National Institute of Dental and Craniofacial Research

National Advisory Dental and Craniofacial Research Council

Minutes of Meeting
January 21, 2026

Via Videoconference

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NATIONAL INSTITUTE OF DENTAL AND CRANIOFACIAL RESEARCH

MINUTES OF THE
NATIONAL ADVISORY DENTAL AND CRANIOFACIAL RESEARCH COUNCIL

January 21, 2026

The 241st meeting of the National Advisory Dental and Craniofacial Research Council (NADCRC) was convened on January 21, 2026, at 11:15 a.m., via videoconference. The meeting was open to the public from 11:15 a.m. until 2:01 p.m.; it was followed by the First Closed Session for Council business and consideration of grant applications from 2:15 p.m. until adjournment at 4:38 p.m. The Second Closed Session has been scheduled for March 17, 2026, from 2:00-3:30 p.m. Dr. Jennifer Webster-Cyriaque presided as Acting Chairperson.

OPEN SESSION

Members Present

Dr. Luisa DiPietro
Dr. Stephany Duda
Dr. Hyun (Michel) Koo
Dr. Paul H. Krebsbach
Dr. Jose Moron-Concepcion
Dr. Terry Dickinson

National Institute of Dental and Craniofacial Research

Dr. Jennifer Webster-Cyriaque, Acting Director
Dr. Sanoj Suneja, Executive Secretary, Division of Extramural Activities (DEA)
Dr. Yasaman Shirazi, Designated Federal Official, DEA
Ms. Julie Orban
Dr. Wendy Knosp
Dr. Jason Wan
Dr. Shoba Thirumangalathu
Dr. William Elwood
Dr. Marushka Silveira
Mr. Dandre Amos
Dr. Dena Fischer

Guests

Dr. Janine Clayton, NIH Office of Research on Women's Health
Dr. George Hajishengallis, University of Pennsylvania
Dr. Jon Lorsch, NIH Office of Extramural Research
Dr. Suchitra Nelson, Case Western Reserve University
Mr. David Selvaraj, Case Western Reserve University

Mr. Sam Wojack, Neal R. Gross & Co.

I. WELCOME AND INTRODUCTIONS

Dr. Sanoj Suneja, Advisory Council Executive Secretary, called the open session of the 241st Advisory Council meeting to order at 11:15 a.m. He noted that they would not be taking questions or comments from the public during the live webcast, but members of the public may submit written comments until February 2, 2026, at NIDCRCouncilMail@nidcr.nih.gov. Members of the Advisory Council introduced themselves.

II. APPROVAL OF THE SEPTEMBER 2025 MEETING MINUTES

Dr. Suneja asked Advisory Council members if they had comments regarding the minutes of the September 2025 Advisory Council meeting. There were no comments, and the Council voted unanimously to approve the minutes.

III. APPROVAL OF THE REVISED COUNCIL OPERATING PROCEDURES

Dr. Suneja asked Advisory Council members if they had comments regarding the Revised Council Operating Procedures. There were no comments, and the Council voted unanimously to approve the Revised Council Operating Procedures.

IV. NIDCR DIRECTOR'S REPORT AND DISCUSSION

Dr. Webster-Cyriaque began the Director's Report with an update on the appropriations and budget landscape. The Department of Health and Human Resources (HHS), including the National Institutes of Health (NIH), is operating at Fiscal Year 2025 (FY2025) levels under a continuing resolution (CR) while Congress completes FY2026 appropriations. Authorization for Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) programs expired on October 1, 2025. SBIR and STTR Notices of Funding Opportunities (NOFOs) have expired, though active SBIR and STTR awards are continuing. The new minibus appropriations package released on January 20, 2026 includes the Labor, Health and Human Services, Education, and Related Agencies funding bill. The bill reflects an overall increase of approximately $300M in budget authority, with directed increases for specific programs. The bill also retains limits on the use of multiyear funding and language that prohibits changes to indirect cost rates.

Dr. Webster-Cyriaque presented updates from HHS. The U.S. Food and Drug Administration (FDA) has taken several actions on fluoride drug products informed by scientific evaluation and public input. These actions aim to protect children from unapproved ingestible fluoride prescription drug products, advance the development of a coordinated fluoride research agenda, and support the creation of a national oral health strategy. In October 2025, the FDA issued notices to four companies outlining its intent to pursue enforcement action against those marketing fluoride-containing ingestible drugs labeled for use in all children under age three or in older children at low or moderate risk of tooth decay. The FDA also sent a letter to healthcare

professionals warning about potential risks associated with ingestible fluoride drug products. In parallel, HHS, NIH, and FDA launched a partnership to develop a fluoride research agenda and the first national oral health strategy.

