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Priority 1: Research Areas

The American College of Emergency Physicians (ACEP) and the Society for Academic Emergency Medicine (SAEM) strongly urge NIH to recognize emergency care science as a trans-NIH strategic priority. Emergency care research is where biomedical discovery meets time-sensitive, urgent human need: undifferentiated illness, injury, behavioral health crises, disasters, public health threats, and the consequences of chronic disease. Because emergency care spans prehospital care, emergency departments, trauma systems, emergency operative and critical care interfaces, discharge transitions, and early recovery, it cannot be advanced through siloed disease portfolios alone. NIH should make clear in the final Strategic Plan that emergency care science is essential to foundational discovery, prevention, intervention optimization, implementation, health equity, and public trust.

Emergency medicine and emergency care research should be explicitly designated as a cross-cutting strategic priority within Priority 1. Emergency care is not a narrow specialty concern. The emergency care environment is where patients with undifferentiated, time-sensitive, and life-threatening illness and injury first present, including stroke, cardiac arrest, sepsis, trauma, overdose, respiratory failure, acute mental and behavioral health emergencies, pregnancy-related emergencies, and complications of chronic disease. NIH should recognize this setting as indispensable to advancing foundational knowledge of acute pathophysiology, host response, recovery, disability, and treatment effectiveness.

A strong NIH strategic plan should explicitly state that emergency care research encompasses rapid diagnosis, risk stratification, phenotyping, and treatment selection within the first minutes to hours after illness or injury. NIH should prioritize studies that define optimal diagnostic and therapeutic windows; develop and validate deployable diagnostics, devices, therapeutics, and decision-support tools; and evaluate outcomes that matter to patients and families, including survival, function, cognition, symptom burden, and long-term recovery. Emergency care science is one of the few areas where foundational discovery, translational science, and real-world implementation can be studied in the same clinical moment.

Emergency care is equally vital to prevention and health promotion across the lifespan. For many patients, the emergency care setting is the only reliable point of contact with the health system and, therefore, a critical opportunity for overdose prevention, suicide prevention, violence intervention, injury prevention, infectious disease response, maternal and child health, and linkage to ongoing care for poorly controlled chronic illness. NIH should explicitly include health services, systems, implementation, clinical trials (including pragmatic), and policy research within this goal. Discovering an intervention is not enough if care delivery models,

financing, workforce limitations, organizational design, or public policy prevent that intervention from reaching patients in time.

Because emergency care science spans multiple Institutes and Centers, NIH should not leave it to fragmented or incidental support. NIH should name emergency care science as a trans-NIH priority, coordinate strategy through the Office of Emergency Care Research, and use cross-Institute funding opportunities to ensure that research on time-sensitive illness and injury receives the visibility and sustained investment it requires.

Priority 2: Research Capacity

NIH should strengthen Priority 2 by making a more deliberate investment in the emergency care research workforce and the infrastructure that supports it. Each year, more than 150 million people receive care in U.S. emergency departments, yet emergency care science remains underrepresented in the federal research portfolio relative to the scale, acuity, and public health importance of the conditions treated there. Emergency care research depends on interdisciplinary teams that include emergency physicians, nurses, EMS clinicians, surgeons, intensivists, neurologists, cardiologists, pediatricians, geriatricians, psychiatrists, addiction specialists, and pharmacists, among others. Investigators in emergency care face distinctive challenges due to the operational complexity of conducting research in time-sensitive settings and a relatively small cohort of independent investigators and mentors compared with other specialties.

ACEP and SAEM strongly recommend expansion of career development pathways for emergency care researchers across the full pipeline, including T, F, K, K12, R25, transition, and mid-career (K02, K24) mentoring mechanisms. To date, existing T32 and K12 mechanisms have successfully supported many successful investigators in emergency medicine. These opportunities should support both physician-scientists and doctorally trained scientists and should reach investigators in adult, pediatric, rural, community, safety-net, and prehospital settings. NIH should also promote team science training that bridges acute care, behavioral health, data science / artificial intelligence, engineering, public health, and implementation science. As federal research responsibilities evolve, emergency care investigators whose work centers on health services, policy, and delivery science should have a clear home at NIH and prioritization within NIH institutes and centers.

NIH should also make emergency care infrastructure a strategic priority. Large multicenter and pragmatic trials are often necessary because acute illness is heterogeneous, treatments are time-dependent, and outcomes are shaped by systems of care. Continued investment in emergency care research networks, rapid-start trial platforms, and shared data resources will allow NIH to generate stronger evidence in real-world environments. Priority investments should include integrated EMS-ED-hospital-public health data systems, common data elements, interoperable data platforms, biorepositories linked to acute presentations and longitudinal

outcomes, and tools to measure patient-reported outcomes, disability, caregiver impact, and return to work or school.

Finally, emergency care research requires specialized regulatory and ethical infrastructure. NIH should support central IRB capacity, community consultation, exception from informed consent when appropriate, and methods expertise for pragmatic, adaptive, cluster, and platform trials. A strategic plan that is serious about research capacity should correct the long-standing underinvestment in emergency care science.

Priority 3: Research Operations

NIH should use Priority 3 to strengthen the stewardship, transparency, and accountability needed to support high-quality emergency care research and public trust. Emergency departments and prehospital systems are among the most visible interfaces between patients and the biomedical research enterprise. Research conducted in these settings must therefore be scientifically rigorous, ethically sound, operationally feasible, and responsive to the communities it serves. That begins with representation. NIH should ensure that emergency care expertise is meaningfully included in strategic planning, peer review, advisory councils, portfolio analysis, and cross-NIH initiatives. Emergency care proposals should be evaluated by reviewers who understand the science and operational realities of time-sensitive research, not by processes that treat these studies as poor fits for existing silos.

NIH should also make clear that scientific stewardship must be durable, merit-based, and insulated from short-term political shifts. Investigators should not face abrupt changes in terminology, review expectations, or funding pathways that undermine meritorious work. This is especially important in emergency care, where longitudinal, network-based, and public health emergency studies can be severely damaged by unstable support or changing administrative rules. NIH should commit to predictable processes, continuity for approved, meritorious projects, and transparent coordination across Institutes and Centers for research spanning implementation, preparedness, acute care delivery, and outcomes.

Research operations should further recognize that discovering an intervention is not sufficient if it cannot be delivered under real-world constraints such as crowding, boarding, transfer delays, workforce shortages, disasters, or rural access barriers. NIH should support implementation and de-implementation research; evaluation of care models and digital tools; and policy research examining how reimbursement, regulation, and system design affect access, uptake, quality, equity, and outcomes.

To improve public trust, NIH should articulate strong protections for emergency care data, especially in public-private partnerships and in the development of artificial intelligence tools. Emergency care datasets are highly valuable and highly sensitive because they are generated during moments of crisis and vulnerability. NIH should require transparency in secondary data

use, clear safeguards against misuse of identifiable or re-identifiable information, responsible validation of algorithms in acute care settings, and community-engaged approaches to consent, notification, and communication. NIH should also preserve scientifically justified international collaboration and data sharing when they strengthen emergency care science.