Society of Hospital Medicine
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SHM Comments on the National Institutes of Health Strategic Plan 2027-2031

The Society of Hospital Medicine (SHM) submitted the following comments to the National Institutes of Health (NIH) Request for Information (RFI): Inviting Comments and Suggestions on a Framework for the NIH-Wide Strategic Plan for Fiscal Years 2027-2031. The comments underscore funding challenges for multidisciplinary health services and implementation sciences research, hallmarks of research in hospital medicine, and the potential opportunities for improving the quality and efficiency of care for hospitalized patients.

Priority 1: Research Areas

The Society of Hospital Medicine commends NIH for the development of its Strategic Plan for Fiscal Years 2027-2031 and for the invitation for feedback on this plan. The three goals proposed as priority Research Areas in the Plan are necessary to advance the science of human health and disease, promote prevention, and lead to effective treatments and cures. However, we strongly recommend additional NIH investment in health services research and implementation research. Without this investment, the federal government risks wasting billions of dollars annually on basic science, drug development, and clinical trials that fail to impact Americans' health.

The United States health care system has a "last mile" problem. For example, once clinical trials prove that treatments are effective, systematic reviews confirm the reliability of these findings, and guidelines recommend these treatments, it can still take many years for that treatment to become routine practice that improves the health of Americans.

Health services research can close this gap by understanding and addressing the challenges to delivering evidence-based health care in real-world healthcare settings. Implementation research is the scientific study of methods to promote the systematic uptake of evidence-based practices into health care. It focuses on identifying and understanding barriers and facilitators of implementation, using strategies to overcome these barriers and leverage these facilitators, and evaluating the success of implementation, including fidelity to the planned intervention, reaching the patient populations that would benefit from it, and sustainability over time.

Health services research complements basic science and clinical research as the third pillar of health research by evaluating the current status of healthcare delivery, understanding how and why it functions as it does, and identifying the most effective ways to organize, manage, and deliver high quality care in all its dimensions, including safety, efficacy, timeliness, and patient-centeredness.

Together, these distinct but overlapping fields answer the vexing question: 'Why is it so difficult to translate or scale effective approaches into real-world clinical practice?' They help us understand translational challenges in real-world settings and facilitate widespread adoption of evidence-based interventions. They ensure that effective treatments that are often developed through NIH investments, benefit patients as quickly as possible. These research areas should be prioritized as highly as basic science and clinical research to ensure that our investment in health is truly realized.

Priority 2: Research Capacity

We believe the best research in Hospital Medicine emphasizes attention to whole-person care, collaboration across professional disciplines, and close partnerships with health system operations. Building meaningful research capacity will require investments that reflect where care is delivered, how teams function, and the outcomes that matter most to patients, clinicians, and health systems.

First, NIH should prioritize infrastructure that enables research embedded in acute care settings. Hospitals are complex, resource-intensive environments where patients experience high acuity illness, care transitions, and heightened risk for complications. Expanding interoperable data systems, EHR-integrated tools, and shared platforms across hospitals would enable frontline teams to integrate research seamlessly into care delivery. These capabilities are essential to studying and improving outcomes central to patients, while also ensuring care value is improved.

Second, NIH should invest in a workforce capable of conducting interdisciplinary, team-based research in real-world settings. Hospital care is delivered by interprofessional teams—including physicians, nurses, pharmacists, therapists, and social workers—yet research training and funding mechanisms often remain siloed. Strengthening research capacity will require supporting team science models that reflect how care is actually delivered. This includes development of career pathways and career development grants which specifically target inpatient generalists, such as hospitalists, nurses, and pharmacists, and development of grant mechanisms that recognize contributions across disciplines. Developing a strong workforce of researchers who can bridge clinical operations, data science, and patient engagement is particularly important for advancing efficient, high-value care.

Third, NIH should strengthen partnerships between researchers and health system operational leaders to support whole-person, coordinated care. Many of the most pressing challenges in hospital medicine—such as preventable harm, slow adoption of new and effective treatments, and inefficiencies in care delivery—require integrated operational and research approaches.

Funding mechanisms that incentivize co-production of research with health systems, align with operational priorities, and support rapid translation into practice will enhance both feasibility and impact. We believe that co-production of research design and outputs are a key aspect of high-impact studies. An emphasis on co-production – rather than research which solely serves researchers' aims – will speed improved healthcare.

Finally, building capacity across all types of hospitals—from small rural critical access hospitals to large for-profit entities—is essential to ensuring that evidence is broadly applicable and reflects real-world care delivery. Targeted investments in infrastructure, technical support, and multicenter networks will expand participation and strengthen the generalizability of findings.

In summary, strengthening research capacity requires a shift toward interdisciplinary, patient-centered, and health system–embedded approaches that reflect the realities of acute care. These investments will enable NIH-supported research to generate timely, actionable evidence that improves outcomes while supporting high-quality, efficient care for hospitalized patients.

Priority 3: Research Operations

Building on Goals 1 and 2 to strengthen research operations, the Society of Hospital Medicine encourages the NIH-Wide Strategic Plan to prioritize research that is both pragmatic and meaningfully engages patients and other stakeholders.

As noted in our response to Priority 1: Research Areas, it takes many years for research findings to be translated into clinical practice—delaying the delivery of effective, evidence-based care to patients. This lag, combined with the time and cost required to generate new evidence, underscores the need for more efficient, real-world research approaches. Pragmatic study designs offer a clear path forward by improving both the speed and applicability of research. These include: (a) the use of advanced causal inference methods to generate high-quality evidence alongside, and in some cases in place of, traditional randomized clinical trials; (b) embedded clinical trials conducted within health systems and electronic health records—core components of a learning health system—enabling continuous data collection, rapid-cycle evaluation, and recruitment of large patient populations using existing infrastructure; and (c) hybrid designs that integrate implementation science with effectiveness research to ensure that findings are not only valid, but also rapidly adopted in practice.

These approaches are particularly important for emerging areas such as artificial intelligence (AI), where tools are often deployed within clinical workflows and continuously evolve. EHR-embedded trials and other pragmatic designs allow for real-time evaluation of AI tools in real-world settings, ensuring they are safe, effective, and generalizable before widespread adoption. This approach

supports responsible innovation while minimizing waste and avoiding costly downstream consequences of poorly validated technologies.

Overall, these strategies reduce unnecessary costs, maximize the value of federal research investments, and produce findings that are more generalizable to everyday clinical care—ultimately benefiting the American public.

Equally important is the early and sustained engagement of patients and other stakeholders in the research process. Incorporating patient perspectives helps ensure that research addresses questions that matter most to the public, improving trust, transparency, and uptake of findings. Engaging end-users—from patients to frontline clinicians—throughout the research lifecycle also creates built-in champions for dissemination and implementation, further accelerating the translation of evidence into practice.

By prioritizing pragmatic, patient-centered, and implementation-focused research, NIH can enhance the return on investment in biomedical research, strengthen public trust, and ensure that scientific advances more rapidly improve the health of all Americans.