Alliance FOR AGING RESEARCH
35 Years of Patient Advocacy

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Executive Director
Patient-Centered Outcomes Research Institute
1828 L Street, NW Suite 900
Washington, DC 20036

RE: Patient-Centered Outcomes Research Institute's National Priorities for Health and Research Agenda

Dear Dr. Cook,

On behalf of the Alliance for Aging Research (the "Alliance"), we appreciate the opportunity to offer comments on the Patient-Centered Outcomes Research Institute's (PCORI) Proposed National Priorities for Health to help shape your organization's long-term goals for health through funding of comparative clinical effectiveness research (CER), stakeholder engagement, dissemination and implementation, and health communications. The Alliance aims to strengthen PCORI's efforts to help older adults make better-informed healthcare decisions and create research that will allow our healthcare system to better meet the needs of the aging population.

Overall, the Alliance is pleased with PCORI's ambitious list of proposed priorities. We applaud your efforts to solicit input from as many stakeholders as possible through webinars, virtual community convenings, and written public comments in English or Spanish. Our specific recommendations on each priority reflect PCORI's Congressional mandate to take potential age and other subpopulation differences into account when considering the inclusion criteria and design of research studies on the effectiveness of health care treatments and services.[1]

[1] Patient-Centered Outcomes Research Institute. Authorizing Legislation. https://www.pcori.org/about-us/governance/authorizing-legislation

Feedback on PCORI's Proposed Priorities

Priority: Increasing Evidence for Existing Interventions and Emerging Innovations in Health

Recommendation: Expand emphasis on head-to-head therapeutic and medical device studies

As a research organization designed to help patients and consumers make better-informed choices about their healthcare, PCORI should support more head-to-head studies of drugs and medical devices approved by the U.S. Food and Drug Administration (FDA) for similar indications. The bulk of PCORI-funded head-to-head studies compare the effectiveness of treatments across modalities. While cross-modality studies are important for patients in cases where the evidence has not yet been determined, we believe that comparing treatment options within a therapeutic class or similar medical device indication is equally important. Such head-to-head studies could assist patients and providers in identifying the benefits of a treatment not studied during the clinical trial process. These benefits can help physicians determine how a new medicine or medical device stacks up against the current standard of care, rather than only ensuring its equivalence,[2] and provide physicians with evidence-based recommendations for determining the most appropriate medication or medical device for their patients.

Patients should be involved throughout the process of designing head-to-head studies. Patients can help identify health outcomes and level of clinical meaningfulness that are significant to them, as well as differences in quality-of-life improvements between treatments. Additionally, more head-to-head trials of therapies within the same class can better inform sponsors on how to design future trials. Sponsors will have more information on making future trials more patient-centric, identifying the best endpoints for their trials, and establishing the standard of care for an indication.

Furthermore, there is a strong need for independent head-to-head studies. The literature on head-to-head trials has found that the majority are funded by industry, and resulting comparative assessments are usually favorable toward the company sponsoring the trial.[3] Companies are unlikely to invest in an expensive clinical trial if it may hurt their market share by rendering unfavorable results. PCORI should provide patients with independently collected data to assist in decision-making on multiple treatment options.

The Alliance recommends PCORI explore funding head-to-head studies recommended by the Agency for Healthcare Research and Quality (AHRQ) in its systematic reviews, such as oral

[2] Flacco, Maria Elena, Lamberto Manzoli, Stefania Boccia, "Head-to-head Randomized Trials Are Mostly Industry Sponsored and Almost Always Favor the Industry Sponsor." Journal of Clinical Epidemiology 68.7 (2015): 811-20. Journal of Clinical Epidemiology. 1 July 2015. https://www.jclinepi.com/article/S0895-4356(15)00058-X
[3] Ibid.

anticoagulants for stroke prevention in atrial fibrillation[4] and radiation therapy for brain metastases.[5] The Alliance would also encourage PCORI to fund head-to-head studies for FDA breakthrough therapies to further inform Phase 4 trials.

