Analysis of NINDS Health Disparities and Health Equity Research Portfolio, 2016–2020
Results and a Process for Transparency, Accuracy, and Reliability

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Abstract

Background and Objectives
As detailed throughout this special issue, the National Institute of Neurological Disorders and Stroke (NINDS) recently undertook a strategic planning effort to guide the Institute’s efforts and priorities in health disparities and health equity (HD/HE) research. One input into this effort was to conduct a 5-year longitudinal, in-depth analysis of NINDS-supported HD/HE research newly funded between the years 2016 and 2020. The goals of this analysis were to describe NINDS’s portfolio according to consistent, contemporary definitions and HD/HE disciplinary theory. This required the development of a novel, systematic, and validated analysis protocol. The portfolio analysis was designed to inform the recommendations of an expert working group convened by the NINDS and internal efforts to support high-priority research, training, and infrastructure efforts.

Methods
NINDS staff developed and validated this HD/HE research portfolio analysis protocol. Ultimately, HD/HE projects were characterized by their disease focus, populations of study, the health equity determinant(s) addressed, and the type and phase of research being conducted. For all interventional research, there was further assessment of the type and setting of intervention delivery as well as utilization of evidence-based community engagement and intervention sustainability approaches.

Results
A total of 58 new HD/HE research projects were funded from 2016 to 2020. The results of the descriptive analysis described here help provide a holistic picture of NINDS’s HD/HE research portfolio, revealing strengths and gaps in the portfolio as well as opportunities ripe for future investment.

Discussion
NINDS developed a standardized HD/HE research categorization methodology with imbedded quality control checks that is intended to be transparent, accurate, and reproducible. The results of this HD/HE research portfolio analysis will serve as a baseline from which to assess the success of NINDS’s research investments going forward.

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Introduction

The National Institute of Neurological Disorders and Stroke (NINDS) is deeply committed to the elimination of all health disparities and inequities in neurologic conditions and care through the funding of innovative research, from basic science to implementation, that will identify, monitor, and target biological, environmental, behavioral, social, and/or health care system factors that influence disparities in neurologic disease. As stated in the US Department of Health and Human Services’ “Healthy People,” using common definitions of health equity and health disparities promotes a shared understanding and helps stakeholders to identify areas for collaborative action. Healthy People 2030 defines a health disparity as: “A particular type of health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socio-economic status, gender, age, or mental health; cognitive sensory or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.” Additionally, Healthy People 2030 defines health equity as “the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.” We applied these Healthy People 2030 definitions in this analysis because they are widely recognized by public health researchers and the public alike.

In 2010, the NINDS director organized a workgroup, which included National Advisory Neurological Disorders and Stroke (NANDS) Council members and other experts, to generate recommendations on how the institute should address disparities and inequities in neurologic disorders (2010 Report of the NINDS Advisory Council on Health Disparities). Given that approximately 10 years have passed since the initial NINDS health disparities strategic plan was created, in 2020 the NINDS embarked on another strategic planning process. It was the Institute’s goal that this process be data-driven, standardized, and transparent, reflecting input from a wide range of perspectives from stakeholders interested in the elimination of disparities and/or inequities in neurologic care, outcomes, treatment, services, and research. As described throughout this special issue, NINDS formed a new working group (WG) of the NANDS Council that was charged with generating recommendations on what the NINDS should do to eliminate health disparities and achieve health equity, as well as offering advice, guidance, and expertise throughout the planning process. To help equip the WG with the proper background and contextual information needed to carry out its charge, an analysis of recent NINDS-funded health equity research grants was conducted and described here.

Methods

The goals of this analysis were to (1) describe the NINDS portfolio according to the Healthy People 2030 definitions and salient quantitative and qualitative parameters; (2) anchor description of the NINDS portfolio to health disparities and health equity (HD/HE) disciplinary theory; (3) develop a comprehensive, validated protocol to ensure accurate, reproducible, and transparent results; and (4) provide historical data for the WG and NINDS staff to inform future research, training, and infrastructure gaps and needs. Under the auspices of the NINDS Health Equity Workgroup (HEW), several NINDS staff developed and validated a HD/HE portfolio analysis protocol/standard operating procedure (SOP), which is summarized in this Methods section. Expert guidance on the analysis was provided by the NANDS Council WG, which reviewed both the SOP and analysis results. We also engaged a trans-NIH health disparities workgroup that included diverse NIH staff. The SOP was expanded and revised in response to input from the analysis team, subject matter experts, NINDS staff, and the advisory WG of NANDS Council. A pilot analysis focused on 1 calendar year of NINDS’s research portfolio was conducted to inform considerations of optimizing workload, determining feasibility, and refining analysis methodology that would allow for the highest return on investment for knowledge gained about the HD research projects funded by NINDS.

