research findings and practical applications on Agency priority topics.

– Baseline: The first report will be published in FY 2000.

Budget: Commitment Base | -- Produce an annual report on at least 18 science advances in three research goal areas (outcomes; quality; cost, access, and use).

* For each finding, specific steps in translation and dissemination are identified and initiated.

-- Generate 2-3 synthesis reports on research findings and practical applications of Agency priority topics, particularly for projects funded in FY 99 or before. |

Objective	FY 2001 Indicator	FY 2002 Indicator
Goal 2 continued: **Objective 2:2: Achieve significant findings from AHRQ sponsored and conducted research.**	Findings from at least 40 AHRQ sponsored or funded research are published in major peer reviewed professional publications (*New England Journal of Medicine, Journal of American Medical Association*, etc.); receive national press coverage; are used in Federal or State policymaking; are used by professional associations or health plans as the basis of strategies to achieve quality; or are used to establish coverage decisions by health care purchasers, managed care organizations, or insurers, including Medicare or Medicaid.	Findings from AHRQ sponsored or conducted research are used by public and private partners to improve health care.

Objective	FY 2001 Indicator	FY 2002 Indicator
Objective 2.3: **Initiate the FY Research Initiatives**	Funding of a minimum of 60 projects in the following areas: ♦ 40 projects in reducing medical errors and enhancing patient safety Budget page: 56 ♦ 10 projects in informatics applications in health care Budget page: 63 ♦ 10 projects in quality improvement through improvements in health care corking conditions	Funding of a minimum of 100 projects in the following areas: – 60 projects in patient safety Budget page: – 20 projects in informatics Budget page: – 20 projects in measures development --10 projects in quality improvement through improvements in health care corking conditions Budget page: 30% of these projects address priority populations.

GPRA GOAL 3:	**Foster translation and dissemination of new knowledge into practice by developing and providing information, products, and tools on outcomes; quality; and access, cost, and use of care. (HCQO)**

Strategy   **Cycle of Research Phase 3: Translation and Dissemination**

AHRQ is committed to ensuring that the knowledge gained through health care research is translated into measurable improvements in the American health system.   AHRQ is focusing on closing the gap between what we know and what we do. Under the "Translating Research Into Practice" initiative, the Agency invests in demonstration projects, public (Federal, state, and local government) and private-sector partnerships, and targeted dissemination activities to develop and test implementation strategies in different settings in the health care system and demonstrate their applicability to widespread dissemination in other areas of the system.

Types of Indicators: Output and process.

Use of Results by   The indicators regarding number of partnerships, attendees at User
AHRQ   Liaison Program meetings, or hits on the AHRQ web site help the Agency determine whether what it produces is of use to major audience segments. The Agency evaluates the results of the GPRA plan indicators in combination with other information such as details about what products were released,

feedback from attendees at programs, where the hits are on the web site, and feedback from customers to manage and improve its dissemination efforts.

Frequently, the results of research are not readily implemented in the health care system without an interim step such as the creation of a tool that facilitates use. A major focus for the Goal 3 indicators, therefore, is to look at the creation and use of tools. The indicators for the Agency's investment in training helps the Agency track its success in furthering the field of health services research by fostering new talent. The number of trainees funded are a reflection of Agency commitment and the success of the training programs in attracting successful candidates. This data can be used in combination with other information about individual trainees, their research projects, professional credentials of professors and mentors, etc. to assess the overall success of the program.

Data Issues: The AHRQ has implemented several computer-based reporting tools to monitor usage of Agency information systems and Web sites. Accurate statistics are recorded on the usage of the National Guideline Clearinghouse, Publications Clearinghouse, and various other Agency Web sites and systems using commercially available reliable and accurate tools, e.g., WebTrends. These tools are used by many corporations and government agencies nationwide to monitor usage and have been certified by various information technology testing and review groups. Information on all grants, which can be word searched, is included in the Agency Management Information System (AMIS).

AHRQ tracks print media (newspapers, health care-related trade journals and newsletters, and consumer magazines) and on-line news services for stories about or involving the Agency through the contractor, Burrelle's, which is one of the Nation's largest and oldest news clipping services. The contractor, Video Monitoring Service, monitors TV and radio news reports on selected studies in major markets around the United States. The other statistics are maintained by Agency program staff during the normal monitoring of contracts and grants. Certain items, such as the release of a CONQUEST product, are documented on the AHRQ web site when ready so that consumers are aware of the availability. Other items such as the statistics on the User Liaison Program (ULP) are monitored through the management of support contracts, travel arrangements, and other records kept in administering the program. Anecdotal information is verified with the primary source before being used by the Agency in this report and for any other uses.

GPRA Goal 3 – FY 2000 Results

Objective 3.1:   **Promote distribution of AHRQ publications, products, and tools through intermediary organizations.**

1ˢᵗ Indicator: Formation of a minimum of 5 partnerships to support dissemination of AHRQ products through intermediary organizations, such as health plans and professional organizations.

Results: In FY 2000, AHRQ partnered with over 30 diverse public and private organizations, including Web-based groups, to disseminate evidence-based information. Below are listed a sample of these partnerships:

AHRQ Public/Private Partnerships:

PPIP

✓   **The University of New England, Area Health Education Center in Biddeford, ME** will reprint and disseminate PPIP materials.

In addition, the following 2 organizations has partnered with AHRQ in marketing and/or disseminating PPIP materials:

✓   **HCFA**

✓   **AARP**

Your Guide to Choosing Quality Health Care

✓   **The University of California - Human Resources/Benefits** is reprinting **Your Guide to Choosing Quality Health Care**

Now You Have a Diagnosis: What's Next?

✓   **The National Association for Home Care** is reprinting and disseminating **Now You Have a Diagnosis: What's Next?**

AHRQ Smoking Cessation

✓   **The Pharmacy Council on Tobacco Dependence - FL** is collaborating with AHRQ to disseminate tobacco cessation materials.

Web Partner Activities

✓   **Web MD** has worked on collaborative projects with AHRQ to disseminate and market AHRQ materials.

NASHP

✓   AHRQ in partnership with RWJ, Commonwealth Foundation and CHCF partnerships for NASHP to evaluate state error reporting systems. A final report on this project will be due in Spring 2001. A preliminary report is available now.

✓ **<u>CAHPS</u>**

Partnership with CHCF on the translation of CAHPS instruments into other languages.

Objective 3.2: **Maximize dissemination of information, tools, and products developed from research results for use in practice settings.**

1st Indicator: Number of hits on the Web site (Baseline: FY 1999 - 15.5 M hits 2.9 million per year in 1997, nearly triple the hits in 1996.)

Results: AHRQ promotes widespread distribution and implementation of its information and research products through a variety of dissemination methods: publication in professional journals; provider and consumer materials, media events and outreach; interviews and story placement with medical/trade press and organizations' newsletters; and articles in the popular press. AHRQ also employs public-private partnerships, direct mail, and the World Wide Web to distribute its information.

The AHRQ Web site also provides access to the summaries of reports issued from the Evidence-based Practice Centers. The full text of these reports can be obtained at the National Library of Medicine, accessible through the AHRQ Web site. The Agency continued to work with the National Library of Medicine to upload evidence reports, technology assessments, and preventive services materials for clinicians on the full-text retrieval system HSTAT.

The "healthfinder" gateway site, developed and maintained by the Department of Health and Human Services, was prominently featured on the AHRQ site, and in turn provided 50,000 referrals to the Agency's online consumer health and patient information materials. Nearly 10,000 external Web sites link to the AHRQ Web site home page or content within the site, almost double that of the previous year.

The site was redesigned this year to address feedback from an online customer satisfaction survey. Usability testing has also been conducted with various constituencies to ensure the quality has been upgraded, the content is accessible, and the navigational approaches facilitate information retrieval for users. The site will further be refined based on the results of this effort.

A follow-up online evaluation occurred and the redesigned Web site was highly rated on content, presentation, and ease of use, and for the quality, quantity, and timeliness of information.

The Web site mailbox is used by constituency groups to both communicate with the Agency and ask the Agency for help on a variety of issues. In FY2000, there were 18.8 million Hits on the AHRQ Web site. This is a 21% increase over the 1999 baseline.

2nd Indicator: Number of inquiries handled on Web site. (Baseline: FY 1999 – 2950; FY1998 – 2500; FY 1997 – 1300)

Results: AHRQ handled 3,500 electronic inquiries during FY2000 through it Web site mailbox, a 19% increase over the baseline of 3,000 established in FY99. These inquiries included requests for Agency information products, funded research, consumer health issues and concerns, technical assistance, referrals to other resources, and requests to use AHRQ electronic content on other Web sites or in electronic or print products.

3rd Indicator: Number of Uploaded documents. Baseline: FY 1999 - 4000; FY 1998 – 1450; FY 1997 – 950.

Results: 4,400 Documents were Uploaded in FY 2000 (10% increase over the baseline of 4000 established in FY 1999). In addition to the information provided for the English-speaking public, the AHRQ Web site offers a "Spanish" button, *Información en Español*. A popular feature on the Web site which consistently is within the Top100 features accessed each month, it provides translations of our consumer health and patient information materials, and averages about 1,200 visits each month. Many users are the Spanish-speaking public, but we have also received feedback from clinicians with large Hispanic patient populations on the utility of these materials for their patient education efforts.

4th Indicator: Reports from user surveys on how the information requested was used.

Results: The AHRQ Web site was highly rated on content, presentation, and ease of use, and for the quality, quantity, and timeliness of information. Based on feedback from an online evaluation of the Web site, various audience groups came to the site for:

- New funding opportunities and subsequent award announcements.
- Press releases with contact information on key staff involved.
- Informative electronic newsletters on research activities.
- Clinical research resources to improve practice and health outcomes.
- Strategic planning to establish priorities and directions for State health programs.
- Facilitating health services research at the university level.
- Summaries of evidence-based information for medical practice.
- Research information related to treatment of specific health conditions, such as diabetes, arthritis.
- Recommendations on quality of care issues and suggestions for improving health care.
- Learning more about AHRQ and related resources.
- Keeping abreast of new developments and up-to-date information on the changing health care system.
- Best practices and information on reducing the cost of providing health insurance.

- Data and statistics on health care costs and use.

The following characterizes requests from outside organizations for use of electronic content from the AHRQ Web site:

- Consumer materials on specific conditions and also to better understand the health care system have been incorporated on numerous consumer health Web sites as well as in corporate intranets for employees, e.g. low back pain, quit smoking, and health insurance choices.
- Clinical materials have been adapted for medical Web sites oriented for clinicians as well as in hospital and health plan systems.
- Clinical and research materials have been included in course packs for both medical education programs and graduate training in public health issues.
- Information on reducing medical errors has been distributed by managed care organizations through their member Web sites and newsletters.
- Preventive services information for both adults and children have been used for health education initiatives of health plans and employers.

5th Indicator: Number of State and local governments trained in the understanding and use of health services research findings through User Liaison Program (ULP) Workshops.

- Number of ULP meetings held.

Baseline: 10 meetings held in FY 1997; 9 held in FY 1998; 13+ FY 1999

- Number of attendees.

Baseline: 834 attendees in CY 1999; 538 attendees in CY 1997

- States represented.

Baseline: 48 States plus D.C.

Results: In FY 2000, 17 ULP meetings were held at the national, state and local level (a 70% increase over the baseline of 10 meetings established in FY 1999). These included:

- 13 national workshops
- 1 workshop for Tribal leaders interested in health care issues
- 1 State-specific seminar
- 2 3-hour audio-conferences with telephone call-in capability

The total number of attendees at ULP workshops, seminars and audio-conference calls (1196) increased 143% over the baseline of 834 attendees established in FY 1999, and included:

- 635 State participants in all workshops and seminars
- 513 participants for audio-conference calls

- 48 Tribal workshops

  State representation increased 4% to include participants from *all* the 50 states plus the District of Columbia. Below is the breakdown of participation by state.

State Participant Breakdown

AK	4	ID	11	MT	4	RI	9
AZ	17	IL	13	NE	8	SC	6
AR	6	IN	5	NV	6	SD	2
Bahamas	0	IA	8	NH	9	TN	6
Bermuda	0	KS	7	NJ	8	TX	15
CA	35	KY	11	NM	19	UT	15
CAN	0	LA	9	NY	23	VT	3
CO	8	ME	8	NC	12	VI	0
CT	12	MD	13	ND	1	VA	9
DE	3	MA	15	OH	11	WA	18
DC	5	MI	15	OK	23	WV	3
FL	29	MN	15	OR	15	WI	18
GA	23	MS	5	PA	33	WY	1
HI	9	MO	17	PR	0		

6th Indicator: Reports from annual participants on how the information was used in decisionmaking.

Results: Two examples of how participants used information learned at ULP meetings include the following:

Legislation was introduced in Massachusetts during calendar year 2000 intended to reduce the number of medical errors based on information a State senator learned while attending a User Liaison Program (ULP) workshop in March 2000.

Wyoming decided to implement evidence-based disease management and have been interviewing consultants to help them as a result of a member of the Department of Health attending a ULP meeting in May 2000 on "Using Evidence: Technology Assessment, Disease Management, and Coverage Decisions."

7th Indicator: Statistics on usage of National Guideline Clearinghouse including number of hits, requests, organizations, and total users.. (Baseline: See FY 1999 results for details.)

Results:

The statistics on usage of the National Guideline Clearinghouse (NGC) illustrate the success AHRQ has achieved in FY 2000 in disseminating information to users. In hits alone, there has been a 1037% increase over the baseline established in FY 1999.

