

National Institute of Dental and Craniofacial Research

National Advisory Dental and
Craniofacial Research Council

Minutes of Meeting
May 20, 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

May 20, 2026

The 242nd meeting of the National Advisory Dental and Craniofacial Research Council (NADCRC) was convened on May 20, 2026, at 9:00 a.m., via videoconference. The meeting was open to the public from 9:00 a.m. until 12:35 p.m.; the closed session for Council business and consideration of grant applications was convened on May 19, 2026 from 3:00 p.m. until adjournment at 5:31 p.m. The Second Closed Session was held on July 9, 2026, from 3:00 pm to 5:00 pm. Dr. Jennifer Webster-Cyriaque presided as Acting Chairperson.

OPEN SESSION

Members Present

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

I. WELCOME AND INTRODUCTIONS

Dr. Sanoj Suneja, Advisory Council Executive Secretary, called the open session of the 242nd Advisory Council meeting to order at 9:00 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 June 5, 2026, at NIDCRCouncilMail@nidcr.nih.gov. Members of the Advisory Council introduced themselves.

II. APPROVAL OF THE JANUARY 2026 MEETING MINUTES

Dr. Suneja asked Advisory Council members if they had comments regarding the minutes of the January 2026 Advisory Council meeting. There were no comments, and the Council voted unanimously to approve the minutes.

III. NIDCR DIRECTOR'S REPORT AND DISCUSSION

Dr. Webster-Cyriaque began the Director's Report with an update on the budget and appropriations for the National Institutes of Health (NIH) and the National Institute of Dental and Craniofacial Research (NIDCR). The Fiscal Year 2026 (FY2026) Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act included a 1 percent increase for NIH (\$500M) and NIDCR (\$5M) over FY2025 funding levels. In April 2026, Congress reauthorized the Small Business Innovation Research (SBIR) and Small

Business Technology Transfer (STTR) programs. Also in April, the White House released the President's FY2027 Budget request, which included a \$5B reduction for NIH and a \$35M reduction for NIDCR compared with FY2026 enacted levels. The NIDCR FY2027 Congressional Justification, which incorporates the President's Budget, continues to list NIDCR as an independent Institute. The President's Budget proposes to transfer the National Institute of Environmental Health Sciences (NIEHS) to the Centers for Disease Control and Prevention (CDC), consolidate the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA), and eliminate three existing Institutes, Centers, and Offices (ICOs). Congress will now consider the FY2027 Budget request through the appropriations process and determine any final funding and organizational changes.

Dr. Webster-Cyriaque also provided updates at the Department of Health and Human Resources (HHS) level. As of January 2026, the United States has completed its withdrawal from the World Health Organization (WHO) in accordance with [Executive Order 14155](#). The United States will continue to lead global health efforts independently. She also noted that the Indian Health Service (IHS) plans to eliminate the use of mercury-containing dental amalgam (silver fillings) in its facilities by 2027, marking the completion of a 20-year phase-down process. To support this transition, IHS is investing in training and infrastructure alternatives to increase preventative efforts and decrease the need for restorative treatment.

Dr. Webster-Cyriaque announced several leadership changes across NIH. Recent departures include Ms. Seana Cranston, NIH Chief of Staff; Dr. Alison Cernich, Acting Director of the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD); Dr. Lindsey Criswell, Director of the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS); and Dr. Bruce Reed, Director of the Center for Scientific Review (CSR). Recent appointments include Dr. Elisabeth Armstrong as NIH Chief of Staff; Dr. Jonathan Green as the Chief Executive Officer (CEO) for the NIH Clinical Center; and Dr. Raymond Jacobson as the Acting Director of CSR. Dr. Michael Chiang has also been reappointed as the Director of the National Eye Institute (NEI). In February 2026, NIH Director Dr. Jay Bhattacharya was named the Acting Director of the CDC and will continue to perform the delegable duties of the CDC Director until a permanent director is confirmed. In April 2026 President Trump nominated Dr. Erica Schwartz, former Deputy Surgeon General, to serve as the next CDC Director, pending Senate confirmation.

