DATA ABSTRACTION OF INCLUDED PRIMARY STUDIES

Author Year N Setting	Follow-up	Patient Characteristics Mean age %male %white Severity of chronic disease Severity of periodontal disease Comorbidities	Intervention vs comparator	Outcomes KQ1: Patient-reported symptoms & complications of chronic disease KQ2: Indicators of chronic disease mgmt KQ3: Health care utilization & costs KQ4: Harms
Agado 2012[26] RCT N=30 United States	1 month	Adults with COPD and chronic periodontitis (≥1.5 mm MAL) **Mean age:** 64 **%male:** 67% **%white:** 83% **Severity of chronic disease:** NR **Severity of periodontal disease:** Mean plaque index = 1.9; Mean attachment loss (MAL)= 3.9 mm **% comorbidities:** 87% current or former smokers	Periodontal debridgement using magnetostrictive ultrasonic instruments (n=10) vs same treatment with hand instruments (n=10) vs no treatment (n=10)	**KQ1:** No significant pre-post or between-group differences in quality of life in chronic airway disease (SGRQ-A), overall self-assessment of health, or Illness Questionnaire. **KQ2:** NR **KQ3:** Fewer people had a doctor's visit in the 4 weeks after periodontal treatment/no treatment than the 4 weeks before periodontal treatment- but the ratio was similar across groups. **KQ4:** No adverse events occurred during the study period.
Albert 2006[27] Retrospective cohort N=116,306 United States	NR, but maximum of 2 years possible	People with diabetes mellitus, coronary artery disease, and/or cerebrovascular disease with concomitant and continuous medical and dental coverage **Mean age:** 57.2 years (patients with DM), 63.5 years (patients with CAD), 68.5 years (patients with CVD). **%male:** 48% **%white:** NR **Severity of chronic disease**: NR **Severity of periodontal disease**: NR **% comorbidities:** Diabetes mellitus (44.33%), Coronary artery disease (64.71%), cerebrovascular diseases (19.05%).	(1) periodontal treatment (periodontitis or gingivitis); (2) regular dental maintenance services (DMS); (3) other dental services; or (4) no dental services	**KQ1:** NR **KQ2:** NR **KQ3:** The DM, CAD and cerebrovascular condition groups who received periodontitis treatment incurred significantly higher PMPM medical costs than enrollees who received gingivitis treatment, DMS, other dental services, or no dental services ($p < .001$). **KQ4:** NR
Blaschke 2020[28]	Years 2-3 after T2	Adults newly diagnosed with T2 diabetes who are continuously insured	Any periodontal treatment (codes	**KQ1:** NR **KQ2:** NR

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Retrospective claims analysis N=23,771 Germany	diagnosis	**Mean age:** 61 **%male:** 55% **%white:** NR **Severity of chronic disease**: NR **Severity of periodontal disease**: NR **% comorbidities:** Charlson comorbidity score= 1.2	on German uniform assessment standard for dental services [BEMA] of P200-P203, 108, and 111) vs no periodontal treatment	**KQ3:** People newly diagnosed with DM who undergo periodontal treatment have 4% lower health care costs compared with those who have no periodontal treatment (ATE = 0.96, 95%CI 0.89; 1.04). Those who undergo periodontal treatment also have lower inpatient costs (-13%; 95%CI 0.69; 1.08), in diabetes-related drug costs (-7%; 95%CI 0.84; 1.03) as well as in other drug costs (-3%; 95%CI 0.89; 1.05). All findings were not statistically significant. **KQ4:** NR
Choi 2020[29] Computer-based simulation model N=10,000 simulated patients United States	NR, but data presented as costs or outcomes per year	Data for model drawn from a nationally representative sample of adults 30-85 years old **Mean age:** NR **%male:** NR **%white:** NR **Severity of chronic disease**: NR **Severity of periodontal disease**: NR **% comorbidities:** NR	Increase of periodontal treatment coverage among ppl with T2 diabetes (from 28% to 88%), which would include an initial treatment of scaling and root planing plus maintenance every 3 months. 100% compliance assumed.	**KQ1:** Expanded coverage expected to avert possible tooth loss by 34.1% (95% CI 239.9, 226.5) and reduce CVD incidence by 7.3% (95% CI 220.3, 20.3) and 5.0% (95% CI 220.8, 3.9) for MI and stroke, respectively. Nephropathy, neuropathy, and retinopathy incidence would be expected to decline by 20.5% (95% CI 231.2, 29.1), 17.7% (95% CI 232.7, 24.7), and 18.4% (95% CI 234.5, 23.5). Expanded periodontal treatment coverage produced an estimated gain of 0.6 discounted QALYs per capita (95% CI 0.5, 0.6) over the life course. **KQ2:** NR **KQ3:** Expanded treatment coverage was cost-saving at a net savings of $5,904 per capita (95% CI 26,039, 25,769) and had an incremental cost-effectiveness ratio (ICER) of $10,542 saved

