MDForLives

THE GLOBAL PULSE OF HEALTHCARE · DENTISTRY INSIGHT REPORT

Oral-Systemic Care: Why Dental-Medical Coordination Still Breaks Down

A detailed view of how dentists connect periodontal and systemic risk, how chairside screening turns into medical referral, why records and reimbursement still interrupt collaboration, how prepared dentists feel for co-management, and which care models could make oral-systemic coordination more routine.

Screening → Referral → Shared Information → Coordinated Care

69	6	82.6%
Survey records	Countries represented USA · UK · Canada · Italy · France · Germany	Completion rate

WHY THIS REPORT

Dentists are increasingly asked to recognize systemic risk, but recognition only helps when the medical-dental handoff works

The oral cavity is not clinically separate from the rest of the patient. Diabetes can influence periodontal risk and healing, blood pressure can affect dental treatment decisions, medications can alter oral tissues and procedural risk, and planned medical therapies may require dental evaluation before they proceed. American Dental Association evidence reviews treat these connections as part of contemporary dental practice while also emphasizing that associations should not be presented as causation when the evidence does not support it.

The health-system direction is also moving toward integration. WHO's Global strategy and action plan on oral health 2023-2030 calls for stronger integration of oral health into broader health and noncommunicable-disease strategies. In 2025, an FDI consensus initiative highlighted the need to bring core oral-health indicators into electronic health records, while the ADA has continued to push for standards and policy that make dental-medical data exchange more practical. The ADA Dental Quality Alliance's 2026 measure for adults with diabetes also treats oral evaluation as a measurable component of care for people living with diabetes.

The MDForLives survey examines what that integration looks like from the dentist's perspective. It asks which systemic condition feels most clinically important, what non-dental screening is routine, how often dentists refer to physicians, how often physicians refer back to dentistry, what technology and payment barriers interfere, whether dental training feels adequate for co-management, and which future care model is most likely to bridge the two professions.

The respondent profile matters when interpreting those workflow questions. The largest practice-setting group is solo private general practice at 46.7%, followed by group private practice or DSO settings at 21.7%. Academic or hospital-based dental clinics account for 11.7%, and community health centers and specialty private practice each account for 10.0%. The survey does not test whether practice setting causes any particular barrier, but it shows that proposed integration models must be workable across very different operating environments.

> **Methodology and data note.** Audience: dentists. SGID 8957344. The source report contains 69 survey records, an 82.6% completion rate, and records from the USA, UK, Canada, Italy, France, and Germany. Public quantitative item bases were 60 for practice setting and systemic-condition priority, and 58 for subsequent quantitative items. The hidden country-punching item is used only for geography metadata. Administrative tracking, bad-ID, required-text, after-question, and honeypot fields are excluded from interpretation.

EXECUTIVE SUMMARY

Six signals that explain why oral-systemic care is clinically familiar but operationally fragmented

INSIGHT 01

Diabetes is the clearest clinical anchor

65.0% identify diabetes as the systemic condition where periodontitis and oral inflammation are most clinically critical.

INSIGHT 02

Vital-sign screening is common, but not universal

48.3% report blood pressure and pulse screening at every routine adult visit.

INSIGHT 03

Formal medical referral is a recurring workflow

44.8% generate formal outbound referrals one to three times per month.

INSIGHT 04

Manual record exchange is the digital pain point

37.9% name time and staffing needed to fax, call, or email records as the primary technology barrier.

INSIGHT 05

Coordination work lacks a clear payment path

32.8% identify lack of dedicated reimbursement for consultation and care coordination as the leading financial obstacle.

INSIGHT 06

Interoperable EHRs lead the future model

41.4% believe shared, interoperable records would most effectively bridge dentistry and medicine.

01

PRACTICE CONTEXT

The coordination challenge has to work in solo practices, not only integrated health systems

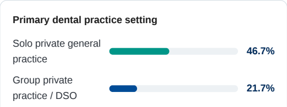
46.7% of respondents practice in solo private general practice, while 21.7% work in group private practice or DSO settings.