Dr. Webster-Cyriaque highlighted several NIH-wide policy updates aimed at accelerating the translation of scientific discoveries into improved health outcomes. These efforts focus on establishing clear scientific priorities, simplifying funding opportunities and application processes, implementing a more unified funding strategy, and strengthening the science enterprise. She reviewed several policy changes affecting NIH research priorities. These include harmonization of the NIH definition of "intervention" with the Common Rule ([NOT-OD-26-063](#)); the removal, as of May 2026, of NIH clinical trial requirements for Basic Experimental Studies Involving Humans (BESH) ([NOT-OD-26-032](#)); and effective January 2026, to discontinue prohibited human fetal tissue (HFT) activities supported by NIH funds ([NOT-OD-26-028](#)). Additional legislative changes are summarized in the Notice of Legislative Mandates in Effect for FY 2026 ([NOT-OD-26-060](#)).

Dr. Webster-Cyriaque also described NIH's efforts to simplify the funding landscape with fewer Notices of Funding Opportunities (NOFOs). [Grants.gov](#) now serves as the single official source for federal funding opportunities and [NIH Grants & Funding](#) has dedicated pages for each ICO outlining its mission, scientific priorities, and highlighted topics (HTs). In addition, separate AIDS application due dates have been eliminated from NOFOs. The [NIH Extramural Nexus](#) newsletter recently outlined these and other changes to the funding opportunity process. Collectively, these efforts are intended to create a more flexible and efficient funding system that emphasizes scientific excellence and innovation.

The [Simplified Review Framework](#), which focuses on three core review criteria, has now been in use for one year. To further align with NIH's [Unified Funding Strategy](#) and its core tenets, NIH continues to refine its peer review practices. NIH has also adopted common forms for biosketches and other support, with compliance becoming mandatory after the current transition period ends. Dr. Webster-Cyriaque also highlighted recent NIH notices addressing salary limitations for grants and cooperative agreements; updates to the required elements of NIH Data Management and Sharing Plans; a reminder of the requirement to certify Institutional Review Board (IRB) approval; revisions to the NIH Late Application Submission Policy, including the end of Continuous Submission; updated implementation of Uniform Administrative Requirements for Federal Financial Assistance, including indirect costs (IDC); and a reminder that all NIH applications must be complete and compliant with NIH policy and application instructions at the time of submission.

Dr. Webster-Cyriaque highlighted recent policy updates addressing prior approval requirements for changes to domestic subawards; the applicability of Transparency Act subaward reporting requirements; and a new application structure for NIH-funded international collaborations. She also noted that the March 2026 NIH [Grants Policy Statement](#) supersedes the April 2024 version in its entirety as the standard terms and conditions of NIH awards.

Dr. Webster-Cyriaque also highlighted NIH initiatives to strengthen science, including efforts to enhance scientific rigor and reproducibility, promote data harmonization through the use of Common Data Elements (CDEs), improve data management and sharing, leverage data science and artificial intelligence (AI), and expand the use of human-focused, non-animal models, where appropriate. Collectively, these policy changes are intended to support the goals of the Unified Funding Strategy by streamlining NIH processes, promoting gold standard science, and improving health outcomes.

Dr. Webster-Cyriaque also highlighted several fiscal policies in effect for FY2026. In March 2026, NIH released a notice on Fiscal Operations for FY2026 and implementation of the Consolidated Appropriations Act, 2026 ([NOT-OD-26-059](#)). Under NIH's FY2026 funding policy, non-competing awards will generally be funded at previously committed levels, while competing awards will be funded based on the availability of funds and ICO priorities. NIDCR will continue to follow its longstanding funding approach by considering the scientific merit of competing applications, as determined through peer review, in conjunction with other programmatic factors, and will continue to provide individual consideration for all competing applications. The institute's funding goal is to provide stable support for high-quality scientific

research and research training while maintaining additional funding considerations for early-stage and at-risk investigators.

NIH is developing its FY2027-2031 Strategic Plan, which will guide the agency's efforts to achieve its mission while ensuring responsible stewardship of taxpayer funds. To inform the plan, NIH issued a Request for Information (RFI) seeking public input on three priority areas: research areas, research capacity, and research operations ([NOT-OD-26-047](#)). Electronic comments must be submitted by 11:59 p.m. on May 26, 2026.