Dr. Webster-Cyriaque announced recent NIH leadership departures and appointments. Recent departures from NIH include Dr. Nina Schor, NIH Deputy Director for Intramural Research; Dr. Helen Langevin, Director of the National Center for Complementary and Integrative Health (NCCIH); Dr. Walter Koroshetz, Director of the National Institute of Neurological Disorders and Stroke (NINDS); and Dr. Gary Gibbons, Director of the National Heart, Lung and Blood Institute (NHLBI). Recent appointments include Dr. Jon Lorsch as NIH Deputy Director for Extramural Research, following his previous service as Director of the National Institute of General Medical Sciences (NIGMS); Dr. Rick Woychik as a Senior Advisor to the NIH Director, following his previous service as Director of the National Institute of Environmental Health Sciences (NIEHS); Dr. Anthony Letai as Director of the National Cancer Institute (NCI); Dr. Kyle Walsh as Director of NIEHS; and Dr. Nicole Kleinstreuer as NIH Deputy Director for Program Coordination, Planning and Strategic Initiatives (DPCPSI).

Dr. Webster-Cyriaque presented several NIH policy updates focused on strengthening data security and research integrity. NIH is establishing consistent and robust security and operational standards for NIH controlled-access data repositories. The policy applies to all NIH-supported repositories (intramural and extramural) that provide long-term storage or access to human data. The policy requires standardized processes for data submission, access review, and data sharing, along with enhanced security controls, and mandates adherence to the NIH Controlled-Access Data Repository Guidebook for security, operations, and transparency. Implementation of the policy will occur in phases; by November 1, 2025, repositories must document compliance and implement standardized access processes, and by February 26, 2026, full operation and security compliance will be required.

In December 2025, NIH notified the extramural community of Research Security Training (RST) requirements under the CHIPS and Science Act of 2022. Covered individuals listed on NIH grant applications must certify completion of RST within 12 months of application submission, and applicant institutions must certify that employed covered individuals have completed the training. These requirements apply to applications with due dates on or after May 25, 2026.

Effective October 24, 2025, NIH also established new security requirements for NIH-supported human biospecimens. The policy applies to all human biospecimens from U.S. persons supported by NIH funding, regardless of identifiability, and prohibits direct and indirect distribution of human biospecimens to institutions or entities in ‘countries of concern,’ with limited, fully documented exceptions. In September 2025, NIH issued guidance detailing options for disposition of de-identified biospecimens that respect Tribal sovereignty and cultural sensitivities, including direct return to Tribes, indirect return to designated third parties by Tribes or NIH in consultation with Tribes, Tribes' designation of NIH stewardship, or culturally sensitive disposition following consultation.

The goal of these and other new policies is to strengthen the processes that support the continuum from project conception to improved health outcomes. These policies include identifying clear scientific priorities, promoting funding opportunities, streamlining application processes, use of a unified funding strategy, and strengthening science through rigor, reproducibility and transparency. The agency's scientific priorities include ending America's chronic disease epidemic, leveraging available tools such as artificial intelligence (AI), use of alternative testing models and real-world data platforms; taking action-oriented and solution-oriented approaches to health disparities; participating in interdisciplinary collaborations; and engaging strategic foreign collaborations with a U.S. focus.

NIH is working to promote, streamline, and simplify funding opportunities. Grants.gov now serves as NIH's single official source for grant and cooperative agreement funding opportunities, and researchers can identify Highlighted Topics and simplified notices through the NIH Find a Fit for Your Research site. The application process has been streamlined with the 2025 Simplified Peer Review Framework, reducing five scored review criteria to three factors: importance, rigor/feasibility, and expertise/resources. Additional changes reduce administrative burden, including the use of common forms for Biosketches and Current/Pending (other) Support, elimination of letters of intent, and removal of the requirement for budget justifications for projects of $500K or more. NIH has updated policies on lateness and completeness, allowing the Division of Receipt and Referral (DRR) to request application changes without requiring withdrawal.

These efforts are paired with clearer funding priorities grounded in merit-based peer review and alignment with mission and health priorities. Funding priorities will also consider the diversity of research topics and approaches, support investigators across career stages, promote geographically balanced funding distribution, and reflect budget availability and responsible stewardship. These changes are intended to strengthen science through rigor and reproducibility, through promotion of common data elements that will facilitate harmonization across different studies, through promotion of appropriate data management and sharing, through increased biosafety and laboratory safety, and through the use of human-focused models. Cumulatively, these efforts will lead to streamlined processes, rigorous science, and better health outcomes.

