SANTA FE GROUP

Improving Lives Through Oral Health

NATIONAL CONVENING REPORT

Oral Health as a Pathway to Wellness and Longevity

A Living Framework for Collective Action



OCTOBER 2026

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Preface

The 2026 National Convening began with a question:

What will it take for oral health to become inseparable from whole-person health?

The answer did not emerge as a single recommendation, policy proposal, or organizational initiative. Instead, it emerged as something larger. Across sectors, disciplines, and experiences, participants discovered a shared conviction that the separation of oral health from the broader health system is neither inevitable nor acceptable. More importantly, they discovered that they are not working alone.

Our hope is that this convening will ultimately be remembered not as a meeting, but as the beginning of a movement.

We envision a future in which the relationships formed during these conversations mature into a durable network of leaders, organizations, communities, practitioners, researchers, educators, policymakers, and advocates working toward a common goal. A future in which the ideas generated during the convening are tested, refined, implemented, and shared. A future in which collective action becomes the connective tissue between innovation and system change.

The work ahead is not to create a single program. It is to create the conditions under which many programs, policies, partnerships, and innovations can flourish.

We hope participants will see themselves not merely as recipients of this report, but as co-creators of what comes next. Some may lead efforts to advance integrated care. Others may focus on workforce development, public policy, data infrastructure, community engagement, or narrative change. Still others may contribute by connecting people, sharing evidence, amplifying successful models, or bringing new voices into the conversation. Every contribution has value because lasting systems change requires many forms of leadership.

We hope the network continues to grow more inclusive over time. The conversation must expand beyond those already engaged. Communities with lived experience, employers, payers, public-sector leaders, technology innovators, frontline providers, and emerging leaders must all help shape the next chapter. Progress will depend not only on expertise, but on our ability to listen, collaborate, and act across traditional boundaries.

We hope that the concept of "oral health is health" becomes more than a slogan. We hope it becomes a shared public narrative that influences education, financing, research, policy, care delivery, and public understanding. A narrative capable of building the political will and institutional commitment necessary to move from isolated successes to widespread adoption.

Most of all, we hope this work remains grounded in accountability. The convening demonstrated alignment. The next phase must demonstrate progress. We envision a culture of learning in which participants share successes and failures openly, measure what matters, support one another's efforts, and continually adapt based on evidence and experience. The goal is not simply to generate ideas. The goal is to improve lives.

If this effort succeeds, the most important outcome will not be the publication of a report, the endorsement of a statement, or the formation of a network. Success will be measured by whether future generations experience a health system that recognizes what should have been obvious all along: that oral health is an essential part of health, that whole-person care requires whole-system thinking, and that meaningful change is possible when people and institutions choose to act together.

The convening was the beginning. The network is the next step.The future will be built by what we choose to do together. Let us begin.

On behalf of the Santa Fe Group,
Dushanka V. Kleinman, DDS, MScD (RADM, USPHS (ret.)),
President, Santa Fe Group



Introduction

A shared vision and commitment

Across the United States, financing, workforce preparation, care delivery, data systems, and public policy continue to separate oral health from the rest of health care. That fragmentation produces practical consequences: preventable disease goes untreated, patients navigate parallel systems, clinicians lack shared information, public and private payers face avoidable costs, and access remains inequitable. Oral health therefore provides both a clear example of the cost of fragmentation and a practical entry point for whole-person health reform.

Whole-person health reform means breaking down boundaries and building systems that recognize the supports needed for the full range of human health and well-being. It requires shared language, shared information, coordinated care, and sustained collaboration across sectors, professions, and institutions.

> This is a critical moment to break down the silos separating dental, medical, mental health, and social services. No single profession or institution acting alone can change the conditions that have led us to this structure. Decisions made now will shape access to care, health financing, workforce education, public health, and care delivery for generations. We need to align our goals, accelerate what works, and build a unified commitment to making whole-person health the standard of care.

120+

Leaders across sectors

June 22-24

2026 National Convening

Washington, D.C.

Convening location

From Convening to Action

A living framework for whole-person health

The Santa Fe Group launched its *2026 National Convening* to catalyze a national network capable of responding to this critical moment. From June 22-24, more than 120 leaders in health care, public health, education, public policy, financing, industry, and community and patient advocacy gathered in Washington, D.C. Using an Appreciative Inquiry process, participants examined existing successes, imagined what was possible, identified areas for systems transformation, and developed commitments for future action. After the Convening, the planning team synthesized the outcomes and gathered additional participant input. Part I of this report presents the results of this work in the form of a living framework that can evolve as our collective efforts move forward. Part II includes the acknowledgements and glossary. Part III documents the process and supporting evidence.

SFG National Convening Goals and Principles

STRATEGIC GOALS

- Elevate oral health as an essential part of health and well-being, grounded in evidence.
- Accelerate the integration of oral and general health to achieve equitable, person-centered care, translating lessons from successful innovations into actionable reforms.
- Mobilize and sustain a network of aligned organizations to champion, implement, and scale agreed-upon actions.

GUIDING PRINCIPLES

- Oral health is inseparable from whole-person health.
- Integration of oral and general health is a critical public value.
- A common language creates shared identity and accountability.
- Trust and commitment are essential to build on what works - together.
- Policy enables; implementation transforms - and barriers must be named.
- People and communities are partners, not recipients.
- Collaboration requires sustained investment and networking.

PART I

A Living Framework for Collective Action

Through our collaborative work, we identified elements of a living framework for collective action to make oral health inseparable from whole-person health in policy, practice, financing, and culture. This emerging framework will guide us in developing a national collective action network that can catalyze systems change. The framework is living in the sense that it is an initial iteration that will continue to evolve as the work progresses. It has four parts:

Emerging Consensus

An emerging consensus statement outlining a shared vision and commitment

Strategic Levers

A set of strategic levers or areas within the system where collective action will produce positive change

Network Structure

A decentralized, multi-hub structure for the emerging network

Evaluation Protocol

A proposed approach for monitoring and evaluating the network's development and progress

The Convening was just the beginning. There is still much to do in order to activate this framework, and we invite you all to join in the work.

Emerging Consensus Statement

A shared vision and commitment

Convening attendees called for a consensus statement to capture the shared goals and commitments that unite us in this work. The emerging statement below is based on input from Convening discussions as well as the post-Convening attendee survey. In follow-up communications, we will share how individuals and organizations whose missions and goals align with this statement can sign on.

WE RESOLVE

We resolve that the separation of oral health from the nation's health, public health, and care systems can no longer be accepted. Meaningful progress requires dismantling structural barriers, directing resources where needs are greatest, and ensuring equitable access to integrated care. This effort extends beyond improving coordination between medical and dental services. It represents an opportunity to transform how the United States defines health, organizes care, allocates resources, and holds institutions accountable for improving well-being.

WE COMMIT

We commit to a shared vision: a future in which every person has access to integrated, equitable, person-centered care, and in which oral health is fully embedded within the nation’s approach to health, wellness, and longevity.

WE AFFIRM

We affirm a shared commitment to ensuring that oral health is recognized, financed, delivered, and measured as an essential component of whole-person care. The long-standing separation of oral health from the broader healthcare system contributes to preventable disease, fragmented care, inequitable access, avoidable costs, and diminished quality of life. We commit to mobilizing collective action by aligning with network priorities, sustained leadership, enabling infrastructure, and accountability. Our priorities include advancing policies, payment models, education, workforce development, care delivery, research, data interoperability, health literacy, and community partnerships within health and healthcare systems. We also commit to changing the narrative by recognizing oral health as a vital pathway to wellness and longevity.

WE FURTHER AFFIRM

We further affirm that communities most affected by health inequities must be active partners in shaping priorities, designing solutions, implementing changes, and evaluating outcomes. Together, we will align our efforts, measure progress, share learning, and advance the systems change necessary to ensure that oral health is no longer treated as separate from health itself.

Levers for Systems Change

Five connected points of leverage

Making oral health inseparable from whole-person health requires systems change, defined as shifting "the conditions that hold a problem in place."[1] During the Convening, attendees gathered several times in multi-stakeholder working groups. Drawing on the many success stories and models shared by panelists and attendees, these groups identified levers - points in the system where small changes could yield large impacts - and considered the impacts that moving those levers could have. Additional comments were received after the Convening. This input was then synthesized into the five proposed focus levers below.

Narrative Change, Shared Vision and Community Voice allows us to build political will and shift public understanding through a common, audience-centered narrative grounded in the principle that oral health is health.