Dr. Webster-Cyriaque shared several updates on NIDCR's funding opportunities. She noted that the institute's Extramural Research Program plans, develops, and manages basic, translational, and clinical research in dental, oral, and craniofacial (DOC) health and disease through grants and cooperative agreements. These activities advance NIDCR's goal to accelerate promising discoveries and emerging technologies towards clinical applications that improve the health of all across the lifespan.

Dr. Webster-Cyriaque highlighted NIDCR's funding opportunity forecasts and several NOFOs currently open for applications: Community-Based Participatory Research (CBPR) to Advance Data and Practice Transformation (ADAPT) for Optimizing Oral Health for All ([PAR-27-015](#)), which also includes a Community Engagement Evaluation and Data Coordination (CEED) Hub ([RFA-DE-27-001](#)); Accelerating Product Excellence in Innovation and for Clinical Adoption (APEX) ([RFA-DE-27-002](#)), which is version 2.0 of the highly successful [Dental, Oral, and Craniofacial Tissue Regeneration Consortium \(DOCTRC\)](#); and [Next Generation Restorative Dental Systems](#), which uses the Rapid Acceleration of Diagnostics (RADx) Tech Innovation Funnel. NIDCR also has several highlighted topics for use with broader parent mechanisms related- to cancer and HIV; the microbiome, autoimmune, nutrition, and ethics; and technology, AI, and the science of science.

Dr. Webster-Cyriaque highlighted FY2026 due dates for NIDCR fellowship and career development funding mechanisms and shared several related policy updates. NIH has implemented an automatic short-term eligibility extension for K99/R00 applicants whose final due dates for new or resubmission applications fell between January and March 2026, extending their final submission eligibility through June or July 2026. NIH also established a temporary exception for K awards that prematurely ended on or after January 1, 2025, allowing affected investigators to remain eligible to apply for new K awards through July 31, 2026.

Dr. Webster-Cyriaque also noted that NIDCR now uses the NIH Parent T32 NOFO ([PA-25-168](#)), as revised by [NOT-OD-25-036](#), for Institutional Training Programs. Applications are now reviewed by CSR rather than by NIDCR. In addition to the T32 program, NIDCR continues to support several active training grants and is developing additional R25 research programs focused on mentoring activities, research experiences, and curriculum and methods development.

Dr. Webster-Cyriaque shared brief updates on NIDCR's Strategic Plan, recent awards to staff, outreach, and community tools. Development of the NIDCR's FY2027-2031 Strategic Plan will begin later this year, and an RFI will be published to Grants.gov and in the Federal Register to solicit public input on areas of focus, opportunities, and challenges. She also noted that

applications for the NIDCR Director position, which was open from November 14 to December 12, 2025, remain under review. Several NIDCR staff members received 2025 NIH Director's Awards, including Drs. Lu Wang and Vidhya Venkateswaran for developing the [Data Driven Science \(DDS\) Hub](#); Dr. Lu Wang, individually, for fostering collaboration between human resources staff and scientific managers to strengthen NIH's data science workforce; Dr. Pamela Robey in recognition of 50 years of service at NIH; and Ms. Diana Rutberg for exemplary leadership and mentorship.

Dr. Webster-Cyriaque highlighted NIDCR's recent outreach and engagement activities. Over 40 NIDCR staff participated across booth engagement, conference sessions, symposia, and training events at the 2026 International Association for Dental, Oral, and Craniofacial Research/American Association for Dental, Oral, and Craniofacial Research/Canadian Association for Dental Research (IADR/AADOCR/CADR) General Session & Exhibition. NIDCR also participated in the 2026 National Oral Health Conference. She noted several resources available to the research community, including a [webpage](#) with tools, templates, and policy resources for clinical researchers; the DDS Hub, a centralized resource for DOC science and data; and the [FaceBase](#) Data Repository.

