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Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 3. Licensing and Certification

Chapter 90. Psychiatric Residential Treatment Facilities (under 21)

Subchapter A. General Provisions

§9001. Purpose

A. The purpose of this Chapter 90 is to provide for the development, establishment and enforcement of statewide standards for the care of residents who are under 21 years of age in psychiatric residential treatment facilities (PRTFs) participating in the Medicaid Program, to ensure maintenance of these standards, and to regulate conditions in these facilities through a program of licensure which shall promote the health, safety and welfare of residents of PRTFs participating in the Medicaid Program.

B. In addition to requirements stated herein, all licensed PRTFs shall comply with applicable local, state, and federal laws and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:54 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:371 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:287 (February 2018).

§9003. Definitions

A. The following defines selected terminology used in connection with this Chapter 90.

Abuse—any one of the following acts which seriously endangers the physical, mental or emotional health of the resident:

a. infliction, attempted infliction, or, as a result of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon the resident;

b. exploitation or overwork of a resident;

c. involvement of the resident in sexual activity constituting a crime under the laws of this state.

Accreditation—official notification given the provider of compliance to standards established by either:

a. the Joint Commission (TJC), formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);

b. the Commission on Accreditation of Rehabilitation Facilities (CARF); or

c. the Council on Accreditation for Children and Family Services (COA).

Active Treatment—implementation of a professionally developed and supervised individual plan of care that is developed no later than 14 days after admission and designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

Administrator—the person responsible for the on-site, daily implementation and supervision of the facility's overall operation commensurate with the authority conferred by the governing body.

Behavior Management—techniques, measures, interventions and procedures applied in a systematic fashion to promote positive behavioral or functional change fostering the resident's self-control, and to prevent or interrupt a resident's behavior which threatens harm to the resident or others.

Cessation of Business—provider is non-operational and/or has stopped offering or providing services to the community.

Change of Ownership (CHOW)—the sale or transfer whether by purchase, lease, gift or otherwise of a PRTF by a person/corporation of controlling interest that results in a change of ownership or control of 30 percent or greater of either the voting rights or assets of a PRTF or that results in the acquiring person/corporation holding a 50 percent or greater interest in the ownership or control of the PRTF.

Clinical Director—the person who has responsibility for the psychiatric aspects of the program and who has to provide full-time coverage on an on-site or on-call basis.

CMS—the Centers for Medicare and Medicaid Services, Department of Health and Human Services.

Core Mental Health Disciplines—academic training programs in psychiatry, psychology, social work and psychiatric nursing.

DCFS—the Department of Children and Family Services.

Department (LDH)—the Louisiana Department of Health.

Discipline—the ongoing practice of helping residents develop inner control so they can manage their own behavior in an appropriate and acceptable manner.

Documentation—written evidence or proof, including signatures of appropriate staff and date, shall be maintained on site and available for review.

Emergency Safety Intervention—the use of restraint or seclusion as an immediate response to an emergency safety situation.

Emergency Safety Situation—unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an *emergency safety intervention*.

Governing Body—the board of trustees, owner or person(s) designated by the owner with ultimate authority and responsibility (both moral and legal) for the management, control, conduct, and functioning of the PRTF.

Group (*or Unit*)—refers to the residents who share a common space and relate to one primary staff person (who may be assisted by others) on a consistent or daily basis.

HSS—the Department of Health, Health Standards Section.

License—the legal authority to operate as a PRTF in the state of Louisiana.

Licensed Mental Health Professional (LMHP)—an individual who meets one of the following education and experience requirements:

a. a physician duly licensed to practice medicine in the state of Louisiana and has completed an accredited training program in psychiatry; or

b. a psychologist licensed as a practicing psychologist under the provisions of R.S. 28:2351-2370; or

c. a medical psychologist licensed under the provisions of R.S. 28:2351-2370; or

d. a social worker who holds a master's degree in social work from an accredited school of social work and is a licensed clinical social worker under the provisions of R.S. 37:2701-2718, as amended; or

e. an advanced practice registered nurse licensed as a registered nurse in the state of Louisiana by the Board of Nursing who may practice to the extent that services are within the nurse's scope of practice; and

i. who is a nurse practitioner specialist in adult psychiatric and mental health and family psychiatric and mental health; or

ii. who is a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health;

f. a licensed professional counselor who is licensed as such under the provision of R.S. 37:1101-1115 and has at least two years post master's supervised experience delivering services in the mental health-related field; or

g. a licensed marriage and family therapist who is licensed as such under the provisions of R.S. 37:1116-1121; or

h. a licensed addiction counselor who is licensed as such under the provisions of R.S. 37:3387.

LSUCCC—the Department of Public Safety and Corrections, Louisiana State Uniform Construction Code Council.

Mechanical Restraint—any device attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

Mental Health Professional (*MHP*)—an individual who is supervised by a LMHP and meets the following criteria as documented by the provider:

a. has a Master of Social Work degree; or

b. has a Master of Arts degree, Master of Science degree or a Master of Education degree in a mental health-related field; and

i. has a minimum of 15 hours of graduate level course work and/or practicum in applied intervention strategies/methods designed to address behavioral, emotional and/or mental problems. These hours may have been obtained as a part of, or in addition to, the master's degree.

Mental Health-Related Field—academic training programs based on the principles, teachings, research and body of scientific knowledge of the *core mental health disciplines*. Programs which qualify include, but are not limited to sociology, criminal justice, nursing, marriage and family counseling, rehabilitation counseling, psychological counseling and other professional counseling. For any other program to qualify as a related field, there shall be substantial evidence that the academic program has a curriculum content in which at least 70 percent of the required courses for graduation are based on the knowledge base of the *core mental health disciplines*.

Mental Health Service Delivery Experience—mental health service delivery experience at the professional or paraprofessional level delivered in an organized mental health or psychiatric rehabilitation setting such as a psychiatric hospital, day treatment or mental health case management program or community mental health center.

Mental Health Specialist (*MHS*)—a person who delivers direct care services under the direct supervision of a LMHP or MHP and who meets one of the following criteria, as documented by the provider:

a. has completed at least two years of education from an accredited college or university; or

b. has a high school diploma or equivalent and has completed two years of documented experience providing direct care services in a mental health, physical health, social services, educational or correctional setting.

Minor—a minor as defined under state law and, for the purpose of this Chapter, includes a resident who has been declared legally incompetent by the applicable state court.

Neglect—the unreasonable refusal or failure of a facility to supply a resident with necessary food, clothing, shelter, care, treatment, or counseling for injury, illness, or condition of the resident, as a result of which the resident's physical, mental or emotional health and safety is substantially threatened or impaired.

New Construction—any of the following started after January 1, 2004:

a. new buildings to be used as a PRTF;

b. additions to existing buildings to be used as a PRTF;

c. conversions of existing buildings or portions thereof for use as a PRTF;

d. alterations other than minor alterations to an existing PRTF.

Non-Operational—the HCBS provider location is not open for business operation on designated days and hours as stated on the licensing application and business location signage.

Normal Business Hours—between the hours of 7 a.m. and 6 p.m. every Monday-Friday, except for holidays.

OBH—the Department of Health, Office of Behavioral Health.

OPH—the Department of Health, Office of Public Health.

OSFM—the Department of Public Safety and Corrections, Office of State Fire Marshal.

Personal Restraint—the application of physical force, without the use of any device, for the purpose of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding without undue force a resident in order to calm or comfort him/her, or holding a resident's hand to safely escort a resident from one area to another.

Psychiatric Residential Treatment Facility (PRTF)—a facility other than a hospital, that provides inpatient psychiatric services, as described in 42 CFR part 441 subpart D, to individuals under age 21, in a residential setting.

Restraint—a personal *restraint*, mechanical *restraint*, or drug used as a *restraint*.

Seclusion—the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.

Serious Injury—any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Staff—those individuals with responsibility for managing a resident's health or participating in an *emergency safety intervention* and who are employed by the facility on a full-time, part-time or contract basis.

Time Out—the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:54 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:371 (February 2012), LR 39:2510 (September 2013), LR 42:277 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:288 (February 2018).

Subchapter B. Licensing

§9007. General Provisions

A. All psychiatric residential treatment facilities shall be licensed by the department. A PRTF shall not be established, opened, operated, managed, maintained, or conducted in this state without a current valid license issued by the department. The department is the only licensing authority for PRTFs in the state of Louisiana. It shall be unlawful to operate a PRTF without possessing a current, valid license issued by the department. Each PRTF shall be separately licensed.

B. A PRTF license shall:

1. be issued only to the person or entity named in the license application;

2. be valid only for the facility to which it is issued and only for the specific geographic address of that facility;

3. be valid for up to one year from the date of issuance, unless revoked, suspended, modified, or terminated prior to that date, or unless a provisional license is issued;

4. expire on the expiration date listed on the license, unless timely renewed by the PRTF facility;

5. not be subject to sale, assignment, donation, or other transfer, whether voluntary or involuntary; and

6. be posted in a conspicuous place on the licensed premises at all times.

C. In order for the PRTF to be considered operational and retain licensed status, the facility shall meet the following conditions.

1. The PRTF shall always have at least two employees, one of whom is a licensed nurse, on duty at the facility location at all times.

2. There shall be staff employed and available to be assigned to provide care and services to each resident. Services rendered shall be consistent with the medical needs of each resident.

D. The licensed PRTF shall abide by and adhere to any state law, rules, policy, procedure, manual, or memoranda pertaining to such facilities.

E. A separately licensed PRTF shall not use a name which is substantially the same as the name of another such facility licensed by the department, unless such PRTF is under common ownership with other PRTFs.

F. No branches, satellite locations or offsite campuses shall be authorized for a PRTF.

G. No new PRTF, except one that has a Child Residential License by DCFS, shall accept residents until the PRTF has written approval and/or a license issued by HSS.

H. Plan Review. Construction documents (plans and specifications) are required to be submitted and approved by both the OSFM and the Department of Health as part of the licensing procedure and prior to obtaining a license.

1. Submission Plans

a. Submittal Requirements

i. One set of the final construction documents shall be submitted to the OSFM for approval. The Fire Marshal's approval letter and final inspection shall be sent to the LDH.

ii. One set of the final construction documents shall be submitted to the OSFM for the LDH plan review along with the appropriate review fee and a "plan review application form" for approval.

b. Applicable Projects. Construction documents require approval for new construction and major alterations.

c. Design Criteria. The project shall be designed in accordance with the following criteria:

i. the latest OSFM adopted edition of the *National Fire Protection Agency (NFPA) 101-Life Safety Code*;

ii. the latest LSUCCC adopted edition of the *International Building Code*; and

iii. the current licensing standards for psychiatric residential treatment facilities.

d. Construction Document Preparation. Construction documents submitted to LDH shall be prepared only by a Louisiana licensed architect or licensed engineer as governed by the licensing laws of the state for the type of work to be performed. These documents shall be of an architectural or engineering nature and thoroughly illustrate the project that is accurately drawn, dimensioned, and contain noted plans, details, schedules and specifications. At a minimum the following shall be submitted:

i. site plans;

ii. floor plans. These shall include architectural, mechanical, plumbing, electrical, fire protection, and if required by code, sprinkler and fire alarm plans;

iii. building elevations;

iv. room finish, door and window schedules;

v. details pertaining to the Americans with Disabilities Act (ADA) requirements; and

vi. specifications for materials.

2. Waivers. The secretary of LDH may, within his/her sole discretion, grant waivers to building and construction guidelines which are not part of, or otherwise required under, the provisions of the state sanitary code. The facility shall submit a waiver request in writing to HSS. The facility shall demonstrate how patient safety and quality of care offered is not compromised by the waiver, and must demonstrate the undue hardship imposed on the facility if the waiver is not granted. The facility shall demonstrate their ability to completely fulfill all other requirements of service. The department will make a written determination of the requests.

a. Waivers are not transferable in an ownership change and are subject to review or revocation upon any change in circumstances related the waiver.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:372 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:288 (February 2018).

§9009. Initial Licensing Application Process

A. An initial application for licensing as a PRTF shall be obtained from the department. A completed initial license application packet for a PRTF shall be submitted to and approved by the department prior to an applicant providing PRTF services.

B. Licensed DCFS child residential facilities that are converting to PRTFs shall comply with all of the initial licensure requirements, except plan review, and may be eligible for the exception to the bedroom space requirement of this Chapter.

C. An applicant shall submit a completed initial licensing application packet to the department, which shall include:

1. a completed PRTF licensure application and the non-refundable licensing fee as established by statute;

2. a copy of the approval letters of the architectural and LDH licensing facility plans for the PRTF from the OSFM, and any other office/entity designated by the department to review and approve the facility's architectural plans, if the facility shall go through plan review;

3. a copy of the on-site inspection report with approval for occupancy by the Office of the State Fire Marshal;

4. a copy of the health inspection report with approval of occupancy from the Office of Public Health (OPH);

5. a copy of statewide criminal background checks on all individual owners with a 5 percent or more ownership interest in the PRTF entity, and on all administrators or managing employees;

6. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $100,000;

b. general and professional liability insurance of at least $300,000; and

c. worker's compensation insurance;

7. if applicable, Clinical Laboratory Improvement Amendments (CLIA) certificate or CLIA certificate of waiver;

8. a floor sketch or drawing of the premises to be licensed; and

9. any other documentation or information required by the department for licensure.

D. If the initial licensing packet is incomplete when submitted, the applicant will be notified of the missing information and will have 90 days from receipt of the notification to submit the additional requested information. If the additional requested information is not submitted to the department within 90 days, the application will be closed. After an initial licensing application is closed, an applicant who is still interested in becoming a PRTF shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

E. Once the initial licensing application packet has been approved by the department, notification of the approval shall be forwarded to the applicant. Within 90 days of receipt of the approval notification, the applicant shall notify the department that the PRTF is ready and is requesting an initial licensing survey. If an applicant fails to notify the department within 90 days, the initial licensing application shall be closed. After an initial licensing application has been closed, an applicant who is still interested in becoming a PRTF shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

F. Applicants shall be in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the PRTF will be issued an initial license to operate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:373 (February 2012), amended LR 39:2510 (September 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 44:289 (February 2018).

§9011. Types of Licenses

A. The department shall have the authority to issue the following types of licenses.

1. Full Initial License. The department shall issue a full license to the facility when the initial licensing survey finds that the PRTF is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees. The license for a PRTF shall be valid until the expiration date shown on the license, unless the license is revoked, suspended, modified, or terminated prior to that time. The initial license shall specify the capacity of the facility.

2. Provisional Initial License. The department may issue a provisional initial license to the facility when the initial licensing survey finds that the PRTF is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, Rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the residents or participants. The provisional license shall be valid for a period not to exceed six months.

a. At the discretion of the department, the provisional initial license may be extended for an additional period not to exceed 90 days in order for the PRTF to correct the noncompliance or deficiencies.

b. The facility shall submit a plan of correction to the department for approval and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional initial license.

c. A follow-up survey shall be conducted prior to the expiration of the provisional initial license.

i. If all such noncompliance or deficiencies are determined by the department to be corrected on a follow-up survey, a full license will be issued.

ii. If all such noncompliance or deficiencies are not corrected on the follow-up survey, the provisional initial license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee.

3. Full Renewal License. The department may issue a full renewal license to an existing licensed PRTF who is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, Rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

4. Provisional Renewal License. The department, in its sole discretion, may issue a provisional license to an existing licensed PRTF for a period not to exceed six months.

a. At the discretion of the department, the provisional renewal license may be extended for an additional period not to exceed 90 days in order for the PRTF to correct the noncompliance or deficiencies.

b. A provisional renewal license may be issued for the following reasons:

i. the existing PRTF has more than five deficient practices or deficiencies cited during any one survey;

ii. the existing licensed PRTF has more than three validated complaints in a one year period;

iii. the existing PRTF has been issued a deficiency that involved placing a resident or participant at risk for serious harm or death;

iv. the existing PRTF has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey; or

v. the existing PRTF is not in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, Rules regulations and fees at the time of renewal of the license.

c. When the department issues a provisional renewal license to an existing licensed PRTF, the provider shall submit a plan of correction to the department for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license. The department shall conduct an on-site follow-up survey at the PRTF prior to the expiration of the provisional license.

i. If the on-site follow-up survey determines that the PRTF has corrected the deficient practices and has maintained compliance during the period of the provisional license, the department may issue a full license for the remainder of the year until the anniversary date of the PRTF license.

ii. If the on-site follow-up survey determines that the PRTF has not corrected the deficient practices or has not maintained compliance during the period of the provisional license, the provisional renewal license shall expire and the facility shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee, if no timely informal reconsideration or administrative appeal is filed pursuant to this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:373 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:289 (February 2018).

§9013. Deemed Status

A. A licensed PRTF may request deemed status from the department. The department may accept accreditation in lieu of a routine on-site licensing survey provided that:

1. the accreditation is obtained through an organization approved by the department;

2. all services provided under the PRTF license shall be accredited; and

3. the provider forwards the accrediting body's findings to the Health Standards Section within 30 days of its accreditation.

B. If approved, accreditation will be accepted as evidence of satisfactory compliance with all of the provisions of these requirements.

C. Occurrence of any of the following may be grounds for the department to perform a survey on an accredited PRTF provider with deemed status:

1. any valid complaint in the preceding 12-month period;

2. addition of services;

3. a change of ownership in the preceding 12-month period;

4. issuance of a provisional license in the preceding 12-month period;

5. serious violations of licensing standards or professional standards of practice that were identified in the preceding 12-month period that placed residents at risk for harm;

6. a report of inappropriate treatment or service resulting in death or serious injury; or

7. a change in geographic location.

D. A PRTF with deemed status is responsible for complying with all of the provisions of this Rule and is subject to all of the provisions of this Rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:374 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:289 (February 2018).

§9015. Licensing Surveys

A. Prior to the initial license being issued to the PRTF, an initial licensing survey shall be conducted on-site at the facility to assure compliance with licensing standards. Except for facilities that have a Child Residential License issued by DCFS, every PRTF shall not provide services to any resident until the initial licensing survey has been performed and the facility found in compliance with the licensing standards. The initial licensing survey shall be an announced survey.

B. Once an initial license has been issued, the department may conduct licensing and other surveys at intervals deemed necessary by the department to determine compliance with licensing standards and regulations, as well as other required statutes, laws, ordinances, Rules, regulations, and fees. These surveys shall be unannounced.

C. A follow-up survey may be conducted for any survey where deficiencies have been cited to ensure correction of the deficient practices. The department shall issue written notice to the provider of the results of the follow-up survey.

D. An acceptable plan of correction may be required for any survey where deficiencies have been cited.

E. If deficiencies have been cited during a licensing survey, regardless of whether an acceptable plan of correction is required, the department may issue appropriate sanctions, including, but not limited to:

1. civil fines;

2. directed plans of correction;

3. provisional licensure;

4. denial of renewal; and/or

5. license revocations.

F. Surveyors and staff on behalf of the department shall be:

1. given access to all areas of the facility and all relevant files during any licensing survey or other survey; and

2. allowed to interview any provider staff, resident, or participant as necessary to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:375 (February 2012), amended LR 42:277 (February 2016).

§9017. Changes in Licensee Information or Personnel

A. A PRTF license shall be valid only for the person or entity named in the license application and only for the specific geographic address listed on the license application.

B. Any change regarding the PRTF's name, "doing business as" name, mailing address, phone number, or any combination thereof, shall be reported in writing to the department within five days of the change. Any change regarding the PRTF name or "doing business as" name requires a change to the facility license and the required fee for the issuance of an amended license.

C. Any change regarding the facility's key administrative personnel shall be reported in writing to the department within five days of the change.

1. Key administrative personnel shall include the:

a. administrator;

b. clinical director; and

c. program manager.

2. The facility's notice to the department shall include the individual's:

a. name;

b. hire date; and

c. qualifications.

D. A change of ownership (CHOW) of the PRTF shall be reported in writing to the department at least five days prior to the change of ownership.

1. The license of a PRTF is not transferable or assignable. The license cannot be sold.

2. In the event of a CHOW, the new owner shall submit the legal CHOW document, all documents required for a new license, and the applicable licensing fee. Once all of the application requirements are completed and approved by the department, a new license shall be issued to the new owner.

3. A PRTF that is under provisional licensure, license revocation or denial of license renewal may not undergo a CHOW.

E. Any request for a duplicate license shall be accompanied by the required fee.

F. A PRTF that intends to change the physical address of its geographic location is required to have plan review approval, Office of State Fire Marshal approval, Office of Public Health approval, compliance with other applicable licensing requirements, and an on-site licensing survey prior to the relocation of the facility.

1. Written notice of intent to relocate shall be submitted to HSS when the plan review request is submitted to the department for approval.

2. Relocation of the facility's physical address results in a new anniversary date and the full licensing fee shall be paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:375 (February 2012), amended LR 42:278 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:289 (February 2018).

§9019. Cessation of Business

A. Except as provided in §9089 of these licensing regulations, a license shall be immediately null and void if a PRTF becomes non-operational.

B. A cessation of business is deemed to be effective the date on which the PRTF stopped offering or providing services to the community.

C. Upon the cessation of business, the provider shall immediately return the original license to the department.

D. Cessation of business is deemed to be a voluntary action on the part of the provider. The provider does not have a right to appeal a cessation of business.

E. Prior to the effective date of the closure or cessation of business, the PRTF shall:

1. give 30 days' advance written notice to:

a. HSS;

b. the prescribing physician; and

c. the parent(s) or legal guardian or legal representative of each resident; and

2. provide for an orderly discharge and transition of all of the residents in the facility.

F. In addition to the advance notice of voluntary closure, the PRTF shall submit a written plan for the disposition of residents' medical records for approval by the department. The plan shall include the following:

1. the effective date of the voluntary closure;

2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed provider's residents' medical records;

3. an appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the resident or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing provider, at least 15 days prior to the effective date of closure.

G. If a PRTF fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a PRTF for a period of two years.

H. Once the PRTF has ceased doing business, the PRTF shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:375 (February 2012), amended LR 42:278 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:289 (February 2018).

§9021. Renewal of License

A. To renew a license, a PRTF shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the existing current license. The license renewal application packet shall include:

1. the license renewal application;

2. a copy of the current on-site inspection report with approval for occupancy from the Office of the State Fire Marshal and the Office of Public Health;

3. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $100,000;

b. general and professional liability insurance of at least $300,000; and

c. worker's compensation insurance;

4. the license renewal fee; and

5. any other documentation required by the department.

B. The department may perform an on-site survey and inspection upon annual renewal of a license.

C. Failure to submit a completed license renewal application packet prior to the expiration of the current license shall result in the voluntary non-renewal of the PRTF license.

D. The renewal of a license does not in any manner affect any sanction, civil fine, or other action imposed by the department against the facility.

E. If an existing licensed PRTF has been issued a notice of license revocation, suspension, or termination, and the facility's license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:376 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:290 (February 2018).

§9023. Denial of License, Revocation of License, Denial of License Renewal

A. In accordance with the provisions of the Administrative Procedure Act, the department may:

1. deny an application for an initial license;

2. deny a license renewal; or

3. revoke a license.

B. Denial of an Initial License

1. The department shall deny an initial license when the initial licensing survey finds that the PRTF is noncompliant with any licensing laws or regulations or with any other required statutes, laws, ordinances, Rules or regulations and such noncompliance presents a potential threat to the health, safety, or welfare of the residents who will be served by the facility.

2. The department shall deny an initial license for any of the reasons in this Chapter that a license may be revoked or non-renewed.

C. Voluntary Non-Renewal of a License

1. If a provider fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the provider.

2. If a provider fails to timely renew its license, the facility shall immediately cease providing services, unless the provider is actively treating residents, in which case the provider shall:

a. immediately provide written notice to the department of the number of residents that are receiving treatment at the PRTF;

b. immediately provide written notice to the prescribing physician and to every resident, parent, legal guardian, or legal representative of the following:

i. voluntary non-renewal of the facility's license;

ii. date of closure of the facility; and

iii. plans for orderly transition of the resident;

c. discharge and transition of each resident within 15 days of voluntary non-renewal; and

d. notify the department of the location where records will be stored and the contact person for the records.

3. If a PRTF fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a PRTF for a period of two years.

D. Revocation of License or Denial of License Renewal. A PRTF license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the PRTF licensing laws, rules and regulations, or with other required statutes, laws, ordinances, rules, or regulations;

2. failure to comply with the terms and provisions of a settlement agreement or education letter with or from the department, the Attorney General's Office, any regulatory agency, or any law enforcement agency;

3. failure to uphold a resident's rights whereby deficient practices result in harm, injury, or death of a resident;

4. negligence or failure to protect a resident from a harmful act of an employee or other resident including, but not limited to:

a. mental or physical abuse, neglect, exploitation, or extortion;

b. any action posing a threat to a resident's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. criminal activity;

5. failure to notify the proper authorities, as required by federal or state law, rules, or regulations, of all suspected cases of the acts outlined in §9023.D.4;

6. knowingly making a false statement in any of the following documentation, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. records, including:

i. clinical;

ii. resident; or

iii. facility;

d. matters under investigation by the department or the Office of Attorney General; or

e. information submitted for reimbursement from any payment source;

7. knowingly making a false statement or providing false, forged, or altered information or documentation to department employees or to law enforcement agencies;

8. the use of false, fraudulent or misleading advertising;

9. fraudulent operation of a PRTF by the owner, administrator, manager, member, officer, or director;

10. an owner, officer, member, manager, administrator, director, or person designated to manage or supervise resident care has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court:

a. For purposes of these provisions, conviction of a felony means a felony relating to any of the following:

i. violence, abuse, or neglect of another person;

ii. misappropriation of property belonging to another person;

iii. cruelty, exploitation, or sexual battery of a juvenile or the infirmed;

iv. a drug offense;

v. crimes of a sexual nature;

vi. possession or use of a firearm or deadly weapon; or

vii. fraud or misappropriation of federal or state funds, including Medicare or Medicaid funds;

11. failure to comply with all of the reporting requirements in a timely manner as required by the department;

12. failure to allow or refusal to allow the department to conduct an investigation or survey, or to interview provider staff or the residents;

13. failure to allow or refusal to allow access to facility or resident records by authorized departmental personnel;

14. bribery, harassment, or intimidation of any resident or family member designed to cause that resident or family member to use or retain the services of any particular PRTF; or

15. failure to maintain accreditation or failure to obtain accreditation.

E. If a PRTF license is revoked or renewal is denied, or the license is surrendered in lieu of an adverse action, any owner, officer, member, director, manager, or administrator of such PRTF may be prohibited from opening, managing, directing, operating, or owning another PRTF for a period of two years from the date of the final disposition of the revocation, denial action, or surrender.

F. The denial of the license renewal application shall not affect in any manner the license revocation, suspension, or termination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:376 (February 2012), amended LR 42:278 (February 2016).

§9025. Notice and Appeal of License Denial, License Revocation, and Denial of License Renewal

A. Notice of a license denial, license revocation or denial of license renewal shall be given to the provider in writing.

B. The PRTF has a right to an informal reconsideration of the license denial, license revocation, or denial of license renewal. There is no right to an informal reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The PRTF shall request the informal reconsideration within 15 calendar days of the receipt of the notice of the license denial, license revocation, or denial of license renewal. The request for informal reconsideration shall be in writing and shall be forwarded to the Health Standards Section.

