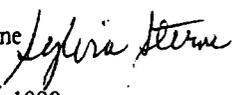


Louisiana Department of Health and Hospitals, Office of Public Health
Adolescent School Health Initiative, School-Based Health Centers

MEMORANDUM

To: All SBHC Administrators

From: Sylvia Sterne 

Date: October 20, 1999

Re: OPH-ASHI CODING COMPLIANCE POLICY

I. BACKGROUND

- A. At the March 16, 1999 Louisiana SBHC Network meeting, the SBHCs agreed to discontinue the local practice of adding "dummy" codes to the standardized OPH-ASHI Medical/Mental Health Encounter Form. At the October 5, 1999 Network meeting, OPH-ASHI agreed to develop standard guidelines for utilizing the Clinical Fusion software system to process codes.
- B. Poor coding does not directly cause injury or death, but it can diminish the quality of care. Standardized code sheets (encounter forms) are a valuable source of information regarding the patient's actual status, interventions performed, and the response to those interventions. Encounter form codes must document an accurate and thorough view of the patient's situation as it occurred. The factors related to standardized coding can be summarized as follows:

If you do not define it, you can not observe it, measure it, research it, teach it, practice it, finance it, or put it into public policy.

II. FEDERAL STANDARDS FOR HEALTH CARE CODES

- A. Per the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a code can be defined as an encoded data element; such as a medical concept, a medical diagnosis or a medical procedure. There are numerous health care codes. There are codes for diseases, causes of diseases, injuries, causes of injuries, impairments, causes of impairments, health related problems, causes of health related problems and manifestations of health related problems. There are also codes that describe the "medical necessity" for actions taken to prevent, diagnose, treat or manage diseases, injuries and impairments. There are additional codes for substances, equipment, supplies or other items used to provide health care services.

- B. Standardized code sets are essential for accurate and efficient electronic data exchange between the many providers and users of the health care system. The HIPAA mandates national code sets for some Federal and State programs; e.g., Medicare and Medicaid.
- C. Regardless of health care coverage or reimbursement policies for medical conditions or procedures, the HIPAA requires utilization of the following standardized national code sets (which are already being used nationally by all hospital and ambulatory facilities, most health care plans and most health care providers):
1. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM; or the most recent version) Volume 1 & 2 to capture diagnostic codes in all hospitals and ambulatory care settings, plus Volume 3 to capture inpatient procedures codes;
 2. The Physician Current Procedure Terminology (CPT-4; or the most recent version) to capture physician service codes, which comprise level one of the Health Care Financing Administration Procedure Coding System (HCPCS);
 3. The Alpha-numeric HCPCS to capture codes for medical equipment, injectable drugs, transportation services and other services not found in the CPT-4, which comprise level two of HCPCS;

* * To designate dental, "D" is used as the first digit in the Alpha-numeric HCPCS. (Therefore, "D" can not be arbitrarily redefine to designate "dummy" code.)
 4. The Current Dental Terminology (CDT) to capture dental service codes; and/or
 5. The National Drug Codes (NDC) to capture prescription drugs in pharmacy transactions and some claims by health care professionals.
- D. Per Federal law (18 USC 1035):

Anyone who knowingly and willfully falsifies or conceals a material fact or makes a materially false, fictitious or fraudulent statement in connection with the delivery of, or payment for health care benefits, items or services may face fines and up to five years imprisonment.

III. OPH CONTRACT STANDARDS FOR COLLECTING HEALTH CARE CODES

- A. To demonstrate SBHC progression towards self-sufficiency, the OPH-ASHI Contract (Attachment A, Paragraph 8), requires each SBHC to maximize health care revenues by billing for eligible Medicaid reimbursements. Therefore, Louisiana SBHC codes must comply with the HIPAA standards.
- B. For statistical verification of health care services, the OPH-ASHI Contract (Attachment A, Paragraph 11), requires SBHCs to utilize a standardized data collection system and quarterly statistical reporting form. The standardized OPH-ASHI Medical/Mental Health Encounter Form and the standardized Clinical Fusion software system are included within the definition of this contract requirement.
- C. In compliance with HIPAA, the standardized OPH-ASHI Medical/Mental Health Encounter Form is restricted for the exclusive purpose of capturing the HIPAA mandated national code sets. The Clinical Fusion software system is utilized as the standardized OPH-ASHI data repository for the HIPAA codes.

IV. GUIDELINES FOR CODES THAT DO NOT MEET THE HIPAA STANDARDS

- A. OPH-ASHI will not authorize any SBHC to utilize codes in lieu of the HIPAA mandated national code sets or in lieu of the OPH-ASHI Contract standards.
- B. A SBHC medical or psychosocial practitioner may request assistance from the respective Peer Advisory Committee in defining a code that does not meet the HIPAA standards. A SBHC practitioner may also seek assistance in developing separate forms for manually capturing and processing any such code; i.e., independently of the standardized OPH-ASHI Medical/Mental Health Encounter Form, and independently of the standardized Clinical Fusion software system.
- C. If a SBHC medical or psychosocial practitioner desires to utilize the Clinical Fusion software system to process any additional code that does not meet the HIPAA standards, a majority in the respective Peer Advisory Committee must vote to collect the code, and the Committee Facilitator must submit a written request to the OPH-ASHI Data Coordinator.
- D. If the OPH-ASHI Data Coordinator can guarantee that the central OPH-ASHI data repository for the HIPAA codes will not be invalidated by an additional code that does not meet the HIPAA standards, written authorization to enter the Peer recommended code into the Clinical Fusion software system will be distributed by the Data Coordinator at a quarterly SBHC Network meeting.

V. **GUIDELINES FOR CODES THAT COULD INVALIDATE THE CENTRAL OPH-ASHI DATA REPOSITORY FOR HIPAA CODES**

A SBHC may unilaterally develop any additional code. But, the SBHC must capture it independently of the standardized OPH-ASHI Medical/Mental Health Encounter Form, and process it independently of the standardized Clinical Fusion software system; e.g., collect it on a separate form and process it manually or with a separate software system.

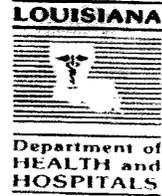
VI. **SUMMARY**

- A. The HIPAA mandates that Medicare and Medicaid providers utilize standardized national code sets. The OPH-ASHI Contract, requires each SBHC to bill for eligible Medicaid reimbursements. Therefore, Louisiana SBHCs must comply with the HIPAA.
- B. It is within the realm of a Louisiana licensed practitioner's clinical judgment to select the "best fit" CPT code (from the CPT code book) for each service and procedure performed; and to select the "best fit" ICD-9-CM code (from the ICD-9-CM code book) for each presenting problem or diagnosis. (CPT codes describe *what* the practitioner did. ICD-9-CM codes describe *why* the practitioner did it.)
- C. OPH-ASHI compliance policy requires that Louisiana SBHC practitioners refrain from the practice of utilizing "dummy" codes in lieu of national code sets, and/or arbitrarily "force-fitting" non-clinical information into national code sets (e.g., valid CPT and ICD-9-CM codes).

cc: OPH-ASHI Staff



STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Kathleen Babineaux Blanco
Governor

Frederick P. Cerise, M.D., M.P.H.
Secretary

Memorandum

Date: February 18, 2004
To: SBHC Directors
From: Maureen Daly

*MD 10/11/07
original lost to
KATRINA*

RE: Storage of Encounter Forms

Several SBHCs have inquired about how long encounter forms need to be kept. This question arose because the OPH contract, item #4 states "Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended there under for at least four (4) years after final payment or as described in 45 CFR 74:53 (b) whichever is longer..." Donna Adorno with DHH Legal responded to this question by stating that "the encounter form is a book, record or document relevant of the contract and funds expended there under. So they have to be kept for at least 4 years under the provisions of the contract."