Recommendation: Lead efforts to identify non-QALY alternatives

Traditional value assessments typically use the problematic quality-adjusted life-year (QALY). The QALY was developed as an attempt by economists to combine the complexities of human health and the value of a particular medicine into a single metric. The Alliance is greatly concerned about the ethical and real-world implications of utilizing a metric that discounts older adults' – and individuals with a disability – health and does not account for the diversity of patient experience.[6] The Alliance requests that PCORI take a leadership role in identifying non-QALY economic approaches emphasizing patient-centered outcomes and preferences. While PCORI has funded external groups to explore such approaches, we believe the organization should make this effort a core internal initiative and convene external groups to help advise measure development.

We believe there are several actions that PCORI could take to move beyond this ageist metric and create a more patient-centered approach toward clinical effectiveness research.

First, we recommend that PCORI work with the FDA on patient-reported outcomes (PROs) as the agency develops guidelines and guidance on including PROs in evaluating new treatments. The FDA has several initiatives on PROs, and coordination with the agency would support additional advancement in identifying and collecting PROs. For example, in June 2021, the FDA released draft guidance on recommendations on how sponsors can collect meaningful PRO measurements to assess results from oncology clinical trials. The guidance focuses on identifying a set of core PRO measures for patients. PCORI should explore opportunities to work with the FDA to develop future guidances and hold public workshops on PROs.

Second, we believe that PCORI could serve a role in helping to identify relevant PROs and validating PROs. It would be useful for PCORI to help identify PROs that go beyond merely identifying symptoms to measuring aspects such as quality of life, functional status, and global ratings.

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[4] Agency for Healthcare Research and Quality and Patient-Centered Outcomes Research Institute. "Stroke Prevention in Patients With Atrial Fibrillation: A Systematic Review Update." Oct 2018. https://www.pcori.org/sites/default/files/PCORI-AHRQ-Stroke-Prevention-Atrial-Fibrillation-Patients-Systematic-Review-Update-Report-October-2018.pdf

[5] Patient-Centered Outcomes Research Institute. "Radiation Therapy for Brain Metastases: A Systematic Review." Updated 11 June 2021. https://www.pcori.org/research-results/2019/radiation-therapy-brain-metastases-systematic-review

[6] National Council on Disability. *Quality-Adjusted Life Years and the Devaluation of Life with Disability*. Nov 2019. https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf

Recommendation: Explore opportunities to incorporate its principles into IND applications

PCORI should fund research into identifying effective strategies for patients to be involved at the beginning of an investigational new drug (IND) application and trial design. As an organization with a mission to "focus on outcomes that people notice and care about…," we believe PCORI should serve a key role in empowering patients to become more involved as advisors in the design of clinical research and dissemination of findings. Patient involvement in the trial design process is crucial for identifying pertinent research questions for patients and ensuring the study measures meaningful concepts. One of the most significant barriers for more involvement of patients in the design of clinical trials is insecurity about their role on the trial and unfamiliarity with topics of discussion.[7] Accordingly, there is a need to create educational resources that will make patients more comfortable informing the design of an IND, with specific information about how their perspectives can be most helpful, and to fund engagement programs that train patients on the clinical trial review process with industry and payer partners that agree to enlist them as advisors. The Alliance's Talk NERDY to Me program includes training on the clinical trials process that other engagement programs have utilized.[8]

PCORI principles should be incorporated in the early phases of a study design to ensure that measured outcomes in a clinical study are meaningful to patients. Such involvement can inform how patients value the intended clinical outcomes of a medical product, considerations on the benefits and risks of the treatment, and the heterogeneity of preferences across patient subgroups. Patient involvement can help trials produce more relevant data while helping to recruit and retain study participants.