Defining the HD/HE research portfolio started with developing a balanced method that leveraged existing automated tools with manual review/coding. Primary considerations were given to developing a systematic, reproducible data query, standardizing the screening and coding process/terms, and determining the power in the data set, including the types of information we could readily or not readily obtain. Consistent with best practices in qualitative analysis, this analysis involved multiple steps to develop a comprehensive, well-tested SOP to ensure transparency and reproducibility that would translate to future comparative portfolio analysis efforts. Steps included the
following: (1) generate an enriched subset of projects to screen, (2) screen and determine which projects fit the HD/HE research definition, (3) code for salient descriptors, and (4) verify with intermediate reconciliation and validation steps at each level (Figure 1). This path enabled a robust description of the portfolio that was previously unavailable to NINDS.

### Identifying Projects to Screen

The portfolio analysis focused on calendar years 2016 through 2020 and included all new projects across all funding mechanisms that received NINDS funding, including projects that were cofunded by other NIH Institutes, during the period of January 1, 2016–December 31, 2020. To identify potential projects for the analysis, we used the NIH Query View Report (QVR) system, one of several internal data systems that interconnect to facilitate NIH extramural program staff to review, award, manage, and close out the multitude of grant applications and awards NIH handles each year. Overall, NINDS funded a total of approximately 9,100 new projects from 2016 to 2020. To winnow the screening data set down to a manageable size, we applied research category filters in QVR that were based on the NIH’s Research, Condition, and Disease Categorization (RCDC) system, which is used to categorize every funded study and report the amount NIH funds in each of more than 280 publicly reported categories of disease, condition, or research area. We determined that the following RCDC categories could potentially capture relevant HD/HE research projects: Health Disparities, Health Disparities for IC Use (not publicly reported), Rural Health, Sexual and Gender Minorities, American Indian or Alaska Native, Child Abuse and Neglect Research, Homelessness, Mental Illness, Serious Mental Illness, Minority Health, and Minority Health for IC Use (not publicly reported). Once the data set was restricted to these categories—termed the enriched data set—approximately 910 projects were identified for the manual screening stage of the analysis.

### Screening Projects to Identify HD/HE Research

The SOP detailed how to screen projects to determine whether they fit the Healthy People 2030 definitions of HD/HE research. Per the Healthy People 2030 health disparities definition, we included only those research projects that sought to understand or intervene in health differences closely linked with economic, social, or environmental disadvantage. The Healthy People 2030 definition is somewhat different from NIH’s RCDC “Health Disparities” definition, which in addition to HD research studies includes all clinical studies with high inclusion rates of race or ethnic minorities, research workforce diversity development, relevant conferences, and clinical research infrastructure development. Such non-“HD research” projects were screened out of this analysis.

The SOP included operational definitions of important components of NINDS HD research projects and categories of interest (eAppendix I, links.lww.com/WNL/C928). Training materials were developed that included a list of guiding questions to help analysts identify projects that fit the HD definition. The training materials explained that several different types of research across the basic to applied spectrum can be classified as HD/HE research, including those that study or measure whether a health disparity exists; seek to determine why a known health disparity exists; develop and/or test interventions (including preventive approaches) to reduce disparate health outcomes; or model a selected population-related biological difference at a mechanistic level that could relate to disparate health outcomes. Also developed was a diverse sample set of HD/HE research project descriptions and descriptions of projects that fell just outside of the definition to help analysts identify any nuanced differences.

The process of screening involved determining whether the project should be categorized as HD/HE research by an examination of the title, abstract, and specific aims of the research.
Coding Projects to Describe to the HD/HE Research Portfolio

In the coding phase, analysts examined the entire research application to assess several descriptive characteristics. See eAppendix 1 (links.lww.com/WNL/C928) for the full coding schematic and operational definitions. Coding parameters were informed by and aligned with contemporary research frameworks and definitions and were vetted by the expert advisory WG. For example, the HD/HE determinants that were assessed aligned with the domains of influence defined in the “Minority Health and Health Disparities Research Framework” developed by NIH’s National Institute of Minority Health and Health Disparities (NIMHD): Biological, Behavioral, Physical/Built Environment, Sociocultural Environment, and Healthcare System.6 The phase of study was determined using the “Translational Science Spectrum” published by NIH’s National Center for Advancing Translational Sciences: T0 (basic), T1 (preclinical research), T2 (clinical research), T3 (clinical implementation), or T4 (public health).7