The question then arose can these encounter forms be scanned in and kept electronically instead of keeping a hard paper copy. The answer is "yes" as long as they are accessible if needed.

cc Donna Adorno – DHH Legal



by Mike" Foster, Jr.
GOVERNOR

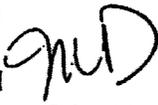
STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Memorandum

DATE: November 26, 2001

All SBHC Administrators

FROM: Maureen Daly, MD, MPH 
Medical Director, Adolescent School Health Program

Health Fairs for School Staff and Faculty

Enclosed is the Louisiana State Board of Medical Examiners Statement of Position on the performance of public cholesterol screening, blood tests, and other clinical laboratory analyses. Please share with all your nursing staff and medical directors. This statement should be referred to when planning health fairs for school staff/faculty and the general public. Thank you

According to Pat Ladner, MN, RN, Nursing Consultant for Practice with the Louisiana State Board of Nursing, taking vitals and checking weights for school staff and faculty is within the scope of practice for a registered nurse as long as a medical judgement is not rendered regarding the outcome. Any invasive testing or procedure for school staff and faculty requires a patient specific standing order from that individual's primary care provider.

cc Pat Ladner
Virginia Moore

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"AN EQUAL OPPORTUNITY EMPLOYER"

Louisiana State Board of Medical Examiners
630 Camp Street, New Orleans, LA 70130
(504) 568-6820



***** STATEMENT OF POSITION *****

**Non-Physician Cholesterol Screening,
Clinical Laboratory Testing**

February 9, 1990

Digest of Statement

The performance of cholesterol level screening and other clinical laboratory analyses constitutes the practice of medicine under Louisiana law. When not performed by a physician in a medical office, but as made available at shopping malls, supermarkets, pharmacies and similar commercial locations, public cholesterol testing is often associated with critical deficiencies which compromise its safety and effectiveness. Infection, inaccurate and misleading results, and misinformation concerning the significance of results have been associated with such cholesterol testing services.

In the interest of the public health, welfare and safety, accordingly, the Louisiana State Board of Medical Examiners advises that public cholesterol screening should be: (1) performed only under the general supervision of a qualified physician; (2) operated and provided so as to ensure proper calibration of instruments and systems; (3) administered only by personnel properly qualified in the drawing of blood samples and proper sterile techniques, and the proper operation of testing instruments; (4) administered without interpretation of the clinical significance of test results or indication of the medical necessity or lack of necessity of any form of treatment, but with notice to persons submitting to such tests of the risk of falsely positive, falsely negative and anomalous results and that the clinical significance of results may be determined only by a physician in light of history and physical examination.

As an important element of an individual's health care, the Board encourages cholesterol screening by, or on the referral of, a qualified physician in conjunction with history and physical examination.

calibrated systems or methodological errors by the person administering the test.⁶ One survey indicated that, even in the controlled environment of clinical pathology laboratories, nearly half of all laboratories produced results varying from true value by five percent or more with nearly 25% deviating by 10% or more.⁷ Perhaps needless to say, in the less controlled environment of cholesterol testing at retail storefronts, the risk of inaccurate results must be assumed to be at least as great, if not substantially greater. An apparently minor degree of inaccuracy, moreover, can have significant and serious consequences. With improperly calibrated systems, consistent negative or positive biases in results can in fact lead to misdiagnosis. A testing service, for example, that measures cholesterol with a method having a positive bias of 10% would report a value of 264 mg/dL for an individual with a true value of 240 mg/dL. In such an instance, the recipient of the result might be subject to unnecessary anxiety and even prolonged, if not life-long, dietary and medication treatment, unnecessarily. Worse, from a testing system having a similar degree of negative bias, the same individual would receive a falsely low result of 216 mg/dL. Such an adult might then consider himself as not being at risk by elevated cholesterol and would not be motivated to seek proper medical treatment.

Even given accurate results, cholesterol level measurements are subject to anomalies in a given individual over a relatively short span of time. And it should be acknowledged, finally, that cholesterol test results can ultimately be meaningful for diagnostic and treatment purposes only when interpreted in correlation with history and physical examination. Many if not all of these observations and concerns, of course, relate similarly to blood tests other than cholesterol measurement.⁸

Significantly, the Inspector General of the Department of Health and Human Services (HHS), which conducted an investigation of public cholesterol screening at the request of Congress, recently reported finding that the accuracy and usefulness of public cholesterol screening are compromised by poor quality assurance, inadequate on-site counseling, and lack of referral to a physician when appropriate.⁹ More particularly, the Inspector General observed that the qualifications and training of staff conducting public cholesterol screening may vary widely and include persons without any health care experience; that basic rules of hygiene are frequently disregarded; and that methods employed for collecting blood samples often impair the accuracy of results.¹⁰

In light of such concerns and others, and quite aside from legal considerations, some

⁶In this context, "precision" relates to reproducibility of results, while "accuracy" relates to agreement with true value. While the dangers of inaccuracy are somewhat obvious, imprecision can also be significant. As observed by two leading authorities, "[a]n analytical system with a 10% imprecision would mean that with 95% confidence limits . . . , values between 192 and 288 can be generated around a true value of 240 mg/dL . . ." H. Naito, Ph.D., A. Hartmann, M.D., *Cholesterol Standardization*, at 4 (1988) [hereinafter *Cholesterol Standardization*]. Herbert K. Naito, Ph.D., is Chairman of the Laboratory Standardization Panel, National Institutes of Health Cholesterol Education Program; Alfred E. Hartmann, M.D., is Chairman of the Chemistry Resource Committee, College of American Pathologists.

⁷Such results are reported by the College of American Pathologists' proficiency testing surveys from 5,000 participants in its Comprehensive Chemistry Survey. See *Cholesterol Standardization*, at 5.

⁸Inaccurate blood glucose values, by way of example, can directly affect diagnosis of diabetes.

⁹R. P. Kusserow, Inspector General, U.S. Dept. of Health & Hum. Services, PUBLIC CHOLESTEROL SCREENING (Nov. 1989) (draft) (cited hereinafter as *OIG Report*); see also Testimony of Richard P. Kusserow, Inspector General, Dept. of Health & Human Services before the Subcommittee on Regulation, Business Opportunities and Energy, Committee on Small Business, on Public Cholesterol Screening (Nov. 27, 1989).

¹⁰Both the manner and timing of the blood sample collection are significant. Reliable cholesterol testing requires prior fasting, something irregularly achieved by public screening services. Squeezing, or "milking" a fingerstick, a technique common to the services inspected by OIG, can affect the accuracy of test results by diluting the sample and yielding a lower than normal result.

medical authorities, including those directly concerned with public health, have seriously questioned the propriety and value of nonphysician cholesterol and blood testing of the type which this Statement concerns. The Association of State and Territorial Public Health Laboratory Directors (APHLD), for example, while acknowledging that “[a]ppropriately performed tests accompanied by counseling and education can be of value in motivating the public to adopt life styles which promote health,” observes that “shopping mall and storefront laboratory testing can be a gross disservice to the American public when tests are not performed by trained personnel on quality controlled instrumentation and coordinated with one-on-one consultation.” As a result, APHLD has formally taken the position that as currently performed, it “does not support this type of . . . testing and strongly discourages it.”¹¹ Similar views have been expressed by other governmental and private health care concerns.¹² Similarly, the Inspector General, noting the “numerous shortcomings which compromise the safety and effectiveness of public screening,” and observing that the public is generally unaware of such shortcomings and hazards, has recommended that HHS should “discourage public cholesterol screening” which is unregulated, not conducted by health care professionals and otherwise does not meet the guidelines prescribed by the National Cholesterol Education Program.¹³ Strong and legitimate arguments, that is, can and have been made that an outright ban should be enforced against such nonphysician cholesterol/blood testing services.