Dr. Webster-Cyriaque also highlighted examples of NIDCR research demonstrating the connections between oral and systemic health. She described work from Dr. Niki Moutsopoulos' laboratory showing how studies of leukocyte adhesion deficiency-1 (LAD1), a rare genetic immune disorder, have provided insight into the immune mechanisms underlying periodontal (gum) disease. This research team identified disturbances in neutrophil function in people with LAD-1 that triggers an inflammatory response driving periodontal inflammation and bone loss. Another study from this laboratory showed that neutrophil defects are clearly linked to mucosal inflammatory disease, resulting in severe periodontal disease at a young age. She also highlighted Dr. George Hajishengallis' laboratory demonstrating how the bone marrow can develop a harmful "memory" that keeps immune cells in an overactive, inflammatory state. This memory arising from trained immunity (TRIM) where immune cells are primed to react more aggressively or clonal hematopoiesis (CIP) where mutated blood-forming cells multiply, may mechanistically link periodontal disease with other inflammatory conditions, including rheumatoid arthritis and cardiovascular disease. Additional NIDCR-supported research continues to demonstrate the shared connection between oral health and systemic conditions, including cardiovascular outcomes, ventilator-associated pneumonia, diabetes, temporomandibular disorder (TMD), and dementia.

Advancing research on the oral-systemic health connection now requires translating mechanistic discoveries into population-level solutions, clinical trials, and improved patient care. To support this effort, NIDCR investigators have developed innovative research tools, including a microfluidic, three-dimensional humanized oral tissue platform that models the oral cavity and how it acts as a protective barrier; and a tissue-on-a-chip platform that examines how metals, mechanical stress, and bacteria affect the integrity of the mouth's protective lining during peri-implantitis, an inflammation around tooth implants.

She also highlighted research advances in several priority areas, including studies of the oral-gut axis, demonstrating that segmented filamentous bacteria (SFB), a type of bacteria

present in the gut, promote immunity to *Candida albicans*, a fungus present in the oral cavity. She described research evaluating oral care provided via human milk as a strategy to reduce gastrointestinal disturbances and inflammation in infants. Additional examples included studies of shared microenvironments between temporomandibular joint (TMJ) arthritis and other arthritic conditions, using a technique called spatial transcriptomics, to identify potential therapeutic targets; collaborative efforts between FaceBase and Clinical Genome Resource (ClinGen) to define gene-disease relationships across craniofacial disorders; intramural research on mineral metabolism as a link between oral and systemic health, including studies on denosumab for fibrous dysplasia and a forthcoming [Phase 1/2 open-label first-in-human trial of subcutaneous parathyroid hormone receptor inverse agonist \(PTH-IA\) in adults and children with Jansen's metaphyseal chondrodysplasia \(JMC\)](#), an ultra-rare genetic condition that disrupts bone development starting in infancy; and investigations into the mechanisms underlying multilevel pain modulation.

NIH-wide efforts to better understand oral-systemic connections are also underway. The DOC System has been incorporated into the Whole Person Health Research Framework as a distinct organ system, with Dr. Hajishengallis serving as the designated subject matter expert. Progress also continues in the development of organs-on-a-chip within the DOC field, creating opportunities to integrate oral chip systems with the National Center for Advancing Translational Sciences' (NCATS) Human Body-on-a-Chip program. Data integration remains central to advancing research on oral-systemic connections, with interoperability between electronic health records (EHR) and electronic dental records (EDRs) identified as a key priority. NIDCR is supporting several initiatives in this area, including EHR-EDR interoperability at Temple University; implementation of Fast Healthcare Interoperability Resources (FHIR) to incorporate medical summaries at Indiana University Health; expansion of the BigMouth Dental Data Repository at the University of Texas Health Science Center at Houston, which includes EDR data from more than 19 dental entities; development of SmartNote, a structured electronic medical record note, within FaceBase to improve diagnostic accuracy; and collaboration with the American Dental Association (ADA) to support the Observational Medical Outcomes Partnership (OMOP) common data model.

