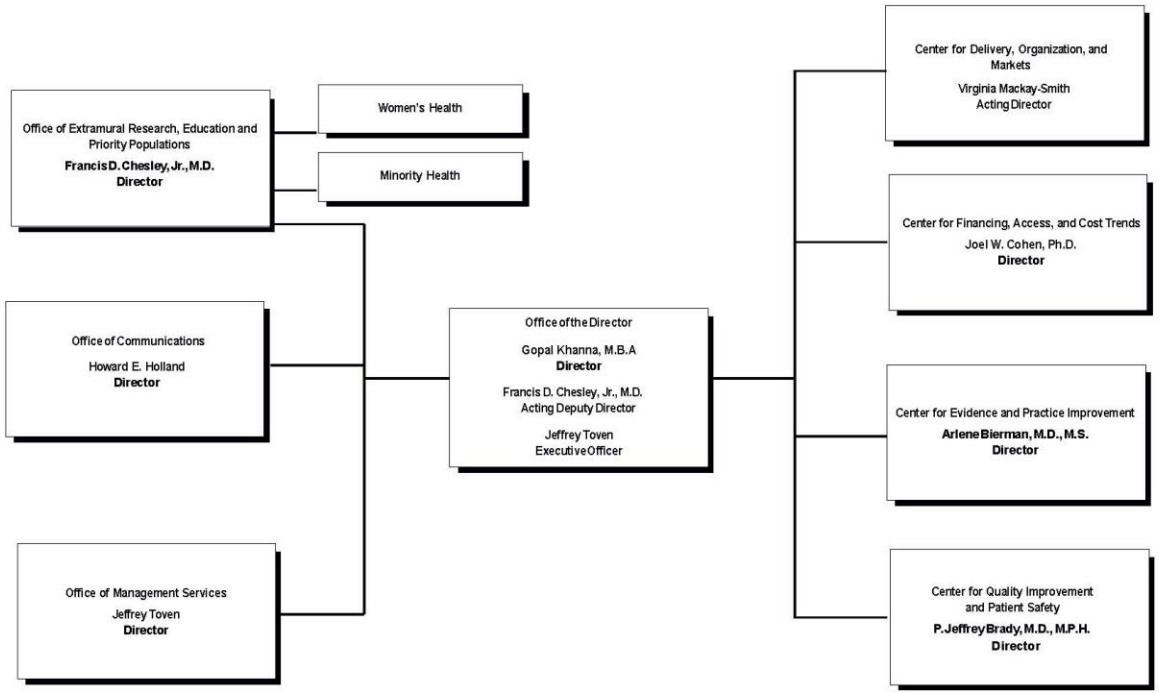
DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

National Institute for Research on Safety and Quality (NIRSQ)

NATIONAL INSTITUTES OF HEALTH
National Institute for Research on Safety and Quality (NIRSQ)



NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE FOR RESEARCH ON SAFETY AND QUALITY

For carrying out titles III and IX of the PHS Act, part A of title XI of the Social Security Act, and section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, $255,960,000: Provided, That section 947(c) of the PHS Act shall not apply in fiscal year 2020: Provided further, That in addition, amounts received from Freedom of Information Act fees, reimbursable and interagency agreements, and the sale of data shall be credited to this appropriation and shall remain available until expended.

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE FOR RESEARCH ON SAFETY AND QUALITY

Amounts Available for Obligation [1/]
(Dollars in Thousands)

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
General Fund Discretionary Appropriation:			
Appropriation (L/HHS, Ag, or, Interior)	$ 334,000	$ 338,000	$ 255,960
Across-the-board reductions (L/HHS, Ag, or Interior)			
Subtotal, Appropriation (L/HHS, Ag, or Interior)			
Rescission			
Reappropriation			
Proposed Supplemental Appropriation			
Proposed Rescission			
Proposed Reappropriation			
Subtotal, adjusted appropriation			
Secretary's transfer to ACF:	$ (829)		$ -
Comparable transfer from:			
Subtotal, adjusted general fund discr. appropriation	$ 333,171	$ 338,000	$ 255,960
Trust Fund Discretionary Appropriation:			
Appropriation Lines			
Transfer Lines			
Subtotal, adjusted trust fund discr. appropriation			
Total, Discretionary Appropriation			
Mandatory Appropriation:			
Appropriation Lines			
Transfer Lines (non-add)	*$ 98,626*	*$ 112,527*	*$ -*
Subtotal, adjusted mandatory. appropriation	*$ 98,626*	*$ 112,527*	*$ -*
Offsetting collections from:			
Unobligated balance, start of year			
Unobligated balance, end of year			
Unobligated balance, lapsing	$ 234	$ -	
Total obligations	$ 332,937	$ 338,000	$ 255,960

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE FOR RESEARCH ON SAFETY AND QUALITY

Mechanism Summary Table by Portfolio 1/ 2/

	FY 2018 Final		FY 2019 Enacted		FY 2020 President's Budget	
	No.	Dollars	No.	Dollars	No.	Dollars
RESEARCH GRANTS						
Non-Competing						
Patient Safety	50	21,612,239	62	24,073,445	85	33,573,000
Health Serv Res, Data & Diss	155	41,989,837	155	40,951,722	144	39,860,282
Health Information Technology	24	7,541,586	29	10,101,820	0	0
U.S. Preventive Services Task Force	0	0	0	0	0	0
Medical Expenditure Panel Survey	0	0	0	0	0	0
Total Non-Competing	229	71,143,662	246	75,126,987	229	73,433,282
New & Competing						
Patient Safety	36	13,765,994	37	14,043,816	18	7,000,000
Health Serv Res, Data & Diss	95	16,119,430	74	16,771,000	14	3,131,718
Health Information Technology	20	6,958,414	13	4,398,180	0	0
U.S. Preventive Services Task Force	0	0	0	0	0	0
Medical Expenditure Panel Survey	0	0	0	0	0	0
Total New & Competing	151	36,843,838	124	35,212,996	32	10,131,718
RESEARCH GRANTS						
Patient Safety	86	35,378,233	99	38,117,261	103	40,573,000
Health Serv Res, Data & Diss	250	58,109,267	229	57,722,722	158	42,992,000
Health Information Technology	44	14,500,000	42	14,500,000	0	0
U.S. Preventive Services Task Force	0	0	0	0	0	0
Medical Expenditure Panel Survey	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS	380	107,987,500	370	110,339,983	261	83,565,000
CONTRACTS/IAAs						
Patient Safety		34,068,767		34,158,739		24,703,000
Health Serv Res, Data & Diss		36,174,733		38,561,278		14,950,000
Health Information Technology		2,000,000		2,000,000		0
U.S. Preventive Services Task Force		11,649,000		11,649,000		7,400,000
Medical Expenditure Panel Survey		69,991,000		69,991,000		71,791,000
TOTAL CONTRACTS/IAAs		153,883,500		156,360,017		118,844,000
RESEARCH MANAGEMENT		71,300,000		71,300,000		53,551,000
GRAND TOTAL						
Patient Safety		69,447,000		72,276,000		65,276,000
Health Serv Res, Data & Diss		94,284,000		96,284,000		57,942,000
Health Information Technology		16,500,000		16,500,000		0
U.S. Preventive Services Task Force		11,649,000		11,649,000		7,400,000
Medical Expenditure Panel Survey		69,991,000		69,991,000		71,791,000
Research Management		71,300,000		71,300,000		53,551,000
GRAND TOTAL		333,171,000		338,000,000		255,960,000

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

2/ Does not include mandatory funds from the PCORTF.

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE FOR RESEARCH ON SAFETY AND QUALITY

Major Changes in the Fiscal Year 2020 President's Budget Request

The FY 2020 Budget proposes to consolidate the Agency for Healthcare Research and Quality's (AHRQ) highest priority activities in NIH in order to maximize efficiency of research. This narrative compares NIRSQ funding levels to levels previously funded within AHRQ. However, in addition to these quantifiable comparisons, additional efficiencies are anticipated as NIRSQ works to coordinate health services and patient safety research across NIH and leverage other NIH activities and resources.

Major changes by budget portfolio are briefly described below. NIRSQ's FY 2020 President's Budget discretionary request totals $256.0 million in budget authority, a decrease of $82.0 million from AHRQ's FY 2019 Enacted level. NIRSQ's total program level at the FY 2020 President's Budget is $256.0 million, a decrease of $194.6 million from AHRQ's FY 2019 Enacted level. The total program level included $112.5 million in mandatory funds from the Patient-Centered Outcomes Research Trust Fund (PCORTF) in FY 2019. AHRQ's total program level at the FY 2020 Request no longer includes mandatory funds from the PCORTF. This mandatory funding stream ends in FY 2019.

Patient Safety (-$7.0 million; total $65.3 million): This research portfolio prevents, mitigates, and decreases patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients. NIRSQ will provide $65.3 million for this research portfolio, a decrease of $7.0 million from the prior year. Of this total, $32.5 million will support research grants and contracts to advance the generation of new knowledge and promote the application of proven methods for preventing Healthcare-Associated Infections (HAIs). Within this amount, $12 million will be invested in support of the national Combating Antibiotic-Resistant Bacteria enterprise.

Health Services Research, Data and Dissemination (HSR) (-$38.3 million; total $57.9 million): HSR funds foundational health services research through research grant support to the extramural community. NIRSQ will provide $39.9 million for non-competing research grant support. A total of $3.1 million is provided for new investigator-initiated research grants. NIRSQ proposes to request investigator-initiated applications targeting research focused on two of the nation's most pressing health care issues: Opioid Abuse (+$1.5 million) and Transforming to a Value-based Delivery (+$1.5 million). Health Services Research Contracts total $15.0 million, including $4.5 million to accelerate evidence on preventing and treating opioid abuse in primary care, especially in older adults. In total, the FY 2020 President's Budget provides $6.0 million in funding to support the Secretary's initiative to combat opioid abuse, misuse, and overdose.

Health Information Technology (-$16.5 million; total $0.0 million): The FY 2020 President's Budget ends dedicated funding for health information technology. Instead, health IT research

will compete for related funding opportunities within patient safety and health services research to ensure the highest priority research is funded.

U.S. Preventive Services Task Force (-$4.2 million; total $7.4 million): The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of nationally-recognized experts in prevention and evidence-based medicine whose mission is to improve the health of all Americans through evidence-based recommendations regarding the effectiveness of clinical preventive services and health promotion to the general population. This program provides ongoing scientific, administrative, and dissemination support to assist the USPSTF in meeting its mission. A reduction of $4.2 million in FY 2020 will reduce the number of recommendations the USPSTF will make from an average of 12 recommendations per year to 6 recommendations in FY 2020.

Medical Expenditure Panel Survey (+$1.8 million; total $71.8 million): The Medical Expenditure Panel Survey (MEPS), is the only national source for comprehensive annual data on how Americans use and pay for medical care. The survey collects detailed information from families on access, use, expenses, insurance coverage and quality. The funding requested primarily supports data collection and analytical file production for the MEPS family of interrelated surveys, which include a Household Component (HC), a Medical Provider Component (MPC), and an Insurance Component (IC). A total of $70.0 million is required to provide ongoing support to the MEPS, allowing the survey to meet the precision levels of survey estimates, maximize survey response rates, and maintain the timeliness, quality and utility of data products specified for the survey in prior years. In addition, an increase of $1.8 million is provided to augment both the sample by 1,000 completed households (2,300 persons) and to redistribute the sample across states. This will allow MEPS to improve its national estimates and increase its capacity for making estimates of individual states and groups of states.

Research Management & Support (-$17.7 million; total $53.6 million)**:** RMS activities provide administrative, budgetary, logistical, and scientific support in the review, award, and monitoring of research grants, training awards, and research and development contracts. As the organization transitions to the NIH as an Institute, some programmatic activities will end. This reduction in scope will require a decrease of 39 FTEs in FY 2020 from the FY 2019 Enacted level, anticipated to be achieved through attrition, retirements, and a reduction in force if necessary.

Patient-Centered Outcomes Research Trust Fund (-$112.5 million; total $0.0 million): AHRQ's total program level at the FY 2020 President's Budget no longer includes mandatory funds from the PCORTF. This mandatory funding stream ends in FY 2019. The end of the PCORTF could affect the Agency's ability to ensure evidence from patient centered outcomes research is used by health care systems and professionals to improve the quality, safety, and value of health care. NIRSQ will use carryover resources until expended to disseminate and implement PCOR research findings; obtain stakeholder feedback on the value of the information to be disseminated and subsequent dissemination efforts; assist users of Health IT to incorporate PCOR research findings into clinical practice; and provide training and career development for researchers and institutions in methods to conduct comparative effectiveness research.

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE FOR RESEARCH ON SAFETY AND QUALITY

Summary of Changes

(Dollars in thousands)

AHRQ 2019 Enacted [1/]	
Total estimated budget authority	$ 338,000
(Obligations)	
NIRSQ 2020 President's Budget [1/]	
Total estimated budget authority	$ 255,960
(Obligations)	
Net Change	$ (82,040)

	FY 2019 Enacted FTE	FY 2019 Enacted	FY 2020 PB FTE	FY 2020 PB BA	FY 2020 +/- FY 2019 FTE	FY 2020 +/- FY 2019 BA
Increases:						
A. Built-in:						
1.						
2.						
Subtotal, Built-in Increases						
A. Program:						
1. Medical Expenditure Panel Survey		$ 69,991		$ 71,791		$ 1,800
2.						
Subtotal, Program Increases		**$ 69,991**		**$ 71,791**		**$ 1,800**
Total Increases						
Decreases:						
A. Built-in:						
1.						
2.						
Subtotal, Built-in Decreases						
A. Program:						
1. Patient Safety		$ 72,276		$ 65,276		$ (7,000)
2. Health Services Research, Data and Dissemination		$ 96,284		$ 57,942		$ (38,342)
3. Health Information Technology		$ 16,500		$ -		$ (16,500)
4. U.S. Preventive Services Task Force		$ 11,649		$ 7,400		$ (4,249)
5. Research Management and Support (Program Support)	277	$ 71,300	238	$ 53,551	-39	$ (17,749)
Subtotal, Program Decreases	277	**$ 268,009**	238	**$ 184,169**	-39	**$ (83,840)**
Total Decreases	**277**	**$ 268,009**	238	**$ 184,169**	-39	**$ (83,840)**
Net Change					-39	**$ (82,040)**

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE FOR RESEARCH ON SAFETY AND QUALITY

Budget Authority by Activity

(Dollars in Thousands)

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Research on Health Costs, Quality and Outcomes	$191,880	$196,709	$130,618
Medical Expenditure Panel Survey	69,991	69,991	71,791
Research Management and Support	71,300	71,300	53,551
Total, Budget Authority AHRQ 1/	333,171	338,000	
Total, Budget Authority NIRSQ 1/			255,960
FTE	273	277	238

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE FOR RESEARCH ON SAFETY AND QUALITY 1/

Authorizing Legislation

(Dollars in Thousands)

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
Research on Health Costs, Quality, and Outcomes:				
Secs. 301 & 926(a) PHSA.....	SSAN	$ 196,709	SSAN	$ 130,618
Research on Health Costs, Quality, and Outcomes:				
Part A of Title XI of the Social Security Act (SSA) Section 1142(i) 4/ 5/				
Budget Authority.....				
Medicare Trust Funds 5/ 6/				
Subtotal BA & MTF.....	Expired 7/		Expired 7/	
Medical Expenditure Panel Surveys:				
Sec. 947(c) PHSA.....	SSAN	$ 69,991	SSAN	$ 71,791
Program Support:				
Section 301 PHSA.....	Indefinite	$ 71,300	Indefinite	$ 53,551
Evaluation Funds:				
Section 947 (c) PHSA		$0		$0
Total appropriations, AHRQ 3/		$338,000		
Total appropriations, NIRSQ 2/, 3/				$ 255,960
Total appropriation against definite authorizations.....				