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				per QALY gained. People with higher HbA1c (>8%) experienced more QALY gains compared to those with lower HbA1c (<7%). People who were older (65+), and those who were low income and part of racial/ethnic minority groups (black and Mexican Americans) also experienced more QALY gains. **KQ4:** NR
Das 2019[30] RCT N=51 India	3 months	T2DM patients with moderate to severe periodontitis **Mean age:** 45.9 **%male:** 59% **%white:** NR **Severity of chronic disease**: NR **Severity of periodontal disease**: All had moderate to severe periodontitis **% comorbidities:** All ppts had no evidence of other oral or systemic diseases	Scaling and root planing (SRP) vs SRP with doxycycline (dox) vs no treatment	**KQ1:** NR **KQ2:** SRP with dox reduced HbA1c compared to no treatment (.87%, p>.01) and SRP without dox reduced HbA1c compared to no treatment (.55%, p>.01). SRP with dox reduced fasting plasma glucose (FPG) compared to no treatment (13.23 mg/dL, p>.01) and SRP without dox reduced FPG compared to no treatment (4.99 mg/dL, p>.01). SRP with dox reduced PPG compared to no treatment (22.11 mg/dL, p>.01) and SRP without dox reduced PPG compared to no treatment (13.28 mg/dL, p>.01). **KQ3:** NR **KQ4:** NR
El-Makaky 2020[31] RCT	3 months	T2DM patients with chronic periodontitis **Mean age:** 52 **%male:** 43.2% **%white:** NR **Severity of chronic disease**: None had	Treatment with SRP with antibiotics and oral hygiene instructions vs	**KQ1:** NR **KQ2:** HbA1c decreased in the intervention group and increased in the control group at 3 months (difference in difference of .98%). Difference between groups was significant at 3 months

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N=88 Egypt		major diabetic complications **Severity of periodontal disease**: All had moderate to severe periodontitis **% comorbidities:** None had any systemic conditions besides hypertension	delayed treatment	(p<.001). **KQ3:** NR **KQ4:** No side effects of periodontal therapy.
Hsu 2019[32] Case-control N=440 Taiwan	NR	T2DM patients with poor and good glycemic control **Mean age:** 56.9 **%male:** 57% **%white:** NR **Severity of chronic disease**: NR **Severity of periodontal disease**: 24% good or very good oral health, 48% common, 27% poor or very poor **% comorbidities:** 15% were smokers	Non-periodontal disease (NPD), Periodontal treatment (PT), and Non-periodontal treatment (NPT)	**KQ1:** Among those with well-controlled T2DM, there was no significant difference between PT group and non-PT group on OHIP-14T (7.99 vs 8.43). Patients with poorly controlled T2DM in the PT group had a significantly lower OHIP-14T score than did those in the NPT group (6.05 vs 9.02). **KQ2:** NR **KQ3:** NR **KQ4:** NR
Jeffcoat 2014[33] Retrospective observational cohort N=338,891 United States	NR, but maximum of 5 years possible	Patients who had at least 1 pregnancy between 2005-2009 or had a diagnosis of 1 or more specified systemic condition (T2DM, coronary artery disease, cerebrovascular disease, rheumatoid arthritis). **Mean age:** 48.7 **%male:** 55% **%white:** NR **Severity of chronic disease**: NR **Severity of periodontal disease**: NR **% comorbidities:** NR	Periodontal treatment vs untreated controls)	**KQ1:** NR **KQ2:** NR **KQ3:** Patients with cerebrovascular, diabetes or CAD who received periodontal tx had significantly lower rates of inpatient admissions than those who did not receive periodontal tx. Patients with CVD, diabetes, or CAD who received periodontal tx had significantly lower annual medical costs. **KQ4:** NR
Kucukcoskun 2013[34]	12 months	Patients with COPD with chronic periodontitis (CP) and a history >1 infective exacerbation in the previous	Periodontal treatment vs no periodontal	**KQ1:** Intervention group had lower frequency of exacerbations (1.95 vs 3.25 exacerbations/patient-year) and lower median number of exacerbations

