PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE

BOARD OF GOVERNORS MEETING

Tuesday, December 13, 2022

Washington, D.C.

[Transcribed from the PCORI webcast.]

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A P P E A R A N C E S

BOARD OF GOVERNORS PRESENT:

KARA AYERS, PHD
KATE BERRY
CHRISTOPHER BOONE, PHD
RYAN BRADLEY, ND, MPH
JENNIFER DEVOE, MD, MPHIL, MCR, DPHIL, FAAFP
ALICIA FERNANDEZ, MD
CHRISTOPHER FRIESE, PHD, RN, AOCN, FAAN
ZOHER GHOGAWALA, MD, FACS
RUSSELL M. HOWERTON, MD, FACS [CHAIRPERSON]
JAMES HUFFMAN, MSC
CONNIE HWANG, MD, MPH
BARBARA J. MCNEIL, MD, PHD
DEBBIE PEIKES, PHD, MPA
EBONI PRICE-HAYWOOD, MD, MPH, FACP
KIMBERLY RICHARDSON, MA
JAMES SCHUSTER, MD, MBA
LAWARENCE A. TABAK, DDS, PHD
KATHLEEN TROEGER, MPH
ROBERT OTTO VALDEZ, PHD, MHSA
DANNY VAN LEEUWEN, MPH, RN
CHRISTOPHER L. WHITE, ESQUIRE

A G E N D A

A G E N D A [CONTINUED]

P R O C E E D I N G S

[1:01 p.m. EST]

DR. HOWERTON: Thank you. Good afternoon and welcome to the December 13th, 2022 meeting of the PCORI Board of Governors. My name is Russ Howerton, Chairperson, and I would like to welcome everyone who has joined us for today's board meeting. We are pleased that you are here.

I would like to take a brief moment and say that I am honored and humbled in this, my first board meeting as the chairperson, to serve and help provide leadership for such an accomplished group of individuals as these Board members. It is truly an exciting time for PCORI, and we are blessed to have all of you as our leaders and Board members.

Before we proceed with our further business, on behalf of the continuing Board members and staff, I would like to give a warm welcome to our six new Board members. I think we have -- thank you for the next slide. Who were appointed by the GAO in September of this year, 2022: Chris Boone, Ryan Bradley, Zoher Ghogawala, Kimberly Richardson,

Debbie Peikes, and Christopher White.

They bring remarkable expertise and experience and varied perspectives that will be invaluable to us as we work to advance PCORI's missions. Welcome again. We look forward to working with you.

Maureen, will you call the roll, please?

MS. THOMPSON: Yes. Thank you. Kara Ayers.

DR. AYERS: Present.

MS. THOMPSON: Kate Berry.

MS. BERRY: Present.

MS. THOMPSON: Christopher Boone.

[No response.]

MS. THOMPSON: Ryan Bradley.

DR. BRADLEY: Present.

MS. THOMPSON: Jen DeVoe.

DR. DEVOE: I'm here. Sorry.

MS. THOMPSON: Thank you, Jen. Alicia Fernandez.

DR. FERNANDEZ: Present.

MS. THOMPSON: Chris Friese.

[No response.]

MS. THOMPSON: Zoher Ghogawala.

[No response.]

MS. THOMPSON: Mike Herndon.

[No response.]

MS. THOMPSON: Russell Howerton.

DR. HOWERTON: Present.

MS. THOMPSON: James Huffman.

MR. HUFFMAN: Present.

MS. THOMPSON: Connie Hwang.

DR. HWANG: Present.

MS. THOMPSON: Barbara McNeil.

DR. McNEIL: Present.

MS. THOMPSON: Debbie Peikes.

DR. PEIKES: Present.

MS. THOMPSON: Eboni Price-Haywood.

DR. PRICE-HAYWOOD: Present.

MS. THOMPSON: Kimberly Richardson.

MS. RICHARDSON: Present.

MS. THOMPSON: James Schuster.

DR. SCHUSTER: Present.

MS. THOMPSON: NIH Director Larry Tabak or

Michael Lauer, designee for the NIH Director.

DR. TABAK: Present.

MS. THOMPSON: Kathleen Troeger.

[No response.]

MS. THOMPSON: AHRQ Director Robert Valdez or Karin Rhodes, designee for the AHRQ Director.

DR. VALDEZ: Present.

MS. THOMPSON: Danny Van Lewin.

MR. VAN LEEUWEN: Present.

MS. THOMPSON: Christopher White.

MR. WHITE: Present.

MS. THOMPSON: Christopher, thank you. And Janet Woodcock.

[No response.]

MS. THOMPSON: And we have a quorum.

DR. HOWERTON: Thank you. As a reminder, Board members' conflict of interest disclosures are publicly available on PCORI's website and are required to be updated annually. In fact, Board members, tomorrow you'll receive an email asking you to complete the annual update of your conflict-of-interest disclosures.

Please complete your annual updates before January 31st, 2023.

Board members are also reminded to update their conflict-of-interest disclosures at any point in time when the information would change throughout the year. If the Board will deliberate or act on a matter that presents a conflict of interest for you, please recuse yourself or inform me if you have questions. If you have questions about disclosures or recusals relating to you or others, please contact your staff representative.

Today's meeting is being recorded.

The agenda for today's meeting, along with the approved minutes from the Board's prior meeting and an archived webinar will be posted on PCORI's website within a week. Board members please remember to raise your hand if you wish to speak and identify yourself before making a comment.

Our agenda today includes approving prior meeting minutes, as well as items for approval to include implementation of new governance frameworks related to our Governance Work Group, as well as

considering for approval our fiscal year 2023 to 2025 commitment plan. We will hear an update from the Healthcare Cost and Value Work Group, as well as review our end-of-year dashboard and hear about the latest editions to PCORI's portfolio of funded awards. And then we hope to wrap up and adjourn on time.

I would ask you, as Board members, to keep us informed about your attendance at the meeting we have, as mentioned, two voice votes in a roll call vote and we'll need to keep close track of attendance.

With that, I would like to introduce the first item of business, which is to consider approval of the minutes from the September 20th, 2022 board meeting. Are there any corrections, additions, or subtraction to these minutes that you received in your packet? Please raise your hand if you wish to speak, and identify yourself before making a comment or a motion.

[No response.]

DR. HOWERTON: Hearing none, is there a --

DR. VALDEZ: I move approval of the minutes.

DR. HOWERTON: That was Danny, I believe. Or did I mishear that?

DR. VALDEZ: Bob Valdez.

DR. HOWERTON: Bob. Okay. And is there a second?

DR. SCHUSTER: James.

DR. HOWERTON: James. All those in favor say aye.

[Ayes.]

DR. HOWERTON: Any in opposition or abstention? All right.

DR. BRADLEY: I'll abstain, I wasn't present.

DR. HOWERTON: Okay. Who was that? I'm sorry, I missed that.

DR. BRADLEY: That was Ryan Bradley.

DR. HOWERTON: Ryan. Okay. I just wanted that so we could mark that down. Thank you. Entirely appropriate.

All right. I would now like to take us to

the next agenda item. If you could advance the slides, please. And that is, relates to implementation of a board-approved governance framework.

As Board chairperson, I also serve as the chair of the Governance Committee; in this capacity, I will introduce the next agenda item.

The Board will now consider approving a number of proposed amended and new governance documents to implement the new governance framework that the Board approved at its September 2022 meeting.

Could I have the next slide, please?

At our September 2022 meeting, the Board approved a new governance framework to enhance our ability to advance PCORI's new strategic plan, to provide strategic oversight, to leverage the full board's input on strategic issues, to enable PCORI's staff to implement and lead PCORI's programs, and to meet PCORI's needs for advancing our mission.

The approved governance framework includes a number of key elements, including retaining

essential standing committees, creating a new Strategy Committee, expanding the current Standing Selection Committee to include consideration of additional award types, incorporating ad hoc work groups into the governance framework, pausing convenings of three standing strategic committees tied to PCORI's previous strategic plan, those being the Engagement, Dissemination, and Implementation Committee, the Research Transformation Committee, and the Science Oversight Committee; and assessing the new governance framework.

The Governance Committee has considered how to implement the approved new governance framework and is recommending that the Board approve a package of proposed new and amended governance documents. The package of documents also includes revised governance documents reflecting recommendations of the Finance and Administration Committee.

Mary Hennessey, PCORI’s General Counsel, will outline key elements of the proposed new and amended governance documents to implement the approved governance framework. Mary.

MS. HENNESSEY: Thanks so much, Russ. I appreciate it. Why don't we move to the next slide, and I think I'll just focus on some of the key governance documents that will serve to implement the Board's approved framework.

So there are a number of different committee charters, some of which are new, some of which are revised, as reflected here. Additionally, the Board will consider amending PCORI's bylaws, which function as the Board and PCORI's constitution. There'll be new committee charters such as the new Nominating Committee for members of the Methodology Committee, and there'll be some actions relating to amending certain policies.

Why don't we go to the next slide?

I want to highlight some of the key elements in the proposed documents that the Board will consider as part of the package. One is the new charter for the Strategy Committee. This charter reflects that the key responsibilities of this new committee will be to consider various strategic issues as assigned by the Board or Board

chairperson, which will support the Board's desire for the Board to be the primary body that will consider strategic issues.

Additionally, the Standing Selection Committee charter is revised to recognize that it will consider slates of awards from all programmatic award initiatives. And likewise, there will be an ability for special selection committees to be formed to address specialized needs, timing needs, et cetera. And so, this standing committee with the opportunity to form special committees will enable this structure to be able to proceed to meet PCORI's needs based on its award cycles.

Why don't we move to the next slide?

So the Governance Committee charter that the Board will be considering as part of the package, similar to other committees, makes standard the number of Board members that can serve on a standing committee. There's also some revisions that in making nominations to committees, the Governance Committee should take into account the needs of PCORI and committees, length of service on

the Board and on committees, and other considerations recognizing that the Governance Committee should be attentive to meeting the needs of committees and not necessarily making automatic re-nominations.

The Finance and Administration Committee, similar to the other charters, has an increased composition of maximum number of Board members to increase consistency in committee structure.