In response to the President's Executive Order on Restoring Gold Standard Science, NIH released an implementation plan in August 2025 outlining a roadmap for embedding these principles across its scientific activities, with periodic assessment and annual public updates. At NIDCR, this commitment is reflected in a Collaborative Common Data Element (CDE) Framework to enhance standardization and interoperability, a new electronic accrual and retention monitoring system to strengthen transparency and stewardship in clinical research, and the Data Driven Science (DDS) Hub to promote sharing, replication, reproducibility and AI use. Support for sharing high-resolution data, including spatial genomics through the FaceBase repository, further advances data integration, access, and impactful science.

Dr. Webster-Cyriaque presented updates on NIDCR leadership, outreach, funding, and training initiatives. The NIDCR Director position was posted from November 14 to December 12, 2025, and applications are currently under review. She also recorded an upcoming episode of the NIH Director's podcast *The Director's Desk*, highlighting NIDCR's research impact. On

November 17, 2025, NIDCR met with the Friends of NIDCR Patient Advocacy Council to discuss current research priorities and opportunities for patient advocate engagement in research and research-related activities. February 20-27, 2026 marks the Fibrous Dysplasia and McCune - Albright Syndrome (FD/MAS) Awareness Week, with NIDCR's intramural FD/MAS research to be highlighted on NIH Rare Disease Day (February 27, 2026).

Dr. Webster-Cyriaque highlighted key funding opportunities and interests, including PA-26-001, Administrative Supplements to Existing NIH Grants and Cooperative Agreements (Parent Admin Supp Clinical Trial Optional) and PAR-26-116, Opportunities for Collaborative Research at the NIH Clinical Center (U01 Clinical Trial Optional), as well as examples of Highlighted Topics (posted on NIH Highlighted Topics) and forecasts of interest to NIDCR (posted on grants.gov). Training updates included discontinuation of the T90/R90 program and participation in the parent T32 NOFO (PA-25-168). While this NOFO allows for multiple applications, NIDCR will only fund one T32 application per institution. All current T90/R90 and T32 awardees must submit as new T32 applications. Dr. Webster-Cyriaque also discussed expectations for T32 applications, K99/R00 eligibility extensions, foreign component guidance. She discussed continuation and development of R25 programs (including mentoring, research experiences, curriculum development) and the planned NIGMS reissuance of the NIH Science Education Partnership Award (SEPA) R25 Award that NIDCR plans to sign on to.

Dr. Webster-Cyriaque emphasized the importance of NIDCR to help make Americans healthy and tackle the chronic disease epidemic. Poor oral health amplifies the nation's broader health challenges, including rising chronic disease, obesity, diet-related illness, health care costs, and even military readiness. Oral diseases are among the most common chronic conditions across the lifespan. In addition to the direct impacts of conditions such as untreated caries, gum disease, tooth loss, temporomandibular disorders (TMD), cancers of the lip or oral cavity, and oropharyngeal cancers, the associated infection and inflammation in the mouth is a significant threat to health everywhere else in the body. NIDCR's focus areas include children's health; cancer, environmental exposures, and nutrition; reducing oral, dental, and craniofacial disease burden by understanding disease and developing therapeutic treatments; improving chronic oral and systemic disease outcomes and understanding the microbiome, inflammation, and immune contributions; and bringing research to the American public. Dr. Webster-Cyriaque cited dental caries as an example of NIDCR work benefitting public health. NIDCR research helped scientists understand the role of infection and bacteria in this transmissible disease and the value of interventions like dental sealants, and NIDCR-supported technologies including the ultrasonic toothbrush and topical fluorides helped to reduce the disease burden of untreated caries from 90% in the mid-1900s to 20-28% in 2020. Moreover, the Institute's initiatives such as the National Caries Program helped inform the public about effective dental interventions. Beginning in the 1970s, the National Health and Nutrition Examination Survey has provided critical oral health data on disease burden and continues to guide research priorities.

Dr. Webster-Cyriaque also highlighted NIDCR's contribution to improving children's health. Approximately 22% of NIDCR's budget supports pediatric research, including collaborative efforts with the FDA to study the effects of ultra-processed foods and added sugars. Additional research examines environmental toxins such as mercury, and the effects of fluoride exposure. Dental disease remains the most common chronic disease among children, and NIDCR

is exploring a range of preventive and therapeutic strategies, along with fluoride, to address this ongoing public health challenge.

