# Provision of fluoride varnish treatment by medical and dental care providers: variation by race/ethnicity and levels of urban influence

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#### Keywords

fluoride varnish treatment; children; ethnic groups; health services accessibility.

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## Abstract

**Objective:** In 2004, Wisconsin Medicaid policy changed to allow medical care providers to be reimbursed for fluoride varnish treatment (FVT) to children's teeth to improve access and utilization. To date, no study has been published on whether geographic and racial/ethnic variation in the provision of FVT in response to this policy change exists. This study's objective is to examine the association of rates of FVT for children enrolled in Wisconsin Medicaid with race/ethnicity, urban influence codes (UIC), and dental health professional shortage area (DHPSA) designation based on county of residence.

**Methods:** A retrospective, pre–post design was used based on FVT claims for children in the Wisconsin Medicaid program from 2002 to 2006. Poisson regression models were used to evaluate the association of rates of FVT claims with race/ ethnicity, UIC, and DHPSA designation.

**Results:** The rate of FVT claims varied by resident county-type according to UIC and DHPSA designation, age, and race/ethnicity. Post-policy, the largest increases were observed for Native Americans residing in non-DHPSA counties, enrollees living in rural counties, and for Hispanics living in partial and entire DHPSA counties. African-Americans residing in partial DHPSA and metropolitan counties displayed the lowest rates of FVT claims.

**Conclusions:** Overall access and utilization of FVT increased, but substantial racial/ ethnic and geographic variation in the provision of FVT for children enrolled in Wisconsin Medicaid was observed. Future policies should incorporate measures that will specifically address the racial and geographic variations identified in this study.

# Introduction

The dental Medicaid program has made considerable changes aimed at improving access to dental care, including increased reimbursement, broadened coverage, and reduced administrative burden (1-3). However, many Medicaid

Presented in part as an oral presentation at the annual meeting of the American Association of Public Health Dentistry, National Oral Health Conference, April 20, 2009, in Portland, Oregon. enrollees still suffer disproportionately from dental disease (4). To reduce oral health disparities and improve access to primary preventive dental care, many states now involve medical care providers as an additional source of primary preventive procedures and oral health risk assessment (5,6). Fluoride varnish treatment (FVT) represents one such procedure advocated by the American Dental Association for caries prevention for children as young as 6 months old (7). As of December 2008, 28 states have implemented policies whereby medical care providers can be reimbursed for FVT to

children's teeth (8). In a recent study by our group, it was shown that such a policy, implemented in 2004, has led to an appreciable increase in the rate of FVT received by children enrolled in the Wisconsin Medicaid program (9). In particular, medical care providers were instrumental in the provision of FVT for children under the age of 3, accounting for approximately three-quarters of claims submitted after the policy change (9).

However, an issue that was not addressed in this previous study was the relationship of race/ethnicity and geographic variation in the provision of FVT following the involvement of medical care providers. This relationship is particularly important given that the shortage and geographic maldistribution of dentists nationally has led many areas to be designated as dental health professional shortage areas (DHPSAs) (10,11). In 2008, the Health Resources and Services Administration identified 4,048 DHPSAs nationally with 48 million residents, implying that approximately 9,432 additional dental providers would be needed (assuming a population to practitioner ratio of 3,000:1) to meet the dental care needs of the population (12,13). From a policy and planning perspective, it is important to assess whether the involvement of medical care providers is more or less effective in areas suffering from deferential shortages of dental professionals. Such investigations could illuminate geographic regions that may be less receptive to the involvement of medical care providers in the delivery of preventive oral health care, thus necessitating further alternative approaches.