SSAN = Such Sums As Necessary

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

2/ For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

3/ Excludes mandatory financing from the PCORTF.

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

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

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

7/ Expired September 30, 2005.

Agency for Healthcare Research and Quality (2011-2019) [1/ 2/]
National Institute for Research on Safety and Quality (2020) [1/ 2/]
Appropriations History Table

		Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
AHRQ 2011					
Budget Authority……		$ -	$ -	$ -	$ -
PHS Evaluation Funds……..		$ 610,912,000	$ -	$ 397,053,000	$ 372,053,000
	Total……..	$ 610,912,000	$ -	$ 397,053,000	$ 372,053,000
AHRQ 2012					
Budget Authority……..		$ -	$ -	$ -	$ -
PHS Evaluation Funds……..		$ 366,397,000	$ 324,294,000	$ 372,053,000	$ 369,053,000
	Total……..	$ 366,397,000	$ 324,294,000	$ 372,053,000	$ 369,053,000
AHRQ 2013					
Budget Authority……..		$ -	$ -	$ -	$ -
PHS Evaluation Funds……..		$ 334,357,000	$ -	$ 364,053,000	$ 365,362,000
	Total……..	$ 334,357,000	$ -	$ 364,053,000	$ 365,362,000
AHRQ 2014					
Budget Authority……..		$ -	$ -	$ -	$ -
PHS Evaluation Funds……..		$ 333,697,000	$ -	$ 364,008,000	$ 364,008,000
	Total……..	$ 333,697,000	$ -	$ 364,008,000	$ 364,008,000
AHRQ 2015					
Budget Authority……..		$ -	$ -	$ 373,295,000	$ 363,698,000
PHS Evaluation Funds……..		$ 334,099,000	$ -	$ -	$ -
	Total……..	$ 334,099,000	$ -	$ 373,295,000	$ 363,698,000
AHRQ 2016					
Budget Authority……..		$ 275,810,000	$ -	$ 236,001,000	$ 334,000,000
PHS Evaluation Funds……..		$ 87,888,000		$ -	$ -
	Total……..	$ 363,698,000	$ -	$ 236,001,000	$ 334,000,000
AHRQ 2017					
Budget Authority……..		$ 280,240,000	$ 280,240,000	$ 324,000,000	$ 324,000,000
PHS Evaluation Funds……..		$ 83,458,000	$ -	$ -	$ -
	Total……..	$ 363,698,000	$ 280,240,000	$ 324,000,000	$ 324,000,000
AHRQ 2018					
Budget Authority……..		$ 272,000,000	$ 300,000,000	$ 324,000,000	$ 334,000,000
PHS Evaluation Funds……..			$ -	$ -	$ -
	Total……..	$ 272,000,000	$ 300,000,000	$ 324,000,000	$ 334,000,000
AHRQ 2019					
Budget Authority……..		$ 255,960,000	$ 334,000,000	$ 334,000,000	$ 338,000,000
PHS Evaluation Funds……..		$ -	$ -	$ -	$ -
	Total……..	$ 255,960,000	$ 334,000,000	$ 334,000,000	$ 338,000,000
NIRSQ 2020					
Budget Authority……..		$ 255,960,000			
PHS Evaluation Funds……..		$ -			
	Total……..	$ 255,960,000			

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.
2/ Excludes mandatory financing from the PCORTF.

Justification of Budget Request

National Institute for Research on Safety and Quality

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

Budget Authority (BA)[1]:

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
AHRQ Total[2]	$333,171,000	$338,000,000		
NIRSQ Total[2]:			$255,960,000	-$82,040,000
AHRQ FTEs[2]:	273	277		
NIRSQ FTEs[2]:			238	-39

[1]For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.
[2]Excludes mandatory financing and FTEs from the PCORTF. Includes reimbursable FTE.

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

Director's Overview

The FY 2020 President's Budget transitions the highest priority activities of the former Agency for Healthcare Research and Quality to an Institute at the National Institutes of Health (NIH) – the National Institute for Research on Safety and Quality (NIRSQ). Further integration in NIH is anticipated in future years pending the results of a study whose findings will inform future consolidation efforts. This proposed consolidation will allow for a more efficient, coordinated, and seamless transfer of research efforts on the diagnosis, prevention, and cure of human diseases developed by NIH to the frontlines of care. As a result of the ever-changing landscape of the healthcare ecosystem, policymakers at the Federal, State, and local levels are grappling with how to make qualitative and quantitative policy decisions in the absence of reliable, integrated, accessible information. NIRSQ is uniquely positioned to leverage its core competencies in health systems research, practice improvement, and data and analytics to address these questions and improve quality, safety, and value of care. NIRSQ will better ensure that NIH's investments in medical science are translated into knowledge and practical tools that can be adopted by physicians and other health care professionals to benefit patients and drive toward value-based transformation.

Fundamental Principle – Practice Improvement. Medical breakthroughs, increasing numbers of people living with multiple chronic conditions, and the shifting landscape of the health care delivery system all increase the challenges and complexities around providing safer care. Since 2000, with Congressional support, AHRQ has focused on assisting doctors and nurses in their efforts to keep patients safe when they receive medical care. AHRQ has invested in research to understand how health care systems can safely and reliably provide high-quality health care and has translated the resulting findings into practical tools and training ready for real-world implementation. We continue to develop new and innovative partnerships to ensure that more health systems, doctors, nurses, patients, and communities are using them. The potential benefit to American patients is extraordinarily high, as is the potential return on investment. AHRQ has made progress in health care safety at the front lines of care, taking stock of the best science and safe practices and giving providers the tools they need to implement changes to keep patients safe. For example, AHRQ's longstanding Comprehensive Unit-based Safety Program has been shown to substantially reduce healthcare-associated infections. Building on this successful foundation, AHRQ programs have reduced the rates of infections in long-term care facilities, improving safety for mechanically ventilated patients in intensive care units, and helping ambulatory surgery centers make care safer for their patients. AHRQ recognized that multiple perspectives are needed to develop solutions to complex challenges. Our Patient Safety Learning Laboratories take a systems engineering approach to allow researchers and health care professionals to identify and create practical solutions to patient safety problems. The learning laboratories involve cross-disciplinary teams to address the patient safety-related challenges providers face. As a result of these and other activities, AHRQ's National Scorecard on Rates of Hospital-Acquired Conditions shows that about 350,000 hospital-acquired conditions were avoided and the rate was reduced by 8 percent from 2014 to 2016. National efforts to reduce hospital-acquired conditions, such as adverse drug events and injuries from falls, helped prevent an estimated 8,000 deaths and save $2.9 billion between 2014 and 2016, according to the latest report.

Fundamental Competency – Health Systems Research: To improve health, the health care delivery systems must put patients at the center of care. NIRSQ will continue to promote an approach to health systems research called Person360 that asks researchers to place health care delivery in context with both the individual patient's social context and in relation to social and human services. NIRSQ will continue to fund critical research on how the health care delivery systems is organized and operates. We facilitate the analysis of current patterns of care in current practice so that health outcomes can be improved. Health care delivery organizations are rich with data, and those data are the fuel that transforms a health care delivery organization into a learning health system. In a learning health system, internal clinical data are systematically collected and analyzed, along with external data, to inform improvements in clinical practice. We have demonstrated our continued commitment to health system improvement by awarding $40 million in grants from Patient Centered Outcomes Research Trust Fund funding over 5 years grants to 11 institutions that will represent a new, driving force to accelerate health system performance and improvements in patient outcomes. These institutions also will establish Learning Health System Centers of Excellence in Learning Health System Researcher Training that will produce the next generation of LHS researchers to conduct patient-centered outcomes research and implement the results to improve quality of care and patient outcomes. In FY 2020, NIRSQ will continue funding for all continuing investigator-initiated health systems research,

which creates a distributed portfolio in which researchers investigate a wide range of scientific questions. History strongly suggests that letting scientists drive the research topics is the most productive route to findings that will eventually translate into research that improves the quality of health care. NIRSQ's current delivery system research investments include the foundational areas of health systems research (including safety, quality, and access) as well as emerging areas and current topics (such as opioids, drug pricing, and value-based care). NIRSQ recognizes the value of engaging operational leadership, including chief executive officers and other members of the C-suite, in the development, conduct, and use of health systems research. NIRSQ will continue to engage these organizational leaders to join clinical and research teams in efforts to shrink the time between research advances and implementation to create better patient outcomes. NIRSQ will continue to engage health care operation leaders in research to improve safety and quality, and embed those results in how care is provided—all while continuing to engage patients as partners in this critical process.

Fundamental Capability – Data: The healthcare system is undergoing transformation with a drive toward value-based care. In alignment with the Secretary's vision, achieving high value for patients remains the overall goal of health care delivery, with value defined as treating patients as consumers, treating providers as accountable patient navigators, paying for outcomes and preventing disease before it occurs. The velocity, variety, and volume of data flowing into and through the healthcare system is redefining how care will be delivered, what care patients will receive, where the care is delivered, and how it is delivered. Transitions of care are the movement of patients between providers or clinical settings and typically occur when primary care providers refer patients to specialty care or when patients are discharged from the hospital to subsequent care settings. Our grand challenge is developing data platforms to use this information to improve patient safety, health care quality, and value. NIRSQ is in the preeminent position to analyze this data with our two powerful data platforms—the Medical Expenditure Panel Survey (MEPS) and the Healthcare Cost and Utilization Project (HCUP) MEPS is the only national source of data measuring how Americans use and pay for medical care, examining health insurance, and out-of-pocket spending. HCUP is the Nation's most comprehensive source of hospital data and also includes information on inpatient care, hospital-based outpatient surgery, and emergency department visits.

MEPS data have been able to show insurance trends over time. Its 2017 Chartbook showed that the percentage of employees working at establishments that offer health insurance ("the offer rate") is very high when all private-sector employees are considered together (85 percent in 2017). However, the offer rate varies substantially by firm size. In 2017, the offer rate was 99 percent in firms with 100 or more employees and only 48 percent at small employers (those with fewer than 50 employees). MEPS finds that that the offer rate was 94 percent for employees working for large employers (50 or more employees) with primarily low-wage workers (where 50 percent or more of the employees made less than $12 an hour) but only 24 percent for low-wage employers with fewer than 50 workers. MEPS data also showed estimates for average annual premiums for employer-sponsored insurance in three coverage categories: single coverage ($6,368), employee-plus-one coverage ($12,789), and family coverage ($18,687), and found that, between 2016 and 2017, premium increases ranged from 4.4 percent to 5.5 percent—higher than increases in recent years. MEPS data are used by the Bureau of Economic Analysis in computing the U. S. Gross Domestic Product (GDP), by the Office of the Actuary in

calculating the National Health Expenditure Accounts, and by many states to assess time trends in the provision of employer health benefits in their state. In addition, MEPS data are used extensively to inform Congress on the impacts of changes in policy. For example, MEPS data are used by the Congressional Budget Office to model the effects of policy proposals on health care spending, and by the Medicaid and Chip Access and Payment Commission in determining recommendations to Congress on periodic reauthorizations of the Children's Health Insurance Program (CHIP).

AHRQ's data have also helped describe the impact of the opioid crisis. MEPS data show that in 2015 and 2016, nearly 4 million seniors, on average, filled four or more opioid prescriptions, and nearly 10 million seniors filled at least one opioid prescription in those years. HCUP data showed nearly 125,000 hospitalizations among older Americans involved opioid-related diagnoses in 2015. HCUP data also show that opioid-related hospitalizations increased more than 50 percent and opioid-related emergency department visits more than doubled between 2010 and 2015. In 2015, 124,300 hospitalizations and 36,200 emergency department visits occurred due to complications resulting from opioid use. HCUP data also show that seniors' inpatient hospital costs and emergency department charges were higher in 2015 if related to opioid use ($14,900) rather than other conditions ($13,200) and that those admitted with an opioid-related problem were also more likely to be discharged to another institution for post-acute care (37 percent) than cases not involving opioids (30 percent). These data have been used to brief the Assistant Secretary of Health on the use of opioids and rates of hospitalizations for opioid misuse among the elderly, as well as the extent to which hospital-based births involve complications related to the use of opioids and stimulants. AHRQ researchers also conducted analyses using MEPS for the HHS Secretary's initiative on drug pricing that examined trends in drug prices by payer and drug patent status to help inform Departmental efforts to address the issue of rising prices.