Recommendation: Evaluate the Geriatric Medicines Strategy and FDA guidance

PCORI should fund research projects that evaluate FDA guidances in select clinical areas that disproportionately impact older adults to study whether they adhere to the European Medicine Agency's (EMA) Geriatric Medicines Strategy.[9] This is a strategy employed by the EMA to ensure that the needs of older adults are considered in the development, approval, and use of medicines. The EMA employed this strategy to ensure that European Union's regulatory system for reviewing medicine adapted to the unique medical needs of older adults. The Geriatric Medicines Strategy seeks to address the paradox of older adults being underrepresented in clinical trials, despite this population having the most common need to utilize therapeutics.

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[7] Baedorf Kassis, Sylvia, Sarah A. White, Laurie Myers, "Advancing Health Literacy in Clinical Research: Clear Communications for Every Participant." NAM Perspectives (2019). National Academy of Medicine. 28 Oct 2019. https://nam.edu/advancing-health-literacy-in-clinical-research-clear-communications-for-every-participant

[8] Alliance for Aging Research. 2020 NERDY Training. https://www.agingresearch.org/nerdy/2020-nerdy-training/

[9] European Union. European Medicines Agency. Committee for Medicinal Products for Human Use. EMA Geriatric Medicines Strategy. European Medicines Agency, 17 Feb. 2011. Web. https://www.ema.europa.eu/en/documents/other/geriatric-medicines-strategy_en.pdf.

A core tenet of the Geriatric Medicines principle is that regulatory frameworks and guidance must be designed to ensure that the risk-benefit balance is supported by relevant data on the intended population. Older adults should not be considered a minority or special population in the drug review process. Instead, collecting data on the use of medicines in older adults should be regarded as essential. The strategy prohibits the use of unjustifiable age limits in the exclusion criteria of trials. Furthermore, the strategy allows older adults taking a commonly prescribed medicine to remain eligible to participate in clinical trials unless there is a compelling medical reason to prohibit using a specific background therapy.

The Geriatric Medicines Strategy acknowledges that older adults are a heterogeneous population that should be stratified based on their frailty status. The benefit-risk balance can be different for an older adult with frailty than a generalized clinical trial participant. We need to ensure that our regulatory guidance encourages data collection on frail older adults to understand this patient population's benefit-risk better.

A second tenet of the Geriatric Medicines Strategy is that older adults are complex patients. As people age, they are more likely to be frail, have coexisting conditions, and be prescribed multiple medicines. In accordance with this principle, the EMA tries to ensure clinical trials have participants representing the health needs of people both older than 65 and older than 75. Regulatory guidance for patients 75 years and older is often missing, and more work is needed to improve the guidance on expectations concerning such patients when guidelines are drafted or revised. Additionally, older adults have distinctive pharmacokinetics and pharmacodynamics and are frequently prescribed multiple medications to treat one or more chronic conditions.

The Alliance for Aging Research encourages PCORI to fund research that studies whether the unique healthcare needs of older adults are represented in FDA regulatory guidance.

Recommendation: Fund research to examine Medicare coverage decision process for equity impacts

The Medicare program increasingly has relied on coverage with evidence development (CED) to provisionally cover FDA-approved therapeutics via national coverage decisions (NCD). In theory, CED allows for the expansion and collection of real-world evidence around a therapeutic or medical intervention, allowing for a more informed NCD to follow within a few years. However, CED in practice has looked much different than this ideal.

Under CED, guidelines on clinical sites eligible to utilize the intervention being studied are often restrictive, leading to a reconstitution of many factors leading to underrepresentation – such as availability only at large academic centers or urban facilities – in clinical trials. However, these constructs are even more egregious under an NCD with CED. These coverage determinations extend coverage to all Medicare patients for a new therapy but with access limitations. For example, the Centers for Medicare and Medicaid Services (CMS) has undergone two cycles of the NCD process for transcatheter mitral valve repair (TMVR [alternatively known as

transcatheter edge to edge repair]), completed in 2014 and 2021.[10] In both NCDs, CMS placed arbitrary minimum requirements on open-heart surgical volume – in addition to mitral valve repair volume – to identify sites eligible to perform the procedure despite evidence illustrating no connection between volume and clinical outcomes.[11,12] Further, these non-evidence supported minimums for TMVR disproportionately limit access in the Midwest and Southeast U.S., causing an outsized restriction on access for Black and Hispanic populations.[13] Similar access constraints have been noted in other CEDs.[14]