Geographic variation in the provision of FVT is also invariably tied to the issue of rural-urban disparities in access to dental care. For example, Byck et al., in a study of Medicaid enrolled children in Illinois, documented lower dental service utilization rates in rural counties compared with metropolitan counties (14). Vargas et al., using data from the National Health and Nutrition Examination Survey, reported that rural children were more likely to lack dental insurance, report unmet dental needs, and to not have visited the dentist in the past year (15). The goal of the present study was to examine geographic and racial/ethnic variation in the provision of FVT following the 2004 policy change that allowed medical care providers to be reimbursed for FVT in Wisconsin. The policy change was statewide and included training sessions for physicians. The Department of Health Services (formerly Department of Health and Family Services), Division of Public Health led the training and recruited physicians through office contact. We sought to investigate such variation at the county-level both as a function of whether an enrollee lives in a county designated as a DHPSA and according to its urban influence code (UIC, see methods). We also sought to examine whether there is a racial/ethnic component to this variability, i.e., whether the provision of FVT across racial/ethnic groups differed by geographic location.

# Methods

#### Data source

We used Medicaid claims data from 2002 to 2006 from the Electronic Data Systems of Medicaid Evaluation and Decision Support (MEDS) database for the state of Wisconsin. This database, managed by the Division of Health Care Financing in the Wisconsin Department of Health and Family Services, contains all Medicaid claims for the state of Wisconsin. The claims data consisted of fee for service claims and managed care encounter information for those children receiving FVT (procedure code D1203). We employed a retrospective pre-post design whereby FVT claims were extracted 2 years prior to the policy change involving medical care providers, as well as for the 3 years following its initiation. Because an individual's enrollment status can change within the course of a year, enrollment data were used to normalize the rate of claims for FVT relative to the number of person-years of enrollment. The Medicaid enrolled population was defined as children between the ages of 1 and 6 years with at least 1 month of eligibility between January 1, 2002 and December 31, 2006. As an example, a child enrolled for an entire year contributes one person-year of enrollment for calculating the rate of FVT.

#### **Demographic variables**

Demographic variables obtained from the MEDS database included the race/ethnicity and age of each Medicaid enrolled child. Race/ethnicity was self-designated under the following categories: White, African-American, Hispanic, Asian/Pacific Islander, Native American, Multiracial, and Unknown. In all analyses, unknown race/ethnicity was treated as a separate category (2,189 records, 6.7 percent), rather than as missing. Age groups were defined as 1 to  $\leq$  2 years, 2 to  $\leq$  3 years, 3 to  $\leq$  4 years, 4 to  $\leq$  5 years, and 5 to  $\leq$  6 years.

#### **County-level information**

County of residence at the time of the claim was used to define two county-level variables: DHPSA designation and UIC. DHPSA designation was developed by the federal government to address communities with high unmet dental needs and services (16,17). In this study, we used the classification followed in a recent oral health report by the Wisconsin Department of Health Services (formerly the Wisconsin Department of Health and Family Services) (18). Under this classification scheme, a county is considered an entire DHPSA when it meets the criteria established by the Bureau of Health Professionals, which are "that the area should be a rational area for the delivery of dental services; the population to full-time dentist ratio should be less than 5,000:1 but greater than 4,000:1 and has unusually high needs for dental services or insufficient capacity of existing dental providers; or dental professionals in the contiguous area are over utilized, or excessively distant, or inaccessible to the population of the area under consideration." (16,17) For the 72 counties in Wisconsin, 29 were classified as non-DHPSA, 9 as partial DHPSA, and 34 were designated as entire DHPSA.

The 2003 UIC, published by the United States Department of Agriculture, were used as a measure of the rurality of the county of residence for each enrollee (19). The UICs use population and commuting data from the 2000 Census to classify the 3,141 United States counties and county equivalents into 12 groups. For the purposes of this study, we only used the three major classification levels: metropolitan, micropolitan, and non-core/rural. Based on this classification, 25 counties were designated as metropolitan, 13 as micropolitan, and 34 as non-core/rural.