Public Policy and Payment Reforms promotes federal, state, and local policies and infrastructure that recognize oral health as an essential part of health.

Workforce, Education, and Health Literacy helps us to build the knowledge, roles, and learning systems needed to make oral health integral to whole-person health for patients, providers, and policymakers.

Integrated Care Delivery and Financing Models moves from parallel medical and dental systems toward coordinated, preventive, interprofessional, person-centered care.

Data, Technology, and Interoperability create the shared information infrastructure needed to coordinate care, measure outcomes, and build the case for change.



1. Kania J, Kramer M, Senge P. The Water of Systems Change. FSG; 2018.

The 5 Proposed Focus Levers

PROPOSED FOCUS LEVERS	POTENTIAL IMPACTS	EXAMPLE OF STRATEGIES
NARRATIVE CHANGE, SHARED VISION & COMMUNITY VOICE	A meta-lever that builds political will, amplifies community voices, and shifts public understanding of oral health toward longevity and wellness.	• Develop a shared narrative with tailored messages • Leverage evidence, success stories, and lived experience • Co-create messages with impacted communities
PUBLIC POLICY AND PAYMENT REFORMS	Advances federal, state, and local infrastructure that prioritizes and incentivizes oral health.	• Develop a shared legislative agenda • Advocate for redesigned payment incentives • Communicate the economic and public value of integration
WORKFORCE, EDUCATION AND HEALTH LITERACY	Builds oral health literacy for patients, providers, and policymakers. Unlocks all other levers.	• Promote oral health literacy • Advance interprofessional preparation • Create new and expand existing roles • Develop a common oral health vocabulary
INTEGRATED CARE DELIVERY AND FINANCING MODELS	Shifts from episodic, treatment-focused silos to frontline prevention and interprofessional care.	• Offer care and prevention at multiple entry points • Scale interprofessional delivery models (FQHCs, school-based clinics, etc.) • Coordinate referrals, navigation, and care planning • Build infrastructure for payment, data, workforce, and community participation
DATA, TECHNOLOGY AND INTEROPERABILITY	Serves as connective tissue allowing providers to see the whole patient and generates evidence for policy.	• Connect EHRs and dental records • Develop common diagnostic codes, measures, terminology, and documentation • Empower patients through accessible information about their health • Generate evidence through linked data, analytics, and research

A Collective Action Network Model

A decentralized, multi-hub approach

Convening attendees confirmed the need for a cross-sector collective action network. The convening did not include dedicated time to describe a network model. The proposed model incorporates suggestions made by participants and raises key questions for further development.

The model uses five hubs organized around the strategic levers described above, supported by an infrastructure organization. Leadership would be distributed across the network, with significant cross-hub collaboration.

The next phase will define who authorizes priorities, selects hub leads, finalizes hub titles, resolves cross-hub conflicts, allocates resources, and monitors, evaluates, and reports on progress. Until those decisions are made, the model should be treated as a proposed operating structure rather than a settled governance system. Its purpose is to align efforts, spread successful models, create conditions for new initiatives, and multiply impact without placing control in a single organization.

As this work moves forward, critical questions will need to be asked about who participates in the network, whose priorities shape decisions, how affected communities share power, where resources are directed, who is missing from decision making, and who benefits from proposed changes. Similar equity-oriented questions will need to be addressed by the hubs when selecting priorities, designing interventions, allocating resources, and evaluating results.

For example:

> How will community and patient advocates participate as co-creators of public messaging?

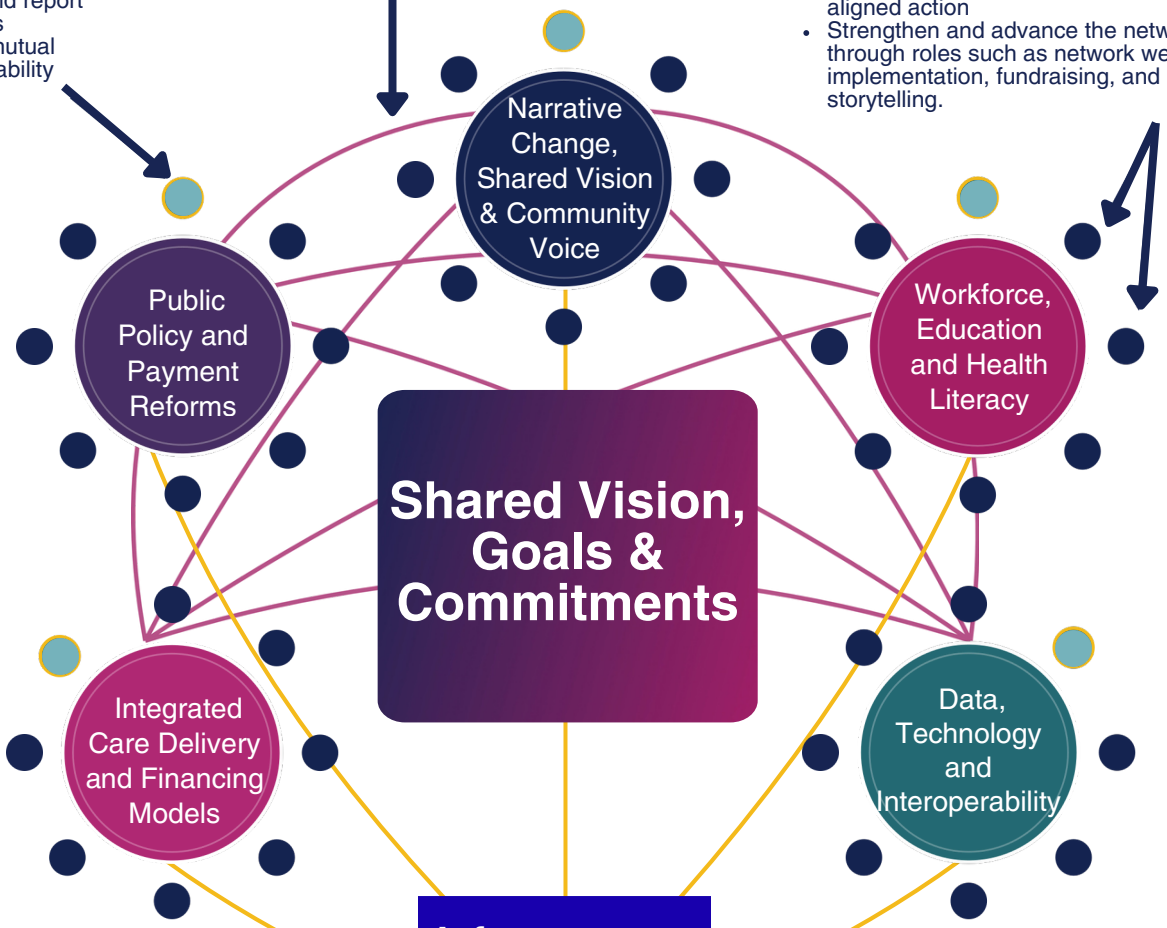
> How can integrated-care models be designed and tested in under-resourced communities?

> How will financing reforms reduce disparities, and who may remain excluded?

Hub Leads
- Convene hub members
- Coordinate with infrastructure organization and other hubs
- Track and report progress
- Foster mutual accountability

Cross-Hub Connections
Communication, resource sharing, collaboration, and accountability among hubs

Hub Members
- Engage in Appreciative Inquiry process
- Develop and implement plans for aligned action
- Strengthen and advance the network through roles such as network weaving, implementation, fundraising, and storytelling.



Infrastructure supports
Coordination, data sharing, and resource sharing

Infrastructure Organization
- Support communication and resource sharing
- Coordinate with hub leads
- Monitor, evaluate, and report on progress
- Build alignment across hubs
- Foster mutual accountability
- Facilitate use of Appreciative Inquiry process

Advisory Group
- Advise on network strategy and supports
- Represent diverse stakeholder groups and areas of expertise
- Help recruit hub leads, members, and partners

Examples of common cross-hub intersections

Workforce + Integrated Care Delivery
Workforce education serves as a bridge from integration concepts to daily practice.

Data + Public Policy
Interoperability, common measures, and economic evidence are linked to reimbursement, regulation, and the case for scale.

Financing Models + Public Policy
A shared public policy platform advances new financing models in public systems.

Narrative + All Other Hubs
A shared “oral health is health” narrative gives technical, clinical, educational, and policy work a common public purpose.