It is, accordingly, the Board’s position that any such testing facility should satisfy the following conditions:

- (1) *Physician General Supervision.* The testing service should be organized and provided under the general supervision of a physician licensed in this state who is qualified by education and training to conduct and interpret the tests offered and who is responsible and accountable to the Board for the service’s compliance with these conditions. Such physician may be employed or serve as a consultant to the testing service.
- (2) *Instrumentation Quality Assurance.* Systems and instruments used for cholesterol blood level and other blood tests should employ a method and be properly calibrated, and periodically checked for calibration, by a person qualified and trained to do so. The testing service should be able to achieve and to demonstrate and document achievement of reasonable precision and accuracy with respect to results reported.
- (3) *Qualified Administration.* The testing should be performed only by personnel properly qualified, by education and training, in the drawing of blood samples, proper sterile techniques, and the correct operation of testing instruments.
- (4) *Information Provided.* No testing service or person administering such tests should undertake to interpret the clinical significance of tests results,

¹¹Ass’n of State and Territorial Pub. H. Lab. Directors, Position Statement on Shopping Mall-Storefront Laboratory Testing Sites (1989).

¹²We note, for example, that the Florida Department of Health and Rehabilitative Services (HRS) has for some time sought to prevent such cholesterol testing at shopping malls and that, earlier this year, the Florida legislature enacted a Cholesterol Screening Act requiring direct supervision of cholesterol screening services by a licensed clinical laboratory or licensed physician and further requiring that a person or business that performs screening services be licensed by HRS. Similarly, we understand that the Michigan legislature is considering a bill prohibiting the testing of blood for serum cholesterol unless the test is ordered by a physician. A Louisiana parish medical society has also communicated with the Board, opposing such testing with reference to many of the health concerns expressed herein, as well as the fact that such testing constitutes the practice of medicine as a matter of law.

¹³OIG Report 14.

render or express a medical diagnosis, or in any way suggest the necessity or appropriateness, or lack of necessity or appropriateness of any form of treatment. Persons tested may be provided only with medically accurate written information concerning the significance and limitations of the tests offered and the test results reported. In the case of cholesterol testing, persons submitting to nonphysician-administered blood testing should be informed of the risk of falsely positive, falsely negative and anomalous test results and further informed that the clinical significance of test results, even if accurate, may be determined only by a physician in light of history and physical examination. Information equivalent to the following classifications may be provided to persons utilizing cholesterol blood level testing services:

Total Cholesterol (mg/dL)	LDL-Cholesterol (mg/dL)
< 200: Desirable	< 130: Desirable
200-239: Borderline/High	130-159: Borderline/High Risk
240: High	160: High Risk

LOUISIANA STATE BOARD
OF MEDICAL EXAMINERS

Louisiana State Board of Medical Examiners
630 Camp Street, New Orleans, LA 70130
(504) 568-6820



***** STATEMENT OF POSITION *****

Public Immunization

Revised September 27, 2000

The administration of influenza, pneumonia, diphtheria, tetanus, or other vaccines constitutes the practice of medicine, as defined by Louisiana law, and may therefore be performed only by a physician licensed to practice medicine in this state or by a licensed practical or registered nurse under the specific direction and supervision of a physician. A nurse's legal capacity to administer vaccines requires the order of a physician given with respect to an identified, individual patient. A physician's blanket, undifferentiated authorization for administration of influenza or other vaccinations to the public is legally insufficient and ineffectual. In the absence of a physician's patient-specific order, that is, or where a licensed physician is not physically present, the administration of vaccinations by nurses or other personnel would constitute the unauthorized practice of medicine.

The Board has determined, however, that there are certain situations in which it may be acceptable for immunizations to be administered to the public without the necessity of the continuous presence of a physician. The Board believes that it is acceptable, that is, for immunizations to be administered to the public at and by licensed health care facilities, by state or federal public health immunization programs or by other programs approved by the Board, provided that such programs are conducted under general supervision of a licensed physician who is promptly available for consultation regarding contraindications and adverse reactions and provided that a single physician assumes responsibility for the safe conduct of the immunization program.

Louisiana State Board
of Medical Examiners

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

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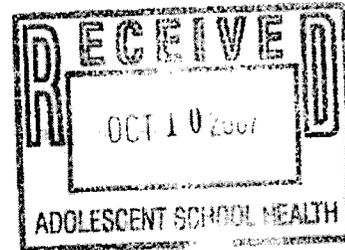


September 28, 2007

Telephone: (504) 588-8820
FAX: (504) 588-8883
Writer's Direct Dial:

(304) _____

Maureen Daly, M.D.
Medical Director,
Adolescent and School Health Program
Louisiana Office of Public Health
1450 L & A Road
Metairie, LA 70001



RE: SCHOOL BASED IMMUNIZATIONS

Dear Dr. Daly:

During its most recent meeting the Louisiana State Board of Medical Examiners (the "Board") considered your request for approval for Louisiana school-based health center (SBHC) registered nurses to administer immunizations to students without a patient specific order from, or the continuous presence of, a physician. As explained in your letter, the Office of Public Health (OPH) currently funds 52 SBHCs throughout the state, contracting with local sponsors (hospitals, community clinic, school board, etc.) to operate the SBHCs. The SBHCs are staffed with physicians, nurse practitioners, and registered nurses who provide comprehensive health services to students. Each SBHC is required to have a medical director, who is a Louisiana licensed physician, to provide supervision and medical consultation and who is available in person or by telephone whenever the SBHC is open. In addition, you have advised that all SBHCs are required to be enrolled users of LINKS, a statewide, web-based system designed to track immunization records for patients. Further, all nurses are trained in the administration of vaccines and in entering and updating patient immunization data and management in LINKS.

To insure safety and management of emergency situations you have advised that OPH will require that: all SBHC nursing personnel are trained in the management of emergency reactions, including cardiopulmonary resuscitation and other procedures, with new nursing personnel receiving such training in the first quarter of employment. In addition, refresher courses for nursing personnel will be conducted and documented annually. Each SBHC will, further, be required to have an emergency kit on-site that includes supplies and equipment including, among other items, epinephrine and benadryl for injection, along with standing physician orders for administration in emergency situations. Maintenance of kits will be

Maureen Daly, M.D
Sept. 28, 2007
Page 2

performed on a regular basis and will include renewal of medication, testing and replacement of equipment as needed and itemized documentation of regularly conducted inspection dates.¹

With apologies for the delay in responding, the Board has asked that I acknowledge your correspondence of August 31, 2007, advise you that it is well aware of OPH's fine efforts to increase the immunization rate of Louisiana's students and finds that the criteria outlined in your letter, that will be required by OPH of every local sponsor who operates an SBHC, are virtually identical to those identified in the Board's Statement of Position on Public Immunizations ("SOP").² For these reasons, and because the Board is of the view that your request is consistent with the intent of our SOP on this issue, the Board has determined it appropriate to grant OPH's request and approve the program you have described for SBHC administration of immunizations to students. The Board's decision and approval is, however, predicated upon OPH: (i) insuring that each of its local sponsors is aware of and strictly adheres to the components outlined in your letter;³ (ii) providing the Board with an on-going current list of OPH's local SBHC sponsors so that we may note them in our records as approved programs; and (iii) insuring that a student's parental or guardian consent is secured prior to each immunization.