Next, Dr. Webster-Cyriaque discussed cancer, noting that oral cancer is a leading cause of cancer deaths due to late-stage detection. NIDCR's Advancing Head and Neck Cancer Early Detection (AHEAD) initiative aims to improve early diagnosis. For example, an NIDCR-supported investigator is developing and testing an Automated Mobile Detection of Oral Cancer system that uses smartphone-based autofluorescence and white light imaging to enhance early detection in primary dental care settings. NIDCR's Integration of Medically Necessary Prevention, Treatment, and Monitoring of Oncologic-Related Oral, Dental and Craniofacial Complications initiative examines oral complications associated with cancer treatments, including chemotherapy, biologics, and radiation.

In the area of environmental exposures and toxins, NIDCR is advancing the Screening for Conditions by Electronic Nose Technology (SCENT) initiative. NIDCR is in conversation with the Defense Health Agency (DHA) and collaborating with the National Institute of Biomedical Imaging and Bioengineering (NIBIB) to develop mercury-free alternatives to dental amalgam.

Studies conducted outside the United States have reported that fluoride exposure in drinking water above 1.5 mg/L is associated with small decreases in IQ. NIDCR is leveraging large-scale longitudinal cohorts that begin during pregnancy and include detailed neurocognitive and fluoride exposure data across the United States. Examples include the Healthy Brain and Child Development (HBCD) study, as well as secondary data analyses in the Environmental Influences on Child Health Outcomes (ECHO) cohort and the Adolescent Brain Cognitive Development (ABCD) study.

Dr. Webster-Cyriaque also highlighted NIDCR's work in nutrition, emphasizing that poor oral health can limit an individual's ability to maintain a healthy diet. NIDCR is pursuing multiple, complementary efforts in this area, including an initiative to understand the tri-directional relationship between oral health, nutrition, and comprehensive health. NIDCR also supports investigator-led research projects and engages in interagency collaborations, including participation in the Nutrition Research Coordinating Committee (NRCC) and collaboration with the FDA to study added sugar consumption and its impact on oral health.

A core component of NIDCR's mission is reducing the burden of oral disease. Many major chronic conditions share common risk factors with oral diseases, including high sugar consumption, tobacco and alcohol use, and poor diet. NIDCR is advancing a broad portfolio of initiatives to address these challenges. For example, Advancing DAta and Practice Transformation (ADAPT) for Oral Health for All initiative focuses on integrating oral and systemic health care, while the TMD Collaborative for IMproving PAtient-Centered Translational Research (TMD IMPACT) highlights NIDCR's commitment to patient-centered research. Additional efforts further illustrate the breadth of NIDCR's work to improve oral and overall health outcomes, including in areas such as digital health, behavioral science, microbiome research, and chronic inflammation.

In addition, NIDCR's Intramural Research Program is addressing a wide range of conditions, including graft-versus-host disease, autoimmune disorders, Sjögren's disease and VEXAS syndrome. Recent advances include research on Loeys-Dietz syndrome and efforts to inhibit craniosynostosis, highlighting examples of the breadth and impact of NIDCR's efforts.

One barrier to improving oral health outcomes is dental anxiety. To address this, an NIDCR investigator is developing a brief one-hour pre-dental visit intervention that has been shown to reduce dental anxiety for up to a year.

Dr. Webster-Cyriaque also highlighted NIDCR's contributions to foundational scientific advances. Notably, the 2025 Nobel Prize for Physiology and Medicine was awarded for the discovery of the *Foxp3* gene, with significant contributions from NIDCR-supported researchers.

NIDCR is working to translate scientific findings into practice by helping lead the U.S. oral health research strategy, supporting the expansion of access to evidence-based care. This includes delivering advanced dental care through patient- and practice-based research networks such as the National Dental Practice-Based Research Network, the Practice-Based Research Integrating Multidisciplinary Experiences in Dental Schools (PRIMED), and the NIH Dental Clinic and Consult Service. In addition, NIDCR-supported research has contributed to the development of more than 175 FDA-approved drugs across all areas of medicine.

Dr. Webster-Cyriaque concluded the Director's Report and introduced the speakers for the program presentations.

V. ORAL HEALTH AS A GATEWAY TO SYSTEMIC HEALTH

Dr. George Hajishengallis presented to the Council on oral health, with a focus on periodontal disease as a gateway to system health. His laboratory's recent work demonstrates that periodontal disease is not simply caused by bacterial growth, but rather by a self-sustaining cycle between microbial dysbiosis and inflammation. With longstanding support from NIDCR, his research has focused on disrupting this cycle by targeting the complement system to inhibit inflammatory bone loss. This approach aims to rebalance the microbial environment by limiting the inflammatory conditions that sustain dysbiosis. Recently, Dr. Hajishengallis' team published promising results demonstrating the potential to reduce inflammatory bone loss in human patients.