Initial Evaluation Protocol

Learning, adaptation, and shared accountability

Time did not allow convening participants to design a monitoring and evaluation protocol during the convening itself. The Santa Fe Group therefore gathered initial input from members and experts to propose one for the network's early phase. As the network infrastructure matures, network participants will need to validate a full evaluation protocol before it becomes the basis for shared accountability.

The proposed evaluation protocol will guide learning and decisions in three areas: implementation of post-Convening coordination and network development; the emerging capacity of the network and its hubs; and early outcomes. It also identifies longer-term outcomes and impacts that should be considered as the network matures, although measuring those results is outside the scope of this initial phase.

The emerging network is operating in a complex and dynamic ecosystem alongside diverse efforts to advance systems change. For that reason, evaluation will focus on the network's contribution to change rather than seeking to attribute changes directly to the work of the network.

The proposed evaluation protocol is intended to be used primarily by the organizations facilitating network implementation and network participants themselves. It has four purposes: promote learning and action; guide continuous improvement in post-Convening support and network-building activities; document early results and the network's contribution to them; and inform next-phase strategy, sustainability, resource allocation, and communication with participants and funders.

Evaluation Framework

The evaluation protocol centers on a three facets of collective action. Questions are being developed for each area.

Coordination of network development

Tracks the process of implementing network development activities and adapting those activities in response to ongoing learning and context changes and includes convening follow-up, communications, coordination, and other post-convening activities.

Network capacity

Examines early measures of the network's capacity - which includes elements such as trust and alignment among participants, governance and decision-making processes, and near-term sustainability.

Early outcomes

Asseses changes in collaboration, access to expertise and partners, resource and data sharing, coordinated action, practice, prototypes, narratives, and/or policy.

Further information regarding the proposed evaluation protocol can be found in Part III.

Moving Forward

Together we weave. Together we act. Together we transform.

Through the work and input of more than 120 cross-sector leaders, the Convening established a shared direction and an initial emerging framework for action. The next phase requires moving from an emerging framework toward alignment around five immediate tasks: broaden participation beyond the June attendees; determine communication and information sharing for mutual accountability; shape governance and decision-making processes; delineate organizational units and functions; and secure resources for coordination, implementation, and evaluation.

The network would be organized into hubs that continue the Appreciative Inquiry process and develop their own action plans. The development of a shared monitoring and evaluation approach will help the network learn across hubs, track implementation, assess reach and equity, and understand how collective efforts are contributing to changes in policy, practice, financing, and care. These steps will encourage forward action and ultimately determine whether the Convening becomes a durable operating network with the capacity to effect change in health systems or remains a statement of alignment.

Building and sustaining this network will require shared investment. It will require funders, public and private partners, participating organizations, community leaders, and other champions who are willing to contribute financial resources, expertise, relationships, and implementation capacity. We invite those who share this vision to continue their commitment to whole person health and shape the network's next phase.

- Network Weaving: Connecting people across sectors
- Direct Implementation: Changing practice, policy, and contracts
- Administration/ Backbone: Coordinating and tracking progress
- Fundraising and Resource Development: Securing funding
- Communications and Storytelling: Sharing data and stories
- Data, Measurement, and Evaluation: Tracking metrics and evidence
- Other Emergent Roles

Subsequent communications will offer opportunities to help define the proposed governance structure, participation pathways, initial priorities, resource strategy, and measures of progress.

The goal is to create a network that is accountable to communities, responsive to learning, and capable of sustaining action over time. The Convening was a catalyst. Now we will build on our commitments to create the structures that can turn shared purpose into lasting change.

Part II

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Glossary

Terms used throughout the report

Collective Action Network: A group of people and organizations, connected by relationships, working across sectors and areas of expertise toward a shared vision and coordinated action. The emerging network outlined in this document creates conditions for distributed action, shared ownership, and emergent coordination that no single organization controls.

Hub: A group of network participants organized around a specific strategic lever. Hubs bring together people and organizations with relevant expertise, relationships, and interests to coordinate action, share learning, and advance priorities, while coordinating with other hubs across the network.

Infrastructure Organization: An organization that provides the coordination, communication, resource-sharing, and other support needed to help the network function effectively. In the emerging collective action network, it works across hubs while leadership and action remain distributed across the network. It is a coordination layer, not a command center.

Lever: A strategic point in a system where action can have an outsized impact. The five levers identified in this report are areas where coordinated action could have a "cascading effect throughout the entire system. This can be more efficient and effective than trying to make changes at other points within the system, which may have less of an impact or may be more difficult to implement."[2]

Prototype: An early version of an idea, approach, or initiative developed to test what might work in practice. At the Convening, the term prototype was used to encompass ideas at a range of implementation stages, from promising concepts not yet tested at scale, to pilots that already have multiple implementation sites and available outcome data.

System: The interconnected people, organizations, policies, practices, resources, discourses, and conditions that shape how health and health care work.

Systems Change: Changing "the conditions that hold a problem in place,"[3] including structures, relationships, policies, practices, and patterns of resource allocation. By shifting the parts of a system and how they interact, the process produces "a new system that behaves in a qualitatively different way."[4]

Whole-Person Health: An approach to health that recognizes the full range of factors affecting a person's health and well-being and connects care across health and related services.

2 Murphy RJA. Finding (a theory of) Leverage for Systemic Change: A systemic design research agenda. Contexts - The Systemic Design Journal. 2022;1:v1004. doi:10.58279/v1004

3 Kania J, Kramer M, Senge P. The Water of Systems Change. FSG; 2018.

4 Jetel R. What is systems change? Six questions answered. World Resources Institute; 2022. https://www.wri.org/insights/systems-change-how-to-top-6-questions-answered

Part III

Our Path to Collective Action

- 2026 National Convening: Structure, Process and Outcomes
- Proposed Evaluation Protocol

Appreciative Inquiry

A strengths-based approach to organizational and social change

The Convening was designed according to the principles of Appreciative Inquiry, a strengths-based approach to organizational and social change. Developed by David Cooperrider and Suresh Srivastva at Case Western Reserve University, it begins with a foundational assumption: every system, sector, and community has something that works. The work of change is to find that generative core - and build from it.

Appreciative Inquiry does not ignore challenges. It reframes them. Rather than asking "What is broken and who is to blame?" it asks, "What is working, what is possible, and how do we build more of it?" This is not naive optimism - it is strategic. Systems built on what works are more durable, more motivating, and more likely to sustain commitment than systems built on deficit and blame.

Appreciative Inquiry asks us to shift our approach to change.

INSTEAD OF
"What are the biggest failures of our current system?"

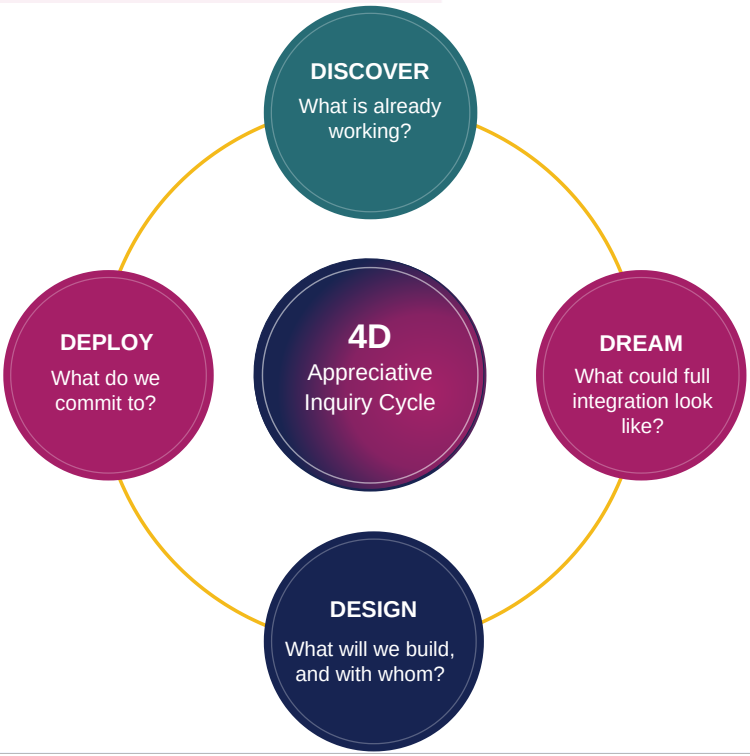
ASK
"Tell us about a time when something worked. What made it possible?"