We hope that the Board's decision will assist OPH in its task of encouraging and increasing the immunization rate of Louisiana's children and adolescent population. As always, if we can be of further assistance, please feel free to contact us.

Sincerely yours,

**LOUISIANA STATE BOARD OF
MEDICAL EXAMINERS**

By:


Robert L. Marier, M.D.
Executive Director

RLM/mtf

Corr., Maureen Daly, M.D., Med. Dir., Adolescent School Health Program, to Robert L. Marier, M.D., Exec., Dir., La. State Bd. Med. Exam. (Aug. 31, 2007).

² Louisiana State Board of Medical Examiners, Statement of Position, Public Immunizations (Sept. 27, 2000).

³ The Board assumes that OPH will continue to assume overall responsibility for the safe conduct of the immunization program.



Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Department of
HEALTH and
HOSPITALS
Roxane A. Townsend, M.D.
SECRETARY

Date: October 22, 2007
To: SBHC Directors and Medical Staff
From: Maureen Daly, MD *MD*
RE: RN Immunization Administration in SBHCs

The Louisiana State Board of Medical Examiners (LSBME) has approved SBHC registered nurses administering immunizations to students without a patient specific order from, or the continuous presence of, a physician. Attached is the letter from the LSBME granting this approval. **Please read it carefully.** Also attached is the original letter I sent to the LSBME requesting their approval.

The LSBME's approval is predicated upon the following safeguards being adhered to:

- SBHCs have a medical director who is a Louisiana licensed physician, provides supervision and medical consultation, and is available in person or by telephone whenever the SBHC is open
- SBHCs are enrolled users of LINKS
- SBHC registered nurses are trained in the administration of vaccines and entering/updating patient immunization data and management in LINKS
- SBHC registered nurses are trained in the management of emergency reactions, including cardiopulmonary resuscitation (CPR) and other emergency procedures, with new nursing personnel receiving such training in the first quarter of employment
- Refresher courses for nurses on the management of emergency reactions is conducted annually and documented. (The responsibility for coordinating and documenting the training will rest with the sponsoring agency. The medical director will be responsible for signing off that nursing personnel have undergone annual training.)
- SBHCs have an emergency kit on-site that includes supplies and equipment, including epinephrine and benadryl for injections, along with standing physician orders for administration in emergency situations
- Emergency kit maintenance is performed on a regular basis and will include renewal of medication, testing and replacement of equipment as needed and itemized documentation of regularly conducted inspection dates.
- Parental/guardian consent is secured prior to immunizations

The LSBME also predicates this approval on the Office of Public Health (OPH) insuring that each local sponsor is aware of and strictly adheres to the above safeguards. Most of the safeguards are already required by OPH-ASHP and incorporated into the LAPERT monitoring tool. Any that are not, will be incorporated and become part of the monitoring tool. As requested, OPH will also provide the LSBME with an on-going list of OPH local SBHC sponsors so that they may note them as approved programs. SBHC sponsors not funded by OPH will have to seek their own approval from the LSBME.

Thank you. Please let me know if you have any questions or comments.

att: 2

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

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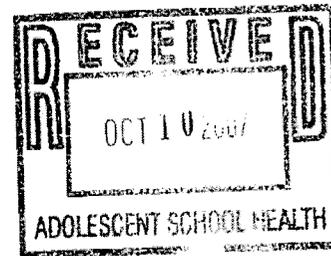


Telephone: (504) 568-6820
FAX: (504) 568-8893

September 28, 2007

(504)

Maureen Daly, M.D.
Medical Director,
Adolescent and School Health Program
Louisiana Office of Public Health
1450 L & A Road
Metairie, LA 70001



RE SCHOOL BASED IMMUNIZATIONS

Dear Dr. Daly

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Maureen Daly, M.D.
Sept. 28, 2007
Page 2

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We hope that the Board's decision will assist OPH in its task of encouraging and increasing the immunization rate of Louisiana's children and adolescent population. As always, if we can be of further assistance, please feel free to contact us.

Sincerely yours,

LOUISIANA STATE BOARD OF
MEDICAL EXAMINERS

By:



Robert L. Marier, M.D.
Executive Director

RLM/mtf

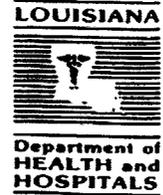
¹ Corr., Maureen Daly, M.D., Med. Dir., Adolescent School Health Program, to Robert L. Marier, M.D., Exec., Dir. La. State Bd. Med. Exam. (Aug. 31, 2007).

² Louisiana State Board of Medical Examiners, Statement of Position, Public Immunizations (Sept. 27, 2000).

³ The Board assumes that OPH will continue to assume overall responsibility for the safe conduct of the immunization program.



STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Kathleen Babineaux Blanco
Governor

Frederick P. Cerise, M.D., M.P.H.
Secretary

August 31, 2007

Louisiana State Board of Medical Examiners
Robert L. Marier, MD, MHA
Executive Director
PO Box 30250
New Orleans, LA 70190-0250

Dear Dr. Marier

This letter is to request the approval of the Louisiana State Board of Medical Examiners for Louisiana school-based health center (SBHC) registered nurses (RNs) to administer immunizations to students without a patient specific order and without the continuous presence of a physician. (Attached is the Board's Statement of Position on Public Immunization, 2000.)

As background, Office of Public Health (OPH) currently funds 52 SBHCs throughout the state. OPH contracts with a local sponsor (hospital, community clinic, school board, etc) to operate the SBHCs. The SBHCs are staffed with physicians, nurse practitioners, and registered nurses who provide comprehensive health services to students. Each SBHC is required to have a medical director (licensed physician) to provide supervision and medical consultation and who is available in person or by phone whenever the SBHC is open.

In addition, all SBHCs are already required to be an enrolled user of *LINKS*, the statewide, web-based system designed to keep track of immunization records for patients. As enrolled users, nurses are trained in the use of vaccines in ordinary and catch-up situations. As *LINKS* users, they receive trainings in entering/updating patient demographic/immunization data and management of vaccine inventory. They, also, receive technical/programmatic support and regular vaccine updates.

To ensure the safety of immunization administration and the appropriate management of emergency reactions, the following will be implemented:

SBHC nursing personnel will be trained in the management of emergency reactions, including cardiopulmonary resuscitation (CPR) and other emergency procedures necessary to deal with reactions to vaccines.

All new nursing personnel will be trained as above within the first quarter of employment with the SBHC sponsoring agency.

- 3 Refresher courses in management and emergency reactions will be conducted at least annually. The responsibility for coordinating and assuring adequate training will rest with the sponsoring agency. The medical director of each SBHC will be required to sign off that

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PHONE #: 504/219-4419 • FAX #: 504/219-4637
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Louisiana State Board of Medical Examiners

nursing personnel have undergone annual training.

4. SBHCs will be required to have an emergency kit onsite that includes epinephrine and benadryl for injection and physician standing orders for the administration of these emergency medications.
5. The emergency kit supplies and equipment will be maintained by each SBHC. Maintenance includes renewal of medications as needed, testing of equipment and replacement of used or worn-out components. In order to assure proper maintenance an itemized sheet will be used regularly to record dates that emergency kit was checked.