HCUP's Community-Level Statistics on Hospitalization Rates Related to Substance Use provide substance use-related hospitalization rates in 2014 for opioids, alcohol, stimulants, and other drugs and conditions drawn from more than 1,600 counties and two cities in 32 States to help public health officials, clinicians, first responders, researchers and others help define and tackle the most pressing local health challenges. While hospitalization rates in one county may suggest that alcohol persists as the most urgent substance-related problem, rates in a neighboring county may show an alarming rate in opioid-related hospitalizations. Having this data may assist local health officials quantify the comparatively high burden of stimulant misuse on local hospitals. Enhancing both the MEPS and HCUP platforms by greatly expanding the public data they use gives Americans greater return on their investment in NIRSQ by adding to the types of data the Agency make available; increasing the number of users; and by diversifying the ways in which these data, tools, and research can be applied to make the best health care decisions possible. All of these data efforts further NIRSQ's critical mission to improve safety, quality, and access to care.

Vision for the Future: NIRSQ remains fully aligned with the DHHS value-based transformation efforts. Recognizing the dynamic shifts that are occurring across the health care delivery landscape and leveraging NIRSQ's work, NIH is prepared to lead the Department in meeting the enormous need for transformational strategies within health care organizations to move from

“volume” to “value” in which the focus is on improving outcomes, reducing cost and expanding choice for consumers. Moving forward, NIRSQ will focus its competencies of practice improvement, health systems research, and data and analytics to address the most pressing issues in healthcare using the latest technology available, including creating seamless care transitions using interoperable digital health, creating a community-level data source for social determinants of health, harnessing the power of predictive analytics to improve diagnosis, transforming care for people living with multiple chronic conditions, and powering innovation in healthcare through data to drive value-based transformation. NIRSQ will also share these strategies across NIH and build upon existing work at NIH to increase the impact for the healthcare system.

Research on Health Costs, Quality, and Outcomes (HCQO)				
	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$ 191,880,000	$ 196,709,000	$ 130,618,000	$ (66,091,000)

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

FY 2020 Authorization……....Expired.
Allocation Method.....Competitive Grant/Cooperative Agreement, Contracts, and Other.

Summary

NIRSQ's program level for Research on Health Costs, Quality, and Outcomes (HCQO) at the FY 2020 President's Budget Level is $130.6 million, a decrease of $66.1 million from the FY 2019 Enacted level. A detailed table by research portfolio is provided below. Detailed narratives by research portfolio begin on page 17.

AHRQ/NIRSQ Budget Detail

(Dollars in Millions)

Division	AHRQ FY 2018 Final 1/	AHRQ FY 2019 Enacted 1/	NIRSQ FY 2020 President's Budget 1/
Research on Health Costs, Quality, and Outcomes (HCQO):			
Patient Safety	$ 69.447	$ 72.276	$ 65.276
Health Services Research, Data and Dissemination	94.284	96.284	$ 57.942
Health Information Technology	16.500	16.500	$ -
U.S. Preventive Services Task Force	11.649	11.649	$ 7.400
Subtotal, HCQO	**191.880**	**196.709**	**130.618**

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information about the Agency for Healthcare Research and Quality (AHRQ) and are provide for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ into the National Institutes of Health (NIH), and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

HCQO: Patient Safety				
	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$ 69,447,000	$ 72,276,000	$ 65,276,000	$ (7,000,000)

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2020 Authorization……Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

Patient Safety Research: The objectives of this program are to prevent, mitigate, and decrease patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients. This mission is accomplished by funding health services research in the following activities: Patient Safety Risks and Harms, Healthcare-Associated Infections (HAIs), and Patient Safety Organizations (PSOs). A table showing the allocation by these activities is provided below. Projects within the program seek to inform multiple stakeholders including health care organizations, providers, policymakers, researchers, patients and others; disseminate information and implement initiatives to enhance patient safety and quality; improve teamwork and communication to improve organizational culture in support of patient safety; and maintain vigilance through adverse event reporting and surveillance in order to identify trends and prevent future patient harm.

Patient Safety Research Activities
(in millions of dollars)

	FY 2018 Final	FY 2019 Enacted	FY 2020 Request
Patient Safety Risks and Harms	$28.581	$31.410	28.368
Patient Safety Organizations (PSOs)	4.866	4.866	4.395
Healthcare-Associated Infections (HAIs)	36.000	36.000	32.513
Patient Safety Research Activities	**$69.447**	**$72.276**	**$65.276**

FY 2018 Accomplishments by Research Activity:

Patient Safety Risks and Harms: The issue of diagnostic safety has not received the same level of attention as other patient safety harms. In a study of patients seeking second opinions from the Mayo Clinic, researchers found that only 12 percent were correctly diagnosed by their primary care providers. More than 20 percent had been misdiagnosed, while 66 percent required some changes to their initial diagnoses. By the end of FY 2018, AHRQ expects to fund $5.0 million in new patient safety learning laboratories (PSLLs) along with $5.0 million in continuing PSLL grants for a total investment of $10.0 million. These new PSLLs apply systems engineering approaches to address both diagnostic and treatment errors in health care. AHRQ also continued to support grants to combat the opioid epidemic. The early successful results of one grant project will be spread among additional settings in a contract to be awarded by the end of FY 2018. According to the Joint Commission, an estimated 80 percent of serious medical errors

involve miscommunication between caregivers when responsibility for patients is transferred or handed-off. Therefore in FY 2018, AHRQ continued accomplishments built on past successes and focused on the continued expansion of projects that demonstrate impact in improving patient safety, including ongoing support for the dissemination and implementation of successful initiatives that seamlessly integrate the use of evidence-based resources in multiple settings such as TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety) and the Surveys on Patient Safety Culture. These projects address the challenges of healthcare teamwork, communication and coordination among provider teams. Better teamwork and the establishment of safety cultures in healthcare organizations are critically important to patient safety. Both of these topics are widely recognized as foundational bases on which patient safety can be improved.

Healthcare-Associated Infections (HAIs): In FY 2018, AHRQ released a new Toolkit to Promote Safe Surgery. This toolkit, a product of the AHRQ Safety Program for Surgery, is designed to help surgical units apply proven CUSP principles to improve safety culture and reduce surgical site infections and other complications. Also in FY 2018, AHRQ made significant progress in the three CUSP projects that are currently under way. 1) CUSP for antibiotic stewardship (official title: AHRQ Safety Program for Improving Antibiotic Use) completed a pilot cohort in March 2018 in three integrated delivery systems that comprise all three care settings addressed by the project: acute care hospitals, long-term care facilities, and ambulatory care settings. An acute care cohort is currently ongoing in over 400 hospitals, including 6 Department of Defense and 79 critical access hospitals. Recruitment has begun for a long-term care cohort scheduled to begin in 250-500 facilities in FY 2019. 2) As of July 2018, CUSP for intensive care units (ICUs) with persistently elevated rates of CLABSI and CAUTI (official title: AHRQ Safety Program for Intensive Care Units: Preventing CLABSI and CAUTI) has recruited 425 ICUs in three cohorts from six regions of the country to actively participate in the project. An additional 115 units have been recruited to participate in a fourth cohort beginning in August 2018. 3) As of July 2018, CUSP for improving surgical care and recovery (official title: AHRQ Safety Program for Improving Surgical Care and Recovery) has recruited 277 hospitals in 44 States to participate in the project. The hospitals range from those with fewer than 100 beds to those with more than 500 beds. The first cohort addresses colorectal surgery, and the second cohort also includes a focus on orthopedic surgery.

Patient Safety Organizations (PSOs): Within the protected environment that affords privilege and confidentiality safeguards, PSOs have used AHRQ tools to expand their implemented quality and safety improvement programs to in nearly every State in the Nation. For example, The Society for Vascular Surgery PSO utilized surgical data to reduce hospital stays and surgical site infections and improve survival among patients on antiplatelet and statin medicines. By aggregating and analyzing data from the vascular surgeons in their registries across the country, the SVS PSO found that elective carotid endarterectomy (CEA) and endovascular aneurysm repair (EVAR) were associated with significantly decreased post-operative length of stay (LOS) from 2011 to 2017. Mean post-operative LOS for elective EVAR for all SVS centers plunged from 2.75 days in 2010 to 1.8 days in 2017. Mean post-operative LOS for elective CEA for all SVS centers plunged from 2.12 days in 2011 to 1.75 days in 2017. Also, use of chlorhexidine to prepare the skin of surgical site incisions significantly reduced post-operative surgical site

infections (SSIs). For every 25 patients discharged on an antiplatelet agent and a statin medication, an additional 3.5 were alive at 5 years.

FY 2020 President's Budget Policy: The FY 2020 Request for Patient Safety research is $65.3 million, a decrease of $7.0 million from the FY 2019 Enacted level.

In FY 2020, Research related to Risk and Harms will total $28.4 million, a decrease of $3.0 million from the FY 2019 Enacted level. The FY 2020 budget will fund $17.9 million in continuing grants, $0.7 million in new grants, and $9.8 million in research contracts. With FY 2020 resources, AHRQ will continue to fund $10.0 million for the PSLLs to use system's engineering approaches to reduce patient harm due to treatment and diagnostic errors. NIRSQ will not have the funding to continue to support diagnostic safety grants awarded in FY 2019. Under this RFA, grantees have partnered with other organizations in order to more fully utilize currently available sources of data and analytics to examine patterns in the diagnostic process and the incidence of diagnostic errors for different clinical conditions and in different populations and healthcare settings as well determine the impact of such errors on patient harm, cost, expenditures, and utilization. We will also continue to fund grants that seek to address challenges associated with opioids. The Medicare Patient Safety Monitoring System (MPSMS) is being used to help understand the extent of medical errors taking place in U.S. hospitals. AHRQ is developing and testing an improved patient safety surveillance system to replace MPSMS that is known as the Quality and Safety Review System (QSRS). QSRS will generate adverse event rates, trend performance over time, and unlike MPSMS, QSRS was designed to also serve as a local hospital and health system tool to identify and measure adverse events to inform safety improvement projects. In FY 2020, AHRQ anticipates making QSRS available to hospitals.

Within the overall patient safety budget, FY 2020 funds totaling $32.5 million, a decrease of $3.5 million from the FY 2019 Enacted level will support research grants and contracts to advance the generation of new knowledge and promote the application of proven methods for preventing Healthcare-Associated Infections (HAIs). Within this amount, $12.0 million will be invested in support of the national Combating Antibiotic-Resistant Bacteria (CARB) enterprise. AHRQ will fund research grants and implementation projects to further expand efforts to develop and apply improved approaches for combating antibiotic resistance. Program activities will include efforts in antibiotic stewardship, with a focus on ambulatory and long-term care settings, as well as hospitals. In FY 2020, AHRQ's Safety Program for Improving Antibiotic Use, which is applying CUSP to promote implementation of antibiotic stewardship, will continue to expand its reach beyond earlier cohorts of hospitals and long-term care facilities to address antibiotic stewardship in ambulatory settings, using FY 2019 funds. AHRQ will also continue to expand the CUSP projects aimed at reducing central line-associated blood stream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) in intensive care units (ICUs) with elevated level of these infections, and enhancing care and recovery of surgical patients, using FY 2019 funds. In early FY 2020, AHRQ will assess the history and experience with AHRQ's CUSP projects to date, as well as then-current HAI and antibiotic resistance issues, to determine which new CUSP project to initiate. A potential FY 2020 project that is envisioned is CUSP for Clostridioides difficile (C. diff), a stubbornly persistent HAI related to antibiotic use (see Program Portrait on the following page). The evidence and products of the

CUSP projects are shared with other HHS OPDIVs. CDC and CMS staff serve on the Technical Expert Panels of these projects and are involved in the development and dissemination of toolkits that are produced by the projects.

Finally, AHRQ will provide $4.4 million to continue conformance with administrative requirements of the Patient Safety Act (2005), a decrease of $0.5 million from the prior year. The Patient Safety Act (2005) provides protection (legal privilege) to health care providers throughout the country for quality and safety improvement activities. The Act promotes increased voluntary patient safety event reporting and analysis, as patient safety work product reported to a Patient Safety Organization (PSO) is protected from disclosure in medical malpractice cases. HHS issued regulations to implement the Patient Safety Act, which authorized the creation of PSOs, and AHRQ administers the provisions of the Patient Safety Act dealing with PSO operations.

Program Portrait: Comprehensive Unit-based Safety Program (CUSP) – Assessment to identify one potential project:

1. CUSP for Clostridioides difficile (C. diff)

FY 2019 Enacted Level:	$10.6 million
FY 2020 President's Budget Level:	$ 5.2 million
Change:	-$ 5.4 million

The Comprehensive Unit-based Safety Program (CUSP), which was both developed and shown to be effective with AHRQ funding, involves improvement in safety culture, teamwork, and communication, together with a checklist of evidence-based safety practices. CUSP was highly effective in reducing central line-associated blood stream infections in more than 1,000 ICUs that participated in AHRQ's nationwide CUSP implementation project for central line-associated blood stream infections. Subsequently, AHRQ expanded the application of CUSP to prevent other HAIs, including catheter-associated urinary tract infections in hospitals and long-term care facilities, surgical site infections and other surgical complications in inpatient and ambulatory surgery, and ventilator-associated events.

AHRQ will provide $5.2 million for CUSP activities in FY 2020, a decrease of $5.4 million from the prior year. This decrease does not reflect a reduced interest in CUSP implementation. Instead, the decrease is related to two factors. The first is the $3.5 million reduction from the FY 2019 Enacted level in the overall funding of the HAI Program. The second is related to the stage of CUSP funding. The FY 2020 CUSP project is new in FY 2020 and AHRQ anticipates higher second year costs for this implementation project.

In FY 2020, AHRQ's three current CUSP projects will continue their expansion efforts. AHRQ's Safety Program for Improving Antibiotic Use, which is applying CUSP to promote implementation of antibiotic stewardship, will continue to expand its reach beyond earlier cohorts of hospitals and long-term care facilities to address antibiotic stewardship in ambulatory settings, using FY 2019 funds. AHRQ will also continue to expand the CUSP project aimed at reducing central line-associated blood stream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) in intensive care units (ICUs) with elevated level of these infections, as well as the CUSP project for enhancing care and recovery of surgical patients, using FY 2019 funds.

In early FY 2020, AHRQ will assess the history and experience with AHRQ's CUSP projects to date, as well as then-current HAI and antibiotic resistance issues, to determine which new CUSP project to initiate. A potential FY 2020 project that is envisioned is CUSP for Clostridioides difficile (C. diff), a stubbornly persistent HAI that is related to antibiotic use and that causes potentially fatal diarrhea. AHRQ will assess the appropriateness of applying the CUSP method to this problem and will complete the planning of the project and its funding with FY 2020 funds.