INSTEAD OF
"What barriers are preventing progress?"

ASK
"What has already broken through? What can we learn from that breakthrough?"

INSTEAD OF
"What needs to be fixed?"

ASK
"What prototype could we build on the foundation of what already works?"

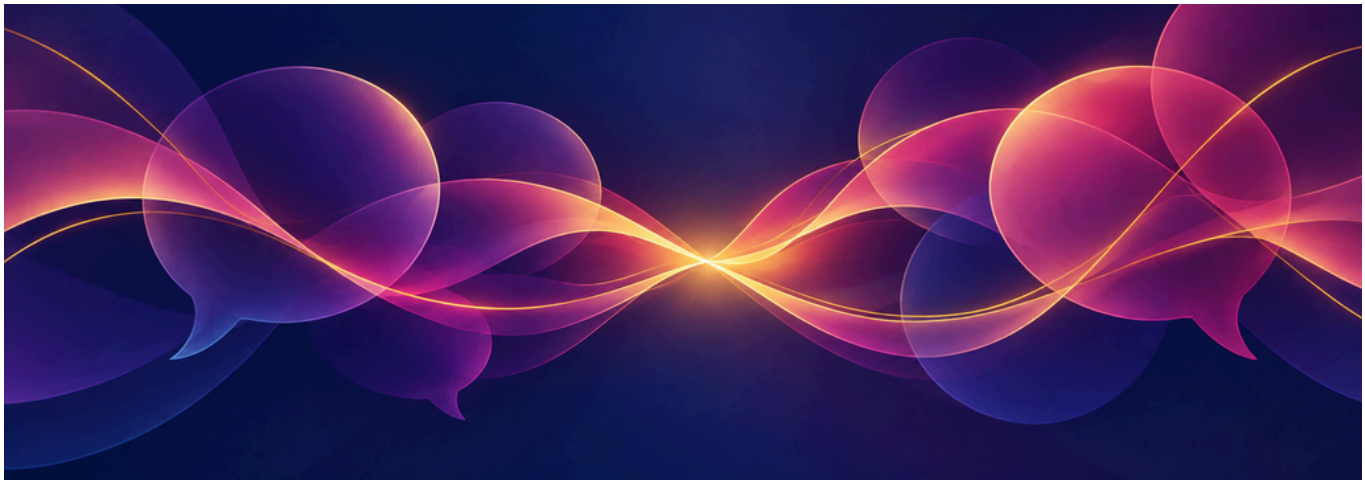


Convening panels and small group activities took attendees through the 4D Cycle of Appreciative Inquiry. The Convening's process of discovering, dreaming, designing, and committing to deployment was just the beginning. We offer Appreciative Inquiry as a framework for network hubs to continue this work in their respective areas.

Panels

Stories, provocations, and practical examples

Across the three days, cross-sector panels took to the stage to share ideas, stories, challenges, and successes, to ignite, inform, and inspire the thinking of attendees as they took part in the design process. The panels went through the staged of Appreciative Inquiry (AI).



Panels	AI Stage
Opportunities for Momentum	DREAM
Igniters	DISCOVER
Real-World Prototypes	DESIGN
Moving from Design to Deployment	DEPLOY
Fireside Chat: How Do We Change the System?	DEPLOY

PANEL 1 | DREAM

Opportunities for Momentum

This panel featured industry, foundation and public health leaders sharing ideas and provocations to inform the work of the Convening.

> "I'm convinced that the highest order thing that I can do as CEO of the company is push forward the notion that oral health is systemic health."
>
> **Fred Lowery**
> CEO of Henry Schein
>
> Sharing perspectives in his opening remarks as the panel moderator.

> "There needs to be collaboration between organized dentistry and the organized medical world."
>
> "We have to make it super easy for physicians and dentists to be able to do the right thing…to be able to collaborate and work easily together at the very beginning."
>
> "I would put out a challenge to the group in the room – to figure out models on how we can convince those that pay for healthcare, whether its government or companies or businesses to integrate oral health into overall health."
>
> **Stanley Bergman**
> Chairman of the Board and former CEO of Henry Schein
>
> Pointing out the urgency of addressing rising chronic disease costs and calling for a high level meeting of medical and dental associations and for a joint messaging campaign.

PANEL 1 | DREAM | CONTINUED

> "The size and scale of what we're trying to tackle is enormous and it is what requires the ability for us to come together."
>
> **Wade Rakes**
> CEO of CareQuest Institute for Oral Health
>
> Discussing the scale of the oral health industry and the importance of translating research into action.

> "We have an opportunity for all of us to be in one basket...what it takes is a common vision and understanding that we all ascribe to – one vision where we are consistent, where we are committed, and we're prepared to deploy. We've never really had it."
>
> **Dr. Caswell A. Evans, Jr.**
> Emeritus Professor at the University of Illinois at Chicago, College of Dentistry
>
> Reflecting on the essential aspects and the importance of working together at this point in time.



PANEL 2 | DISCOVER

Igniters

This panel of “igniters” shared stories of successful integration across sectors, setting the tone for the process.

> “We formed an affinity group and one of the first things that we set out to do, based on the recommendations of a former governor in the United States, was to make the economic rationale for a global investment in oral health, framing a $710 billion annual burden not as a health crisis but as a workforce and productivity crisis.”
>
> **Dr. Maria Ryan**
> Chief Clinical Officer and Executive Vice President at Colgate Palmolive
>
> Discussing her work on oral-systemic health integration, including partnerships and prevention initiatives.

> “Health literacy is how people find, understand, and use health information to make informed decisions for themselves and others. It has a personal dimension, but it also has an organizational dimension as a responsibility of health care systems. It’s not their job to understand us. It’s our job to understand them.”
>
> **Dr. Cynthia Baur**
> Director of the Horowitz Center for Health Literacy at the University of Maryland School of Public Health
>
> Discussing health literacy and communication approaches to oral health.

> “To influence policy action with Medicaid, Marketplace and Medicare, you need an institutional expert on the inside, data and storytelling, and operational execution. Without all three, nothing moves.”
>
> **Dr. Natalia Chalmers**
> Chief Dental Officer and Head of Clinical Innovation at Overjet and former Chief Dental Officer at the Centers for Medicare and Medicaid Services
>
> Providing perspective on federal and state efforts to integrate oral health into Medicaid and Medicare.

PANEL 2 | DISCOVER | CONTINUED

"We intentionally set out to change the messaging and consistency of the messaging so it's not if we get adult dental coverage, but when we get adult dental coverage. And it's not the cost; it's an investment in individuals and communities."

Mary Backley

CEO of the Maryland Dental Action Coalition

Describing Maryland's campaign for comprehensive adult dental coverage, including the coalition's successful 2022 legislation.

"We're trying to improve the connection to the dental home within six months from when a patient receives a provision of oral health services in the primary care practice. We're trying a financial lever by asking the state to set aside some money for a bonus payment that if the child gets connected within a certain amount of time, that will be split between the primary care provider and the dentist who sees the patient."

Dr. David Krol

Pediatrician and Medical Director of the Connecticut Children's Care Network

Discussing Connecticut's pediatric medical-dental integration efforts, including the state's Access to Baby and Child Dentistry (ABCD) program and efforts to increase fluoride varnish/oral-health services in pediatric practices.



PANEL 3 | DESIGN

Real-World Prototypes

Before attendees began designing prototypes together, this panel shared successful prototypes and long-running initiatives that could inspire and inform the process.

> “Somehow, we get CMS to require that an oral health exam be documented in the medical record for every patient admitted to the hospital. When that happens, things will change.”

Dr. Dian Baker
Anurseand Professor Emeritus at California State University, Sacramento

Discussing an initiative to reduce hospital-acquired pneumonia by making oral health assessment and care part of hospital patient safety.

> “We were late to the social media game. If you build it, they will come is only partly true. Programs need implementation support, not just education, so education is necessary, but insufficient to move a needle on integration. It requires workflow tools and meaningful change.”

Dr. Melinda Clark
Academic pediatrician at Albany Medical Center

Speaking about Smiles for Life, the national oral-health curriculum for primary-care professionals.

> “We don't go to a community and say, we're just going to do something for 6 months and go away. We want something where once we're in that community, we're there until the problem is solved or as long as it takes. So, we did very detailed business planning with, you know, food shelves and long-term care in the schools, and the preschools, and county public health, and the city, and the hospital and the hospital administration, and so forth.”