2. The request for informal reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an informal reconsideration is received by the Health Standards Section, an informal reconsideration shall be scheduled and the facility shall receive written notification of the date of the informal reconsideration.

4. The facility shall have the right to appear in person at the informal reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the denial, revocation or non-renewal shall not be a basis for reconsideration.

6. The informal reconsideration process is not in lieu of the administrative appeals process.

7. The facility shall be notified in writing of the results of the informal reconsideration.

C. The PRTF has a right to an administrative appeal of the license denial, license revocation, or denial of license renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the provider.

1. The PRTF shall request the administrative appeal within 30 calendar days of the receipt of the notice of the results of the informal reconsideration of the license denial, license revocation, or denial of license renewal.

a. The facility may forego its rights to an informal reconsideration, and if so, the facility shall request the administrative appeal within 30 calendar days of the receipt of the notice of the license denial, license revocation, or denial of license renewal.

2. The request for administrative appeal shall be in writing and shall be submitted to the DAL or its successor. The request shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the DAL or its successor, the administrative appeal of the license revocation or denial of license renewal shall be suspensive, and the facility shall be allowed to continue to operate and provide services until such time as the DAL issues a final administrative decision.

a. If the secretary of the department determines that the violations of the facility pose an imminent or immediate threat to the health, welfare, or safety of a resident, the imposition of the license revocation or license non-renewal may be immediate and may be enforced during the pendency of the administrative appeal. The facility shall be notified of this determination in writing.

4. Correction of a violation or a deficiency which is the basis for the license denial or revocation shall not be a basis for the administrative appeal.

D. If an existing licensed PRTF has been issued a notice of license revocation and the facility's license is due for annual renewal, the department shall deny the license renewal. The denial of the license renewal does not affect in any manner the license revocation.

E. If a timely administrative appeal has been filed by the facility on a license denial, denial of license renewal, or license revocation, the Division of Administrative Law shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

1. If the final DAL decision is to reverse the license denial, the denial of license renewal, or the license revocation, the facility's license will be re-instated or granted upon the payment of any licensing fees or other fees due to the department and the payment of any outstanding sanctions due to the department.

2. If the final DAL decision is to affirm the denial of license renewal or the license revocation, the facility shall discharge any and all residents receiving services according to the provisions of this Chapter. Within 10 days of the final agency decision, the facility shall notify the department's licensing section in writing of the secure and confidential location of where the residents' records will be stored.

F. There is no right to an informal reconsideration or an administrative appeal of the issuance of a provisional initial license to a new PRTF or a provisional license to an existing PRTF. The issuance of a provisional license is not considered to be a denial of license, a denial of license renewal, or a license revocation.

G. A facility with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an informal reconsideration and the right to an administrative appeal regarding the deficiencies cited at the follow-up survey.

1. The correction of a violation, noncompliance, or deficiency after the follow-up survey shall not be the basis

for the informal reconsideration or for the administrative appeal.

2. The informal reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

3. The provider shall request the informal reconsideration in writing, which shall be received by the Health Standards Section within five calendar days of receipt of the notice of the results of the follow-up survey from the department.

4. The provider shall request the administrative appeal within 15 calendar days of receipt of the notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law, or its successor.

H. A facility with a provisional initial license or an existing provider with a provisional license that expires under the provisions of this Chapter shall cease providing services and discharge the residents unless the Division of Administrative Law issues a stay of the expiration.

1. A stay may be granted upon application by the provider at the time the administrative appeal is filed and only after a contradictory hearing and upon a showing that there is no potential harm to the residents being served by the facility.

I. If a timely administrative appeal has been filed by a facility with a provisional initial license that has expired or by an existing provider whose provisional license has expired under the provisions of this Chapter, the Division of Administrative Law shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

1. If the final DAL decision is to remove all deficiencies, the facility's license will be reinstated upon the payment of any licensing fees or other fees due to the department, and the payment of any outstanding sanctions due to the department.

2. If the final DAL decision is to uphold the deficiencies and affirm the expiration of the provisional license, the facility shall discharge all residents receiving services. Within 10 calendar days of the final agency decision, the facility shall provide written notification to HSS of the secure and confidential location of where the resident's records will be stored.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:377 (February 2012), amended LR 42:278 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:290 (February 2018).

§9027. Complaint Surveys

A. The department shall conduct complaint surveys in accordance with R.S. 40:2009.13, et seq. on any PRTF, including those with deemed status.

B. Complaint surveys shall be unannounced surveys.

C. An acceptable plan of correction may be required by the department for any complaint survey where deficiencies have been cited. If the department determines other action, such as license revocation is appropriate, a plan of correction may not be required and the facility will be notified of such action.

D. A follow-up survey may be conducted for any complaint survey where deficiencies have been cited to ensure correction of the deficient practices. If the department determines that other action, such as license revocation, is appropriate, a follow-up survey may not be required. The facility will be notified of any action.

E. The department may issue appropriate sanctions, including but not limited to, civil fines, directed plans of correction, and license revocations, for deficiencies and non-compliance with any complaint survey.

F. LDH surveyors and staff shall be given access to all areas of the facility and all relevant files during any complaint survey. LDH surveyors and staff shall be allowed to interview any provider staff, resident, or participant, as necessary or required to conduct the survey.

G. A PRTF which has been cited with violations or deficiencies on a complaint survey has the right to request an informal reconsideration of the validity of the violations or deficiencies. The written request for an informal reconsideration shall be submitted to the department's Health Standards Section. The department shall receive the written request within 10 calendar days of the facility's receipt of the notice of the violations or deficiencies.

H. A complainant shall have the right to request an informal reconsideration of the findings of the complaint survey or investigation that resulted from his/her complaint. The written request for an informal reconsideration shall be submitted to the department's Health Standards Section. The department shall receive the written request within 30 calendar days of the complainant's receipt of the results of the complaint survey or investigation.

I. An informal reconsideration for a complaint survey or investigation shall be conducted by the department as an administrative review. The facility or complainant shall submit all documentation or information for review for the informal reconsideration and the department shall consider all documentation or information submitted. There is no right to appear in person at the informal reconsideration of a complaint survey or investigation. Correction of the violation or deficiency shall not be the basis for the reconsideration. The provider and the complainant shall be notified in writing of the results of the informal reconsideration.

J. Except for the right to an administrative appeal provided in R.S. 40:2009.16(A), the informal reconsideration shall constitute final action by the department regarding the complaint survey or investigation, and there shall be no right to an administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR

38:378 (February 2012), amended LR 42:279 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:290 (February 2018).

§9029. Statement of Deficiencies

A. The following statements of deficiencies issued by the department to the PRTF shall be posted in a conspicuous place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. any complaint survey statement of deficiencies issued after the most recent annual survey.

B. Any statement of deficiencies issued by the department to a PRTF shall be available for disclosure to the public 30 calendar days after the provider submits an acceptable plan of correction of the deficiencies or 90 calendar days after the statement of deficiencies is issued to the provider, whichever occurs first.

C. Unless otherwise provided in statute or in this Chapter, a facility shall have the right to an informal reconsideration of any deficiencies cited as a result of a survey or investigation.

1. Correction of the deficient practice, of the violation, or of the noncompliance shall not be the basis for the reconsideration.

2. The written request for informal reconsideration of the deficiencies shall be submitted to the Health Standards Section and will be considered timely if received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies.

3. If a timely request for an informal reconsideration is received, the department shall schedule and conduct the informal reconsideration.

4. Except as provided for complaint surveys pursuant to R.S. 40:2009.11 et seq., and as provided in this Chapter for license denials, license revocations, and denial of license renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies. There is no administrative appeal right of such deficiencies.

5. The provider shall be notified in writing of the results of the informal reconsideration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:379 (February 2012), amended LR 42:279 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:291 (February 2018).

Subchapter C. Organization and Administration

§9031. General Provisions [Formerly §9027]

A. Purpose and Organizational Structure. The purpose of the PRTF shall be clearly defined in a statement filed with the Department. The statement includes the:

1. program philosophy;

2. program goals and objectives;

3. ages, sex and characteristics of residents accepted for care;

4. geographical area served;

5. types of services provided;

6. description of admission policies; and

7. needs, problems, situations or patterns best addressed by the provider's program.

B. House Rules. The provider shall have a clearly written list of rules governing conduct for residents in care and shall document that these rules are made available to each staff member, resident, and where appropriate, the resident's parent(s) or legal guardian(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:59 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:379 (February 2012).

§9033. Governing Body [Formerly §9029]

A. The PRTF shall have either an effective governing body or individual(s) legally responsible for the conduct of the PRTF operations. No contracts/arrangements or other agreements may limit or diminish the responsibility of the governing body.

B. The governing body shall:

1. establish PRTF-wide policy;

2. adopt bylaws;

3. appoint an administrator;

4. designate qualified clinical director to assume responsibility for the psychiatric aspects of the program and to provide full-time coverage on an on-site or on-call basis;

5. maintain quality of care;

6. ensure the provider's continual compliance and conformity with all relevant federal, state, local and municipal laws and regulations;

7. meet with designated representatives of the department whenever required to do so;

8. inform the department or its designee prior to initiating any substantial changes in the services provided by the facility; and

9. provide an overall institutional plan and budget, and ensure the facility is adequately funded and fiscally sound.

C. The governing body and/or their designee(s) shall develop and approve policies and procedures which define and describe the scope of services offered. They shall be revised as necessary and reviewed at least annually.

D. There shall be an organizational chart that delineates lines of authority and responsibility for all PRTF personnel.

E. The PRTF shall, when required by law, have a representative present at all judicial, educational, or administrative hearings that address the status of a resident in the care of the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:59 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:380 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:291 (February 2018).

§9035. Administrative Policies and Records [Formerly §9031]

A. Every PRTF shall have policies that are clearly written and current. All policies shall be available for review by all staff and LDH personnel. All policies shall be available for review upon request by a resident or a resident's parent or legal guardian.

B. All policies shall be reviewed annually by the governing body.

C. The PRTF shall have policies governing:

1. admission and discharge;

2. personnel;

3. volunteers;

4. grievance procedures;

5. behavior management;

6. use of restraint and seclusion;

7. mandatory reporting of abuse or neglect;

8. administering medication;

9. confidentiality of records;

10. participation of residents in activities related to fundraising and publicity;

11. participation of residents in research projects;

12. the photographing and audio or audio-visual recording of residents and clarification of the agency's prohibited use of social media to ensure that all staff, either contracted or directly employed, receive training relative to the restrictive use of social media;

13. all hazards risk assessment and emergency/disaster procedures, including the provision that when the PRTF has an interruption in services or a change in the licensed location due to an emergency situation, the PRTF shall notify the HSS no later than the next stated business day;

14. sentinel events and critical incidents; and

15. factors that determine room assignments, including, but not limited to, age and diagnoses.

D. Admission Policy

1. A PRTF shall have written admission policies and criteria which shall include the following:

a. intake policy and procedures;

b. admission criteria and procedures;

c. policy regarding the determination of legal status, according to appropriate state laws, before admission;

d. the age of the populations served;

e. the services provided by the PRTF;

f. criteria for discharge;

g. only accepting residents for placement from the parent(s), legal guardian(s) custodial agency or a court of competent jurisdiction;

h. not admitting more residents into care than the number specified on the provider's license; and

i. ensuring that the resident, the resident's parent(s) or legal guardian(s) and others, as appropriate, are provided reasonable opportunity to participate in the admission process and decisions. Proper consents shall be obtained before admission.

2. Notification of Facility Policy Regarding the Use of Restraint and Seclusion. At admission, the facility shall:

a. inform both the incoming resident and, in the case of a minor, the resident's parent(s) or legal guardian(s) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;

b. communicate its restraint and seclusion policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility shall provide interpreters or translators;

c. obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff shall file this acknowledgment in the resident's record; and

d. provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s).

i. The facility's policy shall provide contact information, including the phone number and mailing

address, for the appropriate state protection and advocacy organization.

E. Behavior Management

1. The PRTF shall develop and maintain a written behavior management policy which includes:

a. the goals and purposes of the behavior management program;

b. the methods of behavior management;

c. a list of staff authorized to administer the behavior management policy;

d. the methods of monitoring and documenting the use of the behavior management policy; and

e. minimizing the use of restraint and seclusion and using less restrictive alternatives whenever possible.

2. The facility policy shall prohibit:

a. shaking, striking, spanking or any cruel treatment;

b. harsh, humiliating, cruel, abusive or degrading language;

c. denial of food or sleep;

d. work tasks that are degrading or unnecessary and inappropriate to the resident's age and ability;

e. denial of private familial and significant other contact, including visits, phone calls, and mail, as a means of punishment;

f. use of chemical agents, including tear gas, mace, or similar agents;

g. extreme physical exercise;

h. one resident punishing another resident;

i. group punishment;

j. violating a resident's rights; and

k. use of restraints or seclusion in non-emergency situations.

3. The PRTF shall satisfy all of the requirements contained in federal and state laws and regulations regarding the use of restraint or seclusion, including application of time out.

F. Resident Abuse or Neglect

1. The provider shall have comprehensive written procedures concerning resident abuse or neglect including:

a. a description of ongoing communication strategies used by the provider to maintain staff awareness of abuse prevention, current definitions of abuse and neglect, and mandated reporting requirements to HSS and the DCFS, Child Welfare Division;

b. a procedure for disciplining staff members who abuse or neglect a resident;

c. procedures for insuring that the staff member involved in suspected resident abuse or neglect does not work directly with the resident involved or any other resident in the program until the investigation is complete.

2. Any case of suspected resident abuse or neglect shall be reported immediately to the HSS and, unless prohibited by state law, the DCFS, Child Welfare Division.

3. Staff shall report any case of suspected resident abuse or neglect to both HSS and the DCFS, Child Welfare Division by no later than close of business the next business day after a case of suspected resident abuse or neglect. The report shall include:

a. the name of the resident involved in the suspected resident abuse or neglect;

b. a description of the suspected resident abuse or neglect;

c. the date and time the suspected abuse or neglect occurred;

d. the steps taken to investigate the abuse and/or neglect; and

e. the action taken as a result of the incident.

4. In the case of a minor, the facility shall notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the suspected resident abuse or neglect.

5. Staff shall document in the resident's record that the suspected resident abuse or neglect was reported to both HSS and the DCFS, Child Welfare Division, including the name of the person to whom the incident was reported. A copy of the report shall be maintained in the resident's record.

G. The facility shall report each serious occurrence to both HSS and, unless prohibited by state law, the DCFS, Child Welfare Division. Serious occurrences that shall be reported include a resident's death, or a serious injury to a resident or a suicide attempt by a resident.

1. Staff shall report any serious occurrence involving a resident to both HSS and the DCFS, Child Welfare Division by no later than close of business the next business day after a serious occurrence. The report shall include the name of the resident involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility. The facility shall conduct an investigation of the serious occurrence to include interviews of all staff involved, findings of the investigation, and actions taken as a result of the investigation.

2. In the case of a minor, the facility shall notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

3. Staff shall document in the resident's record that the serious occurrence was reported to both HSS and the DCFS, Child Welfare Division, including the name of the person to whom the incident was reported. A copy of the report shall

be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

H. The PRTF shall have a written policy regarding participation of residents in activities related to fundraising and publicity. Consent of the resident and, where appropriate, the resident's parent(s) or legal guardian(s) shall be obtained prior to participation in such activities.

I. The PRTF shall have written policies and procedures regarding the photographing and audio or audio-visual recordings of residents.

1. The written consent of the resident and, where appropriate, the resident's parent(s) or legal guardian(s) shall be obtained before the resident is photographed or recorded for research or program publicity purposes.

2. All photographs and recordings shall be used in a manner that respects the dignity and confidentiality of the resident.

J. The PRTF shall have written policies regarding the participation of residents in research projects. No resident shall participate in any research project without the express written consent of the resident and the resident's parent(s) or legal guardian(s).

K. Administrative Records

1. The records and reports to be maintained at the facility and available for survey staff to review are:

a. residents' clinical records;

b. personnel records;

c. criminal history investigation records;

d. orientation and training hour records;

e. menus of food served to residents;

f. fire drill reports acceptable to the OFSM as defined by the most current adopted edition of the *NFPA 101, Life Safety Code*;

g. schedules of planned recreational, leisure or physical exercise activities;

h. all leases, contracts and purchase-of-service agreements to which the provider is a party;

i. all written agreements with appropriately qualified professionals, or state agencies, for required professional services or resources not available from employees of the provider;

j. written policies and procedures governing all aspects of the provider's activities to include:

i. behavior management;

ii. emergency evacuation; and

iii. smoking policy.

L. Information obtained by the department from any applicant or licensee regarding residents, their parents, or other relatives is deemed confidential and privileged communication. The names of any complainants and information regarding a resident abuse report or investigation is kept confidential.

1. The PRTF shall ensure the confidentiality and security of resident records, including information in a computerized medical record system, in accordance with the HIPAA Privacy Regulations and any Louisiana state laws and regulations which provide a more stringent standard of confidentiality than the HIPAA Privacy Regulations. Information from, or copies of records may be released only to authorized individuals, and the PRTF shall ensure that unauthorized individuals cannot gain access to or alter resident records. Original medical records shall not be released outside the PRTF unless under court order or subpoena or in order to safeguard the record in the event of a physical plant emergency or natural disaster.

a. The provider shall have written procedures for the maintenance and security of clinical records specifying who shall supervise the maintenance of records, who shall have custody of records, and to whom records may be released. Records shall be the property of the provider, and the provider as custodian shall secure records against loss, tampering or unauthorized use.

b. Employees of the PRTF shall not disclose or knowingly permit the disclosure of any information concerning the resident or his/her family, directly or indirectly, to any unauthorized person.

c. When the resident is of majority age and noninterdicted, the provider shall obtain the resident's written, informed permission prior to releasing any information from which the resident or his/her family might be identified, except for accreditation teams and authorized state and federal agencies.

d. When the resident is a minor or is interdicted, the provider shall obtain written, informed consent from the parent(s) or legal guardian(s) prior to releasing any information from which the resident or his/her family might be identified, except for accreditation teams, authorized state and federal agencies.

e. The provider shall, upon written authorization from the resident or his/her parent(s) or legal guardian(s), make available information in the case record to the resident, his counsel or the resident's parent(s) or legal guardian(s).

f. If, in the professional judgment of the clinical director, it is felt that information contained in the record is reasonably likely to endanger the life or physical safety of the resident, the provider may deny access to the record. In any such case the provider shall prepare written reasons for denial to the person requesting the record and shall maintain detailed written reasons supporting the denial in the resident's file.

g. The provider may use material from case records for teaching for research purposes, development of the governing body's understanding and knowledge of the facility's services, or similar educational purposes, provided names are deleted, other identifying information is disguised or deleted, and written authorization is obtained from the resident or his/her parent(s) or legal guardian(s).

2. PRTF records shall be retained by the PRTF in their original, microfilmed or similarly reproduced form for a minimum period of 10 years from the date a resident is discharged.

a. Graphic matter, images, x-ray films, nuclear medicine reports and like matter that were necessary to produce a diagnostic or therapeutic report shall be retained, preserved and properly stored by the PRTF in their original, microfilmed or similarly reproduced form for a minimum period of five years from the date a resident is discharged. Such graphic matter, images, x-ray film and like matter shall be retained for longer periods when requested in writing by any one of the following:

i. an attending or consulting physician of the resident;

ii. the resident or someone acting legally in his/her behalf; or

iii. legal counsel for a party having an interest affected by the resident's medical records.

3. The written record for each resident shall include:

a. administrative, treatment, and educational data from the time of admission until the time the resident leaves the facility, including intake evaluation notes and physician progress notes;

b. the name, home address, home telephone number, name of parent(s) or legal guardian(s), home address, and telephone number of parent(s) or legal guardian(s) (if different from resident's), sex, race, religion, birth date and birthplace of the resident;

c. other identification data including documentation of court status, legal status or legal custody and who is authorized to give consents;

d. placement agreement;

e. the resident's history including educational background, employment record, prior medical history and prior placement history;

f. a copy of the resident's individual service plan and any modifications to that plan;

g. progress reports;

h. reports of any incidents of abuse, neglect, accidents or critical incidents, including use of passive physical restraints;

i. reports of any resident's grievances and the conclusions or dispositions of these reports. If the resident's grievance was in writing, a copy of the written grievance shall be included;

j. a summary of family visits and contacts including dates, the nature of such visits/contacts and feedback from the family;

k. a summary of attendance and leaves from the facility;

l. the written notes from providers of professional or specialized services; and

m. the discharge summary at the time of discharge.

4. All of the resident's records shall be available for inspection by the department.

M. Quality Assessment and Improvement

1. The governing body shall ensure that there is an effective, written, ongoing, facility-wide program designed to assess and improve the quality of resident care.

2. There shall be a written plan for assessing and improving quality that describes the objectives, organization, scope and mechanisms for overseeing the effectiveness of monitoring, evaluation and improvement activities. All organized services related to resident care, including services furnished by a contractor, shall be evaluated. The services provided by each LMHP shall be periodically evaluated to determine whether they are of an acceptable level of quality and appropriateness.

3. Assessment of quality shall address:

a. resident care problems;

b. cause of problems;

c. documented corrective actions; and

d. monitoring or follow-up to determine effectiveness of the corrective actions taken.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:60 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:380 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:291 (February 2018).

§9037. Notifications
[Formerly §9033]

A. The facility shall comply with the following notification requirements.

1. The facility shall notify the department on the next working day in the event of temporary or permanent closing of the facility due to natural or man-made disasters or damage to the premises of the facility caused by fire, accident, or other elements that seriously affects the provision of services.

2. If a resident is absent without permission, the resident's parents or custodians are to be notified immediately.

B. The facility shall comply with the notification requirements regarding:

1. any case of suspected resident abuse or neglect;

2. each serious occurrence; and

3. the death of a resident.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:63 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:383 (February 2012).

Subchapter D. Human Resources

§9041. Personnel [Formerly §9043]

A. The PRTF shall have personnel policies which include, but are not limited to, defining staff, essential job functions, qualifications, and lines of authority.

1. The PRTF shall have:

a. a written plan for recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of staff members whether directly employed, contract or volunteer;

b. written personnel policies and written job descriptions for each staff position;

c. written employee grievance procedures; and

d. written nondiscrimination policy that shall ensure that the provider does not discriminate in the employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, veteran's status or any non-merit factor in accordance with all state and federal regulations.

2. The PRTF shall have written policies, contracts and practices to assure:

a. the availability of adequate psychiatric services to meet the following requirements:

i. provide medical oversight of all of the clinical aspects of care, and provide 24-hour, seven days per week psychiatric on-call coverage;

ii. assess each resident's medication and treatment needs including administration of medication; prescribe medications or otherwise assure the case management and consultation services are provided to obtain prescriptions, and prescribed therapeutic modalities to achieve the resident's individual treatment plan's goals; and

iii. participate in the facility's plan of care team and quality assessment and improvement process;

b. sufficient supervision of all residents 24 hours a day.

3. Staff Medical Requirements

a. The PRTF shall have policies and procedures that define how the facility will comply with current regulations regarding healthcare screenings of PRTF personnel.

b. The PRTF shall have policies and procedures and require all personnel to immediately report any signs or symptoms of a communicable disease or personal illness to their supervisor or administrator as appropriate for possible reassignment or other appropriate action to prevent the disease or illness from spreading to other residents or personnel.

B. There shall be a single organized professional staff that has the overall responsibility for the quality of all clinical care provided to residents, and for the ethical conduct and professional practices of its members, as well as for accounting to the governing body. The manner in which the professional staff is organized shall be consistent with the facility's documented staff organization and policies and shall pertain to the setting where the facility is located. The organization of the professional staff and its policies shall be approved by the facility's governing body.

C. The staff of a PRTF shall have the appropriate qualifications to provide the services required by its residents' comprehensive plans of care. Each member of the direct care staff may not practice beyond the scope of his/her license, certification or training.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:63 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:383 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:292 (February 2018).

§9043. Personnel Qualifications and Responsibilities

A. Staffing Definitions. All experience requirements are related to paid experience. Volunteer work, college work/study or internship related to completion of a degree cannot be counted as work experience. If experience is in a part-time position, the staff person shall be able to verify the amount of time worked each week. Experience obtained while working in a position for which the individual is not qualified may not be counted as experience.

B. Criminal History Investigation and References

1. The PRTF shall arrange for a criminal history investigation, as required by R.S. 15:587.1 for any applicant for employment, contractor, volunteer and other person who will provide services to the residents prior to that person working at the facility.

2. Staff criminal history investigations shall be maintained in a confidential manner, separate from the individual's personnel record.

C. Prohibitions

1. The facility is restricted from knowingly employing and/or contracting with a person who:

a. has entered a plea of guilty or nolo contendere, no contest, or has been convicted of:

i. any criminal activity involving violence against a person;

ii. child abuse or neglect;

iii. possession, sale, or distribution of illegal drugs;

iv. sexual misconduct and/or is required to register pursuant to the Sex Offenders Registration Act; or

v. gross irresponsibility or disregard for the safety of others;

b. has a finding placed on the Louisiana State Nurse Aide Registry or the Louisiana Direct Service Worker Registry.

2. The restrictions contained in this Subsection apply to employees and contractors who provide direct care to the residents of the facility.

3. Persons who are employed by the facility or who provide services to the facility may not use or be under the influence of, alcohol or illegal drugs during hours of work.

4. If a staff member is alleged to have committed an act described in §9043.C.1, the accused shall be removed from contact with residents until the allegations are resolved. If criminal charges are filed, the accused shall be removed from contact with residents until the charges are resolved.

a. A person who has received a deferred sentence for any charge in §9043.C.1 shall be removed from contact with residents for the duration of the deferment.

D. The PRTF shall check the Louisiana State Nurse Aide Registry and the Louisiana Direct Service Worker Registry to ensure that every individual providing direct care does not have a finding placed against him/her on either registry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:384 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:292 (February 2018).

§9045. Personnel Orientation and Training

A. Orientation. Staff shall receive orientation within 30 days of employment.

1. Staff who will work with residents shall receive orientation before being assigned as the only staff responsible for residents.

2. Orientation includes, but is not limited to:

a. confidentiality;

b. grievance process;

c. fire and disaster plans including evacuations;

d. emergency medical procedures;

e. organizational structure;

f. program philosophy;

g. personnel policy and procedure, including the prohibited use of social media. Such training shall, at a minimum, include confidentiality of resident information, preservation of resident dignity and respect, protection of resident privacy and personal and property rights;

h. detecting and mandatory reporting of resident abuse, neglect or misappropriation of resident's funds;

i. detecting signs of illness or dysfunction that warrant medical or nursing intervention;

j. basic skills required to meet the health needs and problems of the resident;

k. crisis de-escalation and the management of aggressive behavior including acceptable and prohibited responses;

l. physical restraint which is to include a practice element in the chosen method; and

m. safe administration and handling of all medications including psychotropic drugs, dosages and side effects.

3. Orientation may be counted toward the total training hours for the first year.

B. The staff shall meet the following requirements for training.

1. Licensed mental health professionals (LMHPs), mental health professionals (MHPs), and mental health specialists (MHSs), with the exception of the administrator and clinical director shall obtain training according to the facility policy at least annually and as deemed necessary depending on the needs of the residents. The content of the training shall pertain to the roles and responsibilities of the position. Content areas shall include, but are not limited to:

a. crisis intervention and the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations;

b. child/youth development;

c. discipline;

d. stress management;

e. therapeutic relationship;

f. therapeutic intervention;

g. abuse prevention, detection, and reporting;

h. techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations; and

i. the safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress or injury in residents who are restrained or in seclusion.