## **Analytic methods**

Descriptive statistics were computed to examine the distribution of study variables within the Wisconsin Medicaid population. The primary statistical analysis consisted of comparing the overall rate of claims for FVT before and after the policy change in 2004. The rates were computed as the number of claims relative to the number of person-years of Medicaid enrollment within each study period. Poisson

regression, allowing for over-dispersion, was used to compare FVT rates pre- and post-policy. Stratified analyses were performed by DHPSA and UIC designation in comparing the rate of FVT claims across racial/ethnic groups. All analyses were performed using SAS v9.1.3 (SAS Institute, Cary, NC, USA). The study was approved by the Institutional Review Boards of Marquette University and the Medical College of Wisconsin.

# Results

# Characteristics of Wisconsin Medicaid enrollees with FVT claims pre- and post-policy period

Overall, 3,631 and 28,304 FVT claims were analyzed in the pre- and post-policy periods. Before the policy change, 4-6 year olds (0.86 per 100 person-years) and African-Americans (1.22 per 100 person-years) had the highest rates of FVT claims (Table 1). Residents of metropolitan counties and those designated as partial DHPSA accounted for 96.3 percent and 87.2 percent of FVT claims, respectively. Following the policy change, the overall rate of FVT claims increased almost four times. Rates of FVT claims were once again higher for children in the 4- to 6-year-old group (3.11 per 100 person-years), as well as for Native Americans (7.09), residents of rural counties (3.64), and those living in partial DHPSA counties (2.87).

Table 1 Characteristics of Wisconsin Medicaid Enrollees with Fluoride Varnish Treatment (FVT) Claims: 2003-2006

Characteristics	Pre-policy period (2002-2003)			Post-policy period (2004-2006)		
	# FVT claims	Person-years of eligibility	Rate of FVT per 100 person-years	# FVT claims	Person-years of eligibility	Rate of FVT per 100 person-years
Age (years)						
1-3	557	266,565	0.21	9,053	446,060	2.03
4-6	3,074	355,980	0.86	19,251	618,587	3.11
Race/ethnicity						
White	874	294,120	0.30	12,062	503,451	2.40
African-American	1,789	146,355	1.22	4,112	222,935	1.84
Native American	39	12,534	0.31	1,613	22,762	7.09
Asian	62	20,722	0.30	869	35,868	2.42
Hispanic	583	84,550	0.69	7,315	164,908	4.44
Multiracial	42	11,948	0.35	497	24,508	2.03
Unknown	242	52,316	0.46	1,836	90,216	2.04
UIC						
Metropolitan	3,498	455,786	0.77	18,739	780,418	2.40
Micropolitan	41	65,322	0.06	4,026	120,352	3.35
Rural	18	84,172	0.02	5,198	142,676	3.64
DHPSA						
No shortage	375	185,828	0.20	7,947	340,494	2.33
Partial shortage	3,165	299,498	1.06	14,264	496,768	2.87
Entire shortage	17	119,954	0.01	5,752	206,181	2.97

UIC, urban influence codes; DHPSA, dental health professional shortage area.

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### Multivariable Poisson regression for the rate of FVT claims at baseline and effect of the policy change

Prior to the policy change, Asians [rate ratio (RR):0.46; 95 percent confidence interval (CI) 0.32, 0.65] and the unknown group (RR:0.63; 95 percent CI 0.51, 0.70) were the racial/ ethnic group with a rate of FVT claims significantly lower from that of Whites (Table 2). However, after the policy change, Asians, Hispanics, and Native Americans all displayed rates that were approximately twofold higher than Whites. Compared with metropolitan counties, residents of micropolitan counties had higher rates of FVT, while those in rural counties had lower rates of FVT in the pre-policy period. After the policy change, the rate of FVT claims was approximately 10-fold higher for residents of micropolitan and rural counties. While the adjusted rate of FVT claims for enrollees living in entire DHPSA counties was the lowest pre-policy, residents of these counties actually displayed the highest adjusted rate following the policy change (RR: 10.65; 95 percent CI 5.49, 20.60) compared with non-DHPSA.

#### Stratified analysis of rate differences for FVT claims

Figure 1 shows rate differences for FVT claims by age and race/ethnicity stratified by UIC and DHPSA designation.