Dr. Michael Helgeson
CEO and co-founder of Apple Tree Dental

Discussing rural medical-dental integration in Little Falls, Minnesota, developed through community planning, including an outreach clinic, telehealth, and ultimately a permanent dental clinic.

PANEL 3 | DESIGN | CONTINUED

> "You can't do integration if you design it in a silo. It really must involve all the stakeholders."
>
> **Dr. Brad Rindal**
> Senior Research Investigator and Associate Dental Director at Health Partners
>
> Describing the HealthPartners TMD (temporomandibular disorders) integrated-care prototype.

> "If one of our champions is in your state, we would love for you to get to know them, work with them, think how you can support them."
>
> **Dr. Shenam Ticku**
> Assistant Professor at the Harvard School of Dental Medicine
>
> Discussing the 100 Million Mouths initiative, training and mentoring state-level oral-health champions to integrate oral health into primary-care education.



PANEL 3 | DESIGN | CONTINUED

"People are 99% at home, work and play, and spend 1% with a provider, right? Health outcomes are decided by what people do on their own between clinical visits. That's when we need to reach people."

Bob Gold

Founder and CEO of GoMo Health

Discussing a medical-dental integration program in New York that incorporates oral health into digital whole-person care for people with chronic conditions.

"If you look at all the specialties, vision, oral, brain, cardio, they all end in health. One of the major paradigm shifts that we're trying to incorporate in our professional setting is making sure that dental workers feel confident in saying that you are a part of a person's healthcare team. When you do that blood pressure screening, the person is more apt to follow up, because you care about them as a person."

Bianca Pressley

National Director of Quality Outcomes, Research, and Analytics at the American Heart Association

Discussing Healthy Smiles, Healthy Hearts, a medicaldental integration project focused on blood-pressure screening and cardiovascular risk identification in dental settings.





PANEL 4 | DEPLOY

Moving from Design to Deployment

These speakers helped move the group's thinking from dreaming and designing to deploying prototypes in the real world.

"Look, you've got a statutory exclusion for routine dental care. We're not going to argue about that. But it's for routine dental care. We asked what about nonroutine dental care? Does the statutory exclusion apply to non-routine care?"

Eric Berger
Executive Director of the Consortium for Medically Necessary Oral Health Coverage

Discussing the Consortium's policy and advocacy work with HHS/CMS to establish coverage for non-routine medically necessary dental care.

"Why couldn't we create an oral screening system that's part of the check-in process in primary care, that triggers an automatic referral all the time. It is absolutely possible."

Dr. Patricia Braun
Professor of Pediatrics and Public Health at Denver Health and the University of Colorado

Talking about the need to sustain integration by building it into measurable clinical systems and processes, touching on oral-health education in medical training, dental hygienists in medical settings, EHR screening/referral tools, and interoperable medical-dental systems.

"The continuum is clearly important, but so is continuity. I come from a background where we start all these wonderful initiatives, and then we go to something else, and we wonder why we don't have change. For me, this long game is about building resistance for persistence."

Dr. Joan Reede
Dean for Culture and Community Engagement at Harvard Medical School

Focusing on workforce development and leadership pipelines, including the importance of sustaining programs from concept through implementation, rather than continually abandoning them for new initiatives.

PANEL 4 | DEPLOY | CONTINUED

> “Don't let what you can't do stop you from doing what you can do, so I encourage all of you, as we're thinking about this, be bold. Walk in the rain, walk in the snow, walk in the heat of the day. Do it because you can, for as long as you can. Say no to the things that don't matter. Say yes to things that do, and if you fail, fail forward.”

Gary J. Pickard

Director of Government and Industry Affairs at PDS Health

Sharing PDS Health’s work on clinics where medical and dental care are integrated, emphasizing experimentation, taking risks, learning from failure, and identifying the “doers” who can move prototypes forward.



PANEL 5 | DEPLOY

Fireside Chat: How Do We Change the System?

During the final panel, speakers turned their attention to the work of systems change, from policy advocacy to storytelling and mobilization.

"We're making sure that we're all speaking the same language, and that our data is interoperable. Why do we need that? Because that's what underpins guidelines, and then guidelines will underpin practice. And that's how we make sure that it's sustainable, and it can continue to happen."

Dr. Jennifer Webster-Cyriaque
Interim Director, National Institute of Dental and Craniofacial Research

Discussing the role of research, data, and standardized evidence in establishing oral health as part of mainstream healthcare.

"I also came to understand the tensions that endure between the comparative public health, to deliver timely, routine services for care, to an entire population, and the imperatives of our largely private healthcare system to protect professional autonomy in the marketplace for services. And these tensions endure, and we're sitting here talking about addressing the conditions that hold the problems in place."

Mary Otto
Independent Journalist, The New Press

Speaking about storytelling and systems change, including the history of dentistry's separation from medicine and the role of the Deamonte Driver story in mobilizing policy and advocacy.

"We're dealing with a behavioral disease, a dietary disease and we're treating it like surgeons."

"What if we develop programs and endeavors that involved community health workers, and address high risk families, where they are in their homes, in their communities, in ways that help them change and sustain their behaviors."

Dr. Burt Edelstein
Founding Member, Berkshire Smiles LLC

Talking about reorienting dentistry around health outcomes and prevention.

PANEL 5 | DEPLOY | CONTINUED

> “I realized, for the first time, it's not what I want to sell; it's what they want to buy. That's what's going to work.”
>
> **Dr. Michael Glick**
> Fields Rayant Professor, University of Pennsylvania
>
> Speaking about positioning oral health within broader healthsystem priorities, emphasizing the need to connect oral health to outcomes that matter to policymakers, employers, health systems, and communities.

> "Most legislators are not neutral because they have carefully studied an issue like oral health and remain undecided. They are neutral because they do not yet know enough to have formed a position. They are looking for cues. Engaging those members and educating them is a key effective way to build additional support."
>
> **Dr. John Pournoor**
> Founder and President, Government Analytica, LLC
>
> Discussing policy advocacy and implementation strategy, focusing on identifying decision-makers, influencers, their interests, and who will actually execute each commitment.



From Alignment to Action

Dr. Zachary Brian, Santa Fe Group Fellow and Assistant Dean for Community Partnerships and External Affairs at the University of North Carolina Adams School of Dentistry, strategically analyzed the input from the workgroups and individual commitment cards to identify areas of alignment. This analysis informed the identification of strategic levers and network hubs. The following narrative includes the introduction to the guide.

Participant Emerging Network Connection Guide

Shared priorities, emerging network hubs, and direct pathways for connecting with convening peers.

This guide brings together three complementary streams of Convening input. Across 12 workgroups, participants identified Levers for Collective Action: systems, strategies, or enabling conditions they believed could accelerate progress. Workgroup momentum statements expressed the shared directions or outcomes groups wanted to carry forward. Individual commitment cards captured participants' proposed activities, the contributions they were prepared to make, and the partners, connections, or support they believed would help move the work forward. By cross-mapping these group-level and individual-level signals, the guide highlights where interests converged while distinguishing a workgroup's collective discussion from a participant's own stated commitment.

How to read the guide

Core alignment. The same hub appeared in the participant's workgroup levers, workgroup momentum statement, and individual commitment. This is the strongest starting point for outreach.

Direct alignment. The participant's own commitment supports the hub, although all three evidence streams did not match. This is still a meaningful individual connection.

Workgroup signal. No individual commitment card is on file; the person's workgroup discussed the hub.

Treat this as an invitation to explore, not as an individual endorsement.

Prepared August 2026

Five Emerging Network Hubs

The hubs are themed groupings rather than formal committees. They are intentionally interconnected, and participants may appear in several hubs when their commitments bridge multiple priorities. The core cohort includes the initial group of cross-sector partners who have participated in the process and will help advance the shared vision, goals, and commitments to engage and expand participation.

EMERGING NETWORK HUB

Workforce, Education & Literacy

Build the knowledge, roles, and learning systems needed to make oral health integral to whole-person health.

Alignment signal. 10 workgroups named this lever; 10 carried it into momentum statements; 48 participants expressed direct alignment, including 33 in the core cohort.

What connected participants. Education across audiences: Participants repeatedly connected professional education with public, employer, payer, and policymaker literacy. Interprofessional preparation: Redesigned curricula, continuing education, accreditation, and licensure were seen as practical routes to shared practice. Workforce capacity and scope: New roles, broader scopes of practice, and community-based training were linked to prevention, access, and integrated care. Shared language: A common oral-health vocabulary was treated as a prerequisite for referral, documentation, collaboration, and public understanding.