2. Certification in the use of cardiopulmonary resuscitation, including periodic recertification, along with an annual demonstration of competency in the use of cardiopulmonary resuscitation is required.

3. Staff training shall be provided by individuals who are qualified by education, training, and experience.

4. Staff training shall include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

5. Staff shall be trained and demonstrate competency before participating in an emergency safety intervention.

6. All training programs and materials used by the facility shall be available for review by HSS.

7. The PRTF shall maintain documentation of all of the training of its staff.

C. The provider shall complete and document an annual performance evaluation of all staff members. For any person who interacts with residents, the provider's performance evaluation procedures shall address the quality and nature of a staff member's relationships with residents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:384 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:292 (February 2018).

§9047. Personnel Requirements

A. Staffing Requirements. The PRTF shall meet minimum licensure requirements for staffing, staff qualifications and staffing ratios.

1. A PRTF that serves individuals from special risk populations shall modify staffing patterns to fit their increased needs.

2. The PRTF shall ensure that an adequate number of qualified staff members are present with the residents as necessary to ensure the health, safety and well-being of residents. Staff coverage shall be maintained in consideration of the time of day, the size and nature of the PRTF, the ages and needs of the residents, and shall assure the continual safety, protection, direct care and supervision of residents.

3. When residents are at school, work or recreation outside the facility, the provider shall have a plan ensuring the availability and accessibility of direct care staff to handle emergencies or perform other necessary direct care functions.

4. The PRTF shall make sufficient provisions for housekeeping and maintenance to ensure that staff is able to adequately perform direct care functions.

B. The facility shall maintain a minimum ratio of one staff person for four residents (1:4) between the hours of 6 a.m. and 10 p.m. The staff for purposes of this ratio shall consist of direct care staff (i.e. licensed practical nurse (LPN), MHS, MHP, LMHP, etc.).

C. The facility shall maintain a minimum ratio of one staff person for six residents (1:6) between 10 p.m. and 6 a.m. Staff shall always be awake while on duty. The staff for purposes of this ratio shall consist of direct care staff (i.e. LPN, MHS, MHP, LMHP, etc.).

D. Staffing ratios listed above are a minimum standard. The PRTF shall have written policies and procedures that:

1. demonstrate how the staffing pattern will be adjusted when necessary to meet the individual needs and acuity of youth as those fluctuate over time;

2. document how the PRTF continuously monitors the appropriateness of its staffing pattern to ensure the safety of both youth and staff;

a. this documentation shall include specific methods used by the PRTF to monitor metrics such as restraints and seclusions and other adverse incidents, and documentation of how the PRTF uses this monitoring to make ongoing decisions about staffing patterns; and

3. document how the PRTF continuously monitors the appropriateness of its staffing pattern to ensure that youth receive appropriate, individualized care and treatment and therapeutic interactions;

a. this documentation shall include specific methods used by the PRTF to monitor metrics such as clinical progress and outcomes, and documentation of how the PRTF uses this monitoring to make ongoing decisions about staffing patterns.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:385 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:329 (February 2017), amended by the Department of Health, Bureau of Health Services Financing, LR 44:292 (February 2018).

§9049. Personnel Records

A. The facility shall maintain on file a written personnel record for each employee working at the facility, which shall be kept for at least one year following an employee's separation from employment. The personnel record shall include:

1. an application, résumé, or staff information sheet that documents qualifications for the position;

2. any health records required by the facility;

3. annual performance evaluations and any reports and notes relating to the individual's employment with the facility;

4. documentation of the successful completion of orientation, training and demonstrations of competency, the dates of completion and the names of the persons certifying the completion of the orientation, training and demonstrations of competency;

5. date of employment; and

6. date and reason for leaving employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:66 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:385 (February 2012).

§9051. Volunteers

A. If a facility uses volunteers, the facility shall have a current, written volunteer policy.

B. Volunteers shall receive orientation before having contact with residents.

C. Volunteers shall work under the direct supervision of a paid staff member. They shall never be left alone or in charge of a resident or group of residents without a paid staff member present, unless they are a master's level or doctorate level student intern.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:66 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:385 (February 2012).

Subchapter E. Facility Operations

§9061. Food and Diet [Formerly §9079]

A. The provider shall ensure that a resident is, on a daily basis, provided with food of such quality and in such quantity as to meet the recommended daily dietary allowances adjusted for age, gender and activity of the Food Nutrition Board of the National Research Council. The facility shall ensure that dietary services are provided by a Louisiana licensed registered dietician. The registered dietician shall be available regarding the nutritional needs, the special diets of individual children, and to assist in the development of policies and procedures for the handling, serving, and storage of food.

1. Menus shall be written and approved annually in writing by a registered dietician.

2. The provider shall develop written menus at least one week in advance.

3. Written menus and records of foods purchased shall be maintained on file for 30 days. Menus shall provide for a sufficient variety of foods, vary from week to week and reflect all substitutions.

B. A person designated by the administrator shall be responsible for the total food service of the facility. This person shall be responsible for:

1. initiating food orders or requisitions;

2. establishing specifications for food purchases and insuring that such specifications are met;

3. storing and handling of food;

4. food preparation;

5. food serving;

6. orientation, training and supervision of food service personnel;

7. maintaining a current list of residents with special nutritional needs;

8. having an effective method of recording and transmitting diet orders and changes;

9. recording information in the resident's record relating to special nutritional needs; and

10. providing information on the resident's diets to the staff.

C. The provider shall ensure that any modified diet for a resident shall be:

1. prescribed by the resident's physician and treatment plan with a record of the prescription kept on file;

2. planned, prepared and served by persons who have received instruction from the registered dietician who has approved the menu for the modified diet.

D. The provider shall ensure that a resident is provided at least three meals or their equivalent daily at regular times with not more than 14 hours between the evening meal and breakfast on the following day.

E. The provider shall ensure that the food provided to a resident in care of the provider is in accord with his/her religious beliefs.

F. No resident shall be denied food or force-fed for any reason except as medically required pursuant to a physician's written order. A copy of the order shall be maintained in the resident's file.

G. When meals are provided to staff, the provider shall ensure that staff members eat the same food served to residents in care, unless special dietary requirements dictate differences in diet.

H. The provider shall purchase and provide to the residents only food and drink of safe quality. The storage, preparation and serving techniques shall ensure that nutrients are retained and spoilage is prevented. Milk and milk products shall be Grade A and pasteurized.

I. The provider shall ensure that food served to a resident and not consumed is discarded.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:69 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:385 (February 2012).

§9063. Admission, Transfer and Discharge Requirements

A. The written description of admissions policies and criteria shall be provided to the department upon request, and made available to the resident and his/her legal representative.

B. A PRTF shall not refuse admission to any client on the grounds of race, national origin, ethnicity or disability.

C. A PRTF shall admit only those residents whose needs, pursuant to the certification of need and comprehensive plan of Care, can be fully met by the facility.

D. When refusing admission to a client, the PRTF shall provide a written statement to the resident with the reason

for the refusal. This shall be provided to the designated representative(s) of the department upon request.

E. To be admitted into a PRTF, the individual shall have received certification of need from the department or the department's designee that recommends admission into the PRTF. The PRTF shall ensure that requirements for certification are met prior to treatment commencing. The certification shall specify that:

1. ambulatory care resources available in the community do not meet the treatment needs of the recipient;

2. proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

3. the services can reasonably be expected to improve the resident's condition or prevent further regression so that the services will no longer be needed.

F. The PRTF shall use the certification of need to develop an initial plan of care to be used upon admission until a Comprehensive Plan of Care is completed.

G. Discharge planning begins at the date of admission, and goals toward discharge shall be continually addressed in the interdisciplinary team meetings and when the comprehensive plan of care is reviewed.

H. Voluntary Transfer or Discharge. Upon notice by the resident or authorized representative that the resident has selected another provider or has decided to discontinue services, the PRTF shall have the responsibility of planning for the resident's voluntary transfer or discharge. The transfer or discharge responsibilities of the PRTF shall include:

1. holding a transfer or discharge planning conference with the resident, family, support coordinator, legal representative and advocate, if such are known, in order to facilitate a smooth transfer or discharge, unless the resident declines such a meeting;

2. providing a current comprehensive plan of care. Upon written request and authorization by the resident or authorized representative, a copy of the current comprehensive treatment plan shall be provided to the resident or receiving provider;

3. preparing a written discharge summary. The discharge summary shall include, at a minimum, a summary on the health, developmental issues, behavioral issues, social issues, and nutritional status of the resident. Upon written request and authorization by the resident or authorized representative, a copy of the discharge summary shall be disclosed to the resident or receiving provider. The written discharge summary shall be completed within five working days of the notice by the resident or authorized representative that the resident has selected another provider or has decided to discontinue services. The provider's preparation of the discharge summary shall not impede or impair the resident's right to be transferred or discharged immediately if the resident so chooses; and

4. not coercing or interfering with the resident's decision to transfer. Failure to cooperate with the resident's decision to transfer to another provider may result in adverse action by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:386 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:293 (February 2018).

§9065. Health Care and Nursing Services [Formerly §9081]

A. Health Care

1. The provider shall have a written plan for providing preventive, routine and emergency medical and dental care for residents and shall show evidence of access to the resources outlined in the plan. This plan shall include:

a. ongoing appraisal of the general health of each resident;

b. provision of health education, as appropriate; and

c. provisions for keeping resident's immunizations current.

2. The provider shall ensure that a resident receives timely, competent medical care when he/she is ill or injured. The provider shall notify the resident's parent or legal guardian, verbally/in writing, within 24 hours of a resident's illness or injury that requires treatment from a physician or hospital.

3. Records of all medical examinations, follow-ups and treatment together with copies of all notices to parent(s) or guardian(s) shall be kept in the resident's file.

4. Within 30 days of admission, the provider shall obtain documentation of a resident's immunization history, insuring that the resident has received all appropriate immunizations and booster shots that are required by the Office of Public Health.

B. Nursing Services

1. There shall be an organized nursing service that provides 24-hour nursing services. The nursing services shall be under the direction and supervision of a registered nurse licensed to practice in Louisiana, employed full time, 40 hours per week during normal business hours.

2. Written nursing policies and procedures shall define and describe the resident care provided. There shall be a written procedure to ensure that all nursing services are performed by nurses and that all licensed nurses providing care in the PRTF have a valid and current Louisiana license to practice, prior to providing any care.

3. Nursing services are either furnished or supervised and evaluated by a registered nurse as determined by the needs of the residents.

4. There shall be at least one registered or licensed practical nurse on duty on site at all times.

C. Medications

1. All PRTFs that store or dispense scheduled narcotics shall have a site-specific Louisiana dangerous substance license and a United States Drug Enforcement Administration controlled substance registration for the facility in accordance with the Louisiana Uniform Controlled Dangerous Substance Act and Title 21 of the *United States Code*.

2. The provider shall have written policies and procedures that govern the safe administration and handling of all drugs as appropriate to the facility.

3. The provider shall have a written policy governing the self-administration of both prescription and nonprescription drugs.

4. The provider shall ensure that medications are either self-administered or administered by qualified persons according to state law.

5. The provider shall have a written policy for handling medication taken from the facility by residents on pass.

6. The provider shall ensure that any medication given to a resident for therapeutic and medical purposes is in accordance with the written order of a physician.

a. There shall be no standing orders for prescription medications.

b. There shall be standing orders, signed by the physician, for nonprescription drugs with directions from the physician indicating when he/she is to be contacted. Standing orders shall be updated annually by the physician.

c. Copies of all written orders shall be kept in the resident's file.

7. Proper disposal procedures shall be followed for all discontinued and outdated drugs and containers with worn, illegible or missing labels.

8. Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.

a. Drugs used externally and drugs taken internally shall be stored on separate shelves or in separate cabinets.

b. All drugs, including refrigerated drugs, shall be kept under lock and key.

9. The provider using psychotropic medications on a regular basis shall have a written description of the use of psychotropic medications including:

a. a description of procedures to ensure that medications are used as ordered by the physician for therapeutic purposes and in accordance with accepted clinical practice;

b. a description of procedures to ensure that medications are used only when there are demonstrable benefits to the resident unobtainable through less restrictive measures;

c. a description of procedures to ensure continual physician review of medications and discontinuation of medications when there are no demonstrable benefits to the resident; and

d. a description of an ongoing program to inform residents, staff, and where appropriate, resident's parent(s) or legal guardian(s) on the potential benefits and negative side-effects of medications and to involve residents and, where appropriate, their parent(s) or legal guardian(s) in decisions concerning medication.

10. All compounding, packaging, and dispensing of drugs, biologicals, legend and controlled substances shall be accomplished in accordance with Louisiana law and Board of Pharmacy regulations and be performed by or under the direct supervision of a registered pharmacist currently licensed to practice in Louisiana.

11. Dispensing of prescription legend or controlled substance drugs direct to the public or resident by vending machines is prohibited.

12. Current and accurate records shall be maintained on the receipt and disposition of all scheduled drugs. An annual inventory, at the same time each year, shall be conducted for all Schedule I, II, III, IV and V drugs.

13. Medications are to be dispensed only upon written orders, electromechanical facsimile, or oral orders from a physician or other legally authorized prescriber, and be taken by a qualified professional.

14. All drug containers shall be labeled to show at least the resident's full name, the chemical or generic drug's name, strength, quantity and date dispensed unless a unit dose system is utilized. Appropriate accessory and cautionary statements as well as the expiration date shall be included.

15. Drugs and biologicals that require refrigeration shall be stored separately from food, beverages, blood, and laboratory specimens.

16. Drug administration errors, adverse drug reactions, and incompatibilities shall be immediately reported to the attending physician. An entry shall be made in the resident's record.

17. Abuses and losses of controlled substances shall be reported to the individual responsible for pharmaceutical services, the administrator, the Louisiana Board of Pharmacy, LDH Controlled Dangerous Substances Program and to the Regional Drug Enforcement Administration (DEA) office, as appropriate.

18. All drugs and biologicals shall be administered in accordance with the orders of the practitioner(s) responsible for the resident's care and accepted standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:69 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:386 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:293 (February 2018).

§9067. Delivery of Services
[Formerly §9083]

A. The PRTF shall have an on-going plan, consistent with available community and PRTF resources, to provide medical, dental, therapeutic, social, psychological, recreational, rehabilitative and educational services to meet the medically related needs of its residents.

B. Arrangement of Residents into Groups

1. The provider shall arrange residents into groups that effectively address the needs of the residents.

2. All residents shall have an opportunity to build relationships within small groups.

3. Residents shall be involved in decision making regarding the roles and routines of their living group to the degree possible considering their level of functioning.

4. No more than 15 residents shall be in a group or unit.

5. The PRTF shall have a distinct unit for minors.

6. Groups shall be separated by gender.

C. The services provided by the PRTF shall involve active treatment.

1. The team of professionals who shall develop the comprehensive plan of care shall be composed of physician(s) and other personnel who are employed by, or who provide services to the recipient in the facility. The team shall be capable of assessing the resident's immediate and long-range therapeutic needs, personal strengths and liabilities, potential resources of the resident's family, capable of setting treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives. The team shall include, at a minimum, either:

a. a board-certified or board-eligible psychiatrist; or

b. a licensed clinical psychologist who has a doctorate degree and a physician licensed to practice medicine or osteopathy; or

c. a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology.

2. The team shall also include one of the following:

a. a psychiatric social worker;

b. a registered nurse with specialized training or one year of experience in treating individuals with mental illness;

c. a licensed occupational therapist with specialized training, or one year of experience in treating individuals with mental illness; or

d. a psychologist who has a master's degree in clinical psychology or who is licensed pursuant to R.S. 37:2351 et seq. or is a licensed medical psychologist pursuant to R.S. 37:1360.51.

3. The comprehensive plan of care is a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan shall:

a. be based on a diagnostic evaluation that includes examination of the medical, psychosocial, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for PRTF services, including:

i. diagnoses, symptoms, complaints, and complications indicating the need for admission;

ii. a description of the functional level of the individual;

iii. any orders for medication and diet;

iv. restorative, social, and rehabilitation services;

v. treatment objectives;

vi. an integrated program of therapies, activities, and experiences designed to meet the objectives;

vii. plans for continued care, as appropriate; and

viii. post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge;

b. be developed and implemented no later than 14 days after the recipient's admission; and

c. be designed to achieve the recipient's discharge at the earliest possible time.

4. The plan shall be reviewed as needed, but at a minimum of every 30 days by the facility treatment team to determine that services being provided are, or were, required on an inpatient basis and recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

D. The provider shall ensure that any provider of professional or special services (internal or external to the agency) meets the following:

1. are adequately qualified and, where appropriate, currently licensed or certified according to state or federal law;

2. have adequate space, facilities and privacy;

3. have appropriate equipment;

4. have adequate supplies;

5. have appropriate resources.

E. The PRTF shall also have an effective, on-going discharge planning program that facilitates the provision of follow-up care. The plan of care shall include, at an appropriate time, post-discharge plans and coordination of inpatient services, with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge. Each resident's record shall be annotated with a note regarding the nature of post PRTF care arrangements.

Discharge planning shall be initiated in a timely manner. Residents, along with necessary medical information (e.g., the resident's functional capacity, nursing and other care requirements, discharge summary, referral forms) shall be transferred or referred to appropriate facilities, agencies or services, as needed, for follow-up or ancillary care.

F. The PRTF shall provide or have available a therapeutic activities program.

1. The program shall be appropriate to the needs and interests of residents and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

2. The number of qualified therapists, support personnel and consultants shall be adequate to provide comprehensive therapeutic activities consistent with each patient's treatment plan.

G. The provider shall have a written plan for insuring that a range of indoor and outdoor recreational and social opportunities are provided for residents. Such opportunities shall be based on both the individual interests and needs of the resident and the composition of the living group.

1. The provider shall be adequately staffed and have appropriate recreation spaces and facilities accessible to residents.

2. Any restrictions of recreational and social opportunities shall be specifically described in the treatment plan, together with the reasons such restrictions are necessary and the extent and duration of such restrictions.

3. The PRTF shall provide a minimum of three hours per week of social and/or recreational activities.

H. The provider shall have a program to ensure that residents receive training in independent living skills appropriate to their age and functioning level. This program shall include instruction in:

1. hygiene and grooming;

2. laundry and maintenance of clothing;

3. appropriate social skills;

4. housekeeping;

5. budgeting and shopping;

6. cooking; and

7. punctuality, attendance and other employment-related matters.

I. Each resident shall have a minimum of one face-to-face contact with a psychiatrist each month and additional contacts for individuals from special risk populations, and as clinical needs of the resident dictate.

J. The services of qualified professionals and specialists from the following areas shall be provided by and in the PRTF when necessary to meet the needs of the residents:

1. medicine and dentistry;

2. nursing;

3. speech, occupational, and physical therapies;

4. psychology and psychiatry;

5. social work;

6. laboratory and diagnostic/radiology services;

7. optometry or ophthalmology; and

8. pharmacy activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:70 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:388 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:293 (February 2018).

§9069. Transportation

A. The PRTF shall ensure that each resident is provided with the transportation necessary for implementation of the resident's treatment plan.

B. The PRTF shall provide or arrange transportation of its residents to and from the facility and is responsible for the safety of the residents during transport.

C. If the PRTF arranges transportation for participants through a transportation agency, the facility shall maintain a written contract which is signed by a facility representative and a representative of the transportation agency. The contract shall outline the circumstances under which transportation will be provided.

1. The written contract shall be dated and time limited and shall conform to these licensing regulations.

2. The transportation agency shall maintain in force at all times current commercial liability insurance for the operation of transportation vehicles, including medical coverage for residents in the event of an accident or injury. The PRTF shall maintain documentation of the insurance which shall consist of the insurance policy or current binder that includes the name of the transportation agency, the name of the insurance agency, policy number, and period of coverage and an explanation of the coverage.

D. Transportation arrangements shall conform to state laws, including laws governing the use of seat belts and resident restraints. Vehicles shall be accessible for people with disabilities or so equipped to meet the needs of the residents served by the PRTF.

E. The driver or attendant shall not leave a resident unattended in the vehicle at any time.

F. Vehicle and Driver Requirements

1. The vehicle shall be maintained in good repair with evidence of an annual safety inspection.

2. The use of tobacco in any form, use of alcohol and possession of illegal substances or unauthorized potentially toxic substances, firearms, pellet or BB guns (loaded or

unloaded) in any vehicle while transporting residents is prohibited.

3. The number of persons in a vehicle used to transport resident shall not exceed the manufacturer's recommended capacity.

4. The facility shall maintain a copy of a valid appropriate Louisiana driver's license for all individuals who drive vehicles used to transport resident on behalf of the PRTF.

5. The facility shall maintain in force at all times current commercial liability insurance for the operation of its vehicles, including medical coverage for residents in the event of accident or injury.

a. The policy shall extend coverage to any staff member who provides transportation for any resident in the course and scope of his/her employment.

b. Documentation shall consist of the insurance policy or current binder that includes the name of the PRTF, the name of the insurance company, policy number, period of coverage, and explanation of the coverage.

6. The vehicle shall have evidence of a current safety inspection.

7. There shall be first aid supplies in each facility or contracted vehicle.

8. Each driver or attendant shall be provided with a current master transportation list including each resident's name, pick-up and drop-off locations, and authorized persons to whom the resident may be released. Documentation shall be maintained on file at the PRTF whether transportation is provided by the facility or contracted.

9. The driver or attendant shall maintain an attendance record for each trip. The record shall include the driver's name, the date, names of all passengers (resident and adults) in the vehicle, and the name of the person to whom the resident was released and the time of release. Documentation shall be maintained on file at the facility whether transportation is provided by the facility or contracted.

10. There shall be information in each vehicle identifying the name of the administrator and the name, telephone number, and address of the facility for emergency situations.

G. Resident Safety Provisions

1. The driver plus one appropriately trained staff member shall be required at all times in each vehicle when transporting any resident. Staff shall be appropriately trained on the needs of each resident.

2. Each resident shall be safely and properly:

a. assisted into the vehicle;

b. restrained in the vehicle; and

c. assisted out of the vehicle.

3. Every resident shall be restrained in a single safety belt or secured in an American Academy of Pediatrics recommended, age appropriate safety seat.

4. The driver or appropriate staff person shall check the vehicle at the completion of each trip to ensure that no resident is left on the vehicle. Documentation shall include the signature of the person conducting the check and the time the vehicle is checked. Documentation shall be maintained on file at the PRTF whether transportation is provided by the facility or contracted.

5. During field trips, the driver or staff member shall check the vehicle and account for each resident upon arrival at, and departure from, each destination to ensure that no resident is left on the vehicle or at any destination. Documentation shall include the signature of the person conducting the check and the time the vehicle was checked for each loading and unloading of residents during the field trip.

6. Appropriate staff person(s) shall be present when each resident is delivered to the facility.

H. The provider shall have the means of transporting residents in cases of emergency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:389 (February 2012).

§9071. Resident Rights and Grievance Procedure [Formerly §9085]

A. Every resident shall have the following rights, none of which shall be abridged by the PRTF or any of its staff. The PRTF administrator shall be responsible for developing and implementing policies to protect resident rights and to respond to questions and grievances pertaining to resident rights. These rights shall include at least the following:

1. every resident, or his/her designated representative, shall whenever possible, be informed of the resident's rights and responsibilities in advance of furnishing or discontinuing resident care;

2. the right to have a family member, chosen representative and/or his or her own physician notified promptly of admission to the PRTF;

3. the right to receive treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay or source of payment;

4. the right to be treated with consideration, respect and recognition of their individuality, including the need for privacy in treatment;

5. the right to receive, as soon as possible, the services of a translator or interpreter, if needed, to facilitate communication between the resident and the PRTF's health care personnel;

6. the right to participate in the development and implementation of his/her plan of care;

7. every resident or his/her representative (as allowed by state law) has the right to make informed decisions regarding his/her care;

8. the resident's rights include being informed of his/her health status, and being involved in care planning and treatment;

9. the right to be included in experimental research only when he/she gives informed, written consent to such participation, or when a guardian provides such consent for an incompetent resident in accordance with appropriate laws and regulations. The resident may refuse to participate in experimental research, including the investigations of new drugs and medical devices;

10. the right to be informed if the PRTF has authorized other health care and/or educational institutions to participate in the resident's treatment. The resident shall also have a right to know the identity and function of these institutions;

11. the right to be informed by the attending physician and other providers of health care services about any continuing health care requirements after the resident's discharge from the PRTF. The resident shall also have the right to receive assistance from the physician and appropriate PRTF staff in arranging for required follow-up care after discharge;

12. the right to consult freely and privately with his/her parent(s) or legal guardian(s);

13. the right to consult freely and privately with legal counsel, as well as the right to employ legal counsel of his/her choosing;

14. the right to make complaints without fear of reprisal;

15. the opportunity for telephone communication;

16. the right to send and receive mail;

17. the right to possess and use personal money and belongings, including personal clothing, in accordance with the facility's policies;

18. the right to visit or be visited by family and friends subject only to reasonable rules and to any specific restrictions in the resident's treatment plan. Special restrictions shall be imposed only to prevent serious harm to the resident. The reasons for any special restrictions shall be recorded in the resident's treatment plan;

19. the right to have the individual resident's medical records, including all computerized medical information, kept confidential;

20. the right to access information contained in his/her medical records within a reasonable time frame subject to the exception contained in §9035.L.1.f;

21. the right to be free from all forms of abuse and harassment;

22. the right to receive care in a safe setting;

23. the right to be informed in writing about the PRTF's policies and procedures for initiation, review and resolution of resident complaints;

24. the provider shall ensure that each resident has access to appropriate educational services consistent with the resident's abilities and needs, taking into account his/her age and level of functioning;

25. the provider shall have a written description regarding the involvement of the resident in work including:

a. a description of any unpaid tasks required of the resident;

b. a description of any paid work assignments including the pay scales for such assignments;

c. a description of the provider's approach to supervising work assignments;

d. assurance that the conditions and compensation of such work are in compliance with applicable state and federal laws;

e. all work assignments shall be in accordance with the resident's treatment plan;

f. the provider shall assign as unpaid work for the resident only housekeeping tasks similar to those performed in a normal family home. Any other work assigned shall be compensated, at such rate and under such conditions as the resident might reasonably be expected to receive for similar work in outside employment;

26. every resident shall be permitted to attend religious services in accordance with his/her faith. Residents shall not be forced to attend religious services; and

27. in addition to the rights listed herein, residents have the rights provided in the Louisiana Mental Health Law.

B. Grievance Procedure for Residents

1. The provider shall have a written grievance procedure for residents designed to allow residents to make complaints without fear of retaliation.

2. The provider shall document that the resident and the resident's parent(s) or legal guardian(s) are aware of and understand the grievance procedure.

3. The provider shall document the resolution of the grievance in the resident's record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:71 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:390 (February 2012).

Subchapter F. Physical Environment

§9075. General Provisions [Formerly §9061]

A. The PRTF shall be constructed, arranged and maintained to ensure the safety and well being of the resident.

B. Buildings

1. The buildings shall reflect good housekeeping and shall by means of an effective pest control program, be free of insects and rodents.

