May 26, 2026

National Institutes of Health
Office of Extramural Research
6705 Rockledge Drive
Bethesda, Maryland 20892

Re: Request for Information Inviting Comments and Suggestions on a Framework for the NIH-Wide Strategic Plan for Fiscal Years 2027-2031

Submitted online via https://rfi.grants.nih.gov/?s=6998c3a23eb404a3e80e8212

The LEAD Coalition (Leaders Engaged on Alzheimer's Disease) appreciates the opportunity to provide comments to the National Institutes of Health (NIH) in response to its request for information (RFI) inviting input on a framework for the NIH-wide strategic plan for fiscal years 2027-2031 (NOT-OD-26-047).

The LEAD Coalition is a diverse and growing national policy coalition committed to overcoming Alzheimer's disease and related disorders (AD/ADRD), including vascular disease, Lewy body dementia, and frontotemporal degeneration. The LEAD Coalition, which serves as the uniting voice of over 260 member and allied organizations as well as hundreds of researchers, works collaboratively to focus the nation's attention on accelerating transformational progress to reduce risk, enhance detection and diagnosis, improve care and support, and develop increasingly effective treatments and eventual cures. LEAD Coalition members include patient advocacy organizations and health non-profits, philanthropies and foundations, trade and professional associations, academic research and clinical institutions, home and residential care providers, and biotechnology and pharmaceutical companies.

Our comments reflect input from members and allies of the LEAD Coalition, including researchers dedicated to serving people living with AD/ADRD, their care partners, and families.

Priority 1: Research Areas

- Goal 1: Advance Foundational Knowledge of Human Health and Disease
- Goal 2: Prevent Disease and Promote Health Across the Lifespan
- Goal 3: Advance and Optimize Interventions, Treatments, and Cures

Comments:

The LEAD Coalition is generally supportive of Priority 1 and its goals.

For Goal 1, advancing foundational knowledge should explicitly prioritize rigor and generalizability as core scientific principles. Such priorities are particularly urgent for research on Alzheimer's and related dementias (AD/ADRD), where longstanding gaps in representativeness have limited progress and the generalizability of findings. For example, AD disproportionately affects women, yet the drivers of this disparity remain underexplored; intentional investment into research on sex differences (e.g., integrating variables like reproductive history into brain health datasets) must be prioritized. Ensuring that research is designed to study group variability is necessary for external validity and translational impact.

For Goal 2, we applaud NIH's efforts to expand emphasis on disease prevention and health across the lifespan. Research funded by the National Institute on Aging (NIA) has long demonstrated the value of the lifecourse approach in understanding age-related conditions. For example, longitudinal studies have led to a deeper understanding of modifiable dementia risk factors (hypertension, social isolation). Applying a lifecourse approach to research at all NIH institutes and centers (ICs) is essential, particularly given the decades-long preclinical phase of many conditions.

For Goal 3, progress in interventions, treatments, and cures depends on the strength and inclusivity of underlying science. While representativeness in clinical trials is improving (and thus generalizability of results), serious gaps persist. Representative trial cohorts are particularly critical in AD/ADRD research, where African Americans are twice as likely and Hispanics 1.5 times as likely to develop AD/ADRD. Efforts to improve participant diversity must continue to be an NIH priority, by engaging individuals from different backgrounds, including racial, ethnic, rural, and indigenous communities who face significant health disparities. Parallel efforts to extend the study of group differences upstream to preclinical and translational research (e.g., through investment and policies such as Sex as a Biological Variable) are essential to meeting Goal 3.

Global research partnerships also strengthen this science by informing how health outcomes are shaped by cultural, environmental, and socioeconomic contexts, and should be prioritized under Goal 3. Through its strategic plan, NIH should renew its commitment to international collaboration, by reassessing policies that have constrained and undervalued global scientific partnerships and reaffirming support for the Fogarty International Center, whose long-standing investments have strengthened both U.S. and global health security.

NIH should also continue elevating rare disease research. Though individually rare, genetic forms of diseases (e.g., for frontotemporal dementia: MAPT-FTD, FTD-GRN) collectively offer critical insights into shared mechanisms and should remain a visible strategic priority.

Though progress on these goals requires collaboration among ICs, scientific expertise must remain at individual ICs. An excellent example of an existing agency-wide collaboration is SenNet, an NIH Common Fund initiative. This collaboration was developed organically through shared learnings across aging and disease-specific research fields. This example should be used as a model for future work, vs. a centralized, top-down approach, which risks hindering IC-led scientific work and slowing research progress. Ideological priorities must not override clear, evidence-based scientific goals.

Priority 2: Research Capacity

- Goal 1: Develop and Sustain an Interdisciplinary Research Workforce
- Goal 2: Build, Improve, and Sustain Research Resources and Infrastructure

Comments:

The LEAD Coalition is generally supportive of Priority 2 and its goals.

Research capacity is foundational to achieving NIH's mission and ensuring a sustainable, competitive research enterprise. Strengthening the workforce and supporting infrastructure are essential to accelerating progress, particularly in complex/interdisciplinary fields like AD/ADRD.

For Goal 1, NIH must prioritize workforce development as a core strategic investment. Emerging scientific challenges require interdisciplinary expertise; accordingly, the strategic plan should prioritize funding mechanisms that support interdisciplinary training

and career transitions across fields. A strong research workforce requires investing in scientists from underserved and underrepresented backgrounds, whose perspectives and experiences strengthen scientific rigor, innovation, and research relevance to broader populations. To move science toward a precision medicine model, NIH must restore funding mechanisms (e.g., diversity supplements) to support these researchers.

