



*Problems of Oral Health Disparities:*  
**Can New Products and Technologies  
 Provide Solutions?**

*Edward F. Rossomando, DDS, PhD, MS*

**The Surgeon General's Report on Oral Health in America**

In May of this year, Dr. David Satcher, the Surgeon General, issued a report "Oral Health in America," (to which Drs. Susan Reisine and James Crall contributed). While the report was generally positive about the oral health of the American people, Dr. Satcher went on to state "...this report illustrates profound disparities that affect those without knowledge or resources to achieve good oral care."

**H**ealth disparities are defined as differences in health status and access to health care among racial and ethnic groups, genders and those with disabilities. To illustrate, consider tooth decay, the most prevalent of childhood diseases. In children, tooth decay is five times as common as asthma and seven times as common as hay fever. The Surgeon General reports that about 25% of white children have untreated tooth decay. By comparison, for Native Americans the proportion is 70%, and for African American and Mexican Americans about 40% of the children have untreated tooth decay.

While socioeconomic factors play a significant role, they are not the entire story. Other factors play a role.

Let me make an analogy between access to health care and access to tickets to UConn basketball games.

**Why Can't We All Get Tickets to UConn Basketball Games?**

Why doesn't everyone have access to a ticket to the basketball game? The reasons:

- Cost - Not everyone can afford the ticket.
- Availability - Even if we could, there are only a limited number of seats.
- Interest and Culture - Some don't value basketball.

**Can New Products and Technologies Affect Cost, Availability, Interest and Culture?**

Not surprisingly, cost, availability, interest and culture are the reasons why everyone does not have access to and there are disparities in oral health care. New products and technologies help deal with these variables and move us closer to eliminating the disparities.

**Cost** - While about half of the oral health care 58 billion dollar cost is paid by insurance, the other half is paid for out-of-pocket. Thus, many are paying "cash" for dental services. Because people pay for food, clothing and shelter out-of-pocket, there is competition for the discretionary oral health care dollar. This competition can limit access. To increase access for the group without insurance, we need: to make it more economical for them to visit the dentist; products that allow dentists and other practitioners to be more efficient in the delivery of service; to deliver services at lower cost; new products that provide more information about the patients' overall health; to utilize saliva tests already on the market to measure hormones like progesterone to obtain information on bone loss; easier tests for oral cancer; more products for prenatal care to



**Message from the Dean**

Peter Robinson, DDS, PhD

**A**t the moment we at the School of Dental Medicine have a very full plate because so many projects are requiring an enormous amount of faculty effort at the same time: new curriculum, accreditation, new strategic plan, new faculty evaluation system, maturing team clinic program; along with rotating into a new research strategic plan and working with state agencies to improve access to dental care for underserved children. We are making tremendous progress on all fronts; incredibly all projects are on schedule, thanks to the diligent, hard work from a broad base of faculty and staff.

Though we are experiencing great success, we naturally are also experiencing some frustrations. The source of much of these frustrations is our being a bit over self-critical and exhibiting our natural instinct to drill down to the trivial. Let's not fall prey to losing site of the big picture – whether it is in critiquing our curriculum or writing our self-study documents for accreditation – but keep the forest in sight. There is an old Arab saying I find appropriate for us at this time, "The dogs bark but the caravan moves on."

Thanks to all for putting in the Herculean effort, which is enabling us to achieve our lofty goals.

*Dedication for the UConn Center for Interdisciplinary Research in Women's Health*



Terri Wilson, District Director of the Connecticut Sixth Congressional District



Dr. Susan Reisine, PI and Dr. Jonathan Covault.



Dr. Judith Fifield, Center Program Director, and Dr. Peter Robinson.

**Problems of Oral Health Disparities**

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reduce the incidence of birth defects; more over-the-counter products that will treat dental decay and periodontal disease.

**Availability of Care** – The distribution of dentists in the US follows population, so for people living in rural areas access to dental services is either restricted or unavailable. Therefore, providing oral care to people in areas of low population density presents a challenge. New technologies, however, may offer a solution. We need to use the potential of teledentistry to provide health care and, equally as important, to educate about health care. Using teledentistry to deliver health care will require unique products and technologies because practitioners are needed at both ends of the internet hook-up. It goes without saying that teledentistry could help solve problems of access caused by limits to transportation.

**Interest and Culture** – For many

Americans, oral health is a luxury. This view cuts across all socioeconomic groups. To deal with this view we need educational products designed to convey the Surgeon General's message that points out the relationship between oral health and other systemic diseases like diabetes and heart disease, and we need to get the message out via culturally sensitive educational programs.

**Conclusion** – If cost, availability, interest and culture are factors affecting access and quality of oral health care, then the development of new products and technologies may make it possible to eliminate the disparities in oral health care.

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# An Update on Accreditation

*Dr. Monty MacNeil, Associate Dean for Dental Academic Affairs*

The accreditation effort for the School of Dental Medicine passed another important landmark on Tuesday, Nov. 21, 2000 when faculty convened for the second general faculty forum to discuss progress to date in self-study and tasks to be completed. The six self-study committee chairs provided updates which, as a whole, suggest that the School of Dental Medicine is more than ready to address the challenges and analyses of the ADA review scheduled for October 23-25, 2001. Our long-standing commitment to quality education, research and service will allow a strong and positive response to the majority of the fifty-five accreditation standards. Those isolated areas where modification of existing programs or approaches must occur to ensure school compliance with all standards were discussed in detail during the three-hour forum. Please let me outline those areas where significant activity will occur over the next six months and where faculty may be called upon for additional help.