The Executive Committee, which functions as a governance tool of the Board, to be available if needed to act on behalf of the Board in urgent situations. That committee charter is revised to reflect an updated composition based on the ex officio committee leadership status that will serve as the ex officio members of the Executive Committee. And thus, the Board chairperson, Board vice chairperson, chair of FAC, Governance Committee, continue to be members.

And now with the new standing committees approved by the Board, the Standing Selection Committee and the Strategy Committee chairs will

also serve as ex officio members of the Executive Committee.

Next slide, please.

There's also a new charter to recognize a committee that will be charged with making nominations, slates of nominations to the Board for appointment to the Methodology Committee. This will be a standing committee, but it will really only be convened based on cycles of appointments that are needed for the Methodology Committee.

The membership will include a combination of Board members, senior staff members and Methodology Committee members.

And in recognition of the need to maintain flexibility in convening this committee, the Board chairperson will be responsible for convening and appointing the committee.

As part of the governance structure, it was recognized that service on work groups and the use of ad hoc work groups is an important component of the tools available to the Board for addressing a variety of issues. And so, the compensation policy

for Board members and Methodology Committee members includes revisions to clarify that service on these committees will be compensated consistent with service on committees.

Likewise, in reviewing the experience with work group service in the immediate past, it was recognized that while appropriately work group members had been compensated, the work group leadership had not been compensated consistent with their responsibilities and commitments. And thus, it is recommended by the Finance and Administration Committee that this implementation of this policy, at least with respect to chairs and vice chairs of work groups, be retroactive to the beginning of the service on the work groups.

Next slide, please.

There are some additional governance changes in other governing documents. It's important to recognize that the bylaws are proposed to amendments to make conforming changes for sections relating to committees to align with the charter revisions and new charters that I just

explained previously.

There's also language that recognizes that the historic three strategic committees: EDIC, RTC, and SOC, are to be paused. And thus, the governance language that is used for amended language in the bylaws is that these committees may only be convened upon the authorization of the Board. The bylaws also now explicitly refer to working groups to recognize the significance of the working group opportunity for the Board.

There's one policy, the Award Project Budget Increased Policy, that is an historic policy that was identified as needing to be addressed as a result of the Board's prior approval in June of a revised authority structure for the approval of slates of awards.

And just to remind everybody, at that time the Board revised the authority structure so that it is the Executive Director who holds the authority to approve slates of awards rather than the Board. Following the Board's approval of that revised authority structure, we reviewed a variety of

policies and documents to consider how to adapt them to the Board's revised structure and have identified this policy, which is a Board-approved policy, as now outdated because it's premised on an authority structure that is now no longer in place. And thus, it is recommended that this policy be sunset by the Board as a Board-approved policy.

So, Russ, I'm happy to address any questions. I'm happy to pass it back to you to consider whether there are any comments or questions from the Board. Thank you.

DR. HOWERTON: Thank you, Mary. The floor is now open for discussion, comments, and questions.

Board members, please remember to raise your hand if you wish to speak and identify yourself before speaking and or making a motion.

I'm looking. Maureen, are there hands up that I am missing?

MS. THOMPSON: I do not see any hands up.

DR. HOWERTON: Well, perhaps we could advance to the next slide, please.

The proposed motion is that the Board

approve the following: the proposed new Strategy Committee charter, the proposed amendments to the Selection Committee charter, the Governance Committee charter, the Executive Committee charter, the Finance and Administration Committee charter, the Board and Methodology Committee Compensation and Reimbursement Policy to include implementation of the compensation and reimbursement policy relating to chairs and vice chairs of work groups to be effective retroactively as of the beginning of their service on prior and existing work groups, and PCORI bylaws, as well the proposed new Nominating Committee for members of the Methodology Committee charter, and the sunset of the Award Project Budget Increase Policy as a Board-approved policy.

Before asking someone to move the proposed motion. I will ask Maureen to let us know if there are any updates to attendance.

MS. THOMPSON: Yes, Dr. Howerton, Chris Boone has joined the meeting.

DR. HOWERTON: Thank you and welcome.

Is there a first for the proposed motion?

DR. McNEIL: So moved.

DR. HOWERTON: Okay. And I think that was Barbara. Am I correct in that?

DR. McNEIL: It was Russ. It was Barbara.

DR. HOWERTON: And is there a second for the proposed motion?

DR. VALDEZ: Bob Valdez.

DR. SCHUSTER: James.

DR. VALDEZ: Second.

DR. HOWERTON: So I think I heard James first. Was that correct, Maureen? Or I'll defer to your judgment.

MS. THOMPSON: I thought I heard Robert Valdez first and then James, but --

DR. HOWERTON: All right. We'll take Robert then. Thank you.

This vote will be by roll call, since the amendments to the bylaws require a two-thirds vote of the Board, which must be documented. Maureen, will you please lead us through the roll call vote?

MS. THOMPSON: Thank you, Dr. Howerton.

Board members, when I call your name,

please say yes if you are in favor of the motion. No, if you are opposed to the motion. Abstain, if you elect to abstain from voting on the motion.

Kara Ayers.

DR. AYERS: Yes.

MS. THOMPSON: Kate Berry.

MS. BERRY: Yes.

MS. THOMPSON: Christopher Boone.

DR. BOONE: Yes.

MS. THOMPSON: Ryan Bradley.

DR. BRADLEY: Yes.

MS. THOMPSON: Jennifer DeVoe.

DR. DEVOE: Yes.

MS. THOMPSON: Yes.

MS. THOMPSON: Chris Friese.

[No response.]

MS. THOMPSON: Zoher Ghogawala.

DR. GHOGAWALA: Yes.

MS. THOMPSON: Mike Herndon.

[No response.]

MS. THOMPSON: Russell Howerton.

DR. HOWERTON: Yes.

MS. THOMPSON: James Huffman.

MR. HUFFMAN: Yes.

MS. THOMPSON: Connie Hwang.

DR. HWANG: Yes.

MS. THOMPSON: Barbara McNeil.

DR. McNEIL: Yes.

MS. THOMPSON: Debbie Peikes.

DR. PEIKES: Yes.

MS. THOMPSON: Eboni Price-Haywood.

DR. PRICE-HAYWOOD: Yes.

MS. THOMPSON: Kimberly Richardson.

MS. RICHARDSON: Yes.

MS. THOMPSON: James Schuster.

DR. SCHUSTER: Yes.

MS. THOMPSON: NIH Director Larry Tabak or Michael Lauer, designee for the NIH Director.

DR. TABAK: Yes.

MS. THOMPSON: Kathleen Troeger.

MS. TROEGER: Approve.

MS. THOMPSON: AHRQ Director Robert Valdez.

DR. VALDEZ: Yes.

MS. THOMPSON: Danny Van Lewin.

MR. VAN LEEUWEN: Approve.

MS. THOMPSON: Christopher White.

MR. WHITE: Yes.

MS. THOMPSON: Janet Woodcock.

[No response.]

MS. THOMPSON: Dr. Howerton, all votes are in favor of the motion.

DR. HOWERTON: Thank you very much. This is an important step in our evolution of our governance framework.

I would remind Board members to turn off your microphones if you had them on while you were speaking as we move to the next presentation.

I now would like -- if you could advance the slides, move to our next agenda item. I would invite James Huffman, chair of the Finance and Administration Committee to introduce the next agenda item about the proposed fiscal year 2023 to fiscal year 2025 commitment plan, which I believe will be presented by Brian Trent, PCORI's Deputy Executive Director for Operations. Jim.

MR. HUFFMAN: Thank you, Russ.

The FAC had the opportunity to review the proposed commitment plan for fiscal year 2023 through fiscal 2025 at its meeting on November 29th, and recommends it for the Board's approval. The three-year proposed commitment plan continues to align with the Board-approved model for commitment planning.

I will now ask Brian to walk us through the commitment plan presentation.

MR. TRENT: Thank you, Jim.

Previously, the Board approved both the long-range funding model for commitment planning and a rolling three-year commitment plan subject to annual review and update by the Board.

In September, the Board approved the PCORI fiscal year '23 budget for expense. The fiscal year '23 budget includes expenses on awards and operating expenses. Today we're asking the Board to consider for approval PCORI's three-year commitment plan for fiscal year '23 through fiscal year '25, commitments represent the amount of funding that PCORI intends to award.

For the updated commitment plan, we're recommending that our overall targets remain unchanged for fiscal years '23 and '24. The fiscal year '25 target reflects an increase from the original Board-approved long-range model up to $600 million, which was made possible by adding uncommitted funds planned for fiscal year '22 to the FY '25 plan.

On the slide that's currently in front of you is a recap of the commitment planning model that the Board approved in December of 2020. Represented on this slide are yearly commitments from the past and projections for the future in this approach.

In the past, yearly commitments averaged $388 million per year. The projections for this model show a front loading that peaks at about $600 million for overall commitments. The steady state period has a range of approximately $340 million to $440 million, which accounts for a low and high assumption about the PCOR fee, which could have some fluctuations over the years.

Next slide, please.

This slide compares our fiscal year '22 actual commitments compared to our target of $600 million. As you can see, we fell short of our target for fiscal year '22. Some of the reasons for the shortfall are in the area of research and D&I. We fell short due to the lingering effects of the COVID-19 pandemic, fewer than anticipated applications, and ongoing attention being paid to COVID-19 enhancements.

In the area of infrastructure, we were under the target because of the planned shift for funding to follow establishment of the PCORnet strategic direction and having fewer than initially anticipated engagement awards.

For new initiatives, funds were committed to a new opportunity to fund a large workforce project with AHRQ.

Next slide, please.

On this slide is a breakdown of the three-year commitment plan by the four large funding categories. In the plan that the Board approved last year, research was targeted to remain steady at

$500 million annually, while there was a targeted increase in dissemination and implementation and a decrease in infrastructure.

Next slide, please. I think there's one slide after that.

DR. McNEIL: Excuse me. Am I the only one who can't hear you well?

DR. TABAK: I hear Brian very well.

DR. McNEIL: Oh, it must be me.

MR. TRENT: I think we're going back to, there's a slide that we skipped. So if you could go back to -- there's -- okay, we're fine there. So for the -- sorry, I apologize. I think we went ahead on one the slides.

[Telephone ringing interference.]