Mechanism Table:

Patient Safety 1/
(Dollars in Thousands)

	AHRQ FY 2018 Final		AHRQ FY 2019 Enacted		NIRSQ FY 2020 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	50	21,612	62	24,073	85	33,573
New & Competing……	36	13,766	37	14,044	18	7,000
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**86**	**35,378**	**99**	**38,117**	**103**	**40,573**
TOTAL CONTRACTS/IAAs.....		**34,069**		**34,159**		**24,703**
TOTAL.....		**69,447**		**72,276**		**65,276**

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information about the Agency for Healthcare Research and Quality (AHRQ) and are provide for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ into the National Institutes of Health (NIH), and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

5-Year Funding Table:

FY 2016:	$74,253,000
FY 2017:	$70,276,000
FY 2018 Final :	$69,447,000
FY 2019 Enacted Level:	$72,276,000
FY 2020 President’s Budget Level:	$65,276,000

HCQO: Health Services Research, Data and Dissemination				
	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$ 94,284,000	$ 96,284,000	$ 57,942,000	$ (38,342,000)

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2020 Authorization…….……..……Expired.
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

Health Services Research, Data, and Dissemination (HSR): The principle goals of HSR are to identify the most effective ways to organize, manage, finance, and deliver high quality care, reduce medical errors, and improve patient safety. The portfolio first conducts research to identify the most pressing questions faced by clinicians, health system leaders, policy makers and others about how to best provide the care patients need, together with appropriate solutions. These questions include ones about how hospitals can address life threatening infections in their intensive care units to how primary care practices can find and use the best evidence to reduce their patients' chances of developing heart disease or having a stroke. It also includes questions about critical public health crises, such as the nation's opioids epidemic. This research is done both through investigator-initiated and directed research grants programs, as well as through research contracts.

The next step in the HSR continuum is to implement the findings of our research. AHRQ supports the implementation of its research findings by creating practical tools and resources that can be used in real-world settings by professionals on the front lines of health care and policy making. For instance, AHRQ has developed a model program for shared decision making between clinicians and their patients, along with creating modules to train physicians and nurses on using the program and training others to use it, as well. In addition, AHRQ ensures that these kinds of resources are widely available by working with partners inside and outside of HHS through public-private partnerships that maximize AHRQ's expertise by leveraging these organizations own networks and members.

Finally, AHRQ creates and disseminates data and analyses of key trends in the quality, safety, and cost of health care to help users understand and respond to what is driving the delivery of care today. These data and analyses take the form of statistical briefs, interactive presentations of information on a national and state-by-state basis, infographics, and articles and commentaries in leading clinical and policy outlets. AHRQ also develops measures of safety and quality that are used to track changes in quality, safety, and health care costs over time, providing benchmarks and dashboards for judging the effectiveness of clinical interventions and policy changes. AHRQ not only provides National data sets and analyses, but where possible, AHRQ provides insights on the State and local levels, too.

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

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Health Services Research Grants	$58.109	$57.723	$42.922
(Investigator-Initiated)	*($52.874)*	*($52.933)*	*($42.922)*
Health Services Contract/IAA Research	$14.000	$14.000	$5.250
Measurement and Data Collection	$14.410	$14.377	$9.700
Dissemination and Implementation	$7.765	$10.184	$0.000
Total, HSR	**$94.284**	**$96.284**	**$57.942**

Health Services Research Grants: Health Services Research grants, both targeted and investigator-initiated, focus on research in the areas of quality, effectiveness and efficiency. These activities are vital for understanding the quality, effectiveness, efficiency, and appropriateness of health care services. Investigator-initiated research is particularly important. New investigator-initiated research and training grants are essential to health services research – they ensure that both new ideas and new investigators are created each year. Investigator-initiated research grants allow extramural researchers to pursue the various research avenues that lead to successful yet unexpected discoveries. In this light, the investigator-initiated grant funding is seen as one of the most vital forces driving health services research in this country. The FY 2018 Enacted provided $52.9 million for this activity. The FY 2019 Enacted maintains this level of support. In addition, the FY 2019 Enacted level provides $2.0 million in targeted funding for population health research.

FY 2020 President's Budget Policy: The FY 2020 President's Budget provides $42.9 million for research grants, a decrease of $14.8 million from the FY 2019 Enacted level. The entirety of this budget supports investigator-initiated grants. A total of $39.9 million supports non-competing research grants, which are continuations of prior year awards. The FY 2020 President's Budget does not include noncompeting support for AHRQ's two directed research programs: Consumer Assessment of Healthcare Providers and Systems (CAHPS) and population health grants.

Support for new research and training grants totals $3.1 million. The entirety of AHRQ's new research grant funding is directed to new investigator-initiated research grants focused on two of the nation's most pressing health care issues: Opioid Abuse (+$1.5 million) and Transforming to Value-based Delivery (+$1.5 million). In 2018, AHRQ is working with health care delivery system leaders and the health services research community to identify and prioritize the most critical areas for research in these areas. Potential targets for opioids research include the need for health system interventions to prevent addiction among people who have experimented with opioids and utilizing mobile apps to provide behavioral support to compliment medication assisted therapy. In the field of value, the ability to incorporate social determinants of health into clinical decision making and utilizing clinical data to improve health system performance are emerging as potential areas of focus. Through active stakeholder engagement, AHRQ will be well prepared to create targeted funding announcements in FY 2019 and NIRSQ will fund innovative health services research to address critical research gaps in FY 2020. AHRQ will

utilize its standard competitive health service research mechanisms to solicit and fund these research grants.

Health Services Contracts/IAA Research: Similar to support of research grants, funding of health services contracts and IAAs support health services research activities that impact quality, effectiveness and efficiency of health care. An example of an HSR contract is support for the Evidence-Based Practice Center (EPC) program. The EPCs review all relevant scientific literature on a wide spectrum of clinical and health services topics to produce various types of evidence reports that are widely used by public and private health care organizations. These reports may be used for informing and developing coverage decisions, quality measures, educational materials and tools, clinical practice guidelines, and research agendas. This research activity also funds HSR implementation research contracts, data security, data analytics, peer review of research grants, and contracts that support public access to research results. The FY 2019 funding for Health Services Contracts/IAAs is $14.0 million.

FY 2020 President's Budget Policy: The FY 2020 Request provides $5.25 million for this activity, a decrease of $8.75 million from the FY 2019 Enacted level. This funding will provide $0.75 million in funding for EPCs. In addition, the FY 2020 President's Budget will provide $4.5 million to support research related to the Secretarial initiative to Address Prescription Drug and Opioid Misuse and Abuse. NIRSQ's funding will accelerating evidence on preventing and treating opioid abuse in primary care, especially in older adults. One exciting component of this research is the development and pilot testing of innovative models of care to address opioid misuse in older adults. In total, the FY 2020 President's Budget provides $6.0 million in funding to support the Secretary's initiative to combat opioid abuse, misuse, and overdose - $1.5 million in new research grants and $4.5 million in contract support.

Measurement and Data Collection: Monitoring the health of the American people is an essential step in making sound health policy and setting research and program priorities. Data collection and measurement activities allow us to document the quality and cost of health care, track changes in quality or cost at the national, state, or community level; identify disparities in health status and use of health care by race or ethnicity, socioeconomic status, region, and other population characteristics; describe our experiences with the health care system; monitor trends in health status and health care delivery; identify health problems; support health services research; and provide information for making changes in public policies and programs. AHRQ's Measurement and Data Collection Activity coordinates AHRQ data collection, measurement and analysis activities across the Agency. In FY 2018 AHRQ provided $14.4 million to support measurement and data collection activities including the following flagship projects: Healthcare Cost and Utilization Project (HCUP), Consumer Assessment of Healthcare Providers and Systems (CAHPS), AHRQ Quality Indicators (AHRQ QIs), and the National Healthcare Disparities and Quality Reports (QDRs). The FY 2019 Enacted continues these programs.

FY 2020 President's Budget Policy: The FY 2020 President's Budget provides $9.7 million for Measurement and Data Collection activities, a decrease of $4.6 million from the prior year. This funding level will provide full funding for Healthcare Cost and Utilization Project (HCUP). No funding is provided for Consumer Assessment of Healthcare Providers and Systems

(CAHPS), AHRQ Quality Indicators (QIs), or the National Healthcare Disparities and Quality Reports (QDRs). For more information about HCUP please see the program portrait on page 30.

Dissemination and Implementation: AHRQ's dissemination and implementation activities foster the use of Agency-funded research, products, and tools to achieve measurable improvements in the health care patients receive. AHRQ research, products, and tools are used by a wide range of audiences, including individual clinicians; hospitals, health systems, and other providers; patients and families; payers, purchasers, and health plans; and Federal, state, and local policymakers. AHRQ's dissemination and implementation activities are based on assessments of these audiences' needs and how best to foster use of Agency products and tools, plus sustained work with key stakeholders to develop ongoing dissemination partnerships. In addition, AHRQ sponsors the dissemination of research findings and tools through tailored, hands-on technical assistance. Support for Dissemination and Implementation activities is $10.2 million at the FY 2019 Enacted level.

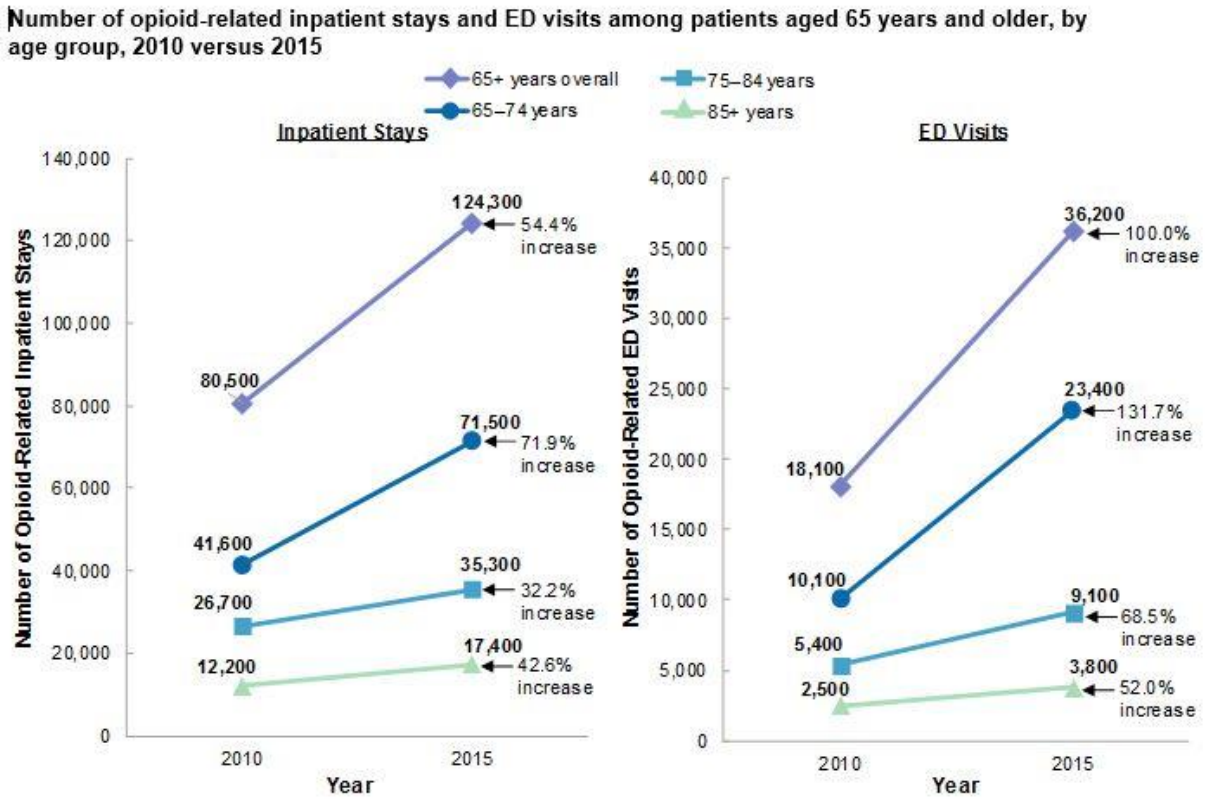
FY 2020 President's Budget Policy: The FY 2020 President's Budget ends support for dissemination and implementation activities as a result of the consolidation with NIH. NIRSQ will end outreach to stakeholders, advocacy and intermediary groups that impact adoption of new findings by end users; vital toolkits used by front-line clinicians; and reduce direct contact with health care industry leaders by attending and exhibiting at their professional meetings. The elimination of dissemination and implementation support will impact the Agency's ability to communicate with physicians, nurses, hospital, and health systems leaders, states, and others. Prior support for dissemination and implementation activities has allowed AHRQ to make more widely available the tools and interventions that have led to reductions in hospital-acquired conditions, preventing 350,000 infections, preventing 8,000 deaths, and saving $2.9 billion in care costs from 2014 to 2016.

Program Portrait: Healthcare Cost and Utilization Project (HCUP) - $9.7 million

HCUP is the Nation's most comprehensive source of hospital care data, including information on in-patient stays, ambulatory surgery and services visits, and emergency department encounters. HCUP enables researchers, insurers, policymakers and others to study health care delivery and patient outcomes over time, and at the national, regional, State, and community levels. This program develops HCUP Statistical Briefs – these briefs present simple, descriptive statistics on a variety of topics including specific medical conditions as well as hospital characteristics, utilization, quality, and cost.

Data from HCUP are used to document dramatic increases in inpatient hospitalizations and emergency department visits related to opioid use. AHRQ is publishing a series of Statistical Briefs that provide descriptive information on opioid-related hospital use by select patient subgroups. A recent report showed that opioid misuse in older adults is an underappreciated and growing problem. Between 2010 and 2015, the number of opioid-related inpatient stays increased over 54 percent among patients aged 65 years and older, from 80,500 stays in 2010 to 124,300 stays in 2015, with the largest increase among patients aged 65–74 years. Similarly, between 2010 and 2015, the number of opioid-related emergency department visits doubled among patients aged 65 years and older, from 18,100 visits in 2010 to 36,200 visits in 2015. Please see the graphs below.

Please visit the HCUP website for more information.