Rate differences are presented (as opposed to RRs) because of many covariate combinations with zero claims prior to the policy change. Further details for the stratified rates are presented in Appendices 1 and 2. The large change in FVT claims observed for Native Americans was largely driven by enrollees residing in non-DHPSA counties. Hispanics and Native Americans (and to some extent Asians) exhibited the largest rate differences, seemingly regardless of the UIC classification for their county of residence. However, it should be noted that estimates for certain groups, such as 4- to 6-year-old Asians living in metropolitan counties, correspond to a small number of person-years of enrollment (see appendixes). Therefore, these estimates should be interpreted with caution as they only represent a very small proportion of the enrolled population.

# Discussion

Fluoride varnish has been shown to be an effective way to minimize the development of dental caries and to remineralize carious lesions, as well as being safe and easy to apply (20-22). It has been widely used for this purpose in Europe, Canada, and other parts of the world for over 40 years (20-22). This study highlights findings concerning the relationship between race/ethnicity, UIC, and DHPSA designation with the provision of FVT following a Medicaid policy

 Table 2
 Multivariable Poisson Regression for the Rate of Fluoride Varnish Treatment (FVT) Claims

 Before and After Policy Change
 Policy Change

	Regression estimates rate ratio (95% CI)			
Characteristic	Pre-policy period	Effect of policy change		
Race/Ethnicity				
White	Reference	Reference		
Asian	0.46* (0.32, 0.65)	2.16* (1.50, 3.10)		
African-American	1.07 (0.90, 1.20)	0.61* (0.53, 0.69)		
Hispanic	0.98 (0.84, 1.10)	2.00* (1.71, 2.33)		
Multiracial	1.04 (0.9, 1.57)	1.12 (0.72, 1.71)		
Native American	0.97 (0.62, 1.49)	1.96* (1.26, 3.04)		
Unknown	0.63* (0.51, 0.70)	1.37* (1.10, 1.68)		
Age (years)				
1-2	0.07* (0.05, 0.09)	9.92* (7.40, 13.20)		
2-3	0.38* (0.32, 0.43)	1.80* (1.53, 2.10)		
3-4	0.82* (0.72, 0.90)	1.24* (1.09, 1.40)		
4-5	0.99 (0.88, 1.10)	1.27* (1.11, 1.43)		
5-6	Reference	Reference		
DHPSA				
No shortage	Reference	Reference		
Partial shortage	4.08* (3.03, 5.46)	0.43* (0.36, 0.50)		
Entire shortage	0.25* (0.12, 0.50)	10.65* (5.49, 20.60)		
Urban influence codes				
Metropolitan counties	Reference	Reference		
Micropolitan counties	1.78* (1.10, 2.85)	10.10* (6.63, 15.30)		
Non-core/rural counties	0.49* (0.24, 0.99)	9.40* (4.93, 17.00)		

\* Indicates significance at the 5% level.

CI, confidence interval; DHPSA, dental health professional shortage area.



change in Wisconsin. Prior to the policy change, residents of rural counties and those classified as entire DHPSA displayed the lowest rates of FVT claims; however, following the involvement of medical care providers, almost an exact opposite situation was observed. This result is promising given that the policy change had a larger impact in areas where access to preventive services was most likely the worst. At the same time, it shows that the policy was less effective in areas with the highest density of enrollees, i.e., metropolitan counties. Therefore, in order to have a larger impact on the Medicaid population as a whole, future policy may need to specifically target enrollees living in urban areas.

Among the racial/ethnic minority groups, Native Americans exhibited the largest increase in the rate of FVT claims, particularly for those residing in non-DHPSA. This finding is not surprising given that a designation as non-DHPSA is based on having favorable conditions for access to dental care. Interestingly, while the policy change only addressed medical care providers and did not include increases in reimbursement, 88.4 percent of FVT claims for Native Americans residing in non-DHPSA were submitted by dental providers. Because we did not have provider specific data, it is unclear why this increase for Native Americans was particularly driven by dentists. Nonetheless, this result is promising given the higher levels of dental disease in Native American populations (23-25). Hispanics residing in counties classified as partial or entire DHPSA also displayed high increases in the rate of FVT claims. In contrast to Native Americans, these rate increases were mostly driven by medical care providers (60.9 percent of FVT claims), indicating a more direct result of the policy change for this ethnic minority group.