NGC Statistics

Number of requests	21,663,521
Number of visits	2,003,786
Average number of requests per visit	10.81
Average visit duration	00:05:03

Number of organizations	68,190
Number of U.S. organizations	15,999
Number of Canadian organizations	248
Number of International organizations	6,626
Number of unknown organizations	45,307

Number of hits	38,961,57

NGC Content Growth # of CPGs
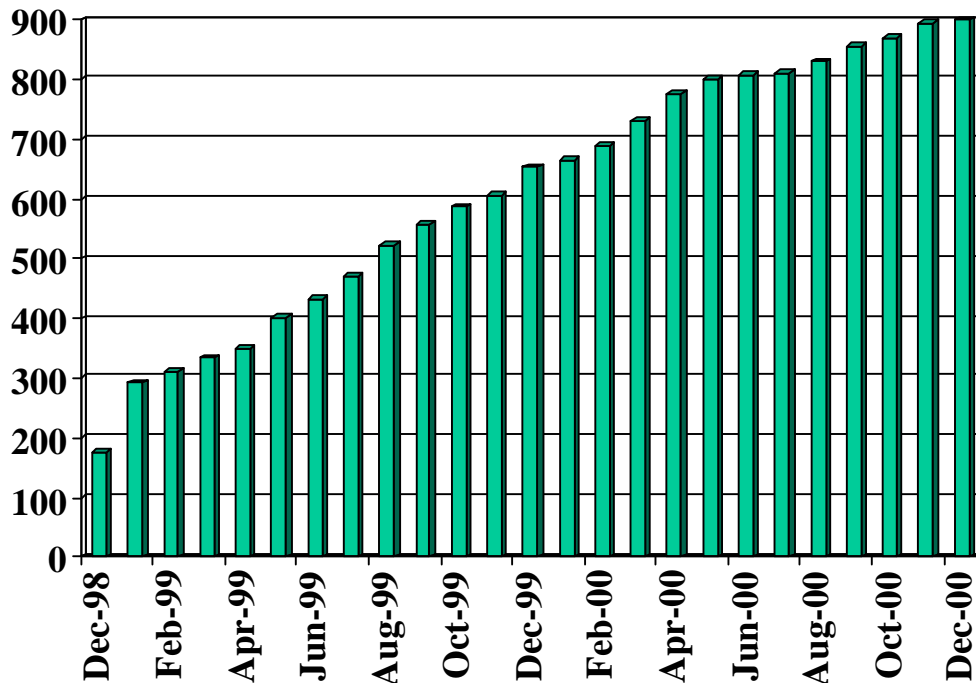
8th Indicator: Survey of a sample of NGC users to understand the impact of use on decisions and patient care.

The National Guideline Clearinghouse First Annual Customer Satisfaction Survey was completed in June 2000. To the survey question, **"How has NGC changed your healthcare-related activities or practices?"**, 902 respondents indicated the impact of NGC use include informing practice patterns, use in educating healthcare staff, and as an aid to cutting health care costs and increasing quality of care. The following excerpts demonstrate the range of impact:

- assists in my research and informs my clinical care
- we are using it to make sure staff are competent in guideline use
- improved analysis of prescribing practice
- changed practice pattern based on guideline
- made it easier for me to use cutting edge information in a very rural environment
- changed management based on practice guidelines
- more evidence-based practice, help cut health care costs but increase quality of care,
- we have used the guidelines to set up our pain management practices at the hospital where I work
- have updated several clinical protocols with information obtained
- many of our policies are based on clinical

The average satisfaction score assigned by the 902 respondents was 1.7 on a scale of 1 to 5, with 1 being very satisfied and 5 being very dissatisfied. The great majority of survey respondents rated the NGC as either good or very good in terms of the comprehensiveness of the guideline collection; whether the guideline summaries present key attributes; the usefulness of the search, browse and index functions; the usefulness of the guideline summaries, synthesis, and tabular comparisons; and the reasonableness of the time required to locate specific information.

An evaluation of the NGC is underway to assess the impact of its use on decisions and patient care and expected to be completed in mid-year 2001.

9th Indicator: At least 10 purchasers/businesses use AHRQ findings to make decisions.

Results: The widespread use of AHRQ findings is providing purchasers with valuable information for making healthcare decisions. The following are examples of this use:

- More than 90 million Americans use AHRQ's Consumer Assessment of Health Plans (CAHPS) to help them decide which health plan best meets their health care needs. CAHPS is now used by more than 20 States; corporations such as Daimler Chrysler, Ford and General Motors; health plans; and employer groups across the country.
- The Health Care Financing Administration (HCFA) has begun using CAHPS to survey Medicare managed care plan enrollees, and the U.S. Office of Personnel Management used CAHPs to report consumer assessments of health plans available to Federal workers and retirees for its FY 2000 open season.

- The Health Care Financing Administration decided to cover cryosurgery as a primary treatment for prostate cancer for Medicare patients, but to leave unchanged it's decision to not cover the operation as a salvage therapy because of the findings of AHRQ's technology assessment, *Cryosurgery for Recurrent Prostate Cancer Following Radiation Therapy.*

- Purchasing decisions of employers are often influenced by how well health plans score on NCQA's Health Employer Data Set (HEDIS). Plans' scores will now reflect how well they screen for chlamydia, as rated by a measure developed through AHRQ's Q-Span research initiative.

- The Leapfrog Group – created by Fortune 500 companies, including General Motors and General Electric, that are committed to using a common set of health insurance purchasing principles -- adapted information from AHRQ's *20 Tips to Help Prevent Medical Errors* for educating employees about medical errors and patient safety.

- Federal agencies are also using *20 Tips to Help Prevent Medical Errors*. The U.S. Office of Personnel Management, which purchases health care for over nine million Federal workers and retirees, has adapted materials from the publication for inclusion in FY 2001 open season informational materials, and the U.S. Department of Defense is making materials adapted from AHRQ's publication available to members of the armed forces and their dependents.

- PEPCO of Washington, D.C. purchased 4,000 copies of the English-language edition of AHRQ's Put Prevention into Practice guide, *Staying Healthy at 50+,* for distribution to the company's employees and retired workers.

- AHRQ partnered with the American Association of Retired Persons, an advocacy group representing health insurance and other interests of over 33 million Americans 50 and older, to partner with it and HRSA to produce and disseminate *Staying Healthy at 50+* in English and Spanish.

- To help their employees in the United States make more informed health care decisions, Bell and Howell, General Motors, YMCA, Inc., and Bank One are giving them information adapted from AHRQ's *Your Guide to Choosing Quality Health Care.*

- Kaiser and the VA are using a health education program for self-management by patients with the four chronic diseases of chronic obstructive pulmonary disease, coronary artery disease with angina, neurological disease with normal mentation and chronic arthritis. The health education program resulted from the AHRQ-funded research project, Improving Chronic Disease by Self-Management Education.

Objective 3.3: **Develop and facilitate the use of new tools, talent, products, and implementation methodologies stemming from research portfolio. FY 2000 Priority (3), "Translating Research into Practice," focuses on the translation and dissemination of research findings, products, and tools to foster adoption and use in health care settings.**

1ˢᵗ Indicator: Demonstration of use of at least 3 AHRQ research findings in systematic efforts to Translate Research Into Practice (TRIP). Baseline: Under development.

Results: In FY 2000 AHRQ funded thirteen TRIP projects to take research findings sponsored by AHRQ, and systematically implement them and measure the impact of their use. The examples of the types of projects are listed below.

- Nancy Watson (University of Rochester) - evaluation of a model of care for translating the AHRQ Urinary Incontinence (UI) Guideline into practice in nursing homes.
- Steve Ornstein (Medical University of South Carolina) - applies approach tested in prior AHRQ research of academic detailing to primary and secondary prevention of coronary heart disease & stroke in outpatient setting.

- David Bates (Brigham & Women's Hospital) - a study to improve safety by computerizing outpatient prescribing. Built on previous AHRQ-funded studies on inpatient errors. Includes studies cited in the IOM report on medical errors.
- Jeroan Allison (University of Alabama) - an Internet intervention to increase Chlamydia screening.

2nd Indicator: Funding of a minimum of 5 major projects that will develop products, tools, or methodologies for implementing research findings into practice in significant segments of the health care system (i.e., potential to be generalizable across health care systems, provider-types, or clinical areas.)

Result: The Agency was extremely successful in launching its new focus on translating research into practice in FY 2000. This initiative consisted of a three part strategy of first, expanding the capacity to conduct and translate research in actual practice settings by developing networks; second, funding new research to determine the most effective behavioral and other interventions to promote practice improvement; and third, sponsoring efforts to take existing AHRQ findings, applying them in practice, and evaluating the impact on patient quality and outcomes. The latter is described above. The first two parts are detailed below.

In FY2000, AHRQ awarded planning grants to19 primary care practice-based research networks (PBRNs). A PBRN is a group of ambulatory practices devoted principally to the care of patients, affiliated with each other in order to investigate questions related to community-based practice. The networks receiving awards are required to design systems that will facilitate the translation of research into practice and to assess the impact of these systems on care delivered. The following are brief descriptions of five of the projects funded through this initiative:

- William Tierney, M.D., Regenstrief Institute for Health Care, Indianapolis, Indiana, is the director of ResNet, a network of 18 practices of general internal medicine, pediatrics, family medicine and obstetrics and gynecology. The network intends to use its highly developed medical informatics system to increase the implementation and evaluation of practice guidelines and survey instruments for assessing patient-centered outcomes.

- George Rust, M.D., M.P.H., Morehouse School of Medicine, Atlanta, Georgia, is the director of the Southeast Regional Clinicians' Network which is composed of 142 federally-funded community health centers in 8 southern states which serve about 1.5 million persons who are medically underserved. The network will concentrate on implementation strategies to improve health outcomes related to high-impact, high-disparity conditions such as asthma and hypertension.

- Richard Wasserman, M.D., M.P.H., the American Academy of Pediatrics and the University of Vermont, Burlington, Vermont, is the director of a network named PROS (Pediatric Research in Office Settings), a national network that includes 1,582 practitioners from 540 pediatric practices in 49 states. PROS will focus on an enhanced process for disseminating practice-specific feedback of study results to participating practitioners as well as dissemination of published data to groups external to the network.

- Ken Kallail, Ph.D., University of Kansas School of Medicine, Wichita, Kansas, is the director of the Kansas Rural Practice Research Network, a new network that includes 26 physicians in primary care practices that serve communities of less than 3000 population in rural Kansas. A priority of the network is the development of systems that will increase the capability of participating practices to obtain data that will improve the quality of care provided. It also proposes to serve as a testing site for implementation tools or methods yet to be tested in primary care practices in small rural communities.

- John Wasson, M.D., Dartmouth Medical School, Hanover, New Hampshire, is the director of COOP, the Dartmouth/Northern New England Primary Care Cooperative Research Network, the oldest primary care practice-based research network in the country. COOP will focus its implementation efforts on collaborative information development, using its interaction technology for information transfer among providers and between providers and patients, including minorities and those who are socio-economically disadvantaged.

In addition, AHRQ has partnered with nine Integrated Delivery System Networks (IDSRN) to link the nation's top researchers with the some of the country's largest health care systems. This new model of field-based research will enable AHRQ to accelerate the pace of its research on key concerns such as medical care quality and safety, access to services and costs. As a group, the networks provide health services to over 34 million Americans, including the privately insured, Medicare and Medicaid patients, and the uninsured. A complete list of these is available on the Agency's website at:

http://www.ahrq.gov/news/press/pr2000/rapresppr.htm.

In FY 2000,10 projects were initiated with these systems, including the following:

- **Researching the Implementation of Practice Guidelines**
  Developed on the basis of AHRQ-Supported Evidence Reports with Priority Populations: More research is needed to understand factors that lead to effective implementation of practice guidelines. In particular, additional research is needed on whether different populations of providers and patients require different factors for effective implementation of change. The purpose of this project is to evaluate evidence-based implementation of a clinical practice guideline based on an AHRQ-supported evidence report. The evaluation will address AHRQ's priority populations within an integrated delivery system.

- **Assessing Impact of Organizational Interventions**
  System design can affect patient access, patient satisfaction, and efficiency of care. Yet little systematic research exists to guide clinic and practice managers. The purpose of this project is to give an integrated delivery system the opportunity to implement an organizational intervention and include an

evaluation component from the outset, so that the integrated delivery system itself and other system and policy leaders can learn from the experiment in real time. Examples of the interventions to be implemented include centralizing medication management for patients requiring anticoagulant (Coumadin) therapy to improve adherence to clinical guidelines, and establishing case management programs to reduce emergency care and promote preventive care for low-income patients.

Under the Translating Research into Practice II (TRIP II) and Systems-related Best Practices to Improve Patient Safety RFAs, the Agency has funded 10 projects which will develop products, tools, or methodologies for implementing research findings. Below are a sampling of these projects which test computer based tools to decrease medical errors and increase the delivery of appropriate care in outpatient settings (Bates), study the determinants of errors in primary care and neonatal intensive care units, improve asthma care to low income children, and increase chlamydiae screening with an internet-based intervention:

- **Improving Quality with Outpatient Decision Support**
  The project will develop paper-based and electronic guideline reminders and alerts for an outpatient setting. Participants will be physicians of the Beth Israel and Massachusetts General Hospitals and their outpatient clinics. The reminders and alerts will target health maintenance (e.g. cholesterol, mammograms, Pap tests and influenza vaccines), disease management (e.g., diabetes), medication management (e.g., statin drugs, H2blockers, NSAIDS, MI and beta blockers, MI and aspirin),and ancillary test ordering. The investigators will evaluate the impact of these alerts, reminders, and guidelines on physician compliance with evidence based recommendations. The impact of electronic result tracking and follow-up systems on physician compliance with guidelines also will be evaluated. Patient, physician, and system barriers to compliance will be assessed in an array of clinical settings.

- **Improving Pain Management in Nursing Homes**
  Jones, Katherine R., Ph.D., University of Colorado Health Sciences Center
  This 3 year study proposes to develop and implement a culturally-competent intervention to improve the quality of pain management in 12 nursing homes. Specific aims are to 1) develop and implement a multi-modal, culturally-competent, evidence-based educational and behavioral intervention to improve pain assessment and pain management in nursing homes; 2) improve pain assessment procedures and pain management strategies being used in nursing homes; 3) improve resident, family, and staff knowledge and attitudes toward pain assessment and pain management; 4) evaluate the influence of organizational variables on achieving desired clinical and educational outcomes; and 5) assess the cost-effectiveness of the multi-modal intervention for disseminating pain assessment and pain management knowledge to nursing homes.

- **Developing an Asthma Management Model for Head Start**
  Perla A. Vargas, Ph.D., Arkansas Children's Hospital
  This randomized design project purposes to develop an evidence-based asthma case management model for low-income minority children enrolled in 29 Head Start Programs in cooperation with Pulaski County Head Start and the Arkansas Foundation for Medical Care. The outcomes of interest include asthma-related school absences, asthma symptoms, asthma management

(drug use, office visits, self-management), quality of life, emergency department visits, hospital use, and program costs.

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3rd Indicator: At least 2 new tools, products, or methodologies become available from projects funded between FY 1993 and FY 1996. (Baseline: 16 projects identified in FY 1999.)

Results: The following are twenty-three examples of the many tools, products and methodologies that have resulted from projects funded by AHRQ between FY 1993 and FY 1996.

> **Medicare Survey Instrument**
> Working with HCFA, AHRQ's Consumer Assessment of Health Plans team and their associated grantees developed a new survey instrument for evaluating the care for Medicare beneficiaries enrolled in fee for service plans. This survey was fielded for the first time in FY 2000 and, for the first time, provides the ability to compare the quality of care between Medicare + choice programs and traditional Medicare fee-for-service plans from the consumer perspective.