CONTEXT

Medical-dental integration is often easiest to picture inside a hospital, academic center, or co-located health system. Much of dentistry, however, is delivered in independent or smaller private-practice environments where the dentist may not share an electronic record, care coordinator, or administrative infrastructure with the patient's medical team.

WHAT THE DATA SHOWS

Solo private general practice is the largest practice-setting group at 46.7%. Group private practice or DSO settings account for 21.7%, academic or hospital-based dental clinics 11.7%, community health centers 10.0%, and specialty private practices 10.0%. These figures describe the respondent mix; they are not a comparison of performance by practice setting.

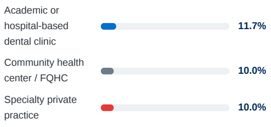


THE INSIGHT

The practice profile changes how the rest of the survey should be read. A coordination model that depends on dedicated staff, shared enterprise software, or informal proximity to physicians may be workable in one setting and unrealistic in another. The survey does not test barriers by practice type, so that relationship should not be assumed, but the diversity of settings makes portability a core design requirement.

WHY IT MATTERS

If oral-systemic care is expected to become routine, the handoff must work for a solo dentist as well as for a health-system clinic. That favors approaches that reduce manual work, make medical information easier to access, clarify referral responsibility, and create a viable way to pay for coordination without requiring every dental practice to become part of a large medical organization.



02

CLINICAL PRIORITY

Diabetes is the oral-systemic connection dentists see as most clinically actionable

65.0% identify diabetes mellitus as the systemic condition where periodontitis and oral inflammation play the most clinically critical role in altering patient outcomes.

CONTEXT

Dentists encounter diabetes through several pathways at once: periodontal inflammation, healing, infection risk, medication review, nutrition, and conversations about glycemic control. The American Dental Association describes diabetes and periodontal disease as having a bidirectional relationship, with hyperglycemia affecting oral health and periodontitis potentially affecting glycemic control. The ADA Dental Quality Alliance's 2026 Adults with Diabetes - Oral Evaluation measure also uses receipt of an oral evaluation as a quality measure for adults with diabetes, reinforcing the practical relevance of the medical-dental connection.

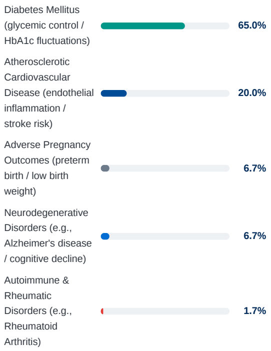
WHAT THE DATA SHOWS

Diabetes mellitus leads by a wide margin at 65.0%. Atherosclerotic cardiovascular disease follows at 20.0%. Adverse pregnancy outcomes and neurodegenerative disorders each account for 6.7%, and autoimmune or rheumatic disorders 1.7%. The hierarchy shows where respondents feel oral inflammation is most clinically consequential, not which systemic diseases have the greatest population burden.

THE INSIGHT

The large diabetes lead suggests that dentists are most comfortable acting on oral-systemic connections when the clinical pathway is well recognized and relevant to routine periodontal decision-making. Cardiovascular disease remains important, but the ADA notes that association between periodontitis and cardiovascular disease does not establish causation. The distinction helps keep oral-systemic care evidence-based rather than promotional.

Systemic condition seen as most clinically affected by periodontitis and oral inflammation



WHY IT MATTERS

For dental teams, diabetes offers a practical model for broader integration: identify risk, document the oral finding, understand the medical context, communicate when control or healing risk is concerning, and avoid making claims beyond the evidence. A reliable workflow around diabetes can become a template for other conditions where dental treatment, systemic disease, and medication decisions intersect.

03

CHAIRSIDE SCREENING

Routine dental visits often include systemic-health screening, but the depth of that screening varies sharply

48.3% report blood pressure and pulse screening at every routine adult visit, while 37.9% rely on medical-history update only.

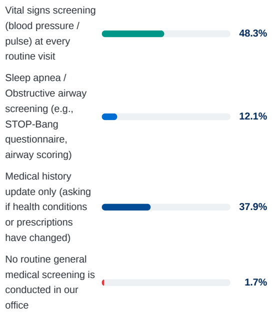
CONTEXT

A dental appointment already requires assessment of medical history, current medications, allergies, treatment risk, and the patient's ability to tolerate planned care. Adding a vital sign such as blood pressure can turn that history review into an active screening moment. The ADA identifies blood pressure measurement as an important screening vital sign in dental care and notes its potential to detect previously unrecognized or poorly controlled hypertension.

