Preparedness and Treatment Equity Coalition Call for Proposal 2021

Deadline for Full Proposals: September 1, 2021

MISSION

The Preparedness and Treatment Equity Coalition (PTEC) brings together multi-sector stakeholders to narrow the disparities in pandemic preparedness, morbidity, and mortality through more effective use of diagnostic tests, vaccines and medicines and supportive care addressing underlying infectious, cardiovascular, and metabolic risk factors. The coalition is focused on developing evidence to guide health system delivery and payment reforms in partnership with data partners including IQVIA and Milliman as well as AcademyHealth. More equitable access will reduce pandemic associated death and devastation for Black, Latinx, Asian, and Native American communities and the underlying conditions that make this pandemic even more deadly in these communities.

BACKGROUND

The COVID-19 pandemic exposed the pervasive inequity that exists in the U.S. healthcare system. Underserved populations, especially Black, Latinx, and Native American communities experienced decreased access to testing, treatment, and vaccination, increasing COVID-19 morbidity and mortality. The high rate of underlying risk factors such as cardiovascular and metabolic disease makes infectious diseases such as COVID-19 deadlier and more destructive. With the advent of effective vaccines, the COVID-19 epidemic will eventually abate. However, the health inequity that imperils the lives of Black, Latinx, Asian, and Native American communities will remain.

Health inequity is not only an ethical failing of the U.S. healthcare system but a costly one. As the available data grows and payment shifts from fee-for service to models based on treatment value and patient outcomes, now is the time to determine how to address underlying inequity in care delivery through more effective use of data and reimbursement models. A coalition of private businesses, health researchers, and advocates are well positioned to work together to narrow known health disparities by developing evidence to inform policy and practice change to promote more effective and equitable use of diagnostic tests, vaccines, and medicines.

Currently, health system reforms are advancing within a pervasively unjust healthcare structure built on a foundation of structural racism. The policy to shift healthcare payment to pay for achieving more value and better health outcomes has the potential to increase health inequity by discouraging care delivery for patients from racialized groups. The Coalition aims to determine how value-based care and outcomes measurement could be reformed with health equity as a goal.

RESEARCH

PTEC is committed to developing methods for the collection and use of data in support of efforts to decrease health inequity in the U.S. healthcare system. Novel approaches and inspired collaborations are necessary to identify ways to measure and reward more equitable health outcomes. PTEC is particularly focused on solutions for vaccine equity and conditions that disproportionally affect racialized communities (Black, Latinx, Asian, and Native American), such as cardiovascular disease and metabolic disorders.

This call for proposals (CFP) will provide grant support for research studies that **harness the power of data to identify metrics, outcome measures, or payment models that can be used to encourage practices that decrease inequity in the healthcare system**. Research supported by this CFP is not intended to be merely descriptive, but to **identify inequitable practices or outcomes and propose a data-driven solution**.

Research examples:

- Value-based metrics for asthma encourage providers to avoid treating children with poorly controlled asthma, who are more likely to be people of color due to discriminatory environmental policies. This often causes children of color to experience delays in their vaccination schedules, increasing their risk of acquiring an infectious disease. How can the metrics be changed to discourage this practice and reward providers who continue to treat these patients?
- Metabolic syndrome, prevalent among women of color, is associated with increased breast cancer risk. A higher proportion of Black, Latina, and Asian women are under 50 when diagnosed with breast cancer compared to white women, but these women are less likely to be asked by their providers to participate in clinical research studies. What factors impact providers' decisions to invite younger women of color to participate in clinical research? Would including "racial/ethnic diversity of study participants" as an outcome measure incentivize providers and researchers to create more equitable studies?
- An insurance company uses an AI product to develop discharge plans for patients after cardiovascular surgery to decrease readmission rates. Black patients are routinely discharged with fewer post-operative support services even though they are more likely to be in poorer general health, resulting in higher readmission rates. The algorithm prioritizes cardiovascular surgery patients who have more contact with the medical system; data shows these patients are overwhelmingly white and of higher socioeconomic status. How can the AI product be improved to assign more post-operative support for Black patients? Does changing the discharge algorithm result in more equitable readmission rates?

AWARDS

- Three (3) grants of $50,000 to support project-related costs, and access to services of data partners.
- Three (3) awards of no-cost access to services of data partners, with no direct financial support for project-related costs.
- Our data partners, IQVIA and Milliman, will work with the awardees to support their research requirements. See appendix for information on available databases and services.