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Prospective controlled group trial N=40 Turkey		year **Mean age:** 59.8 **%male:** 87.5% **%white:** NR **Severity of chronic disease**: COPD severity was as follows: 13 moderate and 7 severe to very severe in the test group; 9 moderate and 11 severe to very severe in the control group. **Severity of periodontal disease**: All had chronic periodontitis **% comorbidities:** NR	treatment	(2 vs 3) in follow-up. Intervention had a greater number of pts that had decreased exacerbations (12 vs 6). **KQ2:** NR **KQ3:** NR **KQ4:** NR
Lee 2013[35] Retrospective cohort study N= 719,436 Taiwan	NR, but max length of 10 years	Adult patients (older than 20 years) with periodontal disease (PD) **Mean age:** 87% were <65 years old **%male:** 51.1% **%white:** NR **Severity of chronic disease**: NR **Severity of periodontal disease**: NR**% comorbidities:** Hypertension (24.15%), Diabetes Mellitus (11.25%), Atrial fibrillation (.83%), atherosclerosis (1.5%), chronic kidney diseases (4.1%), dyslipidemia (15.82%)	PD patients who only received dental prophylaxis, PD patients who received intensive periodontal treatments (*ie*, subgingival curettage and root planing, or periodontal flap operation or tooth extraction), and PD patients who received no treatments	**KQ1:** When comparing stroke incident rates (IRs) after being stratified by comorbidity (including hypertension, diabetes, atrial fibrillation and atherosclerosis), the lowest stroke IR of the PD population always appeared in the dental prophylaxis group, followed by intensive treatment or tooth extraction group, and the highest stroke IR appeared in PD without treatment group (P for trend test <0.001 or =0.006). **KQ2:** NR **KQ3:** NR **KQ4:** NR
Lee 2020[36] RCT	3 months	People with periodontal disease (PD) **Mean age:** 72.6	Scaling and root planing (SRP), vs Scaling and root	**KQ1:**NR **KQ2:** No significant differences in HbA1c between intervention and control group at baseline but

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N=60 Korea		**%male:** 50% male **%white:** NR **Severity of chronic disease**: NR **Severity of periodontal disease**: NR **comorbidities:** NR	planing & toothbrushing (SPRT) vs no treatment	there was a difference favoring intervention group at 3 months (difference of .51 to .55 depending on intervention group; p<.05). No significant differences in serum IL-1b levels between intervention and control groups at baseline or 3 months. No significant differences in serum endotoxin between intervention and control group at baseline but there was a difference favoring intervention group at 3 months (difference of 1.27 to 1.43 depending on intervention group; p<.05). **KQ3:** NR **KQ4:** NR
Minassian 2010[37] Self-controlled case series N=1,175 United States	4.25-year observation period on average	Medicaid recipients exposed to invasive dental treatment with a primary hospital discharge diagnosis of ischemic stroke (n=650) or myocardial infarction (n=525) **Mean age:** 55.4% were <65 years old **%male:** 39.8% **%white:** 48.4% **Severity of chronic disease**: NR **Severity of periodontal disease**: NR **% comorbidities:** Diabetes (41%), hypertension (70.2%) coronary heart disease (40.8%)	Invasive dental treatment (those that may feasibly result in bacteria and induce an inflammatory response, including periodontal therapy and simple or complex tooth extractions). 89% were extractions.	**KQ1:** Rate of vascular events (MI or stroke) significantly increased in the first 4 weeks after invasive dental treatment (incidence ratio, 1.50 [95% CI, 1.09 to 2.06]) compared to baseline and gradually returned to the baseline rate within 6 months. In the entire study population, the rate of myocardial infarction (n =525) was higher in the first 4 weeks after an invasive dental treatment compared with baseline (incidence ratio, 1.56 [CI, 0.98 to 2.47]) and seemed to decrease over 24 weeks. For ischemic stroke (n = 650), a slightly elevated risk was seen during the first 4 weeks after an invasive dental treatment (incidence ratio, 1.39 [CI, 0.89 to 2.15]), although this was less marked and the pattern of resolution was less clear. **KQ2:** NR