2. The PRTF shall maintain PRTF-wide ventilation, lighting and temperature controls.

3. There shall be a policy regarding the provision of services during any period in which the supply of electricity, natural gas, water and fuel is temporarily disrupted.

4. Doors leading into a facility or unit may be locked only in the direction of ingress.

5. Doors in the line of egress shall not be locked. Any deviation to allow the outermost doors in the line of egress to be locked may only be made after approval has been given by the Office of the State Fire Marshal.

C. All PRTFs shall comply with established fire protection standards and enforcement policies as promulgated by the Office of State Fire Marshal, including handicapped accessibility requirements.

1. Prior to new construction, additions, conversions or major alterations, PRTFs shall submit construction documents to the OSFM for review.

D. The PRTF shall comply with the rules, Sanitary Code and enforcement policies as promulgated by the Office of Public Health (OPH).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:66 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:391 (February 2012).

§9077. Interior Space [Formerly §9063]

A. The arrangement, appearance and furnishing of all of the interior areas of the facility shall be similar to those of a normal family home within the community.

B. The provider shall ensure that there is evidence of routine maintenance and cleaning programs in all of the areas of the facility.

C. Each living unit of a facility shall contain a space for the free and informal use of the residents. This space shall be constructed and equipped in a manner in keeping with the programmatic goals of the facility.

D. A facility shall have a minimum of 60 square feet of floor area per resident in living areas accessible to the residents and excluding halls, closets, bathrooms, bedrooms, staff or staff's family quarters, laundry areas, storage areas and office areas.

E. Resident Bedrooms

1. Single rooms shall contain at least 80 square feet and multi-bed rooms shall contain at least 60 square feet per bed, exclusive of fixed cabinets, fixtures, and equipment.

2. All PRTFs shall have bedroom space that does not permit more than two residents per designated bedroom.

a. Exception. If the facility maintains a valid child residential license from DCFS, has more than two residents per bedroom and is converting to a PRTF, the PRTF may have bedroom space that allows no more than four residents per designated bedroom.

3. Rooms shall have at least a 7 1/2 foot ceiling height over the required area. In a room with varying ceiling height, only portions of the room with a ceiling height of at least 7 1/2 feet are allowed in determining usable space.

4. There shall be at least 3 feet between beds.

5. There shall be sufficient and satisfactory separate storage space for clothing, toilet articles and other personal belongings of residents.

6. There shall be at least one toilet bowl with accessories, lavatory basin and bathing facility reserved for resident use on each resident floor and additional toilets, lavatories, and bathing facilities to adequately meet the needs of employees, professional personnel and residents on each unit.

7. Doors to individual bedrooms shall not be equipped with locks or any other device that would prohibit the door from being opened from either side.

8. The provider shall not use any room that does not have a window as a bedroom space.

9. The provider shall ensure that sheets, pillow, bedspread and blankets are provided for each resident. Enuretic residents shall have mattresses with moisture resistant covers. Sheets and pillowcases shall be changed at least weekly, but shall be changed more frequently if necessary.

10. Each resident shall have his/her own dresser or other adequate storage space for private use and designated space for hanging clothing in proximity to the bedroom occupied by the resident.

11. No resident over the age of five years shall occupy a bedroom with a member of the opposite sex.

12. The provider shall ensure that the ages of residents sharing bedroom space are not greater than four years in difference unless contraindicated based on diagnosis, the treatment plan, or the behavioral health assessment of the resident.

13. Each resident shall have his/her own bed. A resident’s bed shall be longer than the resident is tall, no less than 30 inches wide, of solid construction and shall have a clean, comfortable, nontoxic fire retardant mattress.

14. Mobile homes shall not be used for resident sleeping areas.

15. The use of bunk beds is prohibited in resident bedrooms.

16. If the PRTF has a sexually-based treatment program, the residents of that program shall reside in its own unit or wing of the PRTF that is separate from the unit or wing housing the other residents. Residents of the sexually-based treatment program shall reside in single rooms with only one bed per bedroom.

F. Dining Areas

1. The facility shall have dining areas that permit residents, staff and guests to eat together in small groups.

2. A facility shall have dining areas that are clean, well lit, ventilated, and attractively furnished.

G. Bathrooms

1. A facility shall have wash basins with hot and cold water, flush toilets, and bath or shower facilities with hot and cold water according to resident care needs.

a. Bathrooms shall be so placed as to allow access without disturbing other resident during sleeping hours.

b. Each bathroom shall be properly equipped with toilet paper, towels, soap and other items required for personal hygiene unless residents are individually given such items. Residents shall be provided individual items such as hair brushes and toothbrushes.

c. Tubs and showers shall have slip proof surfaces.

d. The PRTF shall have at a minimum the following:

i. one lavatory per eight male residents and one lavatory per eight female residents;

ii. one toilet per eight male residents and one toilet per eight female residents; and

iii. one shower or tub per eight male residents and one shower or tub per eight female residents.

2. A facility shall have toilets and baths or showers that allow for individual privacy unless the residents in care require assistance.

3. Toilets, wash basins and other plumbing or sanitary facilities in a facility shall, at all times, be maintained in good operating condition and shall be kept free of any materials that might clog or otherwise impair their operation.

H. Kitchens

1. Kitchens used for meal preparations shall have the equipment necessary for the preparation, serving, storage, and clean up of all meals regularly served to all of the residents and staff. All equipment shall be maintained in proper working order.

2. The provider shall ensure that all dishes, cups and glasses used by residents are free from chips, cracks or other defects and are in sufficient number to accommodate all residents.

I. Administrative and Counseling Area

1. The provider shall provide a space that is distinct from resident's living areas to serve as an administrative office for records, secretarial work and bookkeeping.

2. The provider shall have a designated space to allow private discussions and counseling sessions between individual residents and staff, excluding, bedrooms and common living areas.

J. Furnishings

1. The provider shall have comfortable customary furniture as appropriate for all living areas. Furniture for the use of residents shall be appropriately designed to suit the size and capabilities of the residents.

2. The provider shall promptly replace or repair broken, run-down, or defective furnishings and equipment.

K. Doors and Windows

1. The provider shall provide insect screens for all windows that can be opened. The screens shall be in good repair and readily removable in emergencies.

2. The provider shall ensure that all closets, bedrooms and bathrooms are equipped with doors that can be readily opened from both sides.

3. Windows or vents shall be arranged and located so that they can be opened from the inside to permit venting of combustion products and to permit occupants direct access to fresh air in emergencies. The operation of windows shall be restricted to inhibit possible escape or suicide. If the PRTF has an approved engineered smoke control system, the windows may be fixed. Where glass fragments pose a hazard to certain residents, safety glazing and/or other appropriate security features shall be used. There shall be no curtain or venetian blind chords.

L. Storage

1. The provider shall ensure that there are sufficient and appropriate storage facilities.

2. The provider shall have securely locked storage space for all potentially harmful materials. Keys to such storage spaces shall only be available to authorized staff members.

M. Electrical Systems

1. The provider shall ensure that all electrical equipment, wiring, switches, sockets and outlets are maintained in good order and in safe condition.

2. The provider shall ensure that any room, corridor or stairway within a facility shall be well lit.

N. Heating, Ventilation and Air Conditioning

1. The provider shall take all reasonable precautions to ensure that heating elements, including exposed hot water pipes, are insulated and installed in a manner that ensures the safety of all residents.

2. The provider shall not use open flame heating equipment or portable electrical heaters.

3. All gas heating units and water heaters shall be vented adequately to carry the products of combustion to the outside atmosphere. Vents shall be constructed and maintained to provide a continuous draft to the outside atmosphere in accordance with the recommended procedures of the American Gas Association Testing Laboratories, Inc.

4. All heating units shall be provided with a sufficient supply of outside air so as to support combustion without depletion of the air in the occupied room.

O. Smoking shall be prohibited in all areas of the PRTF.

P. The layout, design of details, equipment and furnishings shall be such that patients shall be under close observation and shall not be afforded opportunities for hiding, escape or injury to themselves or others. The environment of the unit shall be characterized by a feeling of openness with emphasis on natural light and exterior views. Interior finishes, lighting and furnishings shall suggest a residential rather than an institutional setting while conforming with applicable fire safety codes. Security and safety devices shall not be presented in a manner to attract or challenge tampering by patients.

Q. Seclusion Room

1. A PRTF shall have a seclusion room. This room shall be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

2. The room(s) shall be either located for direct nursing staff supervision or observed through the use of electronic monitoring equipment. If electronic monitoring equipment is used, it shall be connected to the facility's emergency electrical source.

3. Each room shall be for single occupancy and contain at least 60 square feet. It shall be constructed to prevent resident hiding, escape, injury or suicide.

R. Where grab bars are provided, they shall be institutional type, shall not rotate within their fittings, be securely fastened with tamper-proof screw heads, and shall be free of any sharp or abrasive elements. If grab bars are mounted adjacent to a wall, the space between the wall and the grab bar shall be 1 1/2 inches.

S. Where towel racks, closet and shower curtain rods are provided, they shall be the breakaway type.

T. Plastic bags and/or trash can liners shall not be used in patient care areas.

U. The provider shall have a laundry space complete with a minimum of one clothes washer and dryer for each 50 persons.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:66 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:391 (February 2012), LR 39:2510 (September 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 44:293 (February 2018).

§9079. Facility Exterior
[Formerly §9065]

A. The provider shall maintain all areas of the facility that are accessible to the residents in good repair and free from any reasonably foreseeable hazard to health or safety. All structures on the grounds of the facility shall be maintained in good repair.

1. Garbage and rubbish stored outside shall be secured in noncombustible, covered containers and shall be removed on a regular basis.

2. Trash collection receptacles and incinerators shall be separate from recreation/play areas and located as to avoid being a nuisance.

3. Recreation/playground equipment shall be so located, installed, and maintained as to ensure the safety of the residents.

4. Areas determined unsafe, including steep grades, open pits, swimming pools, high voltage boosters or high speed roads shall be fenced or have natural barriers to protect residents.

5. Fences that are in place shall be in good repair.

6. Residents shall have access to safe, suitable outdoor recreational space and age appropriate equipment.

7. The provider shall ensure that exterior areas are well lit at night.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:67 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:393 (February 2012).

§9081. Equipment
[Formerly §9067]

A. Equipment shall be clean and in good repair for the safety and well-being of the residents.

B. Therapeutic, diagnostic and other resident care equipment shall be maintained and serviced in accordance with the manufacturer's recommendations.

C. Methods for cleaning, sanitizing, handling and storing of all supplies and equipment shall be such as to prevent the transmission of infection.

D. After discharge of a resident, the bed, mattress, cover, bedside furniture and equipment shall be properly cleaned. Mattresses, blankets and pillows assigned to residents shall be in a sanitary condition. The mattress, blankets and pillows used for a resident with an infection shall be sanitized in an acceptable manner before they are assigned to another resident.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health

Services Financing, LR 30:68 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:393 (February 2012).

Subchapter G. Emergency Preparedness

§9083. Safety and Emergency Preparedness

A. The PRTF shall incorporate an all hazards risk assessment into the facility's emergency preparedness plan designed to manage the consequences of medical emergencies, power failures, fire, natural disasters, declared disasters or other emergencies that disrupt the facility's ability to provide care and treatment or threatens the lives or safety of the residents. The facility shall follow and execute its emergency preparedness plan in the event or occurrence of a disaster or emergency.

B. Upon the department's request, a facility shall present its emergency preparedness plan for review. At a minimum, the emergency preparedness plan shall include and address the following.

1. The emergency preparedness plan shall be individualized and site specific. All information contained in the plan shall be current and correct. The plan shall be made available to representatives of the Office of the State Fire Marshal and the Office of Public Health upon request of either of these offices. The facility's plan shall follow all current applicable laws, standards, rules or regulations.

2. The facility's plan shall be submitted to the parish or local Office of Homeland Security and Emergency Preparedness (OHSEP) yearly and upon request of either of these offices and verification of this submittal maintained in the plan. Any recommendations by the parish or local OHSEP regarding the facility's plan shall be documented and addressed by the PRTF.

3. The facility's plan shall contain census information, including transportation requirements for the PRTF residents as to the need for:

a. wheelchair accessible or para-transit vehicle transport; or

b. the numbers of PRTF residents that do not have any special transport needs.

4. The plan shall contain a clearly labeled and legible master floor plan(s) that indicate the following:

a. the areas in the facility, either in the resident's individual unit or apartment or the PRTF, that is to be used by residents as shelter or safe zones during emergencies;

b. the location of emergency power outlets (if none are powered or all are powered, this shall be stated on the plan);

c. the locations of posted, accessible, emergency information;

d. the plan shall provide for floor plans or diagrams to be posted in each resident's room and shall clearly indicate that specific room or apartment's location, the fire exits, the fire evacuation routes, locations of alarm boxes and fire extinguishers, and written fire evacuation procedures shall be included on one plan; and

i. a separate floor plan or diagram with safe zones or sheltering areas for non fire emergencies shall indicate areas of building, apartments, or rooms that are designated as safe or sheltering areas;

e. the detail of what will be powered by emergency generator(s), if applicable.

C. The facility's plan shall be viable and promote the health, safety and welfare of the facility's residents. If the plan is found to be deficient the facility shall, within 10 days of notification, respond with an acceptable plan of correction to amend its emergency preparedness plan.

D. The facility will work in concert with the local OHSEP or Office of Emergency Preparedness (OEP) in developing plans.

E. The facility shall provide a plan for monitoring weather warnings and watches and evacuation orders from local and state emergency preparedness officials. This plan will include:

1. who will monitor;

2. what equipment will be used; and

3. procedures for notifying the administrator or responsible persons.

F. The plan shall provide for the delivery of essential care and services to residents during emergencies, who are housed in the facility or by the facility at another location, during an emergency.

G. The plan shall contain information about staffing when the PRTF is sheltering in place or when there is an evacuation of the PRTF. Planning shall include documentation of staff that have agreed to work during an emergency and contact information for such staff. The plan shall include provisions for adequate, qualified staff as well as provisions for the assignment of responsibilities and duties to staff.

H. The facility shall have transportation or arrangements for transportation for evacuation, hospitalization, or any other services which are appropriate. Transportation or arrangements for transportation shall be adequate for the current census and meet the ambulatory needs of the residents.

I. The plan shall include procedures to notify the resident's family or responsible representative whether the facility is sheltering in place or evacuating to another site. The plan shall include which staff is responsible for providing this notification. If the facility evacuates, notification shall include:

1. the date and approximate time that the facility is evacuating; and

2. the place or location to which the facility is evacuating, including the:

a. name;

b. address; and

c. telephone number.

J. The plan shall include the procedure or method whereby each facility resident has a manner of identification attached to his person which remains with him at all times in the event of sheltering in place or evacuation, and whose duty and responsibility this will be. The following minimum information shall be included with the resident:

1. current and active diagnosis;

2. medications, including dosage and times administered;

3. allergies;

4. special dietary needs or restrictions; and

5. next of kin or responsible person and contact information.

K. The plan shall include an evaluation of the building and necessary systems to determine the ability to withstand wind, flood, and other local hazards that may affect the facility. If applicable, the plan shall also include an evaluation of each generator's fuel source(s), including refueling plans and fuel consumption.

L. The plan shall include an evaluation of the facility's surroundings to determine lay-down hazards, objects that could fall on the facility, and hazardous materials in or around the facility, such as:

1. trees;

2. towers;

3. storage tanks;

4. other buildings;

5. pipe lines;

6. chemicals;

7. fuels; or

8. biologics.

M. For PRTFs that are geographically located south of Interstate 10 or Interstate 12, the plan shall include the determinations of when the facility will shelter in place and when the facility will evacuate for a hurricane and the conditions that guide these determinations.

1. A facility is considered to be sheltering in place for a storm if the facility elects to stay in place rather than evacuate when located in the projected path of an approaching storm of tropical storm strength or a stronger storm.

NOTE: Tropical storm strength shall be defined as a tropical cyclone in which the maximum sustained surface wind speed (using the U.S. 1 minute average standard) ranges from 34 kt (39 mph 17.5 m/s) to 63 kt (73 mph 32.5 mps).

2. If sheltering in place, the facility has elected to take this action after reviewing all available and required information on the storm, the facility, the facility's surroundings, and consultation with the local or parish OHSEP.

3. The facility accepts all responsibility for the health and well-being of all residents that shelter with the facility before, during, and after the storm. In making the decision to shelter in place or evacuate, the facility shall consider the following:

a. what conditions will the facility shelter for;

b. what conditions will the facility close or evacuate for; and

c. when will these decisions be made.

4. If the facility shelters in place, the facility's plan shall include provisions for seven days of necessary supplies to be provided by the facility prior to the emergency event, to include drinking water or fluids and non-perishable food.

N. The facility's emergency plan shall include a posted communications plan for contacting emergency services and monitoring emergency broadcasts and whose duty and responsibility this will be.

O. The facility's plan shall include how the PRTF will notify OHSEP and LDH when the decision is made to shelter in place and whose responsibility it is to provide this notification.

P. The facility shall have a plan for an on-going safety program to include:

1. continuous inspection of the facility for possible hazards;

2. continuous monitoring of safety equipment and maintenance or repair when needed;

3. investigation and documentation of all accidents or emergencies;

4. fire control and evacuation planning with documentation of all emergency drills:

a. residents can be informed of emergency drills;

5. all aspects of the facility's plan, planning, and drills shall meet the current requirements of the Office of the State Fire Marshal, and the Life Safety Code National Fire Protection Association (NFPA) 101; and

6. the facility shall inform the resident and/or responsible party of the facility's emergency plan and the actions to be taken.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:394 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:294 (February 2018).

§9085. Emergency Plan Activation, Review, and Summary

A. The facility's emergency plan(s) shall be activated at least annually, either in response to an emergency or in a planned drill. All staff shall be trained and have knowledge of the emergency plan.

B. PRTFs shall conduct a minimum of 12 fire drills annually with at least one every three months on each shift. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, and other natural disasters.

1. All staff shall participate in at least one drill annually. Residents shall be encouraged to participate, but the provider may not infringe upon the right of the resident to refuse to participate.

2. The facility shall test at least one manual pull alarm each month of the year and maintain documentation of test dates, location of each manual pull alarm tested, persons testing the alarm, and its condition.

3. Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers' and applicable NFPA requirements. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance.

C. The facility's performance during the activation of the plan shall be evaluated annually by the facility and the findings shall be documented in the plan.

D. The plan shall be revised if indicated by the facility's performance during the emergency event or the planned drill.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:395 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:294 (February 2018).

§9087. Notification of Evacuation, Relocation, or Temporary Cessation of Operations

A. Emergency preparedness procedures shall specify the following:

1. persons to be notified;

2. process of notification;

3. verification of notification;

4. locations of emergency equipment and alarm signals;

5. evacuation routes;

6. procedures for evacuating residents;

7. procedures for re-entry and recovery;

8. frequency of fire drills;

9. tasks and responsibilities assigned to all personnel; and

10. medications and records to be taken from the facility upon evacuation and to be returned following the emergency.

B. A PRTF shall immediately notify the department and other appropriate agencies of any fire, disaster or other emergency that may present a danger to residents or require their evacuation from the facility.

C. In the event that a PRTF evacuates, temporarily relocates or temporarily ceases operations at its licensed location as a result of an evacuation order issued by the state, local or parish OHSEP, the PRTF shall immediately give notice to the Health Standards Section, the Office of Behavioral Health (OBH), and OHSEP by facsimile or email of the following:

1. the date and approximate time of the evacuation; and

2. the locations of where the residents have been placed, whether this location is a host site for one or more of the PRTF residents.

D. In the event that a PRTF evacuates, temporarily relocates or temporarily ceases operations at its licensed location for any reason other than an evacuation order, the PRTF shall immediately give notice to the Health Standards Section by facsimile or email of the following:

1. the date and approximate time of the evacuation; and

2. the locations of where the residents have been placed, whether this location is a host site for one or more of the PRTF residents.

E. If there are any deviations or changes made to the locations of the residents that were given to the Health Standards Section, OBH and OHSEP, then Health Standards, OBH, and OHSEP shall be notified of the changes within 48 hours of their occurrence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:396 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:294 (February 2018).

§9089. Authority to Re-Open After an Evacuation, Temporary Relocation or Temporary Cessation of Operation

A. In the event that a PRTF evacuates, temporarily relocates or temporarily ceases operation at its licensed location as a result of an evacuation order issued by the state, local, or parish OHSEP, due to a declared disaster or other emergency, and that facility sustains damages due to wind, flooding, precipitation, fire, power outages or other causes, the facility shall not be reopened to accept returning evacuated residents or new admissions until surveys have been conducted by the Office of the State Fire Marshal, the Office of Public Health and the Health Standards Section, and the facility has received a letter of approval from the department for reopening the facility.

1. The purpose of these surveys is to assure that the facility is in compliance with the licensing standards including, but not limited to, the structural soundness of the

building, the sanitation code, staffing requirements and the execution of emergency plans.

B. If a PRTF evacuates, temporarily relocates or temporarily ceases operation at its licensed location as a result of an evacuation order issued by the state or parish OHSEP, due to a declared disaster or other emergency, and the facility does not sustain damages due to wind, flooding, precipitation, fire, power outages or other causes, the facility may be reopened without the necessity of the required surveys.

1. Prior to reopening, the facility shall notify the Health Standards Section in writing that the facility is reopening.

C. The facility shall submit a written initial summary report to the department's Health Standards Section. This report shall be submitted within 14 days from the date of the emergency event which led to the facility having to evacuate, temporarily relocate or temporarily cease operations. The report shall indicate how the facility's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

1. pertinent plan provisions and how the plan was followed and executed;

2. plan provisions that were not followed;

3. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

4. contingency arrangements made for those plan provisions not followed; and

5. a list of all injuries and deaths of residents that occurred during the execution of the plan, including the date, time, causes and circumstances of the injuries and deaths.

D. If a facility shelters in place at its licensed location during a declared disaster or other emergency, the facility shall submit a written initial summary report to the department's Health Standards Section. This report shall be submitted within 14 days from the date of the emergency event which led to the facility having to shelter in place. The report shall indicate how the facility's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

1. pertinent plan provisions and how the plan was followed and executed;

2. plan provisions that were not followed;

3. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

4. contingency arrangements made for those plan provisions not followed; and

5. a list of all injuries and deaths of residents that occurred during the execution of the plan, including the date, time, causes and circumstances of these injuries and deaths.

E. Upon request by the department's Health Standards Section, a report that is more specific and detailed regarding the facility's execution of their emergency plan shall be submitted to the department.

F. Inactivation of License due to Declared Disaster or Emergency

1. A licensed PRTF licensed in a parish which is the subject of an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766 may seek to inactivate its license for a period not to exceed one year, provided that the following conditions are met:

a. the licensed PRTF provider shall submit written notification to the Health Standards Section within 60 days of the date of the executive order or proclamation of emergency or disaster that:

i. the PRTF has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster;

ii. the licensed PRTF intends to resume operation as a PRTF in the same service area;

iii. includes an attestation that the emergency or disaster is the sole casual factor in the interruption of the provision of services;

iv. includes an attestation that all residents have been properly released or transferred to another provider; and

v. provides a list of each resident's name and the location where that resident has been released or transferred to;

b. the licensed PRTF resumes operating as a PRTF in the same service area within one year of the issuance of such an executive order or proclamation of emergency or disaster;

c. the licensed PRTF continues to pay all fees and costs due and owed to the department including, but not limited to:

i. annual licensing fees; and

ii. outstanding civil monetary penalties; and

d. the licensed PRTF continues to submit required documentation and information to the department, including but not limited to cost reports.

2. Upon receiving a completed written request to inactivate a PRTF license, the department shall issue a notice of inactivation of license to the PRTF.

3. Upon completion of repairs, renovations, rebuilding or replacement of the facility, a PRTF which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met:

a. the PRTF shall submit a written license reinstatement request to the licensing agency of the department 60 days prior to the anticipated date of reopening;

b. the license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing survey;

c. the license reinstatement request shall include a completed licensing application with appropriate licensing fees, approval from the Office of Public Health and the Office of State Fire Marshal; and

d. the provider resumes operating as a PRTF in the same service area within one year.

4. Upon receiving a completed written request to reinstate a PRTF license, the department shall schedule a licensing survey. If the PRTF meets the requirements for licensure and the requirements under this Subsection, the department shall issue a notice of reinstatement of the PRTF license.

5. No change of ownership in the PRTF shall occur until such PRTF has completed repairs, renovations, rebuilding or replacement construction and has resumed operations as a PRTF.

6. The provisions of this Subsection shall not apply to a PRTF which has voluntarily surrendered its license and ceased operation.

7. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the PRTF license.

G. Inactivation of Licensure due to a Non-Declared Disaster or Emergency

1. A PRTF in an area or areas which have been affected by a non-declared emergency or disaster may seek to inactivate its license, provided that the following conditions are met:

a. the PRTF shall submit written notification to the Health Standards Section within 30 days of the date of the non-declared emergency or disaster stating that:

i. the PRTF has experienced an interruption in the provisions of services as a result of events that are due to a non-declared emergency or disaster;

ii. the PRTF intends to resume operation as a PRTF agency in the same service area;

iii. the PRTF attests that the emergency or disaster is the sole causal factor in the interruption of the provision of services; and

iv. the PRTF's initial request to inactivate does not exceed one year for the completion of repairs, renovations, rebuilding or replacement of the facility.

NOTE: Pursuant to these provisions, an extension of the 30 day deadline for initiation of request may be granted at the discretion of the department.

b. the PRTF continues to pay all fees and costs due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties and/or civil fines; and

c. the PRTF continues to submit required documentation and information to the department, including but not limited to cost reports.

2. Upon receiving a completed written request to temporarily inactivate a PRTF license, the department shall issue a notice of inactivation of license to the PRTF.

3. Upon receipt of the department's approval of request to inactivate the agency's license, the PRTF shall have 90 days to submit plans for the repairs, renovations, rebuilding or replacement of the facility, if applicable, to OSFM and OPH as required.

4. The PRTF shall resume operating as a PRTF in the same service area within one year of the approval of renovation/construction plans by the OSFM and the OPH as required.

EXCEPTION: If the PRTF requires an extension of this timeframe due to circumstances beyond the agency's control, the department will consider an extended time period to complete construction or repairs. Such written request for extension shall show the agency's active efforts to complete construction or repairs and the reasons for request for extension of the agency's inactive license. Any approval for extension is at the sole discretion of the department.

5. Upon completion of repairs, renovations, rebuilding or replacement of the facility, a PRTF which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met:

a. the PRTF shall submit a written license reinstatement request to the licensing agency of the department;

b. the license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing or physical environment survey, where applicable; and

c. the license reinstatement request shall include a completed licensing application with appropriate licensing fees.

6. Upon receiving a completed written request to reinstate a PRTF license, the department may conduct a licensing or physical environment survey. The department may issue a notice of reinstatement if the agency has met the requirements for licensure including the requirements of this Subsection.

7. No change of ownership of the PRTF shall occur until such PRTF has completed repairs, renovations, rebuilding or replacement construction and has resumed operations as a PRTF facility.

8. The provisions of this Subsection shall not apply to a PRTF which has voluntarily surrendered its license and ceased operation.

9. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the PRTF license for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:396 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:294 (February 2018).