Practical first moves. Learning framework: Develop and share a practical oral-health-is-health curriculum spanning health professions and community settings. Standards and incentives: Advance continuing education, accreditation, licensure, and scope-of-practice approaches that reinforce integration. Peer learning network: Connect educators, workforce leaders, and prototype sites to exchange curricula, implementation lessons, and faculty resources.

EMERGING NETWORK HUB

Integrated Care Delivery Models

Move from parallel medical and dental systems toward coordinated, preventive, person-centered care.

Alignment signal. 6 workgroups named this lever; 9 carried it into momentum statements; 51 participants expressed direct alignment, including 18 in the core cohort.

What connected participants. Care at multiple entry points: Participants envisioned oral-health expertise in medical settings and whole-person prevention in dental settings. Scalable delivery models: FQHCs, school-based centers, hospitals, community settings, and integrated networks surfaced as promising platforms. Coordinated workflows: Referral, navigation, shared care planning, and team-based roles were central to making integration operational. Sustainable infrastructure: Payment, data exchange, workforce design, and community participation were consistently named as enabling conditions.

Practical first moves. Prototype portfolio: Connect leaders of existing models and select a small number of implementation-ready demonstrations. Implementation playbook: Document workflows, roles, financing, technology, and evaluation measures that can travel across sites. Cross-sector partnerships: Pair delivery organizations with payers, educators, community partners, and policymakers needed to scale.

EMERGING NETWORK HUB

Public Policy & Financing Reform

Align benefits, payment, regulation, and advocacy so oral health is supported as an essential part of health.

Alignment signal. 10 workgroups named this lever; 8 carried it into momentum statements; 44 participants expressed direct alignment, including 19 in the core cohort.

What connected participants. Coverage and essential benefits: Medicare, Medicaid, public and private benefits, and medically necessary dental care were recurring priorities. Payment reform: Participants emphasized incentives that reward prevention, integration, access, and measurable whole-person outcomes. A shared policy platform: A common, evidence-backed legislative agenda could concentrate the network's influence across organizations and states. Economic and public value: Medical cost savings, employer value, chronic-disease outcomes, and patient experience were named as persuasive policy evidence.

Practical first moves. Common agenda: Convene policy, payer, employer, provider, and consumer leaders to define a focused set of shared priorities. Evidence package: Assemble economic, clinical, equity, and implementation evidence that partners can use with decision-makers. Pilot-to-policy strategy: Link demonstrations to payment, benefit, billing-code, licensure, and regulatory pathways from the outset.

EMERGING NETWORK HUB

Data, Technology & Interoperability

Create the shared information infrastructure needed to coordinate care, measure outcomes, and build the case for change.

Alignment signal. 9 workgroups named this lever; 9 carried it into momentum statements; 50 participants expressed direct alignment, including 25 in the core cohort.

What connected participants. Medical-dental interoperability: Connecting EHR and dental records was the most consistent infrastructure ambition across workgroups. Common standards: Diagnostic codes, measures, terminology, and documentation practices were linked to care coordination and reimbursement. Patient access and agency: Participants emphasized that people should be able to access and share an understandable summary of their health information. Evidence generation: Linked data, analytics, research agendas, and evaluation were viewed as tools for improvement, financing reform, and policy change.

Practical first moves. Standards coalition: Connect clinicians, payers, vendors, researchers, and standards leaders around a limited set of actionable use cases. Demonstration exchange: Select pilot settings where shared records and diagnostic coding can be tested with clear outcomes and incentives. Shared measurement agenda: Align on measures and data questions that support care improvement, equity, economic evidence, and policy.

EMERGING NETWORK HUB

Narrative Change & Shared Vision

Build a common, audience-centered story that makes oral health inseparable from health, wellness, and longevity.

Alignment signal. 8 workgroups named this lever; 8 carried it into momentum statements; 51 participants expressed direct alignment, including 19 in the core cohort.

What connected participants. A unifying premise: 'Oral health is health' emerged as the clearest common frame across workgroups and individual commitments. Audience-specific value: Patients, clinicians, employers, payers, educators, and policymakers need distinct reasons to act within one shared story. Proof through stories and evidence: Successful prototypes, lived experience, chronic-disease outcomes, and economic value can make the narrative credible. Community-informed communication: Participants favored co-created messages that reflect community priorities and support political and institutional will.

Practical first moves. Message architecture: Develop a shared core narrative with tailored messages, proof points, and calls to action for priority audiences. Story and evidence bank: Gather participant examples, patient stories, prototype results, and reusable communications assets. Coordinated activation: Link communications leaders with policy, education, care-delivery, and data hubs so narrative supports concrete action.

> **Where bridge roles matter most:** Many commitments sit at the intersection of care delivery, financing, data, workforce, and narrative. Participants who span two or more hubs can help translate priorities, connect specialized groups, and keep emerging projects oriented toward shared outcomes.

Common cross-hub intersections

Workforce + care delivery. Education, scope, and team roles repeatedly appeared as the operating bridge from integration conceptsto daily practice.

Care delivery + financing. Prototype sites need payment, benefits, and incentives designed alongside workflows so promising modelscan move beyond pilots.

Data + policy. Interoperability,common measures, and economic evidence were repeatedly linked to reimbursement, regulation, andthe case for scale.

Narrative + every hub. A sharedoral-health-is-health story can give technical, clinical, educational, and policy work a common public purpose.

Prototypes

A starting point for hub design and action

During the convening, working groups submitted prototype ideas that addressed the different levers for systems change. These prototypes were at multiple stages of development — from initial ideas to working examples in the field that could be studied and replicated.

These prototypes have been included in a growing library of prototypes on the convening microsite. This library can serve as a valuable resource for the network and a jumping-off point for Appreciative Inquiry processes led by network hubs.

Explore the Prototypes Library





Interests and Commitments

Early signals of interest, capacity, and influence

Attendees were asked to fill out commitment cards, outlining how they will contribute to the emerging network. 71 individuals submitted cards at the event. These responses are preliminary. Commitments will change as the framework and network structure are clarified and additional people join. Still, they offer evidence of where the initial network is strong and where it may need to grow. Attendees could select multiple answers for each question, so percentages do not add up to 100%. The planning team has begun using this data to guide outreach, in order to strengthen areas where the network needs to increase interest, capacity, and influence.

Which system area(s) will you focus on?

Response	Selections	Percent
Workforce, Education & Professional Organizations	42	59%
Care Delivery Systems & Providers	35	49%
Data, Technology & Measurement	32	45%
Public Policy & Government	31	44%
People & Communities	30	42%
Financing & Funding	13	18%
Other	3	4%

What are you bringing to this lever?

Response	Selections	Percent
Interest - active participation	59	83%
Capacity - time, staff, or resources	44	62%
Influence - role, relationship, or platform	43	61%

How will you contribute?

Response	Selections	Percent
Direct implementation	38	54%
Network weaving	35	49%
Communications & storytelling	32	45%
Data, measurement & evaluation	25	35%
Administrative / backbone	15	21%
Fundraising & resource development	6	8%
Other	5	7%

The Financing Gap

Payment and financing reform were identified by working groups as critical to systems change. They are central to two key levers: Integrated Care Delivery and Financing Models and Public Policy Reform. Yet only 18% of those who filled out a commitment card selected financing as a personal focus. If this gap isn't proactively addressed - for example by bringing in financing experts, payers, and employers - even the most brilliant care delivery pilots will stall once initial grant funding runs out.

Imbalance Between Interest and Capacity/Influence

Most commitment card respondents report bringing interest to the work in their focus area (83%)while a smaller number say they can offer capacity (62%) and influence (61%). All three are necessary for success. The network will be strengthened if it can build connections between the interested and those with influence and capacity, and support capacity building where it is missing.