NIDCR also has several initiatives underway to advance systematic biomedical data integration. The institute has developed a CDE Framework to improve data standardization and interoperability through core and customizable domains that incorporate community engagement and AI-powered mapping. Complementing this effort are the FaceBase controlled-access repository, which houses harmonizable, AI- and machine learning-ready datasets, and the NIDCR Knowledgebase, which integrates multiple federated data sets and repositories using DDS-based cloud analytics and AI to enable new discoveries. NIDCR also supports the FAIR data principles by making data Findable and Accessible through the DDS Hub, Interoperable through the CDE Framework, and Reusable through the CDE Framework, FaceBase, and the DDS Hub. Dr. Webster-Cyriaque emphasized the importance of leveraging the oral cavity and craniofacial complex as targets for improving systemic outcomes. An example is a newly developed floss-based vaccine that targets the space between the tooth and gum and activates protective immune responses against influenza in multiple organs in preclinical models.

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

Discussion

Dr. Hyun Koo suggested that the DDS Hub could be further enhanced by making its data more compatible with AI-based approaches. Dr. Webster-Cyriaque responded that the adoption of CDEs and greater data harmonization are intended to improve interoperability across datasets. She added that the DDS Hub is also advancing low-code and no-code based approaches to enable researchers without specialized AI expertise to more easily access and leverage AI-enabled technologies.

IV. FROM WAISTLINE TO GUMLINE: METABOLIC DYSFUNCTION RESHAPES THE ORAL MICROENVIRONMENT

Dr. Sukirth Ganesan presented research on the relationship between metabolic disease and oral health. He described metabolic syndrome as a constellation of unhealthy factors, including increased waist circumference, elevated fasting glucose and fasting high-density lipoprotein (HDL) cholesterol, fasting triglyceridemia, and high blood pressure. These factors exert a cumulative burden on the body and increase the risk of cardiovascular disease and stroke. Emerging evidence suggests an association between metabolic disease and periodontal disease. Dr. Ganesan's research focuses on understanding how obesity and metabolic syndrome affect the healthy periodontium (tissues surrounding and supporting the teeth) before the onset of clinical periodontal disease.

In an initial study of 300 people with healthy gums, including individuals with obesity or metabolic syndrome, Dr. Ganesan's team found that systemic inflammation was associated with changes in the oral microbiome (the mouth's bacteria) despite the absence of clinical periodontal disease. Participants with obesity or metabolic syndrome exhibited inflammatory markers in the fluid around the gums, increase of several harmful types of bacteria below the gums, and distinct metabolic profiles compared with normal-weight healthy (NWH) controls. Notably, participants with obesity or metabolic syndrome had higher levels of amino acid metabolites, whereas NWH controls had higher levels of short-chain fatty acids. This is contrary to findings from gut microbiome studies and highlights the challenge of extrapolating information from gut to oral studies.

Dr. Ganesan also described an ongoing longitudinal study examining how metabolic health influences inflammation in the mouth. Participants receiving dietary changes, medication, or bariatric (weight-loss) surgery are being followed for two years to evaluate changes in the oral microbiome and inflammatory responses. Preliminary findings indicate that bariatric surgery is associated with reduced inflammatory markers in the mouth. Complementary studies of primary gingival epithelial cells (cells forming the protective barrier of the gums) also demonstrated stronger inflammatory signaling in participants with obesity or metabolic syndrome compared to NWH. Future studies will investigate the tissue layers driving these responses and determine whether the observed changes in gum cells are intrinsically programmed by metabolic disease or reflect the local tissue environment.

Discussion

Dr. Jose Moron-Concepcion asked whether the medications used by participants undergoing treatment for metabolic disease included glucagon-like peptide-1 (GLP-1) receptor agonists. Dr. Ganesan confirmed that they did and noted that the ongoing study is for two years. He explained that the team is interested in understanding the acute and long-term effects of weight loss on oral health and determining how these responses differ over time.

Dr. Hyun Koo asked how the investigators planned to examine the mechanisms underlying changes in the oral microbiome and the host inflammatory response. Dr. Ganesan said the team plans to evaluate microbial markers within tissue to determine whether microbial burden drives inflammation or whether inflammatory changes precede shifts in the microbiome. Dr. Koo asked if the team was also looking at dental caries (tooth decay). Dr. Ganesan noted that although participants did not have caries when recruited for the study, some still exhibited elevated levels of *Streptococcus mutans*, the bacteria that causes dental caries.