In addition to the equity concerns raised by site constraints under CED, the process has proven to be limited in other ways. CMS has limited authority under the NCD statutory authority to enforce timely research reporting compliance, which leads to indeterminable CED processes and little accountability or standards for data registries. In its 2014 guidance on CED, within the section "Ending CED," CMS states that the purpose of the studies is to "produce evidence that will lead to revisions in Medicare coverage policies," and cites two examples of completed CED processes—NCDs for oncologic uses of fluorodeoxyglucose positron emission tomography and ventricular assist devices.[15] The implication is that there would be a clear beginning and end to the CED process. However, the TMVR example above provides a prime example of the limitations of these expectations and financial incentives that data registry stewards have in prolonging the shelf life of registry products. In the case of TMVR, registry sponsors failed to publicly publish outcomes data with any regularity, resulting in limited data available for patients eligible for the procedure and restricted insight for CMS in aiding whether sufficient data existed to end CED. Despite ample evidence,[16] these outcomes contributed to a renewal of CED status for TMVR in 2021, a full seven years after the original NCD with CED was issued. These continued access constraints can leave Medicare beneficiaries in a state of uncertainty regarding treatment, as well as facing ongoing access barriers.

In response to challenges around Medicare coverage requirements, PCORI should investigate the factors leading to undue access constraints. Further, studies should identify challenges to

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[10] Centers for Medicare and Medicaid Services. Transcatheter Edge-to-Edge Repair. Accessed 19 Aug 2021. Updated 5 Apr 2021. https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/TMVR

[11] Barker, Colin M., et al. *Association Between Institutional Mitral Valve Procedure Volume and Mitral Valve Repair Outcomes in Medicare Patients*. Journal of the American College of Cardiology. Vol. 75, No. 11. March 2020.https://www.onlinejacc.org/content/75/11_Supplement_1/1320

[12] Vemulapalli, Sreekanth, et al. *Mitral Valve Surgical Volume and Transcatheter Mitral Valve Repair Outcomes: Impact of a Proposed Volume Requirement on Geographic Access*. Journal of the American Heart Association. Vol. 9, No. 11. 27 May 2020. https://www.ahajournals.org/doi/10.1161/JAHA.119.016140

[13] Ibid.

[14] Centers for Medicare and Medicaid Services. Coverage with Evidence Development. Updated 17 Dec 2020. https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development

[15] Centers for Medicare and Medicaid Services. National Coverage Decision for Ventricular Assist Devices (20.9.1). Accessed 19 Aug 2021. https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=360

[16] Centers for Medicare and Medicaid Services. Proposed Decision Memo for Transcatheter Mitral Valve Repair (TMVR) (CAG-00438R). Accessed 20 Aug 2021. Released 30 June 2020. https://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=297

collecting and disseminating clinical data and evaluate whether alternative pathways to post-market evidence development for coverage assessment are necessary.

Priority: Enhance Infrastructure to Accelerate Patient-Centered Outcomes Research

Recommendation: Fund research evaluating impact of patient registry data restrictions

Patient registries have the potential to help inform—and play an essential role in—decision-making in science, development, and testing of new therapies and devices, and subsequent payment policy for innovations in treatment and care. However, limited oversight of patient registries creates misaligned incentives for stewards and the public good.

The purpose of patient registries is to collect robust data sets on a device or therapeutic. Regularly available data could offer many benefits, including greater data to inform patients' and providers' care decisions. Manufacturers could benefit by understanding safety and efficacy signals earlier, and payers could understand whether a therapeutic merits continued coverage within a reasonable amount of time. However, these goals have not been met. Often, reporting to registries is overly cumbersome for providers andpublic data reporting (or even data sharing with agencies such as CMS) at standard intervals is not required.