In the multivariable and stratified analyses, African-Americans generally had the lowest rate of FVT claims, especially for younger children under the age of 3. While the rate of FVT claims for African-Americans were somewhat higher (relative to the other racial/ethnic groups) for those living in micropolitan counties, it is important to note that the vast majority of African-Americans enrolled in Medicaid reside in metropolitan counties (98.7 percent of person-year of enrollment). Decreased utilization of FVT for African-Americans could be related to findings that African-Americans are less likely to have a usual source of care, thus making them more likely to make emergency department visits for dental conditions (26,27). Future policy changes should thus be tailored to specifically address the shortcoming of this particular policy by targeting African-American children, along with other Medicaid enrollees residing in urban areas.

There have been a number of reports indicating that residents of rural counties experience difficulty accessing and utilizing medical and dental care services (15,28-30), due to fewer numbers of dental and medical providers and hospital settings (15). In our study, the rate of FVT claims for rural residents not only increased substantially, but also surpassed that of enrollees living in metropolitan counties. This result is in line with Larson and colleague, who reported that residents of rural counties were more likely to report that they have a usual source of care, with fewer visits per year compared with metropolitan residents (31). While these results support the involvement of medical care providers in providing oral health services, it is important to recognize that increased utilization of FVT only represents a surrogate for reducing the dental disease burden. Therefore, further monitoring is required in order to validate the success of this policy in reducing the prevalence of dental caries.

#### Limitations

Our results should be interpreted within the context of a number of limitations. We examined only Wisconsin Medicaid enrollees; therefore, it is possible that our findings cannot be generalized to other states. However, given that Wisconsin's Medicaid population consists of a racially/ethnically diverse population with both urban and rural poor, we believe our results should extend to other similar states. We did not have access to detailed provider information beyond whether a claim was submitted by a medical or dental provider. Therefore, we were unable to investigate the role that other provider characteristics (practice size, location, etc.) may play in the provision of FVT. This also prevented us from adjusting the analyses for potential clustering within a specific provider, which has the potential to underestimate variances associated with the various estimated rates of FVT claims. In addition, we did not include medical health professional shortage area information in the study to allow for comparisons with DHPSA information. The pre-post study design suffers from a lack of comparison data from other states that did not allow medical care providers to bill for FVT, limiting our ability to explain the observed increase among dental providers. Finally, the procedure code extracted from the MEDS database (1,203) could include any fluoride treatment in children. Therefore, it is possible that some children could have received fluoride gels in lieu of fluoride varnish, although our data does not permit any assessment of this statement. We believe that the inclusion of other types of fluoride treatment would likely have a minimal impact on our results, as most medical providers were unlikely to be set up to provide anything beyond fluoride varnish. In addition, dental providers are unlikely to use fluoride gels for children under the age of 3 or 4 years because of an inability to control young children from swallowing significant amounts of the gel.

#### Conclusions

This study demonstrates significant geographic and racial/ ethnic variation in the provision of FVT after a policy change allowing medical care providers to be reimbursed for this procedure. Native American children and those living in less populated areas exhibited the largest increases in utilization, supporting the receipt of preventive oral health care for these populations in medical settings. Future policies should incorporate measures that will specifically address the racial and geographic variations identified in this study.