MR. TRENT: So, as I mentioned on this slide is a breakdown of the three-year commitment plan by the four large funding categories. In the plan that the Board approved last year, research was targeted to remain steady at $500 million annually while there is a targeted increase in dissemination and implementation and a decrease in Infrastructure.

Next slide, please.

For the annual commitment plan update, we are proposing to continue the same approach for fiscal year ‘23 and fiscal year ‘24 that was previously reviewed by the Board. For fiscal year ’25, we propose rolling over the shortfall from the fiscal year ‘22 target, extending the peak in the multi-year plan by increasing our fiscal year ‘25 commitments by $100 million.

Under this plan, research represents a balance of broad and focused funding opportunities, full range of study types and projects to address short and long-term needs. We'll continue to launch a range of PFAs in each cycle many more than in previous years. Eleven targeted PFAs in fiscal year ‘22 will result in commitments in fiscal year ‘23.

The plan includes a significant increase over fiscal year ‘22 actual commitments to meet dissemination and implementation targets in fiscal years ‘23 to ‘25. It includes activities related to D&I results from PCORI-funded studies. The plan anticipates an increased number of D&I worthy awards

from larger research investments, and the plan anticipates initial Health Systems Implementation Initiative Awards to move to the next phase.

It should be noted that the dissemination and implementation line does not represent the full extent of our investment in D&I. This line demonstrates the commitment for D&I awards that take PCORI-funded studies to the next step. Research awards focused on health communications, dissemination, and implementation research are represented on the research line.

In the area of infrastructure, this includes Engagement Awards, Workforce, and PCORnet Infrastructure Awards.

Maintenance costs of PCORnet infrastructure in Phase 4 funding is anticipated to land in fiscal years ‘25 and ‘26, with $50 million included as a placeholder for PCORnet infrastructure funding in fiscal year ‘25, which would follow the Board's consideration for approval of development of funding initiatives for Phase 4.

For new initiatives, this includes the

potential for new initiatives that are not yet anticipated and $10 million for the Executive Rapid Response Funding. Next slide, please.

So for today, we're asking the Board to consider for approval the fiscal year ‘23 through fiscal year ‘25 commitment plan, which includes maintaining the plan increase in the fiscal year ‘23 target for D&I, and decreasing the targets for infrastructure, increasing the fiscal year ‘25 target from $500 million reflected in the long-term model to $600 million using the uncommitted funds originally targeted for fiscal year ’22, which would increase the fiscal year ‘25 target for research from $400 million to $460 million, anticipating an increase in the fiscal year ‘25 targets for infrastructure as we plan the PCORnet Phase 4 commitments, which we anticipate will occur in this timeframe following Board consideration for approval for development.

In the upcoming months, we hope to have strategic discussions with the Board on future commitment planning, including adjustments to the

model which was approved in December 2020. We also want to have discussions on potentially changing the timeframe for approving the commitment plan.

And finally, there may be additional strategic discussions that the Board would like to have regarding the commitment plan.

So we look forward to hearing from you today regarding any additional areas of interest for discussion at future Board meetings. And with that, I'd like to turn it back over to you, Russ, for any questions and discussions.

And I apologize, there was a slight mix up with my talking points in the slides, so I apologize for that.

DR. DEVOE: Thanks so much Brian and James. I'm going to take over for Russ. He had another call come in that he's attending to.

So I just want to remind people to raise your hand and we'll go ahead and have any questions or discussion at this time.

Ms. THOMPSON: And Jen, I see that Zoher has a question.

DR. DEVOE: Great. I saw Zoher's hand up and then I saw you Danny, after Zoher.

DR. GHOGAWALA: Hi, can you hear me?

DR. DEVOE: Yep, we can hear you.

DR. GHOGAWALA: Terrific. This may just reflect my lack of understanding about the plan here, but what I've seen here is a request to go to $600 million, but the new initiatives is $50 million and it says on the slide up to 650. And I'm just not understanding why the request isn't to just say 650, as opposed to 600.

MR. TRENT: Because the new initiatives, once they are determined and we know what they are, they will be reflected in the three categories. Right now we don't know what those initiatives are, and so once we determine what they will be, they will be factored in and that will make the total, that would make the total potentially $650 million.

DR. GHOGAWALA: Thank you.

DR. COOK: If I may add one point to that, which is that, you know, back in 2020 when this multi-year commitment plan was developed, the idea

was to set some very ambitious targets that PCORI would strive to achieve with that early upfront investment. And the idea of the new initiatives wasn't necessarily to be part of the target per se, but to say if there was an opportunity for something we wanted to make sure, the Board wanted to make sure, that PCORI had the flexibility to consider it even if it went beyond the $600 million.

And so, that was the construct back then when it was developed in that way.

DR. GHOGAWALA: Thanks. That helps a lot. Thank you.

DR. DEVOE: Russ is back, I think Danny's up next and I'll turn the meeting back over to Russ.

DR. HOWERTON: Thank you Jen for carrying.

MR. VAN LEEUWEN: Well, thank you. So I guess I need to go back to better understanding the decrease for infrastructure. It went quickly for me and I don't remember seeing this before.

So anyway, could we go back and one more time walk through what's happening with the infrastructure and why we're decreasing it?

DR. HOWERTON: Brian, have you got that?

MR. TRENT: Yes. I don't know if we wanted to go back to the actual slide.

MR. VAN LEEUWEN: That would be great. Thank you.

AMY: Brian, this is Amy. Which slide do you need me to go back to?

MR. TRENT: Danny, is this the slide that you were referencing?

MR. VAN LEEUWEN: It's -- the changes are happening slow on my end. I'm still looking at the same summary and next step slide. It might take a couple minutes. There's a lag.

DR. COOK: This may be the one, the recap from the prior years.

DR. HOWERTON: Yeah, it may have also -- I think Brian, since Danny can't see this, just --

MR. VAN LEEUWEN: No, I'm seeing annual review. Oh, here. Recap. Yeah, so infrastructure. I see Engagement Awards, Infrastructure Awards, Workforce Awards.

So are we saying -- like, what are we

decreasing? Are we decreasing Engagement? PCORnet? workforce? Why?

DR. COOK: I'm happy to jump in here, Danny, and just relate a little bit in terms of the way things were planned. There was a planned amount related to PCORnet that related to the funding of the PCORnet Clinical Coordinating Center and clinical research networks that occurred and caused a bump in funding over the years of 2021 and 2022.

And what you're seeing is that after that commitment was made, it came back to the $40 million for infrastructure that was estimated. So this is following that known and planned kind of increase that was necessary for the Phase 3 awards for PCORnet.

MR. VAN LEEUWEN: So one of the things that we've talked about in terms of PCORnet is expanding how PCORnet incorporates patient recorded data in the common data model or however it does it. And I want to make sure that our funding, that we are continuing to prioritize and fund that important shift away from not just, you know, claims and EHR

clinical data. So is there, maybe I'm talking apples and oranges and I just need to be reoriented, I just want to make sure we're not lessening our investment in that process.

DR. COOK: That's correct, Danny. That is not necessarily lessening the investment and the, what at the time I think was called the additional enhancements that may come to infrastructure, which related to the potential opportunities for connection of data and aggregation of data that may be outside of the current infrastructure, as well as the opportunity, as you may recall, to expand for populations that may not have been included.

And so, those efforts were underway in terms of understanding stakeholder input, et cetera, that would guide those types of opportunities. And there was, in the earlier commitment plan multi-year model, a plan for that, that still remains.

MR. VAN LEEUWEN: Okay.

DR. COOK: So what you're just seeing is that that initial bump for Phase 3 awards came back down, but the other activities are still included in

the planned phases here.

MR. VAN LEEUWEN: And Engagement and Workforce hasn't changed. It's just that bump?

DR. COOK: That's correct. That's correct.

MR. VAN LEEUWEN: Okay. Thank you.

DR. HOWERTON: Connie, do you have a question next? And then I see Ryan's hand going up.

DR. HWANG: I do. Thanks, Russ. And Brent, thank you for laying out all these funding targets.

So one of the things I think is really distinctive about PCORI is focusing investment in dissemination and implementation. And in looking at some of the numbers in the charts here it looked like whereas there was a goal for $40 million in spend, maybe 16 million was the actual, and I am in full support of continued growth in, you know, funding that dissemination and implementation at $60 million.

I just wanted to pose the question about what do we feel that PCORI is going to lean into to essentially increase that spend by a factor of four

to reach target?

I think that it is a very worthwhile area and also just wondering where, we, as the Board, could be helpful throughout the upcoming year to help us sort of reach that goal. I think, you know, again, an important area, but it does seem like a large jump from where we are from actual to target in 2023.

DR. COOK: And Connie, were you specifically referring to the $40 million to $60 million transition?

DR. HWANG: Yes. And I think if I, and please correct me if I'm wrong, but I think the fiscal year 2023 target there, I think there was in some previous was the actuals, was around $16 million. I don't know if I've gotten that wrong, let me know.

But yes, interested in, because I think one of the questions was do we approve of the continued, you know, increase in that or the goal? And I do. I just want to understand if we're really at a $16 million spend, you know, where do we see the

opportunities to get to that new level?

DR. COOK: I'm going to mention a few things and also ask if Harv Feldman or Greg Martin wants to chime in here, but one of the things that we had anticipated is that there were several initiatives that were just getting started that will actually have funding lines come into play in the future years. Particularly, as Brian mentioned, the Health Systems Implementation Initiative, which was more of a phased award.

And so, the awards that actually will be funding commitments will be hitting the lines that you see coming later in 2023 and 2024. Whereas the partnership component, which wasn't really a funding commitment, was what we were working on in 2022. So there's these kinds of activities that we know have tails that will actually start to bump things up.

But I think there's probably some additional comments Harv may want to make.

So Harv, did you want to say anything about the increase we're anticipating related to dissemination and implementation?

DR. FELDMAN: Yeah, thanks Nakela. You know, so in addition to the anticipated activities in the next phases of the HSII program, we also are anticipating the increase in dissemination opportunities as so many of our prior funded CER activities have come to fruition and completion and will be able to actually be ready to move into an implementation phase. And so, that was also another part of our thinking and planning and, you know, bringing forward the proposal in this way for the Board so that we are able in fact, to pursue that component of the life cycle of what it is that we fund.