Mechanism Table:

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Health Services Research, Data and Dissemination 1/
(Dollars in Thousands)

	AHRQ FY 2018 Final		AHRQ FY 2019 Enacted		NIRSQ FY 2020 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	155	41,990	155	40,952	144	39,860
New & Competing……	95	16,119	74	16,771	14	3,132
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**250**	**58,109**	**229**	**57,723**	**158**	**42,992**
TOTAL CONTRACTS/IAAs.....		**36,175**		**38,561**		**14,950**
TOTAL.....		**94,284**		**96,284**		**57,942**

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information about the Agency for Healthcare Research and Quality (AHRQ) and are provide for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ into the National Institutes of Health (NIH), and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

5-Year Funding Table:

FY 2016:	$ 89,398,000
FY 2017:	$ 88,731,000
FY 2018 Final:	$ 94,284,000
FY 2019 Enacted:	$ 96,284,000
FY 2020 President’s Budget:	$ 57,942,000

HCQO: U.S. Preventive Services Task Force				
	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$ 11,649,000	$ 11,649,000	$ 7,400,000	$ (4,249,000)

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2020 Authorization……..……..……Expired.
Allocation Method……..... Contracts, and Other.

U.S. Preventive Services Task Force (USPSTF): The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of nationally-recognized experts in prevention and evidence-based medicine. The Task Force makes evidence-based recommendations about clinical preventive services to improve the health of all Americans (e.g., by improving quality of life and prolonging life). Since 1998, AHRQ has been authorized by Congress to provide ongoing scientific, administrative and dissemination support to assist the USPSTF in meeting its mission. AHRQ is the sole funding source of the USPSTF. AHRQ supports the USPSTF by ensuring that it has: the evidence it needs in order to make its recommendations; the ability to operate in an open, transparent, and efficient manner; and the ability to clearly and effectively share its recommendations with the health care community and general public.

Major FY 2018 accomplishments for the USPSTF include:

- Maintained recommendation statements for 83 preventive service topics with 133 specific recommendation grades. Many recommendation statements include multiple recommendation grades for different populations.
- Received 15 nominations for new topics and 6 nominations to reconsider or update existing topics.
- Posted 11 draft research plans for public comments.
- Posted 13 draft recommendation statements for public comments.
- Posted 13 draft evidence reports for public comments.
- Published 15 final recommendation statements in a peer-reviewed journal.

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

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

FY 2020 President's Budget Policy: The FY 2020 Request for the USPSTF is $7.4 million, a decrease of $4.3 million from the FY 2019 Enacted level. With these funds NIRSQ will continue to maintain support for the Task Force, but at a reduced scope (including scientific, methodological, and dissemination support). The FY 2020 President's Budget will allow the USPSTF to make recommendations on approximately 6 topics, 6 fewer than the historical average for the Task Force.

Program Portrait: ***Recommendation on Screening for Prostate Cancer***

Prostate cancer is one of the most common cancers to affect men. Many men with prostate cancer never experience symptoms and, without screening, would never know they have the disease. Screening to detect and treat prostate cancer in men without symptoms may offer benefits, but is also associated with harms.

Given the importance of prostate cancer, the USPSTF sought to update its 2012 recommendation. To do this, the USPSTF commissioned a systematic review of the scientific evidence. Given that new research results are published each year, it is critical for the USPSTF to review the latest scientific literature. The USPSTF used the evidence from the systematic review to develop its recommendation, including examining the evidence for specific populations (e.g., men with a family history and African American men) and specific age groups (men younger than 55, between 55 and 69, and those aged 70 and older).

The USPSTF is committed to transparency when developing its recommendations. Therefore, it also sought input on its draft recommendation from the public, topic experts and clinical specialists, patients, and other stakeholders. The USPSTF also worked closely with other Federal agencies, as well as professional organizations that deliver care. The USPSTF reviewed and considered all of this input when finalizing its recommendations.

To help ensure that clinicians, patients, and other stakeholders are aware of and understand the USPSTF's new recommendation, the USPSTF used several communication and dissemination strategies. It developed an infographic to explain the benefits and harms of screening for prostate cancer, which has been widely used by clinicians, patients, and other stakeholders. The USPSTF also developed a video to help explain the recommendation statement to clinicians and patients in plain language. It also conducted briefings for stakeholders, including patient advocacy groups, prostate cancer specialists, and other medical groups.

The final recommendation was published in the *Journal of the American Medical Association* in May 2018. It received a lot of national attention with over 50,000 page views on the website at the time of the release, with extensive media coverage in over 600 news articles. For example, it received coverage from media outlets including *Reuters, The Los Angeles Times, The Associated Press, ABC, CNN and CBS*.

Mechanism Table:

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

	AHRQ FY 2018 Final		AHRQ FY 2019 Enacted		NIRSQ FY 2020 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**11,649**		**11,649**		**7,400**
TOTAL.....		**11,649**	0	**11,649**	**0**	**7,400**

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information about the Agency for Healthcare Research and Quality (AHRQ) and are provide for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ into the National Institutes of Healh (NIH), and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

5-Year Funding Table:

FY 2016:	$11,649,000
FY 2017:	$11,649,000
FY 2018 Final:	$11,649,000
FY 2019 Enacted	$11,649,000
FY 2020 Request:	$ 7,400,000

Medical Expenditure Panel Survey				
	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$ 69,991,000	$ 69,991,000	$ 71,791,000	$ 1,800,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2020 Authorization……..……..……..……Expired.
Allocation Method……..……..... Contracts and Other.

Medical Expenditure Panel Survey (MEPS): MEPS, first funded in 1995, is the only national source for comprehensive annual data on how Americans use and pay for medical care. The MEPS is designed to provide annual estimates at the national level of the health care utilization, expenditures, sources of payment and health insurance coverage of the U.S. civilian non-institutionalized population. The funding requested primarily supports data collection and analytical file production for the MEPS family of interrelated surveys, which include a Household Component (HC), a Medical Provider Component (MPC), and an Insurance Component (IC). In addition to collecting data that support annual estimates for a variety of measures related to health insurance coverage, healthcare use and expenditures, MEPS provides estimates of measures related to health status, demographic characteristics, employment, access to health care and health care quality. The survey also supports estimates for individuals, families and population subgroups of interest. The data collected in this ongoing longitudinal study also permit studies of the determinants of insurance take-up, use of services and expenditures as well as changes in the provision of health care in relation to social and demographic factors such as employment and income; the health status and satisfaction with care of individuals and families; and the health needs of specific population groups such as racial and ethnic minorities, the elderly and children.

MEPS data continue to be essential for the evaluation of health policies and analysis of the effects of tax code changes on health expenditures and tax revenue. Key data uses include:

- MEPS IC data are used by the Bureau of Economic Analysis in computing the nation's GDP
- MEPS HC and MPC data are used by the Congressional Budget Office, Congressional Research Service, the Treasury and others to inform high level inquiries related to healthcare expenditures, insurance coverage and sources of payment
- MEPS is used extensively to inform policymakers with respect to the Children's Health Insurance Program and its reauthorization
- MEPS is used extensively by the GAO in its studies of the U.S. healthcare system and subsequent reports as requested by the Senate Committee on Health, Education, Labor and Pensions
- MEPS is used by CMS to inform the National Health Expenditure Accounts

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

FY 2020 President's Budget Policy: The FY 2020 President's Budget level for the MEPS is $71.8 million, an increase of $1.8 million from the FY 2019 Enacted level. A total of $70.0 million is required for base funding. Base funding will allow NIRSQ to continue to provide ongoing support to the MEPS, allowing the survey to maintain the precision levels of survey estimates, maximize survey response rates, and the timeliness, quality and utility of data products specified for the survey in prior years.

An additional $1.8 million will be directed to expanding the capacity of the MEPS to address HHS priorities. By both augmenting the sample by 1,000 completed households (2,300 persons) and by redistributing sample across states, MEPS will improve its national estimates and increase our capacity for making estimates of individual states and groups of states, particularly rural states and those with relatively small populations. An additional 1,000 completed household interviews could be used to produce improvements in the precision of State level estimates for about 36 States and D.C. (i.e. all except the 7 largest and 7 smallest States). This augmentation will also enhance the ability of MEPS to support analyses of key population subgroups, such as persons with specific conditions and those at particular income levels or age groups, as well as analyses by insurance status. In the implementation of this investment, MEPS will engage with organizations with interest and expertise in state health matters, such as the State Health Access Data Assistance Center (SHADAC), the National Governors Association (NGA), the National Council of State Legislators (NCSL), and National Association of Counties (NACo) to assist with dissemination activities. The enhanced data will also be disseminated through the program's existing extensive network of users, which includes numerous universities, research organizations, and national, state, and local agencies and organizations. ($1.8 million in FY 2020 with out year costs of $1.1 million in FY 2021 and $0.590 million in FY 2022.)

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

Mechanism Table:

MEPS Mechanism Table 1/
(Dollars in Thousands)

	AHRQ FY 2018 Final		AHRQ FY 2019 Enacted		NIRSQ FY 2020 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**69,991**		**69,991**		**71,791**
TOTAL.....		**69,991**		**69,991**		**71,791**

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information about the Agency for Healthcare Research and Quality (AHRQ) and are provide for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ into the National Institutes of Healh (NIH), and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

5-Year Funding Table:

FY 2016:	$66,000,000
FY 2017:	$66,000,000
FY 2018 Final:	$69,991,000
FY 2019 Enacted:	$69,991,000
FY 2020 President’s Budget:	$71,791,000

Program Portrait: Medical Expenditure Panel Survey (MEPS)

FY 2019 Enacted Level:	$69.991 million
FY 2020 Request Level:	71.791 million
Change:	+$1.800 million

The MEPS Household Component (HC) collects nationally representative information on demographic characteristics, socioeconomic status, health insurance status, access to care, health status, chronic conditions and use of health care services that can be used to examine a broad range of important health issues. The MEPS Insurance Component (IC) is an annual survey of private employers and State and local governments and is designed to provide data representative of all 50 States and the District of Columbia on topics including the number and types of private health insurance plans offered, plan benefits, annual premiums, employer and employee premium contributions, and employer characteristics. Following are key findings from recent research that used the MEPS HC and the MEPS IC to address topics relevant to Secretarial priorities regarding opioids, health insurance reform and value-based care.

Key Findings

Use of Outpatient Prescription Opioids (using data from the MEPS HC):

- In 2015-2016, 19.3 percent of elderly adults and 13.0 percent of non-elderly adults, on average, filled at least 1 outpatient opioid prescription, and 7.1 percent of elderly adults and 3.1 percent of non-elderly adults obtained 4 or more prescription fills during the year.
- The average annual rates of any outpatient opioid use increased as health status declined, ranging from 8.8 percent for elderly adults in excellent health to 39.4 percent for those in poor health, and ranging from 6.1 percent for non-elderly adults in excellent health to 45.4 percent for those in poor health.
- Elderly adults who were poor (9.5percent) or low income (11.3 percent) were more likely than middle-income (6.8 percent) and high-income (4.5 percent) elderly adults to obtain 4 or more opioid prescription fills during the year.
- Non-elderly adults who had family incomes below the federal poverty line (18.5 percent), lived in rural areas (16.5 percent), or were covered by public insurance due to a disability (38.7 percent) were more likely than others to have at least one opioid prescription fill during the year.
- These results can contribute to efforts to make appropriate use of outpatient prescription opioids which can be effective in relieving pain, but also carry serious risks of opioid use disorder and overdose.
-

State Variations in Employer-Sponsored Insurance (using MEPS IC data on private sector workers):

- In 2017, average health insurance premiums for enrollees in private-sector employer plans were $6,368 for single coverage, $12,789 for employee-plus-one coverage, and $18,687 for family coverage. Five States (Arkansas, Idaho, Nevada, Tennessee, and Utah) had average annual premiums that were significantly lower than the national average for all three types of coverage. Six States (Alaska, Connecticut, Massachusetts, New Jersey, New York, and Wyoming) had average annual premiums that were significantly higher than the national average for all three types of coverage.
- Offer rates among small firms with fewer than 50 employees are an important factor contributing to overall State offer rates because almost all large firms offer health insurance coverage. Nationwide, nearly half (48 percent) of employees of small firms worked at establishments that offered insurance in 2017. In eight States, small-employer offer rates were above the national average, including Massachusetts (66%), the District of Columbia (67%), and Hawaii (89%). In 10 States, small-employer offer rates were below the national average, including Alaska (31%), Arkansas (34%), North Carolina (34%), and Utah (34%).
- From 2004 to 2017, the percentage of single enrollees in high deductible health plans (HDHPs) increased from 12 percent to 53 percent and the percentage of family enrollees increased from 9 percent to 52 percent. In ten states, the percent of single enrollees in HDHPs was below the national average, including Hawaii (11%), the District of Columbia (35%), and California (38%). In 16 states, the share was above the national average, including Maine (67%), South Dakota (73%), and New Hampshire (76%).
- These results can inform efforts to improve availability and affordability of employment-based insurance.

Research Management and Support				
	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$ 71,300,000	$ 71,300,000	$ 53,551,000	$ (17,749,000)
FTE	273	277	238	-39

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2020 Authorization……Expired.
Allocation Method…….…….... Other.

Research Management and Support (RMS): RMS (formerly known as Program Support) activities provide administrative, budgetary, logistical, and scientific support in the review, award, and monitoring of research grants, training awards, and research and development contracts. RMS functions also encompass strategic planning, coordination, and evaluation of the Institute's programs, regulatory compliance, international coordination, and liaison with other Federal agencies, Congress, and the public.

FY 2020 President's Budget Policy: The FY 2020 President's Budget level for Research Management and Support (RMS) is $53.5 million, a decrease of $17.7 million from the FY 2019 Enacted level. In FY 2020, the reorganization transitioned AHRQ activities to the NIH as an Institute and ended some programmatic activities. This reduction in scope necessitated a decrease of 39 FTEs funded with discretionary accounts at the 2019 Enacted level. The FY 2020 President's Budget for Research Management and Support provides necessary one-time support related to close-out activities for research that is ending and workforce reduction expenses, as well as ongoing research management costs related to moving AHRQ's activities to the National Institute of Health (NIH).

As shown below, AHRQ does have additional FTEs supported with other funding sources, including an estimated 1 FTE from other reimbursable funding and an estimated 7 FTEs supported by the Patient-Centered Outcomes Research Trust Fund. The estimate for the PCORTF is preliminary and will be finalized once activities are decided for FY 2020.