In brief, the following parameters were assessed and coded: (1) the populations included in the research study: race or ethnic minority, low socioeconomic status (SES), rural, sexual or gender minority, low education, and institutionalized; (2) the race or ethnicity of the minority population studied: Black or African American, Hispanic or Latinx, American Indian or Alaskan Native, Asian American, Native Hawaiian, or other Pacific Islander; (3) the HD/HE determinants being studied: biological, behavioral, sociocultural, health care access, and/or physical/built environment; (4) the types of research being conducted: observational/epidemiologic, interventional, behavioral, mechanistic, and/or technology development; (5) the neurologic disease(s) being studied; (6) the translational phase of research of the study: T0 (basic), T1 (preclinical research), T2 (clinical research), T3 (clinical implementation), or T4 (public health); (7) the type(s) of health equity intervention being studied: case management, community engagement, cultural modification, integrated health care, provider education, patient education, policy intervention, technological interventions to improve health care access or quality, enhancing access and/or capacity to deliver service, public communication/dissemination, other, or no health equity intervention are being used; (8) the types of community-based component being used: none, community advisory board, neighborhood clinic, community health worker, naturally occurring groups, patient advocate, or social media; (9) the setting of intervention delivery: clinic, community, hospital, home, church or religious institution, private practice, and other human services; (10) whether there were considerations for ensuring the sustainability of the intervention after the end of the project funding period; and (11) the NINDS funding contribution for HD research: (i) How many aims focused on HD research? (ii) If cofunded, how much funding did NINDS contribute? This breakdown of information was used to determine how much funding or what percentage of the overall project was devoted to HD research. This was especially important for large projects with a minor HD research focus.

The same process of partner teams used in screening was used to validate project coding. In brief, the 70 projects that advanced from screening to coding were assigned to 10 analysts in a nearly equal distribution. The projects were individually examined by an analyst, and the abovementioned coding questions were answered. The partners then met to discuss and reconcile results. All discrepancies were escalated for a second-level review. Any questions that were not resolved were escalated to the OGHHD for final coding determination, and all projects determined to be HD/HE research were validated by the Program Officers assigned to manage those projects. It was ultimately determined that 58 of 70 projects that underwent the in-depth coding process met the HD research definition. Microsoft Excel was used to generate descriptive statistics and graphs of the results. Given that this was intended to be a descriptive analysis, no statistical analyses were conducted.

Results

Applying the final portfolio screening and coding protocol, a total of 58 HD/HE research projects were newly funded by NINDS between 2016 and 2020, representing $30.6 million in first-year costs (Figure 2). These projects were concentrated in a relatively small number of neurologic disorders, most heavily focused on stroke (n = 25; 43.1%), followed by neurologic complications of HIV (n = 14; 24.1%), opioid use–related pain (n = 6; 10.3%), multiple sclerosis (n = 4; 6.9%), brain injury (n = 3; 5.1%), Alzheimer disease and Alzheimer disease–related dementias (n = 2; 3.4%), and 4 other disorders (6.9%), including 1 project each on Parkinson disease, hypertension, CNS infection, and aging-related neurologic outcomes. In addition to the number of projects addressing each disease area, the first-year project funding per disease area, which includes direct and indirect costs, is plotted in

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Figure 2 (see right axis). It was not our aim to calculate the total funding for HD/HE research over the 5-year analysis period but rather to collect general information related to neurologic disease areas. Note that while the HIV topic area ranked second for number of projects (n = 12), it was fifth for funding ($1.3 million). These 12 HIV projects were all large clinical network grants administered by other NIH Institutes and cofunded by NINDS with modest funds to cover neurologic measures and analyses. It should be reiterated that the budget figures presented here represent only those funds provided for the first year of the project award period, and they were prorated according to the proportion of research aims that addressed HD/HE research questions. As these figures were not calculated by standard reporting means, they will differ from those that have been publicly reported.

Several different funding mechanisms were used to support these projects, including research project grants (RPGs), training awards for graduate students and postdoctoral fellows (F mechanisms), and new investigator/postgraduate training awards (K mechanisms). RPGs accounted for 48 (82.3%) of the awards and training and new investigator awards accounted for the remaining 10 awards (17.2%).