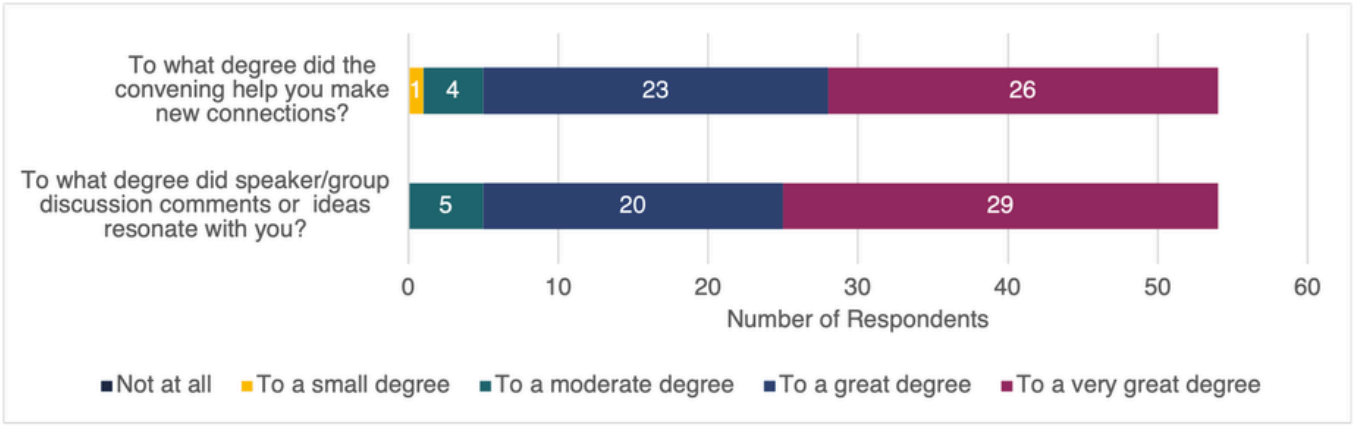
Range in Contribution Types

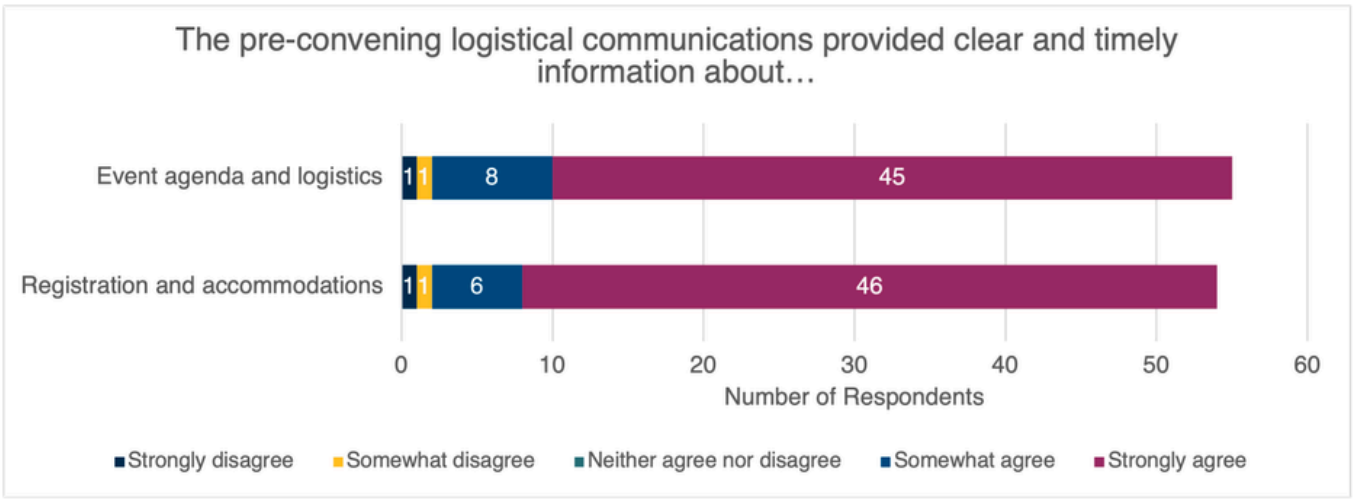
The network appears to be rich in individuals who are committed to direct implementation - creating change in practice and policy - as well as communications and storytelling and helping to weave together the network itself. On the other end of the spectrum, only 8% of respondents committed to helping to secure funding for the work, an essential area that will need bolstering if the network and its initiatives are to be sustained.

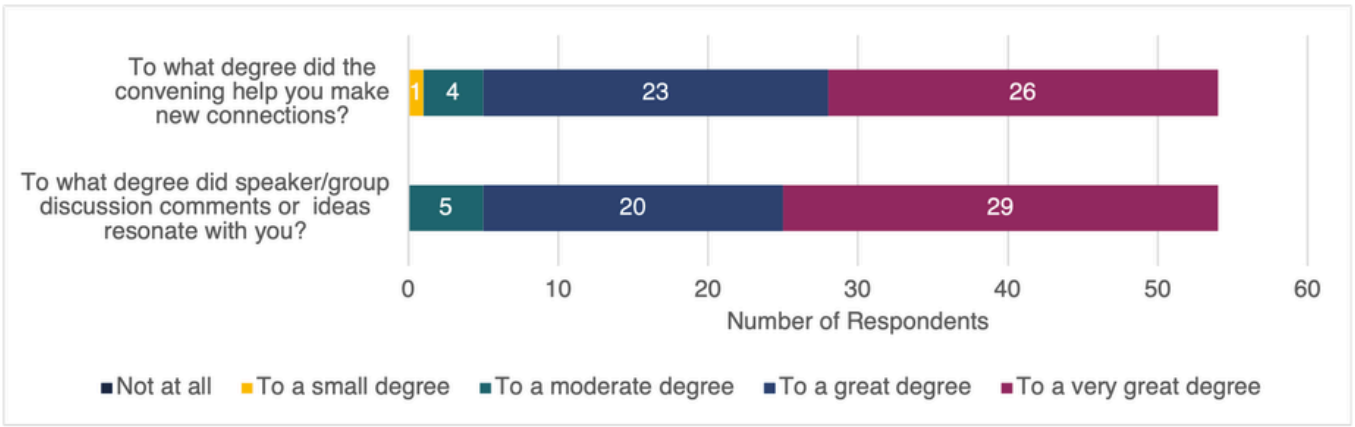
Post-Convening Survey Results

Participant reflections and outcomes

Fifty-five attendees filled out the post-Convening survey, which asked them to reflect on their experience and offer input into the development of the emerging consensus statement. Consensus statement input was used to develop the draft in this report. Below, we share the results of the other survey questions.







Network Representation

Respondents were asked to "identify the individuals, sectors, organizations, institutions, communities, and lived-experience perspectives that were not sufficiently represented at the convening but should be actively included in post-convening activities." The following is a summary of the 42 responses to this question, many of whom named multiple groups.

Non-Oral Health Organizations & Professionals (20 responses): Many respondents called for greater representation from medicine, nursing, primary care, and medical specialties including rheumatology, family medicine, diabetes, and other chronic-disease communities. They mentioned community health community health workers, social workers, vision, audiology, and other health professions.

Consumers & Community (12 responses): Respondents called for more participation from patients and community, including those with Medicaid dental coverage or special oral-health needs. They pointed to the importance of working with people with lived experience and patient advocacy groups.

Payers (12 responses): Respondents mentioned wanting to see a greater role played by insurance companies, benefit managers, and Medicare/Medicaid.

Policy Makers & Agencies (8 responses): Some respondents called for engagement with legislators and policymakers, as well as federal representatives/agencies and public-health leaders.

Dental (8 responses): Several respondents identified gaps in representation related to dentistry, including dental professionals earlier in their careers, dental hygienists, public-health dentistry, dentists practicing in the community, state dental associations, and organizations advocating for dental coverage.

Health Care Institutions (6 responses): Several also mentioned more involvement from hospitals, community health centers, and large medical systems, including institutions where medical-dental integration can be implemented.

Education & Emerging Professionals (6 responses): Other suggestions included more health-professions educators, academic health-center leaders, community colleges, students, and emerging leaders. One respondent emphasized the role of research and scholarship.

Private Companies & Employers (5 responses): A few respondents mentioned representation from Electronic Health Records companies, health-care technology companies, and industry more broadly. Two named large employers and those purchasing dental insurance, including HR departments.

Media, PR, and Communications (4 responses): Communications professionals were mentioned by a few respondents, including advertising experts, specialists in health care marketing, media, and groups focused on messaging about health policy to younger generations.

Reflections

The survey asked attendees share reflections about their experiences at the convening. There were 34 substantive responses. Several touched on more than one theme, so the counts below exceed the number of responses.

Positive experience, energy, and inspiration (23 responses)

Most respondents were highly positive about the convening. They described it as excellent, energizing, inspiring, well organized, purposeful, and solutions-focused. Several emphasized the palpable collective energy, passion, hope, and commitment to improving oral and overall health.