Attached are letters from the American Academy of Pediatrics-Louisiana Chapter, OPH-Immunization Program, Louisiana Assembly on School Based Health Care, Dr. Bienvenu with LSU Department of Medicine in Shreveport, and Dr. Krake with CHRISTUS St. Frances Cabrini SBHCs that support this request. We all appreciate the Board's consideration of this matter. I will be contacting you in the near future to discuss next steps.

Sincerely,

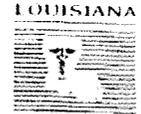


Maureen Daly, MD, MPH
Medical Director, Adolescent School Health Program



Orlando Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Department of
HEALTH and
HOSPITALS

David W. Hood
SECRETARY

13-04

MEMORANDUM

DATE: January 16, 2004
TO: SHBC Directors
FROM: Maureen Daly, ASHI Office *MD*
RE: LICENSURE OF SBHC STAFF

The OPH/ASHI contract requires that you hire, orient, and retain qualified personnel licensed to practice in Louisiana including: physicians, nurse practitioners, registered nurses, and social workers. It is your responsibility to verify licensure prior to hiring. The web sites to verify the licensure of personnel are listed below:

- 1) Louisiana State Board of Nursing (for registered nurses and advanced practice registered nurses) - www.lsbn.state.la.us. Look to left corner; click on licensure status; pull down selection (RN, APRN); type in nurse's license number and nurse's social security number; the individual's name will be displayed.
- 2) Louisiana State Board of Practical Nurse Examiners (for licensed practical nurses/license vocational nurses) - www.lsbone.com. There is a \$5.00 fee per name. Payment can be made with cash (walk-in only), money order or company check. Check or money order must be payable to La. State Board of Practical Nurse Examiners, 3421 N. Causeway Blvd., Suite 203, Metairie, LA 70002, attn: Verification Clerk. Also, if you need more than one license verified, you may submit one money order or check to cover the total fee.
- 3) Also, be sure to view the nurse's license, checking for date of expiration, license number and name of nurse. By the way (at least for the RN/APRN license cards), the color of the card changes yearly.
- 4) Louisiana State Board of Medical Examiners (for physicians) - www.lsbme.org. The license verification link is on the left hand side. You can search by name or license number
- 5) Louisiana State Board of Social Workers Examiners (for social workers) - www.labswe.org. The license verification link is on the left hand side. You need only type in the last name.

As we begin a new year, it would be a good idea to check on the status of licenses for your current personnel. Please remember, your contract requires written OPH authorization prior to hiring any employee with OPH funds.

Louisiana State Board of Nursing
3510 North Causeway Blvd., Suite 501
Metairie, Louisiana 70002
Phone (504) 838-5332
Fax (504) 838-5349

MEMORANDUM

DATE: September 10, 1996

Virginia Moore, RN, C.S.N.P.
Quality Assurance Consultant
1137 Masterson Drive
Baton Rouge, LA 70810

FROM: Pat Ladner, MN, RN *PL*
Nursing Consultant for Practice

Over-The-Counter Medications

Pursuant to your request relative to registered nurses administering over-the-counter medications in school based health clinics, it is within the scope of practice for a registered nurse to administer over-the-counter medications provided that:

1. Standing orders are in place that specify the medication, dose, and route.
2. The registered nurse is not required to make a medical diagnosis.
3. The student is able to identify the problem and choose the medication if the standing order allows for more than one medication.

As you indicated during our meeting, the school base health clinics have on file signed consent forms by the parents allowing the registered nurse to administer over-the-counter medications, these files should be readily available to each registered nurse in these clinics.

Contact me if I can further assist you with nursing practice matters.



Murphy J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



David Hood
SECRETARY

Memorandum

DATE: November 16, 2001

TO: All SBHC Administrators, RNs, NPs, and Medical Directors

FROM: Maureen Daly, MD, MPH
Medical Director, Adolescent School Health Program

RE: Over-the-Counter Medications for School Staff/Faculty in School-Based Health Centers (SBHCs)

*MD 10/11/07
original lost in
Kartina*

This memo is in response to a question ASHI received regarding the administration of over-the-counter medications to school staff/faculty in SBHCs. Pat Ladner, MN, RN, Nursing Consultant for Practice with the Louisiana State Board of Nursing, was consulted and the following was clarified: It is within the scope of practice for a registered nurse to administer over-the-counter medications to school staff/faculty at the SBHC provided that a patient-specific standing order for that individual from his/her primary care provider is in place that specifies the medication, dose, and route.

If no such standing order is available, over-the-counter medications can be made available to the school staff/faculty in pre-packaged doses only. The staff/faculty select the medication and self-administer it.

Attached is a 1996 memorandum clarifying the administration of over-the-counter medications to students for your review. Thank you and please feel free to call if you have questions.

cc Pat Ladner, MN, RN
Virginia Moore, RN, MN, FNP

DHH/OPH/Adolescent School Health Initiative
Medical Advisory Subcommittee Meeting Minutes

The Medical Advisory Subcommittee Meeting was held at the Bienville Building in Baton Rouge on September 24, 2007 from 10:00-12:00 pm. Thank you to everyone that attended.

Attendees

Maureen Daly-ASHI	Mary B. Green – McDonogh 35/LPHI
Angela Nicholson -ASHI	Shelly Dubriel – St. Gabriel
Virginia Moore -ASHI	LaQuita Johnson – Oakdale
Gail Collins – Science& Math/ Mc Main	Denise Lemelle – CHRISTUS
Sylvia Redd – Madison	St.Patrick
Rodger Puckett – Madison	Melanie Petchak – CHRISTUS
Glinda Jenkins – West Feliciana FSC	Shumpert
Sheila Solomon – West Feliciana FSC	Connie Jackson – CHRISTUS
Theresa Savant – CHRISTUS	St. Patrick
St. Patrick	Rhonda F. Clofer – McDonogh 35
Jody West – St. Martin	Letarsha Campbell – St. Helena
Lisa Burns – St. Helena	Judy Bayer – Riverdale
Tonya Mayer – St. Helena	Kim Lange – McDonogh 35
Debra Green – St. Martin	Jennifer Adams – Bogalusa
Mae Juan – Chalmette High School	Marsha Bonnet – Bogalusa
Tanya Cobb- Delhi	Anna Busby – Bogalusa
Shanon McLaughlin – Northside	Phyllis Crawford – Oakdale
Iris Malone – Northside	LaShauna Johnson – CHRISTUS
JoAnn Derbonne – CHRISTUS Cabrini	St. Patrick
Monique Dematteo – Butler	Denise Hughes – CHRISTUS
Eileen Sonnier – West Feliciana FSC	Shumpert
Alfred Krake – CHRISTUS Cabrini	Linda Matessino – Innis Community
Beth Edwards – HCCS	Health Center
Liz Dimitry – MCLNO /O’Perry Walker	Tammy Stewart – Bogalusa
Julie Finger – McDonogh 35	Jessica Spears – Innis Community
	Health Center

Minutes

I. Administration of OTC Medications/ Update on Immunizations Administration

Maureen Daly welcomed all present and after brief introductions opened the meeting with the first agenda item, the issue of registered nurses (RNs) administering Over-the-counter (OTCs) medications in SBHCs. Maureen provided background by explaining that this summer OPH/ASHI was asked by the field to get a legal opinion regarding whether it is in the scope of practice of SBHC RNs to administer immunizations to students without a patient order for each immunization and when the physician/medical director is not onsite. This question was prompted by the Louisiana

Board of Medical Examiners September 27, 2000 Statement about Public Immunizations and how it affects giving immunizations in the SBHC in Louisiana. This document from the Medical Board states that for RNs to administer immunizations under such circumstances would constitute the unauthorized practice of medicine. This question led to the question of whether it is in the scope of practice for RNs to administer OTCs on a physician standing order without a patient specific order and without the physician onsite. She further said she was hoping this committee would achieve clarity on this as well as the way forward after the committee had exhausted all discussion on the topic. Maureen pointed out that this issue was only for the SBHC RNs and not the School RNs.