> **Nursing Home Data Book**
> The Nursing Home Compare Web site (http://www.medicare.gov/nhcompare/home.asp) permits comparison of quality indicators among nursing homes nationally. This data system was developed by Charlene Harrington at the University of California, San Francisco, with support from AHRQ. Quality indicators were developed using data from HCFA surveys and input from groups of stakeholders.

> **EDECS Web Site**
> The Emergency Department Expert Charting System (EDECS), is a set of clinical guidelines embedded in an electronic charting system. It was designed to improve care of pediatric fever, low back pain, recurrent seizure, discharge/dysuria in males, and occupational exposure to blood and body fluids. Using a quasi-experimental design, the system was tested and found to improve appropriateness of diagnostic testing and treatment decisions, although effects varied by treatment module. The most striking success was with the module on occupational exposure. The CDC has supported establishment of a Web site (to be added) so that the system is available for use by any provider. Initially funded earlier, the project was still receiving funds in FY 1993.

> **Stroke Policy Model on CD-ROM**
> The Stroke Prevention PORT and AHRQ distributed a CD-ROM in FY2000 that provided complete documentation specifications for the Stroke Policy Model. The Stroke Policy Model is a clinical policy decision simulation tool for studying the costs and outcomes of the natural history of stroke, as well as the costs and outcomes associated with various preventive or therapeutic intervention strategies. The documentation, including programming codes, algorithms, and all input

data used in the model is designed to help facilitate and encourage the use of this model in other related studies of stroke interventions by other researchers and clinical policy makers. In addition, this new tool can be used to help determine the return on investment from quality improvement programs focused on stroke prevention and treatment.

▸ **Health Outcomes Research Methodology**

The Center for Outcomes and Effectiveness Research organized a health outcomes methodology symposium in FY1999 and published all the symposium manuscripts and proceedings in the September 2000 supplement to the journal Medical Care. Health outcomes research in the past two decades has brought into focus the essential role of patients' perspectives in assessing effectiveness of health services. While the research field has benefited from the proliferation of patient-centered outcomes measures, most of which have not been evaluated extensively. Many methodological issues pertaining to measurement validity and interpretation also have yet to be adequately addressed. The symposium proceedings and manuscripts in the special issue of the Medical Care supplement reflect the collective and collaborative effort by the leading health outcomes researchers and the Agency in addressing those methodological challenges. It represents an important contribution to the outcomes research methodology field in guiding and motivating further deliberating, progress, and fulfillment in health outcomes assessment.

▸ **Child Health Toolbox: Measuring Performance in Child Health Programs**

AHRQ created an online learning program to help State and local policymakers and program directors and staff to answer questions about measuring health care performance in child health programs. The program provides a guide to using performance measurement in child health programs, and provides detailed information on a number of measures in general use.

▸ **Artificial Neural Networks Statistical Modeling**

Web-based tool that allows prediction of the five year survival rate for breast and colorectal cancer using artificial network modeling (a class of statistical methods).

▸ **Six (6) State Ambulatory Surgery Databases (SASD) from HCUP**

Six of the nine State Ambulatory Surgery Databases (SASD) from HCUP were made publicly available for the first time in FY 2000. All six are available from a single point of access, the Central Distributor, under the auspices of AHRQ.

▸ **Three (3) Statewide Inpatient Databases (SID) from HCUP**

Three additional states of the 22 Statewide Inpatient Databases (SID) from HCUP are now available from a single point of access, the Central Distributer, under the auspices of AHRQ. These additional states increase the total number of states available through the Central Distributer to 14.

▸ **Two (2) Clinical Classification Software (CCS)**

Two classification systems (single-level and multi-level) of the Clinical Classification Software (CCS) were updated in FY 2000. The single-level CCS classifies all diagnoses and procedures into unique groups, and aggregates illnesses and conditions into 259 mutually exclusive categories. The multi-level CCS expands the single-level CCS into a hierarchical system, and groups single-level CCS categories into

broader body systems or condition categories (e.g., "Diseases of the Circulatory System").

▸ **Child Health Status Measure**

Riley, Anne, Johns Hopkins University

The overall purpose of this project was to develop a health status instrument that can be used to measure comprehensively the health and illness profile of children aged 6-11. This instrument will have the potential of detecting aspects of child health that are responsive to health services or social interventions. It will be useful for describing the health of children in communities, for monitoring the impact of health plans serving defined populations of children, for evaluating the effect of interventions on children's health, and for relating differences in access and services to the health status of children from various sociodemographic groups.

▸ **Adolescent Health Services Measure**

Klein, Jonathan, University of Rochester

This project tested the validity and reliability of survey instruments to evaluate preventive services and the accessibility, comprehensiveness, and coordination of care delivered to adolescents by primary care providers.

▸ **Clinical Performance Measures for Dental Care Plans**

Development of standardized measures to assess clinical aspects of the performance of managed dental care plans:

- Seven effectiveness of care measures assessing disease activity classification, preventive treatment, and outcomes for caries, periodontal disease, and tooth loss were developed.

- Six use of services measures focusing on prophylaxes, third molar surgery, preventive, restorative, prosthetic, surgical and endodontic care were specified.

- Five access to services measures addressing visit and examination rates, appointment waiting time, and provider availability and turnover were also specified.

▸ **Database for Pediatric Studies (DPS) from HCUP**

To address the need to provide a larger sample of pediatric conditions to facilitate study of specific conditions and procedures, a new data set was drawn from the SD, comprised of only children's hospitalizations. The DPS includes all pediatric discharges form all community hospitals from the 22 frame states, comprising 2581 hospitals and 3.7 million discharge records.

▸ **The Children with Special Health Care Need (CSN)**

A component of the CAHPS family of instruments, CSN includes:

- The Core CAHPS 2.0 Child Survey

- The CSN screening tool to identify children with chronic or special health care needs

- The CSN question supplement

- A CSN screener to identify children whose caretakers should complete the survey

- Guidelines for scoring and presenting the CSN measures

In the development of these tools, the CAHPS team (funded by AHRQ) has collaborated with the National Committee for Quality Assurance (NCQA), and the Foundation for Accountability (funded by

the Packard foundation). Like all CAHPS tools, the purpose of the CSN instrument is to obtain valid and reliable information from consumers to assist them in selecting a high quality health plan that meets their needs. The Committee for Performance Measurement of the NCQA is considering accepting the CAHPS CSN survey as part of HEDIS.

4th Indicator: Support a five percent increase, at a minimum, in number of pre- and post-doctoral trainees. (Baseline: 167 trainees funded in FY 1999.)

Results: In FY 2000, AHRQ increased by 40% the number of pre- and postdoctoral trainees and fellows it supported. Support was provided for 218 scholars through a variety of programs, including institutional and individual National Research Service Awards (NRSA) and dissertation grants. In addition, AHRQ launched two new career development programs: the Independent Scientist Award (K02) and the Mentored Clinical Scientist Development (K08) programs. These latter two programs supported an additional 16 scholars.

GPRA Goal 3 – FY 2001 and 2002 Indicators

Objective	FY 2001 Indicator	FY 2002 Indicator

Objective	FY 2001 Indicator	FY 2002 Indicator
3.1 Maximize dissemination of information, tools, and products developed from research results for use in practice settings.	**Partnerships** – At least 5 public-private partnerships are formed to implement research findings for decisionmakers. Budget: Commitment Base – Formation of a minimum of 10 partnerships to support dissemination of AHRQ products through intermediary organizations, such as health plans and professional organizations. Budget: Commitment Base **Web site:** • Number of hits on the Web site • Number of inquiries handled on web site • Number of Uploaded documents. Budget: Commitment Base **User Liaison Program** • Number of State and local governments trained in the understanding and use of health services research findings through ULP Workshops . Budget: Commitment Base	# of state and local governments trained and/or receiving technical assistance through ULP. Budget: Commitment base At least 20 partnerships to disseminate and implement research findings are formed with public and private-sector organizations. Budget: Commitment base Synthesis of at least 5 grant portfolio areas on quality of care across Agency's goals for persons with chronic care needs produced and disseminated with particular focus on outreach to managed care executives. Budget: Commitment base Initiate development of a web-based toolbox to disseminate instruments used in translating research into practice; partner with at least five professional organizations, PROs, payers or advocacy groups to implement findings. Budget: Commitment base

Objective	FY 2001 Indicator	FY 2002 Indicator

| **Objective 3.2 in FY 01 Develop and facilitate the use of new tools, talent, products, and implementation methodologies stemming from research portfolio.** | Produce evidence summaries for use in Federal direct care providers' efforts to create guidelines.   Budget: Commitment Base

Evidence-based practice centers (EPCs) will produce a minimum of 12 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality by improving practice. Budget: Commitment Base

Support a minimum of 165 pre- and post-doctoral trainees. Budget: Commitment Base

Support up to 3 Minority Research Infrastructure Support Program IM-RISP) grants in order to develop the health services research capabilities of traditionally minority-serving institutions.

Support up to 6 Building Research Infrastructure and Capacity (BRIC) two-year planning grants in EPSCOR states and states which historically have received little or no research support from AHRQ.

Fund at least 10 projects in tool development.

Budget: pages 61, 65 and commitment base. | – Produce evidence summaries for use in Federal direct care providers' efforts to create guidelines Budget: Commitment base

– Evidence-based practice centers (EPCs) will produce a minimum of 12 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality by improving practice. Budget: Commitment base

– Build on and expand current efforts geared toward fostering and encouraging interest in health services research careers and outreach through the following.

 Enhanced infrastructure development and capacity building:
 + Support a minimum of 165 pre- and post-doctoral trainees.
+ Support up to 3 Minority Research Infrastructure Support Program IM-RISP) grants in order to develop the health services research capabilities of traditionally minority-serving institutions.
+ Support up to 6 Building Research Infrastructure and Capacity (BRIC) two-year planning grants in EPSCOR states and states which historically have received little or no research support from AHRQ.
+ Fund at least 10 projects in tool development. + Supporting up to 10 new individual predoctoral awards to underrepresented minority students.

Fund at least 15 projects in tool and data development.
Budget page:
Commitment base |

| **GPRA Goal 4:** | **Evaluate the effectiveness and impact of AHRQ research and associated activities. (HCQO)   (Note: All Agency evaluation activities, including MEPS-related studies, are included under Goal 4. This is because the MEPS budget line covers only costs associated with data design, data collection and analysis, and data products.)** |

Strategy   **Cycle of Research Phase 4:**   **Evaluation**

As explained in other portions of this document, interim outcomes of research can be evaluated on a relatively short-term basis. However, the ultimate outcome of how the research affects people receiving health care or people interacting with the system requires large, expensive retrospective studies. AHRQ is implementing a growing portfolio of evaluations that will show, iteratively, the outcomes of the investments of Agency funds.

Types of indicators   Interim outcomes of research

Use of results by   AHRQ conducts evaluations of its major programs or products to achieve one or more of the following:
- evaluate the current state of the program or product including impact in health care
- improve customer satisfaction with the program or product
- target or prioritize future activities to increase their usability or usefulness

Data Issues   Many of the evaluations are conducted with the assistance of consultants who are highly skilled in evaluation research and/or the subject matter. Some are done through surveys for customer satisfaction that were cleared through OMB. The third category is evaluations conducted through consultations with experts and users to obtain direct feedback on a particular product. In order to ensure the integrity of the evaluations, the AHRQ staff assigned to the projects were not program staff responsible for the day-to-day administration of the program. Additionally, advice on the evaluation questions as well as on the interpretation and use of the results is often sought from experts on the AHRQ National Advisory Council.

GPRA Goal 4 – FY 2000 Results

Objective 4.1 & 4.2:   **Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care. [2]**

The following evaluations of core Agency program/projects were completed in FY 2000.

1st Indicator: AHRQ's HCUP Quality Indicators(QI's) will be redesigned based on consultations with state policy makers, researchers, hospital associations, and others about their past use of the QI's. By the end of March 2001, a new set of quality indicators will be defined and feedback obtained from a new set of HCUP QI users. In addition,

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[2] Objectives 4.1 and 4.2 were inadvertently the same. They have been consolidated to simplify the reporting.

AHRQ will provide access to recent national-level QI information via both the Internet and through published reports, with special focus on disseminating information to hospital users and organizations with responsibility for hospital quality reporting.

Results: A new set of HCUP Quality Indicators (QIs) has been defined, and some feedback has been obtained. The new set of QIs include several measures that were contained in the original version. Additional QIs will encompass new areas such as chronic medical conditions, pediatric conditions, and volume of procedures. The first round of feedback helped the Stanford team to focus on particularly effective measures and to fine tune their descriptions of the results of the literature review and the empirical evaluation. The QI portion of the project was complete in March, 2001. Patient Safety indicators are expected to be complete by May, 2001.

National-level QI information was made available via the Internet during September 2000. Due to technical difficulties, the information has been removed. When it is re-posted to the Internet, it will contain the most current information available for 1996 and 1997. The QI Web site was developed by NAHDO, under sponsorship from AHRQ. NAHDO provides for the development and enhancement of statewide and national health information systems, bringing together a network of state, federal, and private sector technical and policy leaders and consultants to expand health systems development and shape responsible health information policies. The website developed by NAHDO provides statistics on the QIs by patient and hospital characteristics, while protecting the privacy of patients and hospitals. The information can be employed by users of the QIs as benchmarks in order to compare performance of their own organizations.

2nd Indicator: Use of evidence reports (ERs) and technology assessments (TAs) to create quality improvement tools in at least 10 organizations.

Results: The Agency has been very successful in its partnerships with a wide variety of health care organizations. While the majority of evidence reports are being used by professional associations to create clinical practice guidelines, they are also being used by patient groups and health systems. Examples of the uses of the Agency's ERs and TAs are listed below:

1) **Depression Treatment with New Drugs**
   The American Psychiatric Association used the ER in developing their Practice Guidelines for the Treatment of Psychiatric Disorders. The guideline was published as a Supplement to the American Journal of Psychiatry, Volume 157, No. 4, April 2000, and is also a book published by the APA in 2000.

2) **Management of Unstable Angina**
   Guidelines based on this evidence report were developed by the American College of Cardiology and the American Heart Association and published in the Journal of the American College of Cardiology (September 2000).

3) **Diagnosis of Attention-Deficit/Hyperactivity Disorder**

The American Academy of Pediatrics (AAP) developed practice guidelines based on this ER. They were published in the AAP Journal in May 2000 (Committee on Quality Improvement, Subcommittee on Attention-Deficit/Hyperactivity Disorder, AAP. Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity Disorder (AC002). *AAP Journal.* Volume 105, No. 5. May 2000. pp. 1158-1170).

4) **Treatment of Attention-Deficit/Hyperactivity Disorder**
The American Academy of Pediatrics (AAP) is currently finalizing a guideline on treatment of ADHD, based on the ER, expected to be completed in November or December 2000. In addition the UK National Institute for Clinical Excellence (NICE) may consider this ER as they appraise the use of methylphenidate (Ritalin) for hyperactive children.