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#### References

- Gehshan S, Hauck P, Scales J. Increasing dentist's participation in Medicaid and SCHIP. Denver, CO: National Conference of State Legislatures, Forum for State Health Policy Leadership; 2001.
- Borchgrevink A, Snyder A, Gehshan S. The effect of Medicaid reimbursement rates on access to dental care. Washington, DC: National Academy of State Health Policy; 2008.
- Cuadro R, Scanlon A. Does raising rates increase dentists' participation in Medicaid? The experience of three states [Internet]. National Conference of State Legislatures, Promising Practices Issue Brief; 2004 [cited 2009 May 21]. Available from: http://www.ncsl.org/print/health/forum/ dentalreimbursementrates\_04.pdf
- General Accounting Office. Oral health: dental disease is a chronic problem among low-income populations [Internet]. United States General Accounting Office (GAO), Report to Congressional Requester. Washington, DC: GAO/HEHS-00-72. 2000 Apr [cited 2008 Feb 14], [about 44p.]. Available from: http://www.gao.gov/new.items/ he00072.pdf
- 5. Dela Cruz G, Rozier GR, Slade G. Dental screening and referral of young children by pediatric primary care providers. *Pediatrics*. 2004;**114**(5):3642-52.
- Schafer T, Adair S. Prevention of dental disease. The role of the pediatrician. *Pediatr Clin North Am*. 2000;47(5):1021-42, v-vi.
- American Dental Association Council on Scientific Affairs. Professionally applied topical fluoride: evidence-based clinical recommendations. *J Am Dent Assoc*. 2006;137(8): 1151-9.
- Cantrell C. The role of physicians in children's oral health [Internet]. State Health Policy Monitor; Dec 2008 [cited 2010 Mar 22]. Available from: http://www.nashp.org/files/ Fluoride%20Varnish%20Monitor.pdf
- 9. Okunseri C, Szabo A, Jackson SC, Pajewski NM, Garcia RI. Increased children's access to fluoride varnish treatment by

involving medical care providers: effect of a Medicaid policy change. *Health Serv Res.* 2009;**44**(4):1144-56.

- Mertz E, Grumbach K. Identifying communities with low dentist supply in California. *J Public Health Dent*. 2001;61(3): 172-7.
- Krause D, Frate D, May W. Demographics and distribution of dentists in Mississippi: a dental work force study. *J Am Dent Assoc.* 2005;136(5):668-77.
- U.S. Department of Health and Human Services. Health Resources and Services Administration. Find shortage areas: HPSA by state & county [Internet]. [cited 2008 Dec 29]. Available from: http://hpsafind.hrsa.gov/
- U.S. Department of Health and Human Services. Health Resources and Services Administration. Shortage designation: HPSAs, MUAs & MUPs [Internet]. [cited 2008 Dec 29]. Available from: http://bhpr.hrsa.gov/shortage/
- Byck GR, Walton SM, Cooksey JA. Access to dental care services for Medicaid children: variation by urban/rural categories in Illinois. *J Rural Health*. 2002;18(4):512-20.
- Vargas C, Ronzio C, Hayes K. Oral health status of children and adolescents by rural residence, United States. *J Rural Health*. 2003;19(3):260-8.
- Bureau of Health Professions. Health professional shortage area dental designation criteria [Internet]. [cited 2006 Sep 7]. Available from: http://bhpr.hrsa.gov/shortage/hpsacritdental. htm
- Orlans J, Mertz E, Grumbach K. Revising dental health shortage area methodology: a critical review [Internet]. San Francisco, UCSF Center for Health Professions CA. October 2002 [cited 2008 Feb 14]. Available from: http://futurehealth. ucsf.edu/cchws/DHPSA.html
- Overview of children's oral health in Wisconsin, youth oral health data collection report. Oral Health Program Division of Public Health, Wisconsin Department of Health and Family Services; 2001-02.
- Economic Research Service, US Department of Agriculture. Measuring rurality: urban influence codes [Internet]. [cited 2007 May 25]. Available from: http://www.ers.usda.gov/ Briefing/Rurality/urbaninf/
- Helfenstein U, Steiner M. Fluoride varnishes (Duraphat): a meta-analysis. *Community Dent Oral Epidemiol*. 1994; 22:1-5.
- 21. Weintraub JA, Ramos-Gomez F, Jue B, Shain S, Hoover CI, Featherstone JDB, Gansky SA. Fluoride varnish efficacy in preventing early childhood caries. *J Dent Res.* 2006;**85**(2): 172-6.
- 22. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine. Recommendations for preventive pediatric health care (RE9939). *Pediatrics*. 2000;**105**:645.
- Vargas CM, Crall JJ, Schneider DA. Socio-demographic distribution of pediatric dental caries: NHANES III, 1988-1994. J Am Dent Assoc. 1998;129:1229-38.
- 24. Phipps K, Reifel N, Blahut P. The 1999 Oral Health Survey of American Indian and Alaska Native Dental Patients: findings, regional differences and national comparisons. Rockville,