Maureen stated that after consultation with Dr. Gordon, Dr. Perrin, Virginia Moore, and Sandra Adams, she sent a letter to the Board of Medical Examiners asking for approval for SBHC RNs to administer immunizations without the patient specific order and without a physician (MD) present. In the letter, safeguards that SBHCs would take were outlined.

On September 21, 2007, Maureen was contacted by the Board of Medical Examiners and told that SBHCs will be acknowledged as a special group in which RNs can administer immunizations to students under a physician standing order, without an individual order for each immunization and when a physician is not onsite. She said that she has yet to receive a formal letter stating this but will send to all SBHCs once she receives it.

Virginia Moore, the ASHI Quality Control Consultant next explained how SBHC RNs have operated under the assumption that they could administer OTC medications to students under physician standing orders since 1996. She referred to a memo from the Louisiana State Board of Nursing (LSBN) dated September 10, 1996 stating that it was "within the scope of practice for a registered nurse to administer over-the-counter medications provided that:

1. Standing orders are in place that specify the medication, dose, and route.
2. The registered nurse is not required to make a medical diagnosis.
3. The student is able to identify the problem and choose the medication if the standing order allows for more than one medication."

The memo further states that "the school base health clinics have on file signed consent forms by the parents allowing the registered nurse to administer over-the-counter medications, and these files should be readily available to each registered nurse in these clinics."

She explained that at the time there were few nurse practitioners (NPs) in SBHCs and that prescriptive authority was just in the process of being obtained for NPs. She felt that the memo was old and written at a time when circumstances were different from the present day running of a SBHC where at present most Louisiana SBHCs now have NPs with prescriptive authority.

Virginia reiterated that the Statement about Public Immunizations from the Board of Medical Examiners stated that the administration of specified vaccines by RNs under physician standing orders without a patient specific order or the physician being present constituted the practice of medicine and therefore could only be performed under the order of a physician given with respect to an identified, individual patient or when a licensed physician is physically present. This document raised the concern that if the Board of Medical Examiners could raise concerns on the need to have patient specific orders for immunizations, the same might true of OTC medications.

Virginia requested the members to collectively decide how to address this issue, which might involve going to the LSBN and seeking clarification on the issue. She also said that she had conducted extensive research to find out if there are any SBHCs nationwide that have had to deal with a similar issue. She said that in Maryland, there were SBHCs that had come up with an agreement between the Maryland Board of Nursing and Board of Medicine, which permits the RNs in schools to give OTC medications in specific limited situations under protocols.

Members that were in attendance were asked to voice their opinions and concerns regarding the issue of RNs in SBHCs administering OTCs without patient specific orders. This matter was discussed at length and the following are some of the sentiments that were conveyed:

- “Why bring up this issue again to the Board when there is already a memo allowing us to do this?”
- “Our Joint Commission surveys us routinely and the case of patient specific orders has never been an issue.”
- “I would prefer to have written orders, I have a Medical Director and an NP.”
- “I am an NP, we told our RN to do it if she felt comfortable, if not call your provider and get their order signed off.”

Members were asked to vote on whether or not to go to the LSBN for clarification on the issue of OTCs and SBHC RNs. Of the 42 members that attended the meeting, 40 were against going to the LSBN and only 2 voted to go to the LSBN.

Virginia pointed out that if SBHCs are going to use the 1996 memo as their guiding opinion, then SBHC RNs need to follow the 1996 memo to the letter and also have provisions on consent forms that state that the RN would be administering listed OTC medications. JoAnn Derbonne agreed to email her consent form to OPH/ASHI for distribution to serve as an example. The consent form will be e-mailed to members as soon as it is received from JoAnn.

OPH/ASHI was asked to e-mail the members the nurse standing orders from Maryland. (See Attachment)

II. New Contract Requirements for 2009

Members were informed that beginning in the 2008-2009 fiscal year, all sites will be required to conduct a minimum of 10% comprehensive physicals on students at the host school. Maureen informed all that for the 2005-06 school year, 51% of the sites were already at 10% or more.

Members were also informed that for school year 2009, all SBHCs serving 9th graders and above will need to provide STD screening, diagnosis, and treatment onsite. Maureen pointed out that the STD best practices for SBHCs recommends that all sexually active kids be screened at least annually for STDs even if they are asymptomatic.

III. STD Training Survey Results

Angela Nicholson explained to members that a survey on STD training had been passed out to NPs and MDs in SBHCs and she gave out the results of this survey. Maureen informed members that, most likely, a STD Train the Trainers would be conducted so that those that participate in the training could in turn go and train others.

IV. Election of Medical Subcommittee Co-Chair

The OPH-ASHI office received a nomination for Sheila Solomon, an RN from West Feliciana Family Service Center, to be the next SBHC Medical Subcommittee Co-Chair. The nomination was seconded by Beth Edwards, NP at Health Care Centers in Schools.

Congratulations to Sheila Solomon, our new Co-Chair.

V. Questions/Comments

Having no further comments, the meeting ended at 11:50 am and the date for the next Medical Subcommittee meeting will be communicated to members in due course.

Submitted by:

Angela Nicholson, MPH

OPH-ASHI, Medical Co-Chair



Murphy J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA



Department of
HEALTH and
HOSPITALS

David Hood
SECRETARY

MEMORANDUM

Date: February 5, 2002

All SBHC Administrators and Medical Personnel

From: Maureen Daly, MD, MPH *MD*
ASHI Medical Director

Tuberculin Skin Test Recommendations

It has come to our attention that some of the school-based health centers are performing routine tuberculin skin testing as part of a sports physical/comprehensive physical assessment. **Routine Tuberculin Skin Testing (PPD) is NOT recommended and should not be part of a routine physical assessment.** Tuberculin skin testing is reserved for those at high risk for the development of tuberculosis.

The Office of Public Health (OPH) TB Control Program uses the same guidelines for tuberculin skin testing of children and adolescents as those recommended by the American Academy of Pediatrics. Attached are the current guidelines from the American Academy of Pediatrics for tuberculin skin testing in infants, children, and adolescents. If you have a student who you believe is at high risk for the development of tuberculosis, please notify your local parish health unit or the OPH TB Control Program at the OPH (504)568-5015 for assistance.

Thank you.

cc Louis Trachtman, MD, Medical Consultant, TB Control Program/OPH
Charles DeGraw, Administrator, TB Control Program/OPH
ASHI staff

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FAXED
2-5-02

Table 3.65. Tuberculin Skin Test (TST) Recommendations for Infants, Children, and Adolescents*

Children for whom immediate TST is indicated:

- Contacts of persons with confirmed or suspected infectious tuberculosis (contact investigation): this includes children identified as contacts of family members or associates in jail or prison during the last 5 years
- Children with radiographic or clinical findings suggesting tuberculosis disease
- Children immigrating from endemic countries (eg, Asia, Middle East, Africa, Latin America)
- Children with travel histories to endemic countries and/or significant contact with indigenous persons from such countries

Children who should have annual TST†:

- Children infected with HIV or living in household with HIV-infected persons.
- Incarcerated adolescents

Children who should be tested every 2–3 years‡:

- Children exposed to the following persons: HIV-infected, homeless, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults, and migrant farm workers; foster children with exposure to adults in the preceding high-risk groups are included

Children who should be considered for TST at 4–6 and 11–16 years of age:

- Children whose parents immigrated (with unknown TST status) from regions of the world with high prevalence of tuberculosis; continued potential exposure by travel to the endemic areas and/or household contact with persons from the endemic areas (with unknown TST status) should be an indication for a repeated TST
- Children without specific risk factors who reside in high-prevalence areas; in general, a high-risk neighborhood or community does not mean an entire city is at high risk; rates in any area of the city may vary by neighborhood or even from block to block; physicians should be aware of these patterns when determining the likelihood of exposure; public health officials or local tuberculosis experts should help physicians identify areas with appreciable tuberculosis rates

Children at increased risk for progression of infection to disease: Those with other medical conditions, including diabetes mellitus, chronic renal failure, malnutrition, and congenital or acquired immunodeficiencies deserve special consideration. Without recent exposure, these persons are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically would enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosuppressive therapy for any child with an underlying condition that necessitates immunosuppressive therapy.