DR. COOK: And I'll just ask if there was anything else, Greg, you wanted to add. I saw you there on camera.

MR. MARTIN: No, I think those are both excellent points. And, you know, I think that we're all very excited about what the next few years are going to bring relative to this new implementation initiative of HSII, the increased amount of evidence that the early years investments are now producing,

as well as the increasing bandwidth that we're seeing within the sites that are the implementation sites of awards to be able to start participating in applications again --

DR. HWANG: Great. Well, thank you.

Greg, I think that's terrific. I am a huge fan of the HSII initiative. I'm excited for that to expand. I just, yeah, like I said, looking at that sort of 4X gap, I thought, well, you know, if there's anything else that we could be helpful with throughout the year in, you know, as you said, more studies are coming online and make awareness there. I just, you know, anytime there's a jump like that, it just, I think it does require some other, potentially some concerted effort, further concerted effort, but very hopeful. That's great.

DR. HOWERTON: All right. Thank you. I think, Ryan, are you next with a question?

DR. BRADLEY: I think Robert actually had his hand up prior.

DR. HOWERTON: Okay. Robert, you go first and then it'll be Ryan.

DR. VALDEZ: I just wanted to follow up on that. You know AHRQ is funded through the trust fund to do dissemination and implementation as well as training. And so, as we've geared up our dissemination and implementation efforts, there'll be new opportunities for collaborations directly with PCORI that I'm looking forward to having Harv and others discuss with our staff. So there's really no shortage of opportunities, I think, in the coming years to really focus on this really important area of dissemination, and particularly the implementation phase, which is often ignored.

DR. HOWERTON: Thank you. Ryan, do you have a question?

DR. BRADLEY: I do, briefly. My question or comment was actually very similar to Connie's, but it seemed like multiple categories were underspent, if you will. And so, I don't have any comments or questions related to the proposed allocations. I trust the experience of past Board members in making those determinations.

But there was some attribution given to

some of the reasons why funding was, you know, there's some underspending in multiple categories, including fewer than expected applications.

And I'm just sort of curious, is that really true? Is it just an absolute reduction in numbers of applications or was the quality of applications lower and are more applications deemed non-meritorious enough to get support?

It just, it seems to me that we want to spend our allocations and if our application numbers are down, then some additional solicitations or other outreach to make sure that relevant investigators are fully aware of the viability of PCORI as a funding option for some of their work. Just increases its level of importance.

And similar to Connie, I'm just wondering if there's more that we can do as a board or an organization to, you know, make sure that we remain attractive for those applications.

MR. TRENT: I mean, I'll answer part of this and I'll turn the rest over to Nakela.

I think a large part of it was still in the

sort of recovery phase of COVID-19. A lot of the individuals who would have applied were sort of doing other things such as working on the COVID-19 enhancements. And that led to, I think, a significant amount of our, the decreased number of applicants in that area, particularly in the research area.

And I'll turn it over to Nakela to answer that further.

DR. COOK: I'm also just going to allow Harv this space to respond here, given he's closest to some of this. And then, I'll happily wrap up.

DR. FELDMAN: Yeah. Thanks Nakela and Brian, and thanks for the question, Ryan. I think that it's already been covered, but I'll just emphasize it.

The impact of COVID-19 on our applicant pool was quite substantial and we saw it sort of come in in two ways. One is a diminished count number of applications during a period when we know, obviously, researchers and medical centers were responding to the crisis in all sorts of ways that

diminished their ability to apply for research funding. And we did, I think, also see some diminution in some of the quality of what we received as well, probably related to similar workforce issues out there in the world where our applications emanate from.

We fully anticipate, and I think are already beginning to see recovery there, as we've moved into a very different phase of the pandemic.

But I think it was definitely demonstrable and, you know, we think explains in a substantial way some of the patterns that we shared with you.

DR. COOK: Maybe the one piece I'll add to those both excellent responses, is that when we were looking at the commitments for fiscal year 2022, especially for our new Board members, I wanted to emphasize that those commitments are in response to funding announcements and applications that were typically coming in, in 2021. And so, there was a much closer proximity to some of the acuity of things that were happening related to COVID-19 at that time period.

So that time lapse I think, is also important in terms of understanding some of the target issues.

And then maybe the last thing I'll say is that, you know, we, in response to what we saw, as ambitious targets for us to meet, we geared up with a lot more announcements, as well as kind of an anticipated rebound, I think, from some of the early things we were seeing in the pandemic that we weren't able to see recover as quickly as we had anticipated. And so, that's why we mentioned it was a less than anticipated number of applications and ability to make awards because we really were hoping for something that would've been more robust in that time period. But it just didn't pan out in that way.

DR. BRADLEY: Thank you for the clarifications and I have one really what I hope is really quick follow up, if you don't mind. And it really has to do with if there's flexibility to reallocate amongst these categories and how that process would be pursued.

So, for example, I'm hearing COVID had a major impact on applications. Obviously, there was an enormous research need at the time from a wide variety of different areas of research in terms of, you know, what patients were doing, what centers were doing, you know, obviously efficacy and effectiveness of therapy. Was there consideration or is there flexibility in the structure to reallocate budget?

I see that we have the Executive Rapid Response Fund. But if we're seeing underspending in one category is there a process by which we can increase funding in in response to this type of emergency?

MR. TRENT: I would say that's sort of the part of the ongoing discussions we want to have with the Board to maybe adjust, you know, where we are making some of our commitments for fiscal years '23 through '25.

And I'll let Nakela, if she wants to add anything to that.

DR. COOK: I'll just add that one of the

things that we were thinking about as we put forward this three-year kind of update with you, is that the Board has an opportunity to revisit this on a yearly basis. And so, we do have that opportunity to come back and talk further about the targets, et cetera, that we're trying to proceed with and the other piece that we thought is that this would be an opportunity for us to hear from all of you about those areas that you think we may want to go deeper in discussion together with before we get to that next three-year revisit of our approach.

And so, we wanted to collect these types of questions and issues that are on your mind about the commitment plan. So that as we go through our meetings in 2023, we can take them in deeper dive and then make sure we're ready to look at another three-year model for the next three years when we come back and hopefully do that in September of next year.

So this is exactly what we'd hope to hear and it is a planning exercise in many ways, and so there is always the opportunity to think about how

what we've learned can kind of enhance our planning moving forward.

And the last thing I'll mention, is that I think it also, what we were in an effort to do here, is stay true to that multi-year model that you saw before, that the Board approved in 2020. And if the Board wants to reconsider that multi-year model, we want to make the space and time for that discussion to happen.

DR. HOWERTON: I think perhaps we have all of the questions.

For some of the "old Board members," who remember Bob Zwolak, we may have to give Ryan Bradley the Honorable Bob Zwolak question of: "Why haven't we gotten more money out the door?" If someone can find that motion from Bob Zwolak and share it with Ryan, that would be great.

Maureen, are there any updates to attendance?

MS. THOMPSON: Dr. Howerton, Robert Valdez has a question.

DR. HOWERTON: I'm sorry. My mistake. Go

ahead.

DR. VALDEZ: No problem, Russ. I just wanted to follow up Nakela's comments about thinking about what we should be talking about this next year as a result of this three-year, multi-year planning And part of it has to do with the infrastructure investments that would go up to deal with the Phase 4 of the PCORnet infrastructure.

That's probably a good topic for the Board to revisit as we think about the out years of that, what that Phase 4 really looks like and what it's for and whether we're going to accomplish what we need to. Just a placeholder.

DR. HOWERTON: All right. I will ask Maureen and Nakela to make note of that for upcoming agenda items.

Maureen, any updates to attendance?

MS. THOMPSON: Yes, Dr. Howerton. James Schuster has left the meeting.

DR. HOWERTON: Okay. Do I have a motion to approve the fiscal year 2023 to 2025 commitment plan?

DR. McNEIL: So moved.

DR. HOWERTON: That was Barbara, I believe.

DR. McNEIL: Mm-hmm.

DR. HOWERTON: And is there a second?

DR. GHOGAWALA: I'll second.

DR. HOWERTON: And that was Zoher Ghogawala.

All right, I'll now call for a voice vote.

All those in favor, please say aye.

[Ayes.]

DR. HOWERTON: Any in opposition or abstention?

[No response.]

DR. HOWERTON: All right. I believe the motion passes. Thank you.

And please turn off your microphones if you're not speaking.

And perhaps that will take us to the next agenda item, and that is the update from the Healthcare Cost and Value Work Group. Eboni Price-Haywood, chair of the Healthcare Cost and Value Work Group will introduce the work group's update, which

will be presented by Greg Martin, Acting Chief Engagement and Dissemination Officer.

Eboni.

DR. PRICE-HAYWOOD: Thanks, Russ. Good afternoon, everyone.

Greg and I are happy to share with you today our closing report for the Healthcare Costs and Value Work Group. If you'll recall, in the 2019 reauthorization, PCORI's funding included a provision clarifying that research funded by the Institute, clinical and patient-centered outcomes shall include potential burdens and economic impacts of intervention studies.

So in response throughout 2022, the PCORI has taken on a scope of work in informing the value conversation. So for over a little over a year, the work group has discussed PCORI mandate regarding the collection of the full range of outcomes data and how PCORI can best contribute to ongoing conversations around value. We've engaged patients and stakeholders to better understand their unique perspectives on value in health and healthcare,

particularly patient-centered value.

We are providing information this afternoon through a landscape review and a draft report to help inform conversations around patient-centered value.

Today's session provides an opportunity for your reflections on this work and the next steps. We're looking forward to discussions with you this afternoon. And with that, I'll turn it over to you, Greg.

MR. MARTIN: Thank you, ma'am, I appreciate the kind introduction. Next slide, please.

First off, before we get too far into this, I do want to acknowledge the members of the work group, including those who have since stepped away from PCORI. They all have my personal thanks for the perspectives, guidance, and wisdom that they brought to our conversations and to our efforts, all of which were essential to our success.

Next slide.

So what was the purpose of the work group?

It was really to guide PCORI's emerging

approach to the critical intersection of cost and value, building upon the principles for the collection of the full range of outcomes data that this Board approved. We recognize that healthcare cost and value does remain an important topic, and the work group did identify an approach that we shared with you back in February to position PCORI as a trusted contributor to conversations around cost and value. And we made sure that efforts would be aligned with the reauthorization provision that Dr. Price-Haywood just mentioned.