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				KQ3: NR **KQ4:** NR
Mizuno 2017[38] RCT N=40 Japan	6 months	Adults (age 30+) with T2 diabetes and mild to advanced periodontitis **Mean age:** 61 (tx) vs 63 (control) **% male:** 76% male **% white:** NR **Severity of chronic disease:** 38% used insulin **Severity of periodontal disease**: mean PPD 2.4 **Comorbidities:** 19% smokers, 38% drinkers,	Scaling and root planing w/ oral hygiene instruction vs oral hygiene instruction alone	**KQ1:** Intervention and control groups were not significantly different in their total diabetes therapy-related QoL score at 3 months. **KQ2:** No differences between intervention and control in changes in HbA1c at 3 or 6 months. There were improvements in oxidative index (oxidative stress) in intervention vs control at 3 months (-1.19, 95% CI [-2.03 to -0.35]). **KQ3:** NR **KQ4:** No serious study-related adverse events occurred in either group.
Nasseh 2017[39] Retrospective claims analysis N=15,002 United States	Years 3-4 after T2 diagnosis	Adults (age 18-64) newly diagnosed with T2D with continuous medical and dental insurance coverage **Mean age:** 50.9 (PT) vs 50.1 (no PT) **% male:** 58% (PT) vs 53% (no PT) **% white:** NR **Severity of chronic disease:** NR **Severity of periodontal disease**: NR **Comorbidities:** Charlson index = 0.15 (PT) vs 0.14 (no PT)	Any periodontal treatment (PT) visit (codes on dental procedures and nomenclature D4000 through D4999) vs no PT	**KQ1:** NR **KQ2:** NR **KQ3:** Those newly diagnosed with T2D who undergo a periodontal intervention have total health care costs that are $1799 lower on average over years 3 and 4 compared with those who have not had a periodontal intervention. In subgroup analyses, this association was only noted among individuals who did not initiate diabetes prescription drug therapy after diagnosis. Overall, net savings ($1799 savings - $408 periodontal treatment) was $1328 over 2 years. Total medical costs are $1577 less on average for the treatment group. Total diabetes-related healthcare costs are $408 lower on average for the treatment group.

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				There are not statistically significant differences in total outpatient physician visits, probability of a hospitalization, or the occurrence of an emergency room visit between the treatment and control groups. **KQ4:** NR
Peng 2017[40] Retrospective cohort N= 15,195 Taiwan	NR, but max of 3 years	Patients with type 2 diabetes and periodontal problems. **Mean age:** 53.1 vs 53.0 (unmatched advanced vs non-advanced); 53.1 (matched) **% male:** 60% vs 53.9% (unmatched advanced vs non-advanced); 60% (matched) **% white:** NR **Severity of chronic disease**: NR **Severity of periodontal disease**: NR **% comorbidities:** hypertension 54.6-56.2%; chronic liver disease 18.6%-20.3%; COPD 6.9%-8.9%; renal disease 3-3.7%, mental disorder 11-11.3%; cancer 3.1-3.5% depending on group	Periodontal treatment (advanced periodontal treatment group and the non-advanced periodontal treatment group)	**KQ1:** The Cox proportional hazards analysis revealed that although the overall incidence of CVD was not significantly improved (Hazard ratio, HR 0.95; 95% CI 0.90-1.01), advanced periodontal treatment reduced the rates of myocardial infarction (HR 0.92; 95% CI 0.85-0.99) and heart failure (HR 0.60; 95% CI 0.45-0.80). There was no significance difference in the incidence of stroke (HR 0.95; 95% CI 0.85-1.06). **KQ2:** NR **KQ3:** NR **KQ4:** NR
Smits 2020[41] Retrospective claims analysis N=41,598	NR, but 7 years max	Individuals with diabetes **Mean age:** 73.5% <65 years old **%male:** 54.3% **%white:** NR **Severity of chronic disease:** All ppts were taking medication (insulin, metformin, or other DM medication)	Periodontal treatment	KQ1: NR KQ1: NR KQ2: NR KQ3: The median diabetes-related health care costs per patient in 2012 were €38.45 per quarter (IQR €11.52–€263.14), including diagnoses, treatment, medication and hospitalization costs. The fixed