WHAT THE DATA SHOWS

Vital signs screening leads at 48.3%. Medical-history update only follows at 37.9%. Sleep apnea or obstructive airway screening is routine for 12.1%, and 1.7% report no routine general medical screening. The data therefore shows that almost every respondent performs some systemic-health review, but the clinical intensity of that review differs considerably.

Non-dental health screening routinely performed during adult hygiene or diagnostic examinations



THE INSIGHT

The difference is not simply between practices that care about systemic health and practices that do not. It is a workflow-design difference. Some practices collect an objective physiologic measure at every visit; others use the medical history as the main filter and may add screening only when the history or planned procedure raises concern.

WHY IT MATTERS

Screening matters only when the dental team knows what to do next. For blood pressure, that means consistent measurement technique, repeat readings when needed, documentation, thresholds for modifying or deferring care, and a clear referral route when medical assessment is warranted. Adding more screening tools without an action pathway could increase workload without improving coordination.

04

OUTBOUND REFERRAL

Dentists are sending patients back into medical care, but the referral process is not equally formal in every practice

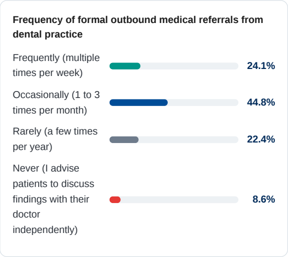
44.8% generate a formal outbound medical referral one to three times per month, and 24.1% do so multiple times per week.

CONTEXT

A chairside finding becomes a medical-dental coordination event only when information moves beyond the operatory. That may be a blood pressure concern, glycemic risk, medication interaction, healing issue, suspected sleep-disordered breathing, or a question requiring medical clearance. The dentist then has to decide whether to document a formal referral, call a physician, send records, or ask the patient to raise the issue independently.

WHAT THE DATA SHOWS

The most common pattern is occasional formal referral, one to three times per month, at 44.8%. Frequent referral multiple times per week is reported by 24.1%. Another 22.4% refer only a few times per year. The final 8.6% do not generate formal referrals and instead advise patients to discuss findings with their doctor independently.



Frequency of formal outbound medical referrals from dental practice

THE INSIGHT

The spread suggests that oral-systemic concerns are common enough to generate recurrent medical handoffs, but formalization varies. The patient-mediated model is the least integrated because it transfers responsibility for explaining the finding, reaching the right clinician, and closing the loop to the patient. Even when appropriate, that approach creates more opportunities for information loss.

WHY IT MATTERS

For dentists, a formal referral should ideally carry the specific concern, the relevant dental finding, urgency, and the question being asked of the medical clinician. The value comes from making the medical decision easier to understand and returning the answer to the dental record so treatment planning can proceed with shared information rather than assumptions.

05

INBOUND REFERRAL

Medical-to-dental collaboration is most visible around specific procedures, not as a routine stream of shared care

41.4% receive referrals selectively, especially before joint replacement, cardiac valve surgery, or bisphosphonate therapy.

CONTEXT

Medical referral into dentistry often becomes most explicit when the oral condition could delay, complicate, or change a planned medical intervention. Dental clearance before selected surgeries or antiresorptive therapy is a familiar example because both sides of the care pathway recognize a concrete risk and a time-sensitive decision.

WHAT THE DATA SHOWS

Selective referral is the leading pattern at 41.4%. Another 34.5% say medical providers in their area rarely initiate oral-health referrals. Routine referral from local medical providers is reported by 19.0%, and 5.2% say they never receive such referrals. The strongest medical-dental linkage is therefore event-driven rather than continuous.