* Bacille Calmette-Guérin immunization is not a contraindication to TST. HIV indicates human immunodeficiency virus.

† Initial TST is at the time of diagnosis or circumstance, beginning at 3 months of age.

AAP Redbook 2000

from lymph node, pleura, liver, bone, diagnosis, but *M tuberculosis* cannot be identified in stained specimens. Rapidly growing polymerase chain reaction, for rapid diagnosis, is approved only for smear-positive tuberculosis. Length polymorphism analysis is used in research and reference laboratories. Both methods require a specialist in tuberculosis. These activities should be actively pursued to support the prevention of disease if *M tuberculosis* is isolated from children who will affect the choice of drugs for the child or disease. These activities should be

in children with evidence of tuberculosis from a source case is not available; in children with HIV infection;

A practical tool for diagnosing tuberculosis is the Mantoux test containing 5 tuberculin units (TU), administered intradermally, is the standard skin test (1 of 250 TU) should be recommended because they lack adequate

recommends a TST for children who are at risk of infection and disease (see Tuberculin Skin Test Recommendations for Infants, Children, and Adolescents, Table 3.65). School-based programs that include annual testing yield of positive results or a large number of children who are younger than 1 year of

measures that immunizations are given. Immunization with bacille Calmette-Guérin (BCG) is not recommended for skin testing.

of results should be performed by personnel who have been trained in the proper methods. Results obtained by unskilled persons are unreliable. The standard dose of 5 TU of PPD intradermally (Mantoux test) is administered using a 27-gauge needle and a tuberculin syringe. To interpret the TST, it can be interpreted by a physician, a nurses clinic or local public health staff, or emergency department personnel notified of the result promptly.

Pediatrics Committee on Infectious Diseases. *Pediatrics*. 1994;93:131–134; and American Academy of Pediatrics. Update on tuberculosis skin testing

Table 3.70. Tuberculin Skin Test (TST) Recommendations for Infants, Children, and Adolescents¹

Children for whom immediate TST is indicated²:

- Contacts of people with confirmed or suspected contagious tuberculosis (contact investigation)
- Children with radiographic or clinical findings suggesting tuberculosis disease
- Children immigrating from countries with endemic infection (eg, Asia, Middle East, Africa, Latin America, countries of the former Soviet Union) including international adoptees
- Children with travel histories to countries with endemic infection and substantial contact with indigenous people from such countries³

Children who should have annual TST:

- Children infected with HIV
- Incarcerated adolescents

Children at increased risk of progression of LTBI to tuberculosis disease: Children with other medical conditions, including diabetes mellitus, chronic renal failure, malnutrition, and congenital or acquired immunodeficiencies deserve special consideration. Without recent exposure, these people are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically would enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosuppressive therapy, including prolonged steroid administration, use of tumor necrosis factor-alpha antagonists, or immunosuppressive therapy in any child requiring these treatments.

HIV indicates human immunodeficiency virus; LTBI, latent tuberculosis infection.

¹ Bacille Calmette-Guérin immunization is not a contraindication to a TST.

² Beginning as early as 3 months of age.

³ If the child is well, the TST should be delayed for up to 10 weeks after return.

Induration (mm) for a positive result varies with the person's risk of LTBI and progression to tuberculosis disease.

Current guidelines from the Centers for Disease Control and Prevention (CDC), American Thoracic Society, and American Academy of Pediatrics accept 15 mm or greater of induration as a positive TST result for any person. Interpretation of 5 mm or more or 10 mm or more induration is summarized in Table 3.69 (p 680). Interpretation is aided by knowledge of the child's risk factors for LTBI and tuberculosis disease. Prompt clinical and radiographic evaluation of all children and adolescents with a positive TST reaction is recommended.

INTERPRETATION OF TST RESULTS IN PREVIOUS RECIPIENTS OF BCG VACCINE Generally, interpretation of TST results in BCG recipients is the same as for people who have not received BCG vaccine. After BCG immunization, distinguishing between a positive TST result caused by *M tuberculosis* or *M bovis* infection and that caused by BCG can be difficult. Reactivity of the TST after receipt of BCG vaccine does not occur in some patients. The size of the TST reaction (ie, mm

mon method for diagnosis of 5 tuberculin units using a 27-gauge needle. Creation of a visible wheal. Other strengths of multiple puncture tests are not available. Specificity.

Increased risk of acquiring tuberculosis disease (TST administration, day camps that include population either a low yield of tuberculosis disease, leading to an inefficient tuberculin skin test. Notify children with risk factors (Table 3.71, p 684). Risk factors include contact with a child and adolescent for 4 to 6 weeks and 6, 12, 18, and 24 months. If the result is determined, a TST should be performed in children younger than 3 years of age. Tuberculosis should be per-

immunizations, including live-attenuated vaccines, should be deferred for 4 to 6 weeks. Although tuberculin skin testing is reasonable to assume tuberculin skin testing. Previous immunization is a contraindication to TST. Tuberculin skin testing should be performed by trained personnel using the proper methods, including the Mantoux and family members. Tuberculin skin test result is 48 to 72 hours after the site of administration. Read the result. The diameter of the long axis of the forearm should be measured for several

tuberculosis disease. Approximate tuberculin skin test results in children with culture-documented disease, including age, poor nutrition, diabetes, measles, varicella, and influenza. Tuberculosis disease can be associated with HIV and *M tuberculosis*. Tuberculin skin test results in children with tuberculin skin test results are not

TABLE 3.69, P 680). Clinical factors. The size of

AAP "Redbook" 2006

10-11-07

For your convenience, we have included the TB Skin Test Recommendation from the AAP Redbook, which is updated annually.



Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Roxane A. Townsend, M.D.
SECRETARY

Date: September 28, 2007

SBHC Directors, SBHC Medical Providers

From: Rubén Tapia, OPH/Immunization Program Director
Maureen Daly, OPH/ASHI Medical Director

RP
MD

Exemption from OPH to Provide Immunizations to Underinsured Students

As you may know, all Louisiana School Based Health Centers (SBHCs) are eligible "Vaccines for Children (VFC)" providers. Through the VFC program public purchased vaccine is available at no charge to enrolled public and private health care providers for VFC and vaccine eligible children. Children through 18 years of age (<19) that meet at least one of the following criteria are eligible for VFC: Medicaid Eligible, the Uninsured, American Indian or Alaskan Native - as defined by the Indian Health Services Act. VFC funding does not cover underinsured children, however funding under Section 317 of the Public Health Service Act of 1963 does.