ELIGIBILITY

- Based in United States or U.S. territories.
- Applicants must be research teams comprised of research institutions (academic or nonacademic), healthcare providers, and/or community-based partners. Research teams from multiple organizations must designate a primary applicant responsible for grant stewardship. Awards will not be granted to individual researchers.
- Must examine health inequity within the United States healthcare system. Projects proposing independent or comparative study of other healthcare systems are excluded.

DATES AND DEADLINES

July 16, 2021: Brief Proposals Due (*Deadline has passed*)

- 2-page concept proposal, single-spaced, size 12 font (maximum)
- Consisting of Summary, Specific Aims, and Research Strategy
- Please include cover page with Proposal Title, Names, Affiliations (not part of page limit)
- Please include biography page with 1 paragraph bios of key personnel (not part of page limit)

September 1, 2021: Full Proposals Due

- 5-page full proposal, single-spaced, size 11 Arial or Times New Roman font for the main body of the text (figures and captions may have smaller type), 0.75-inch margins.
- Consisting of Background & Significance, Innovation, Aims, Research Strategy, and Implementation Design.
- Endnotes should be limited to one page (not part of page limit)
- Please include cover page with Proposal Title, Names, Affiliations (not part of page limit)
- Please include biography page with 1 paragraph bios of key personnel (not part of page limit)

REQUIREMENTS

Proposals should examine **systemic racism** as a cause of inequity in the United States healthcare system, and focus on **cardiovascular disease, metabolic disease**, or **vaccination**. We strongly encourage proposals that also examine intersectional characteristics that increase health inequity including **age, disability,** or **LGBTQ+ identities**. Proposals may include research on other disease states as long as they demonstrate a connection to cardiovascular disease, metabolic disease, or vaccination.

SELECTION CRITERIA

- **Significance**: (30%)
  - Does the proposal impact racial/ethnic equity and social justice?
  - Does the proposal focus on cardiovascular disease, metabolic disease, or vaccination?
  - Does the proposal consider the impact of intersectional characteristics on racial/ethnic equity?
  - Does the proposal add to existing literature and implementation science?
  - *Note: Proposed research may be used to generate preliminary data for future projects.*
- **Innovation**: (20%)
  - Is the proposal innovative in approach?
- **Application**: (20%)

- Does the research create a foundation (individually or building on existing literature) for implementation in the provider, payer, or policy space?
- Does the research lend itself to a targeted audience (policymakers, payers, providers, etc.) with an ability to influence with findings?

- **Research Team**: (30%)
  - Applicants are encouraged to develop a multidisciplinary research team with diverse personal and professional backgrounds. These include:
    - Individuals from groups historically underrepresented in research including (but not limited to): race/ethnicity, disability, lower socioeconomic status.
    - Individuals from non-academic settings including (but not limited to): community-based organizations and advocacy groups.
    - Individuals from disciplines including (but not limited to): applied mathematics and mathematics; business administration; communications; computer science; design; economics and finance; education; engineering; geography and demography, law; political science; psychology; public administration; public policy; social work; sociology; transportation; urban/regional planning.
    - Individuals on interdisciplinary research teams with expertise in evaluation and implementation as well as scientific research.
  - Research teams are encouraged to demonstrate expertise in research design and data analysis. Community-based organizations and healthcare providers without this expertise are urged to identify well-equipped partners.
    - *Note: Researchers collaborating with Milliman as a data partner will have access to in-house analysts. Researchers <u>will not</u> have direct access to Milliman databases.*

IQVIA Information Sources

Real World Data via P360

Prescription Claims (LRx): IQVIA receives nearly four billion prescription claims per year with history from January 2006 with coverage over 90% for the retail channel, 60–85% for mail service, and 75– 80% for long-term care. Longitudinal data derives from electronic data received from pharmacies, payers, software providers and transactional clearinghouses. This information represents activities that take place during the prescription transaction and contains information regarding the product, provider, payer, and geography. Rx data is longitudinally linked back to an anonymous patient token and is linkable to events within the data set itself and across other patient data assets

> **Key Data Elements:** De-Identified Patient ID, Patient Age, Patient Gender, Pharmacy Type, Pay Type, Product Name, Molecule Name, Brand/Generic Category, Product Form, Product Strength, NDC, Therapeutic Class (USC), Provider NPI, Provider Specialty, Provider State, Provider Zip Code, Claim ID, Dispensed Quantity, Days Supply, Co-Pay Amount, Month ID, Week ID, Service Date

Medical Claims (Dx): Unadjudicated office and institutional medical claims data covering approximately 191M patients. Office claims include patient level diagnosis, procedures and in-office treatments for visits to U.S. office based professionals, ambulatory and general healthcare sites. Institutional claims data include claims generated for work performed by hospitals, skilled nursing facilities, and other institutions for outpatient and inpatient procedures and services. Data are sourced from 837p and 837i claims collected through practice management software vendors and switch clearinghouses.