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
FTEs – Budget Authority	269	276	237
FTEs – PCORTF	8	7	7
FTEs – Other Reimbursable	4	1	1

Mechanism Table:

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

	AHRQ FY 2018 Final		AHRQ FY 2019 Enacted		NIRSQ FY 2020 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**0**		**0**		**0**
RESEARCH MANAGEMENT……		**71,300**		**71,300**		**53,551**
TOTAL.....		**71,300**		**71,300**		**53,551**

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information about the Agency for Healthcare Research and Quality (AHRQ) and are provide for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ into the National Institutes of Health (NIH), and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

5-Year Funding History:

FY 2016:	$71,200,000
FY 2017:	$70,844,000
FY 2018 Final:	$71,300,000
FY 2019 Enacted:	$71,300,000
FY 2020 President’s Budget:	$53,551,000

Nonrecurring Expenses Fund

Budget Summary
(Dollars in Thousands)

	FY 2018[2]	FY 2019[3/4]	FY 2020[5]
Notification[1]	--	$1,500	TBD

Authorizing Legislation:
Authorization……Section 223 of Division G of the Consolidated Appropriations Act, 2008
Allocation Method…….……..……..Direct Federal, Competitive Contract

Program Description and Accomplishments:

The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds from FY 2008 and subsequent years into the NEF account. Congress authorized use of the funds for capital acquisitions necessary for the operation of the Department, specifically information technology (IT) and facilities infrastructure acquisitions.

As mandated by Congress, AHRQ produces an annual comprehensive overview of the quality of U.S health care and disparities in that care. The National Healthcare Quality and Disparities Report (QDR) serves as the Nation's dashboard on healthcare quality, disparities, and patient safety for Congress, state and local policymakers, and public health officials. It currently consists of a suite of resources including a core report, chart books on select topics, a website that features information for national benchmarks and state-level snapshots, and a basic online data query system. The NEF will support a one-time investment to upgrade the QDR IT platform. AHRQ will transition the current QDR to an interactive and integrated online dashboard incorporating national, state and local statistics from across HHS. It will serve as a flexible and interactive tool that has the capacity to add new dashboards that support HHS and Secretarial Priority areas in order to inform decision-makers in a timely manner.

The goal of the QDR is to assess the performance of our health care system and identify areas of strengths and weaknesses, as well as disparities, for access to health care and quality of health care. The current QDR includes more than 250 measures of quality and disparities covering a broad array of health care services and settings. NEF funding will allow AHRQ to expand the data capabilities of the QDR while unleashing the data for use by state and local decision makers. The new QDR data platform will advance the nation's efforts to improve health care quality safety, and disparities by building on the strong foundation already established by AHRQ. The entire healthcare ecosystem is data-driven and digitized. Hence, it is an operational imperative that our QDR platform reflect that reality.

The AHRQ QDR platform was built using technology that is more than a decade old. Given the rapid technology advancements that has since occurred it requires a significant overhaul. In its current state, it is difficult and costly to maintain and support. There is an urgent need to upgrade the platform so that it can meet the requirements for real-time data and predictive analytics. While the QDR has evolved over its 14 years, the data needs of health care decision makers and the capacities of data platforms have also evolved. In order to maximize our annual federal investment and meet the needs of Departmental, state, and local policy makers, AHRQ must update the underlying data platform that powers the QDR. By advancing our data technology, this one-time investment will expand the Agency's ability to incorporate national data sources, enhance real-time data query capacities and predictive analytics, thereby improving the accessibility, utility, and timeliness of the QDR resources for Congress, HHS, and state and local health care decision makers.

Additionally, the NEF has provided approximately $13 million to AHRQ for the development of the Quality and Safety Review System (QSRS) to replace the antiquated Medicare Patient Safety Monitoring System (MPSMS), which has been used by CMS and AHRQ to manually abstract a sample of medical records to determine at national rate of hospital-acquired conditions. To date, QSRS has been extensively tested by abstractors in the CMS Clinical Data Abstraction Center (CDAC) and by approximately 10 hospitals in two hospital systems. With feedback received from the CDAC and hospital pilots, AHRQ has continued to improve the validity and reliability of QSRS, while enhancing usability. AHRQ has further developed QSRS to refine the underlying algorithms to ensure correct measurement, and added data visualization functionality among other enhancements in the past year.

Budget Allocation:
The development of the new QDR data platform will be funded in its entirety from NEF with the operations and maintenance activities covered under AHRQ's annual appropriation using existing staffing and support contracts. AHRQ anticipates the project costs to be approximately $1.5 million in FY 2019 including all planning, development, and deployment activities.

[1] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.

[2] There was no Congressional notification for the planned uses of NEF funds in FY 2018.

[3] Notification #6submitted to the Committee on Appropriations in the House of Representatives and the Senate on December 4, 2018.

[4] Amounts notified are approximations of intended use. Amounts displayed here are current best estimates.

[5]HHS has not yet notified for FY 2020.

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

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
Personnel compensation:				
Full-time permanent (11.1)	30,438,301	30,648,547	26,107,731	(4,540,816)
Other than full-time permanent (11.3)	3,559,006	3,575,911	3,052,653	(523,258)
Other personnel compensation (11.5)	1,113,054	1,118,341	954,696	(163,645)
Military personnel (11.7)	731,363	750,013	513,706	(236,307)
Special personnel services payments (11.8)				
Subtotal personnel compensation	**35,841,724**	**36,092,812**	**30,628,785**	**(5,464,027)**
Civilian benefits (12.1)	10,687,229	10,737,993	7,942,065	(2,795,928)
Military benefits (12.2)	333,686	342,195	219,091	(123,104)
Benefits to former personnel (13.0)			1,518,334	1,518,334
Total Pay Costs	**46,862,639**	**47,173,000**	**40,308,276**	**(6,864,724)**
Travel and transportation of persons (21.0)	257,943	262,328	250,000	(12,328)
Transportation of things (22.0)	5,000	5,085	5,000	(85)
Rental payments to GSA (23.1)	3,233,669	3,288,641	2,800,000	(488,641)
Rental payments to Others (23.2)				
Communication, utilities, and misc. charges (23.3)	129,249	131,446	100,000	(31,446)
Printing and reproduction (24.0)	25,136	25,563	25,000	(563)
Other Contractual Services:				
Advisory and assistance services (25.1)				
Other services (25.2)	9,923,614	10,092,315	9,402,724	(689,591)
Purchase of goods and services from government accounts (25.3)	20,350,470	20,696,428	11,701,458	(8,994,970)
Operation and maintenance of facilities (25.4)				
Research and Development Contracts (25.5)	142,392,758	144,215,766	110,323,886	(33,891,880)
Medical care (25.6)				
Operation and maintenance of equipment (25.7)	480,778	488,951	340,000	(148,951)
Subsistence and support of persons (25.8)				
Subtotal Other Contractual Services	**173,147,620**	**175,493,461**	**131,768,068**	**(43,725,393)**
Supplies and materials (26.0)	120,868	122,923	120,000	(2,923)
Equipment (31.0)	1,138,220	1,157,570	200,000	(957,570)
Land and Structures (32.0)				
Investments and Loans (33.0)				
Grants, subsidies, and contributions (41.0)	108,016,631	110,339,983	80,383,656	(29,956,327)
Interest and dividends (43.0)				
Refunds (44.0)				
Total Non-Pay Costs	**286,074,336**	**290,827,000**	**215,651,724**	**(75,175,276)**
Total Budget Authority by Object Class	**332,936,975**	**338,000,000**	**255,960,000**	**(82,040,000)**

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.
2/ Does not include mandatory financing from the PCORTF.

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

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
Personnel compensation:				
Full-time permanent (11.1)	30,438,301	30,648,547	26,107,731	(4,540,816)
Other than full-time permanent (11.3)	3,559,006	3,575,911	3,052,653	(523,258)
Other personnel compensation (11.5)	1,113,054	1,118,341	954,696	(163,645)
Military personnel (11.7)	731,363	750,013	513,706	(236,307)
Special personnel services payments (11.8)				
Subtotal personnel compensation	**35,841,724**	**36,092,812**	**30,628,785**	**(5,464,027)**
Civilian benefits (12.1)	10,687,229	10,737,993	7,942,065	(2,795,928)
Military benefits (12.2)	333,686	342,195	219,091	(123,104)
Benefits to former personnel (13.0)			1,518,334	1,518,334
Total Pay Costs	**46,862,639**	**47,173,000**	**40,308,276**	**(6,864,724)**
Travel and transportation of persons (21.0)	257,943	262,328	250,000	(12,328)
Transportation of things (22.0)	5,000	5,085	5,000	(85)
Communication, utilities, and misc. charges (23.3)	129,249	131,446	100,000	(31,446)
Printing and reproduction (24.0)	25,136	25,563	25,000	(563)
Other Contractual Services:				
Other services (25.2)	9,923,614	10,092,315	9,402,724	(689,591)
Operation and maintenance of equipment (25.7)	480,778	488,951	340,000	(148,951)
Subtotal Other Contractual Services	**10,404,392**	**10,581,267**	**9,742,724**	**(838,543)**
Supplies and materials (26.0)	120,868	122,923	120,000	(2,923)
Total Non-Pay Costs	**10,942,588**	**11,128,612**	**10,242,724**	**(885,888)**
Total Salary and Expense	57,805,227	58,301,612	50,551,000	(7,750,612)
Direct FTE	273	277	238	(39)

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

2/ Does not include mandatory financing from the PCORTF.

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

	2018 Actual Civilian	2018 Actual Military	2018 Actual Total	2019 Est. Civilian	2019 Est. Military	2019 Est. Total	2020 Est. Civilian	2020 Est. Military	2020 Est. Total
Office of the Director (OD)									
Direct:	7	0	7	8	0	8	6	0	6
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	7	0	7	8	0	8	6	0	6
Office of Management Services (OMS)									
Direct:	55	0	55	57	0	57	57	0	57
Reimbursable:	1	0	1	0	0	0	0	0	0
Total:	56	0	56	57	0	57	57	0	57
Office of Extramural Research, Education, and Priority Populations (OEREP)									
Direct:	31	2	33	33	2	35	33	1	34
Reimbursable:	1	0	1	1	0	1	1	0	1
Total:	32	2	34	34	2	36	34	1	35
Center for Evidence and Practice Improvement (CEPI)									
Direct:	43	2	45	43	2	45	31	1	32
Reimbursable:	1	0	1	0	0	0	0	0	0
Total:	44	2	46	43	2	45	31	1	32
Center for Delivery, Organization and Markets (CDOM)									
Direct:	25	0	25	27	0	27	20	0	20
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	25	0	25	27	0	27	20	0	20
Center for Financing, Access, and Cost Trends (CFACT)									
Direct:	42	0	42	42	0	42	42	0	42
Reimbursable:	1	0	1	0	0	0	0	0	0
Total:	43	0	43	42	0	42	42	0	42
Center for Quality Improvement and Patient Safety (CQuIPS)									
Direct:	31	2	33	31	2	33	29	2	31
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	31	2	33	31	2	33	29	2	31
Office of Communications and Knowledge Transfer (OCKT)									
Direct:	29	0	29	29	0	29	15	0	15
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	29	0	29	29	0	29	15	0	15
AHRQ FTE Total	267	6	273	271	6	277			
NIRSQ FTE Total							234	4	238

Average GS Grade	
FY 2016	13.1
FY 2017	13.1
FY 2018	13.1
FY 2019	13.1
FY 2020	13.1

1/ Excludes mandatory PCORTF FTEs. Includes reimbursable FTEs.

2/ For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

NATIONAL INSTITUTES OF HEALTH
National Institute for Research on Safety and Quality
Detail of Positions [1/] [2/]

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Executive level I	3	3	3
Executive level II	6	5	5
Executive level III			
Executive level IV			
Executive level V			
Subtotal Executive Level Positions	9	8	8
Total - Exec. Level Salaries	$ 2,048,949	$ 1,919,881	$ 1,919,881
Total SES, AHRQ	4	4	
Total - ES Salary, AHRQ	$ 788,097	$ 782,518	
Total SES, NIRSQ			4
Total - ES Salary, NIRSQ			$ 782,518
GS-15	63	63	40
GS-14	69	71	59
GS-13	68	69	47
GS-12	16	16	11
GS-11	8	8	8
GS-10			
GS-9	9	9	9
GS-8			
GS-7	4	5	2
GS-6	2	2	2
GS-5	2	2	1
GS-4	1	1	
GS-3			
GS-2			
GS-1			
Subtotal	242	246	179
Average GS grade, AHRQ	13.1	13.1	
Average GS salary, AHRQ	$ 96,970	$ 97,431	
Average GS grade, NIRSQ			13.1
Average GS salary, NIRSQ			$ 97,431

1/ Excludes Special Experts, Serivces Fellows and Commissioned Officer positions. Also excludes positions financed using mandatory financing from the PCORTF.
2/ For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

National Institute for Research on Safety and Quality

FY 2020 Congressional Justification

Programs Proposed for Elimination

Health Information Technology Research Portfolio

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

Budget Authority (BA)[1]:

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$16,500,000	$16,500,000	$0	-$16,500,000

[1]For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

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

Program Description and Accomplishments

The purpose of the Health Information Technology (Health IT) portfolio is to rigorously show how health IT can improve the quality of American health care. The portfolio develops and synthesizes the best evidence on how health IT can improve the quality of American health care, disseminates that evidence, and develops evidence-based tools for the effective use of health IT. By identifying what works and developing resources and tools, the portfolio has played a key role in the Nation's drive to accelerate the use of safe, effective, patient-centered health IT innovations.

In FY 2018, the Health IT portfolio within AHRQ will fund $14.0 million in research grants to increase understanding of the ways health IT can improve health care quality. Early research efforts built the evidence base regarding facilitators and barriers to health IT adoption and the value of health IT implementation. Research in 2018 expanded on solutions for health IT access to healthcare consumers through patient-facing technologies like patient portals. AHRQ supports research to determine how these patient-facing technologies can best improve the quality and effectiveness of care and several of these studies are scheduled for completion in 2018. Results from these studies are providing evidence-based, practical methods to improve the adoption and accessibility of these technologies.

AHRQ's health IT research also supported key HHS priorities such as alleviating EHR-related provider burden through usability research that focuses on how to design and implement electronic health records (EHRs) so that they are more intuitive to use and more readily support clinical workflow. In addition, $2.5 million in contract funds were used to support the synthesis and dissemination of health IT evidence. At the FY 2019 Enacted level, the Health IT portfolio continues total funding of $16.5 million.