V. ORAL HYGIENE: IMPLICATIONS FOR PREVENTION OF INFECTIVE ENDOCARDITIS

Dr. Peter Lockhart presented an overview of infective endocarditis (IE) and the role of oral hygiene in its prevention. IE is an infection of the heart valves or endocardium (innermost layer of the heart) that affects more than 20 million individuals in the United States who are at risk for the disease. IE results in an estimated 30,000 to 50,000 hospitalizations each year and is associated with high rates of hospitalizations and deaths within a year of diagnosis. Approximately 40% of IE cases are caused by bacterial species in the mouth, particularly viridans group streptococci (VGS), normally present in the gap between the gums and teeth. Since 2007, the American Heart Association (AHA) has recommended antibiotic prophylaxis (AP) before certain dental procedures only for individuals at highest risk for IE, representing only about 10% of those at risk. As a result, there has been increasing attention on oral hygiene and oral bacteremia (mouth bacteria present in the bloodstream) as potential strategies to reduce IE risk among the remaining population at risk. Although oral hygiene has been included in the AHA guidelines since 1972, no direct evidence has linked poor oral hygiene with the risk of IE.

Dr. Lockhart reviewed findings from several NIDCR-funded studies on IE prevention. A 2008 bacteremia study demonstrated that poor oral hygiene and gum inflammation were likely greater risk factors over time for IE than invasive dental procedures. The investigators also found that tooth brushing frequently resulted in bacteremia involving IE-associated oral species, with the incidence increasing as dental plaque and calculus (tartar) accumulated. A subsequent case-control study further showed that patients hospitalized with IE had significantly higher plaque and calculus scores than matched outpatient controls at risk for IE.

Dr. Lockhart then described the Prevention of Infective Endocarditis Bacteremia (PIE-B) study, an ongoing multi-center, parallel-arm randomized clinical trial evaluating whether improved oral hygiene and reduced gum inflammation decrease the incidence and duration of bacteremia caused by IE-associated oral species. The primary outcome is the change in tooth

brushing-related bacteremia among participants receiving professional teeth cleaning and oral hygiene instruction (intervention) compared with those receiving routine oral care. To date, 202 ambulatory participants classified by the AHA as having no/low and moderate risk for IE have been enrolled across four study sites. Participants are randomized to the intervention or routine oral care group and undergo standardized tooth brushing with serial aerobic and anaerobic blood cultures collected before, during, and after brushing at baseline and at 3- and 15-week follow-up visits.

VI. PROPOSED MAKE AMERICA HEALTHY AGAIN (MAHA) IMPLEMENTATION STRATEGY AND GOVERNANCE STRUCTURE

Dr. Richard Woychik presented the proposed NIH MAHA implementation strategy and governance structure, which is intended to address the root causes of chronic disease by aligning research across food, health, and scientific systems. HHS has identified 33 scientific mandates for NIH including nutrition, environment, physical activity, mental health, substance use, cancer, and vaccines. As part of this effort, NIH will launch an Initiative on Chronic Disease to leverage and align existing NIH research projects, improve NIH coordination on chronic disease research, and generate actionable results for diseases arising in childhood and adulthood. The NIH will use the existing shared infrastructure developed from previously successful cross-NIH models, including the Program on Health and Extreme Weather (HEW) and the Whole Person Health (WPC) Framework, to design and implement the MAHA strategic framework.

The MAHA strategic framework includes seven Thematic Coordination Groups (TCGs) focused on major areas of chronic disease research: Nutrition, Metabolism & Health Promotion; Environmental & Chemical Exposures (Exposomics); Oral-Systemic Health, Physiologic Resilience & Inflammation; Neurodevelopment, Mental Health & Cognitive Resilience; Substance Use, Prescribing & Therapeutic Safety; Immunologic Interventions & Differential Response; and Cancer Etiology, Early Detection & Survivorship. Composed of subject matter experts nominated by participating ICO directors, the TCGs will focus on ICO research portfolios and facilitate cross-ICO collaboration, identify scientific research gaps and set priorities, leverage existing NIH-wide research platforms and collaborations, and report to the Steering Committee and MAHA leadership.