Effective immediately, the Office of Public Health (OPH) - Immunization Program will recognize SBHCs as "Health Unit-like" facilities. This action will allow SBHCs to administer vaccines to underinsured children up to 19 years of age using federal Section 317 funding. "Underinsured" is defined as a child whose health insurance benefit plan does not include vaccinations, or provides limited coverage, or whose co-pay/deductible makes vaccination costly.

As a "Health Unit-like" facility, the SBHCs agree to follow all vaccine policies applicable to OPH parish health units, must utilize the Louisiana Immunization Network for Kids Statewide (LINKS) in real time, be subject to vaccine quality assurance reviews, and adhere to and comply with the Immunization Program "Discrepancy or Misuse Policy." The OPH Immunization Policies and Procedures Manual can be found at the LINKS web homepage under Document Center:

<https://linksweb.oph.dhh.louisiana.gov/linksweb/main.jsp>. Continue to submit your vaccine orders in your usual manner. The Office of Public Health Immunization Program agrees to provide vaccines only. No other immunization supplies will be provided.

CAVEAT: Unfortunately, the meningococcal conjugate vaccine (MCV-4) and the recombinant Human Papillomavirus Vaccine (HPV), can presently only be administered to Vaccine For Children (VFC) eligible adolescents. The Immunization Program does not yet have funding to provide the MCV-4 or HPV vaccines for any other individuals, including adolescents who have health insurance that covers vaccines, or the underinsured. Failure to strictly adhere to ALL OPH Immunization Program policies will result in suspension of this initiative to all SBHCs.

The Immunization Program is 100% Federally Funded and the guidelines are strict as to who can be vaccinated. For several years, federal funding has not kept up with the vaccine costs and/or introductions of new vaccines, consequently, we are doing more with less.

Should you need further information or explanation, please feel free to contact us.

cc Virginia Moore, Pat Simon

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M. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA



Department of
HEALTH and
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David W. Hood
SECRETARY

MEMORANDUM

Date: December 20, 2002
To: SBHC Directors
From: Maureen Daly *MD*
RE: CommunityCARE Exemption for SBHCs

Great news! The Louisiana Medicaid office has just informed me that the SBHCs will be exempt from PCP (primary care physician) prior authorization for services provided on site for the 10-21 year old population. This means SBHCs will be able to bill Medicaid for services provided to students 10-21 years of age without prior authorization from the student's primary care physician. In turn, however, the SBHCs will be required to share the visit information with the PCP.

The details of this plan are still being worked out including the effective date of this exemption. Medicaid will soon begin working on the system changes to make this happen. The changes necessary are complicated and tedious and may take some time. Your continued patience is greatly appreciated.

It is recommend at this time that you continue to submit KIDMED claims even if they are denied in order to establish the 60 day time.

The ASHI staff would like to wish you and your families a safe and happy holiday season.

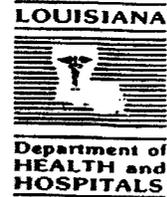
cc ASHI
Virginia Moore
Deirdre Arnaud

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"AN EQUAL OPPORTUNITY EMPLOYER"



Kathleen Babineaux Blanco
Governor

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Frederick P. Cerise, M.D., M.P.H.
Secretary

MEMORANDUM

To: SBHC Directors

Christine Armand-Perret *CAP*

October 15, 2004

Re: Medicaid Website

FAXED
10/15/04

The Medicaid website is available at www.lamedicaid.com. This resource is very valuable and provides access to the following information at no cost:

1. Medicaid code fee schedule (link for forms/files);
2. Medicaid eligibility for students;
3. name and contact information of the PCP for students; and
4. status of claims.

Please note that it is necessary to have a working email and a Medicaid provider number to utilize numbers 2-4 above.

**The 123rd Annual Meeting
of the LSMS House of Delegates was held on
October 24-26, 2002
at the Radisson Hotel & Convention Center
in Baton Rouge, Louisiana**

The LSMS House of Delegates meets annually for the purpose of setting policy through the adoption of resolutions, reports and motions from the floor accepted as business of the House. Two resolutions in support of SBHCs passed during the 2002 Annual Meeting.

RESOLUTION 306

SUBJECT: Physician Support of School-based Healthcare

INTRODUCED BY: Committee on Public Relations

Adopted 10/25/2002

RESOLVED, the LSMS encourage its members, active and retired, and its component societies to participate in and/or to be supportive of the school-based health centers in their locales, and therefore be it further

RESOLVED, the LSMS Board of Governors seek input from appropriate LSMS standing committees or an appointed task force to help determine the need for involvement by its members with school-based centers state-wide and to report its findings and recommendations to the 2003 LSMS House of Delegates.

RESOLUTION 308

SUBJECT: Support of School-Based Health Centers

INTRODUCED BY: Orleans Parish Medical Society

Adopted 10/25/2002

RESOLVED, the Louisiana State Medical Society support the intent of Senate Concurrent Resolution 20 (SCR 20) by disseminating information to the membership regarding the opportunity for members to serve on the "Project: HEAL Schools" task force, and by encouraging physician members to become aware of and to support the efforts of school-based health centers, and be it further

RESOLVED, the LSMS encourage their representatives on the "Project: HEAL Schools" task force to consider expanding the policies of school-based health centers to allow them to address non-traditional services for school-based health centers, including, but not limited to, obesity screening and education and physical activity programs for school-age children.

RULE

Department of Health and Hospitals Office of Public Health

Expedited Partner Therapy-Patient/Partner Notification (LAC 51:II.117)

The Department of Health and Hospitals, Office of Public Health, has amended LAC 51:II.117 as authorized by Act 449 of the 2008 Regular Session of the Louisiana Legislature. This Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq. Act 449 of the 2008 Regular Session of the Louisiana Legislature directs that the Secretary of the Department of Health and Hospitals promulgate a Rule to allow as a legitimate alternative for the provision of medications or prescriptions by any physician licensed to practice medicine in this state, or any advanced practice registered nurse, who is licensed to practice nursing in this state, or any physician assistant, who is licensed to practice in this state, provided such physician or nurse or physician assistant has the authority to write prescriptions in this state, to individuals who may have been exposed to gonorrhea or chlamydia. This legitimate alternative, known as expedited partner therapy, is authorized absent a doctor-patient relationship and absent clinical assessment.

Title 51

PUBLIC HEALTH—SANITARY CODE

Part II. The Control of Disease

Chapter 1. Disease Reporting Requirements

§117. Disease Control Measures Including Isolation/Quarantine [formerly paragraph 2:011]

A. - G. ...

H. If expedited partner therapy is chosen as an alternative by the before mentioned physician, advanced practice registered nurse or physician assistant, the patient with a case of gonorrhea or chlamydia will be given a written document that the patient agrees to give to his or her sexual contact. The document will contain, but will not be limited to the following information.

1. The sexual contact should be examined and treated by a physician, advanced practice registered nurse or physician assistant, if at all possible.

2. The medicine or prescription for medicine given to the sexual contact by the patient should not be taken by the contact if the contact has a history of allergy to the antibiotic or to the pharmaceutical class of antibiotic in which case the sexual contact should be examined and treated by a physician, advanced practice registered nurse or physician assistant and offered another type of antibiotic treatment.

3. The medicine or prescription for medicine given to the sexual contact by the patient should not be taken by the contact if the contact is pregnant, in which case the sexual contact should be examined by a prenatal care health care provider.

4. Additionally, any pharmacist licensed to practice pharmacy in this state may recognize a prescription authorized by this section as valid, notwithstanding any other provision of law or administrative rule to the contrary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4 (A) (2) and R.S. 40:5

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1214 (June 2002), amended LR 35:249 (February 2009).