Although periodontitis is a local disease, it has many systemic effects and is associated with increased risk of inflammatory diseases such as cardiovascular disease, rheumatoid arthritis, and Alzheimer's disease. Dr. Hajishengallis' work seeks to determine whether a shared underlying mechanism drives both periodontal disease and these comorbidities, and whether this knowledge can support the development of integrated therapeutic strategies that address multiple inflammatory conditions simultaneously. A recent advancement is the discovery that immune cells can retain a "memory" of past inflammatory events; targeting this hyper-inflammatory training may offer new opportunities to mitigate periodontitis and related systemic diseases.

Inflammatory memory can be long-lasting but is potentially reversible. Dr. Hajishengallis examined whether certain hyper-inflammatory conditions may instead be driven by more fixed epigenetic reprogramming. One such mechanism is clonal hematopoiesis of indeterminate potential (CHIP), a condition in which aging hematopoietic stem cells accumulate somatic mutations that provide a selective growth advantage. As these mutant cells expand, they produce a disproportionate number of progeny cells with altered, often hyper-inflammatory, functions that can contribute to the development of inflammatory diseases.

Dr. Hajishengallis' laboratory has demonstrated that CHIP is associated with increased susceptibility to and prevalence of periodontal disease at the population level. In animal models, CHIP has also been shown to exacerbate inflammatory bone loss in both periodontitis and rheumatoid arthritis.

Overall, Dr. Hajishengallis' work suggests that maladaptive epigenetic memory in the bone marrow, arising from either trained immunity (TRIM) or clonal hematopoiesis (CHIP), may serve as a mechanistic link among multiple inflammatory comorbidities.

Discussion

Dr. Luisa DiPietro asked whether there is evidence that certain individuals have more active CHIP processes, which could help explain a genetic predisposition to periodontal or other inflammatory diseases. Dr. Hajishengallis responded that while aging is the major risk factor for CHIP, additional contributors include genetic susceptibility, a poor diet, environmental exposures, and chronic inflammation.

Dr. Paul Krebsbach asked whether the complement-targeted strategy used to address periodontitis, inflammation, and dysbiosis might also affect inflammatory processes elsewhere in the body, particularly given differences in intensity of inflammation (chronic versus acute), and whether this approach could have unintended negative effects. Dr. Hajishengallis explained that the therapy is administered locally and is not expected to produce systemic effects.

VI. MEDICAL-DENTAL INTEGRATION IN PRIMARY CARE IMPLEMENTING INTERVENTIONS AND SYSTEM CHANGES

Dr. Suchitra Nelson presented on the role of medical-dental integration as a bridge to oral health and overall physical health. This value-based care approach aims to improve health outcomes, reduce overall healthcare costs, and promote early management of medical and dental conditions by expanding access to preventive dental care.

She highlighted several challenges to medical-dental integration. First, limited interoperability between electronic health record (EHR) systems creates barriers, as medical and dental providers often use different platforms, and dentistry has historically lacked standardized diagnostic coding. Second, workforce and access issues contribute to a scarcity of dental services, with patients facing long wait times and difficulty finding dentists who accept their medical coverage. Inconsistent messaging further complicates access, for example, pediatricians

may recommend dental visits for children at age one, yet some dentists do not accept patients under age three.

In response to these challenges, the Agency for Healthcare Research and Quality (AHRQ) recommends that primary care interventions include systematic assessment and treatment at every clinical encounter, along with clinician- and patient-focused strategies to improve health outcomes. Building on AHRQ's recommendations, Dr. Nelson's team has developed two multilevel clinical trials, one focused on pediatric populations and the other on older adults. Each trial includes an intervention arm, featuring practice-level and provider-level changes, and a control arm without practice-level system modifications.

For the pediatric trial, completed in 2025, the team enrolled 18 pediatric primary care practices, 63 providers, and over 1,000 Medicaid-enrolled children ages three to six. The intervention included EHR modifications, standardized oral health assessment questions at every visit, and provided training to improve the delivery of oral health guidance. Results showed a 34% increase in dental visits and a 27% reduction in untreated tooth decay. To support broader implementation, Dr. Nelson's team developed an online educational toolkit accessible by all primary care providers. Notably, the oral health intervention requires only one to two minutes of a clinician time per visit.

The older adult trial is currently underway and aims to enroll 12 primary care practices, 95 clinicians, 95 medical staff, and 800 Medicaid-enrolled adults aged 55 and older. Like the pediatric study, it uses a two-arm design with practice-level and provider-level interventions, and a control arm. EHR modifications within the Epic system prompt medical staff to ask five oral health questions, advise patients to see a dentist, and assess and facilitate referrals using the Ask, Advise, Assess, Connect (AAAC) framework. The trial’s goal is to improve dental utilization and overall systemic health. To date, 385 older adults, 54 clinicians, and 42 medical staff members have been enrolled.