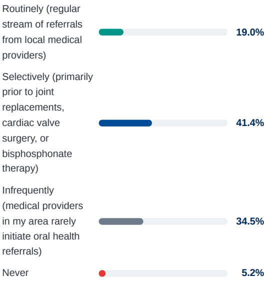
THE INSIGHT

The asymmetry between outbound and inbound patterns matters. Dentists report recurrent reasons to send patients into medical care, yet routine medical-to-dental referral remains relatively uncommon. This may reflect the historical separation of dental and medical systems, different reimbursement structures, limited shared records, or uncertainty among medical teams about when an oral-health referral changes management.

WHY IT MATTERS

The policy environment is beginning to move toward greater integration in some markets. In the United States, CMS added a 2026 MIPS improvement activity for integrating oral health in primary care, including oral-health risk assessment, screening, education, referral, and creation of dental referral networks. That does not solve the dentist-side workflow, but it signals that medical referral into oral care is increasingly being treated as part of broader health-system quality work.

Frequency of physician or specialist referral for oral or periodontal clearance



06

TECHNOLOGY AND WORKFLOW

The most important digital barrier is the human work created by disconnected systems

37.9% say time constraints and lack of staff to manually fax, call, or email records are the primary technological barrier.

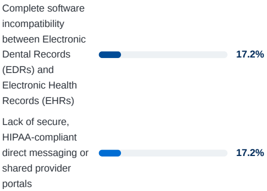
CONTEXT

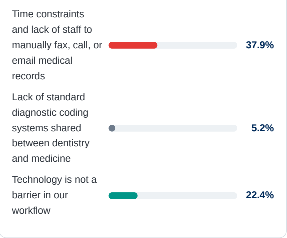
Digital integration is often discussed as a software problem, but the daily burden appears in tasks: locating a physician, finding the right fax number or portal, preparing records, sending them securely, confirming receipt, and tracking a response. A system can be electronically documented and still be operationally fragmented if these steps require manual work every time.

WHAT THE DATA SHOWS

Manual record exchange driven by time and staffing constraints leads at 37.9%. Complete incompatibility between dental and medical record systems and lack of secure direct messaging each account for 17.2%. Lack of shared diagnostic coding systems accounts for 5.2%. At the same time, 22.4% say technology is not a barrier in their workflow, showing that the coordination problem is not uniform.

Primary technological barrier to medical-dental care coordination





THE INSIGHT

The leading answer reframes interoperability as a workforce issue. When data cannot move in a structured, reliable way, practices absorb the gap through administrative labor. A 2025 review of EHRs in dentistry similarly describes uneven integration of dental information into broader health systems and emphasizes common standards, secure exchange, and interoperable workflows. FDI has also called for oral-health indicators to be included in integrated health records.

WHY IT MATTERS

For dental practices, the most useful technology is the technology that shortens the handoff. Shared medication lists, relevant diagnoses, periodontal status, allergies, referral status, and secure messaging can reduce duplication only if the information is accessible in the workflow clinicians already use. Otherwise digital fragmentation can simply replace one manual task with another.

07

FINANCIAL AND ADMINISTRATIVE BARRIER

The economics of coordination remain poorly aligned with the work dentists are being asked to do

32.8% identify lack of dedicated reimbursement for interprofessional consultation and care coordination time as the greatest obstacle.

CONTEXT

Expanded oral-systemic care can add activities that do not look like a conventional procedure: chairside screening, interpretation, documentation, contacting a physician, reviewing returned information, coordinating timing, and counseling a patient about why medical follow-up is needed. Whether those tasks fit existing payment systems varies by market, payer, scope of practice, and service.

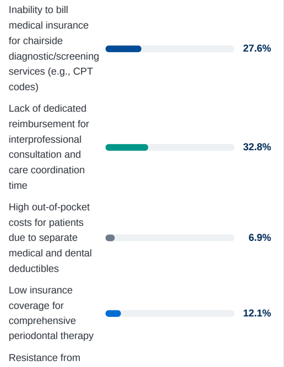
WHAT THE DATA SHOWS

Lack of dedicated reimbursement for interprofessional consultation and coordination is the leading obstacle at 32.8%. Inability to bill medical insurance for chairside diagnostic or screening services follows at 27.6%. Patient resistance to paying out of pocket for non-traditional dental services is 20.7%, low insurance coverage for comprehensive periodontal therapy 12.1%, and separate medical and dental deductibles 6.9%.