NIH investment in mentorship is vital to achieving Goal 1 and should be a formal, valued component of the research enterprise. Mid-career and established investigators are essential to developing early-career scientists, yet recent funding mechanism changes disincentivize mentorship opportunities. NIH must ensure adequate salary support and protected time to enable established researchers to nurture the next generation of researchers.

In parallel, small but meaningful investments in training programs (e.g., increasing stipends for National Research Service Awards, "NRSAs") improve trainee recruitment and retention, particularly those from underserved backgrounds and in fields facing workforce shortages (e.g., gerontology, geriatrics). These investments demonstrate the value placed on training and help reduce financial barriers disproportionately affecting individuals entering biomedical research careers. Unfortunately, NIH's shift toward parent awards and multi-year funding models have devastated the training community; greater attention is needed to ensure investigator-focused training mechanisms are not overlooked in future strategic planning efforts.

For Goal 2, NIH must continue to build and modernize research infrastructure, emphasizing data use and protections. Expanding existing platforms to capture longitudinal, harmonized, and interoperable datasets is essential to advancing science, yet data standards and sharing requirements must be consistently enforced to maximize the value of NIH-funded research and enable collaboration. NIH's *All of Us* Research Program provides a valuable model for integrating data types across large populations. On the NIH campus, the Center for Alzheimer's and Related Dementias (CARD) is a prime example of intentionally designing infrastructure for team science and accelerated discovery. The new strategic plan should prioritize continued investment in these examples and similar infrastructure.

NIH should invest in emerging technologies that expand research capacity and accelerate discovery. Innovations including CRISPR, advanced imaging, and AI-driven analytics, hold significant promise for identifying disease mechanisms and therapeutic targets. Strategic investments in such technologies will aid in ensuring broad accessibility and effective utilization. Strengthening research capacity also requires heightened emphasis on implementation and real-world translation. It is essential to

move discoveries from the laboratory into clinical practice and community settings, particularly for AD/ADRD. NIH must expand support for pragmatic trials, community-based research, and public-private partnerships, such as the Accelerating Medicines Partnership Program for Alzheimer's Disease (AMP-AD), to ensure scientific advances translate into meaningful, generalizable improvements in health outcomes.

Priority 3: Research Operations

- Goal 1: Enhance Scientific Stewardship and Decision-Making
- Goal 2: Foster Transparency and Accountability to Improve Public Trust in Science

Comments:

The LEAD Coalition is generally supportive of Priority 3 and its goals.

NIH must ensure timely, transparent, and scientifically grounded decision-making that supports both the research community and the public. Effective stewardship depends on clear communication channels between NIH leadership, program staff, the extramural research community, and the public, as well as predictable, efficient, and full-year funding processes.

Pertaining to Goals 1 and 2, the AD/ADRD community is deeply troubled by the reduction and centralization of public-facing functions across ICs, including communications, legislative affairs, policy, and evaluation offices. While central coordination may improve consistency, the elimination and consolidation of these functions has threatened information accuracy, reduced visibility of NIH-supported science, and limited direct engagement with the public and scientific stakeholders. This is particularly consequential given the scale of NIH's public health mission; no longer are there dedicated channels to the community on specific health conditions such as AD/ADRD, common comorbid conditions, and actionable risk reduction evidence. For example, NIA previously reached more than 125,000 subscribers through weekly e-alerts, and its social media platforms engaged more than 187,000 followers (*HHS National Plan to Address Alzheimer's Disease: 2024 Update*). The absence of the NIA communications staff is calamitous for the aging and AD/ADRD community, as these communication channels were essential tools for disseminating research advances, and should be strategically reestablished in the near future.

A lack of transparency has emerged in the last year between program officers and grantees, one of the most essential relationships for NIH. Historically, IC's program officials played a critical role in identifying emerging scientific priorities and rapidly

translating them into funding opportunities, and were able to share research priorities early with the scientific community. Unfortunately, since 2025, changes to NIH structures and systems have dramatically slowed and undermined scientific opportunities. For example, an attempt to streamline funding opportunities has led to the radical decrease in the number of Notice of Funding Opportunities (NOFOs), eliminating a vital and transparent avenue. While efforts to reduce redundancy are appropriate in principle, these changes have overlooked the importance of meaningful engagement between IC staff and the extramural community. The next strategic plan must prioritize identifying new ways in which program staff responsible for managing research portfolios can directly communicate effectively and efficiently with prospective applicants and current grantees.

Additional strategic attention is needed to ensure adequate staffing across all NIH functions, especially leadership positions. Many IC leadership positions were left vacant in 2025, and concerns have emerged regarding how scientific leadership will be selected going forward. To strengthen confidence in leadership transitions, NIH should ensure that – at minimum – IC Director interview and selection processes are rigorous, transparent, and inclusive, incorporating input from external advisory committees and key stakeholders, including scientists, clinicians, patient advocacy organizations, and community representatives.

Lastly, current Advisory Council membership and processes must be reviewed to ensure a quorum and fidelity to Federal Advisory Committee Act (FACA) requirements, preserving both legitimacy and accountability.

Thank you for the opportunity to provide input on the framework for the NIH-wide strategic plan for 2027-2031. The LEAD Coalition would be pleased to provide any additional information or clarification on these comments. For questions about these comments, please contact Ian Kremer, JD, Executive Director (ikremer@leadcoalition.org) or Courtney Wallin, PhD, Federal Policy Director (cwallin@leadcoalition.org).