Part of the problem lies in that specialty societies, patient advocacy organizations, and academic centers can materially profit from running these registries by charging providers and industry annual fees. Further, they have monopolistic control over the registries and operate with very little, if any, transparency. Currently, registry sponsors appoint the advisors that decide on the health outcomes information collected, own the registry data, control who can access the data, and determine what types of analyses may be conducted using the data. These challenges are problematic, as a number of CMS national coverage decisions include a coverage with evidence development (CED) provision that relies on output from data registries to determine when the CED provision should be withdrawn. However, the agency currently has no direct access to the registry data and no enforcement authority over whether the agency's registry-related evidence questions are answered, let alone answered within a designated period. As a result, CEDs may drag out for a decade or more with no definitive end.

This status quo creates situations that do not align with beneficiaries' interests. Transparency and accessibility are essential for the public, policymakers, and patients to have confidence in data and processes. We encourage PCORI to support research efforts to examine patient registries' real-world performance and impact on patients, providers, payers, and manufacturers. We further encourage the advancement of data-supported recommendations on how registry stewards and partners can ensure timely data collection and dissemination and reduce provider burden.

Priority: Advance the Science of Dissemination, Implementation, and Health Communication

Recommendation: Expand payer dialogue

PCORI was founded with the mission of funding research that helps patients, clinicians, and payers make better-informed decisions about evidence-based healthcare choices. Yet, it can be unclear how stakeholders, particularly payers, use and implement PCORI-funded research in decision-making.

We suggest that PCORI review its Dissemination and Implementation Framework to ensure that it is engaging with all audiences in the health research ecosystem about ongoing and completed studies. PCORI should also consider hosting a webinar within the next calendar year for payers on how PCORI disseminates its research findings and create a dialogue on how PCORI can better disseminate its findings with the payer community.

Furthermore, we encourage PCORI to develop a metric on the dissemination of its research. Defining and measuring the impact of research dissemination is challenging and will involve short-term, medium-term, and long-term measurements. *The Journal of Public Health Management and Practice* has suggestions for what such a metric could incorporate, including publication downloads, citation rates, h-index scores, inclusion of studies in systematic reviews, and use of studies in tools for policymakers.[17] We also encourage PCORI to make available regular reports and/or a dashboard about how payers utilize PCORI reports in their decision-making.

Recommendation: Fund study on effective communication strategies for diverse populations in clinical trials

PCORI should explore funding a study on the most effective communication strategies to engage diverse populations in clinical trials. The inclusion of diverse populations in clinical studies is essential to improve the development of medicines and understanding the benefit-risk of treatments. Unfortunately, clinical trials almost always fail to recruit participants reflective of an indication's real-world population. Women, ethnic and racial minorities, and older adults are underrepresented in clinical trials.

We are in a unique moment in history, in that clinical trials have become a prominent fixture in the public consciousness during the COVID-19 pandemic. To take advantage of this increased awareness of clinical trials, PCORI should explore how best to provide education for multiple and varied populations about participating in trials and providing patient input on clinical trial design. Such a study should evaluate culturally appropriate ways to increase engagement in different populations. The general public is often unfamiliar with clinical research concepts, and the often confusing and opaque terms can serve as barriers to communicating details about the

[17] Brownson, Ross C., et al. "Getting the Word out: New Approaches for Disseminating Public Health Science." Journal of Public Health Management and Practice, vol. 24, no. 2, 2018, pp. 102–111. https://journals.lww.com/jphmp/Fulltext/2018/03000/Getting_the_Word_Out__New_Approaches_for.4.aspx

process. It would be useful for PCORI to create guides to the clinical trial process and identify ways to convey concepts and jargon to different audiences. People who do not understand their role in a clinical trial or the benefits of clinical research are unlikely to actively seek participation in a study.