Subchapter H. Additional Requirements for Mental Health PRTFs

§9091. General Provisions

A. A mental health PRTF is a PRTF that provides inpatient psychiatric services to its residents who are suffering from mental illness, or who are suffering from co-occurring mental illness and a substance abuse/addiction disorder. In addition to the provisions applicable to all PRTFs, a mental health PRTF shall comply with the provisions of this Subchapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:397 (February 2012).

§9093. Personnel Qualifications, Responsibilities, and Requirements

A. A mental health PRTF shall have the following minimum personnel.

1. Administrator. The administrator shall have a Bachelor's degree from an accredited college or university in a mental health-related field, plus at least five years of related experience. The administrator is responsible for the on-site, daily implementation and supervision of the overall facility's operation commensurate with the authority conferred by the governing body.

a. Grandfathering Provision. For a facility with a current child residential license from DCFS at the time of the promulgation of this rule, the current administrator may remain the administrator of the facility provided the following conditions are met.

i. The administrator has been the administrator on a full time basis for the facility for at least five years.

ii. The administrator was approved by the governing body to hold the position of administrator of the PRTF.

iii. An administrator under this grandfathering provision may not transfer as an administrator to another PRTF.

2. Clinical Director

a. The clinical director shall be a physician holding an unrestricted license to practice medicine in Louisiana and who has the following:

i. unrestricted Drug Enforcement Agency (DEA) and state controlled substance licenses;

ii. if the license(s) is from another jurisdiction, the license(s) shall be documented in the employment record and shall also be unrestricted;

iii. board-certification in general psychiatry; and

iv. satisfactory completion of a specialized psychiatric residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), as evidenced by a copy of the certificate of training or a letter of verification of training from the training director, which includes the exact dates of training and verification that all ACGME requirements have been satisfactorily met. If the training was completed in a psychiatric residency program not accredited by the ACGME, the physician shall demonstrate that he/she meets the most current requirements as set forth in the American Board of Psychiatry and Neurology's board policies, rules and regulations regarding information for applicants for initial certification in psychiatry.

b. The clinical director is responsible for the following:

i. providing clinical direction for each resident at a minimum of one hour per month, either in person on-site, or via telemedicine pursuant to R.S. 37:1261-1292 et seq., and LAC 46:XLV.408 and Chapter 75 et seq.;

(a). the governing body may delegate some or all of this responsibility to another physician(s) who meets the qualifications of a clinical director; and

ii. monitoring and evaluating the quality and appropriateness of services and treatment provided by the facility's direct care staff.

3. LMHPs, MHPs, and MHSs. The PRTF shall provide or make available adequate numbers of LMHPs, MHPs, and MHSs to care for its residents. There shall be at least one LMHP or MHP supervisor on duty at least 40 hours/week during normal business hours at the facility and as required by the treatment plan. When not on duty at the facility, there shall be a LMHP or MHP on call. The PRTF shall develop a policy to determine the number of LHMPs, MHPs, MHSs on duty and the ratio of LHMPs and MHPs to MHSs based on the needs of its residents.

a. A LMHP or a MHP shall be designated and assigned as treatment plan manager for each resident and given responsibility for and authority over those activities detailed in the minimum licensure requirements, including:

i. supervision of the treatment plan;

ii. integration of the various aspects of the resident's program;

iii. recording of the resident's progress as measured by objective indicators and making appropriate changes/modifications; and

iv. serving as liaison between the resident, provider, family, and community during the resident's admission to and residence in the facility, or while the resident is receiving services from the provider.

b. A LMHP or MHP shall provide for each resident a minimum weekly total of 120 minutes of individual therapy.

c. A LMHP or MHP shall provide a minimum of two group therapy sessions per week for each resident.

d. A LMHP or MHP shall have a maximum caseload not to exceed 12 residents.

e. LMHPs, MHPs, and MHSs shall be responsible for:

i. evaluating residents;

ii. formulating written individualized plans of care;

iii. providing active treatment measures; and

iv. engaging in discharge planning.

f. The MHSs shall be under the supervision of LMHPs and/or MHPs to assist with the duties and requirements of the PRTF.

4. Psychologist. Psychological services shall be provided by, or supervised by, a psychologist with a doctorate degree from an accredited program in clinical or counseling psychology and with appropriate post-graduate experience. The PRTF shall provide or have available a psychologist to provide psychological testing and psychological services, as necessary to assist in essential diagnostic formulations as requested, and participate in program development and evaluation of program effectiveness, in therapeutic interventions and in treatment plan team meetings. Psychological services may be provided directly or by contract.

5. Registered Nurse

a. A registered nurse licensed to practice in Louisiana shall oversee and direct the nursing services of the PRTF. He/she shall be employed full time and be on-site 40 hours per week during normal business hours.

b. Nursing services shall be provided by or supervised by a registered nurse licensed to practice in Louisiana. There shall be an adequate number of registered nurses, licensed practical nurses, and other staff, to provide the nursing care necessary under each resident's treatment plan. When no RN is on site, there shall be an RN available to be on-site within 30 minutes as needed.

6. Physician. The PRTF shall have available a physician licensed in the state of Louisiana who shall assume 24-hour on-call medical responsibility for non-emergent physical needs of the facility's residents.

7. A licensed dietician, whether provided directly or by contract, shall be responsible for the dietary services program of the PRTF.

B. If the PRTF is providing both mental health and substance abuse treatment, the PRTF shall also meet the staffing requirements for the resident's ASAM level required by the department, or the department's designee, in addition to the mental health PRTF requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:397 (February 2012), amended LR 39:2511 (September 2013), LR 42:279 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:295 (February 2018).

Subchapter I. Additional Requirements for Addictive Disorder PRTFs

§9095. General Provisions

A. An addictive disorder PRTF is a PRTF that provides inpatient psychiatric services to its residents who are admitted primarily for treatment for substance abuse or addictive disorders, not including mental illness. In addition to the provisions applicable to all PRTFs, an addictive disorder PRTF shall comply with the provisions of this Subchapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:398 (February 2012).

§9097. Personnel Qualifications, Responsibilities, and Requirements for Addictive Disorder PRTFs

A. An addictive disorder PRTF shall have the following minimum personnel.

1. Administrator. The administrator shall have a bachelor's degree from an accredited college or university in a mental health-related field, plus at least five years of related experience. The administrator is responsible for the on-site, daily implementation and supervision of the overall facility's operation commensurate with the authority conferred by the governing body.

a. Grandfathering Provision. For a facility with a current substance abuse license from LDH at the time of the promulgation of this final Rule, the current administrator may remain the administrator of the facility provided the following conditions are met.

i. The administrator has been the administrator on a full time basis for the facility for at least five years.

ii. The administrator was approved by the governing body to hold the position of administrator of the PRTF.

iii. An administrator under this grandfathering provision may not transfer as an administrator to another PRTF.

2. Clinical Director

a. The clinical director shall be a physician holding an unrestricted license to practice medicine in Louisiana and who has the following:

i. unrestricted DEA and state controlled substance licenses;

ii. if the license(s) is from another jurisdiction, the license(s) shall be documented in the employment record and shall also be unrestricted; and

iii. one of the following:

(a). board certification in general psychiatry and is eligible for certification in the subspecialty of addiction psychiatry by the American Board of Psychiatry and Neurology (ABPN);

(b). board eligible in general psychiatry with ABPN and has current certification in addiction psychiatry by the American Society of Addiction Medicine (ASAM); or

(c). an ABMS board-certified physician (non-psychiatrist) with ASAM certification and consultation with an ABPN board-certified psychiatrist. Proof of consultation shall be a current contract with a board-certified psychiatrist and written documentation of consults in the resident's medical record.

b. The clinical director is responsible for the following:

i. providing a monthly minimum of one hour of on-site clinical direction per resident;

(a). the governing body may delegate some or all of this responsibility to another physician(s) who meets the qualifications of a clinical director); and

ii. monitoring and evaluating the quality and appropriateness of services and treatment provided by the facility's direct care staff.

3. LMHPs, MHPs and MHSs. The PRTF shall provide or make available adequate numbers of LMHPs, MHPs and MHSs to care for its residents. There shall be at least one LMHP or MHP supervisor on duty at least 40 hours/week during normal business hours at the facility and as required by the treatment plan. When not on duty at the facility, there shall be a LMHP or MHP on call. The PRTF shall develop a policy to determine the number of LHMPs, MHPs, MHSs on duty and the ratio of LHMPs and MHPs to MHSs based on the needs of its residents.

a. A LMHP or a MHP shall be designated and assigned as treatment plan manager for each resident and given responsibility for and authority over those activities detailed in the minimum licensure requirements, including:

i. supervision of the treatment plan;

ii. integration of the various aspects of the resident's program;

iii. recording of the resident's progress as measured by objective indicators and making appropriate changes/modifications; and

iv. serving as liaison between the resident, provider, family, and community during the resident's admission to and residence in the facility, or while the resident is receiving services from the provider.

b. A LHMP or MHP shall provide a minimum of three individual therapy sessions each week for each resident (a minimum weekly total of 120 minutes) and a minimum of two group therapy sessions per week for each resident; for detoxification programs, there shall be at least 25 hours of structured treatment activities per week including counseling and educational activities.

c. LMHPs, MHPs, and MHSs shall be responsible for:

i. evaluating residents;

ii. formulating written individualized plans of care;

iii. providing active treatment measures; and

iv. engaging in discharge planning.

d. The MHSs shall be under the supervision of LMHPs and/or MHPs to assist with the duties and requirements of a PRTF.

4. Psychologist. Psychological services shall be provided by or supervised by a psychologist with a doctorate degree from an accredited program in clinical or counseling psychology and with appropriate post-graduate experience. The PRTF shall provide or have available a psychologist to provide psychological testing and psychological services, as necessary to assist in essential diagnostic formulations as requested, and participate in program development and evaluation of program effectiveness, in therapeutic interventions and in treatment plan team meetings. Psychological services may be provided directly or by contract. PRTFs that provide only a detoxification program are not required to provide a psychologist.

5. Registered Nurse

a. A registered nurse licensed to practice in Louisiana shall oversee and direct the nursing services of the PRTF. He/she shall be employed full time and be on-site 40 hours per week during normal business hours.

b. Nursing services shall be provided by or supervised by a registered nurse licensed to practice in Louisiana. There shall be an adequate number of registered nurses, licensed practical nurses, and other staff, to provide the nursing care necessary under each resident's treatment plan. When no RN is on site, there shall be an RN available to be on-site within 30 minutes as needed.

6. Physician. The PRTF, except one that provides a social detoxification program only, shall have available a physician licensed in the state of Louisiana who shall assume 24-hour on-call medical responsibility for non-emergent physical needs of the facility's residents; the PRTF may have available, in place of the physician, a licensed advanced nurse practitioner who has a collaborative agreement with a physician or a physician's assistant who has a supervising physician and works under the licensed physician.

7. A licensed dietician, whether provided directly or by contract, shall be responsible for the dietary services program of the PRTF.

B. The PRTF shall abide by the staffing requirements for the ASAM level of the admitted resident required by the department or the department's designee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR

38:399 (February 2012), amended LR 39:2511 (September 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 44:295 (February 2018).

Chapter 91. Minimum Standards for Home Health Agencies

§9101. Definitions

A. The following words and terms, when used in this Chapter, shall have the following meanings, unless the context clearly indicates otherwise:

Abuse—

a. the willful infliction of physical or mental injury;

b. causing deterioration by means including, but not limited to:

i. sexual abuse;

ii. exploitation; or

iii. extortion of funds or other things of value to such an extent that the health, moral or emotional well-being of the individual being supported is endangered; or

c. the willful infliction of injury, unreasonable confinement, intimidation or punishment which results in or which could reasonably be expected to result in physical or mental harm, pain or mental anguish. Lack of awareness or knowledge by the victim of the act which produced, or which could have reasonably been expected to produce, physical or mental injury or harm shall not be a defense to the charge of abuse.

Activities of Daily Living (*ADL*)—the functions or tasks which are performed either independently or with supervision or assistance:

a. mobility;

b. transferring;

c. walking;

d. grooming;

e. bathing;

f. dressing and undressing;

g. eating; and

h. toileting.

Administrator—a person who is designated in writing as administratively responsible and available in person or by telecommunication at all times for all aspects of an agency's operations.

Advanced Practice Registered Nurse (*APRN*)—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certificates.

Allied Health Personnel—nursing assistants, licensed practical nurses, licensed physical therapy assistants, and other health care workers who require supervision by other licensed health care professionals in accordance with their scope of practice.

Branch—an office from which a home health agency (HHA) provides services within a portion of the total geographic service area served by the parent agency. The branch office is part of the parent HHA; is located within a 50-mile radius of the parent agency; and shares administration and supervision.

Bureau—Bureau of Health Services Financing.

Cessation of Business—agency is non-operational and/or has stopped offering or providing services to the community.

Change of Ownership (CHOW)—the addition, substitution, or removal, whether by sale, transfer, lease, gift, or otherwise, of a licensed health care provider subject to this Rule by a person, corporation, or other equity, which results in a change of controlling interest of assets or other equity interests of the licensed entity may constitute a CHOW of the licensed entity.

Clinical Manager—a person designated in writing to supervise all aspects of patient care, all activities of professional staff and allied health personnel, and be responsible for compliance with regulatory requirements.

Clinical Note—a written or electronic notation of each visit with a patient, which shall include the date and time of the visit, services rendered, and the signature of person providing services. The note shall include any pertinent information related to the visit.

Clinical Nurse Specialist (CNS)—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

Clinical Records—those documents maintained on all patients accepted for care by an HHA. The records shall be retained in accordance with existing state laws.

Controlling Ownership or Controlling Interest—an equity or voting interest possessed by a person or entity that:

a. has a direct or indirect equity interest equal to 5 percent or more in the capital, the stock, or the profits of an HHA; or

b. is an officer or director of an HHA which is organized as a corporation; or

c. is a partner in an HHA which is organized as a partnership; or

d. is a member or manager of an HHA which is organized as a limited liability company. The term controlling ownership is synonymous with the terms controlling interest or control interest as defined by the Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS).

Department—the Department of Health (LDH) or any of its sections, bureaus, offices or its contracted designee.

Employed—being assigned the performance of a job or task for compensation, such as wages or a salary. An

employed person may be one who is contracted or one who is hired for a staff position.

Full Licensure—issued only to those agencies that meet all criteria for licensure. It is valid for one year unless specified otherwise (the expiration date is on the license).

Geographic Service Area—area within a 50-statute mile radius of the parent agency.

Governing Body—the person or group of persons who have legal authority for and/or ownership of the corporation of the HHA and responsibility for agency operations. A governing body assumes full legal authority and responsibility for the operation of the agency.

Home Health Agency—a state-owned and operated agency, or a subdivision of such an agency or organization; or a private nonprofit organization; or a proprietary organization which provides skilled home health care and support services to the public. Skilled home health care is provided under the order of an authorized healthcare provider, in the place of residence of the person receiving the care, and includes skilled nursing and at least one of the following services:

a. physical therapy;

b. speech therapy;

c. occupational therapy;

d. medical social services; or

e. home health aide services.

Home Health Agency Premises—the physical site where the HHA maintains staff to perform administrative functions, and maintains its personnel records, or maintains its patient service records, or holds itself out to the public as being a location for receipt of patient referrals. The HHA shall be a separate entity from any other entity, business, or trade. If office space is shared with another healthcare related entity, the HHA shall operate independently, have a clearly defined scope of services, and ensure confidentiality is maintained for the HHA's patients. The HHA may not share office space with a non-healthcare related entity.

Home Health Aide—a person qualified to provide direct patient care in the home under the supervision of a RN or physical therapist to assist the patient with ADLs, in accordance with a written plan of care (POC), and requiring a clinical note for each patient visit.

Home Health Licensure Forms—the collection of appropriate forms for licensure that may be obtained from the department's website. Home health licensure forms shall be completed by all initial applicants before the licensure process can begin.

Jurisdiction—all home health agencies shall be under the jurisdiction of the LDH, which promulgates and enforces the rules governing the operation of such agencies or organizations. However, nothing in this Part shall be construed to prohibit the delivery of personal care, homemaker, respite, and other in-home services by a person or entity not licensed under this Rule unless provided with other home health services.

Licensed Practical Nurse—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications and who works under the supervision of an RN.

Life-threatening—causes or has the potential to cause serious bodily harm or death of an individual.

Misappropriation—taking possession without the permission of the individual who owns the personal belongings or the deliberate misplacement, exploitation or wrongful temporary or permanent use of an individual's belongings or money without the individual's consent.

Neglect—the failure by a caregiver responsible for an individual's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his/her well-being, unless the patient exercises his/her right to refuse the necessary care.

Non-Licensed Person—any person who provides health-related services for compensation directly related to patient care to patients of an HHA and who is not a licensed healthcare provider. A non-licensed person is also any person who provides such services to individuals in their own homes as an employee or contract provider of an HHA.

Non-Operational—the HHA is not open for business operation on designated days and hours as stated on the licensing application and business location signage.

Nurse Practitioner (NP)—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

Physician—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

Physician Assistant (PA)—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

Professional Staff—health care providers who are required to possess current licensure and/or board certification and are authorized to supervise other health professionals as indicated.

Provisional License—a license issued to those agencies that do not meet criteria for full licensure. It is issued by the department and is valid for six months or until the termination date.

Registered Nurse—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

Skilled Care—services provided by an agency for patients who are not medically stable or have not attained a satisfactory level of rehabilitation. These patients require frequent monitoring by licensed professional health care personnel.

Supervision—authoritative procedural guidance by a qualified person who assumes the responsibility for the accomplishment of a function or activity and who provides direction, ongoing monitoring and evaluation of the actual act of accomplishing the function or activity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2239 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1826 (July 2022), repromulgated LR 48:2567 (October 2022).

§9102. Governing Body

A. The governing body shall designate an individual who is responsible for the day-to-day management of the HHA and shall ensure that all services provided are consistent with accepted standards of practice.

B. Responsibilities. The governing body shall:

1. conduct an annual documented review of the policies and procedures, the budget, overall program evaluation, statistical information, complaint resolutions, any projected changes, and emergency preparedness;

2. maintain written minutes of meetings with the signatures of all attendees, dates, and times; and

3. receive written notification of any of the following:

a. the agency's administrator or clinical manager is fired, resigns, or becomes incapacitated to the extent that he/she can no longer perform his/her duties;

b. the agency is surveyed and found to be in violation of the state law, minimum standards, Rules, or regulations of LDH;

c. any other grounds which adversely affect the agency's operation;

4. shall receive and acknowledge the results of any QAPI evaluation; and

5. maintain an organizational chart that delineates lines of authority and responsibility for all home health personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:1827 (July 2022).

§9103. Personnel Qualifications and Responsibilities

A. Administrator. The administrator shall be appointed by and answer directly to the governing body of the agency. The administrator of the agency shall be designated in writing. The administrator shall be administratively responsible and available in person or by telecommunication at all times for all aspects of facility operation. The administrator and the clinical manager or the alternate clinical manager may be the same individual if dually qualified. If an individual is designated as the administrator for more than one agency, then he/she shall designate an alternate who is a full-time, on-site employee of each agency and meets the qualifications for an administrator.

1. Qualifications

a. The administrator shall have three years of management experience in the delivery of health care service and meet one of the following criteria:

i. is a licensed physician; or

ii. is an RN; or

iii. is employed as an administrator on or after January 13, 2018, and is a college graduate with a bachelor's degree; or

iv. is employed as an administrator prior to January 13, 2018, and has had three additional years of documented experience in health care delivery service; or

v. is an administrator who has experience in health service administration with at least one year of supervisory or administrative experience related to home health care or a home health care program.

2. Responsibilities. The administrator shall:

a. be available in person or by telecommunication at all times for all aspects of agency operation;

b. designate in writing an individual, who meets the qualifications for an administrator, to assume the authority and the control of the agency if the administrator is unavailable;

c. direct the operations of the agency;

d. be responsible for compliance with all regulations, laws, policies and procedures applicable to home health and Medicare (when applicable) issues;

e. employ qualified individuals and ensure adequate staff education and evaluations;

f. ensure the accuracy of public information materials and activities;

g. act as liaison between staff, the group of professional personnel, and the governing body;

h. implement an ongoing accurate and effective budgeting and accounting system; and

i. ensure that complaints reported by patients, families, caregivers, authorized healthcare providers, agency staff or public are investigated and addressed in a timely manner.

3. Continuing Education. The administrator shall annually obtain two continuing education hours relative to the administrator's role, which may include, but not be limited to the following topics:

a. Medicare and Medicaid regulations;

b. management practices;

c. labor laws;

d. Occupational Safety and Health Administration rules, laws, etc.;

e. ethics; and

f. quality improvement.

B. Clinical Manager

1. Qualifications. The clinical manager shall be an RN who is currently licensed to practice in the state of Louisiana and has at least three years of experience as an RN. One of these years shall consist of full-time experience in providing direct patient care in a home health setting. The clinical manager shall be a full-time employee of the licensed HHA and shall not work full-time at any other licensed healthcare agency. The clinical manager shall be available at all times during operating hours and additionally as needed.

NOTE: The clinical manager may not work for another licensed healthcare entity when on call or during operating hours of the HHA.

2. Responsibilities. The clinical manager shall:

a. be a full-time employee of only one HHA;

b. supervise all patient care activities to assure compliance with current standards of accepted nursing practice;

c. establish personnel and employment policies to assure that only qualified personnel are hired; employ qualified personnel by verifying licensure and/or certification (as required by law) prior to employment and annually thereafter; and certify and maintain records to support competency of all allied health personnel;

d. develop and maintain agency policy and procedure manuals that establish and support the highest possible quality of patient care, cost controls, quality assurance, and mechanisms for disciplinary action for infractions;

e. supervise employee health program;

f. assure compliance with local, state, and federal laws as well as promote the health and safety of employees, patients and the community with the following non-exclusive methods:

i. resolve problems;

ii. perform complaint investigations;

iii. refer impaired personnel to proper authorities;

iv. provide for orientation and in-service to personnel to promote the health and safety of the patient as well as to familiarize staff with regulatory issues and agency policy and procedures;

v. ensure orientation of health care personnel who provide direct patient care;

vi. ensure timely annual evaluation of health care personnel;

vii. assure regularly scheduled appropriate continuing education for all health professionals and home health aides;

viii. assure that the care provided by the health care personnel promotes the health and safety of the patient; and

ix. assure that agency policies are enforced, including but not limited to checking the direct service worker (DSW)/certified nurse aide (CNA) registry for adverse actions against non-licensed employees in accordance with state laws;

g. be on site or immediately available to be on site and available by telecommunications during normal operating hours. The agency shall designate in writing an RN who shall assume the responsibilities of the clinical manager during his/her absence, i.e., on vacation, ill time, at a workshop, etc.

3. Continuing Education. The clinical manager shall annually obtain two continuing education hours relative to the clinical manager's role, which may include, but not be limited to the following topics:

a. Medicare and Medicaid regulations;

b. management practices;

c. labor laws;

d. Occupational Safety and Health Administration rules, laws, etc.;

e. ethics; and

f. quality improvement.

C. Home Health Aide

1. Qualifications. A home health aide shall meet the following criteria:

a. have current nursing assistant certification and successfully complete the agency's competency evaluation; or

b. have successfully completed a home health aide training program and successfully complete the agency's competency evaluation and meet each of the following:

i. exhibit a sympathetic attitude toward the patient, an ability to provide care to the sick, and the maturity and ability to deal effectively with the demands of the job;

ii. have the ability to read, write, and carry out directions promptly and accurately; and

iii. shall inform all employers when employed with one or more agencies; cooperate and coordinate to assure highest performance of quality when providing services to the patient.

2. Responsibilities. The home health aide:

a. shall obtain and record vital signs during each visit in addition to notifying the primary RN of deviations according to standard practice;

b. may provide assistance with the following ADL's during each visit: mobility, transferring, walking, grooming, bathing, dressing or undressing, eating, or toileting. Some examples of assistance include:

i. helping the patient with a bath, care of the mouth, skin and hair;

ii. helping the patient to the bathroom or in using a bed pan or urinal;

iii. helping the patient to dress and/or undress;

iv. helping the patient in and out of bed, assisting with ambulation;

v. helping the patient with prescribed exercises which the patient and the health aide have been taught by appropriate personnel; and

vi. performing such incidental household services essential to the patient's health care at home that are necessary to prevent or postpone institutionalization;

c. may perform care assigned by an RN if the delegation is in compliance with current standards of nursing practice;

d. may administer over the counter disposable enemas, saline or vinegar douches, and glycerine or Ducolax suppositories if such are included in the patient's POC; and

e. shall complete a clinical note for each visit, which shall be incorporated into record at least on a weekly basis.

3. Restrictions. The home health aide shall not:

a. perform any intravenous procedures, procedures involving insertion of feeding tubes or urinary catheters, the administration of tube feedings, or any other sterile or invasive procedures;

b. administer medications to any patient; and

c. perform any of the following tasks which are not home health aide services:

i. transporting the patient;

ii. general housekeeping duties; or

iii. shopping.

4. Training. An HHA that offers a training program shall, at a minimum, include the following in the training program:

a. communication skills;

b. observation, reporting and documentation of patient status and the care or service furnished;

c. reading and recording temperature, pulse, and respiration;

d. basic infection control procedures;

e. basic elements of body functioning and changes in body function that shall be reported to the patient's RN;

f. maintenance of a clean, safe, and healthy environment of the patient's immediate surroundings;

g. recognizing emergencies and knowledge of emergency procedures;

h. the physical, emotional, and developmental needs of the patient and methods for working with the populations served by the agency, including the need to respect the patient, his/her privacy and his/her property;

i. safe transfer techniques and ambulation;

j. appropriate and safe techniques in personal hygiene and grooming that include:

i. bed bath;

ii. sponge, tub, or shower bath;

iii. sink, tub, or bed shampoo;

iv. nail and skin care;

v. oral hygiene; and

vi. toileting and elimination.

k. normal range of motion and positioning;

l. adequate nutrition and fluid intake;

m. any other task, within state regulations, that the agency may choose to have the home health aide perform.

5. Orientation. The content of the basic orientation provided to home health aides shall include the following:

a. policies and objectives of the agency;

b. duties and responsibilities of a home health aide;

c. the role of the home health aide as a member of the health care team;

d. ethics and confidentiality;

e. record keeping;

f. information on the process of aging and behavior of the aged;

g. information on the emotional problems accompanying illness; and

h. principles and practices of maintaining a clean, healthy and safe environment.

6. Assignment. The home health aide is assigned to a patient by an RN in accordance with the POC. Specific written instructions for patient care are prepared by an RN or therapist as appropriate. All personal care services are described to the patient, in writing, by the RN in charge of that patient.

7. Supervision. An RN or licensed therapist shall provide direct supervision to the home health aide as follows.

a. An RN shall supervise and evaluate the home health aide's ability to perform assigned duties, relate to the patient, and work effectively as a member of the health care team.

b. Periodic on-site supervision with the home health aide present shall be established as part of the agency's policies and procedures.

c. If the patient is receiving a skilled service (nursing, physical therapy, occupational therapy, or speech language pathology), the supervisory visits shall be made to the patient's residence at least once every two weeks (not to exceed 14 days) by the RN or appropriate therapist to assess relationships and determine whether goals are being met.

d. If the patient is not receiving skilled services, an RN shall make a supervisory visit to the patient's residence at least once every 60 days. In order to ensure that the aide is properly caring for the patient, the supervisory visit shall occur while the home health aide is providing patient care.

e. Documentation of supervision shall include the aide-patient relationships, services provided, and instructions and comments given as well as other requirements of the clinical note.

f. Annual performance review for each aide shall be documented in the individual's personnel record.