> **Key Data Elements:** De-Identified Patient ID, Patient Age, Patient Gender, Pay Type, Diagnosis Code, Diagnosis Description, Procedure Code, Procedure Description, Type of Service, NDC, Dosage Amount, Provider NPI, Provider Specialty, Provider State, Provider Zip Code, Claim ID, Service To Date, Service From Date, Month ID, Week ID

IQVIA Information Sources

National Data via SMART

National Sales Perspectives (NSP): Measures revenue within the U.S. pharmaceutical market by pharmacies, clinics, hospitals, and other healthcare providers. NSP reports 100% coverage of the retail and non-retail channels for national pharmaceutical sales at actual transaction prices. The prices do not reflect off-invoice price concessions that reduce the net amount received by manufacturers

> **Key Data Elements:** Channel of Distribution, Product Name, Molecule Name, Brand/Generic Category, Product Form, Product Strength, Product NDC, Rx/OTC Status, Therapeutic Class (USC or ATC), Corporation/Manufacturer, Sales Dollars (USD), Unit Volume, Data Month, Data Week

National Prescription Audit (NPA): The industry standard source of national prescription activity for all pharmaceutical products. It measures demand for prescription drugs, including dispensed pharmaceuticals to consumers across three unique channels: retail, mail service, and long-term care pharmacies. From sample pharmacies, IQVIA collects new and refilled prescription data daily. NPA represents and captures over 92% of all outpatient prescription activity in the United States and covers all products, classes, and manufacturers.

> **Key Data Elements:** Channel of Distribution, Product Name, Molecule Name, Brand/Generic Category, Product Form, Product Strength, Product NDC, Rx/OTC Status, Therapeutic Class (USC or ATC), Corporation/Manufacturer, Prescriber Specialty, New/Refill/Total Prescription Volume, New/Refill/Total Prescription Quantity, Data Month, Data Week

MILLIMAN'S LONGITUDINAL RESEARCH DATASETS

Milliman Consolidated Health Sources Database (CHSD)

- Includes Milliman (deidentified) client contributor data from several national and regional health plans for nearly 70 million insured lives (over 50 million **commercially** insured lives).
- Consists of real-world patient-specific detailed claims data including utilization and costs for inpatient, outpatient, pharmacy and other healthcare services with linked enrollment and member demographic information
- Used to support Milliman products like the Health Cost Guidelines, Milliman research and client engagements.
- The CHSD also includes data for **Managed Medicaid**, Medicare Advantage, and Medicare Supplement populations
- **Does not include race and ethnicity data**

Milliman Part D Consolidated Database (PDCD)

- Includes Milliman (deidentified) client contributor data for over 9 million lives enrolled in **Medicare Part D**
- Consists of real-world patient-specific detailed Prescription Drug Event (PDE) data consistent with CMS data layout specifications
- Includes linked enrollment and member demographic information including risk scores and **low-income subsidy (LIS)** flags consistent with the CMS Monthly Membership Report (MMR) data layout specifications
- Used to support Milliman research, actuarial pricing tools and client engagements.
- **Does not include race and ethnicity data**

Medicare 100% Innovator Research, 5% Sample

- 100% Innovator Research (**IR**) data has linked Parts A & B and D for all **Medicare Fee-for-Service (FFS)** beneficiaries nationwide and Part D only for all **Medicare Advantage** beneficiaries nationwide
- Research protocol for the IR includes benchmarking and socio-economic research
- The CMS 5% Sample (CMS5%) contains claims and enrollment data for a statistically balanced sample of all **Medicare FFS** beneficiaries nationwide
- Both the IR and CMS5% contain real-world patient-specific detailed claims data with linked enrollment and member demographic information
- **IR data includes race and ethnicity information for beneficiaries**

IBM Marketscan®

- Includes private sector health benefit claims and enrollment data from approximately 100 payers with over 28 million **commercially** insured lives.
- Consists of detailed patient-specific health benefit claims and enrollment data from a selection of large employers and health plans.
- The databases link paid claims and encounter data to detailed patient demographic information across sites and types of providers over time.
- **Does not include race and ethnicity data**