5) **Testosterone Suppression Treatment for Prostate Cancer**
The Department of Veterans Affairs Employee Education System is using the meta-analysis on monotherapies for androgen suppression in men with advanced prostate cancer as part of their continuing medical education program and are disseminating results of the meta-analysis to VA medical personnel.

6) **Evaluation of Cervical Cytology**
The UK National Institute for Clinical Excellence (NICE) issued a Technology Assessment (TA) on Liquid-Based Cytology in Cervical Screening in January 2000. i
In their analysis, the report's authors included AHRQ's ER, along with other published systematic reviews. The report includes a comparison table, and it favorably cites AHRQ's ER (Payne N, Chilcott J, and McGoogan E. Liquid-Based Cytology in Cervical Screening: A Report by the School of Health and Related Research (ScHARR), the University of Sheffield, for the NCCHTA on behalf of NICE. Trent Institute for Health Services Research. January 2000, Revised May 2000). The full text of the report can be obtained from the NICE website at www.nice.org. The American College of Obstetricians and Gynecologists (ACOG) is also developing a clinical practice guideline based on this ER.

7) **Prevention of Venous Thromboembolism After Surgery**
Our partner, the Eastern Association for Surgery of Trauma, is developing a guideline based on this evidence report that will be submitted for publication to the Journal of Trauma by the end of September. In addition, a multi-centered trial, sponsored by a pharmaceutical company manufacturing low-molecular heparin, will be getting underway shortly to answer the research gap identified by the evidence report regarding the best method of prophylaxis for venous thromboembolism.

8) **Clinical Preventive Services**
Based on the work of the USPSTF, the RTI-UNC EPC is developing promotional awareness messages for Medicare beneficiaries and providers on selected topics including: prostate specific antigen testing; screening mammography; and Papanicolaou testing. The first set of messages is due to be completed by the end of this calendar year.

9) **Anesthesia Management During Cataract Surgery**
Our partner, the American Academy of Opthalmology considered this ER in updating their Preferred Practice Parameter for Cataract in the Adult Eye. The updated guideline will be issued in September 2001 and will be posted on the AAO's website and disseminated to new opthalmic residents.

10) **Treatment of Co-Existing Cataract and Glaucoma**
Our partner, the American Academy of Opthalmology will consider this ER when it becomes available later this year to update their Preferred Practice Parameter for Cataract in the Adult Eye. The updated guideline will be issued in September 2001 and will be posted on the AAO's website and disseminated to new opthalmic residents.

11) **Use of Epoetin in Oncology**
Our partners, the American Society of Hematology/American Society of Clinical Oncology (ASH/ASCO) are currently developing a guideline based on this ER which is to be completed by the end of this year or early next year.

12) **Pharmacotherapy for Alcohol Dependence**
The American Society of Adolescent Medicine (ASAM) is developing guidelines based on this ER.

(13) **Evaluation and treatment of new onset atrial fibrillation in the elderly**
The ACP-ASIM, with representation from AAFP, is developing guideline based on this evidence report. The American College of Cardiology (ACC), in conjunction with European Society of Cardiology is also planning to develop a guideline based on this report.

14) **Management of Neurogenic/Neuropathic Pain Following Spinal Cord Injury**
Our partner for the ER, the Paralyzed Veterans of America: Consortium for Spinal Chord Medicine is organizing to develop a guideline based on this ER. They will initiate work once the final evidence report is approved for publication and expect the process to take 10 to 12 months.

15) **Otitis Media with Effusion**
The American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) are developing guidelines based on the ER.

16) **Acute Otitis Media**
The American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) are developing guidelines based on the ER.

3rd Indicator: For at least four evidence reports (ERs) or technology assessments TAs) per year, work with partners to measure how the reports or

assessments were used and what impact they had on clinical decision making and patient care.

Results: Following are highlights of some of the Agency's efforts in FY 2000 to work with partners to assess the use and impact of ERs and TAs on clinical decision making and patient care:

- AHRQ hosted a users meeting in October 2000 with partners that have participated in evidence reports to date. A key theme of the meeting was the critical role of the partners in using the evidence reports to develop guidelines and other quality improvement tools. Not only is it important to develop guidelines, it is equally important to promote their implementation and to assess their impact on clinical decisionmaking and patient care. This emphasis will be incorporated into the next round of EPC topic selection. Options for encouraging greater partner involvement in translation, implementation, and assessment are being explored. While some partners have initiated efforts to promote and evaluate the use of their guidelines and quality improvement tools, it is often difficult for professional associations to find the financial resources for these kinds of activities.

- AHRQ awarded a grant to collect baseline data for evaluating the impact of guidelines developed by the American Society of Clinical Oncology/American Society of Hematology (ASCO/ASH) **based on the *Uses of Epoetin in Oncology* Evidence Report.** The investigators have surveyed practicing clinician members of ASCO and ASH to assess patterns of EPO use prior to the dissemination of the ASCO/ASH guideline. They intend to submit a subsequent grant application to assess the impact of the introduction of the guidelines.

- AHRQ funded a project on the use of the evidence report on Management of Uterine Fibroids. As a first step in assessing the impact of the evidence report, this project will determine the degree to which clinicians informed about best evidence make global judgments consistent with the **evidence-based decision model developed in the evidence report**. Validation of the decision model will facilitate the adoption of evidence-based practices for the management of uterine fibroids.

- As part of an initial evaluation of the AHRQ Evidence-Based Practice Center (EPC) Reports, a survey was conducted of potential users of the EPC evidence reports. The survey population included quality improvement organizations, health care providers, third-party payers/managed care plans, health-related schools, health-related professional associations, government organizations, and government research agencies. The contractor conducted interviews with representatives of organizations that have collaborated in the development of EPC evidence reports, including topic nominators/partners, technical experts, and peer reviewers. The survey was conducted three months after the release of the first evidence reports to provide an early look at the potential market for these products. Selected key findings include:

1.Of those surveyed, 34 percent indicated that they had or would use the EPC report that was mailed to them as part of the survey. In addition, 53 percent of the respondents said they had used or planned to use another EPC report. Details of this use are now being collected.

2.The most common reason given for not using a report was that it was not relevant to their activities.

3.The most common reason for using the EPC reports were for education of health professionals and the development of guidelines. Other reasons given for using the reports included making coverage decisions, creating patient education materials, assessing health care quality, and improving one's own clinical practice.

4[th] Indicator: At least 3 examples of how research informed changes in policies or practices in other Federal agencies. (Baseline under development.)

Results: Examples based upon AHRQ-sponsored programs include:

HCUP Data

Agency staff are working with NIH to provide HCUP data for a decision that will be made this fall about disseminating rotavirus vaccine to developing countries. From October 1998 to July 1999 rotavirus vaccine was used in the United States to prevent infant diarrhea. The vaccine was withdrawn from the market after it was linked with intussusception, a potentially life-threatening complication. Unfortunately, preliminary reports about the link with intussusception were dramatized and misunderstood to a degree that some believe there actually was a large vaccine-attributable increase in intussusception rates during the vaccination period. These circumstances have created a difficult climate for re-considering the rotavirus vaccine for use outside the U.S. This is unfortunate as this vaccine has the potential of reducing childhood mortality due to diarrheal diseases dramatically if used widely in developing countries. It is estimated that half a million lives could be saved with use of the rotavirus vaccine. The Agency is providing HCUP data for 1997-1999 to help estimate the impact of the vaccine on intussusception rates in 5 states in which rotavirus vaccine was widely used.

In addition, AHRQ supports two studies conducted by Richard Zimmerman (Univ Pittsburgh) to understand the causes of low childhood immunization rates. A focus of the work has been an evaluation of why children are referred from private practices to public clinics for vaccinations (with attendant risks of lower immunization rates due to fragmented care and longer windows of inadequate vaccination). While the insurance status of the child turned out to be the major determinant, the effect of being uninsured was greatly reduced if the physician's office received free vaccine supplies through the Vaccines for Children Program (VFC). The VFC is administered by the CDC, and Zimmerman's study has bolstered support for this program.

MEPS Data

The Agency's design for the MEPS Nursing Home Component Questionnaire informed the design of the MCBS sponsored by HCFA.

AHRQ's research related to the design and implementation of the MEPS Insurance Component resulted in the best estimates of employer contributions to health insurance coverage costs that were adopted by the Bureau of Economic Analysis to inform the national estimates of the Gross Domestic Product (GDP)

Evidence Based Practice Centers (EPCs)

In August, 2000, AHRQ signed an inter-agency agreement with the NIH Office of Medical Applications of Research (OMAR) to increase the scientific rigor of the Consensus Development Conference process, and to more effectively communicate evaluative summaries of the quality of research evidence to the medical research community, by routinely relying on scholarly input from the Evidence-Based Practice Centers (EPCs) on topics to be addressed at NIH Consensus Development Conferences and State-of-the-Science Conferences. The first EPC evidence report will be developed on Clinically Inaparent Adrenal Mass, for an NIH State-of-the-Science Conference to be held in early 2002. Other reports will be prepared on the role of Endoscopic Retrograde Cholangiopancreatography (ERCP) in Clinical Practice for a State-of-the-Science Conference to be held in December, 2001, Antisocial and Related Problem Behaviors for a Consensus Development Conference in April, 2002, and Management of Cancer-Associated Pain, Depression, Nausea, and Other Related Symptoms for a Consensus Development Conference in April, 2002.

Quality Interagency Coordination (QuIC) Task Force

AHRQ has taken a lead role in the QuIC Task Force efforts to address medical errors and patient safety in the U.S. Medical error and patient safety aren't well understood by most Americans. When the need for vital or risky health services occurs, patients want to believe that someone else has made sure the care they receive is safe. Sadly, every hour, 10 Americans die in a hospital due to avoidable errors; another 50 are disabled. As part of its efforts to improve patient safety and reduce medical errors, the QuIC Task Force has published *Five Steps to Safer Health Care*. The five steps were distilled from an earlier AHRQ publication, "20 Tips to Reduce Medical Errors." Those evidence based recommendations provide patients with guidance on how to improve their safety and have been widely adopted across the government through the QuIC. The OPM has included them in this years health benefits brochure and you can see them on the Web site at http://www.opm.gov/insure/health/five_steps.htm

5ᵗʰ Indicator: AHRQ will report on the extent to which CONQUEST assists those who are charged with carrying out quality measurement and improvement activities and the extent to which it helps further state-of-the-art in clinical performance measurement. (Baseline will be established by the evaluation study.)

Results: AHRQ has funded an evaluation of CONQUEST. The evaluation, completed in FY 1999, indicated CONQUEST needs to be available on the Internet to be maximally useful. In FY 2000, AHRQ initiated a feasibility study to determine how to effect this transition, and in FY 2001 the Agency will release a RFC to accomplish this.

6ᵗʰ Indicator: CAHPS® has assisted the Health Care Financing Administration (HCFA) in informing Medicare beneficiaries about their health care choices. The use and

impact of this information is determined by surveying a sample of these beneficiaries.

Results: In a controlled study HCFA evaluated the impact of the information CAHPS provides in bulletins and the handbook, Medicare & You, about the performance of health plans on beneficiaries' confidence in their choice of plan and their use of such information. Findings showed, that beneficiaries who received this information were more confident in their choices, indicating that choosing a plan was made easier for them, and that they used the information to confirm their choice of plan. A journal article will be published in the Journal of Health Services Research in July 2001.

7th Indicator: At least one quality measure from Q-span (or instances where AHRQ research contributes to the development of measures) are used in the Health Plan Employer Data Information Set (HEDIS) by the National Committee for Quality Assurance (NCQA), measurement activities of the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) or other organizations monitoring health care quality. (Baseline in FY 1998 –   One quality measure adopted and one instance of AHRQ-sponsored research contribute to adoption of measures.)

Results: The Achievable Benchmarks of Case (ABC) system of performance profiling, is now adopted by many of HCFA's PROS (from the Kiefe Qspan project) as part of their response to the 6th SOW. The ABC system will be used for quality improvement efforts over the next two to three years with results becoming available at that time.

Objective 4.3:   Evaluate the impact of MEPS data and associated products on policymaking and research products.

1st Indicator: Use of MEPS data in 1% of research applications received by AHRQ.

Results: AHRQ periodically issues program announcements to solicit applications for extramural grants. A program announcement was released on June 22,2000 to solicit applications pertaining to priority interests of AHRQ (health outcomes, quality measurement, access/use/cost). The solicitation encourages the use of MEPS data. Of 684 research applications received by AHRQ in FY 2000, 32 (4.7%) included the use of MEPS data. 10 (31%) of the 32 applications containing MEPS data were actually funded.

2nd Indicator: Distribution of MEPS data sets to at least 2500 requestors.   Baseline in FY 1998 – 916 data sets downloaded from Web site. 1000 CD's distributed at conferences and other venues.

Results: Over 5,700 MEPS data files were downloaded from the MEPS Web site in FY 2000 (a 500% increase over the baseline of 916 downloads established in FY 1998). An additional 379 CD ROM's containing MEPS data were distributed via the AHRQ clearinghouse.

3rd Indicator: At least 5 examples of how research using MEPS has been used to inform decisions by Federal, state, and private sector policymakers.

Results: In FY 2000, the expertise of AHRG staff was utilized in providing technical assistance to numerous public and private groups as they used MEPS data to initiate and implement healthcare-related projects. The following are examples of how the MEPS data were used to inform the activities of a diversity of groups:

- MEPS data were used to establish a baseline measure for healthy people 2010 objective on oral health and preventive dental visits.

- MEPS data were used as supporting evidence for a GAO analysis on oral health.

- MEPS data were used to inform the DHHS Report to the president on Prescription Drug Use, Coverage, Spending, Utilization, and Prices. The MEPS data were particularly useful for comparing estimates of prices paid for drugs by elderly and non elderly persons with and without health insurance for prescribed medications.

- MEPS data were used to validate and benchmark the Hay Group Actuarial Model used to produce estimates of the costs of mental health parity for a recently released NIMH report to Congress and in testimony by Steven Hyman, MD, Director NIMH at a Senate hearing in May 2000.

- Data from the MEPS-IC were used by the Bureau of Economic Analysis to derive revised Gross Domestic Product Estimates for 1997 through the first quarter of 2000.

- MEPS data were used as part of a comprehensive study on chronic illness by investigators at the Johns Hopkins School of Public Health, the national program office for the Robert Wood Johnson Foundation's National Public Engagement Campaign on Chronic Illness, to create a profile of the population living with chronic illness.

- MEPS data were used in several tables in a study conducted for the Health Insurance Association of America (HIAA) on employment-based health insurance coverage produced by researchers at the Center for Risk Management and Insurance Research at Georgia State University.