Dr. Nelson concluded with several key insights gained from these clinical trials. Early input from focus groups and pilot studies is critical when designing interventions for primary care settings. Dedicated informatics support is essential for implementing EHR changes, and all medical providers should be trained to ensure consistent adoption. The workflows developed are transportable and scalable, offering practical solutions to improve access for low-income young children and younger adults, with primary care clinicians acting as gatekeepers of the overall health of children and older adults. Ultimately, strong buy-ins from physicians, nurse practitioners, medical and office staff, and primary care leadership is essential for successful implementation.

Discussion

Dr. Stephany Duda noted that many patient questions are increasingly being shifted from in-person clinician encounters to pre-visit online questionnaires and asked whether Dr. Nelson's study sites incorporate this approach. Dr. Nelson responded that, in her studies, medical staff typically administer the questionnaire with patients prior to rooming. This workflow helps conserve clinician time and, to date, has not generated patient complaints.

Dr. Hyun Koo asked how to overcome resistance among dental schools and other institutions to adopting systems such as Epic and improving EHR integration. Dr. Nelson emphasized that the use of standardized diagnostic coding, particularly International Classification of Diseases (ICD) codes, is essential, and that dental education must prioritize the importance of diagnosis. She noted that progress begins with training future providers, followed by the more complex process of transitioning practices toward unified EHR systems.

VII. PUTTING SCIENCE TO WORK FOR THE HEALTH OF WOMEN – TRANSFORMING WOMEN'S HEALTH THROUGH RESEARCH INNOVATION

Dr. Janine Clayton reviewed the 35-year history of the Office of Research on Women's Health (ORWH) and highlighted its major achievements over the past two decades. ORWH has supported over 2,000 grants, resulting in over 73,000 publications. From those publications, about 7,000 have contributed to over 28,000 patent applications and nearly 200 drug licenses, including licenses for drugs in dementia, depression, hyperlipidemias, and cancer, among others. ORWH collaborates with every NIH Institute and Center to co-fund research and amplify their impact.

NIH's current priority is addressing the high prevalence of chronic conditions in the United States. Nearly 50% of Medicare beneficiaries live with four or more chronic health conditions. ORWH is leveraging available data to identify and target those chronic conditions most prevalent among women. For example, over 60% of women Medicare beneficiaries have hypertension and high cholesterol, and women report higher rates of dental problems than men. Additionally, over 63% of women ages 25 and older nationwide are overweight or obese. Geographic disparities are also evident; for instance, the heart disease death rate among women in Oklahoma (478 per 100,000) is more than twice that of Minnesota (231 per 100,000).

Since its establishment in 1993, ORWH's mission has been to advance research on women's health, both by supporting studies focused on conditions affecting women and by advancing the careers and training of women's health researchers. NIH's vision to consider sex as a biological variable (SABV) is integrated across the entire research continuum. This vision aims to ensure that every woman receives evidence-based care tailored to her needs and that women in science are supported in reaching their full potential. ORWH has also adopted a multidimensional, life-course framework to guide research on women’s health.

Dr. Clayton highlighted several key NIH programs and initiatives for the Council, including the Building Interdisciplinary Research Careers in Women's Health (BIRCWH), the Specialized Centers of Research Excellence on Sex Differences (SCORE), the NIH policy on Sex as a Biological Variable (SABV), the Institutional Development Award (IDeA) programs, and targeted funding opportunities focused on chronic conditions affecting women.

NIH policy requires that sex as a biological variable be incorporated into the research design, analysis, and reporting of vertebrate animal and human studies, with strong justification provided for single-sex studies. Integrating SABV across the research continuum, from preclinical studies through Phase IV clinical trials, is essential to improving health outcomes. To

expand the reach of women's health research, ORWH partners with NIGMS to build research capacity in IDeA states and Puerto Rico, which historically receive lower levels of NIH funding. Through these efforts, ORWH aims to ensure that sex-informed research is applied broadly to achieve its goal of a healthier population.

ORWH is expanding the pipeline of women's health researchers through the BIRCWH Program. The program currently supports 23 active K12 awards, encompassing over 830 scholars across 42 institutions. Notably, approximately 60% of BIRCWH researchers secure independent funding within five years of entering the program.

ORWH's SCORE program is the NIH's only center-level, disease-agnostic initiative focused on sex differences. Through partnerships with NIH Institutes and Centers, SCORE supports research across a wide range of conditions, including sex differences in Alzheimer's disease, depression, cardiovascular disease, and cardiometabolic health, among others.