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Netherlands		**Severity of periodontal disease**: NR **% comorbidities:** NR		effect models showed €12.03 (95% CI −€15.77 to −€8.29) lower diabetes-related health care costs per quarter of a year following periodontal treatment compared with no periodontal treatment. KQ4: NR
Solowiej-Wedderburn 2017[42] Modeling study N= NA UK	NR	Patients with type 2 diabetes **Mean age:** Base case based on a male(female) aged 46 (49), 58 (61), or 69 (72) **%male:** NR **%white:** NR **Severity of chronic disease**: Base case based on those in the 7-7.9%, 8-8.9% and 9-9.9% HbA1c range **Severity of periodontal disease**: NR **% comorbidities:** NR	Periodontal treatment (assumed to be 2 60-minute sessions with a practitioner then regular maintenance therapy every 3 months with a hygienist), repeated every 3 years with 30% compliance	KQ1: NR KQ2: NR KQ3: Cost savings from reduction in HbA1c, and from reductions in tooth loss following periodontal treatment, are modest. After including these savings, total cost in the treatment arm remains higher than the control. Intervention is more cost-effective in patients with higher HbA1c for whom DiabForecaster predicts larger health gains. The intervention is also more cost-effective in older patients for whom lifetime costs of periodontal treatment are lower. KQ4: NR
Wang 2020[43] RCT N=58 China	6 months	Adults (over 40 yrs old) with T2 diabetes with chronic periodontitis **Mean age:** 64 **%male:** 57% **%white:** NR **Severity of chronic disease**: 38% had microvascular complications **Severity of periodontal disease**: NR **% comorbidities:** 12% were smokers, 66% had hypertension, 53% had hyperlipidemia	Non-surgical periodontal treatment (oral health instruction, scaling and root debridement, removal of teeth as needed, reinforcement of oral hygiene & plaque control at 2-3 months) vs oral health instruction & reinforcement only	KQ1: NR KQ2: Periodontal treatment reduced the mean E/e' ratio by 1.66 (95% CI: −2.64 to −0.68, p < .01) compared to controls. Left ventricle mass index (LVMI) was not improved after treatment. There was also no significant improvement in mean HbA1c, hs-CRP, IL-6, or NT-proBNP in intervention compared to control group. KQ3: NR KQ4: NR

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United Health care 2013[44] Retrospective claims analysis N=130,546 United States	1-4 years, but annual costs reported	Adults (18-65) dual enrolled in medical and dental benefits with 1 of 6 chronic diseases (diabetes, asthma, CAD, congestive heart failure, COPD, chronic kidney/renal disease) **Mean age:** NR **%male:** NR **%white:** NR **Severity of chronic disease**: NR **Severity of periodontal disease**: NR **% comorbidities:** 6.8% of those with diabetes also had CAD; other comorbidities NR	Periodontal treatment (surgical or non-surgical, with or without maintenance) vs cleanings (frequent or infrequent) vs no periodontal treatment (bacteria-removing treatments, other dental claims, no dental claims)	**KQ1:** NR **KQ2:** NR **KQ3:** **Diabetes:** Annual medical costs were $7,838 for diabetics receiving periodontal care. Diabetics receiving other or no dental treatments had medical costs of $9,588, for a medical-only savings of $1,750. **CAD:** Individuals with CAD who visited the dentist for cleanings and/or periodontal treatment had lower medical costs than individuals who received no dental treatment (average annual costs NR). Those received periodontal treatment had lower annual medical costs compared to those who did not receive periodontal treatment (average $15,549-$16,271 in periodontal treatment group vs $20,502-$21,202 in no treatment group depending on compliance with medical care). **Congestive heart failure**: Those with congestive heart failure who received periodontal treatment had lower annual medical costs compared to those who did not receive periodontal treatment (average $35,669-$36,172 vs $47,332-$49,064 depending on medical compliance). **COPD**: Those with COPD who received periodontal treatment had lower annual medical costs compared to no periodontal treatment (average $12,938-$38,450 vs $15,817-$52,484 depending on medical compliance).