Regarding research phase, projects fell heavily in the T2/c clinical research space (50; 86.2%), with 6 studies (10.3%).
classified as T3/clinical implementation and dissemination research and no studies in the T4/public health research phase (Figure 3, left panel). One project each was determined to be T0/basic and T1/preclinical research. To further describe the kinds of research being conducted across the HD/HE portfolio, we categorized each study by "research type." The results were as follows: 43 clinical observational studies (74.1%), 13 mechanistic (22.4%), 12 diagnostic/screening (20.7%), 9 clinical interventional (15.5%), and 5 technology development (8.6%) (Figure 3, right panel). Note that projects could be categorized as more than one type of research.

For the 56 projects that were classified as clinical (T2 or T3), the number of studies examining the following study populations were as follows: 53 projects studied race/ethnic minorities (94.6%), 14 studied individuals of lower socioeconomic status (25.0%), 10 studied rural populations (17.9%), 8 studied individuals with low education (13.8%), and 6 studied a sexual or gender minority (10.7%) (Figure 4, left panel). Because most of the HD/HE research portfolio focused on populations of underrepresented race and ethnic (R/E) minorities, a further classification of R/E populations was conducted (Figure 4, right panel). For the 56 projects that were classified as clinical (T2 or T3), the number of studies examining the following study populations were as follows: 53 projects studied race/ethnic minorities (94.6%), 14 studied individuals of lower socioeconomic status (25.0%), 10 studied rural populations (17.9%), 8 studied individuals with low education (13.8%), and 6 studied a sexual or gender minority (10.7%) (Figure 4, right panel). Forty-six studies examined Black or African American

**Figure 4** Population Demographics (Left) and Race and Ethnicity of Minority Populations Studied (Right) Were Assessed for Each of the 56 NINDS Clinical HD/HE Research Projects

![Image: Population Demographics and Race/Ethnicity](Image)

Most clinical HD/HE research projects (n = 53, 94.6%) studied race/ethnic minorities, which largely consisted of Black or African American participants (n = 46, 79.3%). Twenty-one (36.2%) of the clinical research studies examined more than 1 R/E group, typically including Black/African American and Hispanic/Latinx individuals in the same study. None of the HD/HE projects examined American Indian/Alaskan Native, Native Hawaiian, or other Pacific Islander individuals.

HD/HE = health disparities and health equity; NINDS = National Institute of Neurological Disorders and Stroke; SES = socioeconomic status.

**Figure 5** Projects Were Categorized by the Types of Health Determinants Addressed

![Image: Determinants Addressed](Image)

Although biological determinants were the most frequently examined type of determinant (n = 42, 72.4%), 86.2% of projects examined at least one of the other 4 determinants (i.e., behavioral, sociocultural, health care system, and physical/built environment).
individuals (79.3%), 27 examined Hispanic or Latinx American individuals (46.5%), and 5 examined Asian American individuals (8.6%). Twenty-one (36.2%) of the clinical research studies examined more than 1 R/E group, typically including substantial proportions of Black/African American and Hispanic/Latinx individuals in the same study. None of the HD/HE projects examined American Indian/Alaskan Native, Native Hawaiian, or other Pacific Islander individuals. Given the importance of intersectional effects on health inequities, secondary population demographic characteristics were also assessed. For example, sex was examined in 30 projects (51.2%), aging (65 years or older) in 14 projects (24.1%), marginalized health status (e.g., substance users, individuals living with HIV) in 12 projects (20.1%), and pediatric status in 4 projects (6.9%). We did not identify any projects that examined disparities in the following secondary populations: individuals with disabilities, institutionalized individuals, individuals with serious mental illness, religious minorities, immigrants, and non-English speaking individuals.

To drill down on how projects included or addressed important HD/HE research approaches, projects were characterized by several project parameters informed by contemporary HD/HE research theory. First, we determined the type(s) of HD/HE health determinant addressed by each project, as described in NIMHD’s Health Disparities Research Framework (Figure 5). The full operating definition of biological determinants is provided in eAppendix 1 (links.lww.com/WNL/C928); in brief, they were defined as factors of differential biological vulnerability, including genetics/heritable factors (e.g., risk genes and sex), epigenetics, clinical measures (e.g., blood pressure, weight, and brain imaging results), and health status/history. The 4 other determinants categorized were all considered nonbiological. The majority of projects examined 1 or more biological determinants (42, 72.4%), followed by 30 addressing sociocultural determinants (51.7%), 29 addressing behavioral determinants (50.0%), 22 addressing health care system determinants (37.9%), and 8 addressing physical/built environment determinants (13.8%). The number of projects that addressed at least 1 nonbiological determinant totaled 50 (86.2%).