8. In-service. The agency shall offer a minimum of 12 hours of appropriate in-service training to each home health aide every calendar year. The in-service may be furnished while the aide is providing service to the patient, but shall be documented.

a. These in-service sessions should include, but are not limited to:

i. care of the body;

ii. communication;

iii. infection control;

iv. safety and documentation.

b. In-service training may be prorated for employees who only worked a portion of the year; however, part-time employees who work throughout the year shall attend 12 hours of in-service training.

c. Documentation should include the outline and length of the in-service training.

D. Licensed Practical Nurse

1. Qualifications. A licensed practical nurse (LPN) shall:

a. be currently licensed by the Louisiana State Board of Practical Nurse Examiners with no restrictions;

b. have worked at least one year as an LPN prior to being employed by an HHA; and

c. inform all employers when employed with one or more agencies and cooperate and coordinate to assure highest performance of quality when providing services to the patient.

2. Responsibilities. The LPN shall:

a. perform skilled nursing services under the supervision of an RN in accordance with the laws governing the practice of practical nursing;

b. observe and report the patient’s response to treatment and any changes in the patient’s condition to the authorized healthcare provider and the supervising RN;

c. administer prescribed medications and treatments as permitted by the laws governing the practice of practical nursing;

d. prepare clinical and/or progress notes and incorporate them into the clinical record at least weekly;

e. perform wound care as ordered in accordance with the POC; and

f. perform routine venipuncture (phlebotomy) if written documentation of competency is in personnel record. Competency shall be evaluated by an RN even if LPN has completed a certification course.

3. Restrictions. The LPN shall not:

a. access any intravenous appliance for any reason;

b. perform supervisory visit for a home health aide;

c. develop and/or alter the POC;

d. make initial assessment visit;

e. prepare the recertification;

f. make aide assignments; or

g. function as a supervisor of the nursing practice of any RN.

E. Medical Social Services

1. Qualifications. A medical social worker shall:

a. be currently licensed by the Louisiana Board of Certified Social Work Examiners; or

b. have a master’s degree from a school of social work accredited by the Council on Social Work Education in accordance with the requirements of the Louisiana State Board of Social Work Examiners.

2. Responsibilities. The medical social worker shall:

a. assist the authorized healthcare provider and other members of the health care team in understanding significant social and emotional factors related to the patient’s health problems;

b. assess the social and emotional factors having an impact on the patient's health status, and assist in the formulation of the POC;

c. provide services within the scope of practice, as defined by state law, in accordance with the POC and in coordination with other members of the health care team;

d. prepare clinical and/or progress notes and incorporate them into the clinical record at least weekly;

e. participate in discharge planning and in-service programs related to the needs of the patient; acts as a consultant to other members of the health care team; and

f. prepare a written assessment and summary of services provided when medical social work services are discontinued, including an assessment of the patient’s current status that shall be retained in the patient’s clinical record, and a copy forwarded to the attending authorized healthcare provider within five business days.

3. Restrictions. An unlicensed medical social worker may not contract directly with the HHA for clinical services, consultation, supervision or educational services.

F. Nutritional Guidance Services

1. Qualifications. If an agency provides or arranges for nutritional guidance, the staff member or consultant shall be a professional dietitian who meets the qualification standards of the Commission on Dietetic Registration of the American Dietetic Association.

2. Responsibilities. The dietitian shall:

a. document each visit made to the patient and incorporate notes into the clinical record on a weekly basis;

b. prepare initial nutritional dietary assessment;

c. communicate with the clinical manager, the nurse supervisor and/or the primary nurse assigned to the patient regarding the need for a continuation of services for each patient;

d. evaluate compliance with authorized healthcare provider ordered therapeutic diet and makes recommendations as needed;

e. evaluate patient's socio-economic factors to develop recommendations concerning food purchasing, preparation and storage;

f. train those persons who are responsible for purchasing and storing food;

g. evaluate food preparation methods to ensure that nutritive value is conserved in addition to flavor, texture and temperature principles being adhered to in meeting the individual patient's needs;

h. participate in all related case conferences with agency staff. Minutes of case conferences are retained in patient's clinical record;

i. prepare a written discharge summary and ensure that a copy is retained in patient's clinical record and a copy is forwarded to the attending authorized healthcare provider within five business days;

j. assess and evaluate the food and nutritional needs of the patient in accordance with the plan of treatment and the recommended daily dietary allowances established by the Food and Nutrition Board, National Academy of Sciences-National Research Council;

k. participate in discharge planning and in-service training programs related to the needs of the patient and acts as a consultant to the other members of the health care team; and

l. ensure that a current diet manual (within five years of publication) is readily available to agency staff where applicable.

G. Occupational Therapist

1. Qualifications. An occupational therapist shall be currently licensed by the LSBME.

2. Responsibilities. The occupational therapist shall:

a. assist the authorized healthcare provider in evaluating the patient's functional status and occupational therapy needs, and assist in the development of the POC;

b. provide services within the scope of practice as defined by the state laws governing the practice of occupational therapy, in accordance with the POC, and in coordination with other members of the health care team;

c. observe and report the patient's response to treatment and any changes in his/her condition to the authorized healthcare provider and the supervising RN;

d. instruct and inform participating members of the health care team, the patient, and the family/caregivers regarding the POC, functional limitations and progress towards goals;

e. prepare clinical and/or progress notes for each visit and incorporate them into the clinical record at least weekly;

f. when occupational therapy services are discontinued, prepare a written discharge summary of services provided, including an assessment of patient's current status, for retention in the patient's clinical record, and forward a copy to the attending authorized healthcare provider within five business days; and

g. provide supervision of the occupational therapy assistant (OTA) as follows:

i. be readily available to the OTA by telecommunications;

ii. assess the competency and experience of the OTA;

iii. establish the type, degree and frequency of supervision that is required for an OTA in a home health setting; and

iv. conduct a face-to-face patient care conference with each OTA once every two weeks, or once every four to six treatment sessions, to review progress and modification of treatment programs for all patients.

H. Occupational Therapy Assistant

1. Qualifications. The OTA shall:

a. be currently licensed by the Louisiana State Board of Medical Examiners to assist in the practice of occupational therapy under the supervision of a licensed registered occupational therapist; and

b. have, at a minimum, two years' experience as a licensed OTA before starting a home health caseload.

I. Physical Therapist

1. Qualifications. The physical therapist shall be currently licensed by the Louisiana State Board of Physical Therapy Examiners.

2. Responsibilities. The physical therapist shall:

a. assist the authorized healthcare provider in evaluating the patient's functional status and physical therapy needs, and assist in the development of the POC;

b. provide services within the scope of practice as defined by the state laws governing the practice of physical

therapy, in accordance with the POC, and in coordination with other members of the health care team;

c. observe and report the patient's reaction to treatment and any changes in his/her condition to the authorized healthcare provider and the supervising RN;

d. instruct and inform participating members of the health care team, the patient, and the family/caregivers regarding the POC, functional limitations and progress towards goals;

e. prepare clinical and/or progress notes for each visit and incorporate them into the clinical record at least weekly;

f. when physical therapy services are discontinued, prepare a written discharge summary and ensure that a copy is retained in the patient's clinical record and a copy is forwarded to the attending authorized health care provider;

g. may supervise home health aides in lieu of an RN if physical therapy is the only skilled service being provided;

h. provide supervision to a physical therapy assistant (PTA) as follows:

i. be readily accessible by telecommunications;

ii. evaluate and establish a written treatment plan on the patient prior to implementation of any treatment program;

iii. treat and reassess the patient on at least every sixth visit, but not less than once per month;

iv. conduct a face-to-face patient care conference every two weeks with each PTA to review progress and modification of treatment programs for all patients; and

v. assess the final treatment rendered to the patient at discharge and include in the discharge summary.

J. Physical Therapy Assistant

1. Qualifications. The PTA shall be currently licensed by the Louisiana State Board of Physical Therapy Examiners and be supervised by a licensed physical therapist. The PTA shall have, at a minimum, one year of experience as a licensed PTA before assuming responsibility for a home health caseload.

2. Restrictions. The PTA's duties shall not include interpretation and implementation of referrals or prescriptions, performance evaluations, or the determination or major modifications of treatment programs.

K. Registered Nurse

1. Qualifications. The RN shall be currently licensed by the LSBN without restrictions and have, at a minimum, one year of clinical experience as an RN. This requirement may be waived for an RN with one year's clinical experience as an LPN.

a. Special Qualifications. In addition to the above qualifications, an RN shall have one of the following credentials in order to provide psychiatric nursing services. Work experience shall have been obtained within the last five years. If experience is not within the five-year time period, then documentation shall be provided to support either psychiatric retraining, classes, or CEUs to update psychiatric knowledge:

i. a master's degree in psychiatric or mental health nursing; or

ii. a bachelor's degree in nursing and one year of work experience in an active treatment unit in a psychiatric or mental health facility or outpatient mental health clinic; or

iii. a diploma or associate degree and two years of work experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic.

2. Responsibilities. The RN shall:

a. provide or supervise skilled nursing services in accordance with authorized healthcare provider orders;

b. assess and regularly re-evaluate the nursing needs of the patient;

c. develop, initiate, implement, and update the POC as needed or at least every 60 days, or as needed;

d. provide specialized nursing services, which may include treatments and diagnostic and preventive procedures;

e. initiate preventive and rehabilitative nursing procedures as appropriate for the patient's care and safety;

f. coordinate services and inform the authorized healthcare provider and other personnel of changes in the patient's condition and needs;

g. teach, supervise and counsel the patient, family members and other members of the health care team regarding the nursing care needs and other related problems of the patient at home;

h. prepare clinical and/or progress notes and incorporate them into the clinical record at least weekly;

i. observe and report the patient's response to treatment and any changes in his/her condition to the authorized healthcare provider and supervising RN;

j. conduct on-site supervisory evaluations at least every six months of each licensed practical nurse while he/she is providing care and document such supervision in the LPN's personnel file;

k. conduct on-site supervision of patient care provided by the home health aide; and

l. function as patient advocate in all medical decisions affecting the patient.

3. Restrictions. An RN applicant may not work in the home health setting as an RN.

L. Speech Pathology Services

1. Qualifications. The speech pathologist shall be currently licensed by the Louisiana Board of Examiners of Speech Pathology and Audiology.

2. Responsibilities. The speech pathologist shall:

a. assist the authorized healthcare provider and other members of the health care team in evaluating the patient's speech or language needs and formulating the POC;

b. provide service within the scope of practice as defined by the state law governing the practice of speech pathology, in accordance with the POC and in coordination with other members of the health care team;

c. observe and report the patient's response to treatment and any changes in the patient's condition to the authorized healthcare provider and supervising RN;

d. instruct and inform participating members of the health care team, the patient, and the family/caregivers regarding the POC, functional limitations and progress towards goals;

e. prepare clinical and or progress notes for each visit and incorporate them into the clinical record at least weekly; and

f. prepare a written summary of the services provided when speech therapy services are discontinued, including an assessment of the patient's current status which shall be retained in the patient's clinical record and a copy forwarded to the authorized healthcare provider within five business days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2240 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1828 (July 2022).

§9105. State Licensure

A. Initial Licensure

1. The LDH is the only licensing authority for home health agencies in the state of Louisiana. To initiate the review process for licensure as an HHA, the applicant shall submit the following:

a. a completed home health application form;

b. the required fee for licensure by corporate check, certified check or money order or in other manner as determined by the department. This fee is non-refundable;

c. documentation of a line of credit from a licensed lending agency for at least $75,000 as proof of adequate finances to sustain an agency for at least six months;

d. proof of general and professional liability insurance as well as worker's compensation insurance. The general and professional liability coverage shall be for at least $300,000. The agency shall maintain these insurance requirements at all times, and be able to provide proof of insurance upon request as follows:

i. proof of general liability insurance of at least $300,000 per occurrence;

ii. proof of worker's compensation insurance as required by state law;

iii. proof of professional liability insurance of at least $100,000 per occurrence/$300,000 per annual aggregate, or proof of self-insurance of at least $100,000, along with proof of enrollment as a qualified health care provider with the Louisiana Patient's Compensation Fund (PCF):

(a). if the HHA is self-insured and is not enrolled in the PCF, professional liability limits shall be $1 million per occurrence/$3 million per annual aggregate.

NOTE: The LDH-Health Standards Section (HSS) shall specifically be identified as the certificate holder on any policies and any certificates of insurance issued as proof of insurance by the insurer or producer (agent);

e. résumés and documentation of qualifications for administrator and clinical manager. Additional information may not be submitted after the original resumé is submitted for review, except for changes in the designated positions or with approval of the HSS;

f. proof of criminal background investigations on the owners and administrative personnel. If the agency is a corporation, proof of criminal background investigations on all directors and officers shall also be submitted;

g. written documentation of any financial or familial relationship with any other entity providing home health care services in the state;

h. proof of citizenship or a valid green card for all administrative personnel, officers, directors, and owners;

i. any other forms for initial licensure as required by the HSS; and

j. the "doing business as" (DBA) name of the agency shall not be the same or similar to another licensed HHA registered with the Secretary of State.

2. An application shall not be reviewed until payment of application fee has been received. All requirements of the application process shall be completed by the applicant within 90 days of the date of the initial submission of the home health license application. Upon approval of the application by LDH, the applicant shall agree to become fully operational and prepared for initial survey within 90 days. Any application not completed within 90 days after the initial submission shall be closed.

3. The applicant shall be notified in writing when the application process is completed and the application is approved. The applicant shall receive instructions regarding requesting an initial licensing survey.

4. Approved applicants shall be fully operational, in compliance with all licensing standards and providing care to only two patients at the time of the initial survey.

B. Types of Licenses. The LDH shall have the authority to issue the three types of licenses described below:

1. Full License—issued to those agencies which have achieved substantial compliance with the Minimum Standards.

2. Provisional License—may be issued to those existing agencies that do not meet criteria for full licensure.

Such licenses may be issued to any agency by the department when the agency:

a. receives more than five violations of the minimum standards in a one-year period;

b. receives more than three valid complaints in a one-year period;

c. has placed a patient at risk according to a documented incident;

d. fails to correct deficiencies within 60 days of being cited;

e. fails to submit assessed fees after notification by the department;

f. has an owner, administrator, officer, director or clinical manager who has pled guilty or nolo contendere to a felony, or been convicted of a felony as documented by a certified copy of the record of the court of conviction. If the applicant is a firm or corporation, a provisional license may also be issued when any of the members, officers, or the person designated to manage or supervise the agency has been convicted of a felony; or

g. fails to notify the department in writing within 30 days of the occurrence of a change in any of the following:

i. controlling ownership;

ii. administrator;

iii. clinical manager or alternate;

iv. address/telephone number, either parent or branch;

v. hours of operation; and

vi. after-hours contact procedures.

C. Licensure Renewal

1. Full License

a. A full license shall be for a term of one year and shall expire on the date shown on the license unless it is renewed.

b. It is the responsibility of the agency to ensure that a renewal application and appropriate fees are submitted to the Department at least 30 days prior to the expiration of the existing license.

2. Provisional License

a. A provisional license shall be valid for six months or until its expiration date.

b. Any agency issued a provisional license shall pay an additional amount equal to the annual fee for each follow-up survey. Fees shall be paid to the department prior to the survey being performed and shall be non-refundable.

D. Display of License. The agency's current license shall be displayed in a conspicuous place in the agency at all times.

E. Survey Process

1. Initial. An on-site survey shall be conducted to assure compliance with the minimum standards. The request for initial licensing survey shall be accepted after the applicant has been notified in writing by the department that the application process is completed and the applicant is approved for an initial survey. This survey shall be unannounced and the agency shall have only one opportunity to be in compliance with the minimum standards. If the initial survey finds that the agency is not in substantial compliance with the minimum standards, then the agency shall transfer all patients and close.

2. Renewal. An unannounced, on-site visit may be conducted to assure compliance with the minimum standards as determined by the department. This survey may be conducted in conjunction with a survey for Medicare recertification or other reasons.

3. Follow-up. An unannounced survey may be conducted following annual re-licensing, complaint, or previous follow-up survey when the agency is not in substantial compliance with the minimum standards.

4. Complaint Investigation. The LDH has the authority to conduct investigations regarding home health agencies. A complaint investigation may be conducted during an unannounced on-site visit, by administrative review, or by telephone, as appropriate.

5. Violations of Minimum Standards. If the agency is found to be in violation of the minimum standards during any survey, a statement of deficiencies listing those violations shall be issued to the agency. The agency shall respond to these violations with an acceptable plan of correction, which shall be submitted to the department. The plan of correction shall be received by the department within 10 days of receipt of the statement of deficiencies by the agency. A follow-up survey may be conducted to assure that the agency has achieved substantial compliance with the minimum standards. If the follow-up survey reveals that the agency is still not in substantial compliance with the minimum standards, then a provisional license may be issued or a revocation action may be initiated in accordance with R.S.40:2116.32 and R.S. 40:2116.36.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2245 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1833 (July 2022).

§9107. Fees

A. Licensing Fee. A licensing fee, in the amount determined by LDH, is required to be submitted with the initial application. The department shall not consider an application as complete without the required licensing fee.

B. Renewal Fee. A license renewal fee is required to be submitted annually to the department prior to the expiration of the license.

C. Change of Ownership Fee. A fee equal to the amount of licensing fee is to be paid to the department by the new owner when a CHOW occurs.

D. Change of Ownership Fee. A fee equal to the amount of licensing fee is to be paid to the department by the new owner when a CHOW occurs.

E. Branch Fee. A fee shall be paid when a new branch office is established. The branch fee shall be submitted annually with the license renewal fee.

F. Provisional License Fee. Any agency issued a provisional license shall pay an additional amount equal to the annual fee for each follow-up survey. Fees shall be paid to the department prior to the survey being performed and shall be non-refundable.

NOTE: All fees submitted to the department shall be in the form of a certified check, company check, or money order or in other manner as determined by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2246 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1834 (July 2022).

§9109. Changes

A. Notice of Changes. The department shall be notified in writing by mail/e-mail or by facsimile no later than five days prior to the occurrence of any of the following changes:

1. geographic address of the parent or branch office (change fee required);

2. name of the agency (change fee required);

3. mailing address (if different from geographic address);

4. telephone number or FAX number of the parent or branch office

5. hours of operation;

6. 24-hour contact procedures;

7. administrator or clinical manager;

8. controlling ownership; and

9. closure of the agency or a branch;

B. Change of Ownership. The department shall be notified in writing of a CHOW or change of controlling interest.

1. A CHOW packet is required to be submitted with required fees.

2. When a change in controlling interest occurs, written documentation and disclosure of the change shall be submitted.

3. The purchaser of the agency shall meet all criteria for an initial application for licensure. (See §9105, State Licensure.)

C. Voluntary Termination of License. If at any time the agency ceases to operate, the agency shall meet the requirements of §9110.

D. Relocation of an Agency. The department shall be notified in writing of any relocation of an agency. An agency may only relocate within a 50-mile radius of the location where the agency was originally licensed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2246 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1834 (July 2022).

§9110. Cessation of Business

A. Except as provided in §9116 and §9117 of these licensing regulations, a license shall be immediately null and void if an HHA becomes non-operational.

B. A cessation of business is deemed to be effective the date on which the HHA ceases offering or providing services to the community and/or is considered non-operational in accordance with the requirements in §9115.B.1-3.c.

C. Upon the cessation of business, the HHA shall immediately return the original license to the department.

D. Cessation of business is deemed to be voluntary action on the part of the agency. The HHA does not have a right to appeal a cessation of business.

E. Prior to the effective date of the closure or cessation of business, the HHA shall:

1. give 30 days' advance written notice to:

a. each patient or patient's legal representative, if applicable;

b. each patient's authorized healthcare provider; and

c. Health Standards Section.

2. provide for a safe and orderly discharge and transition of all of the HHA's patients.

F. In addition to the advance notice, the HHA shall submit a written plan for the disposition of patient related records for approval by the department. The plan shall include the following:

1. the effective date of the closure;

2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed agency's patient related records;

3. the name and contact information for the appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the patient or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction;

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing agency, at least 15 days prior to the effective date of closure.

G. If an HHA fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning an HHA for a period of two years.

H. Once any HHA has ceased doing business, the agency shall not provide services until the agency has obtained a new initial HHA license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:1834 (July 2022).

§9111. Denial, Revocation or Denial of License Renewal

A. Denial of Licensure Applications. If an agency's license is revoked or denied renewal, no other HHA license application shall be accepted from that agency for approval by the department for two years from the date of the revocation or denial of renewal of the license.

B. Grounds for Denial or Revocation of License. The LDH may deny an application for a license, refuse to renew a license or revoke a license in accordance with R.S. 40:2116.36 and 40:2116.37.

C. Grounds for Immediate Denial or Revocation. A license shall be immediately denied or revoked if the department determines that the agency either knowingly and willfully or through gross negligence allowed or directed actions which resulted in:

1. cruelty to patients;

2. failure to uphold patient rights resulting in actual or potential harm or injury;

3. failure to protect patients or persons in the community from the harmful actions of the agency employees including, but not limited to coercion, threat, intimidation, solicitation and harassment;

4. failure to notify an appropriate governmental agency of any suspected cases of neglect, criminal activity, or mental or physical abuse which could potentially cause harm to the patient;

5. acceptance of a patient when the agency has insufficient capacity to provide care for that patient;

6. misrepresentation or other fraudulent conduct in any aspect of the conduct of home care business;

7. bribery, harassment, or intimidation of any person designed to cause that person to use the services of any particular HHA;

8. pleading guilty or nolo contendere to a felony, or being convicted of a felony by an owner, administrator, officer, director, or clinical manager as documented by a certified copy of the record of the court of conviction. If the applicant is a firm or corporation, a license may also be immediately denied or revoked when any of its members, officers, or the person designated to manage or supervise the home care has been convicted of a felony. For purposes of this Paragraph, conviction of a felony means and includes:

a. conviction of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services program since the inception of those programs;

b. conviction of a felony relating to violence, abuse, and/or negligent of a person; or

c. conviction of a felony related to the misappropriation of property belonging to another person.

D. Additional Grounds for Denial or Revocation. A license may be denied, revoked or not renewed for failure to correct any violation of law and regulation for which a provisional license may have been issued under R.S. 40:2116.31, et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2247 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1835 (July 2022).

§9113. Informal Dispute Resolution Process, Notice and Appeal Procedure

A. Informal Dispute Resolution Process. An agency has one opportunity to question citations of deficient practice through an informal dispute resolution process. To request an informal dispute resolution discussion, the agency shall submit a written request specifying the deficient practice(s) that are being disputed and why the agency is questioning the deficient practice(s). The request shall be made within 10 calendar days of the date of the agency's receipt of the notice of the deficient practice(s). Reconsideration shall be made solely on the survey report, statement of violations and all documentation the agency submits to the department at the time of its request for reconsideration. Correction of a violation shall not be a basis for reconsideration. Since this is an informal dispute resolution discussion, it is not necessary for the agency's attorney to be present. However, if the agency wishes to include their attorney in the informal dispute resolution discussion, the agency shall indicate this in their written request. The informal dispute resolution process is not in lieu of the appeals process.

B. Notice. Notice of reasons for denial of renewal or revocation of a license shall be given in accordance with the current Louisiana Revised Statutes.

C. Administrative Appeal Process. When an administrative appeal is requested in a timely manner, the Division of Administrative Law (DAL) shall provide an administrative hearing in accordance with the provisions of the Louisiana Administrative Procedure Act (APA) and the current Louisiana Revised Statutes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2247 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1835 (July 2022).

§9115. Agency Operations

A. Hours of Operation. An agency shall be required to have regular posted business hours and be fully operational at least eight hours a day, five days a week between 7 a.m. and 6 p.m. Patient care services shall be made available as needed 24 hours a day, seven days a week.

B. Operational Requirements

1. An HHA shall:

a. be open for the business of providing home health care services;

b. post its hours of operation and emergency contact procedures in a prominent and easily accessible manner;

c. have an RN immediately available by telecommunications at all times;

d. respond to patient care needs and authorized healthcare provider orders in a timely manner;

e. be able to accept referrals at all times;

f. have at least two patients at all times;

g. have adequate staff to provide for patient care needs according to accepted standards of practice;

h. have policies and procedures specific to the agency which address staff responsibilities and qualifications; agency operations; patient care standards; problem and complaint resolution; purpose and goals of operation; and regulatory and compliance subjects;

i. have policies and procedures that are written, current, and annually reviewed by appropriate personnel;

j. accept medical orders only from an authorized healthcare provider or authorized healthcare provider representative (e.g., hospital discharge planner);

k. use only factual information in advertising;

l. have an emergency preparedness plan (which conforms to the Louisiana Model Home Health Emergency Preparedness Plan) designed to manage the consequences of natural disasters or other emergencies that disrupt the HHA's ability to provide home health services;

m. limit the geographic service area of the agency to a 50-mile radius of the parent agency;

n. act as the patient advocate in medical decisions affecting the patient;

o. protect the patient from unsafe clinical practices;

p. ensure that staff is competent in the treatments and procedures provided to patients prior to the treatments or procedures being provided;

q. operate within the laws and regulations of all local, federal and state agencies which have authority over the operations of such businesses;

r. notify the department of any change of address, services added or ceased, and change of all key employees in accordance with §9109;

s. maintain general and professional liability insurance and workers' compensation insurance in accordance with the requirements of §9105.

2. An HHA may:

a. participate as educators in public health fairs and may provide free non-invasive services, such as blood pressure screenings; and

b. advertise its services and provide truthful and accurate informational material to the public in so doing.

3. An HAA shall not:

a. harass, bribe, coerce, or intimidate any patient to change agencies or to select an agency;

b. allow, permit, or encourage any employee or volunteer representing the agency to harass, bribe, coerce, or mistreat any patient in any manner or form; and

c. advertise untruthfully regarding the services provided, professional credentials of any employee, accreditation awards, or other such information that misleads and misinforms the public.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2248 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1835 (July 2022).

§9116 Inactivation of License Due to a Declared Disaster or Emergency

A. An HHA licensed in a parish which is the subject of an executive order or proclamation of emergency or disaster issued in accordance with R.S.29:724 or R.S.29:766, may seek to inactivate its license for a period not to exceed one year, provided that the following conditions are met:

1. the licensed agency shall submit written notification to the HSS within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the agency has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

b. the licensed agency intends to resume operation as an HHA in the same service area;

c. includes an attestation that the emergency or disaster is the sole causal factor in the interruption of the provision of services;

d. includes an attestation that all patients have been properly discharged or transferred to another provider; and

e. provides a list of each patient and where that patient is discharged or transferred to;

2. the licensed agency resumes operating as an HHA in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766;

3. the licensed HHA continues to pay all fees and costs due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties; and

4. the licensed HHA continues to submit required documentation and information to the department.

B. Upon receiving a completed written request to inactivate an HHA license, the department shall issue a notice of inactivation of license to the HHA.

C. Upon completion of repairs, renovation, rebuilding or replacement, an HHA which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met.