MD: Indian Health Service, Division of Dental Services; 2002:106.

- Nash DA, Nagel RJ. Confronting oral health disparities among American Indian/Alaska native children: the pediatric oral health therapist. *Am J Public Health*. 2005;**95**(8):1325-9.
- 26. Center for Health Statistics. Health, United States, 2006 with chartbook on trends in the health of Americans [Internet]. Hyattsville, MD; 2006 [cited 2008 Feb 14]. Available from: http://www.cdc.gov/nchs/data/hus/hus06.pdf
- 27. Okunseri C, Pajewski NM, Brousseau DC, Tomany-Korman S, Snyder A, Flores G. Racial and ethnic disparities in non-traumatic dental condition visits to emergency departments and physician offices: a study of the

Wisconsin Medicaid Program. J Am Dent Assoc 139(12): 1657-66:2008.

- 28. Ricketts TC. Access an ambulatory care conditions. *J Rural Health*. 1997;**13**:275-6.
- 29. Ghelfi LM, Parker TS. A county-level measure of urban influence. *Rural Dev Perspect*. 1997;12:32-41.
- North Carolina Rural Health Research and Policy (NCRHRP). Facts about rural physicians. Washington, DC: Office of Rural health Policy, U.S. Department of Health and Human Services; 1997.
- Larson LS, Fleishman JA. Rural–urban differences in usual source of care and ambulatory service use: analyses of national data using urban influence codes. *Med Care*. 2003;41(7 Suppl):III65-74.

# Appendixes

Appendix 1 Rate of Fluoride Varnish Treatment (FVT) Claims for Wisconsin Medicaid Enrollees Stratified by Age, Race/Ethnicity, and Dental Health Professional Shortage Area (DHPSA)

	Rate of FVT claims f	or 1- to 3-year-olds	Rate of FVT claims for 4- to 6-year-olds		
Characteristic	Pre-policy period*†	Post-policy period	Pre-policy period*†	Post-policy period*†	
Non-DHPSA					
White	0.17 (15,745)	3.51 (27,341)	0.91 (22,042)	8.09 (40,055)	
African-American	0.11 (1,893)	2.58 (3,064)	1.53 (2,752)	4.67 (4,434)	
Native American	0.00 (680)	28.55 (1,272)	0.11 (912)	50.21 (1,681)	
Asian	0.11 (932)	1.92 (1,723)	0.54 (1,301)	8.56 (2,300)	
Hispanic	0.07 (4,470)	3.4 (8,743)	0.96 (4,583)	8.93 (10,507)	
Multiracial	0.14 (711)	5.16 (1,433)	1.44 (902)	10.54 (1,821)	
Unknown	0.10 (1,978)	3.78 (3,735)	1.00 (2,690)	7.74 (4,767)	
Partial DHPSA					
White	0.79 (10,979)	3.92 (17,559)	3.55 (14,423)	9.60 (24,893)	
African-American	1.53 (17,230)	2.53 (25,713)	5.69 (24,663)	8.02 (38,281)	
Native American	1.88 (320)	7.22 (776)	6.17 (518)	12.94 (842)	
Asian	0.41 (1,457)	4.79 (2,526)	2.28 (1,977)	11.13 (3,487)	
Hispanic	1.19 (8,217)	21.36 (13,790)	4.75 (8,892)	14.95 (18,079)	
Multiracial	0.16 (643)	2.89 (1,317)	3.47 (779)	5.51 (1,562)	
Unknown	0.72 (3,875)	5.87 (7,722)	2.82 (5,858)	6.02 (9,044)	
Entire DHPSA					
White	0.02 (13,153)	7.61 (21,842)	0.06 (18,697)	9.21 (32,193)	
African-American	0.00 (217)	2.20 (364)	0.00 (291)	6.72 (536)	
Native American	0.00 (721)	6.06 (1,206)	0.00 (950)	9.14 (1,675)	
Asian	0.00 (420)	2.55 (667)	0.17 (591)	9.94 (956)	
Hispanic	0.00 (596)	11.35 (1,243)	0.30 (657)	13.07 (1,530)	
Multiracial	0.00 (402)	4.27 (842)	0.00 (432)	6.56 (990)	
Unknown	0.00 (1,026)	5.49 (1,750)	0.00 (1,532)	8.41 (2,414)	