Funding History within AHRQ

Fiscal Year	Amount
FY 2016	$21,500,000
FY 2017	$16,500,000
FY 2018 Final	$16,500,000
FY 2019 Enacted	$16,500,000
FY 2020 President's Budget	$0

Budget Request

The FY 2020 President's Budget does not consolidate this activity of AHRQ's in NIH. The FY 2020 Budget Request is $0.0 million, a decrease of $16.5 million from AHRQ's FY 2019 Enacted. The goal of the reorganization is to focus resources on the highest priority research, reorganize federal activities in a more effective manner, and provide increased coordination on health services research activities and patient safety. The FY 2020 President's Budget ends dedicated funding for health IT. Instead, health IT research will compete for funding opportunities within patient safety and health services research to ensure the highest priority research is funded.

NATIONAL INSTITUTES OF HEALTH
National Institute for Research on Safety and Quality
FTEs Funded by the Affordable Care Act 1/
(Dollars in Thousands)

Program	Section	FY 2010			FY 2011			FY 2012			FY 2013			FY 2014			FY 2015		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
Prevention and Public Health Fund	4002																		
AHRQ Mandatory		$ -	0	0	$ 384	3	0	$ -	0	0	$ -	0	0	$ -	0	0	$ -	0	0
NIRSQ Mandatory																			
Patient-Centered Outcomes Research Trust Fund	6301																		
AHRQ Mandatory		$ -	0	0	$ -	0	0	$ 366	4	0	$ 633	6	0	$ 1,505	13	0	$ 1,644	10	0
NIRSQ Mandatory																			

Program	Section	FY 2016			FY 2017			FY 2018			FY 2019			FY 2020		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
Prevention and Public Health Fund	4002															
AHRQ Mandatory		$ -	0	0	$ -	0	0	$ -	0	0	$ -	0	0			
NIRSQ Mandatory														$ -	0	0
Patient-Centered Outcomes Research Trust Fund	6301															
AHRQ Mandatory		$ 1,430	10	0	$ 1,387	8	0	$ 1,129	8	0	$ 1,500	7	0			
NIRSQ Mandatory														$ 1,500	7	0

1/ For this and all other tables, the FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

NATIONAL INSTITUTES OF HEALTH

National Institute for Research on Safety and Quality

Key Outputs and Outcomes Tables

Program: Patient Safety

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
1.3.38 Increase the number of users of research using AHRQ-supported research tools to improve patient safety culture (Outcome)	FY 2018: 3531 users of research (Target Exceeded)	3650 users of research	3750 users of research	+100 users of research
1.3.41 Increase the cumulative number of evidence-based resources and tools available to improve the quality of health care and reduce the risk of patient harm. (Outcome)	FY 2018: 191 tools and evidence-based resources (Target Exceeded)	200 tools and evidence-based resources	215 tools and evidence-based resources	+15 tools
1.3.62 Reduce the rate of CAUTI cases in hospital intensive care units (ICUs) (Outcome)	FY 2017: 1.60 CAUTI/1,000 catheter days: Baseline NHSN Rate 10.26 CAUTI/10,000 patient days: Baseline Population Rate Target: Baseline NHSN Rate and Population Rate established (Target Met)	5% reduction from FY 2019 Baseline NHSN and Population Rates.	5% reduction from FY 2020 Baseline NHSN and Population Rates	N/A

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

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

Healthcare organizations can use SOPS to: raise staff awareness about patient safety, examine trends in culture over time, conduct internal and external benchmarking, and identify strengths and areas for improvement. SOPS can be used to assess the safety culture of individual units and departments or organizations as a whole.

Since the 2004 release of the hospital SOPS, thousands of health care organizations have implemented the surveys and downloaded SOPS and the related resources from the AHRQ Web site. The interest in the resources has remained strong over the past 13 years as evidenced by electronic downloads, orders placed for various products, participation in SOPS Webinars, and requests for technical assistance.

In response to requests from SOPS users and patient safety researchers, AHRQ established comparative databases as central repositories for survey data from healthcare organizations that have administered the SOPS. Upon meeting minimal eligibility requirements, healthcare organizations can voluntarily submit their survey data for aggregation and compare their safety culture survey results to others. In FY 2014, AHRQ moved to a bi-annual collection of survey data to enhance accuracy of the survey results and reduce the burden on organizations.

In FY 2018, the submissions to the comparative databases were provided by 3,531 users of research, including: 630 hospitals; 2,437 medical offices; 209 nursing homes; and 255 community pharmacies. This number does not reflect users of the Ambulatory Surgery Center SOPS since there is not currently a comparative database for this particular SOPS survey. In FY 2019 and 2020, the Agency projects that the users of the comparative databases will remain in a steady state due to a levelling off of comparative database activities. The number of SOPS users, who submit results to the comparative databases, is only a portion of the total number of users.

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

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

The Agency has provided resources and tools such as:

- AHRQ Patient Safety Network (AHRQ PSNet) & Web M&M (Morbidity and Mortality Rounds on the Web);
- AHRQ's Safety Program for Nursing Homes: On-Time Pressure Ulcer Prevention;
- Common Formats (standardized specifications for reporting patient safety events);
- The Community-Acquired Pneumonia (CAP) Patient Safety Clinical Decision Support Implementation Toolkit;
- Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families;
- Improving Medication Safety in High Risk Medicare Beneficiaries Toolkit;
- Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation;
- Nursing Home Antimicrobial Stewardship Modules;
- Preventing Hospital-Acquired Venous Thromboembolism: A Guide for Effective Quality Improvement
- Re-Engineered Discharge (RED) Toolkit;
- The Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care;
- The Toolkit to Engage High-Risk Patients In Safe Transitions Across Ambulatory Settings;
- The Toolkit to Improve Safety for Mechanically Ventilated Patients; and
- The Toolkit to Promote Safe Surgery.

The Patient Safety Portfolio is projecting that the number of evidence-based resources and tools will continue to increase with a projected cumulative number of 200 in FY 2019 and 215 in FY 2020.

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

A performance measure has been developed in connection with an HAI project as follow-on to earlier CUSP projects. Data from the CUSP for CAUTI project have shown that hospital units other than intensive care units (ICUs) have achieved greater reductions in CAUTI rates than ICUs. It appears that this difference is related to the clinical culture of the ICU, where staff who are treating critically ill patients favor maintaining indwelling urinary catheters to closely monitor urine output for relatively longer times than in non-ICUs. In a similar vein, some hospitals in the CUSP for CLABSI project did not achieve the significant reductions in CLABSI rates that were attained by their peers. The current HAI project is adapting CUSP to bring down persistently elevated CAUTI and CLABSI rates in ICUs. The performance measure focuses on CAUTI rates because the baseline rate for CAUTI is likely to be easier to estimate and more stable than for CLABSI.

In FY 2020, AHRQ will continue the expansion of the CUSP project for reducing CAUTI and CLABSI rates in ICUs with persistently elevated rates of these infections, using FY 2019 funds. This expansion from four regions of the country to nationwide coverage was initially funded

with FY 2017 funds, and expansion activities began at the beginning of FY 2018. The FY 2020 HAI performance measure assesses progress toward reducing the rate of CAUTI in ICUs participating in the CUSP project.

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

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

The FY 2017 baseline rate provides an initial picture of the CAUTI rates in the ICUs. However, this rate will not be used to gauge progress in FY 2018, FY 2019, or FY 2020 because ICUs will be recruited into the project on a rolling basis. Instead, a contemporaneous baseline CAUTI rate will be derived from all the ICUs participating in the project in FY 2018, FY 2019, and FY 2020, respectively. Given the virtual absence of reductions in CAUTI rates observed in ICUs in the nationwide CUSP for CAUTI project, the targets for FY 2018, FY 2019, and FY 2020 will have to be set quite conservatively in light of the fact that the participating ICUs have been chosen because they are among the lower-performing units in terms of reducing their rate of CAUTI (and/or CLABSI).

Recruitment of the project's FY 2018 cohort, consisting of 126 ICUs, has been completed. The baseline period for the cohort runs from May 2017 to April 2018. In light of data lags, complete baseline data for the entire cohort are expected to be available in October 2018. The intervention period for the cohort runs from May 2018 to April 2019. Results are expected to be available in late summer 2019.

Program: Health Services Research, Data and Dissemination (HSR)

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
2.3.8 Increase the availability of electronic clinical decision support tools related to safe pain management and opioid prescribing (Output)	FY 2018: Developed and tested a dashboard that aggregates pain-related information into one consolidated view for clinicians. Information includes data such as pain medications, pain assessments, pain-related diagnoses, and relevant lab test results. (Target Met)	Test, revise, and disseminate at least one new electronic clinical decision tool related to safe pain management and opioid prescribing Partner with stakeholders to identify additional evidence-based electronic clinical decision tools related to safe pain management and opioid prescribing and make them publicly available	Develop, test, and disseminate at least one electronic clinical decision support tool related to opioids or safe chronic pain management	N/A

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

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

In FY 2018, AHRQ developed a dashboard that aggregates pain-related information from the EHR into one consolidated view for clinicians. The information includes data such as pain medications, pain assessments, relevant diagnoses, and lab test results. The dashboard was tested in partnership with OCHIN, a network of community health centers, and uses the HL7 FHIR standard, which allows for interoperability and implementation in different EHRs.

In FY 2018 and continuing in FY 2019, AHRQ will disseminate safe pain management and opioid-related CDS through CDS Connect. This includes the pain management dashboard developed in FY 2018. AHRQ continues to present its work in CDS at national meetings of key organizations, such as the American Medical Informatics Association and the Healthcare Information and Management Systems Society. In addition, AHRQ will continue to work with its federal partners to disseminate safe pain management and opioid CDS tools. For example, the CDC uses AHRQ's CDS Connect web platform as a dissemination mechanism for two opioid CDS tools that were developed by CDC and ONC.

In FY 2019 and continuing in FY2020, AHRQ will develop, test, and disseminate another electronic clinical decision support tool related to opioids or safe chronic pain management. AHRQ will continue to work with its partners and stakeholders on dissemination.

Program: United States Preventive Services Task Force (USPSTF)

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
2.3.7 Increase the percentage of older adults who receive appropriate clinical preventive services (Output)	FY 2018: PSAQ data collection began and is underway. (In Progress)	Continue PSAQ data collection through 2019. The panel design of the survey features several rounds of interviewing covering two full calendar years. Data should be available in 2020.	New data for the PSAQ prevention items available Begin analysis on the new data	N/A

2.3.7: Increase the percentage of adults who receive appropriate clinical preventive services

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

For several years, AHRQ has invested in creating a national measure of the receipt of appropriate clinical preventive services by adults (measure 2.3.7). A necessary first step in creating quality improvement within health care is measurement and reporting. Without the ability to know where we are and the direction we are heading, it is difficult to improve quality. This measure will allow AHRQ to assess where improvements are needed most in the uptake of clinical preventive services. It will help AHRQ support the USPSTF by targeting its recommendations and dissemination efforts to the populations and preventive services of greatest need. Thus, making sure the right people get the right clinical preventive services, in the right interval. The data from this measure can also identify gaps in the receipt of preventive services and therefore inform the Department's and the public health sector's prevention strategies.

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

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

Program: Medical Expenditure Panel Survey (MEPS)

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
1.3.16 Maintain the number of months to produce the Insurance Component tables following data collection (MEPS-IC) (Output)	FY 2018: 6 months (Target Met)	6 months	6 months	Maintain
1.3.19 Increase the number of tables per year added to the MEPS table series (Output)	FY 2018: 9,377 total tables in MEPS table series (Target Exceeded)	9627 total tables in MEPS table series	9877 total tables in MEPS table series	+250 total tables in MEPS table series
1.3.21 Decrease the number of months required to produce MEPS data files (i.e. point-in-time, utilization and expenditure files) for public dissemination following data collection (MEPS-HC) (Output)	FY 2018: 9 months (Target Met)	9 months	9 months	Maintain

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

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

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

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

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

Schedules for data release will be maintained for FY 2018 through FY 2019. Further reducing the target time is not feasible because the proration and post-stratification processes are dependent upon the timing and availability of key IRS data that are appended to the survey frame. Data trends from 1996 through 2016 are mapped using the MEPSnet/IC interactive search tool. In addition, special runs are often made for federal and state agencies that track data trends of interest across years.

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

The MEPS HC Tables Compendia has recently been updated moving to a more user friendly and versatile format (https://meps.ahrq.gov/mepstrends/home/index.html). Interactive tables are provided for the following: use, expenditures and population; health insurance, accessibility and quality of care; medical conditions and prescribed drugs.

The MEPS Tables Compendia is scheduled to be expanded a minimum of 250 tables per year. For the Insurance Component there are a total of 2,603 national level tables and 5,443 state and metro area tables. The total number of tables available to the user population is currently 8,046.

The MEPS Tables Compendia is a source of important data that is easily accessed by users. Expanding the content and coverage of these tables furthers the utility of the data for conducting research and informing policy. Currently data are available in tabular format for the years 1996 – 2016. This represents twenty years of data for both the Household and Insurance Components, enabling the user to follow trends on a variety of topics.

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

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

We have achieved the data release schedule for all the targeted MEPS public release files that were scheduled for release during FY 2018. We are on target to also meet the data release schedule for the MEPS public use files scheduled for release during FY 2019. The release date for public use files (jobs, home health, other medical expense, dental visits, medical provider visits, outpatient department visits, emergency room visits, hospital stays, prescribed drugs, and full year consolidated) will be maintained moving from FY 2018 to FY 2019. The current release dates for all public use files will be maintained for FY 2020.

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

Summary of Proposed Changes in Performance Measures

AHRQ/NIRSQ 1/

Unique Identifier	Change Type	Original in FY 2019 CJ	Proposed Change	Reason for Change	HHS Performance Plan (APP/R) Measure
1.3.19	Modify Target	9449 total tables in MEPS table series	9627 total tables in MEPS table series	Increase in target based on FY 2018 Results	No
1.3.60	Delete	Measure was defunded in 2020 President's Budget	Delete measure: Identify key design principles that can be used by health IT designers to improve Personal Health Information Management (PHIM)	Program defunded	No

1/ The FY 2018 and FY 2019 columns contain information for the Agency for Healthcare Research and Quality and is provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the requests for the National Institute for Research on Safety and Quality.

