



U.S. Department of Health and Human Services



Agency for Healthcare Research and Quality

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Friends of AHRQ FY 2017 Briefing

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How AHRQ Makes a Difference

- AHRQ **invests in research and evidence** to understand how to make health care safer and improve quality
- AHRQ creates materials to **teach and train** health care systems and professionals to **catalyze** improvements in care
- AHRQ **generates measures and data** used to track and improve performance and evaluate progress of the U.S. health system



Patient Safety Results: Healthcare-Acquired Conditions

- An AHRQ report released at the end of 2015 shows that hospital care was much safer in 2014 than in 2010.
 - ▶ 2.1 million fewer harms to patients
 - ▶ 87,000 lives saved
 - ▶ \$20 billion in health care cost reductions from 2010 to 2014.
- The causes of this remarkable improvement are not fully understood, but are almost certainly related to AHRQ's patient safety activities, which have produced evidence over the past decade about how to improve safety, have invested in tools and training to make sure the evidence is understood and used, and in data and measures, as well as to the CMS Partnership for Patients initiative and Medicare payment reforms, which provided technical assistance and focused hospitals' attention on the problem.



EHRs Improving Patient Safety

- A new AHRQ [study](#) found that cardiovascular, surgery, and pneumonia patients whose complete treatment was captured in a fully electronic EHR were between **17 and 30 percent less likely to experience in-hospital adverse events.**
- The findings suggest that hospitals with EHRs can provide better coordinated care from admission to discharge that reduces the risk of harm reaching patients.



New Resources for Primary Care

- AHRQ published two new resources to help primary care clinicians and their patients make evidence-based decisions about which medications to use for treating alcohol use disorder (AUD).
- The new resources are designed to facilitate treatment discussions between clinicians and patients.
- Primary care providers are typically trained to refer patients with AUD for specialized treatment, and fewer than 10 percent of people treated for AUD receive medications currently



Opioid Misuse and Abuse

- AHRQ data helped to highlight a jump in hospitalizations among Medicare, Medicaid and private pay patients for overuse of Opioids.
- FY 2016 Initiative: Recent FOA for \$3M in grants funding demonstration projects that explore overcoming barriers to medication-assisted treatment (MAT) in primary care practices in rural areas. \$1M in contracts to fund evidence reviews regarding MAT on patient outcomes and research gaps.
- Applications due March 4, 2016.
- FY 2017 \$3M in continuation funding for grants and \$0.25 M in contract support for dissemination and technical support.



FY 2016 Impact

- Eliminate the following programs: HIV Research Network, National Quality Measures Clearinghouse, MONAHRQ, and Health Care Innovations Exchange.
- Seek efficiencies in the production of the National Healthcare Quality and Disparities Reports (QDRs), which may change the frequency with which data is updated.
- No new evidence reviews (except for Opioid research), no new implementation and rapid cycle research projects, no program evaluations, and decreased dissemination and implementation activities.



FY 2016 Impact

- No new research related to Multiple Chronic Conditions (MCC). People with MCC represent a growing segment of the population and currently comprise over one-quarter of the U.S. population and two-thirds of Medicare beneficiaries. Two-thirds of total health care spending in the United States is devoted to the care of persons with multiple chronic conditions.
- Reduction of \$1 Million in new grant funding to reduce the abuse of opioid drugs.



FY 2017 Request

- AHRQ's FY 2017 **discretionary** request totals **\$363.7 million** (\$280M in BA; \$83M in PHS Evaluation Funds)
- Increase of \$29.7 million from the FY 2016 Enacted.
- AHRQ's **total program level** at the FY 2017 Request is **\$469.7 million**, an increase of \$41.2 million from the FY 2016 Enacted.
- The total program level includes \$106.0 million in mandatory funds from the Patient-Centered Outcomes Research Trust Fund, an increase of \$11.5 million from the prior year.



FY 2017 Planning Priorities

- Priority 1: Improve Health Care Quality
 - ▶ \$9M Initiative within HSR, Data, and Dissemination (HSR) for research that optimizes care for Patients with **Multiple Chronic Conditions**.
 - ▶ **\$47.4M in investigator-initiated grant funding** within the HSR portfolio.
 - ▶ \$3.25M continuing funds within HSR, Data, and Dissemination to improve substance abuse (prescription drug and opioid) treatment.

- Priority 2: Make Health Care Safer
 - ▶ A total of \$76M for the Patient Safety Portfolio
 - ▶ \$35M for general patient safety research.
 - \$10M for Patient Safety Learning Labs
 - ▶ \$34M for research related to Healthcare-Associated Infections (HAIs).
 - \$12 M for Combatting Antibiotic-Resistant Bacteria
 - ▶ \$7M Patient Safety Organization (PSO) program.



FY 2017 Planning Priorities

- Priority 3: Increase Accessibility
 - ▶ \$68.9M to support the Medical Expenditure Panel Survey (MEPS). MEPS is the only national source for comprehensive annual data on how Americans use and pay for medical care.
- Priority 4: Improve Health Care Affordability, Efficiency and Cost Transparency
 - ▶ Continues funding within the HSR portfolio for several measurement and data collection activities that directly impact this priority.
 - ▶ \$17.1M for continued funding of the AHRQ Quality Indicators (QI) program, Consumer Assessments of Healthcare Providers and Systems (CAHPS), National Quality and Disparities Reports (QDRs), and the Healthcare Cost and Utilization Project (HCUP).
- Overall priority to maintain funding for MEPS, USPSTF, and total grant support (\$117.4M at the Request Level.)



Medical Expenditure Panel Survey

FY 2017 Request = \$68.9 M, an increase of \$2.9 M from the FY 2016 Enacted.

- The increase of \$2.9M will permit the MEPS to meet the precision levels of survey estimates, survey response rates and the timeliness, quality and utility of data products specified for the survey in prior years.
- The increase is associated with a change to the National Health Interview Survey (NHIS) sample. MEPS will have to interview people from the NHIS old sample and the new NHIS sample for a two year period. In addition, the new sample is more geographically dispersed causing increased fielding costs.