Finally, projects were coded for whether the investigators described using community engagement approaches in the recruitment and/or research design and which type of community engagement was used (Figure 6). Of the 56 clinical HD/HE projects, 22 applications (39.3%) described at least 1 form of community engagement, including community advisory boards (n = 18; 32.1%), a naturally occurring patient or community group (n = 9; 16.0%), neighborhood clinic (n = 4; 7.1%), or community health worker(s) (n = 3; 5.4%). The 9 interventional HD/HE research studies (15.5% of the full portfolio) were further characterized by type of intervention and the setting that the intervention was being delivered. The 3 most common intervention types were enhancing access to care (n = 5; 55.6%), patient education (n = 5; 55.6%), and using integrated health care approaches (n = 4; 44.4%). Most interventions were delivered in a research hospital (n = 4; 44.4%) or clinic (n = 3; 33.3%). Only 2 projects included an intervention setting outside of the hospital or clinic.

Discussion

The findings of the analysis described here were used by the NANDS Council working group, among other data, to help identify strengths, opportunities, and gaps of the NINDS-funded HD/HE research portfolio and programs as detailed throughout this special issue. In undertaking this longitudinal analysis of NINDS-funded HD/HE projects, much was learned about the portfolio of research investments and the systematic approach needed to accurately determine and describe the portfolio. The final screening and coding parameters were rigorously developed, tested, and refined at several points along the analysis. Defining the portfolio benefitted from an iterative, stepwise methodology with checks and balances that was rooted in health equity research theory and detailed
operational definitions. Our definitions are being shared with other stakeholders across NIH, and NINDS is part of a trans-NIH effort to develop a more standardized and valid HD/HE research classification that is conducted using consistent definitions and approaches. Expanded guidance and training will be important for staff who perform annual coding of HD/HE research projects.

The NINDS HD/HE portfolio analysis highlighted potential areas of opportunity to foster HD/HE research. For example, only a small proportion of NINDS’s overall research portfolio examined health disparities and inequities (58 of ~9,100 new research projects funded between 2016 and 2020). The findings suggest the need for a stronger focus on studying and intervening in structural barriers and social determinants of health that affect neurologic disease treatment and outcome in a disease agnostic fashion. Although the purview of NINDS’s research mandate includes hundreds of neurologic diseases and disorders, the portfolio was concentrated on a limited number of disease areas. Approximately half of the projects examined stroke disparities, with 4 disease areas accounting for the bulk of the remainder. There is also an opportunity to examine disparities of a broader swath of vulnerable and underrepresented populations, including low SES populations, rural populations, sexual and gender minorities, and a greater range of racial and ethnic minorities. A clear gap is that none of the projects identified in this analysis addressed disparities in American Indian/Alaskan Native, Native Hawaiian, or other Pacific Islander individuals. Given the importance of intersectional aspects of health inequities, it is worth reiterating that none of the projects in this analysis examined individuals with disabilities, institutionalized individuals, individuals with serious mental illness, religious minorities, immigrants, and non-English speaking individuals.

Furthermore, our findings illustrate gaps and opportunities in interventional HD/HE research. NINDS has a distinct opportunity to support not only observational studies that measure health disparities (currently the bulk of the HD/HE portfolio) but also expand into research that is focused on developing, testing, and scaling up interventions (currently accounting for approximately 15% of the portfolio). For interventional studies, HD/HE theory underscores the value of engaging participant communities in the design and conduct of research as well as delivering interventions in community and other nontraditional settings. To this end, only 2 studies were designed to deliver an intervention outside of a formal research hospital or clinical setting, and only approximately 40% of projects described the use of community engagement approaches. There are at least 2 explanations: community engagement approaches are being underutilized or they are not being sufficiently described in research applications. This points to a clear area of opportunity for NINDS to enhance community engagement in funded studies.