THE INSIGHT

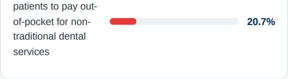
The two largest answers both concern payment for work that sits between traditional dental and medical benefit structures. Respondents are not only describing the patient's ability to afford treatment. They are describing whether the system financially recognizes screening and coordination as legitimate parts of dental care.

Greatest financial or administrative obstacle to expanded screening and coordination



WHY IT MATTERS

WHO's global oral health action plan explicitly links oral-health integration with primary health care, universal health coverage, and financial protection. The survey shows why that matters at practice level: a coordination model can be clinically sensible and still remain fragile if every referral, consultation, or screening step depends on uncompensated time or an uncertain billing pathway.



08

EDUCATION AND CO-MANAGEMENT

Most dentists feel prepared enough to recognize complexity, but not fully prepared for routine interprofessional co-management

53.4% describe themselves as moderately prepared, compared with 31.0% fully prepared and 15.5% slightly prepared.

CONTEXT

Dental education necessarily includes medical sciences, pharmacology, pathology, emergency management, and the systemic conditions that alter dental care. The harder skill is interprofessional co-management: deciding what information a physician needs, interpreting medical input, coordinating treatment timing, and working across different documentation and accountability systems.

WHAT THE DATA SHOWS

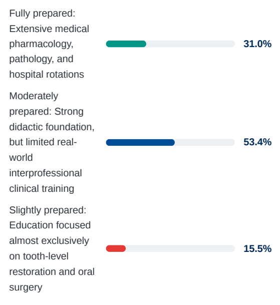
A majority, 53.4%, say they have a strong didactic foundation but limited real-world interprofessional clinical training. Another 31.0% feel fully prepared through extensive medical pharmacology, pathology, and hospital rotations. The remaining 15.5% describe education focused almost exclusively on tooth-level restoration and oral surgery.

THE INSIGHT

The center of gravity is not lack of knowledge. It is incomplete translation of knowledge into shared-care practice. Dentists may understand that diabetes, hypertension, pregnancy, medications, or cardiovascular disease matter, yet still have limited experience navigating a live physician-dentist handoff, especially outside hospital or academic settings.

WHY IT MATTERS

Training that mirrors actual coordination work may be more useful than adding another lecture. Case-based exercises can focus on referral wording, medical clearance questions, medication reconciliation, blood pressure management, treatment modification, documentation, and closing the loop. The survey's practice-setting mix, including 46.7% in solo private general practice, also suggests that interprofessional skills must be usable beyond large integrated institutions.


Preparedness to co-manage complex medical conditions alongside physicians

09

FUTURE CARE MODEL

Dentists favor shared information and aligned coverage over simply moving dentistry into the medical building

41.4% choose interoperable EHR systems as the care model most likely to bridge dentistry and medicine over the next five to ten years.

CONTEXT

The future of medical-dental integration can be imagined in several ways: co-locating services, expanding scope, using teleconsultation, integrating insurance, or connecting records. Each model solves a different problem. Co-location changes physical access. Telehealth changes communication. Coverage changes financial incentives. Interoperability changes the information available at the moment of care.

WHAT THE DATA SHOWS

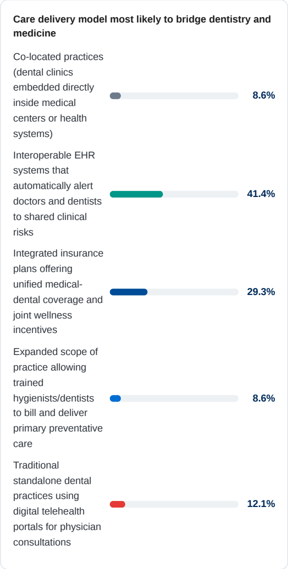
Interoperable EHR systems lead at 41.4%. Integrated insurance plans with unified medical-dental coverage and joint wellness incentives follow at 29.3%. Traditional standalone dental practices using telehealth portals account for 12.1%. Co-located practices and expanded scope of practice each account for 8.6%.