ORWH collaborates with the Accelerating Medicines Partnership Autoimmune and Immune-Mediated Diseases (AMP AIM), a public-private partnership, to support research on Sjögren's disease. This effort has also expanded to include support for teen science scholars, helping build the next generation of researchers in this field.

Autoimmune diseases disproportionately affect women, who account for approximately 80% of all cases. In 2023, Congress established the Office of Autoimmune Disease Research (OADR) within ORWH. OADR is charged with coordinating a strategic plan, identifying opportunities for innovation, evaluating the portfolio, and managing a publicly accessible central data repository. OADR recently launched the NIH-Wide Strategic Plan for Autoimmune Disease Research and is coordinating its implementation across all NIH Institutes and Centers.

NIH is increasingly emphasizing a whole-person health approach, examining the human physiome and the interactions among organ systems to improve overall health outcomes. In parallel, ORWH is advancing New Approach Methodologies (NAMs). NIH recently established the nation's first dedicated Standardized Organoid Modeling (SOM) Center to reduce reliance on animal models. In addition, the Complement Animal Research In Experimentation (Complement-ARIE) challenge prize, led by the Office of Strategic Coordination, continues to drive innovation, with the next Phase I deadline scheduled for March 1, 2026.

The ORWH Coordinating Committee on Research on Women's Health has also reviewed recent and ongoing work in NAMs, identifying opportunities for future ORWH research, including sex differences in cardiac mitochondrial responses to inflammation and the use of three-dimensional organoid models to study breast cancer progression.

Another example of synergy with NIDCR investments is NIH's work on human papillomavirus (HPV)-positive oral cancer and the development of cancer biomarkers. ORWH has made sustained investments in HPV research over many years, contributing to advances in this area.

Dr. Clayton also emphasized the importance of applying systems biology approaches to better understand women's midlife health. Key factors include nutrition, sleep, physical activity, and the microbiome, alongside conditions such as metabolic dysfunction, pelvic floor disorders, and oral health. ORWH recognizes the need for interventions across the life course to reduce chronic disease risk and highlight the importance of giving greater attention to midlife transitions, including biological and ovarian aging, alongside early-life and maternal mortality priorities.

Dr. Clayton highlighted opportunities for women's health innovation in small businesses, citing examples including a saliva-based diagnostic platform for head and neck cancer and a probiotic therapy for Sjögren's disease, as well as efforts such as injectable hydrogel for salivary gland regeneration, a digital platform for sleep apnea detection, a diagnostic test for sarcoidosis, and a novel thrombolytic therapy, demonstrating the breadth of NIH-supported innovation advancing oral and women's health.

Dr. Clayton also described the NIH Discover Women's Health Research (DiscoverWHR) resource. DiscoverWHR is a publicly available platform that serves as a centralized hub for women's health research, providing access to funding opportunities, funded research projects, plain-language health information, recruiting clinical trials, and NIH-supported medical literature.

Dr. Clayton concluded by emphasizing the value of the women's health research, highlighting findings from studies using self-reported oral health questionnaires. These studies showed that fair or poor oral health is correlated with increased risk of cardiovascular disease, osteoporosis, and diabetes. In settings with limited access to dental care, such questionnaires can serve as a practical tool to monitor oral health and link it to broader systemic outcomes. She also underscored the economic importance of investing in women's health, noting that improvements in health outcomes can yield substantial returns. A recent World Economic Forum publication estimated that every dollar invested in closing the women's health gap could generate approximately three dollars in economic growth.

VIII. PRIORITIES FOR THE NIH OFFICE OF EXTRAMURAL RESEARCH

Dr. Jon Lorsch provided an overview of the NIH Office of Extramural Research's (OER) priorities and ongoing efforts to advance them. He emphasized that reducing administrative burden and complexity is the overarching priority. OER is also focused on promoting innovation, experimentation, and evaluation in funding approaches; strengthening research integrity; enhancing biosafety and laboratory safety; and preventing foreign interference. In addition, OER aims to expand researcher access to high-end technologies through shared research resources.

OER has begun efforts to simplify NOFOs, with a goal of streamlining them and reducing their number by 50% in 2026. This will involve greater use of parent NOFOs and directing applicants to the NIH Highlighted Topics website in place of topic-specific NOFOs. NIH also plans to eliminate distinctions among NOFO types, such as Requests for Applications (RFAs), PARs, and PASs, and discontinue the letters of intent requirement. Application

requirements are also being simplified, including the elimination of prior approval letters for applications requesting $500,000 or more in direct costs per year.