Three Integration Platforms (IPs) will provide shared infrastructure to support all TCGs in the areas of Real World Data (RWD) & Artificial Intelligence (AI) Platform; Clinical and Community Networks that Integrate the Whole Person Health Framework; and Life-Course Cohort Integration. Oversight of the framework will be provided by the MAHA Steering Committee composed of ICO directors leading the TCGs and the IPs. The Steering Committee will provide strategic oversight of the MAHA implementation, oversee TGC and IP portfolio performance, guide Common Fund programs and review NOFOs, and oversee data coordination and reporting through the MAHA Coordination Office using the Strategic Tracking and Reporting Tool (START) platform within the Division of Program Coordination, Planning, and Strategic Initiatives (DPCPSI).

The proposed implementation strategy has been presented to NIH ICO directors for review, and their feedback has been incorporated into the framework. Dr. Woychik and his team

are also conducting an NIH-wide portfolio analysis to map existing research activities to the HHS mandates, identify gaps and opportunities, and inform future priorities for the TCGs and IPs.

Discussion

Dr. Hyun Koo asked whether data from the CDC National Health and Nutrition Examination Survey (NHANES) would be involved in the MAHA strategy. Dr. Woychik replied that NHANES aligns naturally with TCG 2 and noted that, at the direction of NIH Director, Dr. Jay Bhattacharya, he is working with the CDC National Center for Health Statistics to explore opportunities for collaboration. Dr. Koo also noted that discussions of AI should consider the substantial computing infrastructure required to process multidimensional, multiscale datasets and the associated environmental impacts. Dr. Woychik agreed and emphasized that, rather than centralizing all data at NIH, the priority should be to establish common data standards that enable interoperability across distributed data repositories.

Dr. Janice Lee asked how the Intramural Research Program (IRP) would be incorporated into the MAHA Strategic Framework. Dr. Woychik said that the IRP's complementary expertise will be fully integrated into the framework. He noted that IRP directors will serve on the MAHA Steering Committee and many of the SMEs nominated to the IPs and TCGs are intramural investigators. Dr. Lee added that the Clinical Research Informatics Supporting Principal Investigators (CRISPI) initiative is integrating Clinical Center data into a real-world data framework. Dr. Woychik noted that Dr. Bhattacharya specifically requested that the CRISPI database be incorporated into the MAHA Real-World Data Platform.

Dr. Stephany Duda asked how the broader research community could support the MAHA initiative. Dr. Woychik encouraged investigators to follow emerging plans, NOFOs, and highlighted topics, noting that the long-term goal is to integrate the MAHA agenda into ICOs' strategic plans. Dr. Webster-Cyriaque added that several ongoing data initiatives require participation from extramural and intramural communities and encouraged investigators to begin incorporating CDEs into their research projects.

VII. RECENT DEVELOPMENTS IN PEER REVIEW

Dr. Raymond Jacobson presented an update on recent activities at the Center for Scientific Review (CSR). He began by describing the impact of the 2025 federal government shutdown, which occurred during the peak of the fall peer review cycle. When operations resumed, more than 32,000 grant applications were awaiting review, 379 study section meetings had been cancelled, and many remaining meetings were no longer feasible. CSR ultimately rescheduled more than 500 review meetings, recruited reviewers, and reassigned applications, although the resulting delays continued to affect subsequent review cycles. Dr. Jacobson attributed the successful recovery to the efforts of CSR staff, the flexibility of the extramural research community, assistance from ICO staff, coordinated NIH-wide implementation, and temporary emergency modifications to peer review policies. One more final review cycle will use these emergency modifications before NIH returns to standard review procedures in January 2027.