Part of this approach was ensuring that we could recognize and acknowledge the complexity of the healthcare system in which we all are working, and to really stay focused on what it is that PCORI can accomplish.

So we established a framework emphasizing PCORI's patient-centered approach and our role as a trustworthy convener. We aim to be timely and responsive to the current environment and we aim towards short-term activities, such as convenings and white papers, to help inform stakeholders and

help applicants for PCORI funding.

It was all about ascertaining how we can act on what people care about and ensure that all stakeholders, including patients especially, are reflected in the work we produce. So we engaged our community and we're going to continue to encourage stakeholder comments and input. Next slide, please.

And you'll see here PCORI's framework for our activities. and it's critical to be abundantly clear still, that this is not a value framework. What this is a framework for organization of our activities over the last year to inform discussions around healthcare cost and value.

All three pillars are important. They're all interconnected, but a bit independent. And as a work group, we focused a bit more on that center pillar shaded in the darker blue.

So this was around informing the value conversation. We continue to work on the left column around collecting the full range of outcomes data, and we're taking steps to ensure that the research we fund appropriately considers all the

potential burdens and economic impacts of the conditions and interventions being studied and we're going to continue to clarify promising practices to support recommended approaches and refine guidance.

For informing the value conversation, where we spent so much time, we had heard clearly from our stakeholders, this interest in PCORI continuing to inform this important space and our work was really attempting to help connect the dots between, on the one hand, perspectives on value and on the other, this data that is starting to be collected on cost and burden. So they can be difficult to measure these data. They can be subjective, dependent on the condition or other factors including insurance.

So we wanted to make sure that we were engaging patients, patient advocates, and others.

So as we move forward, we recognize that PCORI should not be arbitrating what is or is not value. Our underlying authorization did set up guardrails to preclude PCORI from issuing payment policy or coverage recommendations or issuing clinical guidelines. So we wanted to instead

provide information to inform decision-makers in the health sector and use our convening power to bring together all of our stakeholders to help us better understand how define value and consider important attributes or components of patient-centered value.

Next slide.

To start down this pathway, we produced our first deliverable, a landscape review that was focused on what are those public statements that patients, patient advocates, disease or condition advocates, clinical societies, all of our stakeholders have published to their websites or put out into the public sphere? And how is it that we could synthesize and summarize these various perspectives that are out there?

We took time to look at these, listen to them, learn from them, and we identified four initial broad domains in 48 distinct components of value.

Now, this landscape review then served as the foundation for our iterative snowballed engagement work. So we adopted this approach to

really build on this foundation from the landscape review, which again, looked at what people are saying, what stakeholders are saying publicly about their perspectives on value and health and healthcare.

And so we took the time to listen to and learn from them, and it culminated in a multi-stakeholder workshop to discuss our evolving understanding. The goal of this work stream was really to help us identify which components may build up into individual definitions of patient-centered value in health and healthcare. We wanted to understand which of these components are critical to which stakeholders, why and how they can be measured. Next slide.

So you'll see here what are the major questions that we were really asking to shake this out. Identifying the components of patient-centered value. What does it mean to different communities? And what elements, attributes, components to different stakeholders consider to be a part of value measurement? Next slide, please.

So again, this demonstrates the iterative approach that we took: Review what's out there in the public sphere. Issue the landscape review, use this as the foundation. Have one-to-one interviews that resulted in this inventory of attributes. Have small group meetings with stakeholder community representatives, that helped us refine the inventory. And then a large convening to really help us elevate additional considerations, the context, the nuance of these different attributes. Next slide.

And we came out the other side with this inventory. Again, 48 attributes across seven distinct domains. These are general categories, but these can then themselves translate into other measures, outcomes, or policy for decision-makers.

In an appendix to the draft report, which you received as part of your materials, there's an early attempt to heatmap some of these attributes to start covering all the attributes and to also identify in these initial conversations what we've heard from stakeholders, which ones are critical to

them, which ones are -- is there some disagreement? And which ones do they think, "Eh, for us, that's not really the most important thing"?

And again, the purpose is to allow stakeholders and applicants as needed, to really consider what might be core inventories and to also help support more nuanced and conversations with greater understanding between and among stakeholders, and particularly those in our applicant teams. The next slide.

So let's talk a little bit about next steps.

So we want this to be a resource for PCORI, for our applicants, for the broader healthcare community. So we want to make sure that we're getting the broadest possible feedback on our understanding from the healthcare community. So we intend to post this draft report for public input early in January, so that way we can hear from all of our stakeholders: Are we hearing you correctly? Have we understood what you've said publicly correctly? Help us understand in greater detail the

nuance, the context, the considerations around each of these attributes or components of what may roll up into patient-centered value.

We want to continue to be able to reflect back to the broader healthcare community and our applicants and our stakeholders, and for ourselves, this understanding of how each of us can approach notions of patient-centered value.

So we're starting to think of what follow on products may be helpful after we've finalized the draft report. What can help us better facilitate understanding of diverse perspectives and what activities can follow on that can help us deepen our understanding of measurement issues? Again, we want to help people that are asking us to fund their studies. We want them to better understand patient perspectives.

This is one of the key things that the work group identified as a strength for PCORI, that ability to elucidate and elevate what matters to patients. We hope that this resource can empower patients, applicants, and stakeholders to ask

stronger questions and submit more rigorous applications that can reflect this nuanced understanding of this intersection between cost and value.

And just as a final note, we want to be clear that we're not asking people to develop applications, to develop value frameworks. That's really a space for others. What we're trying to do here is help, again, elucidate what matters so that way they can have more nuanced conversations, and so we can have more nuanced conversations with each other. Next slide, please.

So we have a few questions for your consideration today. I'm not going to go through them each, but we do have them here for your review, and I'll give you a moment to read through them again. But with that, Dr. Howerton, I will cede the floor back to you for any questions that the group may have.

DR. HOWERTON: Thank you, Eboni and Greg.

The floor is now open for discussion of the questions listed on the slide. Board members,

please remember to raise your hand if you wish to speak and identify yourself before speaking.

DR. McNEIL: It's Barbara, Russ.

DR. HOWERTON: Ryan and then Barbara.

DR. BRADLEY: I have a variety of questions but I'll try to prioritize them.

I think one of my questions about this process is in reviewing the appendix materials and looking at the various stakeholder organizations that were engaged in the process, I'm just curious how socioeconomic status or other barriers to access to care how those factors were considered especially in the engagement of patient groups. Because it looks as though many of the patients who were included as stakeholders were associated with some sort of organization or institution that suggests to me that they have involvement in these organizations. They have access to care.

So just looking at this through an equity lens, I'm just curious, first and foremost, how those issues were considered in the process.

MR. MARTIN: Yeah, that's an excellent

question. And by and large, we did aim for convenience sample of stakeholders. We also aimed for engaging those who have issued public statements in this space, and those that have been conversing with PCORI in this space.

Diversity, equity, inclusivity, accessibility interests were raised throughout conversations across all stakeholders, and that's one of the things that led us to this interest in posting the draft report for public input.

Again, we want to be able to throw the doors open and invite feedback from the broadest possible swath of interested parties to help inform us, to help inform the broader healthcare sector around their perspective on these different attributes within the inventory. How do they approach them? What's the context in which they experience them? What are potentialities for measurement around them? What are some of the trade-offs that may be made as different attributes or components are considered within the definition of patient-centered value?

We're going to work with our stakeholders and our patient advocates, our community, to help us try and get as much of that feedback from diverse communities as possible to get some of those learning and involved and incorporated into --

[Computer noise interference.]

DR. BRADLEY: Thanks for that. And I hear that language and I think the language is really important, but I'm also, I'm a little bit more interested in the deeper process, and there might be others on the Board that have more expertise in this area, certainly than I do. But I guess I question some elements of the process because we know that many disadvantaged groups are mistrusting of organizations. They're distrusting of medicine, they're distrusting of PCORI. They're unlikely to provide important feedback via solicitation on a website or other things.

And so, I guess I'm wondering if there are opportunities to get deeper into those communities by engaging other intermediary groups or some other means to capture those voices, just to make sure

that we don't continue to marginalize them and leave them out of this really important conversation.

MR. MARTIN: No, I think that's exactly right and that's a point that's definitely well met. And we're going to look to how it is that we can work with the network that we've built of stakeholders that are engaged with us, patient advocates that are engaged with us, those that are the trusted intermediaries to their community.

It's not just being totally reliant on larger organizations that may be more familiar names. We've been delighted and humbled by the engagement that we've had from community advocates, community-engaged participants. Our ambassadors program contains many of these individuals and they've been enthusiastic supporters of our work and have been excellent at helping us to understand ground-level nuance and meet people where they are to gain this greater, richer understanding of how care is not only delivered, but experienced across this country.

DR. BRADLEY: Thank you for that. And I

again, I'm just going to do one more important question because I don't want to hog the floor. I know many others have questions, so I promise this is my last one.

But in the appendices, there is, there are comments related to the engagement of complementary integrative health providers.

But yet, when I look at the stakeholder organizations that were involved, I don't see any national representative bodies for chiropractic, naturopathic, acupuncture, oriental medicine, Chinese medicine, massage therapy, et cetera. So these are the large licensed complementary integrative health disciplines. And yet I don't see those organizations amongst the stakeholder groups.

So we know 33 percent of adults in the United States use some form of complementary integrative health. They're paying out-of-pocket. They've made a value judgment about how this care impacts their health to the degree that they're willing to pay out-of-pocket for it.

So I'm just curious about how those voices

were met or were engaged, and if not, how we might revisit that.

MR. MARTIN: Yeah, certainly that's another excellent question. And we definitely are going to be engaging those organizations, those communities of clinicians in our work to ensure that their perspectives are representative as well. And we definitely welcomed the opportunity to work with you to ensure that we can reach those organizations.

DR. HOWERTON: Yeah, that sounds like a great opportunity, Greg, for you to connect with Ryan offline and see if there's the knowledge about the breadth of the field we could go after.

I believe it was Barbara and then Connie for next questions. Is that accurate?

DR. McNEIL: I think so, Russ.

