RESEARCH BRIEF ■ INFORMING PUBLIC HEALTH

Number 34 ■ June 2025

Oral Medical Care Coordination in the United States: Definitions, Opportunities, and Barriers to Implementation

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Introduction

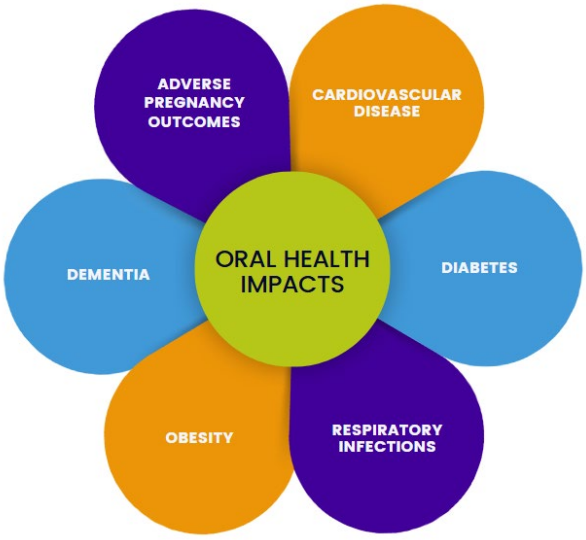
The coordination of oral and medical health* services offer a potentially transformative approach to holistic health care, reflecting truly patient-centered care that addresses both the mouth and body.[1] Historically, oral and medical health care providers (providers hereafter) have operated independently, leading to fragmented care that often overlooks the critical connections between oral health and overall physical well-being. In this research brief, we introduce the evidence base for oral medical care coordination and discuss why it matters. In subsequent briefs, we describe the key findings of a systematic literature review on this topic and offer an organized framework to move integrated care forward toward widespread implementation (see research briefs 35-39 in this series).

Oral and medical health care is fragmented

Oral and medical health care professionals have historically provided separate care to patients (e.g., oral health professionals provide oral health and dental care; medical professionals provide medical care). But this separation has increasingly substantial implications for patient health outcomes. Poor oral health contributes to a range of systemic conditions, including cardiovascular disease, diabetes,

* In this brief, we use the term oral health care to describe care of the teeth, gums, and soft tissue in the mouth, and dental care to refer to care of teeth and gums.

Figure 1. Oral health impacts



respiratory infections, and adverse pregnancy outcomes, among others (see Figure 1).[2–7] Likewise, many chronic diseases manifest with oral health symptoms.[8–10] Despite this well-documented interrelationship, patients often receive disjointed care, with limited communication and coordination between their oral and medical health providers.[11–14]

Several factors underscore the urgency for oral medical care coordination. Demographic changes, such as an aging population, and increasing prevalence of chronic diseases would be addressed more thoroughly with more comprehensive care models.[15–21] Disparities in access to both oral and medical health care persist, particularly among low-income and minority populations.[22–28] Coordinating oral and medical health services can potentially ameliorate disparities by decreasing the number of office visits for patients and ensuring coordinated information on oral and physical health for a broader picture of overall well-being. Recognizing the potential benefits, successful models of coordination are starting to emerge and inform the future (see research briefs 36-39 in this series).[29]

Barriers to oral medical care coordination

Implementing effective oral medical care coordination involves overcoming significant challenges and barriers:

- Lack of provider and patient awareness about the importance of oral medical care coordination
- Limited cross-disciplinary professional education between oral health and medical providers, and siloed educational models about care that address both the mouth and the body
- Poor technological integration between oral and medical health records
- Limited financial reimbursement for oral health care in medical settings, and vice versa
- Policy barriers

We discuss each barrier in turn below.

