



Improving oral health gets boost in N. Carolina

North Carolina pediatricians are sinking their teeth into a program to improve dental care for children.

The initiative, called "Into the Mouths of Babes," provides oral screening training to physicians and selected allied health professionals; educates parents and caregivers on dental health; and provides fluoride varnish applications to children up to 3 years of age enrolled in Medicaid.

The AAP North Carolina Chapter is collaborating on the project with the North Carolina Academy of Family Physicians (AAFP), the North Carolina Division of Medical Assistance (Medicaid), the North Carolina Oral Health Section and the University of North Carolina Schools of Dentistry and Public Health.

"It seems rather elemental to assume that the mouth is indeed a part of the body. Recently, however, that idea has taken on a whole new focus for North Carolina pediatricians as we have sought to acknowledge the significant amount of disease and distress in young children who have no access to dental health care," said Olson Huff, M.D., FAAP.



Dr. Huff

The oral screening training program for health care providers consists of a review of clinical studies, including the efficacy of fluoride varnish, and review of application procedures. Participants also receive an oral health toolkit, which includes parent/caregiver education materials, supplies for 10 screenings and information on ordering additional supplies, demonstrations on fluoride varnish procedures, and information on filing Medicaid claims. Medicaid has agreed that a child can receive up to six fluoride varnish treatments before the age of 3 years with reimburse-

ment at \$43 for the initial screen and \$35 for periodic screenings thereafter.

More than 250 North Carolina pediatricians are participating in the program, which provides 1.5 hours of American Medical Association category I continuing medical education credit. Some participants also receive onsite technical assistance.

Grant funding for the training program is provided by the U.S. Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, and the Health Resources and Services Administration.

University of North Carolina researchers are evaluating the program's effectiveness. Prior to the training session, physicians and office personnel complete questionnaires asking about their knowledge of children's oral health, dental health services provided and practice characteristics. In addition, researchers are recruiting parents to complete surveys before their child is treated. Parents are asked about their child's dental health, home dental habits and family characteristics.

Physicians complete a two-part form that documents risk factors for each child and helps health care providers initiate a conversation with parents or caregivers about daily oral hygiene, eating habits and the importance of regular preventive care. The provider also can document when a referral for caries is made and to whom.

Dr. Huff noted that pediatricians' concern about oral health has resulted in several projects, including mobile dental units, fluoride varnish initiatives and legislative efforts to increase Medicaid reimbursement rates for dental health care.

Pediatricians across the state are taking seriously their role in the prevention of early childhood caries, the infectious nature of this disease and its relationship to nutrition and oral

health care. Educating parents on how to keep their children's mouths and teeth clear of infection and decay-producing sites has become routine in most pediatric practices across the state. This program has also received support from the North Carolina Dental Society and the North Carolina Chapter of the American Academy of Pediatric Dentistry.

North Carolina pediatricians' commitment to improving dental care for children coincides with Academy efforts.

Last year, a resolution titled, "Dental Care for Children," was adopted at the AAP Annual Chapter Forum. The resolution, which was presented by District VIII, called for the Academy to "work with the American Academy of Pediatric Dentistry (AAPD), the Health Resources and Services Administration (HRSA) and other partners to improve access to dental care for children and youth." In addition, it asked the Academy to "work to advance pediatricians' knowledge of oral health and encourage pediatricians to promote oral health."

When chapter officers were asked to prioritize the 2001 resolutions, "Dental Care for Children" was selected as number two on the top 10 list.

The AAP Board of Directors also supports this resolution and believes a more comprehensive approach to addressing pediatric dental care is needed, including an interdisciplinary model for graduate and post-graduate medical education. In addition, several AAP committees and sections are working toward the resolution's goals.

For more information on "Into the Mouths of Babes," contact Steve Shore, AAP North Carolina Chapter executive director, at (919) 839-1156, or e-mail sshore@aap.org, or contact Anjine Emanuel, AAP Chapter Relations, at (800) 433-9016, ext. 7860, or e-mail aemanuel@aap.org.

HIPAA changes would impact patient confidentiality

by Lori O'Keefe
Correspondent

In an effort to clarify the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the U.S. Department of Health and Human Services (HHS) published proposed modifications to the rules on March 27. Among the modifications, physicians would have the discretion to disclose information without patient consent in states where no confidentiality laws exist.

Although the final rule for "Standards for Privacy of Individually Identifiable Health Information" was issued in December 2000 and became effective in April 2001, HHS received many inquiries and comments from people expressing concern or confusion.