A potential study on effective clinical trial communication should focus on how best to communicate the lexicon of clinical trials to a variety of audiences, including patients, caregivers, community leaders, primary care physicians, and the media. Key factors to review include how patient safety is monitored and ensured, the risks and benefits of participating in clinical research, and the specific obligations of sponsors and clinical investigators.

Recommendation: Examine educational programs to demystify the Medicare enrollment process

Enrolling in Medicare can be confusing and burdensome for many older adults as they approach 65 years of age, and this journey can be challenging to navigate alone. The complicated nature of enrolling can lead Medicare-eligible people to postpone their entry into the program and, consequently, delay much-needed healthcare coverage. Enrolling in Medicare is a multiple-step process that involves multiple federal agencies. A paperwork issue can result in a Medicare-eligible person making multiple trips or phone calls to the Social Security Administration (SSA) or to CMS.

Educational programs should start with the basics, such as the difference between traditional fee-for-service Medicare and Medicare Advantage. Medicare-eligible people would further benefit from information about how they should evaluate their options based on their financial situation, current health status, and possible changes in their future health. A literacy program should also explain the differences between the different parts of Medicare and how beneficiaries should evaluate and select a Medicare prescription drug plan.

Priority: Achieve Health Equity

Recommendation: Establish an MOU with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to create a funded program for CER minority investigators similar to the Network of Minority Health Investigators at NIDDK

Under its list of strategies for the health equity priority area, PCORI outlines funding "novel ways to support the professional development and increase the engagement of investigators of color, investigators with disabilities, and populations who are historically underrepresented in research endeavors."

As communities become more diverse, the need for underrepresented faculty, healthcare providers, and researchers increases. Increasing the number of underrepresented minority investigators may facilitate the inclusion of more racial and ethnic minorities in clinical trial and

CER studies, ultimately leading to greater generalizability of research outcomes and reduction of health disparities.[18]

One activity that PCORI should consider to advance this priority is to partner, through a memorandum of understanding, with another well-established minority investigator program at the National Institutes of Health (NIH). Twelve years ago, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), together with other NIH Institutes and Centers, recognized the need to increase the number of minority investigators. The Office of Minority Health Research Coordination (OMHRC) of the NIDDK was subsequently established and tasked to coordinate the development of the Institute's Strategic Plan to reduce minority health disparities.[19]

In 2002, as part of the health disparities strategic plan and based on recommendations of the biomedical research community, OMHRC launched the Network of Minority Health Research Investigators (NMRI) with a mission to establish a network of minority health investigators in fields of interest to the NIDDK, including diabetes, endocrinology, metabolism, digestive diseases, nutrition, kidney, urologic, and hematologic diseases. The network includes biomedical research investigators and technical personnel in minority health research from traditionally under-served communities - African Americans, Hispanic Americans, American Indians, Alaskan Natives, Native Hawaiians, and other Pacific Islanders - to meet the need to increase underrepresented minorities in the biomedical research enterprise. The NMRI program includes ongoing support for career development, mentorship for research, developing or refining skills for grant writing, lab management, poster presentations, and applying for tenure.

Over the past ten years, preliminary results suggest an increase in grant funding and academic promotion through participation in the network. A culturally diverse, interprofessional, and inclusive community allows for both junior and senior members to develop professional identity, rekindle motivation, and obtain and provide emotional support. From this preliminary evidence, NMRI is now embarking on a formalized study to determine if the annual feedback from participants can be correlated with increase in career advancement, number of grant applications, and funding.[20]

There is preexisting precedent for this type of partnership at PCORI. In 2013, PCORI created a unique collaboration joining scientists with clinicians and patients in pursuit of an effective