Despite the growing recognition of the interconnectedness between oral health and overall health, there remains a significant **gap in awareness among both providers and the general public** about the importance of oral medical care coordination.[30–32] This lack of awareness contributes to fragmented care and missed opportunities for early detection and management of chronic diseases that manifest with oral health symptoms. For example, a large systematic review of oral health issues among patients with diabetes found that the patients had limited oral health knowledge despite substantially higher risk of gum disease, tooth decay, and oral infection. However, patients that received oral health information showed fewer oral health sequelae.[33,34]

While oral health and medical providers are well trained in their specific disciplines, neither discipline focuses on the coordination nor the overlap between the two fields. Thus, **limited cross-discipline professional education**, combined with insufficient awareness of the benefits of oral medical care coordination, often leaves providers working in silos,[13,31] and lacking an appreciation of how they can

work together to enhance overall patient care. These educational gaps limit collaboration, hinder the development of the shared understanding that is essential for integrated care and optimal patient outcomes, and result in inadequate coordination between oral and medical health care providers.[35–38] The missed opportunities are quantifiable: for example, roughly 27 million people in the U.S. visit a dentist, but not a physician, annually.[39] If oral health providers screened for chronic disease risk factors (e.g., hypertension, prediabetes, and elevated hemoglobin A1C), annual U.S. health care costs could be reduced by $102.6 million.[39] Likewise, about 109 million Americans visit a medical provider but not a dentist each year.[40] This also increases costs: for example, when patients with periodontal disease receive appropriate oral health care it reduces their medical costs for conditions like type 2 diabetes or cardiovascular disease.[41]

The **lack of coordination between oral health and medical technological systems**, including electronic health records (EHRs), prevents oral health care providers from accessing medical records and primary care doctors from accessing oral health records, perpetuating fragmented care.[13,42] When providers cannot consider the full spectrum of a patient's health, they can miss critical connections, leading to misdiagnoses or incomplete treatment plans. The absence of combined EHRs also hinders the efficient sharing of patient information, making it challenging for providers to collaborate effectively. Lack of coordination also increases redundancies and administrative burden, while compromising continuity of care that is crucial for managing chronic conditions and improving outcomes.

There is limited reimbursement for oral health care in medical settings, and vice versa. Current fee-for-service payment models create barriers to coordinated care by incentivizing volume over value.[13,43] These payment models focus on the quantity of services that health care providers offer rather than the quality or outcome of those services, making it financially challenging for providers to adopt coordinated practice models. Without transitioning to value-based care models that reward providers for achieving positive health outcomes, the uptake of integrated care practices will remain limited. Value-based care models encourage preventive care and coordinated management of chronic conditions, which can lead to both cost savings and better outcomes. However, existing financial structures discourage these practices.

Finally, **policy barriers** impede the successful coordination of oral and medical health services, exacerbating systemic and financial challenges. Legislative action is necessary to expand insurance coverage to include more comprehensive preventive oral health services and to standardize reimbursement rates across states.[13] Without such policies, coordinated care remains financially unviable for many providers. In addition, the absence of uniform billing codes for oral and medical health services complicates the reimbursement process and increases administrative burdens, discouraging providers from adopting integrated care models. Moreover, restrictive scope-of-practice laws for dental hygienists and midlevel medical providers (e.g. nurse practitioners) limits their ability to deliver preventive services in integrated care settings.

Conclusion

Oral medical care coordination would improve public health and make the health care system more effective and efficient, resulting in improved quality of life for myriad patients. The benefits of true oral medical care coordination are vast, including earlier identification of disease, cost savings, and improved health outcomes. However, numerous barriers impede the adoption of these models – and they are substantial barriers indeed.

Enumerating and describing the specific challenges faced by oral medical care coordination is the first step toward fundamental change. Thus, subsequent briefs in this series describe what oral medical care coordination looks like in the United States (see research brief 35 in this series) and present an

organized framework for meaningful oral medical care coordination (see research briefs 36-39 in this series). Taken together, the six briefs in the series provide an evidence-based road map for the future of oral medical care in the United States, with concrete next steps to making coordination a reality.

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Acknowledgements

The National Association of Chronic Disease Directors (NACDD) received funding from the Centers for Disease Control and Prevention (CDC) Division of Oral Health (DOH) for the Medical-Dental Integration (MDI) project (award number 5-NU38OT000286-03, CFDA number 93.421). NACDD contracted with KDH Research & Communication (KDHRC) to assist NACDD.

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