Physicians' Comparability Allowance (PCA)

1) Department and component:

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

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

Most, if not all, of the research positions at AHRQ are in occupations that are in great demand, commanding competitive salaries in an extremely competitive hiring environment. This includes the 602 (Physician) series which is critical to advancing AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable. Since the Agency has not utilized other mechanisms for the 602 series (for example, Title 38), it is imperative that the Agency offers PCAs to recruit and retain physicians at AHRQ. In the absence of PCA, the Agency would be unable to compete with other Federal entities within HHS and other sectors of the Federal government which offer supplemental compensation (in addition to base pay) to individuals in the 602 series.

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

	AHRQ 2018 Final	**AHRQ FY 2019 Enacted**	**NIRSQ FY 2020 President's Budget**
3a) Number of Physicians Receiving PCAs	22	22	21
3b) Number of Physicians with One-Year PCA Agreements	0	0	0
3c) Number of Physicians with Multi-Year PCA Agreements	22	22	21
4a) Average Annual PCA Physician Pay (without PCA payment)	154,213	149,699	143,406
4b) Average Annual PCA Payment	$24,409	24,429	24,285

1/ For this and all other tables, the FY 2018 and FY 2019 column contains information for the Agency for Healthcare Research and Quality and are provided for convenience and transparency. The FY 2020 President's Budget consolidates AHRQ's activities into NIH, and the FY 2020 column represents the request for the National Institute for Research on Safety and Quality.

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

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

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

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

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

Antibiotic Resistance

1. **SENATE (Rept. 115-289)**

The Committee notes that while AHRQ has been the leader in developing the tools and resources to help providers improve their antibiotic stewardship programs, the agency has not updated several publications related to the use of procalcitonin [PCT] tests in sepsis and antibiotic treatment programs in more than 5 years. The Committee encourages AHRQ to collaborate with NIH, HRSA, BARDA, CDC, FDA and other relevant agencies to review and update their publications with the latest FDA approved uses for PCT tests in antibiotic stewardship. The Committee requests an update on these activities in the fiscal year 2020 CJ.

Action Taken or to be Taken:

On November 15, 2018, AHRQ staff met with leadership from Thermo Fisher Scientific, one of the companies that manufactures the procalcitonin test. AHRQ staff discussed the Agency's role in evidence development through AHRQ's Evidence-based Practice (EPC) program, and emphasized the need to forge partnerships with professional and/ or medical societies for the EPC systematic reviews so that the partner organizations could use the latest evidence for the development of best practice tools such as clinical practice guidelines or professional society recommendations. AHRQ recommends such an approach be pursued before updating publications related to PCT tests in sepsis and antibiotic treatment programs. AHRQ staff will reach out to NIH, HRSA, BARDA, CDC, FDA, and other relevant agencies to see if there is interest in supporting a systematic evidence review on PCT tests in sepsis and antibiotic treatment programs

Centers of Diagnostic Excellence

2. **SENATE (Rept. 115-289**)

Centers of Diagnostic Excellence.--The Committee is concerned about the lack of dedicated funding for research into improving how medical conditions are diagnosed, considering the size and impacts of patient harms resulting from diagnostic safety and quality challenges. The Committee encourages AHRQ to dedicate resources to support the creation of Centers of Diagnostic Excellence that will create core diagnostic research hubs for diagnostic safety and quality research; utilize strategic partnerships that capitalize on the capabilities of both academic research institutions and non-academic healthcare, science, and technology stakeholders; and incentivize high-impact research on novel solutions to improve diagnosis.

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

Action Taken or to be Taken:

AHRQ shares the Committee's concern about improving how medical conditions are diagnosed in an effort improve patient safety and quality of care. AHRQ is working to develop a solicitation for grant applications (RFA, Request for Applications) to address diagnostic safety and quality. The additional $2 million AHRQ received in the FY2019 appropriation will be obligated for this grant funding opportunity, which will begin to address the impacts of patient harms resulting from diagnostic safety and quality challenges.

Diabetes

3. **SENATE (Rept. 115-289)**

The Committee is concerned about the significant costs associated with providing care for individuals that suffer from diabetes, including those from medically underserved low health literacy populations. The Committee encourages AHRQ consider a pilot or demonstration program to support safety net clinics in increasing health literacy and preventing diabetes with the goal of reducing long-term costs.

Action Taken or to be Taken:

In FY 2019, AHRQ anticipates funding investigator-initiated grants that use innovative approaches to data analytics to assess community patterns of chronic illness and modifiable risk factors, and clinical and community resources to support chronic disease prevention and management. Successful applicants will propose using data to support patient navigators embedded in primary care practices to identify patients at high risk for preventable disease or disease progression and connect them to clinical and community services in order to improve health outcomes. Given the prevalence of prediabetes and diabetes, we anticipate that some of these projects will focus on diabetes prevention and management.

Malnutrition

4. **SENATE (Rept. 115-289)**

The Committee greatly appreciates AHRQ's work to better understand malnutrition in U.S. hospitals. The Committee particularly notes AHRQ's initiative to support studies, the ``Characteristics of Hospital Stays Involving Malnutrition, 2013'' and follow-up ``All-Cause Readmissions Following Hospital Stays for Patients with Malnutrition, 2013'' that illustrated the consequences of malnutrition in hospital patients. The Committee urges AHRQ to convene a technical expert panel to assess the evidence for a malnutrition-related readmissions quality measure for the prevention of malnutrition in hospitals.

Action Taken or to be Taken

AHRQ has updated the 2013 studies on malnutrition. To further our understanding of malnutrition in U.S. hospitals, AHRQ released a report entitled "Non-Maternal and Non-Neonatal Inpatient Stays in the United States Involving Malnutrition, 2016 (August, 2018). As a follow-up to the 2013 national estimates, this report presents national estimates on the characteristics of inpatient stays and 30-day readmissions for malnutrition in 2016 (https://hcup-us.ahrq.gov/reports/HCUPMalnutritionHospReport_083018.pdf).

AHRQ is exploring the feasibility of convening a technical expert panel to assess the evidence for quality measures related to malnutrition in FY 2020. While the panel would focus on the evidence for all malnutrition-related measures, particular emphasis would be placed on evidence for measures focused on the elderly population.

Nursing

5. **SENATE (Rept. 115-289)**

The Committee notes that AHRQ-led research often highlights the unique contribution of nurses, including advanced practice and doctorally-prepared nurses. The Committee urges AHRQ to continue supporting health services research that takes into consideration the contributions of all providers, including nurses.

Action Taken or to be Taken

AHRQ recognizes the important contributions of all members of clinical teams to improve the quality of care, and the importance of multidisciplinary teams in conducting health services research. AHRQ welcomes all opportunities to support nurses including advanced practice and doctorally-prepared nurses as well as other clinicians in conducting health services research.

Palliative Care

6. **SENATE (Rept. 115-289)**

The Committee encourages AHRQ to consult with appropriate professional societies, hospice and palliative care stakeholders, and relevant patient advocate organizations to develop and disseminate information to patients, families, and health professionals about palliative care as an essential part of the continuum of quality care for patients with serious or life-threatening illness. Such materials and resources should include specific information regarding the demonstrated benefits of patient access to palliative care and the interdisciplinary services provided to patients by professionals trained in hospice and palliative care. The Secretary is encouraged to include

such information and materials on websites of relevant Federal agencies and departments, including the Centers for Medicare & Medicaid Services and the Administration for Community Living.

Action Taken or to be Taken

AHRQ recognizes that hospice and palliative care are a critical part of the continuum of high quality care for patients facing serious or life-threatening illness. AHRQ would be very interested in engaging with a variety of stakeholders on this topic to develop and disseminate information about palliative and hospice care given adequate resources to support this work. AHRQ will explore the feasibility of conducting an evidence synthesis of approaches taken by health systems and health plans to deliver palliative care; evidence about tools and resources for delivery of palliative care and its implementation, or factors associated with the effectiveness of palliative care.

Research and Training

7. **SENATE (Rept.115-289)**

The Committee notes the important role that AHRQ plays in supporting research training and career development activities, such as ``K" Awards and Mentored Clinical-Scientist Development Awards. Considering the current challenges facing physician-scientists and the young-investigator pipeline, AHRQ is encouraged to continue to prioritize these activities.

Action Taken or to be Taken

AHRQ is committed to fostering the next generation of health services researchers and uses investigator-initiated funding announcements to support and enhance the education and career development of young research investigators. AHRQ's research training opportunities are designed to prepare researchers to address the vast changes occurring in health care delivery. In FY2018, AHRQ awarded over $3 million ($3,065,323) in new training grants including dissertation grants and mentored career development awards. In addition, AHRQ awarded over $7 million ($7,410,716) in new institutional training grants and post-doctoral fellowships under the National Research Service Award program. AHRQ receives many inquiries about the research training programs available and will continue to provide these research training opportunities in the upcoming year.

Open Access to Federal Research

8. SENATE (Rept. 115-289)

The Committee has received reports from the Office of Science and Technology Policy [OSTP] on the progress of all Federal agencies in developing and implementing policies to increase public access to federally funded scientific research. The Committee commends the agencies funded in this bill who have issued plans in response to OSTP's policy directive issued in 2013. The Committee urges the continued efforts towards full implementation of the plan, and directs agencies to provide an update on progress made in the fiscal year 2020 CJ. This will ensure that the Committee remains apprised of the remaining progress needed to make federally funded research accessible to the public as expeditiously as possible.

Action Taken or to be Taken

AHRQ implemented its Policy for Public Access to AHRQ-Funded Scientific Publications on February 19, 2016 (https://grants.nih.gov/grants/guide/notice-files/NOT-HS-16-008.html). The Policy requires that AHRQ-funded authors submit an electronic version of the author's final peer-reviewed accepted manuscript to the National Library of Medicine (NLM)'s PubMed Central (PMC) upon acceptance by a journal, and to be made publicly available within 12 months of the publisher's date of publication. PMC is the designated repository of publications from AHRQ-funded grants, contracts, cooperative agreements, and intramural research.

In support of AHRQ users and manuscripts, AHRQ's staff closely monitor the AHRQ PMC submissions and produce monthly internal access reports, in close communications with NLM. Since the AHRQ Policy was in effect in 2016, a total of 4,342 AHRQ funded publications have been submitted to PMC. The submission of and public access to AHRQ funded publications continue to grow. For instance, from 2013-2015 AHRQ was receiving 50-100 submissions per year. Since 2016 the yearly submission reaches over 1,000. Average number of times AHRQ-supported publications accessed per month is 189,282 as of November 2018, as compared to 24,184 as of January 2017.

AHRQ has drafted Policy on Data Management Plan for both extramural and intramural research. This policy is to specify AHRQ's expectations for researchers to describe in the grant application and/or research proposal how the project team will manage and disseminate the primary data, samples, physical collections and other supporting materials created or gathered in the course of work. It is the first step to facilitate the prompt and broad dissemination of data, to make available to the public all scientific data arising from unclassified research and programs funded wholly or in part by AHRQ. The draft policy is currently under review.

SIGNIFICANT ITEMS

FY 2019 HOUSE REPORT 115-862

Sepsis Testing

1. **HOUSE (Rept. 115-862)**

AHRQ has been the leader in developing the tools and resources to help providers improve their antibiotic stewardship programs. The Committee is concerned that AHRQ has not updated several publications related to the use of procalcitonin (PCT) tests in sepsis and antibiotic treatment programs in more than five years. High sensitive PCT tests are critical tools for initiating and discontinuing antibiotic therapies and play a key role in antibiotic stewardship programs. The Committee urges AHRQ to collaborate with NIH, HRSA, BARDA, CDC, FDA, and other relevant agencies to review and update their publications with the latest FDA approved uses for PCT tests in antibiotic stewardship. The Committee requests an update on these activities in the fiscal year 2020 Congressional Justification.

Action Taken or to be Taken

On November 15, 2018, AHRQ staff met with leadership from Thermo Fisher Scientific, one of the companies that manufactures the procalcitonin test. AHRQ staff discussed the Agency's role in evidence development through AHRQ's Evidence-based Practice (EPC) program, and emphasized the need to forge partnerships with professional and/ or medical societies for the EPC systematic reviews so that the partner organizations could use the latest evidence for the development of best practice tools such as clinical practice guidelines or professional society recommendations. AHRQ recommends such an approach be pursued before updating publications related to PCT tests in sepsis and antibiotic treatment programs. AHRQ staff will reach out to NIH, HRSA, BARDA, CDC, FDA, and other relevant agencies to see if there is interest in supporting a systematic evidence review on PCT tests in sepsis and antibiotic treatment programs

SIGNIFICANT ITEMS

FY 2019 CONFERENCE Report (115-952)

Diagnostic Quality and Safety

1. **CONFERENCE (Rept. 115-952)**

Within the patient safety portfolio, the conferees include $2,000,000 to support grants to address diagnostic errors, which may include the establishment of Research Centers of Diagnostic Excellence to develop systems and new technology solutions to improve diagnostic safety and quality.

Action Taken or to be Taken:

AHRQ appreciates the Committee's support for recognizing the importance of improving diagnostic safety and quality in health care. As a result, AHRQ is working to develop a solicitation for grant applications (RFA, Request for Applications) to address diagnostic safety and quality. The additional $2 million appropriation will be obligated for this grant funding opportunity.

Population Health Research

2. **CONFERENCE (Rept. 115-952)**

The conferees provide $2,000,000 for the Director, in consultation with the Centers for Medicare & Medicaid Services, to establish a program to explore the effectiveness of data computing analytics to identify trends in chronic disease management and support the development of protocols for intervention and utilization of health care navigators to carry out those intervention strategies. The Director shall work in cooperation with qualified public institutions of higher education

Action Taken or to be Taken:

AHRQ appreciates the Committee's support to address chronic disease management. On November 26, 2018, AHRQ published a notice of intent to fund investigator-initiated grants in FY 2019 that would use data analytics to assess community patterns of chronic illness, modifiable risk factors, and clinical and community resources to support chronic disease prevention and management. Successful applicants will use data to support patient navigators embedded in primary care practices to identify patients at high risk for preventable disease or disease progression and connect them to clinical and community services in order to improve health outcomes. AHRQ anticipates publishing a Request for Applications or "RFA" early in 2019.