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				KQ4: NR
Vergnes 2018[45] RCT N= 91 France	3 months	Participants with type 1 or 2 diabetes **Mean age (Control vs Treatment):** 53.7 vs 50.9 (Type 1 diabetes) and 63.1 vs 68.3 (type 2 diabetes) **%male:** 57% vs 59% (Type 1 diabetes) and 82% vs 62% (Type 2 diabetes) **%white:** NR **Severity of chronic disease**: HbA1c (baseline 7.83-7.84 T1 diabetes; 7.78-7.96 T2 diabetes) **Severity of periodontal disease**: T1 diabetes (12% generalized/severe, 32% generalized/moderate, 38% localized/severe, 16% localized/moderate periodontal disease); T2 diabetes (25% generalized/severe, 42% generalized/moderate, 33% localized/severe, 0% localized/moderate periodontal disease) **% comorbidities:** Smokers (23-24% T1 diabetes; 0-15% T2 diabetes); receiving drug tx for cardiovascular disease (50-58% T1 diabetes; 30-82% T2 diabetes); receiving drug tx for respiratory tract (0-3% T1 diabetes; 0-8% T2 diabetes)	Periodontal treatment (Non-surgical scaling and root planing, systemic antibiotics, providing supply of if oral hygiene/health products) vs delayed periodontal treatment	**KQ1:** Mean sum of General Oral Health Assessment (GOHAI) increased in the treatment group compared with the control group) when both diabetes types were combined, but there were no differences between treatment and control for T2 diabetes alone. No significant changes any of the 8 domains of the SF-36 for those with either T1 or T2 diabetes. **KQ2:** NR **KQ3:** NR **KQ4:** Fifteen and 18 control and treatment subjects, respectively, experienced oral disorders (p = 0.37). The treatment group experienced more dental hypersensitivity (p = 0.03) but with a tendency towards less diffuse pain (p = 0.07).

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Zhou 2014[46] RCT N=60 China	2 years	COPD patients with chronic periodontitis **Mean age:** 63.9 (SRP group), 65.3 (scaling group), 68 (control) **%male:** 80% (SRP), 75% (scaling), 80% control **%white:** NR **Severity of chronic disease**: Gold stage II (60% for all 3 groups); Gold Stage III or IV; 40% for all 3 groups **Severity of periodontal disease**: All had chronic periodontitis **% comorbidities:** Former or current smoker (80% SRP group; 65% scaling group; 70% control group)	Periodontal treatment including scaling and root planing (SRP) treatment, supragingival scaling treatment, or oral hygiene instructions with no periodontal treatment	**KQ1:** The means of forced expiratory volume in the first second/forced vital capacity (FEV1/FVC) and FEV1 were significantly higher in the 2 therapy groups compared with the control group during the follow-up ($p < 0.05$) Frequencies of COPD exacerbation were significantly lower in the 2 therapy groups than in the control group at 2-year follow-up ($p < 0.05$). **KQ2:** NR **KQ3:** NR **KQ4:** NR

Mgmt= Management, RCT= Randomized controlled trial, COPD= Chronic obstructive pulmonary disease, MAL= Mean attachment loss, NR= Not reported, SGRQ-A= American English modified version of the SGRQ, CAD= Coronary Artery Disease, CVD= Cardiovascular disease, DM= Diabetes Mellitus, DMS= Dental Maintenance Services, PMPM= Per member per month, ATE= Average treatment effect, QALYs= Quality-adjusted life years, T2DM= Type 2 Diabetes Mellitus, Ppts= Participants, OHIP-14T= Oral Health Impact Profile, Tx= Treatment, IR= Incidence Rate, QoL= Quality of life, Yrs= Years