- MEPS data were used by AARP to estimate national health expenditure rates for the elderly.

- MEPS data were used to provide information on days lost from work due to children's illnesses in estimating the indirect costs associated with pediatric acute conditions

- MEPS data were used in a Penn State University project to assess policy options for Medicare buy-in or other incremental reforms for the population near 65.

- MEPS data were used by the Western Psychiatric Institute and Clinic to examine service utilization and costs associated with depression.

- MEPS data used to inform special tables on Insurance Component data for the state agency, Massachusetts Division of Health Care Finance & Policy.

- MEPS data were used to provide Blue Cross Blue Shield of Alabama with regional level estimates of out-of-pocket expenses for health care for the elderly.

- MEPS data were used by NBC Nightly News with Tom Brokaw to estimate how much is spent on out-of-pocket expenditures by individuals not covered by the government or their own insurance policy.

- MEPS data were related to facilitating analyses of health systems for American Indian/Alaska Native (AA/AN) populations in a presentation at a conference co-sponsored by HCFA and IHS held in Denver, Colorado on September 6-8, 2000.

4[th] Indicator: Feedback from recipients of MEPS data indicating that the data were timely, useful, and of high significance. (Baseline under development).

Results: The Consumers Union contracted with Lewin and Associates to analyze the distribution of health care expenditures across the United States. This analysis was based on the 1996 MEPS. The Director for Policy at Consumers Union sent a letter to the director of AHRQ with a note indicating how useful and timely the MEPS data have been to Consumers Union.

GPRA Goal 4 – FY 2001 and 2002 Indicators		
Objective	**FY 2001 Indicator**	**FY 2002 Indicator**

Objective 4.1: Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care.	***Evidence-based Practice Centers*** Use of evidence reports and technology assessments to create quality improvement tools in at least 10 organizations. Budget: Commitment Base	Evaluate the impact of the CERTS program in disseminating information regarding therapeutics to at least 3 health care providers or others in order to improve practice. Budget: Commitment base
	For at least four evidence reports or technology assessments per year, work with partners to measure how the reports or assessments were used and what impact they had on clinical decisionmaking and patient care. Budget: Commitment Base	Evaluation to determine whether AHRQ funded studies in methodological development have been effective in developing at least 3 new research techniques, whether the techniques are being implemented, and how these studies could be improved. Budget: Commitment base
	Findings from at least 3 evidence reports or technology assessments will effect State or Federal health policy decisions. Budget: Commitment Base	Evaluation of the outcomes of the pharmaceutical studies the Agency has funded to assess impact. Budget: Commitment base
	Use of evidence reports or technology assessments and access to NGC site informed organizational decision making in at least 4 cases and resulted in changes in health care procedures or health outcomes. Budget: Commitment Base	Interim assessment of the impact of the management system for tracking project profiles. Budget: Commitment base
	Research At least 3 examples of how research informed changes in policies or practices in other Federal agencies. Budget: Commitment Base	Qualitative review by experts of results of one major research initiative to assess quality and productivity and potential impact. Budget: Commitment base
	Quality Measures -Achievable Benchmarks of Care are used for quality improvement activities by Peer Review Organizations. Budget: Commitment Base -Use of dental measures by dental service and insurance organizations. Budget: Commitment Base	Identify at least 5 private sector uses of AHRQ findings, and describe any assessment of the impact on clinical practice and/or patient care. Budget: Commitment base

Objective 4.1	HCUP quality indicators incorporated into efforts by hospital associations and hospitals to improve the quality of care.	***Evidence-based Practice Centers***
		• Use of evidence reports and technology assessments to create quality improvement tools in at least 10 organizations.
	National Guideline Clearinghouse At least 10 users of the National Guideline Clearinghouse will use site to inform clinical care decisions. Budget: Commitment Base	• For at least four evidence reports or technology assessments per year, work with partners to measure how the reports or assessments were used and what impact they had on clinical decision making and patient care.
	Guideline development or quality improvement efforts by users will be facilitated through use of NGC in at least 5 cases. Budget: Commitment Base	• Findings from at least 3 evidence reports or technology assessments will effect State or Federal health policy decisions.
	NGC information will be used to inform health policy decisions in at least 2 cases. Budget: Commitment Base	• Use of evidence reports or technology assessments and access to NGC site informed organizational decision making in at least 4 cases and resulted in changes in health care processes, quality, or health outcomes.
	Improvements in clinical care will result from utilization of NGC information in at least 3 cases. Budget: Commitment Base	
	Training Programs 2/3 of former pre- and postdoctoral institutional award trainees are active in conduct or administration of health services research. Evaluation results to date show: • 76% (of respondents) embark on a research or research administration career upon completion of training; • 57% are actively involved in a research grant or contract; and • 75% have had at least one publication. Budget: Commitment Base	

Objective	FY 2001 Indicator	FY 2002 Indicator
Objective 4.2 Evaluate the impact of MEPS data and associated products on policymaking and research products.	Use of MEPS data in AHRQ research applications will increase by 10 percent over number received in baseline period of 2000 Budget: Commitment Base Feedback from MEPS workshop participants indicating that they were useful and timely. Budget: Commitment Base At least 5 examples of how research using MEPS has been used to inform decisions by Federal, state and private sector policymakers. Budget: Commitment Base	Have a fully functional MEPS-based MEDSIM model to allow simulation of the potential impact of programmatic changes in health care financing and delivery Dec 2002. Budget: Commitment base – Produce baseline FY statistics on number of MEPS-based articles published in peer review journals. Budget: Commitment base – Conduct customer satisfaction survey for MEPS workshop participants to assess how MEPS data is being used to inform research and public policy. Budget: Commitment base – Develop marketing plan to promote the MEPS-IC data to state officials Dec 2002. Budget: Commitment base – At least 5 examples of how research using MEPS has been used to inform decisions by Federal, state and private sector policymakers.

> **GPRA GOAL 5:** Support of initiative to improve health care
> Quality through leadership and research. (HCQO)

Strategy **Quality Interagency Coordination Task Force (QuIC)**

The President mandated the establishment of the Quality Interagency Coordination Task Force (QuIC) as a vehicle for promoting collaboration among the Federal Agencies with health care responsibilities to improve the quality of care in America. The Secretaries of Health and Human Services and of Labor co-lead this activity and the AHRQ Director serves as operating chair. The QuIC is working to improve patient and consumer information, quality measurement systems, the workforce's ability to deliver high quality care, and the information systems needed to support the analysis of the care provided. Input gathered through these coordinated activities contributes significantly to the development of quality-related research conducted and sponsored by AHRQ.

Types of Indicators Process and output.

Use of Results by AHRQ The QuIC provides AHRQ with opportunities to further two major Agency goals. (1) In working with the Federal agencies that provide and/or purchase health care for millions of Americans, AHRQ is learning what major users of health services research on quality, evidence-based medicine and other topics need. This provides AHRQ with an invaluable source of real-time user input and directly influences the Agency's research agenda and product development. (2) The QuIC provides AHRQ with unparalleled opportunities to advance its *Translating Research Into Practice* agenda. The Agency is able to inform the Federal health care community about the existence of research and products that currently are in the portfolio and are relevant to the issues the community is wrestling with.

Data Issues: The results for these indicators are largely completed work products and success in meeting project milestones. As the Director of AHRQ is the QuIC operational chair the AHRQ Coordinator for Quality Activities is assigned to monitor progress of the various workgroups and maintains to all the pertinent data. The majority of the work products of the group are available upon completion to the public. Beginning in February 2000, the QuIC website will be operational at www.QuIC.gov.

> **GPRA Goal 5 – FY 2000 Results**

Objective 5.1: **Conduct research to help to measure the current status of health care quality in the Nation.**

1st Indicator: Data sources identified that will contribute information as part of the mosaic picture of quality of care in the Nation.

Results: A committee at the Institute of Medicine will make final recommendations to AHRQ for data sources in their report in March 2001.

2nd Indicator: Develop and begin to test some questions to be added to the existing data collection activities to provide a better picture of quality.

Results: MEPS has been expanded to include survey items related to consumer assessments of their health care and the care of children with special health care needs. The survey is being fielded throughout FY 2001 with results available in February 2002.

3rd Indicator: Develop a framework for the National Healthcare Quality Report.

Results: The IOM, working under a contract with AHRQ, developed a vision and framework for the National Quality Report. The final report from the committee, *Envisioning the National Health Care Quality Report*, was made available on 30 March 2001.

4th Indicator: Provide leadership for the Executive Branch's Quality Interagency Coordination Task Force (QuIC)

Results: Since the beginning of FY 2000, its 2nd year of activity, the Quality Interagency Coordinating Committee (QuIC), for which AHRQ serves as the operating chair, has had major accomplishments and has progressed on several of its longer term projects. QuIC also has initiated work that will be fruitful in the next few months. Its three major accomplishments are:

Efforts to reduce medical errors.
In late 1999, QuIC was charged with developing a response to the Institute of Medicine's (IOM) landmark report, To Err is Human: Building a Safer Health System. The QuIC response to the IOM report, Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact, was delivered just 2 months later. It describes more than 100 actions that the QuIC and its participating agencies can take, either alone or in concert with the private sector, State and local governments. The QuIC agencies have already begun work on these actions.

Discovering what is needed to improve patient safety.
In its report to the President, the QuIC described its plan to foster broad discussions on errors and safety improvement. One concrete step the QuIC promised was to conduct three national summits --- one to identify the priority areas for research, one to showcase practices that are effective in reducing errors, and one to focus on drugs and medical devices. AHRQ took the lead for the QuIC in organizing the first of these National Summit on Medical Errors and Patient Safety Research on September 11, 2000 in Washington, DC, with the. This summit provided an opportunity for consumers, health care professionals, health care delivery organization leaders, purchasers, policy-makers, and others to tell Federal research funding agencies and private foundations what research is needed into medical errors and how to prevent them. A follow-up summit occurred November 30, 2000.

Improving Depression Diagnosis and Care.
There is substantial research showing that the diagnosis and treatment of people with mild to moderate depression could be greatly improved. The VA and DoD identified depression as an area in which they needed a guideline for.
Through the QuIC, other Federal agencies were invited to participate in developing a guideline for use by their clinicians in the diagnosis and treatment of people with mild to moderate depression. Research agencies, such as the National Institutes of Health, AHRQ and SAMHSA, supplied compelling scientific evidence that DoD, VA, and the other agencies use to create a guideline. It is circulating for review. After the review, it will be made publicly available. One of the final steps needed to convert this work to improved care is to marry performance measures to the guideline. The measures will allow the VA and DoD to track whether the care for people with depression is improving. The QuIC organized an expert meeting at the end of September, 2000, to determine which are the best measures currently available for monitoring performance and to establish a research agenda for creating a more enduring set of critical measures.

Information on Measures of Quality.
A goal of the QuIC is to ensure that the Federal agencies are using common quality measures and risk adjustment methods whenever possible. These steps help to reduce reporting burden for health care providers and increase our ability to compare performance across providers. The QuIC has created a compendium of all of the quality measures currently in use by Federal agencies, and this information will be available through a National Measures Clearinghouse Web site that is under development by AHRQ.

A Glossary of Commonly Used Terms.
To reduce the chance of confusion by using the same terms to mean different things in our public communications, or vice versa, an initial set of terms was developed and accepted for use by the QuIC agencies. Additional terms are under discussion.

Guidance for Producing Public Reports on Quality.
To inform report card producers about what is effective for reaching people, the QuIC agencies have brought together researchers and report card producers to develop guidance based on scientific evidence and reported experiences. This information is being made available on a new Web site that will be launched this fall called www.talkingquality.gov.

Coalescing around public messages to enhance safety.
Just as with the other efforts to enhance communications, efforts to speak with the public about medical errors need to be coordinated to reduce the confusion and enhance progress. The IOM spoke to the need to inform the public in its report, *To Err is Human*. Under the leadership of the Office of Personnel Management (OPM) and the Health Care Financing Administration (HCFA), the QuIC agencies are working to articulate and disseminate public messages on errors. Working with the Department of Labor's Health Benefits Education Campaign, the QuIC developed five core messages, based on scientific evidence, that all QuIC agencies and interested private purchasers can use to promote public behavior to reduce medical errors. The QuIC is sharing these research-based messages with other purchasers, providers and the mass media, and they have been well received.

Objective 5.2:   **Facilitate use of quality information to improve health care in the Nation**

1ˢᵗ Indicator: Development of at least one tool that can be used by large group purchasers in assisting their beneficiaries to choose the health care plan, provider, or hospital that best meets their needs.

Results: An SBIR that is still in progress, called "Value Based Purchasing: education Small Employers by Abacus Risk Management Technologies, LLC. This project was one of 4 Phase I projects funded in FY 1999 under the topic assisting Small Businesses with Value-based Purchasing and was the only one selected for a Phase II funding. This Phase II project began on Aug 6, 1999 and is due to be completed on August 5, 2001.

AHRQ, working with QuIC partners, have developed a Web-site for consumers, www.talkingquality.gov, that is being beta-tested for release in Spring 2001.

AHRQ has also funded a SBIR project which provides Web-based decision aid for Medicaid-eligible individuals in Florida. This will be released in FY 2001.

Objective 5.3:   **Improve quality measurement**.

1ˢᵗ Indicator: Sponsor research to fill existing gaps in quality measures in areas of high need.

Results: Working with grantees, AHRQ has developed survey items related to consumer assessments of their children's health care with the data published by NCQA in FY 2000 available on the Internet at www.ncqa.org,   A tool for children with special needs, described below, will be fielded in FY 2001 with results available in FY 2002.

Questionnaire for Children with Special Health Care Needs
In the beginning of 1999, the CAHPS team began working with the Child and Adolescent Health Measurement Initiative (CAHMI) to develop a questionnaire to assess the quality of care given to a neglected segment of the population: children with special health care needs (CSN). Thus far in 2000, we have collaborated with the CAHMI in: a) development and testing of a screener to identify CSN; b) creation of items to assess quality of care; and c) draft implementation and scoring instructions. The Committee on Performance Measurement of the National Committee for Quality Assurance approved this measure for inclusion in HEDIS in October 2000.