Modifications would affect the following sections of the privacy rule:

- consent;
- notice of privacy practices for protected health information;
- minimum necessary uses and disclosures, and oral communications;
- business associates;
- marketing;
- parental right to health care information and adolescent right to confidentiality;
- research;
- uses and disclosures of protected health information for which authorizations are required; and
- de-identification of protected health information.

"A lot of the new wording is an explanation rather than a great change," said Edward M. Gotlieb, M.D., FAAP, chair of the AAP Task Force on Medical Informatics.

HHS accepted comments on the proposed modifications until late April and plans to adhere to its original compliance date of April 14, 2003. Revisions will become effective on Oct. 13, 2002, but covered entities can register a one-year extension to Oct. 16, 2003, by submitting a compliance plan to HHS by Oct. 15, 2002.

One area of great interest to the Academy is that of adolescent confidentiality.

"The modifications make some changes with respect to the role of health care provider and physician discretion in determining when to disclose confidential or protected medical information to parents of adolescents or minors,"

said Abigail English, director of the Center for Adolescent Health and the Law.

The current privacy rule says that when state or other applicable laws are silent or provide discretion, minors can decide when health information can be disclosed. Under the proposed modifications, when state or other laws are silent, the health care provider has the discretion to decide when to disclose information.

The privacy rule also indicates that when state laws require physicians to disclose information to parents, they must comply. Likewise, if state laws prohibit physicians from disclosing information to parents, they must protect adolescent confidentiality.

"This (proposed modification) is a retreat with regard to protection of confidentiality in adolescent health care but it also doesn't represent a mandate that providers disclose information to parents," English said.

Parents also play a role in granting consent for their children to participate in clinical trials.

"We are being encouraged to do more research on children to learn more about illnesses and how children respond to medications," said Russell W. Chesney, M.D., FAAP, chair of the AAP Committee on Pediatric Research. "There was a concern among the research community that HIPAA regulations would have unintended consequences ... and would have a stifling affect on research, particularly on public health research."

The proposed modifications allow researchers to use a standard authorization form, rather than multiple forms, for consent to the research and protection of information privacy rights. The modified rule also allows authorizations to expire at the end of research, which must be clearly stated on the authorization form. However, when databases or registries are being created, authorization doesn't expire.

According to Dr. Gotlieb, the research section of the privacy rule also was rewritten to parallel wording and requirements in the Common Rule.

The Common Rule is a guide for interpreting federal policy that was created to protect human subjects. It applies to research involving humans that is supported, conducted or regulated by any of the federal agencies that adopted the Common Rule, including research that uses individually identifiable information. The Common Rule has requirements related to review of research by institutional review boards to ensure that risks to human subjects are minimized and to protect human subjects from privacy risks.

Other modifications proposed by HHS include:

- giving covered entities the option of obtaining consent to use or disclose health information for treatment, payment and health operations;
- restricting covered entities from providing health information for marketing purposes without authorization by the individual;
- using a single form for all authorizations, with the exception of marketing authorizations;
- requiring a covered entity to make a "good faith" effort to obtain a patient's acknowledgment that the provider's privacy practices have been received;
- allowing incidental disclosures if appropriate safeguards and the minimum necessary requirements are met;
- giving covered entities, other than small health plans, an extra year to continue working under existing contracts with business associates;
- de-identifying information by assigning a unique code and reporting an individual's age in months, days or hours;
- allowing any covered entity that performs health or non-health activities to designate itself as a hybrid entity (an organization whose covered health care functions are not the primary functions of the organization, which performs health and non-health activities) regardless of its primary function; and
- exempting covered entities from accounting for disclosure in the cases of treatment, payment or health care operations.

"HIPAA has real potential to help patients, which is what we would like to have happen," Dr. Gotlieb said. "The revision allows for less paperwork but the total package requires more paperwork."

The Academy submitted comments on the proposed changes, which will be posted on the Members Only Channel (MOC) of the AAP Web site (www.aap.org/moc). Also on the MOC are HIPAA compliance manuals. Available to members at no cost, the manuals were written with the office-based physician in mind and include checklists, templates and other helpful tools.

Members with questions about HIPAA can contact the Academy via e-mail at hipaa@aap.org or by calling Aiysha Johnson in the AAP Division of Health Care Finance and Practice at (800) 433-9016, ext. 4089.