There are several limitations of this study. First, there is natural variability in the content and scope of the research grant applications that were analyzed, making it difficult to accurately categorize the projects into discrete groups without overlap or elimination of important variables. Second, the investigators were not instructed to address many of the parameters that were assessed in our analyses, so it is possible that some relevant information may have been collected in the studies but could not be discerned using our methodology. Third, the methods of capturing race and ethnicity are not standardized and often limited and flawed, making it difficult to accurately separate these categories in these analyses. Although binary Hispanic vs non-Hispanic ethnicity is often captured, Asian American subgroups (e.g., Chinese, Filipino, Japanese, Korean, etc), Black/African American subgroups (e.g., Jamaican, Haitian, Kenyan, Nigerian, etc), or mixed ethnicities are often ignored. Another limitation is that, because of feasibility issues, we were not able to analyze unfunded applications. Going forward, a comparative analysis of funded vs unfunded HD/HE research applications would be worthwhile. An additional limitation, although relatively minor, is that a longer time frame for the analysis could have revealed a larger breadth of HD/HE research that has been supported by NINDS. We believe, however, that the findings of this study are comprehensive enough to provide a holistic picture of NINDS’s efforts to support HD/HE research.

As a public funder of biomedical research, NINDS set out to develop a HD/HE research categorization methodology that was transparent, accurate, and reproducible. This analysis represents the first time the NINDS’s HD/HE research portfolio has been examined in such depth. We developed a SOP with imbedded quality control checks for characterizing NINDS-funded HD/HE research projects. Much effort went into selecting the most salient quantitative and qualitative parameters to assess and developing clear operational definitions and examples of HD/HE research. Most of the analysis team had limited exposure to HD research concepts and/or NINDS’s HD portfolio before the training provided. As such, this exercise represented a unique opportunity to educate NINDS staff on principles of health equity and health disparities research. We found that it was imperative to conduct in-person training and to set aside dedicated time for discussion and developing consensus. As the NIH continues to make process improvements in how the agency categorizes and reports on HD/HE research, it is our hope that the protocol and lessons learned provided in this publication will help inform such trans-NIH efforts.

While conducting this detailed analysis of NINDS’s HD/HE research portfolio required committed time and the assistance of many dedicated staff members across the institute, its value is clearly demonstrated on various fronts. The results of the analysis described here provide a holistic picture of NINDS’s recent investments in HD/HE research, revealing strengths and gaps in the portfolio of as well as opportunities ripe for future investment. The analysis revealed previously uncharacterized details about the types of HD/HE research supported by NINDS and the extent to which projects incorporated evidence-based HD/HE research approaches. Among many
To inform future strategic investments in NINDS-supported HD/HE research, NINDS developed and validated a SOP for analyzing funded HD/HE research with quality control checks imbedded throughout the process.

For an accurate and holistic picture of HD/HE research, it was critical to apply clear definitions and to assess funded projects for characteristics known to underly contemporary theory and best practices in HD/HE research.

This analysis revealed previously uncharacterized details about the types of HD/HE research supported by NINDS and the extent to which funded projects incorporated evidence-based HD/HE research approaches.

Clearly documenting and reporting current health equity–related research is important for transparency, accuracy, and reproducibility as well as determining the efficacy of initiatives developed after the strategic planning process.

Conducting a detailed portfolio analysis was time intensive and required the assistance of dedicated staff but provided much value for priority setting purposes.

other inputs, the NANDS Working Group of Council that was charged with advising the Institute on HD/HE research priorities used these results to inform research recommendations discussed throughout this special issue. These results will serve as a baseline from which to assess the evolution of the research portfolio going forward. Clearly documenting and reporting current health equity research is critical for determining the efficacy of initiatives developed after the strategic planning process and for providing accountability to the American public on what progress is being made to reduce and ultimately eliminate disparities in neurologic health. Our goal is to repeat these analyses in approximately 5 years.

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References

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TAKE-HOME POINTS

- To inform future strategic investments in NINDS-supported HD/HE research, NINDS developed and validated a SOP for analyzing funded HD/HE research with quality control checks imbedded throughout the process.
- For an accurate and holistic picture of HD/HE research, it was critical to apply clear definitions and to assess funded projects for characteristics known to underly contemporary theory and best practices in HD/HE research.
- This analysis revealed previously uncharacterized details about the types of HD/HE research supported by NINDS and the extent to which funded projects incorporated evidence-based HD/HE research approaches.
- Clearly documenting and reporting current health equity–related research is important for transparency, accuracy, and reproducibility as well as determining the efficacy of initiatives developed after the strategic planning process.
- Conducting a detailed portfolio analysis was time intensive and required the assistance of dedicated staff but provided much value for priority setting purposes.

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