Objective	FY 2001 Indicator	FY 2002 Indicator
Objective 5.1: Conduct research to help to measure the current status of health care quality in the Nation.	QI Taxonomy meeting held under the auspices of the QuIC Budget: Commitment Base Number of grants and contracts funded in FY2001 that will help to fill gaps in the information available to assess the national quality of care, or will help to expand the use of current measures to provide a broader or richer picture of quality.	Integration of at least one private sector data source into the national quality report by 31 December 2002. Budget: Commitment base

Objective	FY 2001 Indicator	FY 2002 Indicator
Objective 5.2: Facilitate use of quality information to improve health care in the Nation	Number of grants to improve patient safety Users adopt Agency sponsored research and tools developed with user input to facilitate consumer/purchaser decision-making about quality. Budget: Commitment Base	Funding of at least one SBIR project bringing healthcare information to the public in an understandable, user friendly manner which facilitates its use in decision making. Budget: Commitment base

Objective	FY 2001 Indicator	FY 2002 Indicator
Objective 5.3: Improve quality measurement	Identification of collaborators for research projects on electronic medical records integrated with guidelines (e.g., from the Guideline Clearinghouse). Identification of collaborators for research projects on QI measures (e.g., CONQUEST, QI Taxonomy project, HCUP measures). Budget: Commitment Base Adoption of Living With Illness children's health measure by NCQA. Budget: Commitment base	Adoption of at least one quality measure from our vulnerable populations RFA by a national accrediting organization. Budget: Commitment base

2.2 Budget Line (2) -- Medical Expenditure Panel Surveys (MEPS)

Funding Levels: FY 1999 $29,300,000 (Actual)
FY 2000 $36,000,000 (Enacted)
FY 2001 $40,850,000 (Appropriation)
FY 2002 $48,500,000 (President's Budget)

This budget line reflects AHRQ funding for the data collection and related activities conducted through the Medical Expenditure Panel Surveys.

GPRA Goal 6:   Produce and release information from MEPS on health care access, cost, use, and quality.

Strategy   AHRQ's Medical Expenditure Panel Surveys collects detailed information regarding the use and payment for health care services from a nationally representative sample of Americans. No other surveys supported by the Federal Government or the private sector provide this level of detail regarding: the health care services used by Americans at the household level and their associated expenditures (for families and individuals); the cost, scope, and breadth of private health insurance coverage held by and available to the U.S. population; and the specific services that are purchased through out-of-pocket and/or third-party payments.

This level of detail enables public and private-sector economic models to develop national and regional estimates of the impact of changes in financing, coverage, and reimbursement policy and estimates of who benefits and who bears the cost of a change in policy. No other survey provides the foundation for estimating the impact of changes on different economic groups or special populations of interest, such as the poor, elderly, veterans, the uninsured, or racial/ethnic groups.

AHRQ will continue to assess the essential components of the MEPS program – development of new, updated, or otherwise enhanced databases; creation of products for use by researchers and policymakers outside AHRQ; and facilitation of the use of MEPS-related products.

Types of Indicators: Process and output

Use of Results by   The results provide the Agency with a thorough review of AHRQ's data collection and development activities and release of data products and publications associated with MEPS database. AHRQ uses the results for the management of the program.

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Data Issues:	Many of these indicators are yes/no indicators where the data collection or product release happened as scheduled, or didn't. The evidence of successful completion of the indicators will be available on the AHRQ web site, where products can be accessed. Other data will come from contract monitoring files. Where deadlines have been missed, the Agency determined the cause for the delays and is making the necessary corrections. Beginning with the FY 2000 performance report, AHRQ includes the results of evaluations in Section 4.2 of the use of the MEPS products.

GPRA Goal 6 – FY 2000 Results

**Objective 6.1:	Release and disseminate MEPS data and information products in timely manner for use by researchers, policy makers, purchasers, and plans. *(MEPS).***

1st Indicator:	Core MEPS public use files (PUFs) available through Web site and CD-ROM within 9-18 months after data collection completed.

Results:	The MEPS has three core data products: MEPS-HC Point-in-Time files, Insurance Component (IC) tables, and full-year expenditure files. In FY 2000, two of these core files (point-in-time and IC) were available on the MEPS web site and on CD-ROM within 12 months of the end of data collection. The full-year 1996 MEPS expenditure file was available on the MEPS web site 2 years after the end of data collection. Plans are in place to reduce the time lag in producing expenditure files for future years.

2nd Indicators:	Specific products due in FY2000:

- 1999 point-in-time file
- 1997 expenditure data available
- 1996 full panel file available

Results:	
- The 1999 point-in-time file was released in July 2000.
- The 1997 expenditure data file was complicated by data base construction difficulties, and departure of key contractor staff. It is anticipated to be released in the first quarter of 2001. However, an additional file containing 1997 insurance and demographic information was fast-tracked and release in November 2000.
- The full-year 96 MEPS-HC file was released in December 1999.
- In addition, the 1996 event files were released in January 2000.

3rd Indicator:	Customer satisfaction data from use of MEPS tapes and products rated at least 90%.

Results:	In FY 2000 MEPS staff conducted four workshops to help researchers use and understand the MEPS data. 143 of 159 (90%) of workshop participants indicated that they were highly satisfied with the MEPS workshop that they attended.

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4ᵗʰ Indicator: Response time for requests received from policymakers, purchasers and plans for MEPS data tapes, analyses, and/or reports responded to within promised time frames 95% of time. (Baseline: 100% responded to within 5 days).

Results: In FY 2000 AHRQ staff responded to 670 user requests for technical assistance. 96% of all user requests were responded to within 4 working days.

Objective 6.2: **Facilitate use of MEPS data and associated products as tools by extramural researchers, policy makers, purchasers, and plans.**

1ˢᵗ Indicator: Data centers operational
- requests for use of the centers
- user-days at the data centers
- projects completed

These are the categories AHRQ will track in the beginning of the data centers program to illustrate that the program has been established successfully and is fully operational. Baseline to be established in FY 01 when the data centers program begins.

Results: Due to delay in implementing a secure AHRQ LAN, opening of the data centers was deferred to Jan 2001.

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Objective 6.3: **Modify and enhance MEPS to enable reporting on the quality of health care in America.**

1ˢᵗ Indicator: The design decisions necessary for the expansion of MEPS databases in order to collect data that will support the National Healthcare Quality Report are completed by August 2000. The design decisions will be operationalized in the coming fiscal years.

Results: **Available Data in MEPS to Support Quality of Care Analyses at the National Level**
All design enhancement decisions to modify the Medical Expenditure Panel Survey (MEPS) to facilitate collecting data to inform the National Healthcare Quality report were completed by August 2000.

The Medical Expenditure Panel Survey was designed to produce national and regional annual estimates of the health care utilization, expenditures, sources of payment and insurance coverage of the U.S. civilian non-institutionalized population. The MEPS includes a survey of medical providers, to supplement the data provided by household respondents. The design of the MEPS survey permits both person based and family level estimates.

The MEPS collects data on the specific health services that Americans use, how frequently they use them, the cost of these services and how they are paid, as well as data on the cost, scope, and breadth of private health insurance held by and available to the U.S. population.

The data currently collected from MEPS will support quality of health care research directed to the following broad areas: access to care, patient/customer satisfaction, health insurance coverage, health status, health services utilization and expenditures. For the access to care measures, national estimates of the population with a usual source of care, and by site of care, can be derived from the survey in addition to estimates of the percent of families with members experiencing difficulty or delay in obtaining health care, or not receiving needed care. The survey also permits the derivation of national estimates of satisfaction with one's usual source of care and continuity of care.

Inclusion of Additional Questions in a MEPS Self Administered Questionnaire (SAQ) to Measure Quality of Care and Patient Satisfaction for Year 2000 and in a Parent Administered Questionnaire (PAQ) to Measures Parent Satisfaction With Their Children's Health Care

The selection of a core set of questions that measure quality of care and patient satisfaction was governed by the need to adopt measures that were carefully tested and validated, to insure the collection of meaningful and reliable information. Consequently, a subset of questions that were developed for the Consumer Assessments of Health Plans Study (CAHPS) were selected for inclusion in a self-administered questionnaire (SAQ) in the MEPS to measure several dimensions of healthcare quality and patient satisfaction.

Set of medical conditions to be given special emphasis for planning the MEPS health care quality enhancements

The planned MEPS healthcare quality enhancements call for a significant household survey sample expansion of individuals with certain illnesses of national interest in terms of patient satisfaction with care received, the quality of the care and the burden of disease. The intent of this planned enhancement was to permit more focused analyses of the quality of care received for these special populations. In order to move forward with sample design analyses and MEPS questionnaire design modifications according to schedule, it was necessary to finalize the set of medical conditions that would be given special emphasis with respect to health care quality measurement and patient satisfaction.

A set of formal criteria were established to guide the decision making process regarding the selection of the set of medical conditions that were to be given special attention for implementing the planned MEPS healthcare quality enhancements. More specifically, the selection decision was based on an evaluation of conditions using the following criteria:

- Sufficient prevalence to support reliable estimates,
- Availability of diagnostic questions used in other national surveys,
- Accuracy of household reported conditions,
- Availability of evidence-based quality measures, and
- Level of medical expenditures for treatment of the condition.

Based on the review of the criteria under consideration, it was recommended that the following medical conditions be given special attention for implementing MEPS healthcare quality enhancements: Diabetes, Asthma, Hypertension, Stroke, Ischemic Heart Disease, Arthritis, and COPD . It should be noted that the selection of diabetes and ischemic heart disease as targeted conditions also cover two

clinical areas that are the focus of the disparities agenda (i.e., diabetes, cardiovascular disease).

Sample Enhancements

Balancing the tradeoffs between precision and cost, the design recommendation was to increase the number of PSUs for the 2001 MEPS back to 195 PSUs. This design modification has the following attractions :

- It will permit the greatest flexibility in sample selection for improving the sample yields of individuals with the targeted conditions;
- It will yield significant improvements in the precision of survey estimates relative to the current MEPS design (100 PSUs) and equivalent sample size specifications;
- It is a more appropriate design for survey estimates at the national level that are sensitive to geographic variation (e.g. State, county); the greater dispersion in the household sample should reduce the level of respondent burden in the MEPS Medical Provider Component.

MEPS design recommendation to increase the size of the 2001 sample and method of sample allocation.

The planned MEPS healthcare quality enhancements call for a significant household survey sample expansion of individuals with certain illnesses of national interest in terms of quality of care and burden of disease. The intent of this planned enhancement was to permit more focused analyses of the quality of care received for these special populations and the level of satisfaction with the care received. To further improve the precision of the survey estimates beyond the gains from the increase in geographic areas, in particular for individuals with at least one of the medical conditions given special attention for implementing MEPS healthcare quality enhancements, a decision was made to increase the 2001 MEPS sample by ~3,500 households (responding for all 5 rounds of data collection) to a total sample of 13,500.

Objective	FY 2001 Indicator	FY 2002 Indicator
Objective 6.1: **Release and disseminate MEPS data and information products in timely manner for use by researchers, policy makers, purchasers, and plans. (MEPS)**	In FY2001, 1997 Use and Expenditures, 2000 Point-in-Time, and 1998 Health Insurance and Demographics MEPS public use data files will be released Budget: Commitment Base Response time for requests received for information, assistance or specific products is as promised 95 percent of time. Budget: Commitment Base	– Develop a method to facilitate users' custom cross tabulations of MEPS data. Budget: Commitment base – Conduct 8 MEPS data user workshops. Budget: Commitment base – Expand MEPS list-server participation by 20%. Budget: Commitment base – Produce 4 Findings and at least one Chartbook. Budget: Commitment base – Develop Frequently Asked Questions Section for MEPS web site. Budget: Commitment base

Objective	FY 2001 Indicator	FY 2002 Indicator
Objective 6.2: Facilitate use of MEPS data and associated products as tools by extramural researchers, policy makers, purchasers, and plans.	Establish baseline for Data Center capacity.	– Determine the feasibility of existing mechanisms to provide off-site access to confidential MEPS data. Budget: Commitment base – Expand data center capacity by 10% over FY 01 level. Budget page:

Objective	FY 2001 Indicator	FY 2002 Indicator
Objective 6.3: Modify MEPS to support annual reporting on quality, health care disparities, and research on long-term care in adults and children with special needs.	Data collection begins on the treatment of common clinical conditions over time for a nationally representative portion of the population in support of the National Healthcare Quality Report. LTC Measures: 1.Have developed data use agreements (DUA) with with HCFA to assess and begin data development related to the MDS. 2.Design MEPS over sample of adults with functional limitations and children with special needs. 3. Produce one report related to LTC. 4. Have developed IAA with NCHS for LTC frame development activities. 5. Submit at least one peer-reviewed publication in the area of LTC.	Process and make available data to be included in the National Quality Report. Budget: Commitment base Begin data collection to support the disparities report Sep 2002. Budget page:

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2.3 Budget line 3 – Program Support

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Goal 7:   **Support the overall direction and management of AHRQ** (PS)

This goal involves supporting the overall direction and management of AHRQ through prudent acquisition performance management, capital asset planning, personnel support and information technology planning.

Funding Levels:	FY 1999	$2,341,000(Actual)
	FY 2000	$2,484,000 (Enacted)
	FY 2001	$2,500,000 (Appropriation)
	FY 2002	$2,600,000 (President's Budget)

Types of Indicators: Outcome indicators that document customer satisfaction with two major functions within the Agency are used.

Use of Results by   The scores for each of the measures, in combination with the
AHRQ   written comments received in the survey, continue to be used to improve the acquisition systems and the Intranet.

Data Issues: The data collection is accomplished through customer surveys administered   to Agency staff annually.

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GPRA Goal 7 – FY 2000 Results

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Objective 7.1:   **Provide prudent planning for all capital assets.**
AHRQ included this objective in the plan because we understood we needed to acknowledge this requirement. However, the Agency has no capital assets and didn't include any indicators.

Result: Not Applicable

Objective 7.2:   **Maintain acquisition performance management system to ensure: (1) timely completion of transactions, (2) vendor and customer satisfaction, and (3) efficient and effective use of resources.**

1st Indicator: Internal customer satisfaction rated at minimum of 4.5/5.
Baseline in FY 1999 – 4.4/5.

Results:	Internal customer satisfaction rated at minimum of 4.2/5. (Did not meet target). The last survey conducted by the DCM was FY 98. No survey was conducted in FY 99. Due to a significant change in Program personnel and no formal training or workshops conducted by DCM this fiscal year, the target goal fell short by .3 percentage points. DCM will review its current policies and procedures to identify weaknesses that can be improved and will result in a level of satisfaction that will achieve the internal customer goal and provide our customers with quality service.
2nd Indicator:	External customer satisfaction rated at 4.5/5. Baseline in FY 1999 – 4.0/5.
Results:	External customer satisfaction rated at 4.6/5.
3rd Indicator:	Customer satisfaction survey results assessed and used to implement changes to improve and enhance services.
Results:	A study of the procurement planning process has been conducted. The implementation of the improvements outlined in the report will enhance the services provided by contract staff. A plan for identifying improvements as a result of the customer/vendor satisfaction survey was submitted December 15, 2000 with implementation to follow.