Dr. Lorsch also discussed plans to end the modular budget pilot. Originally introduced in 1994 and expanded in 1998, the program was never fully implemented. The modular threshold for R01 awards has remained at $250,000 and has increasingly been perceived as a cap. As of FY2025, only 7.6% of R01 applications used modular budgets, leading NIH to discontinue the pilot.

Additional efforts to reduce administrative burden include simplifying data management and sharing plans, requiring justification only for non-sharing, while emphasizing broad data accessibility. OER is also reclassifying Basic Experimental Studies Involving Humans (BESH) outside of clinical trials; reducing the number of career development activity codes; and expanding the use of just-in-time information. OER has issued a Request for Information (RFI) to solicit community input on further streamlining opportunities and is collaborating with the White House Office of Science and Technology Policy (OSTP) and the National Science Foundation (NSF) on additional burden reduction strategies.

Discussion

Dr. Jose Moron-Concepcion asked whether the planned reduction of K award mechanisms from 26 to 5 would affect the total number of awards or simply consolidate award types. Dr. Lorsch clarified that the goal is not to reduce the number of awards, but to streamline them into fewer award buckets. Dr. Jose Moron-Concepcion also inquired about a recent notice regarding a new international collaboration format expected in May. Dr. Lorsch responded that a notice has been released and that NIH is still determining how best to integrate this process with existing funding mechanisms.

Dr. Luisa DiPietro expressed support for eliminating modular budgets, noting the competitive renewal process can penalize investigators conducting long-term research. She asked whether OER plans to address this issue. Dr. Lorsch agreed that it is an area for improvement across NIH and pointed to NIGMS's Maximizing Investigator's Research Award (MIRA) program as a potential model, where investigators are supported with a single, more sustainable award rather than multiple smaller grants.

Dr. Stephany Duda also voiced support for simplifying data management and sharing plans. She raised a question regarding the PF5 mechanism, noting that under previous grant structures, the primary institution maintained control over subcontracts and could manage site performance. For example, by withholding funds if there were issues with regulatory compliance, data quality, or protocol deviations. She asked whether, under the new model in which funds flow directly from NIH, there will still be a mechanism for coordination and partnership with NIH to address such issues. Dr. Lorsch confirmed that such mechanisms for oversight and partnership will remain in place under the new approach.

IX. ADJOURNMENT OF OPEN SESSION

The open session was adjourned at 2:01 p.m.

CLOSED SESSION

This portion of the meeting was closed to the public in accordance with the determination that it was concerned with matters exempt from mandatory disclosure under Sections 552b(c)(4) and 552b(c)(6), Title 5, U.S. Code and Section 1009(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. §§ 1001-1014).

X. REVIEW OF APPLICATIONS

NADCRC reviewed 470 Research and Training Grant applications requesting Total Project Costs (All Years) at $922,500,668 and Direct Costs (All Years) at $ $638,460,323. Out of these 470 Research and Training Grant applications, 150 Research and Training Grant applications were 'Scored' requesting Total Project Costs (All Years) at $284,541,202 and Direct Costs (All Years) at $193,562,886, 170 Research and Training Grant applications were deemed 'Competitive Not Discussed' requesting Total Project Costs (All Years) at $344,973,672 and Direct Costs (All Years) at $240,933,379, and 150 Research and Training Grant applications were 'Not Discussed' requesting Total Project Costs (All Years) at $292,985,794 and Direct Costs (All Years) at $203,964,058. The NADCRC members performed the second level peer review of all 470 Research and Training Grant applications' Summary Statements and concurred with their initial scientific review.

XI. ADJOURNMENT

CERTIFICATION

I hereby certify that the foregoing minutes are accurate and complete.

/s/ Jennifer Webster-Cyriaque
Dr. Jennifer Webster-Cyriaque
Chairperson
National Advisory Dental and
Craniofacial Research Council

/s/Sanoj K. Suneja
Dr. Sanoj K. Suneja
Executive Secretary
National Advisory Dental and
Craniofacial Research Council

ATTACHMENTS

I. Roster of Council Members

MEETING ROSTER

National Advisory Dental and Craniofacial Research Council
NATIONAL INSTITUTE OF DENTAL & CRANIOFACIAL RESEARCH
NADRC
Agenda Seq Num - 534389
01/21/2026

Notice of NIH Policy to All Applicants: Meeting rosters are provided for information purposes only. Applicant investigators and institutional officials must not communicate directly with study section members about an application before or after the review. Failure to observe this policy will create a serious breach of integrity in the peer review process, and may lead to actions outlined in NOT-OD-22-044, including removal of the application from immediate review.

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