**1)** Minor revisions in the Strategic Plan, approved in principle by faculty in November, must be finalized so that this document is officially adopted by the school and becomes the base upon which programs are developed or revised and future outcomes referenced.

**2)** SDM departments must revise their existing Standards of Care statements so that they appropriately underpin the new-approved SDM Standards of Care document. Taken together, departmental and school Standards of Care statements will constitute the “gold standard” upon which our clinical teaching and care delivery programs will be based and our quality

assurance programs oriented.

**3)** An updated Clinic Manual outlining clinic policies and procedures will be published and distributed to students and faculty. Policies, including those dealing with infection control in clinical practice, will be clearly described and subsequently monitored.

**4)** The Standard 6, Research Programs committee will concentrate on a thorough description of our strong student research program. Few schools can compare with UConn in this category and it is felt that this should be appropriately communicated in the accreditation document.

**5)** Faculty via Dental Council will be asked to help the accreditation effort in several ways. It is important that several changes in school policy be considered and approved (e.g. our new competency statements and evaluation approach must be described within policies for promotion and graduation). In addition, Dental Council will be asked to review and move towards closure on two important submissions, the Faculty Compensation Plan and the Faculty Development Plan; both issues have significance in our response to Standard 3, Faculty and Staff.

**6)** In Standard 2, Educational Program, efforts will continue towards development of our revised approach to assessment of competency. Fortunately, the majority of this work has been completed. Several new competency evaluations must be yet developed and a database to track student progress must be brought on line. There is a need to assign each of our thirty-three new SDM competencies to a “department of record” that will assume responsibility for tracking stu-

dent progress; this will be immediately addressed by the Competencies Committee. An important initiative that may involve many clinical faculty and students will be the acquisition of data that accurately describes the diversity (e.g. racial, cultural, socioeconomic, medical, etc.) of the population of patients treated by our students. All these tasks will require faculty and student effort but are certainly attainable.

**7)** Finally, and perhaps most critically, the school will embark on a new approach to formally assess its outcomes relative to education, research and clinical care. The Standard 1, Institutional Effectiveness committee found that while various school outcomes were periodically reviewed by individuals, groups or committees, the overall process tended to be episodic and too narrow to affect meaningful, global change. It was recommended that a school-wide approach be adopted wherein all key outcomes are considered collectively and referenced to a defined set of criteria or goals (e.g. the school’s strategic plan, school goals/objectives, student competencies, etc.). It is hoped that formation of the Committee for Assessment and Planning will provide faculty with an avenue to truly participate in assessing SDM outcomes and particularly in the realm of academic and clinical programs.

With the continued support of faculty, staff and students, I’m confident that we can accomplish these remaining tasks and submit a self-study document by July 2001 that appropriately describes the strengths of this school’s various programs.



*Dr. Lou Norton was a guest on a one-week training cruise on the U.S. Coast Guard Barque Eagle (WIX-327) during the last week of August 2000. During the cruise an officer candidate and a guest sailor from a tall ship taking part in OpSail 2000 came down with dental emergencies. Although a professor emeritus of orthodontics, Dr. Norton attended to them and both patients did well. Shown with Dr. Norton in the ship's sickbay are a Coast Guard corpsman and one of the patients, a Coast Guard officer candidate.*

## **New Students Welcomed at School of Dental Medicine**

*Edward A. Thibodeau, D.M.D., Ph.D., Assistant Dean for Admissions*

The School of Dental Medicine is pleased to welcome 39 new students to the Class of 2004. Representative of the national applicant pool, approximately a third of the class are women and 18% come minority backgrounds. All students arrived well prepared with excellent undergraduate academic records and standardized admission tests that ranked them in the 85-90th percentile of all applicants to dental schools during the 1999-2000 admission cycle. From all indications the incoming students appear well prepared to face the challenges of the new dental sciences curriculum that is being inaugurated with their class.

In addition to their strong scholastic preparation, the Class represents a diverse range of interests, backgrounds and talents. More than half of the students in the Class are Connecticut residents or New England residents who are participating in the New England Regional School Program. Others come to the school from as far away as California, Utah, Washington, Oregon

and Idaho. The Class also benefits from a diverse cultural background with students born in Vietnam, Jamaica, Canada, Iran, India, Somalia, Armenia and Ecuador. While the majority of students matriculate having just graduated from college, others come from careers in research, the pharmaceutical industry, and related dental healthcare fields.

As a sign of the reputation the School of Dental Medicine holds within the dental and medical communities, the Class of 2004 has one of the highest percentages of students who are the sons and daughters of dentists and physicians. Approximately 28% (11) of the incoming class are children of dentists practicing in Connecticut, Maine, Massachusetts, Pennsylvania, Rhode Island and Florida. Three students are the children of physicians. Two of the incoming students represent a second generation of dentists within the same family to receive their training at the School of Dental Medicine.



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The Compass is written for the dental school. We strongly encourage everyone to participate by submitting articles, events, milestones, etc. If you have any suggestions, please drop us a line.

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