So I'm really confused and I raised this one when we first talked about this, the new expanded mandate for PCORI to consider costs. And that's actually not what this committee has done at all. And I don't know whether we want to do it, but it certainly hasn't been done.

What the committee has done is interviewed lots and lots of people, lots and lots of stakeholders' groups. The slide, a couple of before this, listed all of the domains that people care about. And one of them was, in fact, costs.

But what I'm trying to figure out is what is the report from this committee going to look like?

It is it going to be a big taxonomy of all of the possible things that you have learned from interviewing various groups about what patients value? Quality of life in multiple dimensions, quantity of life, whatever it is. And then in addition, there'll be some things that say, "It really costs a lot to get to the doctor," or whatever.

But that, I don't think that reflects what we've talked about in the past in many of our discussions about various applications, about whether or not to include the costs of whatever it is that we've been evaluating. I don't know whether we should or we shouldn't, but certainly that was

given to us as something that we could do in this new round of our new life. But that's not, you didn't touch that at all. At all. And I'm just wondering what you're thinking, what your thought thoughts are?

DR. PRICE-HAYWOOD: Greg, may I?

MR.MARTIN: Yes, ma'am.

DR. PRICE-HAYWOOD: So one of the things that struck me in listening to the conversations with the stakeholders, is this idea of cost and value, and what do you mean by cost? And there are a lot of people who, when you talk about costs, is not always about the dollar sign. So I wanted to emphasize that.

There is a cost burden, different ways it can be described, that might be described in using the word cost. But there's different ways that, I think the common denominator may be around the dollar, but what I was struck by was the additional perspectives that people brought to the conversation that was not all about the dollar. That there are other things that you experienced that is a cost or

a burden to you as a patient, the caregiver, the family member, the community, and things of that nature.

So I just wanted to put that out there because it did come up in several times.

DR. McNEIL: No, this is absolutely -- I think that's absolutely true, Eboni. There's no question about it.

But what I'm going back to is our original discussions probably over a year ago, and in multiple discussions with the Selection Committee where we were actually looking at A versus B, and there was a big difference in the dollar sign costs.

That's what I thought we were talking about with this committee. Maybe we shouldn't be, but that is what we were talking about then, and I'm just wondering whether that is now a dead issue or whether it's something that you're going to now think about on round two, because it clearly didn't come up on round one in the way that was anticipated a year or a year and a half ago.

That's my only comment.

DR. COOK: I may jump in to provide some insights too, and Greg, feel free to build on this.

But you know, one of the things Barbara, I think you're referring to is that earlier on, over a year ago, we spoke with the Board about the principles around which we were interpreting the new provision in our reauthorizing law and those principles were approved by the Board and moved forward into the guidance that we provide to applicants and teams that are coming in for PCORI awards, and we also anticipate continuing to work with our Methodology Committee in ways in which we can think about the types of approaches that may start to build some degree of standardization of the way in which we collect this information, et cetera, that includes cost and economic burden.

And I think the work group itself, as you saw in that framework, had three different pillars it worked on. And that work that you're describing, I think really aligned to that first pillar and some of the work that's ongoing there, including the fact that we're now supporting that with an Economic

Resource Center that's helping to put that guidance together. So that work is in progress.

But the work group itself focused a bit on the second pillar, which was much more around understanding the broader perspectives that really are important to come into play when you're talking about value and patient-centered value and how we may need to put that type of data in this kind of understanding of the framework of the perspectives of value. And so, it's a second component to all of that work.

And then that third pillar was really how both of the former two pillars are going to inform our ability to really be part of larger, providing that type of information that may be important for policy discussions and things of that nature.

And so, it does all come together and I didn't want to have it seem as though that first line of work is stopping, that's actually still ongoing and we're still supporting that activity at PCORI.

DR. McNEIL: Well, I just, I think that's

really a terrific explanation Nakela. I think I would recommend that when in presenting this pillar number two, you don't give a listener like me the suggestion that you were talking about costs with a dollar sign, because that is the impression that I walked away with.

And clearly from what you just said, that's not it at all. And that that's in bucket number one and there'll be bucket number three. And I have no idea how bucket number three happens, I actually doubt it can happen, where you're going to mix one with two. But two is clearly, in my view, the most important and it will actually relate to all of the stuff that you've talked about with your various interviews, whether they've been complete or incomplete as Ryan suggested.

But just in several slides back, we talked about costs. I think you're going to confuse a lot of the research community with that language. That's my sense.

Zoher actually has a comment.

DR. GHOGAWALA: Sorry, I may be out of

order though. I think there's another question.

DR. HWANG: If you're building on this, go for it.

DR. GHOGAWALA: Okay. So I agree very much with what Barbara is saying.

And I just wonder whether it might be possible to explicitly say really for the research community who will be doing this work, that it's a priority to look at dollar sign cost from a patient perspective when you're comparing A versus B, and understanding, Eboni, that that can be more complicated than just the cost of, you know, a medication or whatnot. It can be taking time off to see the doctor, arranging for childcare when you're seeing the doctor.

All of these are costs, and all of these ultimately have dollar signs associated with them. But at least from my perspective, I think it would be very important for patients as well as our organization and for researchers to know that that's something they should look at if they're going to be understanding value from a patient perspective.

DR. PRICE-HAYWOOD: It was what I was thinking, but I didn't articulate it. And I think from the research perspective, it's a part of the spectrum that's often ignored. And I just wanted to make sure that this value piece is the centerpiece in thinking about the extension of what we typically think about when we talk about costs because it's an added layer from the community's perspective and we just don't give it enough attention.

So I appreciate your comment.

DR. GHOGAWALA: Thanks.

DR. HOWERTON: Thank you. Connie.

DR. HWANG: Yeah, thank you.

Great discussion. And kudos to Greg and Eboni, in terms of their leadership in getting us to this point. And I really do appreciate both Barbara and Zoher's comments about what we need to think about sort of moving ahead.

My question is actually sort of related to the two, latter two on this slide. But thinking a little bit about how in the reauthorization of PCORI, right, is this new flexibility as everyone's

noted to look at cost impacts. I was curious as to what our strategy might be to keep congressional leaders and groups that supported PCORI to have this expanded, you know, scope, sort of updated on the progress, get some feedback or input on where further we need to go. It's never too early to think about the next reauthorization, but just wanting to see like how it, you know, how we're going to leverage some of this work and engage those leaders that have obviously been supporters of PCORI and excited about this expanded space.

MR. MARTIN: That's a great question, Connie. You know, certainly, we're going to be making sure that we can keep all of our friends up on the Hill well-aware, as well as across the federal space as to what we're doing around informing the value conversation.

The policy community was one that we heard from clearly about an interest in helping to elucidate of these varied and diverse perspectives on value. So it's kind of fun actually to be able to deliver them back to something that, you know,

what we're hearing is that has never really been done before as well, which is pulling together in one single resource how diverse stakeholders really do approach value in health and healthcare, and also patient-centered value.

So I know I keep using that line a lot, but there's a richness to what I think we're uncovering that's shown to be welcome, and in particularly, with our policymaker community.

DR. HOWERTON: Thank you. If there are no more comments or questions, am I missing any? I would, on behalf of the Board, like to extend our sincere thanks and appreciation to the members of the work group for their contributions to this very important work.

If I did not miss any other questions, perhaps that will take us to our next agenda item, which is the end-of-year dashboard review. I would like to invite Executive Director, Nakela Cook, to review this for us.

DR. COOK: Great. Thanks so much Russ.

This is an exciting presentation and we're

pleased to present our fiscal year 2022 end-of-year dashboard for review with the Board.

And we're actually in a time of transition at PCORI, where we're closing out the dashboard that's been used to measure progress against our prior strategic plan and thinking about how we want to revise that evaluation framework to generate the metrics that the Board would want to track our strategic plan moving forward given the recent establishment of our new strategic plan. So we're looking forward to standing up this work group of Board and staff that will help us establish the evaluation strategies that are going to inform this future framework for us.

But for today, I wanted to present highlights from the metrics that were tracked in 2022. And hopefully you'll see that this is a really exciting presentation with lots of great information. Let's go ahead to the next slide.

So this slide actually demonstrates the dashboard itself. And the dashboard consists of several quantitative measures that lend themselves

to well-encapsulated reporting. And they're represented here with increasing measures of impact, from inputs to use as you progress down the slide. And over the years, the dashboard really has evolved from a focus that was primarily on inputs and process to progress on the strategic goals articulated in the prior strategic plan, and as well as toward outputs and uptake.

And so, you can see here that the input and process metrics listed are things such as funds committed or time to release of research findings. And they're represented in that first row. And we generally color code things green or yellow to indicate if they're meeting targets or not.

And the second row focuses on output and uptake metrics, and it includes things like CER results that are publicly available and Altmetric scores which measure attention to CER results. And you can also see uptake to patient and public resources.

And then finally on that third row, you see uptake in use metrics with the uptake of results

into things like clinical decision support tools and other examples of uptake such as citations and systematic reviews or guidelines or policy documents, and we have a new measure on the dashboard, which is that patients reached via dissemination and implementation awards.

So at a glance you can see that we're meeting all the targets except in the funds committed, as we discussed earlier today in our commitment plan discussion.

But I'd like to take a few of these and go a little bit deeper to talking about them. And as you can see, and the funds committed to research, this one is in yellow because we weren't meeting the target. And as we discussed, the committed about $481 million to awards in fiscal year 2022, which was approximately 80 percent of the projected amount for the fiscal year.

And in the following slides, I'm going to go through a lot of detail for a lot of the other metrics, so I'm just going to hit some highlights on them here. But I wanted to mention, related to the

time to release of research findings that you can see we're meeting the target here. And PCORI's authorizing law really requires that we make research findings available no more than 90 days after the conduct or receipt of research findings.

So what you see here is a figure that presents both the average days to posting and the percentage of projects that are releasing final research findings within the targeted timeframe with a target of a hundred percent of the projects releasing findings within 90 days. And in quarter three and quarter four of '22, all of our final research findings were released within the 90 days. And the average length of time to abstract posting was about 84 or 83 days, depending on the quarter that you're looking at.

So, and generally I would say that maybe the summary takeaways that PCORI projects do consistently meet the target of abstract posting to our website under 90 days.