Objective 7.3:	**Continued enhancement and expansion of Agency intranet site to ensure staff have immediate access to all current information. The site covers Agency administrative and operational processes, procedures, and policies. It also covers information on ongoing health care research as well as results and findings from all the research supported by the Agency.**
1st Indicator:	Customer satisfaction rated at minimum of 3.5/4. Baseline in FY 1999 – 3.1/4.
Results:	Internal customer satisfaction rated at 3.2/5.0. Our original target was 3.5 out of 4. When the survey was conducted the base was changed to 5. The change in the base, from 4 to 5, makes comparing this target to the original goal more difficult. However, the lower satisfaction rate did surprise staff. Based on the comments and feedback of this survey, AHRQ has made a variety of large scale changes to the Intranet to improve and enhance services, and increase customer satisfaction. These changes are outlined in the next measure.
2nd Indicator:	Demonstration through customer satisfaction surveys that the daily work of staff has been facilitated by the intranet.
Results:	Use of AHRQ's Intranet facilitated work economies to agency staff in the following manner:

• The AMIS application data base can be queried for information via the Intranet; |

- Individual Centers/Offices have home pages for sharing and disseminating information with the rest of AHRQ staff;
- The Intranet provides a single source location for linking Agency data and program information to all AHRQ employees; and
- Many AHRQ related publication are now available on-line via Intranet access.

3ʳᵈ Indicator: Assessment of customer satisfaction surveys and use of such surveys to implement changes to improve and enhance services as necessary.

Results: The use of customer satisfaction surveys are extremely beneficial to AHRQ, providing the necessary feedback to implement process improvements. The general and specific feedback coming from these surveys have helped AHRQ redesign and redirect our efforts to facilitate the varied needs of our many customers.

Objective	FY 2001 Indicator	FY 2002 Indicator
Objectives 7.1, 7.2, 7.3 (Discontinued) **Objective 7.4: Establish and maintain a secure Agency computer network infrastructure.**	Preliminary policies and procedures for reducing security risks will be developed by the end of FY 2001. Initial criteria for reporting security incidents will be established by the end of CY 2001. Initial procedures for responding to security incidents will be established by the end of CY 2001. Implementation of a Secure Phase 1 LAN for analysis of intramural research and survey data will be completed by end of FY 2001. Implementation of a Phase 1 firewall, intrusion detection and virus control system will be in place by end of CY 2001. Initial security awareness training will begin by end of CY 2001.	Perform initial tests, (periodically, beginning in 2nd quarter of FY 2002) to evaluate the preliminary policies and procedures.

APPENDICES TO THE PERFORMANCE PLAN

A.1   Approach to Performance Measurement

The goals and objectives of the AHRQ performance plan are aligned with the Agency's three budget lines.

Budget Line (1) -- Research on Health Costs, Quality, and Outcomes (HCQO)
Budget Line (2) -- Medical Expenditure Panel Surveys (MEPS)

Budget Line (3) -- Program Support (PS), (the goal associated with this budget line has been dropped in the FY 2001 GPRA performance plan. Please see Appendix A.2. for details.

Performance Indicators

Accurately measuring the outcomes of research programs continues to be a challenge. By its very nature, research is unpredictable. Research activities may or may not yield conclusions that are immediately amenable to application. There can be a considerable time lag between research activities and the outcomes of those activities. Whether and how research findings get used in the health care system is dependent on countless variables over which AHRQ has no control. Another important limitation is the nature of extramural research. AHRQ cannot control what types of applications it will receive, nor what the results will be of the funded research. Thus, AHRQ, like other research agencies, continues to face the challenge of showing the impact of research activities within these constraints.

In order to mitigate these factors, the Agency sets research priorities based on its strategic plan and input from the end users of the research. Program announcements and requests for applications are used to communicate the research priorities to the field. The portfolio of research is managed to contain a mix of short and long term projects. Partnerships are integral to the conduct of AHRQ's work to promote timely application.   More recently, added emphasis has been placed on efforts to translate research into practice to assure impact.

To understand and report on the impact of Agency programs on health care, additional emphasis is being placed on evaluation activities. As a result, the Agency will be able to report on process, output, and interim outcome goals through out the course of its major initiatives. Goal 4, Evaluate the effectiveness and impact of AHRQ research and associated activities, is designed to capture the results of the emphasis on evaluation of impact. In each performance plan, the Agency includes a number of evaluations that illustrate the impact of research products when used to inform consumers, measure quality, and make policy decisions.

Alignment with Committee on Science , Engineering, and Public

Policy (COSEPUP) Report on Evaluating Federal Research Programs[3]

In reviewing the COSEPUP report, AHRQ was pleased to find that many steps taken in recent years to improve Agency evaluation processes and connections to users of Agency reserch are supported by the report's recommendations.

On page 6, the reports points to three types of expert review that are the most effective ways of evaluating federally funded research programs. These are quality review, relevance review, and international benchmarking. Agency staff regularly make presentations to the AHRQ National Advisory Council on major research initiatives. The members provide direct feedback on the quality and relevance of the work. National researchers who make presentations to AHRQ staff provide another form of direct feedback on Agency programs. Finally, as part of AHRQ's commitment to have its research begin and end with the user, expert meetings are held to gather input when planning new initiatives. These meetings provide another venue for national experts to provide feedback on the quality and relevance of work-to-date, as well as advice on directions for the future. While AHRQ does not have a formal benchmarking program, increased involvement of Agency staff with health care improvement efforts in Russia, programs at the World Health Organization, and other international activities are providing valuable input on Agency programs.

On page 38, the report states "In addition, agencies should conduct periodic reviews of the overall practical outcomes of an agency's overall past support of applied and basic research." AHRQ previously has conducted this type of review when developing and implementing next steps for major initiatives. With the advent of annual performance plans, evaluations of the outcomes of Agency investments has become integrated into the core processes of AHRQ evaluation activities. Recently, the Agency completed an evaluation of the outcomes of the outcomes research program. The results of the evaluation are informing the next phase of the outcomes research and other initiatives under development. Goal 4 of each GPRA performance plan presents the evaluation studies that the Agency is using to determine impact Agency research and products are having on the health care system.

AHRQ will continue to improve its performance measurement activities by strengthening, and making more explicit, the connections between current evaluation strategies and those recommended in the COSEPUP report.

Data Collection

AHRQ recognizes that its commitment to accountability will not be achieved easily and that it entails an added investment in measurement as part of all of the Agency's programs. The Agency's approach consists of capitalizing on data collection opportunities as a by-product of the work we do or sponsor, partnering with public and private organizations, and maximizing

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[3] The Committee on Science, Engineering, an d Public Policy, *Evaluating Federal Research Programs, Research and the Government Performance and Results Act*, National Academy Press, Washington, D.C. (1999).

the use of information technology applications. AHRQ will use a variety of data collection methods.

Research Applications - Studies which address the translation of research into practice will be required to include in their design appropriate measures of impact.

Grants Management Databases - AHRQ is investing in the development of an intranet based integrated information management system through which progress on funded grants and their results will be captured as part of routine reporting. A number of yes/no indicators are included in the plan, and they should present few data collection problems thanks to this system.

Information technology - Expanded use of technologies (e.g. intranet, extranets, list-serves, etc...) will permit efficient capturing of important qualitative information on the impact of Agency programs. (One example is objective 3.2, where AHRQ will report on the impact of the User Liaison Program by gathering user stories from attendees on their use of program information in decisionmaking.)

Performance Management System - AHRQ has aligned its employee performance management system with each organizational unit's plan and the Agency plan and incorporated many process and output measures into employee plans. These will be aggregated annually to yield some of the measures in the GPRA plan.

Customer surveys - These are a critical source of information on the appropriateness, use, and quality of AHRQ products and services. This approach is expanded in the 2000 plan. In some instances, the mechanisms for collecting customer service data are already in place and the first set of data has been analyzed, such as with the Publications Clearinghouse. In other instances, the customer surveys must be designed, fielded, and responses analyzed. Because of the substantial financial costs involved, often it will be necessary to survey large representative samples to obtain information on the usefulness, relevance, and quality of AHRQ's work and its associated impact. We will work closely with DHHS both to share our experience and to apply the knowledge and expertise of others. Identifying opportunities for collaborations and/or cost sharing will be a priority. Notations are made within the text of the plan for each measure that will use a survey mechanism.

Partnerships - Many public and private sector organizations collect data on processes of care which AHRQ programs and research are intended to improve. For example, Peer Review Organizations (PROs) have taken AHRQ research findings and recommendations, worked with practitioners and institutions to adopt them, and provided the Agency with feedback regarding improvements in practice. The Health Care Utilization Project (HCUP) database, developed in partnership with 22 states, provides additional insights regarding changes in clinical practice in those states. Another source of information will be the growing number of collaborative research projects that make use of the internal databases of large private sector health care delivery organizations. A rich source of information will be the external organizations that serve as partners for the reports being

developed by the Agency's Evidence-based Practice Centers program. They have made a commitment to implement the reports in a variety of ways and will provide the Agency with data on the utilization and impact of their efforts. By working collaboratively we can meet some of our measurement needs more cost-effectively.

Evaluations - Specifically commissioned studies (both intramural and extramural) will be used to evaluate the impact of AHRQ programs more rigorously. These studies are presented in AHRQ's Goal 4. These studies will evaluate such things as: the effect a product, e.g., a quality measurement tool, had on improving the quality of health care; whether a product that is effective in one care setting can be generalized to other settings, e.g. a clinical decision support system; or whether a product is user friendly and useful. Because these studies will be complicated, resource intensive, and expensive, the Agency will propose a limited number each year.

Other Mechanisms - The Agency has developed a variety of other mechanisms that will enable it to collect information on the impact of its work. These include:

- ► *Research Translation Team* - This group is responsible for capturing and distilling qualitative data on the use of Agency sponsored and conducted research and products in the health care system. Through investigating the details of anecdotal evidence, literature searches, tracing the impact of completed research projects and other methods, AHRQ will compile evidence of the impact that it is having in the health care system.

- ► *Partnership liaison* - AHRQ has assigned a senior staff person to stimulate and coordinate partnerships and liaisons with other organizations within the Federal government, State governments, and the private sector. This will help us identify the uses to which existing research and products have been used, stimulate implementation demonstrations, and identify the need for future research. The creation of this position is part of the Agency's increased efforts to create clear and ongoing mechanisms to obtain input from the user community.

- ► *Conferences and expert panels* - The agency will convene conferences and expert panels to help identify effective methods of translating research into practice and evaluating those methods through demonstrations and other projects. The information gained through these activities will impact the Agency's future research agendas and its translation and dissemination activities.

A.2   Changes and Improvements Over Previous Year

Summary

The basic structure of the AHRQ FY 02 performance plan for FY 02 is unchanged. The titles for Goals Five and Six were revised to simplify the presentation, but the program objectives represented under each goal remain the same.

The indicators presented under each objective were updated to reflect where Agency programs are expected to be in FY 2002. That resulted in output and outcome measures being added, particularly in Goals Three and Four, for programs and research initiatives that are expected to come to fruition during that period.   Additionally, the details of some indicators have changed based on results received in FY 1999.

Detailed Presentation of Goals and Objectives (Indicators can be seen in detail in section 1.4 of this report.)

Goal 1:　　　**Establish Research Needs Based on User's Needs**

00 Performance Objective	01	02	Comments
Objective1.1: Define direction of FY project funding priorities, in large part, by needs assessment activities.	Same	Same	None

Goal 2:　　　**Make significant contributions to the effective functioning of the US health care system through *the creation of new knowledge*.**

00 Performance Objective	01	02	Comments
Objective 2.1: Determine annually the salient findings from research in each of the three areas (outcomes; quality; and cost, access, and use) and develop plan for next steps translation and dissemination.	Same	Same	None
Objective 2:2: Achieve significant findings from AHRQ sponsored and conducted research.	Same	Same	None
Objective 2.3 Implement FY 2000 priority (1) "New Research on Priority Health Issues."	Initiate FY Research Initiatives	Same as 01	The wording changes slightly to make applicable across years.

Goal 3:　　　**Foster translation of new knowledge into practice by developing and providing information, products, and tools on outcomes, quality, and access, cost, and use of care.**

00 Performance Objective	01	02	Comments
Objective 3.1: Promote distribution of AHRQ publications, products, and tools through intermediary organizations.	Maximize dissemination of information, tools, and products developed from research results for use in practice settings.	Same as 01	The FY 00 Objectives 3.1 and 3.2 were consolidated in FY 01 to reduce redundancy.
Objective 3.2: Maximize dissemination of information, tools, and products developed from research results for use in practice settings			
Objective 3.3: Develop and facilitate the use of new tools, talent, products, and implementation methodologies stemming from research portfolio.	Objective 3.2: Develop and facilitate the use of new tools, talent, products, and implementation methodologies stemming from research portfolio.	Same as 01	We have maintained this objective with a different number.

Goal 4:   Evaluate the effectiveness and impact of AHRQ research and associated activities.

00 Performance Objective	01	02	Comments
Objective 4.1: Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care.	Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care outcomes and quality.	Same as 01	Objectives 4.1 and 4.2 have been consolidated in the FY 01 plan
Objective 4.2: Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care outcomes and quality.	Evaluate the impact of MEPS data and associated products on policymaking and research products.	Same as 01	The FY 00 plan inadvertently had two objectives of the same title. That redundancy has been removed. With that exception, the objectives remain the same as FY00.
Objective 4.3: Evaluate the impact of MEPS data and associated products on policymaking and research projects.	n/a	n/a	

Goal 5:   Support initiative to improve health care quality through leadership and research.

00 Performance Objective	01	02	Comments
Objective 5.1: Conduct research to help to measure the current status health care quality in the Nation.	Same	Same	none
Objective 5.2: Facilitate use of quality information to improve health care in the Nation.	Same	Same.	none
Objective 5.3: Improve quality measurement.	Same	Same	none

Goal 6:   Medical Expenditure Panel Surveys

00 Performance Objective	01	02	Comments
Objective 6.1: Release and disseminate MEPS data and information products in timely manner for use by researchers, policy makers, purchasers, and plans.	Same	Same	
Objective 6.2: Facilitate use of MEPS data and associated products as tools by extramural researchers, policy makers, purchasers, and plans.	Same	Same	

00 Performance Objective	01	02	Comments
Objective 6.3: Modify and enhance MEPS to enable reporting on the quality of health care in America as part of FY 2000 Priority (3), "New Tools for a New Century."	Modify MEPS to support annual reporting on quality, health care disparities, and research on long-term care in adults and children with special needs.	Same as 01	The name changed slightly to make the objective more generic from year to year. This objective is where the Agency will note the ongoing and important role that MEPS is playing in measuring national quality.