\* Rate of claims per 100 person-years of enrollment.

+ (...) Denotes number of person-years of enrollment.

	Rate of FVT claims	Rate of FVT claims for 1- to 3-year-olds		Rate of FVT claims for 4- to 6-year-olds		
	Pre-policy period*†	Post-policy period*†	Pre-policy period*†	Post-policy period*†		
Metropolitan						
White	0.46 (24,150)	4.54 (40,283)	2.16 (32,064)	6.68 (57,182)		
African-American	1.38 (19,139)	2.51 (28,767)	5.26 (27,378)	7.56 (42,716)		
Native American	0.77 (781)	11.60 (1,569)	2.86 (1,118)	21.11 (1,942)		
Asian	0.28 (2,514)	3.22 (4,354)	1.55 (3,425)	7.56 (5,980)		
Hispanic	0.88 (11,516)	15.44 (20,110)	3.72 (12,317)	12.27 (25,686)		
Multiracial	0.14 (1,418)	3.65 (2,957)	2.30 (1,698)	7.10 (3,535)		
Unknown	0.5 (5,792)	5.13 (11,200)	2.25 (8,404)	5.46 (13,460)		
Micropolitan						
White	0.01 (7,066)	4.22 (12,378)	0.28 (9,569)	13.92 (17,138)		
African-American	0.00 (129)	5.02 (239)	0.00 (187)	19.47 (318)		
Native American	0.00 (60)	6.95 (115)	0.00 (89)	18.52 (157)		
Asian	0.00 (262)	5.35 (505)	0.00 (387)	31.12 (662)		
Hispanic	0.00 (1,243)	3.72 (2,555)	0.87 (1,144)	11.88 (2,988)		
Multiracial	0.00 (180)	4.89 (286)	0.44 (227)	12.98 (416)		
Unknown	0.00 (503)	4.70 (1,065)	0.28 (721)	15.57 (1,284)		
Rural						
White	0.05 (8,662)	6.83 (14,080)	0.05 (13,529)	10.48 (22,821)		
African-American	0.00 (71)	2.96 (135)	2.85 (140)	9.69 (217)		
Native American	0.00 (880)	19.26 (1,568)	0.09 (1,173)	31.77 (2,099)		
Asian	0.00 (33)	7.02 (57)	0.00 (58)	21.93 (100)		
Hispanic	0.00 (524)	16.48 (1,110)	0.00 (672)	23.08 (1,443)		
Multiracial	0.00 (158)	7.46 (348)	0.00 (189)	9.00 (422)		
Unknown	0.17 (584)	6.90 (942)	0.10 (955)	12.23 (1,480)		

Appendix 2 Rate of Fluoride Varnish Treatment (FVT) Claims for Wisconsin Medicaid Enrollees Stratified by Age, Race/Ethnicity, and Urban Influence Code

\* Rate of claims per 100 person-years of enrollment.

t (...) Denotes number of person-years of enrollment.

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