On the next metric here, you can see that we track quarterly the public availability of

results from all PCORI-funded studies, and not just the trials, but also other studies that are not randomized. And our long-term target for CER trials for public availability is with within 24 months of the primary completion date of the trial. And we also have a target of 18 months for non-trial CER studies.

And based on what we see here, our target for fiscal year 2022 is 34 projects expected to have results available to the public, and you can see we met that target with 38 CER projects that had results available to the public exceeding the target.

I'm going to talk a little bit more in detail on Altmetric scores on a following slide, but generally, our goal is to have 10 percent or more of articles that are published related to PCORI-funded studies in the top 10 percent of attention annually and we do expect variation on this by quarter.

But essentially, if you average over the last four quarters, 15 percent of articles have been in the top 10 percent of attention. So we're really

pleased with that result.

And when you look at some of the uptake measures, and particularly in uptake into patient and public facing resources, this is where we're tracking things like Wikipedia, health blogs, WebMD, Mayo Clinic, and other websites to see if CER results are mentioned on those sites from PCORI-funded studies. And we continue to expand this metric as we learn more about what's valuable to track. But in general, we've seen 57 citations or mentions across fiscal year 22, an accumulative total of about 330 citations to-date, which we think is getting more and more robust with time.

We are also tracking uptake into UpToDate, which is one of the point of care decision support tools that's used in clinical practice. And we have seen over the course of this year, 36 citations of results from PCORI-funded studies in UpToDate and a cumulative total of 134 citations to-date. And you'll see later that that continues to grow with time.

And we also are now in this new measure

tracking the number of patients that are reached to-date through dissemination and implementation awards. And this relates to the fact that we are now at the point at PCORI where research results are moving more and more into dissemination and implementation awards. And while the majority of these awards are still in progress, we can track the cumulative number of patients reached. And as more awards draw to completion, we'll be able to add other measures such as the reach for patients, clinicians, and caregivers as well.

But here you can see by the year end of 2022, we had over 330,000 patients reach through dissemination and implementation awards.

Why don't we go ahead to the next slide?

So I'm going to transition from the snapshot review of the dashboard to actually highlight an example related to the strategic goal of increasing information for health decision-making. And this example highlights a recent PCORI-funded CER result that generated a lot of attention.

And this was a single blind, three-arm

randomized controlled trial that compared the effectiveness of treatments for insomnia amongst Black women. And the different interventions were a standard versus culturally-tailored version of cognitive behavioral therapy for insomnia versus sleep education materials. And the study actually found that both of the cognitive behavioral interventions and decreased insomnia severity and improved sleep outcomes more than control.

However, the culturally-tailored program was more effective at engaging participants with the program, and as a greater proportion completed the intervention, it was more associated with greater improvements in sleep.

And so one of the things we really think about this type of result is that there's an opportunity for us to learn more and more across interventions in the PCORI portfolio that have been culturally-tailored because we're starting to see these types of results come to fruition related to culturally tailoring of interventions.

We can go to the next slide.

I also mentioned earlier when we took a snapshot of the dashboard that we track the availability to the public of research results coming out of PCORI-funded studies and trials. And so this slide demonstrates the percentage of CER results that are available by publication or posted abstract relative to the primary completion date.

And so what you can see here is that research results from PCORI-funded trials, in this blue dash line on the slide, were published in the peer review literature at a rate that's better than the benchmark, which is in the orange line. So almost 60 percent of PCORI-funded trials have published preliminary findings in peer-reviewed journals by 30 months after their primary completion date, which is half the time of the benchmark in that orange line.

And then the purple line that you see on this slide is the percentage of CER results from PCORI-funded research studies that are publicly available by publication or posted abstract. And firstly, you can see how remarkably the curve is

bent back into the left with earlier posting of results relative to the benchmark. And when we include the results that are posted via abstracts on the PCORI website, nearly a hundred percent of the results are available to the public after about 35 months, and you see that in the purple line.

So here you can really see, I think relatively quickly, the difference that the peer-review and posting of abstract process that PCORI makes, it provides that complete and earlier availability of research results funded from PCORI trials to the public over and above that of publications alone.

Let's go to the next slide.

So I wanted to also provide you with something that we're beginning to track at PCORI, relatively new in terms of sharing this with the Board. And awardees are asked, when they submit their final draft, final research report to submit information about their plan to return the aggregate results of their study to research participants. And since we've been collecting this information and

initiating this request, which was back in the fall of 2020, we've had 72 PCORI projects that are enrolling patients that have submitted this information and 83 percent of them indicate that they do intend to return study results.

And this really does compare favorably to a survey of clinical trials investigators who found that about 40 percent intended to return results. And so, we are also learning about the ways in which investigators are planning to return these results and the majority of them intend to distribute the PCORI lay language abstract that has been developed to their participants either alone or in conjunction with other materials. So it seems that that abstract is a really useful tool for investigators to return research results to participants.

But in addition to emailing and mailing results, some are also planning to go that extra mile and over half have planned to post results to a public website or portal, or a third have offered to hold webinars or in-person meetings to share results. So this is another exciting component of

really getting the results of PCORI-funded studies out to those who really have the opportunity to benefit from them.

We can go to the next slide.

I also wanted to provide you with a snapshot of year over year cumulative totals of peer-reviewed articles that are resulting from PCORI-funded studies across the portfolio, both as a whole and as well as those that have been conducted using PCORnet on the graph on the right.

And essentially, you can see the trend on the left of an increasing number of articles with time, both primary CER results and all publications with cumulative articles over 3,700. And also just to mention, as we sometimes identify publications months after they're published, the fiscal year 2022 numbers will be expected to grow in the near future.

And on the right, we see a similar increasing trend in the numbers of articles with time resulting from PCORI-funded studies using PCORnet. But the scale's different, so I just want to make sure to point that out to you. It's blown

up here just for readability.

But in fiscal year 2022, the cumulative total of those publications resulting from studies using PCORnet is about 223 articles. And while we're really tracking those articles that are resulting from those PCORI-funded studies using PCORnet data, soon we're going to be presenting a lot more information that more broadly includes both externally funded projects as well as PCORI-funded projects that utilize PCORnet data. But we estimate that if you were to incorporate both those internally and externally funded projects, that there may be over 540 publications to-date.

You can go ahead to the next slide.

So I wanted to spend just a minute in talking about those types of measures that we've been looking at that are related to impacts such as attention and influence. And looking at those measures related to attention and influence of publication of CER results from PCORI-funded studies; and related to attention, we hone in on the Altmetric score as a measure of attention across

different audiences and really this is predominantly from non-academic sources. And we're tracking the percentage of those CER articles that are resulting from PCORI-funded studies during that top 10 percent of attention, as I mentioned before, controlling for the journal and the date of publication.

And as I previously mentioned, our goal is to have 10 percent or more of articles in the top 10 percent of attention annually. And we, as I wanted to point out here, averaged over the last four quarters, 13 percent of articles that's been in the top 10 percent of attention. And in quarter two of 2022 alone, we had 20 percent of articles that were found to be in the top 10 percent of attention.

And as it relates to influence, what you see on the right, we gather and report information on relative citation ratios, which some of you may be familiar with, and we track that by year of publication. And the relative citation ratios really just measure scientific influence in the literature relative to NIH-funded publications in the same year and field.

So the NIH papers are the benchmark that we use for this measure, and any paper essentially with a relative citation ratio that's 1.0 -- any paper with a relative citation ratio of 1.0 has a ratio that's higher than 50 percent of NIH-funded papers. So that's how that benchmark works.

And what we found is that CER results publications from our portfolio, have consistently demonstrated above average influence. And you can see that these relative citation ratios are well above 1.0 in this graph on the right side of the slide. Why don't we go to the next slide?

So I also just wanted to highlight a couple of the uptake measures that you saw on the dashboard and go a little deeper. We are tracking these from a variety of resources, as I mentioned, including patient-facing resources, UpToDate, and other resources. And generally you can just see on this slide that trend of increasing uptake in use of CER results from PCORI-funded studies over time with some of the cumulative statistics seen here in these graphs.

So for example, with patient and public-facing resources, in fiscal year 2022 alone, we identified 57 examples of that uptake in the public and patient-facing materials. And when you look it UpToDate or that point of care decision tool, we saw 36 different citations in fiscal year 2022. And these include things like cancer-related fatigue, prenatal care, and COVID-19-related citations, which is exciting to see that some of that work that we did around COVID-19 was getting this type of uptake. And in addition to UpToDate, we're also tracking other examples such as uptake into systematic reviews, guidelines, and policy documents. And you can see that graph on the right as a steady increase as well.

Why don't we go ahead to the next slide?

So I just wanted to wrap up this report on the dashboard to really walk you through a story about a PCORI-funded study that has actually been on that path to impact and what we've been able to learn as we've moved through the various phases of CER results through dissemination and implementation

to now implementation study results.

And this is a project that focused on health decisions in prostate cancer treatment and our dissemination and implementation awards really promote that uptake in use of PCORI-funded research and practice. And as part of this funding, we anticipate that when we have more and more PCORI-funded research mature, and this came up in our discussion of the commitment plan, that we're going to have more studies that have findings that are ready to move into that dissemination and implementation phase and receive these types of awards that I'll talk about now.

And we have a growing number of awards coming to completion, which will allow us to really assess implementation of these interventions in real-world practice.

But the example I'm going to show you today illustrates that sequence of having results through the implementation into practice and traces that path from the initial publication and posting of our results on our website through the uptake of

findings and UpToDate as well as clinical guidelines and to now the findings of the implementation project results.

Let's go to the next slide.

So beginning with the CER study, this was an example of one of our early funded PCORI-funded studies. It was a population cohort study that compared the effectiveness of three common treatments for localized prostate cancer. And so those three different treatments included surgery, external beam radiation therapy, and active surveillance.

And after three years, patients who had surgery reported that there was lower sexual function and more urinary incontinence than those that had radiation or regular checkups to see if the cancer had spread. And those primary findings from the study were published in JAMA in 2018 and garnered high levels of attention as reflected by the Altmetric score. And the findings from that study were taken into clinical guidelines and cited in UpToDate as well.

And in the following slide, I want to just share with you how a recently completed D&I award implemented those findings in practice. So let's go to the next slide.