GOAL 7: **Support the overall direction and management of AHRQ**
Budget line: Program Support

00 Performance Objective	01	02	Comments
Objective 7.1 is manditory (Capital Assets) but not applicable to AHRQ.	Not Applicable	Not Applicable	The measures for objectives 7.1,7.2, and 7.3 are for internal management and do not warrant being reported outside AHRQ.

The measures for 7.1, 7.2, 7.3 also remain in place internally in the Office of Management Operations Plan and employee performance plans for the managers and staff. |
Objective 7.2: Maintain acquisition performance management system to ensre: (1) timely completion of transactions, (2) vendor and customer satisfaction, and (3) efficient and effective use of resources.	Discontinued	Discontinued	
Objective 7.3: Continued enhancement and expansion of Agency intranet site to ensure staff have immediate access to all current information.	Discontinued	Discontinued	
Objective 7.4: Establish and maintain a secure Agency computer network infrastructure.	Same	Same	

A.3 Linkage to HHS Strategic Plan

AHRQ is guided by and supports the strategic plan goals of the Department of Health and Human Services (HHS).

The Agency's activities contribute to five of the six HHS goals.

HHS Goal 2: Improve the Economic and Social Well-Being of Individuals, Families, and Communities in the United States – For example, through the Agency's research on children's health

HHS Goal 3: Improve Access to Health Services and Assure the Integrity of the Nation's Health Entitlement and Safety Net Programs – For example, through the activities of the Agency's Center for Primary Care Research

HHS Goal 4: Improve the Quality of Health Care and Human Services – For example, through numerous Agency activities including quality measurement research and data development

HHS Goal 5: Improve the Public Health System – For example, through the Agency's data development and monitoring activities and investments

HHS Goal 6: Strengthen the Nation's Health Sciences Research Enterprise and Enhance Its Productivity – For example, through the Agency's research, data development, translation, and dissemination activities

A detailed summary of AHRQ's contributions to the HHS strategic plan follows, however, the Agency's contributions to Goals 4 and 6 are of particular note.

AHRQ is the Department's lead Agency for health care quality activities and is a major contributor to Goal 4. Research on the determinants of health care quality, effective and cost effective ways to improve health care quality, and how to measure health care quality will be instrumental in achieving success in the goal's objectives. Additionally, the new information developed, and then implemented in the health care system, from research on outcomes and effectiveness of care, as well as access to, cost, and use of health care, will help close the gaps between what we know and what we need to know, on the one hand, and what we know and what we do in health care, on the other hand. AHRQ also supports HHS Goal 4 through leadership of the quality initiative, support of the Quality Interagency Task Force, contributions to the HHS Race and Health Disparities Initiative, and close working relationships with other HHS Agencies and the Office of the Secretary.

Within Goal 6, AHRQ's expanding portfolio in outcomes and effectiveness, quality, primary care, and other practice-based research, as well as extramural and intramural studies of issues pertaining to access, cost, organization, and delivery of health care, will contribute to achieving

objective 6.4. Additionally, AHRQ's substantial investment in the development of data bases will enable others to perform research and analyses to answer questions critical to understanding the dynamics of the health care system.

AHRQ maintains its commitment to building the infrastructure needed to continue to conduct high-quality, cutting-edge health care research for the next century through national training programs (including the National Research Service Awards program), service fellows and summer intern programs, mentoring programs, and the provision of technical assistance to a variety of its audiences. AHRQ will continue to support and expand efforts to attract trainees from racial and ethnic minorities into the field of health services research. These activities are aligned with Objective 6.6.

For the Nation's investment in research to reach its full potential, the results must be widely disseminated (Objective 6.7) and implemented. The AHRQ Cycle of Research presented in section E.2. of this plan illustrates the important role that dissemination will play in all areas of activity within the Agency. This focus aligns with Objective 6.7.

Examples of AHRQ's Contributions to the HHS Strategic Plan

HHS Goal 2: **Improve the Economic and Social Well-Being of Individuals, Families, and Communities in the United States**

HHS Objective 2.5: Increase Opportunities for Seniors to Have an Active and Healthy Aging Experience

HHS Objective 2.6: Expand Access to Consumer-Directed, Home and Community-Based Long-Term Care and Health Services

AHRQ will conduct research in areas relevant to improving the aging experience in such areas as: 1) conditions of particular importance to the Medicaid population; and 2) quality measurement issues and tool development for institutional settings. In FY 2001, AHRQ will support important new initiative to improve the knowledge and tools to improve health care quality for Older Americans and optimize their functional outcomes.

HHS Goal 3: **Improve Access to Health Services and Assure the Integrity of the Nation's Health Entitlement and Safety Net Programs**

HHS Objective 3.2: Increase the Availability of Primary Health Care Services

To test the effectiveness of health care improvement approaches, AHRQ will study such topics as: 1) the implementation of evidence-based information in diverse health care settings to determine effective strategies for enhancing practitioner behavior change and improving patient behavior, knowledge and satisfaction; 2) the factors which determine the success of

quality improvement strategies and to what extent these vary by the nature of the problem addressed and the target population; and 3) the factors which influence access to primary care services, and transitions between primary and specialty services.

Projects to evaluate the impact of managed care will constitute a systematic effort to determine the impact of managed care and other changes in the organization of care on health care quality; outcomes; and cost, use and access.

HHS Objective 3.3:   Improve Access to and the Effectiveness of Health Care Services for Persons with Specific Needs

AHRQ will examine how various clinical and system characteristics affect the health outcomes, quality access, and satisfaction, for the elderly and chronically ill. In FY 2001, added emphasis will be given to research and tool development to improve care for persons with chronic conditions, including mental health conditions, and disabilities.

HHS Objective 3.4:   Protect and Improve Beneficiary Health and Satisfaction with Medicare and Medicaid

AHRQ activities supporting Medicare and Medicaid beneficiaries will include:
1) research on conditions that are common, costly, and for which there is substantial variation in practice, conditions that represent major Medicare or Medicaid expenditures; 2) providing objective, science-based, timely information to health care decision makers-- patients and clinicians, health system leaders, and policy makers; 3) health care surveys, such as CAHPS® and MEPS, that provide information supporting health plan choices and coverage decisions; 4) new tools to assist beneficiaries to choose the most appropriate care for their needs; 5) new tools to measure and improve quality of life for Medicare and Medicaid beneficiaries; and 4) studying the national impact public programs on access and cost of care for children.

HHS Goal 4:   **Improve the Quality of Health Care and Human Services**

HHS Objective 4.1:   Promote the Appropriate Use of Effective Health Services

AHRQ is implementing a growing portfolio of evaluations that will show over time the outcomes of the investments of Agency funds.   The Agency will evaluate the use and usability of the Medical Expenditures Panel Survey (MEPS) databases for their intended purposes. Other evaluations will assess: 1) evidence reports and technology assessments of evidence-based practice centers; and 2) products that advance methods to measure and improve health-care quality, including clinical quality improvement software (CONQUEST), the Consumer Assessment of Health Plans Survey, and the Expansion of Quality of Care Measures project (Q-SPAN). In FY 2001, added emphasis will be placed on developing the tools, systems, and partnerships that enable quality improvement strategies to be effective in diverse settings, including public providers.

HHS Objective 4.2:   Reduce Disparities in the Receipt of Quality Health Care Services

AHRQ will expand its commitment to conducting health services research that will help reduce disparities that exist for racial and ethnic minorities. In particular, the Agency will sponsor research to understand the contribution that racial discrimination makes to existing patterns of care for minority Americans. The Agency will also focus on building infrastructure for relevant research by training minority and other investigators to address issues for minority populations.

HHS Objective 4.3:   Increase Consumers' Understanding of Their Health Care Options

The Consumer Assessment of Health Plans (CAHPS®) is a tool for surveying members of health plans about their experience with and assessment of the quality of health care they receive, and for reporting the results to other consumers who are choosing a plan. AHRQ will continue its efforts to enhance CAHPS® and evaluate its use. In FY 2001, additional research will be sponsored to better understand how consumers use quality information.

HHS Goal 5:   **Improve the Public Health System**

HHS Objective 5.1:   Improve the Public Health Systems' Capacity to Monitor The Health Status and Identify Threats to the Health of the Nation's Population

AHRQ will develop a fully integrated strategy to create the national capacity to monitor the quality of care, particularly for populations of national interest, including the chronically ill, poor, racial/ethnic minorities, and children. This includes an increase in the scope of the *Medical Expenditure Panel Survey* (MEPS), partnerships with other Federal Agencies and the private sector.

AHRQ will complete the redesign and expansion of the Healthcare Cost and Utilization Project (HCUP) providing state and community decision-makers a powerful set of linked databases they can use to monitor the impact of major system changes on access, quality, outcomes and cost in their states and communities, and to compare these against the progress of other states and communities.

AHRQ will build on past investments in tool development by focusing on expanding the toolbox. These tools will enable purchasers, policymakers, health plans, providers, and patients to improve care.

Goal 6:   **Strengthen the Nation's Health Sciences Research Enterprise and Enhance Its Productivity**

HHS Objective 6.2:   Improve the Prevention, Diagnosis, and Treatment of Disease and Disability

AHRQ will fund research on the prevention of functional decline in the elderly, the quality of clinical preventive services, and the prevention of medication and other medical errors.

HHS Objective 6.4:   Increase the Understanding of and Response to the Major Issues Related to the Quality, Financing, Cost, and Cost-Effectiveness of Health Care Services

There are many gaps in knowledge in all areas of health care. New questions emerge as new technologies are developed, the population's demographics change, areas of inquiry previously under-emphasized take on greater importance, and research previously undertaken identifies further areas that need attention. Therefore, AHRQ will continue to focus on creating new knowledge and assessing the findings that result from completed projects.

HHS Objective 6.6:   Improve the Quality of Medical and Health Science Research by Strengthening the Base of Highly Qualified Scientific Investigators

AHRQ will invest in a number of programs to further the training of health services researchers to address the research and analytic needs of the changing health care system. These priorities will build on prior efforts to make both curricula and practical research experiences more relevant to decision makers' concerns about the effectiveness of health care and issues of cost, quality, and access. In addition, an added emphasis is being made on increasing the number of minority investigators at both majority and minority institutions.

HHS Objective 6.7:   Ensure That Research Results Are Effectively Communicated to the Public, Practitioners, and the Scientific Community

Building on the previous 10 years of research findings, AHRQ will identify ongoing gaps between what we know now and what we do in health care and will begin to close those gaps through research and demonstrations that develop and test implementation strategies in different settings in the health care system. A major focus within this is identifying existing implementation strategies in use in health care settings and demonstrating their applicability to wide spread dissemination in other areas of the system.

AHRQ places considerable focus on developing tools and products that facilitate the transfer of research findings into practice. The Agency has a well developed dissemination system that includes publications development, the Publications Clearinghouse, and an award winning Web site. This emphasis is critical to the Agency's success. Ongoing plans include incorporating regular customer feedback into our operations to continue to improve our efforts.

A.4   Performance Measurement Linkages with Budget, Cost Accounting, Information Technology Planning, Capital Planning and Program Evaluation

BUDGET LINKAGE   The performance goals and measures are linked directly to two of the Agency's three budget lines. As described previously, the budget line for Research on Health Care Costs, Quality, and Outcomes has five of the six performance plan goals tied to it. The budget line for the Medical Panel Expenditure Surveys is represented in the sixth goal. The Introduction to Part 2 of this document describes these alignments in detail.

The third budget line, Program Support, has been removed from the performance goals in the AHRQ performance plan. The measures previously reported for Program Support focused on internal management issues for contracts management and information system development. We are dropping the measures because they do not rise to the level of being one of the "critical few" measures that should be reported by the Agency in the GPRA plan. The measures continue to be important, however, and remain in place for internal accountability in the Office of Management Operations Plan and performance plans for the managers and staff.

The Agency provides page numbers, both in the body of the performance plan and in the summary table in section 1.4, to crosswalk the specific measures that are related to the programs proposed in the budget document. Many of the measures are for projects and initiatives that were started in past years and are continuing. This has been noted by identifying the budget connection as "commitment base."

COST ACCOUNTING   AHRQ allocates the full cost of all associated research activities, including overhead costs, by our three budget activities: Research on Health Costs, Quality and Outcomes, Medical Expenditure Panel Surveys, and Program Support.

INFORMATION TECHNOLOGY PLANNING   AHRQ is currently completing the infrastructure for a new integrated information system, the Agency Management Information System (AMIS). The goal of AMIS is to provide access to an integrated set of project information that includes the information currently input through multiple systems. When the AMIS is fully operational all Agency staff will have on-demand access to current information for the entire AHRQ research grant, contract, intramural project, and IAA portfolio. This system is one of the major methods the Agency will use to collect data to document its success in meeting its GPRA goals.

In response to the subchapter on "Information Security" added to the Fiscal year 2001 Defense Authorization Act, AHRQ has initiated an Information Security Program (ISP) that will establish and maintain a secure agency computer network infrastructure, protect sensitive information, safeguard mission critical systems and ensure reliable, continuous computer services to customers. The key elements of the IT security plan include performing initial vulnerability assessments, taking remedial action to correct the highest risk vulnerabilities determined by the assessments, installing firewalls, intrusion detection and other security protection systems,

deploying redundant network routing and establishing a secure intramural research LAN with strong authentication and encryption of sensitive data.

Also, the ISP will establish a security incident response capability, periodic security penetration testing and an annual security awareness training program. In addition, an agency Security Plan document will be prepared to promulgate all security policies and procedures needed to safeguard the agency's IT infrastructure. The plan will be reviewed and updated annually.

Preliminary security plans, policies and procedures for reducing/eliminating security risks will be in place by the end of FY 01. Initial tests to evaluate the preliminary security policies and procedures will take place periodically beginning in 2nd quarter of FY-02. Initial criteria for reporting and responding to security incidents will be established by end of CY-01. Implementation of a Secure Phase 1 LAN for analysis of intramural research and survey data will be completed by end of FY-01. Implementation of a Phase 1 firewall, intrusion detection and virus control system will be in place by end of CY-01. Initial security awareness training will begin by end of CY-01.

The agency FY-02 IT security budget requirement was prepared and forwarded for review through the annual departmental budget process. As of this time, the FY-02 IT security program budget requirements has not been approved. Also, the agency is in the process of recruiting an FTE to manage the IT security program. It is anticipated that this position will be filled during 3rd quarter of FY-01.

CAPITOL PLANNING   Does not apply to AHRQ.

PROGRAM EVALUATION   Goal 4 in the AHRQ annual performance plan is devoted to reporting the evaluations that the Agency will do in FY 2001. The evaluations are focused on demonstrating the use of Agency research and products and the resulting impact on organizations within the health care system.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

FISCAL YEAR 2002 PERFORMANCE PLAN

FISCAL YEAR 2001 REVISED FINAL PLAN

FISCAL YEAR 2000 PERFORMANCE REPORT