Networking, relationships, and cross-sector exchange (17 responses)

Many respondents said a major benefit was the opportunity to meet new people, reconnect with colleagues, hear different perspectives, and get out of professional silos. Respondents particularly valued the diversity of professions and perspectives and the chance to learn about other sectors' challenges and experiences. A couple respondents suggested the need for more time to make connections and solidify next steps, and for the inclusion of groups who were not represented.

Small-group discussions and participation (7 responses)

The small-group, breakout format was repeatedly praised for creating productive conversations, bringing diverse perspectives into the room, and allowing participants to share experiences and ideas.

Energy into action (8 responses)

A recurring concern was that the convening needs to translate its energy, relationships, and ideas into concrete action. Suggestions included bringing the group to policymakers, defining next steps for partnerships, creating a set of pilots, matching programs with potential solutions, and coalescing a centralized group that can strengthen efforts instead of competing for resources. One noted that the aspirations of the group are “exceptional but not necessarily realistic.”

Organization and Format (5 responses)

Respondents praised the planning, facilitation, sequencing, panels, and purposeful engagement. A few suggestions for improvement included reducing presentations of initiatives that were difficult to scale and creating more equitable ways to participate in the open discussions, without a small set of voices dominating.

Visual Notetaking

Live illustration and visual storytelling

Collective Next joined the Convening as graphic facilitators, documenting panels and discussions through live illustration and visual storytelling. Below is the complete set of artifacts in chronological order. These visuals provide a complementary record of how participants framed the problem, identified opportunities, and moved from discussion toward action.

WELCOME



FROM THE LIVE RECORDING

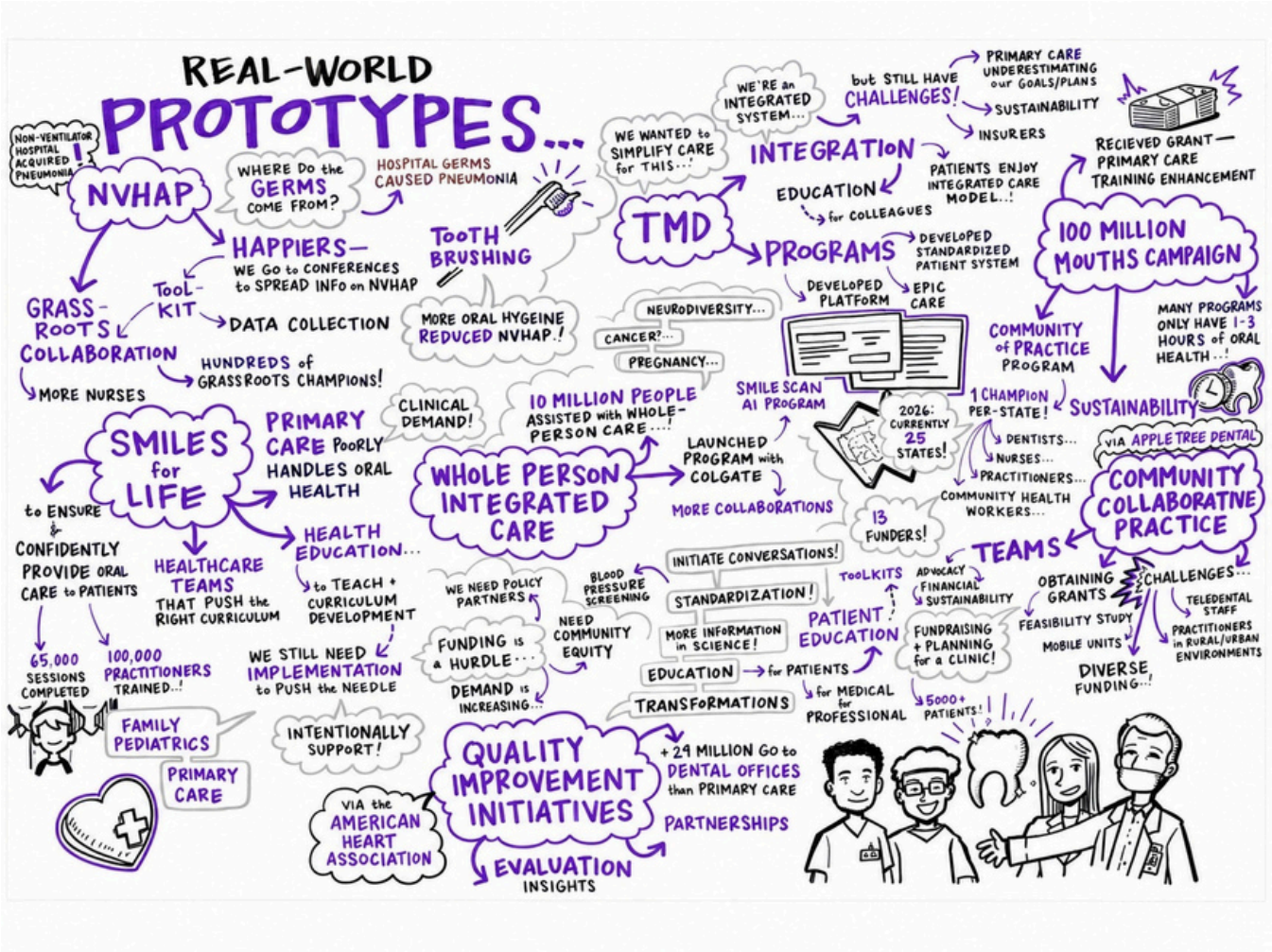
“This is a convening, not a conference. Your participation is critical!”

Ideas in Practice

Real-world prototypes

This illustration captures examples of oral and general health integration, alongside the partnerships, education, funding, and implementation needed to move them forward.

REAL-WORLD PROTOTYPES



Live graphic recording by Collective Next

FROM THE LIVE RECORDING

> **“We still need implementation to push the needle.”**

Integration · Collaboration · Implementation

Commitments to action

Deploying the work

The closing action-oriented illustration connects commitments to policy, medical education, broader teams, and the next generation of leaders.

DEPLOYING THE WORK



Live graphic recording by Collective Next

FROM THE LIVE RECORDING

> **“We can shape policy!”**

Commitments · Leadership · Persistence

Proposed Evaluation Protocol

Additional components of the proposed evaluation protocol

The Santa Fe Group gathered initial input on evaluation considerations from convening members and experts to propose an initial monitoring and evaluation protocol for assessing the network's early phase. The following section outlines additional elements of the proposed protocol: how equity and accountability underpin the approach; illustrative data collection and analysis activities; longer-term evaluation considerations; and a proposed learning agenda to accompany the evaluation framework.

Cross Cutting Equity Lens

The evaluation protocol is informed by a cross cutting equity lens. The primary way the lens is operationalized is that each relevant evaluation question will examine who participates, who is missing, whose priorities influence decisions, how community and patient perspectives shape the work, and how benefits, resources, and decision-making power are distributed. Findings will be disaggregated by participant demographics, stakeholder type, sector, geography, hub, community role, and level or duration of participation, when feasible and appropriate.

Integrating accountability

In line with the collective action approach to the network, the proposed protocol would ask participating organizations to report progress, share learning, and contribute to shared accountability. Additionally, throughout the phases of network development, data collection will be integrated into existing activities to use time and resources efficiently while reinforcing shared accountability.

Initial Monitoring and Evaluation Activities

Early stage data collection and analysis approaches include the continued use of surveys to gain insights from network participants, as well as targeted focus group discussions and engagement with hub leaders and other organizations operating in our ecosystem. Methods will be adapted as the network infrastructure develops.

Longer-term Evaluation Considerations

Beyond the scope of this initial protocol, but nevertheless important to consider, future evaluation questions will examine the hubs and other network components' continued development and contributions to systems change outcomes, drawing on methodologies such as Contribution Analysis and Most Significant Change, as appropriate.

Learning Agenda

To complement the evaluation processes, a shared learning agenda is proposed to guide longer-term strategic considerations to strengthen programming and contribute to broader learning. An initial set of questions is proposed below. Learning activities will be developed alongside development of the hubs and other core network infrastructure.

01 Which strategies and tactics for hub development are working well and replicable in other hubs?

02 Under what conditions, and through what mechanisms, does a collective action network contribute to systems change?

03 What can we learn about the effectiveness of a think tank leading engagement to build momentum and launch a movement?

04 Are our network building efforts prompting movement towards systems transformation? Why or why not?

05 How does the emerging network complement and partner with other networks?

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