So this is the implementation project that was funded through a PCORI D&I award under the initiative on implementation of effective shared decision-making approaches in practice settings. And the project incorporated the findings from that original CER study into existing effective decision aids that were being used in practice. And the aid was really implemented across three different sites that represented very distinct clinical settings and populations with diverse race and ethnicity, socioeconomic status, and even insurance status.

And the project team used a number of strategies to support successful implementation of this shared decision-making tool, including education for physicians, presentations to hospital leadership and staff, translating the tool into the decision aid into Spanish for a Spanish-speaking clinical setting and population, and also

intervention adaptations to improve integration into the site workflow, as well as tailoring the intervention for different patient populations.

And why don't we go to the next slide?

So here you can see that in tracking some of the key metrics that were recently coming out of that implementation study several domains were highlighted: reach, adoption, fidelity, maintenance, and health decisions and care.

And across the three health systems where the study was implemented, over 80 percent of eligible patients were invited to use this decision aid and nearly 60 percent of them completed the tool and over half of them receiving the tool used it as intended. And at the site where the decision aid was translated into Spanish, 85 percent of patients completed the tool and most of them did so in Spanish.

And all of the eligible physicians participating in administering the tool continued to participate and none withdrew from the project.

And all three of the sites continued the

intervention as designed over two and a half years, including a post-implementation phase.

And when we look at decision quality and satisfaction with care, the patients at the implementation sites reported high decision quality and satisfaction. And at one of the sites, the project team actually examined efficiency of care and found that patients served after implementation of the aid, needed less time with their doctor and were less likely to need multiple visits to make a treatment choice.

So the team plans to use all this data, which I think is really rich coming out of this implementation project, as well as some of the findings on increased clinical efficiency to advocate for the implementation of shared decision-making interventions throughout the L.A. County system. And so, this is the second largest public healthcare system in the country, and I think really reflects on how the results from an implementation project can be considered at a much larger scale based on these remarkable learnings.

And a cost of implementation report is in progress to really inform what it takes to implement in at this scale.

Let's go ahead to the next slide.

So this all relates to that metric I mentioned that was new on the dashboard and something that we're continuing to track, and that's how we think about the growing number of D&I projects that are underway, implementing results from PCORI-funded research studies.

And I mentioned we're tracking numbers of patient reach to-date through the dissemination and implementation awards that are in progress and completed. And we're really looking forward to thinking about as awards draw to completion, the ability to report on additional metrics related to patients, clinicians, and caregivers reached through these completed projects by quarter and fiscal year and develop targets against which to measure these measures.

And we'll also be able to report on strategies that are supported in implementation in

real-world practice settings, which is something that I think many of those responsible for thinking about the implementation of these findings will find very helpful.

Why don't we go to the next slide?

So I'd like to end here and just ask you as we're thinking about the end-of-year dashboard report for 2022 and transitioning into this next phase of thinking about the evaluation framework that we'll want to stand up against our newly approved strategic plan, how we may think about what the Board would optimally want to use to monitor progress toward our goals and our National Priorities for Health, our Research Agenda, and Strategic Plan, and what role a dashboard might serve in the future.

We think some of this actually can really dovetail into the way in which we would think with the work group the evaluation strategies for the future.

So, Russ, I'll pause there and turn it back over to you.

DR. HOWERTON: Sure. Thank you, Nakela. The floor is open for discussion. Board members, please remember to raise your hand if you wish to speak or identify yourself before speaking.

We have this discussion and a brief comment about the new additions to our portfolio-funded awards so that we can be careful custodians of your time and end on time at three o'clock.

It may be a lot for anyone to have suggestions off the top of their head of this dashboard, but I would commend to the new Board members that the dashboard has evolved over the years I've been involved with PCORI from the suggestions of Board members of what they would want to see as performance metrics.

So as you reflect upon them, as you go away from this meeting and think about what you would like to see at your next board meeting, please reach out to Nakela or Maureen.

Am I missing any comments? Danny?

MR. VAN LEEUWEN: Yes. Thank you for this. This is great.

I think that I'm looking forward to more sophisticated thinking about what public uptake actually means. I'm not sure that it's just that a study that was in a journal got on Twitter is really a public uptake. And you know, this thinking about taking to the next level what we mean by public uptake.

I also think that thinking about what our stretch goals are, you know, that we have this, you know, really ambitious strategy around equity and inclusion in research, and research and equity inclusion, and equity inclusion in the research process. And so, I think thinking about what our how we're going to recognize success in those areas is also going to be just a hoot-and-a-half challenge to try to figure out.

So I'm looking forward to that.

DR. HOWERTON: Am I missing other questions or comments?

MS. BERRY: It's Kate. If it's okay, I wanted to kind of weigh in to appreciate Danny's comments.

I was thinking along the same lines, sort of the idea of really, you know, maybe trying to more deeply understand what, you know, public uptake means.

So something to think about there.

Nakela, I really liked the example you provided about the prostate cancer study. But of course, I can't help myself but to ask, you know, it's great to use a shared decision tool and, you know, those are fantastic measures and a great story. But, of course, I want to ask were the patient outcomes better, you know, than they would've been if they didn't have that tool available to them.

I think it, you know, should be an obvious yes, but that's another example of just thinking through, you know, what other information might be helpful. So thank you.

DR. HOWERTON: Any others?

[No response.]

DR. HOWERTON: If not, I would ask Nakela to present the latest editions to PCORI's portfolio

of funded awards in our last few minutes.

DR. COOK: Great. Thanks Russ. And I'll go through this rather quickly.

Just to let you know that what I'll show today are the latest additions to awards, but wanted to just flag for you that we anticipate going a lot deeper and talking about the portfolio and the awards within the portfolio in a future board meeting, and have tentatively slated that for hopefully around the March timeframe where we can really go more deeply into an understanding of our awards.

Let's go ahead to the next slide.

So here's the quick summary of awards that following the recommendation by the relevant selection committee. Twenty projects have been recently awarded from six different PCORI funding announcements, totaling about $100 million.

And two of these funding announcements were from our broad funding announcements, our Broad Pragmatic Clinical Studies announcement, as well as our Methods study announcement.

And three of them come from, three of these announcements were from targeted or focused funding announcements. Some, as you can see here, one related to brief interventions for adolescent alcohol use, another on the comparative effectiveness of interventions targeting mental health and individuals with intellectual and developmental disabilities, and a third related to prevention, early identification and treatment of delirium in older adults. And we also had a funding announcement that generated awards in dissemination and implementation and this is the implementation of findings from PCORI's research investments.

Why don't we go to the next slide?

So each of these slides shows you those awards that were made from those different announcements. You can see that there were six research projects that were awarded under the Broad Pragmatic Studies announcement, which is that broad solicitation for research teams to propose ideas that would address a broad range of topics that align with our national priorities.

And so, here you see the awards slate covers multiple health conditions like hemodialysis for end-stage renal disease, bacteremia, aortic stenosis, as well as behavioral health interventions, and longer-term care focused on caregiver burden as well as individuals with disability.

We can go the next slide.

So here you can see the awards related to our methods funding announcement. And the methods funding announcement funds high priority methodological research topics in patient-centered outcomes research and CER. And the studies really try to address methodological gaps as well as support rigorous methods and standards and best practices. And this award slate includes things like an application that seeks methods for innovation and ethical and practical approaches to conducting highly efficient randomized trials, as well as new methods that explain and directly quantify the impact of different factors on the performance of machine learning algorithms between

sites and across time.

And you can see here as well that there's an application, an award here that proposes to develop new waiting methods to quickly handle large data sets. So that gives you the flavor of the types of awards that were coming through this funding announcement.

Why don't we go ahead to the next slide?

And here you can see that there were six applications that were awarded from targeted funding announcements. Under our brief interventions for adolescent alcohol use announcement, we were really seeking to fund studies that compared brief interventions to address alcohol use in primary care or school settings. And so, the applications and awards in this area focused on the comparative effectiveness of brief behavioral interventions that were adapted for adolescents ages 12-to-17 to address alcohol use.

And just one of the studies that you can see here is screening and brief interventions and referrals to treatment as a way to think about an

intervention where many children can be reached.

There's also a funding announcement here related to comparative effectiveness of interventions targeting mental health in individuals with intellectual and developmental disabilities and we were excited to see applications that address cognitive behavioral therapy versus mindfulness for autism, as well as the identification of really cognitive behavioral therapy and mindfulness as treatments that could be effective in for anxiety and depression for autistic adults.

We can also see on this slide the PFA related to prevention, early identification and treatment of delirium in older adults. And this announcement actually yielded projects that look at hospital elder life programs versus family-augmented help for prevention of delirium and exciting opportunities for us to think about filling evidence gaps that can inform decision-making.

Let's go to the next slide.

So on our dissemination and implementation award slate, you see that there were two awards that

were made, and the first project was one that's implementing an evidence-based psychotherapy for post-traumatic stress disorder in six different healthcare systems, and another that's focused on implementing obesity treatment in primary care using different types of evidence-based structures.

Let's go to the last slide.

So I just wanted to put this all into context and mention that of these $101 million of awards, you can see how they'll align in the fiscal year 2023 commitment plan.

So the target in 2023 for research is $500 million, and with the awards that I shared with you today, our cumulative total for this first cycle of 2023 is $96 million. There are two more cycles to go in 2023, and usually our last cycle is our most robust.

And for the dissemination and implementation target in the commitment plan, we have a target in 2023 of $40 million and the two awards that came in this time total $5 million, and we're also anticipating two more cycles of awards

here.

I did have a slide for some discussion, but given the time, I think I'll just turn it back to you, Russ, and let you close out the meeting.

DR. HOWERTON: Thank you very much, Nakela, and I hope all of you, like me, found that to be impressive work that the organization you help lead is doing.

I would like to thank everyone who joined us today. Today's meeting agenda, slides, archived webinar, and approved minutes from the September 20th, 2022 meeting will be posted to PCORI's website within a week.

As always, we welcome your feedback at info@PCORI.org or through our website www.PCORI.org.

Thank you again for joining us. Have a great afternoon and we look forward to seeing you at our next public meeting in February.

Thank you everyone.

[Whereupon, at 3:00 p.m. EST, the Patient-Centered Outcomes Research Institute's Board of Governors meeting was adjourned.]