1. The HHA shall submit a written license reinstatement request to the licensing agency of the department 60 days prior to the anticipated date of reopening.

a. The license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing survey.

b. The license reinstatement request shall include a completed licensing application with appropriate licensing fees.

2. The agency resumes operating as an HHA in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766.

D. Upon receiving a completed written request to reinstate an HHA license, the department shall conduct a licensing survey. If the HHA meets the requirements for licensure and the requirements under this Section, the department shall issue a notice of reinstatement of the HHA license.

E. No CHOW in the HHA shall occur until such HHA has completed repairs, renovations, rebuilding or replacement construction, and the HHA has reinstated its license and resumed operation as an HHA.

F. The provisions of this Section shall not apply to an HHA which has voluntarily surrendered its license and ceased operation.

G. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the HHA license and any applicable facility need review approval for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:1836 (July 2022).

§9117. Inactivation of License Due to a Non-Declared Disaster or Emergency

A. A licensed HHA in an area or areas which have been affected by a non-declared emergency or disaster may seek to inactivate its license, provided that the following conditions are met:

1. The licensed HHA shall submit written notification to the HSS within 30 days of the date of the non-declared emergency or disaster stating that:

a. the HHA has experienced an interruption in the provisions of services as a result of events that are due to a non-declared emergency or disaster;

b. the licensed HHA intends to resume operation as a HHA in the same service area;

c. the licensed HAA attests that the emergency or disaster is the sole causal factor in the interruption of the provision of services; and

d. the licensed HHA's initial request to inactivate does not exceed one year for the completion of repairs, renovations, rebuilding or replacement of the facility.

NOTE: Pursuant to these provisions, an extension of the 30-day deadline for initiation of request may be granted at the discretion of the department.

2. the licensed HHA continues to pay all fees and costs due and owed to the department including, but not limited to annual licensing fees and outstanding civil monetary penalties and/or civil fines; and

3. the licensed HHA continues to submit required documentation and information to the department, including but not limited to cost reports.

B. Upon receiving a completed written request to temporarily inactivate an HHA, the department shall issue a notice of inactivation of its license to the HHA.

C. Upon the agency's receipt of the department's approval of request to inactivate the HHA's license, the HHA shall have 90 days to submit plans for the repairs, renovations, rebuilding, or replacement of the HHA.

D. The licensed HHA shall resume operating as an HHA in the same service area within one year.

EXCEPTION: If the agency requires an extension of this timeframe due to circumstances beyond the agency's control, the department may consider an extended time period to complete construction or repairs. Such written request for extension shall show agency's active efforts to complete construction or repairs and the reasons for request for extension of agency's inactive license. Any approval for extension is at the sole discretion of the department.

E. Upon completion of repairs, renovations, rebuilding or replacement of the agency, an HHA which has received a notice of inactivation of its license from the department shall

be allowed to reinstate its license upon the following conditions being met:

1. the HHA shall submit a written license reinstatement request to the agency of the department;

2. the license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing survey; and

3. the license reinstatement request shall include a completed licensing application with appropriate licensing fees.

F. Upon receiving a completed written request to reinstate an HHA license, the department may conduct a licensing survey. The department may issue a notice of reinstatement if the agency has met the requirements for licensure including the requirements of this Subsection.

G. No CHOW in the HHA shall occur until such HHA has completed repairs, renovations, rebuilding or replacement construction and has resumed operation as an HHA.

H. The provisions of this Subsection shall not apply to an HHA which has voluntarily surrendered its license and ceased operation.

I. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the home health agency license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2248 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1836 (July 2022).

§9118. Operation of Branch Offices [Formally §9117]

A. Branch Office Approval. No branch office may be opened without written approval from the department. In order for a branch office to be approved, the parent agency shall have full licensure for at least one year. Branch office approval shall be renewed at the time of renewal of the parent agency's license if the parent agency meets the requirements for licensure.

B. Identification. The branch shall be held out to the public as a branch or division of the parent agency, so that the public shall be aware of the identity of the agency operating the branch. Reference to the name of the parent agency shall be contained in any written documents, signs, or other promotional materials relating to the branch.

C. Personnel Records. Original personnel files shall not be maintained at the branch office.

D. Survey. A branch office is subject to survey by the department at any time to determine compliance with the minimum standards which apply to HHAs.

E. Operational Requirements. A branch office shall:

1. serve a part of the geographic service area approved for the parent agency;

2. offer all home health services provided by the parent agency;

3. retain all original clinical records for its patients. Duplicate records need not be maintained at the parent agency, but shall be made available to federal/state surveyors during any review upon request; and

4. make personnel policies available to all HHA employees, including employees of the branch office

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:1837 (July 2022).

§9119. Personnel Policies and Records

A. Personnel Policies. Each HHA shall develop and implement personnel policies. The policies shall be reviewed on an annual basis and shall specify agency requirements regarding the following:

1. hours of work;

2. an organizational chart down to the patient care level;

3. job description and realistic performance expectations for each category of personnel;

4. an annual employee health screening in accordance with current local, federal, and state laws;

5. an outline of the planned orientation to be provided to each employee, including the length of the orientation;

6. annual personnel evaluations as well as annual verification of current Louisiana licensure and certification of applicable health professionals;

7. continuing education related to health care activities:

a. health professionals shall attend inservice training as required by respective licensing boards.

b. home health aides shall attend inservice training 12 hours per calendar year;

8. disciplinary actions;

9. grievance proceedings;

10. specifications for employee health/safety;

11. payroll;

12. criminal background investigations (history check), if applicable; and

13. a process for checking the direct service worker registry and the Louisiana certified nurse aide registry upon hiring an employee, and every six months thereafter, to ensure that non-licensed personnel do not have a finding placed against him/her of abuse, neglect, or misappropriation of funds of an individual. If there is such a finding on the DSW and/or CNA registry, the applicant shall not be

employed, nor shall a current employee have continued employment with the HHA.

B. Personnel Records. Original personnel files shall be maintained either at the parent agency or integrated with the human resources department of a hospital, agency home office or the parent corporation of the agency. Personnel records shall be made available to surveyors on request. There shall be a personnel record on file for each employee and contract staff member including, but not limited to, the following information:

1. name, address and telephone number;

2. job application/résumé;

3. the results of an annual employee health screening in accordance with current local, federal, and state laws;

4. current license or certification verification, if applicable;

5. current job description, including duties to be performed;

6. documentation of orientation;

7. current contract, if applicable;

8. annual personnel evaluations;

9. documentation of continuing education;

10. criminal background investigation (history check), if applicable; and

11. registry checks, if applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2248 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1837 (July 2022).

§9120. Home Health Agency Responsibilities

A. Prior to hiring any non-licensed person, the home health agency HHA shall:

1. ensure that the individual is at least 18 years of age;

2. document that the individual is able to read, write and compare the English language; and

3. access the DSW/CNA registry to determine if there is a finding that a prospective hire, or currently employed or contracted non-licensed person, has been determined to have committed exploitation, extortion, abuse or neglect of an individual being supported, or misappropriated the individual's property or funds.

4. Access to the registry shall be limited to an inquiry for a specific individual.

B. The HHA shall have a written policy/process to check the DSW/CNA registry on the department's designated database at least every six months to determine if any currently employed or contracted non-licensed person has been placed on the registry with a finding that he/she has been determined to have committed abuse or neglect of an individual being supported or misappropriated the patient's property or funds or committed exploitation or extortion of a patient.

1. The HHA shall follow the agency's process in demonstration of compliance with this procedure.

2. If there is such a finding on the registry, the employee shall not have continued employment as a non-licensed person with the HHA.

NOTE: The DSW/CNA registry is maintained on the department's designated database which may also contain other exclusionary information on a non-licensed person. The HHA's responsibility to access the database shall also be conducted in accordance with other departmental Rules and regulations, as applicable.

C. Criminal History. In accordance with R.S. 40:1203.1-5 et seq., the HHA shall have a written policy and process to request in writing a security check and the criminal history of an employee, either contracted or directly employed, conducted by the Louisiana State Police or authorized agency, upon offer of employment or contract.

1. The HHA may make an offer of temporary employment to a non-licensed person pending the results of the criminal history and security check on the person. In such instances, the HHA shall provide to the Louisiana State Police, or authorized agency, the name and relevant information relating to the person within 72 hours after the date the person accepts temporary employment.

2. The security check shall consist of the use of personal identifiers, such as name, social security number, date of birth, and driver's license number, to search the national sex offender public registry. The HHA shall obtain from the Louisiana State Police or the authorized agency the results of the security check to verify if an applicant is listed in the national sex offender public registry.

3. Any home health aide offered temporary employment prior to the receipt of the results of the required criminal history and security check shall be under the direct supervision of a permanent employee or shall be in the presence of a member of the immediate family of the patient or of a caregiver designated by the immediate family of the patient.

a. For purposes of this Paragraph, member of the immediate family means a child, parent, grandparent, sibling, uncle, aunt, nephew, or niece of the patient related by blood, marriage, or adoption.

D. The provisions of this Section shall apply to non-licensed persons who are compensated, either by direct employment or through contract, regardless of the setting.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:1838 (July 2022).

§9121. Emergency Preparedness

A. The HAA shall have an emergency preparedness plan which conforms to the current Office of Emergency Preparedness model plan and is designed to manage the

consequences of natural disasters or other emergencies that disrupt the HHA's ability to provide care and treatment or threaten the lives or safety of its patients. The HHA is responsible for obtaining a copy of the current Home Health Emergency Preparedness Model Plan from the Louisiana Office of Emergency Preparedness.

B. At a minimum, the agency shall have a written plan that describes:

1. the evacuation procedures for agency patients who require community assistance as well as for those with available caregivers to another location;

2. the delivery of essential care and services to agency patients, whether they are in a shelter or other locations;

3. the provisions for the management of staff, including distribution and assignment of responsibilities and functions;

4. a plan for coordinating transportation services required for evacuating agency patients to another location; and

5. assurance that the agency shall notify the patient's family or caregiver, if patient is evacuated to another location.

C. The HHA's plan shall be activated at least annually, either in response to an emergency or in a planned drill. The HHA's performance during the activation of the plan shall be evaluated and documented. The plan shall be revised if the agency's performance during an actual emergency or a planned drill indicates that it is necessary.

D. Any updates or revisions to the plan shall be submitted to the parish Office of Emergency Preparedness for review. The parish Office of Emergency Preparedness shall review the HHA's plan by utilizing community wide resources.

E. As a result of an evacuation order issued by the parish Office of Emergency Preparedness (OEP), it may be necessary for an HHA to temporarily relocate outside of its licensed geographic service area. In such a case, the agency may request a waiver to operate outside of its licensed location for a time period not to exceed 90 days in order to provide needed services to its patients and/or other evacuees of the affected areas. The agency shall provide documentation as required by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2249 (December 2001), LR 32:846 (May 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1838 (July 2022).

§9123. Patient Care Standards

A. Admission Criteria. The HHA shall follow written policies in making decisions regarding the acceptance of patients for care. Decisions shall be based upon medical and social information provided by the patient's attending authorized healthcare provider, and the patient and/or the family as well as the agency resources available to meet the needs of potential patients. The HHA shall accept patients for care without regard to age, color, creed, sex, national origin, or handicap. Patients shall be admitted to an agency based on the following written criteria:

1. the ability of the agency and its resources to provide services on a timely basis and available within 24 hours unless specified otherwise by authorized healthcare provider's orders and in accordance with the needs of the patients;

2. the willingness of the patient and caregiver to participate in the POC;

3. the patient's medical, nursing or social needs can be adequately met in his/her residence; and

4. all other criteria required by any applicable payor source(s).

B. Admission Procedure. Patients are to be admitted only upon the order of the patient's authorized healthcare provider. The patient shall have the right to choose an authorized healthcare provider and an HHA without interference. Admission procedures are as follows:

1. an initial visit shall be made by an RN or an appropriate therapist who shall perform the assessment and instruct the patient regarding home care services. This visit shall be made available to an individual in need within 24 hours of referral unless otherwise ordered by an authorized healthcare provider;

2. an initial POC shall be completed by an RN or an appropriate therapist and incorporated into the patient's clinical record within seven days from the start of care; and

3. documentation shall be obtained at admission and retained in the clinical record including:

a. the referral for home care and/or authorized healthcare provider's order to assess patient;

b. a history;

c. a physical assessment;

d. a functional assessment, including a listing of all ADL's;

e. current problems, needs, and strengths;

f. prescribed and over-the-counter medications currently used by the patient;

g. services needed, including frequency and duration expected;

h. defined expected outcomes, including estimated date of resolution;

i. ability, availability, and willingness of potential care-givers;

j. barriers to the provision of care;

k. orientation, which includes:

i. advanced directives;

ii. agency services;

iii. patient's rights and responsibilities, including the telephone number for the home health hotline;

iv. agency contact procedures; and

v. conflict resolution;

l. freedom of choice statement signed by patient or patient representative; and

m. other pertinent information.

C. Plan of Care. The POC for each patient shall be individualized to address the patient's problems, goals, and required services.

1. The POC, telephone and/or verbal orders shall be signed by the authorized healthcare provider within a timely manner, not to exceed 60 days; such orders may be accepted by an RN, a qualified therapist or a licensed practical nurse as authorized by state and federal laws and regulations.

2. Agency staff shall administer services and treatments only as ordered by the authorized healthcare provider.

3. A POC for continuation of services shall be completed by an RN or an appropriate therapist and incorporated into the patient's clinical record within seven days from the date of the development of the POC.

D. Review of the Plan of Care. The total POC shall be reviewed by the patient's attending authorized healthcare provider in consultation with the agency's professional personnel at such intervals as required by the severity of the patient's illness, but at least once every two months.

E. Drugs and Biologicals. The agency shall institute procedures that protect the patient from medication errors. Agency policy and procedures shall be established to ensure that agency staff has adequate information regarding the drugs and treatments ordered for the patient.

1. Agency staff shall only administer drugs and treatments as ordered by the authorized healthcare provider.

2. Only medications dispensed, compounded or mixed by a licensed pharmacist and properly labeled with the drug name, dosage, frequency of administration and the name of the prescribing authorized healthcare provider shall be administered.

3. The agency shall provide verbal and written instruction to patient and family as indicated.

F. Coordination of Services. Patient care goals and interventions shall be coordinated in conjunction with providers, patients and/or caregivers to ensure appropriate continuity of care from admission through discharge.

1. All agencies shall provide for nursing services at least eight hours a day, five days a week and be available on emergency basis 24 hours a day, seven days a week. Agencies shall maintain an on-call schedule for RNs.

2. The agency shall maintain a system of communication and integration of services, whether provided directly or under arrangement, that ensures identification of patient needs and barriers to care, the ongoing coordination of all disciplines providing care, and contact with the authorized healthcare provider regarding relevant medical issues.

G. Discharge Policy and Procedures

1. The patient may be discharged from an agency when any of the following occur:

a. the patient care goals of home care have been attained or are no longer attainable;

b. a caregiver has been prepared and is capable of assuming responsibility for care;

c. the patient moves from the geographic service area served by the agency;

d. the patient and/or caregiver refuses or discontinues care;

e. the patient and/or caregiver refuses to cooperate in attaining the objectives of home care;

f. conditions in the home are no longer safe for the patient or agency personnel. The agency shall make every effort to satisfactorily resolve problems before discharging the patient and, if the home is unsafe, make referrals to appropriate protective agencies;

g. the patient's authorized healthcare provider fails to renew orders for the patient;

h. the patient, family, or third-party payor refuses to meet financial obligations to agency;

i. the patient no longer meets the criteria for services established by the payor source;

j. the agency is closing out a particular service or any of its services;

k. 30 days advance written notice has been provided to the patient, or responsible party, when applicable and appropriate; and

l. death of the patient.

2. The agency shall have discharge procedures that include, but are not limited to:

a. notification of the patient's authorized healthcare provider;

b. documentation of discharge planning in the patient's record;

c. documentation of a discharge summary in the patient's record; and

d. forwarding of the discharge summary to the authorized healthcare provider.

3. The following procedures shall be followed in the event of the death of a patient in the home:

a. the proper authorities shall be notified immediately in accordance with state and local ordinances;

b. the HHA parent office shall be notified;

c. the HHA personnel in attendance shall offer whatever assistance they can to the family and others present in the home; and

d. progress notes shall be completed in detail and shall include observations of the patient, any treatment provided, individuals notified, and time of death, if established by the authorized healthcare provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2249 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1839 (July 2022).

§9125. Patient Rights

A. The patient, or representative if appropriate, shall be informed of the patient's rights in receiving home care services in a language and manner the individual understands. The patient has the right to exercise his/her rights as a patient of the HHA. If the patient has been judged incompetent, the family or guardian may exercise the patient's rights. The agency shall protect and promote the exercise of these rights. The patient has the right to:

1. have his or her property and person treated with respect;

2. be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property;

3. make complaints to the HHA regarding treatment or care that is (or fails to be) furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of the HHA;

4. participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to:

a. completion of all assessments;

b. the care to be furnished, based on the comprehensive assessment;

c. establishing and revising the POC;

d. the disciplines that will furnish the care;

e. the frequency of visits;

f. expected outcomes of care, including patient-identified goals, and anticipated risks and benefits;

g. any factors that could impact treatment effectiveness; and

h. any changes in the care to be furnished.

5. receive all services outlined in the POC;

6. have a confidential clinical record;

7. be advised, orally and in writing, of:

a. the extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA;

b. the charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA;

c. the charges the individual may have to pay before care is initiated; and

d. any changes in the information provided in accordance with §9125.A.7 when they occur. The HHA shall advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit.

8. receive proper written notice, in advance of a specific service being furnished, if the HHA believes that the service may be non-covered care, or in advance of the HHA reducing or terminating on-going care;

9. be advised of the state toll-free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local HHAs;

10. be advised of the names, addresses, and telephone numbers of the following federally-funded and state-funded entities that serve the area where the patient resides:

a. agency on aging

b. center for independent living;

c. protection and advocacy agency;

d. aging and disability resource center; and

e. quality improvement organization.

11. be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the HHA or an outside entity;

12. be informed of the right to access auxiliary aids and language services and how to access these service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21: 177 (February 1995), LR 27:2251 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1840 (July 2022).

§9127. Contract Services

A. An agency may contract with other companies or individuals to provide services to a patient. However, the agency is responsible for the management of the patient's care and for all services provided by the contractor or its personnel.

1. Contract Requirements. Whenever services are provided by an outside agency or individual, there shall be a written contract. The contract shall include each of the following items:

a. designation of the services which are being arranged for by contract;

b. specification of the period of time that the contract is to be in effect, if it is for a specified time period;

c. a statement that services provided to the patient are in accordance with a POC established by the patient's authorized healthcare provider in conjunction with the HHA staff and, when appropriate, others involved in the patient's care;

d. a statement that services are being provided within the scope and limitations set forth in the POC, and may not be altered in type, scope, or duration by the contractor;

e. assurance that the contractor meets the same requirements as those specified for HHA personnel such as staff qualifications, functions, evaluations, orientation and in-service training. The agency shall be responsible for assuring the contractor's compliance with the personnel policies required for an HHA during the contractual period;

f. assurance that the contractor completes the clinical record in the same timely manner as required by the staff personnel of the agency;

g. payment of fees and terms; and

h. assurance that reporting requirements are met.

B. Contract Review. The HHA and contractor shall document review of their contract on an annual basis.

C. Coordination of Contract Services. The HHA shall coordinate services with contract personnel to assure continuity of patient care.

NOTE: Administration and one other service shall be provided directly by the agency at all times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2251 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1840 (July 2022).

§9129. Clinical Records

A. Requirements. A clinical record containing past and current findings shall be maintained either electronically or in paper form for every patient who is accepted by the agency for home health service and shall be accessible to authorized agency staff as needed. In addition, the agency shall comply with the following requirements for clinical records.

1. The information contained in the clinical record shall be accurate and immediately available to the patient's authorized healthcare provider and appropriate HHA staff. The record may be maintained electronically.

2. All entries shall be legible, clear, complete, and appropriately authenticated and dated. Authentication shall include signatures or a secured computer entry with the unique identifier of a primary author who has reviewed and approved the entry.

3. The original clinical records of active patients may be kept in the branch office for the convenience of the staff providing services. The records of patients whose services are provided by parent office staff shall be kept in that office.

4. All clinical records shall be safeguarded against loss, destruction and unauthorized use.

5. A signed consent for treatment form shall be obtained from the patient and/or the patient's family and retained in the record.

6. When applicable, a signed release of information form shall be obtained from the patient and/or the patient's family and a copy shall be retained in the record.

7. Records maintained either in paper or electronically shall be made available to LDH staff upon request.

8. Records shall be retained either electronically or in paper form for a period of not less than six years from the date on which the record was established and, if there is an audit or litigation that involves the records, the timeframe may be extended.

9. The agency shall have internal policies that provide for the retention of clinical records even if the agency discontinues operation.

B. Clinical Note. A clinical note shall be legibly written by the person making the visit and incorporated into the clinical record within one week of the visit. A patient care clinical note shall be completed on each visit and shall contain the following, at a minimum:

1. the date of the visit;

2. time of arrival;

3. time of exit;

4. services rendered and/or justification for the visit;

5. signature of the person making the visit;

6. vital signs, according to authorized healthcare provider’s order or accepted standards of practice; and

7. comments when indicated.

NOTE: The patient or a responsible person shall sign the permanent record of visit that is retained by the agency. However, it is not necessary for the patient or a responsible person to sign on the clinical note.

C. Clinical Record Contents. An active clinical record shall contain all of the following documentation:

1. the initial assessment;

2. the current POC signed and dated by the authorized healthcare provider.

3. the current comprehensive assessment;

4. the current clinical notes for at least the past 60 days, including a description of measurable outcomes relative to the goals in the POC that have been achieved;

5. identifying data, including:

a. name;

b. address;

c. date of birth;

d. gender;

e. agency case number; and

f. next of kin;

6. the date that care started;

7. attending authorized healthcare provider data, including:

a. name;

b. address; and

c. telephone number;

8. the diagnoses, including all conditions relevant to the current POC;

9. the types of services rendered, including frequency, duration and the applicable clinical notes;

10. a list of current medications indicating the drug, dosage, frequency, route of administration if other than oral, dates that a drug was initiated and discontinued, drug allergies, dates that non-prescription remedies were initiated and discontinued, side effects and a tracking procedure, and any adverse reactions experienced by the patient;

11. the current medical orders;

12. diet;

13. functional status;

14. rehabilitation potential;

15. the prognosis;

16. durable medical equipment available and/or needed;

17. when applicable, a copy of the transfer form that was forwarded to the appropriate health care facility that shall be assuming responsibility for the patient's care; and

18. the discharge summary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), amended LR 22:1135 (November 1996), LR 27:2252 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1841 (July 2022).

§9131. Quality Assessment and Performance Improvement

A. The HHA shall develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-drive quarterly quality assessment and performance improvement (QAPI) program. The HHA's governing body shall ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes and takes actions that address the HHA's performance across the spectrum of care.

B. The HHA shall maintain documentary evidence of quarterly QAPI activities and be able to demonstrate its operation. The evaluation shall consist of an overall policy and administrative review and a quarterly clinical record review. The evaluation shall assess the extent to which the agency's program is appropriate, adequate, effective, and efficient. The results of the quarterly QAPI evaluation shall be reported to the governing body which is legally responsible for the operation of the agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2253 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1841 (July 2022).

Chapter 92. Direct Service Worker Registry

Subchapter A. General Provisions

§9201. Definitions

Able to Self-Direct the Services—a person's ability to make decisions about his or her own care and actively participate in the planning and directing of that care.

Abuse—

1. the willful infliction of physical or mental injury;

2. causing deterioration by means including, but not limited to:

a. sexual abuse;

b. exploitation; or

c. extortion of funds or other things of value to such an extent that the health, moral or emotional well-being of the individual being supported is endangered; or

3. the willful infliction of injury, unreasonable confinement, intimidation or punishment which results in or which could reasonably be expected to result in physical or mental harm, pain or mental anguish. Lack of awareness or knowledge by the victim of the act which produced or which could have reasonably been expected to produce physical or mental injury or harm shall not be a defense to the charge of abuse.

Activities of Daily Living (ADLs)—the functions or tasks which are performed by an individual in a typical day, either independently or with supervision/assistance. Activities of daily living may include, but are not limited to, bathing, dressing, eating, grooming, walking, transferring and toileting.

Assistance with Activities of Daily Living—such assistance may be the actual performance of the task for the individual,

or may provide hands-on assistance with the performance of the tasks, or may include supervision and prompting to allow the individual to self-perform such tasks.

Board—the Louisiana State Board of Nursing.

Daily Monitoring—activities pursued on a daily basis by a family member, direct service worker and/or other health care providers for the purposes of collecting critical information needed to assure the individual's welfare. Monitoring activities may include, but are not limited to face-to-face home visits with the person receiving assistance or services and/or daily telephone calls with the individual or communication by other electronic means.

DAL—Division of Administrative Law or its successor.

Department—the Louisiana Department of Health (LDH).

Direct Service Worker (DSW)—an unlicensed person who provides personal care or other services and support to persons with disabilities or to the elderly to enhance their well-being, and who is involved in face-to-face direct contact with the person. Functions performed may include, but are not limited to, assistance and training in activities of daily living, personal care services, and job-related supports. Examples of direct service workers employed or contracted in a licensed and/or certified health care setting include, but are not limited to:

1. patient care technicians;
2. hospital aides;
3. unlicensed assistive personnel (UAPs);
4. home health aides;
5. hospice aides;
6. direct care workers;
7. mental health technicians;
8. mental health aides;
9. mental health orderlies;
10. nursing aides or hospital orderlies;
11. nursing assistants;
12. patient care aides; and/or
13. any persons hired as unlicensed direct care staff that meet the provisions of this Chapter.

NOTE: Those persons who are listed on the Certified Nurse Aide Registry and who are employed as certified nurse aides in a licensed and/or certified nursing facility and/or a skilled nursing facility within a hospital are not included under these provisions as a direct service worker.

Direct Service Worker Registry—the negative database, maintained by the department, or its designee, of unlicensed persons who have a finding placed against them of abuse, neglect, misappropriation, exploitation, or extortion while employed as a DSW at a licensed health care facility or entity who are ineligible to be employed, or have continued employment, as a direct service worker.

Disability—a physical or mental impairment which substantially limits one or more of the major life activities of an individual or who has a history of such impairment or who is regarded as having such impairment; having a condition (such as an illness or an injury) that damages or limits a person's physical or mental abilities, either temporarily or on a permanent basis.

Elderly—any adult over 75 years old or individuals over 65 years old who have functional impairments.

Employed—performance of a job or task for compensation, such as wages or a salary. An employed person may be one who is contracted or one who is directly hired for an on staff position.

Employer—an individual or entity that pays an individual wages or a salary for performing a job.

Exploitation—the illegal or improper use or management of the funds, assets or property of an adult with disabilities or who is elderly, or the use of the power-of-attorney or guardianship of an adult with disabilities or who is elderly for one's own profit or advantage.

Extortion—the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation or abuse of legal or official authority.

Finding—allegations of abuse, neglect, misappropriation, exploitation or extortion that are placed against the DSW on the registry by the department for the following reasons:

1. after a final decision by an administrative law judge or a court of law, after all appeal delays afforded by law are exhausted; or
2. failure by the accused to timely request an appeal in accordance with the provisions of this Rule.