Dr. Jacobson also discussed NIH's consolidation of peer review within CSR. Prior to 2025, peer review was conducted by 24 administratively separate review groups, i.e., CSR and 23 ICOs. CSR reviewed 77% of applications and ICO-based review branches handled the remaining 23%. To improve efficiency, consistency, and coordination, NIH centralized all peer review activities within CSR in 2025. As a result, CSR assumed responsibility for approximately 30,000 additional applications annually and integrated approximately 250 review staff from ICOs.

To support this transition, CSR has reorganized its review structure by establishing 10 new review branches, chartering 52 new standing study sections, and creating recurring Special Emphasis Panels (SEPs) for clustered training grants and multicomponent applications. Dr. Jacobson emphasized that the quality of peer review remained high following centralization. Reviewer expertise has been retained through the transfer of ICO review staff to CSR. He also noted that all NIH Scientific Review Officers (SROs) now participate in CSR's interactive training program and that CSR leadership continues to work closely with each ICO to address special review considerations. Collectively, these organizational changes are intended to provide greater consistency, predictability, and transparency in the review of applications previously managed by ICOs.

Dr. Jacobson also reviewed ongoing efforts to strengthen peer review. The Simplified Review Framework (SRF) was developed to focus reviewer attention on the scientific merit of applications by emphasizing research importance, rigor, feasibility, and expertise and resources. The framework also seeks to increase consideration of significance and innovation while reducing undue emphasis on investigator reputation, institutional environment, and over-emphasis on approach. In parallel, CSR has expanded and varied its reviewer pool through changes in recruitment, training, and policy, resulting in a more balanced distribution of review service and greater participation by mid-career investigators.

Looking ahead, CSR's immediate priorities include completing its organizational restructuring, chartering the remaining study sections, and returning to a normal review schedule. Longer-term efforts will focus on evaluating the impact of the emergency review modifications, monitoring implementation of SRF and revised fellowship review criteria, and developing additional training and public resources to promote consistent, transparent, and high-quality peer review.

Discussion

Dr. Paul Krebsbach asked whether the reorganization would affect the workload of the extramural community in the peer review process. Dr. Jacobson explained that CSR's expectations for reviewer workload have not changed, although reviewers who previously served in smaller ICO review groups may receive more applications than before. Dr. Krebsbach asked how they would maintain consistency when there is more turnover among review panels. In response, Dr. Jacobson noted that members of chartered study sections serve four-year terms and that the structure of standing study sections help preserve continuity and consistency within scientific fields.

Dr. Hyun Koo asked whether each oral health-related application could be reviewed by an oral health expert. Dr. Jacobson replied that, although every panel may not include an oral health expert, SROs recruit reviewers with the expertise needed for the applications assigned to each meeting. He encouraged investigators to contact CSR if they have concerns about reviewer expertise.

Dr. Stephany Duda relayed a question from Dr. Moron-Concepcion, who had to leave the meeting early. Dr. Moron-Concepcion noted that next week CSR will receive the first submissions for the Collaborative International Research Project (PF5), and he asked if these will fit into existing review sections, or if CSR anticipated convening SEPs. Dr. Jacobson said that CSR has been actively planning for these applications and expects them to be reviewed by SEPs, with applications assigned to one or more panels depending on their scientific scope.

VIII. ADJOURNMENT OF OPEN SESSION

The open session was adjourned at 12:35 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).

IX. REVIEW OF APPLICATIONS

NADCRC reviewed 470 Research and Training Grant applications requesting Total Project Costs (All Years) at \$900,481,239 and Direct Costs (All Years) at \$621,639,318. Out of these 470 Research and Training Grant applications, 164 Research and Training Grant applications were ‘Scored’ requesting Total Project Costs (All Years) at \$287,947,645 and Direct Costs (All Years) at \$198,543,389, 135 Research and Training Grant applications were deemed ‘Competitive Not Discussed’ requesting Total Project Costs (All Years) at \$295,281,563 and Direct Costs (All Years) at \$203,370,605, and 171 Research and Training Grant applications were ‘Not Discussed’ requesting Total Project Costs (All Years) at \$317,252,031 and Direct Costs (All Years) at \$219,725,324. 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.

X. ADJOURNMENT

CERTIFICATION

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

/s/Jennifer Webster-Cyriaque

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

/s/Sanoj K. Suneja

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