THE INSIGHT

Respondents appear to prefer integration that can reach many practice settings rather than a model dependent on physical co-location. That is consistent with a distributed dental system in which solo practices, groups, hospitals, community centers, and specialists all need to communicate with medicine. Shared information can travel across those settings in a way that co-location cannot.

WHY IT MATTERS

The preference also aligns with WHO's digital-health and primary-care integration direction and recent FDI work on integrated EHRs. But data exchange alone will not resolve reimbursement, training, referral ownership, or patient follow-through. The likely end state is therefore not one technology. It is a coordinated operating model in which interoperable records, aligned coverage, clear referral pathways, and professional roles reinforce one another.



Care delivery model most likely to bridge dentistry and medicine

OPEN-ENDED PERSPECTIVE

When dentists describe the reform they need most, the recurring request is for a healthcare system that stops making oral-systemic care a workaround.

The open-ended item asked respondents for the single most critical reform needed in healthcare policy or medical-dental practice to make oral-systemic healthcare a standard reality. The source PDF displays 20 response entries. The answers vary in specificity and language, and one response is not interpretable, so the themes are summarized qualitatively without percentages.

Communication and linked records

Several respondents call for better physician-dentist communication, linked EHRs, or integrated records that allow relevant patient information to move across settings without manual reconstruction.

Insurance and reimbursement reform

Coverage, dental insurance design, reimbursement limits, and payment for testing or coordination appear repeatedly. The comments describe financing as a practical determinant of whether broader care can be delivered.

Medical-dental system integration

Some respondents go beyond a single billing change and call for

Education, awareness, and protocols

Patient education, professional awareness, physician broader healthcare reform, medical-dental coverage integration, or greater recognition of dentistry inside the health system.

receptiveness, and more uniform protocols are also raised, suggesting that infrastructure alone will not replace shared expectations and clear clinical rules.

> **What the qualitative responses add:** The quantitative results identify EHRs and reimbursement as leading structural priorities. The open-ended comments show why those priorities matter: dentists want fewer disconnected handoffs, less administrative friction, clearer coverage, stronger collaboration with medical colleagues, and more consistent expectations about who should act on oral-systemic risk.

DENTAL INTEGRATION LENS

What a more workable oral-systemic pathway could look like in everyday dental practice

The survey does not define one universal protocol. It does identify the points where coordination repeatedly becomes fragile: screening, referral, records, payment, and shared clinical responsibility.

1 · Screen with an action threshold

Collecting a vital sign or systemic-health history should connect to a defined response. **Document what triggers repeat measurement, treatment modification, medical consultation, or urgent referral.**

2 · Make referrals closed-loop

A referral should state the dental concern, urgency, and clinical question. **Build a way to confirm receipt and return the medical response to the dental record before key treatment decisions.**

3 · Use interoperability to remove manual work

Shared records are valuable when they reduce faxing, phone calls, duplicate histories, and portal switching. **Prioritize the information that changes dental or medical decisions rather than exchanging every available data field.**

4 · Treat coordination as funded clinical work

Screening and interprofessional consultation consume staff and clinician time. **Sustainable models need reimbursement, staffing, and training that recognize the handoff as part of care rather than an unpaid extra.**

PEOPLE ALSO ASK

Frequently asked questions about oral-systemic dental care

What does oral-systemic health mean in dentistry?

Oral-systemic health refers to the two-way relationship between oral conditions and overall health. In dental practice, it means considering how systemic disease, medications, inflammation, and treatment plans may affect oral care, and when oral findings may warrant medical follow-up.

How are periodontal disease and diabetes connected?

Diabetes and periodontitis have a bidirectional relationship. Hyperglycemia can increase the risk and severity of periodontal disease, while periodontitis may make glycemic control more difficult. Dental and medical teams may therefore need to coordinate care when either condition is poorly controlled.

Should dentists check blood pressure during routine dental visits?

Blood pressure is an important screening vital sign in dental care. The American Dental Association notes that measuring blood pressure can help identify previously unrecognized hypertension and can also inform decisions about dental treatment, medications, and urgent medical referral.

When should a dentist refer a patient to a physician or medical specialist?

Referral is appropriate when a dental examination, medical history, vital sign, medication issue, or planned treatment raises a concern that requires medical evaluation or shared decision-making. The exact trigger depends on the finding, urgency, local scope of practice, and relevant clinical guidance.

Can dental and medical electronic health records be integrated?

Yes. Integrated and interoperable records can allow authorized dental and medical professionals to share relevant information such as medications, allergies, periodontal status, diagnoses, referrals, and imaging. The main challenges are standards, privacy, vendor interoperability, workflow design, and implementation cost.

Does periodontal disease cause cardiovascular disease?

Periodontal disease is associated with cardiovascular disease, but a direct causal relationship has not been established. Shared risk factors and systemic inflammation may contribute to the association, so cardiovascular risk should be managed through established medical care while periodontal disease is treated on its own clinical merits.

CLOSING PERSPECTIVE

Oral-systemic care becomes real when the healthcare system makes the handoff as reliable as the clinical observation

The MDForLives data describes a dental community that already sees systemic health as part of everyday clinical reasoning. Diabetes is the dominant oral-systemic concern, almost half of respondents routinely check vital signs, and formal outbound referral is common enough to be a recurring workflow rather than an exceptional event. The clinical connection is established.

What remains inconsistent is the operating system around that connection. Incoming medical referrals are mostly selective, often tied to surgery or medication-specific clearance. When dentists need to send information out, the leading technology barrier is the staff time required to fax, call, or email records. When practices try to expand screening and coordination, the leading financial obstacle is the absence of dedicated reimbursement for consultation and coordination. These are not abstract barriers. They determine whether a concern identified at 10:15 in the operatory becomes an actionable medical conversation by 10:30 or another task waiting in an administrative queue.

The education finding adds a second layer. Most respondents feel moderately prepared rather than fully prepared for complex medical co-management. That suggests the profession is not starting from zero, but many dentists may have learned the science more consistently than the collaborative workflow. Oral-systemic care therefore needs training that resembles actual practice: how to frame the referral question, what information to exchange, how to reconcile treatment plans, and how to document shared decisions when dental and medical priorities interact.

The future-model question is especially revealing. Respondents choose interoperable EHRs first and integrated insurance second. They do not primarily ask for dentistry to relocate into medical centers. They ask for information and incentives to travel across the boundary. That preference fits a profession delivered through solo practices, groups, community health centers, hospitals, and specialty offices. Integration has to work wherever the patient receives dental care.

The open-ended responses reinforce the same conclusion. Dentists mention communication, linked records, insurance reform, patient education, physician receptiveness, broader system integration, and more uniform protocols. No single reform solves all of those needs. The larger story is that oral-systemic care is moving from a clinical idea toward a health-system design problem. The next step is to make screening, referral, records, reimbursement, education, and responsibility function as one pathway rather than six separate tasks.

1 · Define routine systemic screening

Set a consistent minimum for medical-history review, vital signs, and condition-specific screening based on scope, patient risk, and practice context.

2 · Build explicit referral triggers

Specify which findings need physician input, what urgency applies, and what clinical question the referral is asking.

3 · Close the referral loop

Track whether information was received, whether medical advice returned, and whether the dental treatment plan changed as a result.

4 · Reduce manual record exchange

Use interoperable records or secure messaging to move the small set of medical and dental data that materially changes care.

5 · Fund coordination and screening

Align reimbursement and staffing with the time required for screening, consultation, documentation, and follow-up.

6 · Train for shared care, not only shared knowledge

Give dentists practical experience in medical-dental communication, medication and risk discussions, and interprofessional case management.

Help future dental insights reflect what happens when oral findings extend beyond the operatory.

Share your perspective with MDForLives and help build a clearer view of chairside screening, periodontal-systemic risk, referral pathways, medical-dental records, reimbursement, and co-management in real-world dental practice.

Join the Panel

Sources used for this report

1. MDForLives Dentist Insight Survey_Aug, SGID 8957344. Source survey report: 69 survey records, 82.6% completion rate, six countries, and question-level values used exactly as reported. Public quantitative question bases were 60 for the practice-setting and systemic-condition items and 58 for subsequent quantitative items. Administrative and validation fields were excluded. Open-ended themes were interpreted qualitatively without coding percentages.
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