[18] Getz K, Faden L. Racial disparities among clinical research investigators. Am J Ther. 2008;15(1):3-11. https://pubmed.ncbi.nlm.nih.gov/18223347/.
[19] National Institute of Diabetes and Kidney Diseases (NIDDK) established the Network of Minority Research Investigators (NMRI) in 1999; https://www.niddk.nih.gov/research-funding/research-programs/diversity-programs/network-minority-health-research-investigators-nmri/history-mission.
[20] Blanchard SA, Rivers R, Martinez W, Agodoa L. Building the Network of Minority Health Research Investigators: A Novel Program to Enhance Leadership and Success of Underrepresented Minorities in Biomedical Research. Ethn Dis. 2019;29(Suppl 1):119-122. Published 21 Feb 2019. doi:10.18865/ed.29.S1.119

strategy. PCORI committed funding to the effort and the National Institute on Aging (NIA) administered the project, including the application process and peer review.[21]

Recommendation: Study impacts of safety-net benefit coordination

Reimbursement for healthcare in the U.S. focuses on, and in many cases is limited to, payment for medical interventions. However, recognition has grown in recent years that improving health outcomes should not remain limited to the historical focus on providing "sick-care" but by addressing multifactored inputs that lead to or prolong illness. These social determinants of health (SDoH) considerations include healthcare, public health, social, and environmental factors, among others. However, the current lack of reimbursement and/or coordination with other governmental safety-net programs that combat food or housing insecurity results in gaps that lead to poor health outcomes.

We encourage PCORI to invest in research to identify the most prominent types of gaps resulting from the current fragmented approach to the provision of social and safety-net benefits, as well as potential interventions to improve outcomes. Recently, Medicare Advantage plans have been permitted to offer supplemental benefits to address some of these issues; however, this is a limited and voluntary plan-dependent approach. Systems-level remedies are warranted to help alleviate systemic inequity in health outcomes. The Alliance asks PCORI to invest resources in this essential effort.

Priority: Accelerate Progress Toward an Integrated Learning Health System

Recommendation: Evaluate outcomes important to specific communities

Current assessments and endpoints are often generalized, but in doing so, are often weighted toward preferences of a predominantly White population. However, the outcomes valued within communities are not homogeneous. For example, populations may have differing cultural perspectives and commitment to caring for parents and grandparents in the home versus admission to an institutional long-term care facility.

Understanding these differences has real-world consequences. If data on relevant outcomes are not collected during clinical trials or during post-market data collection for a therapeutic, then utilization may remain limited if the endpoint is not meaningful to the intended patient population.

We encourage PCORI to explore analyses and outcomes that are generally favored within a community. Examples of variables to study relative value may include, but are not limited to:

- Extended lifespan

[21] National Institutes of Health. NIH, PCORI Seek Applications for Falls Prevention Clinical Trial. 17 July 2013. https://www.nih.gov/news-events/news-releases/nih-pcori-seek-applications-falls-prevention-clinical-trial

- Independence/delay in needing assistance with activities of daily living
- Caregiver burden
- Willingness to utilize pharmaceutical vs. device vs. lifestyle interventions
- Costs

Understanding these variables is also essential for the next generation of value assessment model development. Current market standards – i.e., the QALY – include methodological biases that undervalue older adults and individuals with disabilities.[22] Further, current analyses are not appropriately sensitive to potential differences in value for conditions. For example, research on a cure remains ongoing for patients with Alzheimer's disease (AD) and their families. However, first-in-class therapeutics and medications that address side effects rather than the primary condition may delay initial progression of the disease, thereby allowing patients to remain independent longer or treat neuropsychiatric symptoms of dementia that enable families to care for their loved ones at home. By understanding what endpoints are valued within specific communities, studies and value assessments can evaluate the most important outcomes to patients and their loved ones.

Conclusion

Thank you for the opportunity to provide feedback on PCORI's national agenda for health and research priorities. If you have any questions about the included recommendations, please do not hesitate to contact us. Inquiries can be directed to the Alliance for Aging Research's Manager of Public Policy, Ryne Carney, at rcarney@agingresearch.org.

Sincerely,

Michael Ward, MS
Vice President of Public Policy

Ryne Carney
Public Policy Manager

[22] National Council on Disability. *Quality-Adjusted Life Years and the Devaluation of Life with Disability*. November 2019. https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf