Best Practice Approach:

Integrating Oral Health Care into Primary Care

ASTDD
ASSOCIATION OF STATE & TERRITORIAL DENTAL DIRECTORS
WHERE ORAL HEALTH LIVES

OHRC
National Maternal and Child Oral Health Resource Center

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Oral Health Care Is an Integral Part of Primary Care: A Call to Action

While there has been much discussion of oral health care and primary care integration over the past decades, progress on integration has been slow and limited. Evidence demonstrating that oral health is a critical component of overall health and well-being continues to mount. Persistent absence of collaboration and communication between oral health professionals and primary care health professionals has been linked to suboptimal outcomes across a range of chronic health conditions. Such health conditions include, but are not limited to, cardiac and pulmonary diseases, cancer, dementia, diabetes, and osteoporosis. On the other hand, effective collaboration and communication between these professionals has led to improved overall patient health.[1]

This best practice approach report, *Integrating Oral Health Care into Primary Care*, aims to increase awareness and promotion of oral health care and primary care integration, which is effective and important, as a rich body of evidence indicates. The suggested strategies will draw on proven health outcomes attributed to such integration. Numerous national, state, and local programs and initiatives have successfully implemented oral health care and primary care integration. The Association of State and Territorial Dental Directors (ASTDD) and the National Maternal and Child Oral Health Resource Center (OHRC) continue to develop and distribute resources on the importance of integration.

The U.S. Department of Health and Human Services' *National Call to Action to Promote Oral Health* is as relevant now as when it was published in 2003. It asserts that interdisciplinary care is needed to manage the general health—oral health interface. Achieving and maintaining good oral health requires individual action, complemented by professional care and community-based activities. Achieving good oral health and overall health necessitates the combined efforts of social service professionals, educators, and health professionals at state and local levels. Most important, the public, in the form of voluntary organizations, community groups, and individuals, must be part of any partnership that addresses oral health and general health.[2]

For the most part, oral health care and primary care are provided separately, with minimal coordination and integration. For integration to increase, state oral health programs, health departments, and health coalitions must encourage local action by identifying and supporting leaders who focus on integration strategies aligned with the unique characteristics and needs of their communities. Programs developed with community input can then focus on the essential components of bidirectional professional relationships, increasing capacity to identify funding, creating a linked interoperable electronic health record (EHR) capable of supporting effective communication, fostering patient awareness of integrated care, and providing navigational support.

Imagine the costs and time saved when a patient, who needs clearance from a dentist before starting oral cancer treatment, can see a dental specialist with expertise in oncology and who can access the patient's EHR with a few clicks, which shows their overall health care and oral health care information in one place. Imagine the value of having a dental hygienist or a dental therapist embedded in a primary care practice to allow for comprehensive care where most whole-body health needs can be met. Imagine primary care health professionals (such as physicians, nurse practitioners and physician assistants) conducting oral health screenings and risk assessments; applying fluoride varnish and silver diamine fluoride; and providing referrals for additional oral health care, if needed, as part of routine primary care visits.[a] The time is now to imagine less and start focusing on building consensus, moving toward collaboration, and implementing these integration strategies.

Integrating oral health care and primary care reduces oral health disparities for populations that face barriers when accessing oral health care.[3] Examples of barriers include difficulty getting to dental appointments due to geographic distance or lack of transportation, lack of dental insurance and inability to pay for care, and a shortage of oral health professionals in the area. Incorporating oral health education and preventive care, such as fluoride varnish applications, into primary care visits can make a significant difference in patients' long-term health.

When an integrated health care team works together to screen, share information, and address health issues, health conditions are more likely to be identified.[4] Using saliva in place of blood as a diagnostic screening tool, a non-invasive method for early identification of a variety of general health conditions, can be done more readily when oral health professionals work as part of an integrated health care team.

> *The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.*
>
> World Health Organization

State oral health programs, health departments, and health coalitions can assemble key stakeholders to envision and develop an integration model tailored to local circumstances and ongoing participation. Such stakeholders include community leaders who promote awareness of the benefits of overall health care, while assessing expectations and barriers to accessing care; health professionals who promote peer awareness of and buy-in to a team model of care, while providing the technical expertise needed to develop a written care framework; and health system leaders who support consistent financing for and resources that focus on person-centered care.[4]

Integrating oral health care and primary care is best sustained by conducting regular evaluations developed with input from key stakeholders. Evaluation results can be shared with the impacted community, enabling local programs to adjust based on this information. Sharing evaluation results and subsequent progress statewide and nationally will support the continuous focus necessary to fully integrate oral health care and primary care.

[a] On September 15, 2022, the American Medical Association voted to approve a new procedure code for the application of silver diamine fluoride by medical professionals to arrest cavities. For more information, see *The CPT Code for the Application of Silver Diamine Fluoride, Explained* produced by the CareQuest Institute for Oral Health.

Change is difficult, even when the benefits are clear. Historically, sustainable and effective change begins from the ground up, starting with local successes that inform broader health systems. Realizing these gains requires a coordinated public-private partnership. By leveraging community-specific assets and fostering a grassroots movement, health professionals can effectively bridge the gap between oral health care and primary care integration.

It is important to realize that lack of access to oral health care is not solely an American or first-world problem; it is an issue of global significance. Almost a century ago, the World Health Organization asserted that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." Yet few non-oral-health professionals would include oral health as an integral component of overall health.[5]

Oral health is a key driver of economic well-being. Investing in oral health pays an economic dividend in the form of better job prospects, higher earnings, and economic independence. To attain this fundamental right, there is a pressing need for policy reform that emphasizes the integration of oral health care and overall health care.[6]

The time is right for a call to action to focus on how to integrate oral health care and primary care in the most collaborative way, with a focus on training, interactive health information technology, clinical care, and evaluation.

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Integrating Oral Health Care Into Primary Care: National Overview

Since 2000, there has been a sustained effort to integrate oral health care into overall health care, particularly within primary care. Integration is considered an effective approach to realizing multiple benefits:

- Improving access to oral health care.
- Enhancing health care delivery and patient experience and outcomes.
- Educating health professionals about the benefits of interdisciplinary care.
- Reducing the overall cost of oral health care (e.g., by increasing access to preventive oral health care and reducing emergency department visits for non-oral-health issues).

This section describes federal and national reports that discuss the importance of oral health and the relationship between oral health and overall health. It also highlights federally funded initiatives focusing on advancing the integration of oral health care and primary care, with an emphasis on care in public health settings (health centers and health departments) to improve health.

Federal and National Reports

Since the publication of the National Institute of Dental and Craniofacial Research's (NIDCR's) seminal 2000 report, *Oral Health in America: A Report of the Surgeon General*, there has been a paradigm shift in recognizing oral health as integral to overall health.[1] This report served as a cornerstone for numerous publications and calls to action and established the necessary groundwork for integrating oral health care into primary care and for broader population health strategies.

The report was followed by *Advancing Oral Health in America and Improving Access for Oral Health for the Vulnerable* and *Underserved*, published in 2011 by the Institute of Medicine (IOM).[2,3] The two reports provide a comprehensive review of oral health across the lifespan, emphasizing the strong links between oral health and overall health while underscoring the federal government's role, particularly that of the Department of Health and Human Services, in ensuring comprehensive oral health care for underserved populations through the oral health safety net.

In 2014, the Health Resources and Services Administration (HRSA) released *Integration of Oral Health and Primary Care Practice* in response to the IOM reports. The IOM reports directed HRSA to develop core clinical competencies for non-oral-health professionals to improve access to preventive oral health care and early detection of oral disease.[4] The competencies address risk assessment, oral health screening, fluoride varnish, anticipatory guidance, and referral.

In 2015, the National Network for Oral Health Access (NNOHA) partnered with HRSA to pilot test implementation of these competencies and to develop a systems-based framework to support health centers in effectively implementing the competencies in primary care practice.[5] Framework components included focusing on organizational culture and clear processes (e.g., team huddles and feedback loops), and aligning

staff skills with system goals to improve patient care. In 2024, NNOHA updated *User's Guide for the Implementation of the Oral Health Core Clinical Competencies*, which describes the competencies and includes information about three pilot projects' experiences related to implementing them.[6]

In 2021, NIDCR published *Oral Health in America: Advances and Challenges*, which reaffirms the integral relationship between oral health and overall health across the lifespan.[7] It also reinforces evidence presented in the 2000 Surgeon General's report, which demonstrated that many oral health and general health conditions are related and that coordinating care is important to maintain oral health and overall health. Strategies for integrating oral health care and primary care are emerging as part of an overall framework for meeting the population's health needs effectively and efficiently.

The Centers for Disease Control and Prevention (CDC), Division of Oral Health, funded a systematic review of the literature on the integration of oral health care and medical care. The paper, *Oral Medical Care Coordination: A Systematic Literature Review and Guide Forward*, was published in 2024. The paper outlines four main themes or pillars of a national framework (awareness, workforce development and operations, information exchange, and payment) and provides a rationale for promoting the integration of oral health care and medical care.[8]

Federally Funded Initiatives

Many federal agencies, including CDC's Division of Oral Health (DOH), HRSA's Bureau of Primary Health Care (BPHC) and the Maternal and Child Health Bureau (MCHB), have a long history of funding and guiding initiatives that work to integrate oral health care and primary care. The description of federally funded initiatives below highlights some initiatives but is not an exhaustive list.

In 2005, BPHC funded the Oral Health Disparities Collaborative pilot, an 18-month initiative to develop and implement new organizational designs and care models that integrated oral health care into primary care. The initiative was implemented in four health centers and trained primary care health professionals to conduct oral health screenings for pregnant women and young children. The pilot led to the development of tools for integrating oral health care into primary care, with a focus on improving access to and quality of care.

In 2011, BPHC funded the Patient-Centered Health Home project, which assessed integration activities in health centers and identified contributing and limiting factors for sustainable integration.[9] Factors that contributed to health centers achieving a high level of integration included:

- Health center leadership (executive director and chief operating officer) is a primary force behind efforts to achieve medical-dental integration (MDI).
- The oral health department is integrated into the health center executive management team.
- The health center has co-located medical care and oral health care.
- The health center embraces a culture of quality improvement.
- There is staff buy-in because staff understand the "why."
- The health center uses patient-enabling services to facilitate access to oral health care and makes support services, such as translation and transportation, available for patients.
- The dental director has strong leadership skills and advocates for integrating oral health care into primary care at the center.

In 2016, DOH launched the Models of Collaboration pilot and funded six states—Alaska, Colorado, Georgia, Maryland, Minnesota, and

New York—to develop and implement projects that addressed oral health and the following chronic diseases or risk factors: obesity, diabetes, heart disease, stroke, and tobacco use.[10] All six states' oral health and chronic disease programs increased their collaboration with each other. This collaboration was facilitated by investing in relationships, championing integration efforts, and communicating frequently.

In 2018, DOH launched State Actions to Improve Oral Health Outcomes and funded five states—Colorado, Connecticut, North Dakota, South Carolina, and Virginia—to integrate oral health care into chronic disease programs, especially for people with diabetes. These initiatives were part of CDC's strategy to improve overall health by integrating oral health into broader public health efforts. The initiatives recognized the bidirectional relationship between oral health and chronic diseases, as poor oral health can contribute to the development and progression of systemic diseases.

In 2019, MCHB funded the Networks for Oral Health Integration Within the Maternal and Child Safety Network (NOHI) project for a 5-year period to improve access to and use of oral health care for pregnant women, infants, and children at high risk for oral disease.[11] Three regional networks (11 states and the District of Columbia) were charged with developing, implementing, and evaluating approaches for integrating oral health care into primary care in health centers.

Despite the impact of the COVID-19 pandemic on health behaviors and health care, the NOHI projects made substantial progress toward achieving their program objectives.

From March 2020 through February 2024, over 1,300 primary care health professionals, community health workers, and care coordinators received training on preventive oral health care and on the key components of integrating oral health care into primary care. During the same period, participating health centers provided over 369,700 preventive oral health services, including over 119,500 oral health risk assessments, 118,100 fluoride varnish applications, and 56,700 referrals for oral health care. Strategies to help sustain integrated care in health centers included:

- Emphasizing leadership buy-in and multidisciplinary participation during implementation to help make the provision of oral health care in primary care part of the organization's culture.
- Incorporating oral health training as part of onboarding and annual training.
- Establishing policies and procedures for providing preventive oral health care during primary care visits across the lifespan.
- Developing a process to track and monitor referrals within EHRs, while closing the loop between primary care health professionals and oral health professionals whenever possible.

- Incorporating oral health quality measures into quality-improvement programs and data analytics systems to help make integrated oral health care a part of the quality-improvement culture.

In 2019, MCHB also funded the Partnership for Integrating Oral Health Care into Primary Care project that involved state agencies and local primary care settings in five states integrating the interprofessional oral health core clinical competencies into practice.[12] The populations of focus included pregnant women, infants, children, and adolescents. Project settings included community health centers, a local public health department, and a university-based women's health clinic.

In 2022, MCHB launched the Integrating Oral Health Care and Primary Care Learning Collaborative: A State and Local Partnership.[13] This project involved nine teams, each consisting of the state oral health program and a health center prenatal clinic. The state component focused on improving systems-level capacity for integration, while the local component focused on integrating oral health care and prenatal care in health centers. Notable achievements included:

- Oral health training of primary care health professionals.
- Interprofessional collaboration, documenting, and tracking of oral health risk assessments, screenings, fluoride varnish applications, education, and referrals.
- Strong partnerships with state oral health programs and/or maternal and child health (MCH) programs to support and expand upon the success of work in other settings across the state.
- Development and testing of the *Capacity Inventory for Integrating Oral Health Care into Primary Care for Pregnant Women: Tool*, later adapted for the pediatric population.

In 2024, MCHB launched the Maternal and Child Health–Improving Oral Health Integration projects to advance the integration of preventive oral health care (POHC) into primary care to make POHC more accessible to infants, children, adolescents, and pregnant women, including those with special health care needs who are at risk for poor oral health.[14]

Strategies from these initiatives, including improving workforce education, promoting care coordination, and instituting policy changes, can help bridge the historical gap between oral health care and primary care. The strategies serve as valuable promising practices for achieving the goal of integrating oral health care and primary care to improve oral health and overall health.

To sustain and build on this momentum, state oral health programs, state MCH programs, and local clinics can leverage lessons learned from past and current initiatives and proactively seek and apply for funding from federal agencies (announced on Grants.gov) and philanthropic organizations to implement new initiatives. Potential sources of funding include:

- CareQuest Institute for Oral Health
- CDC
- Delta Dental Foundations
- Grantmakers In Health
- HRSA

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Medical Care Professionals: Evidence-Based Models of Oral Health Care and Primary Care Integration

Oral health care and primary care integration refers to coordinated, co-located, and integrated approaches that align primary care and oral health care to improve outcomes, reduce costs, and address health inequities. MDI is a health care approach that blends oral health care with primary care and with behavioral health care to provide care to the whole person.

These approaches exist along a continuum and can be adapted to diverse practice settings, including community health centers, private practices, hospitals, and public health clinics. Integration can occur on multiple levels, for instance, shared health services (e.g., fluoride varnish applications and oral health screenings as part of health visits and vaccinations at dental visits); co-located clinics (e.g., primary care and oral health care provided within the same system, perhaps even the same building); integrated health care teams (e.g., embedded dental hygienists on health care teams with an interoperable EHR); and interprofessional training and communication.

The rationale for oral health care and primary care integration is straightforward. Americans have multiple visits with health professionals each year. In 2024, about 95 percent of children and 85 percent of adults saw a health professional.[1] On average, Americans have roughly 3.2 primary care visits per person annually. Each visit is an opportunity to address oral health issues that relate to overall health. In comparison, the American Dental Association (ADA), Health Policy Institute reported that 45 percent of the U.S. population saw an oral health professional in 2022 (52 percent of children and 51 percent of older adults), with cost being a major barrier to access and utilization.[2] These patterns highlight why primary care visits represent a critical opportunity to deliver preventive oral health care and provide referrals, particularly for people who do not routinely access oral health care.

A real challenge in accessing oral health care for many Americans is a lack of dental insurance. The CareQuest Institute for Oral Health reported that post the COVID-19 pandemic, 27 percent of adults lacked dental insurance compared to 10 percent lacking medical insurance.[3] These coverage gaps disproportionately affect adults enrolled in Medicaid, those living in rural communities, and historically marginalized populations, reinforcing the importance of integrating oral health care into primary care settings that patients already use. Opportunities to incorporate oral health screenings and preventive oral health care, while coordinating referrals to obtain more extensive oral health care, exist across the lifespan.

Preventive Oral Health Care for Children

Nearly all young children see a primary care health professional regularly through well-child visits, but many do not see a dentist until after age three. The American Academy of Pediatrics (AAP), the American Academy of Pediatric Dentistry, and ADA recommend establishing a dental home by age one, yet only about 30 to 40 percent of children

have a dental home by that age. Primary care visits are a critical access point for early oral health promotion and oral disease prevention.

Fluoride varnish application at pediatric primary care visits is now standard of care. The U.S. Preventive Services Task Force recommends that primary care health professionals apply fluoride varnish to the teeth of all children younger than age 5 and provide anticipatory guidance to parents about oral health.[4] Evidence shows that fluoride varnish, when applied at regular intervals, reduces dental caries incidence by 30 to 43 percent in young children.[5] Integrating such preventive oral health care into primary care improves access to early oral health care, particularly for families with low incomes and/or those living in rural areas who may disproportionately face barriers to visiting a dentist. In all U.S. states, Medicaid reimbursement for fluoride varnish applications and oral health screenings further supports the feasibility of delivering such care in primary care settings.

Case Examples

Growing evidence demonstrates that incorporating preventive oral health care into primary care visits improves both oral health and overall health outcomes and can be cost-effective for health systems. Programs such as Into the Mouths of Babes in North Carolina and Cavity Free at Three in Colorado have shown that training primary care health professionals to conduct oral health assessments, apply fluoride varnish, and provide referrals significantly increases preventive care delivery and reduces untreated caries among young children.[6,7] These programs have successfully reached children enrolled in Medicaid who might otherwise lack access to oral health care.

Resources

Many states host oral health training programs for primary care health professionals. Key elements across these programs, which include health professional training, reimbursement mechanisms, and structured referral pathways, can be replicated and adapted by other states seeking to implement similar models. These programs illustrate diverse approaches to training primary care health professionals and are not intended to be an exhaustive list. Here are a few with a long and strong history:

- Colorado's **Cavity Free at Three Program:** This program, housed within the Colorado Department of Public Health and Environment, is a long-standing statewide initiative (established in 2006) that trains oral health and primary care health professionals to deliver preventive oral health care, such as fluoride varnish and anticipatory guidance, to help ensure that young children and pregnant women stay cavity-free.
- Maine's **From the First Tooth:** This oral health program, run by the Maine Center for Disease Control and Prevention, partners with schools and health professionals to deliver preventive oral health care, such as fluoride varnish applications, dental sealants, oral health screenings, and oral health education, to school-age children. It has been operating since the mid-1970s under the Maine School Oral Health Program.
- North Carolina's **Into the Mouths of Babes Program:** This program, housed within the North Carolina Division of Public Health and operating since 2000, trains health professionals to deliver preventive oral health care, such as oral health screenings, caregiver counseling, and fluoride varnish applications, to reduce early childhood caries and improve oral health outcomes for young children.

- ***Smiles for Life: A National Oral Health Curriculum*** (SFL)**:** This is a free, nationally recognized online training program, developed by the Society of Teachers of Family Medicine beginning in 2005, which aims to teach primary care health professionals evidence-based skills to promote oral health across the lifespan.

> *Fluoride varnish application at pediatric primary care visits is now standard of care.*
>
> U.S. Preventive Services Task Force

Cost Savings

Economic evaluations have found that fluoride varnish application in primary care is cost-effective and often cost saving. Quiñonez et al. estimated costs of about $7 per cavity-free mouth gained, while Scherrer et al. found net Medicaid savings of about $75 per child when averted restorative costs were included.[5,8] These findings underscore the efficacy of preventive oral health care and primary care integration, which improves health and reduces downstream treatment expenditures. The findings are particularly relevant for Medicaid agencies and health systems seeking high-value preventive interventions that align with value-based payment models.

Chronic Disease Management in Adults

For adults, integrating oral health care into chronic disease care has shown benefits for diabetes control and cardiovascular health. A 2014 systematic review found that patients with diabetes who received periodontal therapy had modest but significant improvements in hemoglobin A1c (HbA1c) compared to those without such care.[9] This suggests that addressing oral inflammation can support broader chronic-disease-management goals. Additionally, oral health care for older adults prevents caries. Including oral health screenings and referrals into routine diabetes visits offers a practical pathway to operationalize this evidence within primary care.

Case Examples

Patients with diabetes require comprehensive care, including regular eye, foot, and oral health assessments. In a 2014 systematic review, Xiang Wang et al. found that integrating oral health screening and fluoride varnish application into diabetes care, combined with structured oral health referrals and team training, improved access to periodontal treatment and modestly improved glycemic control.[9]

Resources

Several modules within the SFL curriculum highlight evidence-based guidance on assessing oral health risks, delivering preventive counseling, and coordinating care for patients with diabetes.

Pregnancy

The American College of Obstetrics and Gynecologists (ACOG) and ADA support the provision of oral health care during pregnancy for both caries-related and periodontal-disease-related care.[10,11] However, oral health professionals have reported hesitancy to provide care to pregnant women, citing safety concerns, liability, and lack of knowledge as barriers.[12] Because obstetrics/gynecology care is often a consistent health system contact during pregnancy, these visits can be leveraged as an opportunity to provide anticipatory guidance, screen for caries and periodontal disease, and provide referrals to an oral health professional.

A 2019 study by Naavaal et al. found that pregnant women who were referred to an oral health professional during a prenatal visit were more likely to attend the dental visit.[13] Evidence to support the benefits of receiving oral health care during pregnancy is emerging. A 2022 systematic review by Wu et al. shows that scaling and root planning plus chlorhexidine rinsing reduced preterm birth risk and the combined outcome of preterm birth and low birthweight.[14]

Resources

The following provide information about oral health care during pregnancy:

- *Oral Health Care During Pregnancy: A National Consensus Statement:* This consensus statement provides guidance on oral health care for pregnant women, prenatal care health professionals, and oral health professionals. It also includes pharmacological considerations for pregnant women. The 2026 updated edition includes updates on dental amalgam, aspirin to prevent preeclampsia, and nitrous oxide.
- ACOG supports oral health care during pregnancy: To further general health and well-being, women should routinely be counseled about the maintenance of good oral health habits throughout their lives as well as about the safety and importance of obtaining oral health care during pregnancy.

Enhanced Interprofessional Collaboration

Team-based care models are key components of successful integration. Studies of medical teams with embedded dental hygienists demonstrate that when oral health care and obstetric care are integrated, patients receive more comprehensive, coordinated care. Effective interprofessional collaboration depends on shared workflows, clear role delineation, routine communication, and access to clinical information (data) across disciplines. Interprofessional training programs improve health professional confidence in addressing oral health and increase preventive care delivery.

Case Examples

In Colorado, initiatives such as the Colorado Medical Dental Integration project and the Rocky Mountain Network of Oral Health (RoMoNOH) project exemplify how oral health care and primary care integration can improve preventive care delivery and health communication between medical and dental systems. Evaluations of these initiatives demonstrate increased fluoride varnish

application rates, improved referral linkages, and growing clinician confidence in addressing oral health needs.[15,16]

For example, in 22 community health centers participating in the RoMoNOH initiative across four states, there was a significant increase in delivery of preventive oral health care over a 4-year span, including dental referrals, fluoride varnish applications, and oral health anticipatory goal setting. These findings demonstrate that sustained oral health care and primary care integration efforts can reliably increase delivery of preventive oral health care across diverse clinical settings, supporting both improved access to care and more consistent incorporation of oral health care into routine medical practice.

Resources

These organizations provide educational resources, implementation guidance, and technical assistance (TA) to support practice-level integration:

- OHRC, a national professional organization supporting health professionals, provides TA and resources to support interprofessional educational and collaboration.
- NNOHA, a national resource for federally qualified health centers, provides training and TA for interprofessional education and collaboration.

- AAP, a national professional organization supporting pediatricians, provides resources to support interprofessional education and collaboration.

Conclusion

Oral health is integral to overall health. Oral health care and primary care integration offers a practical, evidence-based strategy to advance prevention, reduce costs, and promote health equity. As research continues to highlight the biological and behavioral links between oral and systemic health, health systems have an opportunity and a responsibility to bridge the divide between primary care and oral health care. Expanding integrated preventive care, supporting interprofessional training, and aligning reimbursement policies can help ensure that every child and adult receives comprehensive, whole-person care that includes the mouth as part of the body.

Recommendations

1. Integrate preventive oral health care into primary care visits across the lifespan.
2. Incorporate oral health care into management of chronic disease in adults.
3. Educate women on the importance of optimal oral health before and during pregnancy.
4. Enhance interprofessional collaboration by building interprofessional partnerships.
5. Align payment and reimbursement policies to support preventive oral health care and interprofessional care delivery in primary care settings.
6. Advocate for interoperable EHRs to streamline collaborative practices.

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An Oral Health Perspective: Foundational Pathways Toward Oral Health Care in Primary Care Integration

Oral health care largely remains siloed and independent from medical care, including primary care. Most dental education programs prepare students for traditional dental practice settings and business models. To improve population health and reduce persistent oral health disparities, a broader range of health professionals must collaborate to promote oral health care and primary care integration.[1]

The integration of oral health care into primary care results in more conveniently accessible locations where preventive oral health care, such as fluoride applications and provision of anticipatory guidance, can be delivered. Creating a team that includes community health workers, nursing assistants, and others could make interventions more widely available. Doing this is essential to mitigate oral diseases and disparities that are exacerbated by inadequate and unequal access to oral health care under the current health care system.

Background

Integration efforts will require advocating for a foundational pathway to interprofessional education (IPE) and collaborative practice. Over the past 25 years, the field of IPE and collaborative practice has grown. The National Interprofessional Initiative on Oral Health has gathered select reports from HRSA and others into a collection of useful resources.[2] SFL is a no-cost, comprehensive program to educate and train primary care health professionals in oral health promotion. In its fourth edition, it has been officially endorsed by 20 national organizations and is widely used in professional schools and post-graduate-education programs. Practicing oral health professionals should embrace the content of the curriculum, as have their medical colleagues.[3] A shift toward patient-centered oral health begins with implementing IPE and collaborative practice to break down existing siloes.[4]

Interprofessional Education

IPE occurs when students and health professionals from different professions learn about, from, and with each other to build knowledge and skills to work together.[5] Interprofessional collaborative practice (IPCP) is demonstrated when multiple health professionals apply learned skills in real world settings.[4] In essence, IPE prepares a practice-ready workforce; IPCP is that workforce in action.

Collaboration among a range of health professional academic programs and faculty is critical to the development and implementation of IPE curricula. Such collaboration includes opportunities for students and health professionals in different disciplines to learn together. Experiential learning is a hands-on approach that applies theory to real world situations and reflects on the experience, allowing students and health professionals to gain a deeper understanding and improve skills through activities like internships, simulations, service-learning, and applied coursework via lecture, lab, and clinic. IPE is needed to change the paradigm of health-care-education disciplines so that students learn together with a common aim of improving overall health.[4]

Nationally recognized efforts to accelerate health professional education include development of the 2011 Interprofessional Education Collaborative's (IPEC) four core competencies:[5]

- Values and ethics
- Roles and responsibilities
- Communication
- Teams and teamwork

These four core competencies gained substantial traction with health care accreditors. IPEC started with six founding national organizations in 2009 that focused on allopathic medicine, osteopathic medicine, nursing, pharmacy, dentistry, and public health, with the organization publishing an initial report in 2011.[6] By 2023, IPEC's membership included 22 national health care organizations. That same year, the collaborative enhanced the original framework with updates to competency language to reflect changes in the health and education landscapes and added a brief history of IPEC milestones. The collaborative united around the quintuple aim framework, which provides health systems, public health organizations, and governments a way to design and assess improvements and solutions according to its five aims that seek to improve patient experience and health outcomes, lower costs, enhance health professional well-being, and advance health equity through IPE and practice.[7] IPEC's efforts are supported by multiple private foundations and federal funders including HRSA, the U.S. Departments of Education, and the U.S. Department of Labor.

In 2024, the American Dental Education Association created the Task Force on Envisioning and Transforming the Future of Oral Health and Education, based on the premise that dental education is not functioning optimally.[8] The task force seeks to transform the health care system to make it socially responsive. Forthcoming recommendations will address developing frameworks and forming partnerships to deliver oral health care beyond traditional models and toward integrating oral health care and medical care. A good start will be incorporating the IPEC four core competencies as a foundational education pathway in all dental-education programs and professional continuing education (CE) courses.

Mandatory IPE accreditation standards will change the status quo for most health care disciplines. Development of course content focused on interprofessional oral health care is necessary. However, faculty perceptions of their available time to participate, program schedule coordination, and physical space for IPE activities have been cited as barriers.[9] Online education is a proven method for effective content delivery and may provide a solution to these perceived barriers.

Faculty and administrator champions must question the existing system and promote diverse ideas. IPE advancement requires strategic and collaborative approaches by organizational leadership with input from stakeholders and the community. IPEC data for online IPE learning shows positive trends. Existing research indicates that virtual IPE learning can be as effective as live sessions in improving core competencies like communication and collaboration.

A robust collection of peer-reviewed best practices exists that use components of a systematic instructional design approach for delivery of core IPE competencies. Successful best practice studies must inform higher education so that IPE adapts to the ever-evolving health care landscape and ensures a future-ready workforce. Ongoing longitudinal research is needed to assess its growth and effectiveness.

These IPE competencies must also be applied to professional CE opportunities for license renewal of practicing health professionals. Health professional licensing and certification boards can require content on oral health care and primary care integration in each licensure cycle.

Examples of Integrated Practice

Models for fully integrated oral health care and primary care involve shared access to EHRs, provider collaboration to improve services to patients, teledentistry, and bidirectional referrals to improve access to care. For example, Utah's State Oral Health Program collaborates with the University of Utah's Physician Assistant program and the Brigham Young University School of Nursing on bidirectional training. In 2025, the CareQuest Institute for Oral Health published two excellent resources.[10,11] The first white paper explores IPE from an oral health perspective, while the second looks at policy levers needed to accelerate team-based collaborative practice.

Following are two examples of IPCP care-delivery models pioneered in Minnesota: (1) a collaborative dental hygiene practice that authorizes work in alternative settings to expand access beyond dental offices and (2) utilizing a dental therapist as a new team member with a primary dental care scope of practice.

Sarah Hoerler, EdD, MS, RDH, FADHA

Sarah Hoerler is a licensed dental hygienist within the Department of Dental Specialties at the Mayo Clinic, Rochester, MN. Her work focuses on integrated patient health care via collaboration with primary care health professionals and health care specialists. She provides oral health care for inpatients with advanced periodontal disease, those who have undergone oral cancer treatments, and immuno-compromised patients who live with multiple medical co-morbidities. In addition to providing oral health care to these patients, Sarah created a rotation for dental hygiene students to gain experience managing the oral health of medically complex patients. Improved patient health outcomes truly demonstrate the value of integrated, patient-centered care.

Sarah's work and research demonstrates that consistently applying oral health care protocols reduces biofilm accumulation in critically ill patients and results in improvement in their overall health. Collaboration between dental hygienists and critical care nurses enhanced staff confidence, improved workflow consistency, and increased adherence to oral health care protocols.[12,13] Integrating dental hygienists into interprofessional medical teams improves patient outcomes and overall systemic health. Expanding dental hygienists' role in medical settings demonstrates how collaborative care models can elevate patient safety, health outcomes, and quality of care.

Kelly Meyer, ADT, LDH

Minnesota was the first state to authorize dental therapy, and Kelly Meyer was a member of the first dental therapy graduating class in 2011. Although dental therapists are not yet authorized to practice in all states, where allowed, they are key members of interprofessional teams. Kelly, a dually licensed advanced dental therapist and dental hygienist, provides care at Hennepin Healthcare (HH), which integrates oral health care and primary care with the goal of reducing the impact of chronic illness on patients' lives.

One of Kelly's primary roles is to deliver oral health care at the HH coordinated care center, an intensive care unit designed for ambulatory patients with complex health problems that result in frequent hospitalizations. The unit provides services that include walk-in access for new issues, close medical follow-up after hospitalization, regular oversight by clinic pharmacists through medication-therapy management, and attention to behavioral and social determinants of health.

At the center, patients access comprehensive care more quickly than in the emergency department. The coordinated and shared decision-making

among oral health and primary care health professionals, including nurses and community health workers, results in improved patient outcomes, greater efficiency, lower costs, and increased patient satisfaction.

Kelly provides oral health care within both her dental therapy and dental hygiene scopes of practice and triages for emergent needs. If care beyond the dental therapy scope of practice is needed, she holds a telehealth consultation with her collaborative practice dentist and then arranges referrals to dentists for advanced treatment.

Recommendations

An understanding of the relationship between oral diseases and systemic health provides strong motivation to make positive system change. Health educators and practicing oral health professionals and primary care health professionals all have roles in advancing whole-person collaborative care. In addition, advocates work with state and federal government agencies and policymakers to fund interprofessional integrated care initiatives.

Stakeholder	Needed Actions
Accreditation agencies	• Strengthen standards and require IPE competencies.
Educators	• Adopt the IPEC four core competencies as a foundational education pathway. • Commit to IPE through lifelong learning and adaptation of curricula to prepare a future-ready workforce.
Health licensing boards	• Make IPE mandatory for professional development.
Advocates	• Promote legislation and funding for IPE efforts.
Funders and payors	• Align financial incentives to create sustainable financing models, such as value-based care, in support of IPCP.
Information technology sector	• Create interoperability and shared access to EHRs.
Health systems leadership	• Create structural models that seamlessly include oral health in primary care through integrated EHRs, bidirectional referrals, telehealth technologies, and co-located services.
State oral health programs	• Collect and share data, best practices, and research findings. • Convene stakeholders to gain support for a more unified, proactive approach. • Include oral health care and primary care integration in their state oral health plans.

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Integration of Oral Health and Primary Care Practice in Health Centers

Health centers (HCs) are community-based, patient-centered organizations that provide health care to underserved populations. In 2024, there were 1,359 HCs in the United States, serving over 32 million people. Over 6.7 million people received oral health care from an HC in 2024.[1] HCs function as integrated systems of care that typically encompass multiple locations, services, and delivery models, supporting their patients and communities. HCs offer a wide range of health care services, such as oral health, medical, behavioral health, vision, laboratory, and pharmacy services. In many instances, these services are co-located in the same building. This organizational structure positions HCs as the ideal environment for oral health care and primary care integration, where coordinated workflows and shared systems can be operationalized at scale.

Health Centers' History of Integration

HCs have a long history of piloting integrated care initiatives before they expand to other practice settings. HRSA funded its first oral health care and primary care integration initiative, the Oral Health Disparities Collaborative Pilot, in 2005. This project was an 18-month initiative that trained primary care health professionals to perform oral health screenings for pregnant women and children. In 2011, HRSA funded the *Patient-Centered Health Home Initiative*, which assessed oral health care and primary care integration activities to identify factors that contribute to sustainable integration initiatives in HCs.[2] These early initiatives demonstrated both the feasibility of integrating oral health care into primary care and the importance of identifying systems-level factors that support sustainability.

In 2014, HRSA released *Integration of Oral Health and Primary Care Practice Initiative*, which describes the development of five oral health core clinical competencies for non-oral-health professionals. These competencies are risk assessment, oral health evaluation, preventive interventions, communication and education, and interprofessional collaborative practice. The goal was to improve access to preventive oral health care and early detection of oral diseases by incorporating these care elements into primary care visits. In practice, these competencies enable primary care health professionals to assess oral health risk; provide preventive interventions, such as fluoride varnish applications; educate patients; and coordinate referrals within interprofessional teams.

HRSA partnered with NNOHA in 2015 to pilot the implementation of these oral health core clinical competencies within a systems-based framework that supports HCs to effectively implement integration of oral health and primary care practice (IOHPCP).[3] The framework incorporates four systems: training, health information technology (HIT), clinical care, and evaluation.[4] In order for the IOHPCP framework to be successful in practice, there should be alignment across the four systems. If any one system is not in place, it could challenge the overall implementation and sustainability of the IOHPCP program.

Integration in Maternal and Child Populations

Since 2015, many HCs have implemented initiatives with an IOHPCP framework, incorporating the oral health core clinical competencies. These initiatives focus on specific populations, chronic conditions, or disciplines. The primary care setting is an ideal location for providing oral health care because many patients, especially pregnant women, infants, and children, visit their primary care health professional (PCP) or OB-GYN multiple times a year. The MCH population is often the initial focus of integration efforts because of the frequency of primary care visits, strong prevention opportunities, and existing models of reimbursement.

NNOHA has conducted national and state-level learning collaboratives (LCs) to support over 200 HCs implementing the IOHPCP framework. These LCs include shared learning, didactic training, and individualized support. HCs typically select pregnant women and children from birth through age 5 as their initial IOHPCP population. This aligns with public health principles, supporting early access to preventive oral health care. Additionally, Medicaid programs reimburse PCPs for applying fluoride varnish in the medical setting. Many state reimburse for dental treatment provided during pregnancy, allowing for financial sustainability of the IOHPCP program.

A key quality improvement metric for IOHPCP is the number of dual users—people accessing both oral health care and primary care within the HC. In 2017, NNOHA conducted an LC for HCs to implement IOHPCP for children. One HC had a 28 percent increase in the number of children that accessed both oral health care and primary care from 2017 to 2018. This increase was achieved by creating a training infrastructure for both oral health professionals and non-oral-health professionals on integrated care, care coordination, and preventive oral health care. Additionally, the HC leveraged its HIT to create a referral system between the oral health and medical departments. One key barrier for this organization was buy-in from primary care health professionals, which was improved by creating ongoing training opportunities and establishing standardized workflows for primary care visits to integrate oral health activities.

In addition to this LC, HRSA's MCHB funded a 5-year project in 2019 called Networks for Oral Health Integration. The aim was to improve access to oral health care for pregnant women, infants, and children. The project provided safety net clinics and regional networks with trainings and resources to establish a sustainable framework to integrate oral health care and primary care. The project saw over 369,000 preventive oral health services provided to pregnant women, infants, and children.[5] These services included fluoride varnish applications, oral health education, and oral health risk assessments.

MCHB continues to prioritize oral health for pregnant women and children by funding IOHPCP LCs. From 2022 to 2024, MCHB funded the Integrating Oral Health Care and Primary Care Learning Collaborative: A State and Local Partnership. This project included nine state oral health programs that worked in partnership with a local HC prenatal clinic. Over 7,500 oral health services were provided to pregnant women during the project period.[6]

Chronic Disease Management

In addition to providing care to pregnant women and children, many HCs have implemented IOHPCP programs to improve chronic disease management. There is growing evidence demonstrating the connection between oral health and systemic health.[7] In 2020, NNOHA conducted its first Integration of Diabetes and Oral Health (IDOH) LC, expanding on previous IOHPCP training programs to specifically address diabetes. The IDOH LC helps HCs implement IOHPCP by teaching quality improvement methodology.

As of 2025, over 50 HCs have implemented the IOHPCP framework for patients with diabetes to improve access to oral health care and to improve diabetes care quality. In the bidirectional care system, PCPs screen and assess oral health status by completing oral health risk assessments and conducting oral evaluations during primary care visits. Additionally, PCPs make dental referrals and provide oral health education. Oral health professionals identify HbA1c screening opportunities and arrange HbA1c testing if a patient's test is not current. The oral health team supports self-management goals, provides oral health education, and monitors blood glucose and HbA1c as needed.

One HC in South Dakota participated in NNOHA's IDOH LC. Oral health professionals provided training to their PCPs on fluoride varnish application and oral evaluations. Additionally, the oral health team received training on how to determine when a patient is due for an HbA1c test and provided education on the relationship between diabetes and oral health. Within the first 3 months of implementing their IDOH initiative, the HC saw a 10 percent increase in the number of patients with diabetes who received an oral health evaluation in the primary care clinic.[8]

Emerging Innovations in Integration

HCs continue to expand on IOHPCP, demonstrating the potential for fully integrated health care systems that improve overall health across the lifespan. Some high-performing HCs have integrated tobacco cessation and referral into their dental visits. With increasing numbers of HCs adopting interoperable EHRs and the expanded scope of practice in states, some HCs have grown their integration initiatives to include immunizations.

The oral health team identifies vaccine gaps during dental visits and refers patients to their primary care health professional to complete the vaccines during the same day. Even further, some states allow oral health professionals to deliver immunizations addressing COVID-19, flu, and the human papillomavirus (HPV). Additionally, there are opportunities for oral health professionals to refer patients for other preventive health screenings, such as mammograms, colonoscopies, and Pap/HPV tests.

There has been an increased demand for integration of behavioral health care into primary care. In 2020, NNOHA developed the Integration of Behavioral Health and Oral Health (IBOH) Learning Collaborative. This program trains HCs in integrating behavioral health screenings (like depression screening) during dental appointments and connects dental patients to behavioral health services. Over 60 HCs have engaged in this training program.

IBOH is a strategy to ensure that patients get connected to behavioral health care. It creates opportunities for critical conversations between the patient and oral health professional to enhance patient-centered care. Bilateral integration is an important aspect of IBOH, as many behavioral health professionals now conduct short oral health risk assessments and refer patients to the dental clinic as needed. From 2020 through 2024, participating HCs averaged a 16 percent increase in the number of patients who received behavioral health screenings in the dental clinic.

Challenges

There are challenges that HCs experience when implementing IOHPCP programs, including dental program capacity. HC dental programs have about 25 percent of the capacity of HC medical programs, creating challenges to accommodate referrals from the medical department.[9] Many HCs continue to experience oral health workforce shortages, which makes it even more difficult to meet the oral health needs of the community.

Integration is a strategy to alleviate oral health workforce challenges, as it can increase access to preventive interventions, such as fluoride varnish applications and oral health education. For patients who need more advanced oral health care, such as surgical and restorative treatment, HC oral health departments must develop creative solutions to meet these increasing demands. Collaboration with private dental practices outside of the HC is a strategy to expand capacity and alleviate workforce challenges.

Another challenge is HIT. Many HCs utilize different electronic medical and dental records, which creates obstacles to sharing clinical data and scheduling functions across departments. HCs utilizing interoperable EHRs with shared access have a more efficient process for referrals and information sharing. In recent years, transitioning of the HC oral health department to the same system as the medical department has become a priority.

An HC in Georgia utilizes an integrated EHR, eClinicalWorks, which leverages the interoperable EHR by integrating oral health–related questions into the medical record. Additionally, the integrated EHR allows for seamless electronic referrals between medical and oral health teams, facilitating referral tracking and follow-up.[10] This example highlights that successful integration depends as much on organizational culture and health professional engagement as on technical systems.

Conclusion

Oral health care and primary care integration can support early detection of health conditions and diseases, increased access to preventive care, and improved chronic disease management. HCs have been pioneers in implementing strategies to integrate oral health care and primary care, as well as beginning to integrate oral health care and behavioral health care. HCs demonstrate that such integration is both feasible and impactful when supported by aligned systems, workforce strategies, and policy frameworks.

The HC experience shows that integration is not simply a clinical innovation but also a transformation in how health care is organized, delivered, and measured across disciplines. Oral health care and primary care integration expands opportunities for early detection of oral disease and related health conditions, earlier intervention, and enhanced care coordination. The successes achieved within HCs provide reproducible models for broader adoption across other health settings, including hospital systems, integrated delivery networks, and private practices.

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Championing Integration

Building awareness of the connection between oral health and overall health—and mobilizing leadership, policies, and resources—can advance the integration of oral health care and primary care. This section outlines strategies to promote integration across clinical, systems, and policy settings to improve patient outcomes while enhancing the quality and cost-effectiveness of care.

Meaningful progress often begins with locally driven efforts that reflect a community's unique strengths, needs, and resources. Successful integration initiatives should empower local leaders and organizations to implement practical strategies that connect oral health care and primary care, while advancing policies, partnerships, and community engagement that build support among key decision-makers.

State oral health programs, coalitions, and community partners play a critical role in driving these efforts. By identifying and supporting local champions, communities can encourage integration models that strengthen collaboration among diverse health professionals and improve access to coordinated care.

Starting with Strategy

Effective integration of oral health care and primary care begins with strategic focus. Because communities and health systems vary in their needs, resources, and readiness for change, the first step is identifying where efforts can have the greatest impact rather than trying to address every aspect of integration at once. Prioritizing targeted strategies helps advance sustainable integration and improve health outcomes.

Expanding Workforce Capacity and Team-Based Care

Messages to health system leaders and policymakers should emphasize the efficiency and value of team-based care models that include oral health professionals in primary care settings.

Improving Health Information Exchange

Messages should focus on increasing awareness of the importance of consolidated health records that connect oral health care and primary care. Messages should focus on how integrated EHRs support whole-person care, improve clinical efficiency, and strengthen population health monitoring.

Increasing Public Awareness

Public awareness is an important driver of demand for integrated care. Awareness campaigns, patient-education efforts, and community outreach can help individuals recognize the connection between oral health and overall health and appreciate the benefits of coordinated care. Messaging for the public should be clear, relatable, and focused on health benefits, such as early detection of disease, improved management of chronic conditions, and more convenient access to care.

Engaging Community Stakeholders

Community leaders and organizations play an important role in advancing awareness of and support for integrated care. Engaging these stakeholders—including local health

champions, schools, faith-based organizations, and nonprofit organizations—can identify barriers to care and ensure that integration efforts reflect community priorities.

Advancing Support

Clear and consistent messaging tailored to specific audiences can build momentum for change, advance policies and funding mechanisms, and encourage adoption of the integration of oral health care and primary care. Key audiences may include:

- State and local policymakers, who influence regulations, workforce policies, and funding opportunities
- Health system leaders, who determine organizational priorities and care-delivery models
- Public health leaders, who guide prevention strategies and population-health initiatives
- Professional associations, which influence clinical practice norms and education

With a clear strategic focus and leveraging of targeted outreach, data sharing, and examples of successful integration, a policy and practice environment needed to support widespread adoption of the integration of oral health care and primary care can be realized.

Message Delivery

Messages can take many forms—from social media and emails to one-pagers and videos—but they must be clear to be effective. Because audiences differ in health literacy and motivations, a "copy-paste" approach to communication is rarely effective. Successful messaging is clear, consistent, and tailored to specific audiences. It uses plain language and a structured approach to explain the issue, connect with audience values and concerns, and provide a clear call to action.

Think about the "core messages" that can be used consistently and repeatedly over the course of a campaign or effort. These are a foundation or platform that supports the effort and should connect the goals and strategies with each audience's values, concerns, or interests. Articulate effective messaging by using these suggested steps:[1]

- Open with a statement that engages the audience
- Present the problem
- Provide facts and data about the problem
- Share a story or give an example of the problem
- Connect the issue to the audience's values, concerns, or interests
- Make the request (the "ask")

Channels and Messengers

Messages are most effective when delivered in a variety of ways and include a mix of these communication channels:

- In-person meetings
- Emails
- Social media posts
- Website features and blogs
- One-pagers or briefs

While oral health professionals can be important and credible messengers, finding non-oral-health professionals and others within the local community can help expand support. For example, consider messengers such as:

- Medical professionals
- Community outreach professionals, such as community health workers and promotoras
- Patients
- Parents
- School nurses, teachers, and administrators
- Business owners
- University faculty
- Civic and faith leaders
- Reporters

Offer training opportunities and/or support via information and practice sessions where messengers can hone their skills and responses in a safe and supportive environment.

Integration Framework

When policymakers, clinicians, health systems, public health leaders, and communities understand the importance of integrating oral health care and primary care, the pathway toward meaningful integration becomes clearer and more achievable. The following framework can be used as a planning tool to align goals with specific strategies:

Target Audience	Message Focus	Suggested Tactics	Communication Channels
State and Local Policymakers	Integration improves health outcomes, reduces long-term costs, and expands access to preventive care, especially for underserved populations.	• Policy briefs • Legislative meetings • Testimony at hearings • Site visits to integrated clinics • Sharing local success stories and data	• Legislative briefings • Policy forums • State health committee meetings • Emails • Professional association networks
Health System Leaders and Administrators	Integrating oral health care into primary care improves quality of care, improves patient experience, and supports value-based care goals by preventing costly complications.	• Presentations to executive leadership • Pilot program proposals • Cost-benefit analyses • Case studies • Collaborative planning sessions with clinical leader	• Health-system-leadership meetings • Hospital and clinic networks • Health care forums • Professional leadership conferences
Primary Care Health Professionals	Oral health is essential to overall health. Collaborative care models support early detection, chronic disease management, and better patient health outcomes.	• CE sessions • Interdisciplinary case discussions • Referral-protocol development • Clinical toolkits • Peer champions who model integration practices	• Professional association meetings • CE platforms • Newsletters • Webinars • Medical conferences
Oral Health Professionals	Collaboration with primary care expands prevention opportunities, shows health professionals' commitment to team-based health care for patients, and supports early identification of systemic health conditions.	• Interprofessional training • Referral partnerships • Integration pilot programs • Clinical protocols • Presentations to dental associations	• Oral health professional meetings • CE courses • Dental society communications • Peer networks

Target Audience	Message Focus	Suggested Tactics	Communication Channels
Public Health Leaders and Coalitions	Integration strengthens population health strategies, reduces disparities, and incorporates oral health with broader prevention and chronic disease initiatives.	• Coalition meetings • Collaborative planning sessions • Shared public health campaigns • Development of joint strategic initiatives	• State and local health department meetings • Public health conferences • Coalition newsletters • Public health webinars
Community Organizations	Integrated care improves access, reduces barriers to care, and supports healthier communities. Community voices are essential in encouraging the acceptance of integrated care by the public.	• Community listening sessions • Partnership initiatives • Community advisory groups • Local outreach events • Culturally relevant education materials	• Community forums, local media • Nonprofit networks • Faith-based and civic organizations • Grassroots outreach campaigns
Patients and the Public	Oral health is connected to overall health. Integrated care helps patients receive more complete care, detect health issues earlier, and manage chronic conditions more effectively.	• Public awareness campaigns • Patient education materials • Storytelling • Health fairs • Community health worker outreach	• Social media • Clinic waiting room materials • Community events • Local media coverage • Public health campaigns

Conclusion

Successful oral health care and primary care integration requires a coordinated approach that combines clear strategy, effective messaging, and engagement with the right audiences through trusted messengers and communication channels. While evidence supporting integration continues to grow, meaningful progress depends on raising awareness, building partnerships, and mobilizing leaders across health care clinical systems and policy areas. Highlighting the connection between oral health and overall health, while encouraging stakeholders to implement integrated care policies, programs, and models, can help support and maintain integrated care.

Integrating oral health care and primary care is not solely a clinical or operational challenge; it is also a communication and leadership opportunity. By working collaboratively and effectively, communities, health systems, and public health leaders can accelerate progress toward a health care system where the connections between oral health and overall health are recognized and addressed.

Reference

1. The National Consumer Voice for Quality Long-Term Care. No date. *Crafting an Effective Advocacy Message: Advocacy Toolkit*. Washington, DC: The National Consumer Voice for Quality Long-Term Care.

Summary Listing of Practice Examples

The following table provides a listing of programs and activities submitted by states and organizations. Each practice name is linked to a detailed description.

Practice Examples Illustrating Strategies and Interventions for Integrating Oral Health Care into Primary Care			
#	**Practice Name**	**State**	**Practice**
1	Medical-Dental Integration as an Organizational Strategy in a Safety-Net Dental Program	CA	06015
2	Cavity Free at Three	CO	07009
3	Rocky Mountain Network of Oral Health (RoMoNOH)	CO	07010
4	Improving Oral Health for Young Children in Connecticut Through Policy, Practice, Education and Evaluation	CT	99011
5	Integrating Dental Hygienists into Interprofessional Hospital Care Teams	MN	99012
6	Into the Mouths of Babes (IMB) Program	NC	36010
7	MORE Care Ohio	OH	38011
8	A Unified Approach to Patient Wellness: Integrating HPV Prevention and A1c Testing in Dental Care	OR	99013
9	*Smiles for Life*: A National Oral Health Curriculum	OR	99014
10	Migrant and Ute Tribe Head Start-based Oral Health Interprofessional Collaboration	UT	50001
11	Helen M. Knight School-based Oral Health Program	UT	50002
12	Advancing Maternal and Child Health Through Integrated Oral Health	WI	56008

Highlights of Practice Examples

CA Medical Dental Integration as an Organizational Strategy in a Safety-Net Dental Program (Practice #06015)
Petaluma Health Center's medical-dental integration program has evolved over more than two decades. During this time, the program tested multiple integration models. Key lessons were that integration must be operationalized, not merely encouraged; closed-loop scheduling outperforms passive referral; staff champions are essential; workflows must fit real clinical operations; and sustainability depends on continuous quality improvement, data review, and adaptation to changing conditions. The program's long-term aim is to make oral health a routine and visible part of whole-person care, especially for children, pregnant women, and people with chronic diseases, such as diabetes.

CO Cavity Free at Three (Practice #07009)
Cavity Free at Three (CF3) trains medical professionals and oral health professionals, clinical staff, and health professional students to provide preventive oral health care for children from birth to age 5 and for pregnant women. The CF3 six essential services include the caries risk assessment, clinical evaluation, fluoride varnish application, anticipatory guidance, self-management goal setting, and establishing dental homes. The CF3 training and technical assistance model focuses on clinic-wide implementation, resulting in increased clinic capacity for implementation and supporting sustainability of the program over time, particularly during periods of high turnover.

CO Rocky Mountain Network of Oral Health (RoMoNOH) (Practice #07010)
RoMoNOH developed and implemented a change package to support the integration of oral health clinical competencies into primary care in 34 community health centers (CHCs). RoMoNOH supported CHCs in establishing several models of care depending on the oral health needs of the population, capacity of the CHC to manage these needs, and the state's policies and regulations on the provision of preventive oral health care (e.g., scope of practice of medical and oral health providers and Medicaid reimbursement). The models included delivery of preventive oral health services by medical team members, by dental hygienists embedded in the medical team, or a hybrid of these two models. In all models, referrals to establish a dental home included coordinated referrals from the primary care providers and/or dental hygienists to off-site oral health providers and/or co-located oral health providers depending on the oral health needs and availability of dental services within the CHC and community.

CT Improving Oral Health for Young Children in Connecticut Through Policy, Practice, Education and Evaluation (Practice #99011)
Supported by a $1.7 million federal grant, the project uses robust data collection and evaluation to track implementation and outcomes. Sustainability efforts focus on embedding services into existing clinical systems, securing reimbursement pathways, and advancing supportive policies. Key lessons emphasize the importance of aligning reimbursement policies with clinical workflows, addressing social determinants of health, and actively engaging both providers and caregivers to improve oral health literacy. Strong partnerships across agencies and organizations have been critical, though coordination remains complex.

MN Integrating Dental Hygienists into Interprofessional Hospital Care Teams (Practice #99012)
Integrating dental hygienists into hospital care teams enhances both patient outcomes and interprofessional collaboration. In critical care settings, dental hygienists provide specialized expertise in oral assessment and oral bacterial biofilm management, while promoting a comprehensive approach to

managing medically complex patients, all key components that are often overlooked. By collaborating with nursing and medical staff, dental hygienists help standardize oral care practice; deliver bedside education to patients, caregivers, and medical staff; and reinforce evidence-based oral care protocols. These efforts improve oral care compliance and may reduce the risk of hospital-acquired infections, including ventilator associated pneumonia and non-ventilator hospital acquired pneumonia.

NC Into the Mouths of Babes (IMB) Program (Practice #36010)

Launched in 2000, North Carolina's IMB program reimburses primary care medical providers to deliver preventive oral health services to Medicaid-enrolled children from tooth eruption through age 3.5. Over 25 years, IMB has grown into a nationally recognized model of medical-dental integration cited in federal guidelines and emulated in 35 states. Key success factors include equal and sustained commitment from all partner organizations; bidirectional data loops translating research into protocol updates; intentional quality improvement integration; and preservation of Medicaid reimbursement through multiple managed care transitions.

OH MORE Care Ohio (Practice #38011)

The Medical Oral Expanded Care (MORE Care®) Ohio pilot was a 2-year initiative designed to strengthen medical-dental integration for children by embedding preventive oral health services into pediatric primary care and improving coordination between medical and dental providers. Led by the CareQuest Institute for Oral Health in partnership with Oral Health Ohio, a statewide oral health coalition, the pilot tested a structured, evidence-based approach focused on feasible, practice-level change. This pilot offers several practical considerations for communities interested in applying similar integrations strategies: start with existing resources, prioritize relationships, focus on feasible workflow changes, track progress using simple tools, and support peer learning.

OR A Unified Approach to Patient Wellness: Integrating HPV Prevention and HbA1c Testing in Dental Care (Practice #99013)

In 2019, the Oregon legislature passed a law allowing dentists to administer all vaccinations to patients of all ages after completing a board approved course. The state's childhood immunization rates were already falling, and the dental team could provide another entry point for parents to ensure their children were vaccinated. As HPV-related oropharyngeal cancer cases increased nationally, HPV education and vaccinations were also added to the list. Building on the success of HPV education and vaccination efforts, the dental team's role was expanded to include support for patients with diabetes by offering HbA1c testing during dental visits. This effort strengthens collaboration between dental and medical providers, enhances care coordination, and expands the impact of dental professionals on overall health—positioning oral health settings as a valuable touchpoint for proactive chronic disease management.

***Smiles for Life*: A National Curriculum (Practice #99014)**

Smiles for Life: A National Oral Health Curriculum (SFL) is a comprehensive, peer-reviewed oral health curriculum for primary care clinicians. It was developed for family physicians in 2005 by the Society of Teachers of Family Medicine Group on Oral Health and expanded to include other primary care clinicians (physician assistants, nurses and nurse practitioners, midwives, medical assistants, pharmacists, and front-line healthcare workers). The curriculum is available online as web-based interactive courses. There are nine 1-hour modules, which cover core areas of oral health. They are available both online and as downloadable PowerPoint files that can be used in a train-the-trainer fashion. All courses are free and available for continuing education credit.

UT Migrant and Ute Tribe Head Start-based Oral Health Interprofessional Collaboration (Practice #50001)

Through a partnership between the University of Utah Physician Assistant Program, Utah Department of Health and Human Services (DHHS), and Head Start, this interprofessional initiative provides essential medical and oral health screenings for underserved children aged 0–5 years. By integrating clinical care directly into Migrant and Ute Tribe Head Start centers, the program bypasses traditional barriers to healthcare in rural Utah. Key program components include collaborative care, preventive intervention, continuity of care, and interprofessional development. By identifying health concerns early and providing culturally informed care, this partnership helps ensure that Utah's most vulnerable children meet federal performance standards and remain healthy, ready to learn, and supported within their communities.

UT Helen M. Knight School-based Oral Health Program (Practice #50002)

A school nurse in Grand County, Utah initiated a strategic partnership with Brigham Young University (BYU) College of Nursing and the Utah Department of Health and Human Services Oral Health Program. With funding from the Bates Family Foundation and the BYU College of Nursing, this partnership delivers essential preventive services to a rural community facing considerable geographic and economic barriers to care. Through collaboration with local partners, the nurse successfully facilitated access to care for many children at high-risk. This program, piloted in March 2024, continues to operate in each subsequent school year. It provides classroom education, hygiene kits, oral health risk assessments, and fluoride varnish applications. The program gathers critical data, offering objective evidence of the community's oral health needs and the results of collaborative intervention.

WI Advancing Maternal and Child Health Through Integrated Oral Health (Practice #56008)

The Wisconsin Medical Dental Integration project addresses persistent inequities in early preventive oral health care for children and pregnant women, particularly among families with low-income and communities of color. Since launching in 2019, the project has supported clinics statewide with workflow design, electronic health record modifications, billing strategies, financial planning, referral network development, and evaluation. Current goals focus on expanding oral health literacy, strengthening surveillance, training nondental providers, improving data collection, and disseminating findings to support broader adoption. Sustainability relies heavily on Medicaid billing, which provides a stable revenue stream for preventive services delivered in primary care. Clinics are encouraged to use established procedure codes for assessments, fluoride varnish, and other early interventions to maintain financial viability beyond grant funding. The project collects monthly process data and annually reviews CMS-416 reports to compare medical and dental utilization, helping identify gaps in early preventive care.

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