Health Care Provider—any health care facility, agency, or entity licensed and/or certified by LDH. Such entities may be referred to in other laws, statutes and regulations as providers, agencies, clinics, residential care units, homes or facilities. Health care providers include, but are not limited to, the following:

1. nursing facilities;
2. hospice providers;
3. hospitals;
4. intermediate care facilities;
5. adult residential care providers;
6. adult day health care centers;
7. home health agencies;
8. behavioral health providers;
9. dialysis units; or
10. home and community based services providers.

Health Standards Section (HSS)—the section of the Department of Health responsible for the licensing and/or certification of health care providers.

Home and Community-Based Services—those services as defined in R.S. 40:2120.2 or a successor statute. For the purposes of this Rule, home and community-based services do not include services provided in day or residential congregate care settings including, but not limited to, the following:

1. nursing facilities;

2. hospice care facilities;

3. hospitals;

4. intermediate care facilities;

5. adult residential care providers;

6. adult day health care centers; or

7. any other 24-hour facility licensed by the department, Department of Education or the Department of Children and Family Services, exclusive of center-based respite facilities.

Major Life Activities—functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

Mental Abuse—emotional or mental abuse may involve any activity that is designed to blame, shame, humiliate, or intimidate an individual and includes, but is not limited to abuse that is facilitated or caused by taking or using photographs or recordings in any manner that would demean or humiliate a client using any type of equipment (e.g., cameras, smart phones, and other electronic devices) and/or keeping or distributing them through multimedia messages or on social media sites.

1. Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the client to experience humiliation, intimidation, fear, shame, agitation, or degradation, regardless of whether the client provided consent and regardless of the client's cognitive status. This may include, but is not limited to:

a. photographs and recordings of clients that contain nudity;

b. sexual and intimate relations;

c. bathing, showering or toileting;

d. providing perineal care, such as after an incontinence episode;

e. agitating a client to solicit a response;

f. derogatory statements directed to the client;

g. showing a body part of the client without the client's face, whether it is the chest, limbs or back;

h. labeling a client's pictures and/or providing comments in a demeaning manner;

i. directing a client to use inappropriate language; and/or

j. showing a client in a compromised position.

Misappropriation—taking possession without the permission of the individual who owns the personal belongings or the deliberate misplacement, exploitation or wrongful temporary or permanent use of an individual's belongings or money without the individual's consent.

Neglect—the failure by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his/her well-being, unless the resident exercises his/her right to refuse the necessary care.

Noncomplex Task—a health-related task with predictable results that can be safely performed according to exact directions with no need to alter the standard procedure.

Person-Specific Training—a set of knowledge, skills, training and abilities that address the client's strengths, restrictions relative to aging, disabilities, health care needs and related factors in order to meet the unique needs of the person receiving care.

Plan of Care—a plan that describes the assistance or services required to be provided to a person receiving home and community-based services, as defined herein. The plan also describes who shall provide the assistance and the frequency and/or duration of the services that shall be provided.

Provider—

1. an entity that furnishes care and services to consumers and has been licensed and/or certified by the department to operate in the state;

2. in the case of an authorized departmental self-directed program, provider shall be the entity or individual as specified by the program employing or contracting the direct service worker.

Registered Nurse—any individual possessing a valid, active and unencumbered Louisiana license to practice nursing as a registered nurse (RN).

Stable and Predictable—a situation in which the person's clinical and behavioral status is determined by a licensed RN to be non-fluctuating and consistent. A stable and predictable condition involves long term health care needs which are recuperative in nature and do not require the regular scheduled presence of a RN or licensed practical nurse (LPN).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2058 (November 2006), amended LR 33:95 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3175 (December 2012), LR 42:893 (June 2016), amended by the Department of Health, Bureau of Health Services Financing, amended LR 45:662 (May 2019).

§9202. Introduction

A. The Department of Health (LDH) shall maintain a registry of individuals for whom specific findings of abuse,

neglect, misappropriation, exploitation or extortion have been substantiated by the department, an administrative law judge, or a court of law.

B. The Direct Service Worker Registry will contain the following items on each individual for whom a finding has been placed:

1. name;

2. address;

3. Social Security number;

4. an accurate summary of finding(s); and

5. information relative to registry status which will be available through procedures established by the Health Standards Section (HSS).

C. Licensed and/or certified health care providers shall access the registry to determine if there is a finding that a prospective hire, or currently employed or contracted DSW, has been determined to have committed exploitation, extortion, abuse or neglect of an individual being supported, or misappropriated the individual's property or funds. If there is such a finding on the registry, the prospective employee shall not be hired as a DSW nor shall a current employee have continued employment as a DSW with the licensed and/or certified health care provider.

1. Access to the registry shall be limited to an inquiry for a specific DSW.

D. All provisions of this Chapter, except Subchapter D, §§9241-9261, Medication Administration and Noncomplex Tasks in Home and Community-Based Settings, applies to any licensed and/or certified health care provider who employs or contracts direct service workers who provide personal care or other services and support to persons with disabilities or to the elderly to enhance their well-being, and who is involved in face-to-face direct contact with the person.

1. Exception. Home and community-based services providers are required to meet all provisions of this Chapter, inclusive of Subchapter D, §§9241-9261, if the HCBS provider employs or contracts direct service workers who perform medication administration and noncomplex medical tasks in the HCBS setting.

E. The provisions of this Chapter shall apply to DSWs who are compensated, either by direct employment or through contract, regardless of the setting, and specifically do not apply to those DSWs listed on the Certified Nurse Aide Registry established under rules promulgated by the LDH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2059 (November 2006), amended LR 33:95 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3176 (December 2012), LR 42:894 (June 2016), amended by the Department of Health, Bureau of Health Services Financing, amended LR 45:663 (May 2019).

Subchapter B. Reserved.

Subchapter C. Provider Participation

§9231. Health Care Provider Responsibilities

A. Prior to hiring any DSW or trainee, the licensed and/or certified health care provider shall:

1. ensure that the individual is at least 18 years of age;

2. document that the individual is able to read, write and comprehend the English language; and

3. access the registry in accordance with the provisions of §9202.C-C.1.

B. The health care provider shall have a written policy/process to check the DSW registry on the department's designated database at least every six months to determine if any currently employed or contracted DSW or trainee has been placed on the registry with a finding that he/she has been determined to have committed abuse or neglect of an individual being supported or misappropriated the individual's property or funds or committed exploitation or extortion of an individual being supported.

1. The provider shall follow the agency's process in demonstration of compliance with this procedure.

2. If there is such a finding on the registry, the employee shall not have continued employment as a DSW with the licensed and/or certified health care provider in accordance with the provisions of §9202.C.

NOTE: The DSW registry is maintained on the department's designated database which may also contain other exclusionary information on a DSW. The provider's responsibility to access the database shall also be conducted in accordance with other departmental rules and regulations, as applicable.

D. Criminal History. In accordance with RS 40:1203.1-5 et seq., the provider shall have a written policy and process to request in writing a security check and the criminal history of an employee, either contracted or directly employed, conducted by the Louisiana State Police or authorized agency, upon offer of employment or contract.

1. An employer may make an offer of temporary employment to a non-licensed person pending the results of the criminal history and security check on the person. In such instances, the employer shall provide to the Louisiana State Police, or authorized agency, the name and relevant information relating to the person within 72 hours after the date the person accepts temporary employment.

2. The security check shall consist of the use of personal identifiers, such as name, social security number, date of birth, and driver's license number, to search the national sex offender public registry. The provider shall obtain from the Louisiana State Police or the authorized agency the results of the security check to verify if an applicant is listed in the national sex offender public registry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health

Services Financing, LR 32:2061 (November 2006), amended LR 33:97 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3176 (December 2012), LR 42:894 (June 2016), amended by the Department of Health, Bureau of Health Services Financing, amended LR 45:663 (May 2019).

Subchapter D. Medication Administration and Noncomplex Tasks in Home and Community-Based Settings

§9241. General Provisions

A. Unless authorized to provide medication administration or non-complex tasks by another state law or regulation, all direct service workers providing medication administration or non-complex tasks shall comply with the provisions of Subchapter D of this Rule.

B. In order to perform any of the authorized procedures specified in this Subchapter, the direct service worker shall not have a finding placed against him/her on the DSW Registry. Any direct service worker who has had a finding placed against him/her on the Direct Service Worker Registry shall not perform any of the authorized procedures specified in this Subchapter.

C. The medication administration and non-complex tasks authorized by this Subchapter may be performed only in home and community-based settings by DSWs who meet the requirements of this Subchapter. The requirements of this Subchapter are in addition to the general training, competency, and provider requirements which generally govern direct service workers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3177 (December 2012).

§9243. General Requirements for the Performance of Medication Administration and Noncomplex Tasks in Home and Community-Based Settings

A. A registered nurse shall authorize and monitor medication administration and noncomplex tasks performed by the direct service workers. In order for the RN to authorize these tasks, the direct service worker shall:

1. be employed or contracted by an agency licensed and/or certified by the HSS or employed as part of an authorized departmental self-directed program; and

2. attend to an individual who:

a. is receiving home and community-based services;

b. is able to self-direct the services or resides in a residence where there is daily monitoring by a family member or other health care provider;

c. has an approved current plan of care; and

d. receives periodic assessment by a RN based on the person's health status and specified within the plan of care; in no case shall the periodic assessment be less than annually. A comprehensive assessment performed for a client in accordance with policies and procedures established by Medicaid or by a LDH program office may serve as the basis of the RN assessment but may not be used in lieu of the RN assessment.

B. A registered nurse may delegate to a licensed practical nurse components of the training and supervision of the DSW. The decision is based upon assessment of the individual task to be performed. The RN shall retain the responsibility and accountability for all acts of delegation and ensuring authorization and competency validation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3177 (December 2012), amended LR 42:895 (June 2016), amended by the Department of Health, Bureau of Health Services Financing, amended LR 45:663 (May 2019).

§9245. Training Requirements for the Performance of Medication Administration and Noncomplex Tasks in Home and Community-Based Settings

A. Person-Specific Training. Direct service workers shall receive person-specific training from a RN who has assessed the health status of the person and who has determined that the direct service worker can competently perform the tasks in a safe, appropriate manner for this person.

1. The RN's determination of competency shall be certified by the RN in writing, and the written certification shall be maintained in the direct service worker's personnel file. The RN's determination of competency shall not be delegated.

2. This training shall be repeated if the RN does not certify that the direct service worker has demonstrated a sufficient level of competency in the subject matter.

3. Based on the nursing assessment and clinical judgment, the RN shall provide additional person-specific training when the person receiving care has a change in health status or physician orders and yet remains in a stable, predictable condition. The RN may make a determination based upon his/her assessment of the worker's competency that training can be safely performed via telephone contact, other means of electronic communication, or face-to-face contact with the worker. Examples include, but are not limited to:

a. changes in physician orders concerning health care tasks to be performed;

b. changes in physician orders regarding routine medications; or

c. new physician orders for short-term use of medication for a minor acute health condition.

B. Medication Administration Training. Direct service workers shall attain proficiency in the fundamentals of medication administration. Direct Service Staff shall receive

16 hours of medication administration training which has been coordinated and approved by an RN and which shall include the following.

1. Medication Administration Core Curriculum:

a. legal aspects of administering medication;

b. roles and responsibilities of medication administration;

c. medical terminology;

d. classification and identification of drugs;

e. measuring medications;

f. effects and side effects;

g. distribution and routes of medication;

h. drug interactions;

i. handling and storage of medicines;

j. six fundamental rights of administering medication:

i. give the right medication;

ii. give the right dose;

iii. give the medication to the right individual;

iv. give the medication by the right route;

v. give the medication at the right time; and

vi. provide the right documentation.

2. Documentation Training. Direct service workers shall attain proficiency in documentation which includes:

a. the contents of chart or record;

b. the importance of record keeping;

c. the rules for charting, including time limits;

d. documenting vital signs, as applicable;

e. documenting the condition of the person receiving care and significant changes; and

f. the name of medication, dose, route and time of administration.

3. Skill Proficiency Training. Direct service workers shall attain proficiency in the following skill areas, either by physical or verbal demonstration to the RN:

a. universal precautions and infection control;

b. vital signs, as applicable:

i. counting pulse;

ii. counting respirations;

iii. taking blood pressure; and

iv. taking oral, rectal, or axillary temperature.

C. A direct service worker who has not completed didactic training and demonstrated competency in accordance with guidelines established and approved by the Department of Health and the Louisiana Board of Nursing shall not be allowed to perform medication administration or any noncomplex tasks covered by this Rule.

D. Any direct service worker currently employed or contracted to perform the procedures authorized by this Chapter shall complete the training required by this Subchapter no later than 12 months after promulgation of this Rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3177 (December 2012), amended LR 42:895 (June 2016), amended by the Department of Health, Bureau of Health Services Financing, amended LR 45:664 (May 2019).

§9247. Annual Competency Evaluation

A. The direct service worker shall undergo an annual competency evaluation performed by a RN to determine whether he/she is competent to perform the authorized person-specific medication administration and noncomplex tasks safely and appropriately.

B. The RN shall use professional judgment in assessing whether or not the tasks are being performed correctly and safely by the DSW.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3178 (December 2012).

§9249. Authorized Medication Administration and Noncomplex Tasks in Home and Community-Based Settings

A. Direct service workers who meet the requirements of this Rule, including training and competency assessment, and who are so authorized may perform medication administration and non-complex tasks authorized by this Subchapter. Such a direct service worker may perform the following tasks for a person who is in stable condition only when the tasks may be performed according to exact directions, there is no need to alter the standard procedure, and the results are predictable:

1. administration of oral and topical medication, ointments, suppositories or a pre-measured dosage unit provided by the manufacturer of an oral inhalant aerosol, as ordered by an authorized prescriber;

a. any medication administered by a direct service worker under these provisions shall be in a container which meets acceptable pharmaceutical standards and is marked with:

i. clear instructions;

ii. the prescriber's name;

iii. the prescription number, if any;

iv. the name of the medication;

v. the dosage;

vi. the route;

vii. the frequency; and

viii. the time to be administered, if applicable;

2. provision of routine hydration, nutrition or medication by way of an established gastro-tube; and

3. other noncomplex tasks as identified by guidelines established and approved by the Department of Health and the Louisiana Board of Nursing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3178 (December 2012), amended by the Department of Health, Bureau of Health Services Financing, amended LR 45:664 (May 2019).

§9251. Direct Service Worker Responsibilities

A. The responsibilities of the direct service worker include, but are not limited to:

1. following the exact instructions of the RN in the performance of all authorized procedures;

2. notifying the employer or the RN when the health status of the person receiving assistance changes so the RN can reassess to determine whether or not the procedures can still be performed by the direct service worker in a safe manner;

3. notifying the employer or the registered nurse when the prescribed procedures or medications or dosages change so additional person-specific training can be conducted by the RN if applicable; and

4. notifying the employer, the RN, and the person receiving assistance or services if a finding has been placed against him/her on the Direct Service Worker Registry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3178 (December 2012).

§9253. Registered Nurse Responsibilities

A. The responsibilities of the registered nurse include, but are not limited to:

1. assuring that during person-specific trainings and required evaluations, the direct service worker performs the authorized medication administration and non-complex tasks according to exact directions making certain there is no need to alter the standard procedures and the results are predictable;

2. assuring no direct service worker is authorized to perform medication administration and noncomplex tasks if the health status of the person receiving services is not stable and predictable;

3. assuring that the direct service worker demonstrates a sufficient level of competency in the subject matter as set forth in training;

4. assisting in the development of the plan of care for the person receiving assistance or services;

5. assisting the person's planning team to determine the frequency needed for RN assessments of the health status of the person receiving assistance or services;

6. at least annually, completing the competency evaluation of the direct service worker; and

7. completing and submitting the required documentation to the licensed and/or certified agency employing or contracting the direct service worker.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3178 (December 2012), amended LR 42:895 (June 2016).

§9255. Employer Responsibilities

A. The responsibilities of the employer employing the direct service worker include, but are not limited to:

1. assuring that only direct service workers authorized under these provisions, or other provisions authorized through state laws or regulations, perform medication administration and noncomplex tasks;

2. assuring that the direct service worker performs the authorized procedures as trained by the RN and written in the plan of care;

3. maintaining all of the required documentation in the agency's permanent files;

4. assuring that the registered nurse assesses the health status of the person receiving assistance at least annually, or if required, more frequently as determined by the assessment of the RN and as specified in the plan of care;

5. assuring that the direct service worker received the required training and annual competency evaluation;

6. assuring that the direct service worker does not have a finding placed against him/her on the DSW Registry;

7. assuring that no direct service worker whose authorization has terminated continues to perform the procedures that had been previously authorized;

8. notifying the RN of any changes in the health status of the person receiving services or any concerns regarding the ability of the direct service worker to continue to perform the authorized procedures safely;

9. cooperating with the Health Standards Section during any monitoring of these provisions including, but not limited to:

a. providing access to required documentation; and

b. providing access to the direct service worker and supervisory staff; and

10. assisting the Health Standards Section with obtaining access to persons receiving assistance and their guardians.

B. The employer shall maintain the following documentation within its permanent files:

1. documentation by the RN to show that the person is able to self-direct the services or resides in a residence where there is daily monitoring by a family member, a direct service worker, or other health care provider;

2. a current plan of care for the person receiving services;

3. copies of the RN assessments of the person's health status;

4. documentation that the direct service worker does not have a finding placed against him/her on the DSW Registry;

5. documentation that the direct service worker has met the training requirements, including the additional person-specific training required when tasks or medications or dosages change, as determined by the RN;

6. documentation that the direct service worker has met the medication administration training requirements, including documentation that the RN conducting the training has assessed the proficiency and determined that the direct service worker exhibits sufficient proficiency to be able to administer medications safely and/or to perform non-complex tasks safely;

7. a statement signed by the RN who conducted the annual competency evaluation specifying when it was conducted and what tasks the direct service worker is authorized to perform; and

8. if applicable, a statement regarding termination of authorization with the date that authorization was terminated and the reason for termination. If the termination is due to a RN assessment of the health status of the person receiving assistance or the competency of the direct service worker, the statement shall be written and signed by the RN.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3179 (December 2012).

§9257. Liability

A. Any registered nurse who has properly trained and documented that a direct service worker is competent to perform the prescribed tasks shall not be liable for any civil damages as a result of any act or omission of the direct service worker.

B. Any physician licensed to practice medicine by the Louisiana State Board of Medical Examiners, whether or not the physician developed the person's plan of care, including but not limited to the prescribed medical regime, who is rendering professional medical care services shall not be liable for any civil damages as a result of any negligent or intentional act or omission of the direct service worker or licensed and/or certified agency.

C. Notwithstanding any other provision of law, licensed and/or certified agencies that employ or contract direct service workers shall be liable for acts or omissions of the direct service worker.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3179 (December 2012), amended LR 42:895 (June 2016).

§9259. Termination of Authorization to Perform Services

A. Authorization for a direct service worker to perform medication administration and noncomplex tasks shall terminate for any of the following reasons.

1. The condition of the person for whom the direct service worker is performing the tasks has become unstable.

2. A registered nurse certifies that the direct service worker can no longer perform the prescribed tasks safely.

3. The direct service worker has a finding placed against him/her on the DSW Registry.

4. The direct service worker failed to comply with any provision of the enabling statute.

5. Additional person-specific training by a RN was not completed after the tasks to be performed or the types of medications to be administered changed.

6. The annual competency evaluation was not completed.

7. The person receiving assistance or their guardian has requested that the direct service worker no longer be authorized to administer or perform the authorized procedures for the person.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3179 (December 2012).

§9261. Violations and Noncompliance

A. The Health Standards Section is responsible for investigation of complaints and noncompliance with these provisions.

B. In accordance with §9259.A.2, authorization for a direct service worker to perform any of the tasks specified in R.S. 37:1032 shall be terminated if the registered nurse certifies that the direct service worker can no longer perform the prescribed tasks safely and the direct service worker shall immediately cease performing such procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3180 (December 2012), amended LR 42:895 (June 2016).

Subchapter E. Violations

§9273. Prohibited Direct Service Worker Conduct

A. The department provides a process for the review and investigation of all allegations of wrong-doing by DSWs. The following constitutes prohibited DSW conduct:

1. verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion on an individual being supported;

2. neglect of an individual being supported; or

3. exploitation, extortion, or misappropriation of the individual's person, property or funds, inclusive of, but not limited to, the following:

a. credit card fraud;

b. theft of a firearm;

c. identity theft;

d. fraudulent acquisition of a credit card; or

e. theft of a vehicle.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2061 (November 2006), amended LR 33:98 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3180 (December 2012), LR 42:895 (June 2016), amended by the Department of Health, Bureau of Health Services Financing, amended LR 45:664 (May 2019).

§9275. Notice of Violation

A. When there are substantiated allegations against the direct service worker, either through oral or written evidence, the department will notify the individual(s) implicated in the investigation of the following:

1. the nature of the violation(s) and the date and time of each occurrence;

2. the department's intent to report these violations to the DSW Registry; and

3. appeal rights/opportunities:

a. the right to request from HSS an informal discussion (informal dispute resolution process); and

b. the right to request from the Division of Administrative Law an administrative hearing (appeal); or

c. the right to bypass the informal dispute resolution process and request appeal with the Division of Administrative Law.

B. The specified timeframe, up to and including permanent status, to cease employment as a DSW in a licensed health care facility will be indicated in the notice letter of placement of the finding against the DSW.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2061 (November 2006), amended LR 33:98 (January 2007), LR 42:895 (June 2016), amended by the Department of Health, Bureau of Health Services Financing, amended LR 45:664 (May 2019).

§9277. Informal Dispute Resolution

A. When a direct service worker feels that he/she has been wrongly accused, the following procedure shall be followed:

1. The direct service worker may request an informal dispute resolution (IDR) within 15 calendar days of the receipt of the department’s notice of violation. The request for an IDR shall be made to the HSS in writing.

2. The IDR is designed:

a. to provide an opportunity for the direct service worker to informally discuss the allegations that make the basis for placement of the finding;

b. for the agency to offer alternatives based on corrections or clarifications, if any; and

c. to evaluate the necessity for seeking an administrative hearing.

3. An IDR session will be arranged within 20 days of receipt of the written request.

4. During the IDR, the direct service worker will be afforded the opportunity to:

a. talk with agency personnel assigned to the IDR;

b. review pertinent documents upon which the alleged violation is based;

c. ask questions;

d. seek clarifications; and

e. provide additional information.

5. Notice of the results of the IDR decision will be forwarded to the DSW in writing. Such written notice will include any further opportunities for appeal, if necessary and/or appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2061 (November 2006), amended LR 33:98 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3180 (December 2012), LR 42:895 (June 2016).

Subchapter F. Administrative Hearings

§9285. General Provisions

A. Within 30 calendar days after receipt of the department's notice of violation or the notice of the results of an informal dispute resolution, the direct service worker may request an administrative hearing.

1. The request for an administrative hearing shall be made in writing to the Division of Administrative Law, or its successor.

2. The request shall contain a statement setting forth the specific allegations which the direct service worker disputes and the reasons for this dispute.

3. Unless a timely and proper request is received by the Division of Administrative Law or its successor, the findings of the department shall be considered a final and binding administrative determination.

a. Notification of the finding of abuse, neglect, exploitation, extortion, and/or misappropriation will then be sent to the DSW registry to be recorded.

B. When an administrative hearing is scheduled, the Division of Administrative Law, or its successor, shall notify the direct service worker, his/her representative and the agency representative in writing.

C. The administrative hearing shall be conducted by an administrative law judge from the Division of Administrative Law, or its successor, as authorized by R.S. 46:107 and according to the Administrative Procedure Act.

D. If there is a final and binding administrative hearing decision to place a finding on the DSW registry against the direct service worker, the department shall place the direct service worker's name and the adverse findings on the DSW registry. The finding(s) may remain on the DSW registry against the DSW for a specified length of time up to and including permanently dependent on the severity and nature of the offense.

1. The specified timeframe, up to and including permanent status, to cease employment as a DSW in a licensed health care facility will be stated in the notice letter of placement of the finding against the DSW.

E. Removal of the DSW's name from the DSW registry.

1. For those DSWs who only have a placement of finding of neglect, HSS will consider removal of the DSW's name from the registry only upon the DSW's written request to the department for reinstatement and in accordance with the following:

a. the employment and personal history of the DSW does not reflect a pattern of abusive behavior or neglect or instances of misappropriation, exploitation or extortion of an individual being supported;

b. the neglect involved in the original finding was a singular occurrence; and

c. a period of no less than one year has passed since the DSW's name was placed on the registry barring employment in a licensed health care facility as a DSW.

3. If the DSW successfully petitions the department to remove the DSW's name from the registry, the DSW will be notified in writing of such determination and date of removal.

4. If the DSW unsuccessfully petitions the department to remove the DSW's name from the registry, the DSW will be notified in writing of the department's decision and their right to an administrative appeal in accordance with §9275.A(3)a-c.

5. There shall be only one opportunity for a DSW to request removal of their name from the DSW registry.

6. There is no opportunity afforded for a DSW to request removal of a finding of abuse, extortion, misappropriation or exploitation placed against them on the registry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2062 (November 2006), amended LR 33:98 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3180 (December 2012), LR 42:896 (June 2016), amended by the Department of Health, Bureau of Health Services Financing, amended LR 45:664 (May 2019).

Chapter 93. Hospitals

Subchapter A. General Provisions

§9301. Purpose

A. The purpose of the hospital laws, rules and regulations is to provide for the development, establishment and enforcement of standards for the care of individuals in hospitals and for the construction, maintenance and operation of hospitals which shall promote safe and adequate treatment of individuals in hospitals.

B. A hospital shall be licensed in accordance with state law, rules and regulations adopted and established by the state agency responsible for the licensing of hospitals.

C. Primarily Engaged

1. Except as provided in §9301.C.2, hospitals shall be *primarily engaged*, as defined by this Rule and determined by the Department of Health, in providing inpatient hospital services to inpatients, by or under the supervision of licensed physicians. Inpatient hospital services are services defined in this licensing rule and are provided to inpatients of the hospital as one of the following:

a. diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or

b. rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

2. Exemptions. The following licensed hospitals are not subject to the primarily engaged provisions and/or requirements of this Chapter:

a. a licensed hospital designated as a psychiatric hospital or a critical access hospital as defined by the Code of Federal Regulations;

b. a licensed hospital designated as a rural hospital as defined by R.S. 40:1189.3; and

c. a licensed hospital currently certified and enrolled as a Medicare/Medicaid certified hospital which has not been determined out of compliance with the federal definition of *primarily engaged*; if a hospital is currently Medicare/Medicaid certified, and has been determined to be currently meeting the federal definition of *primarily engaged*, it shall be exempt from compliance with the

following provisions in this section regarding primarily engaged.

3. In reaching a determination as to whether or not an entity is primarily engaged in providing inpatient hospital services to inpatients of a hospital, the Department of Health will evaluate the total facility operations and consider multiple factors, subject to paragraph C.4 below.

a. Total Facility Operations. In evaluating the total facility operations, the department will review the actual provision of care and services to two or more inpatients, and the effects of that care, to assess whether the care provided meets the needs of individual patients by way of patient outcomes.

b. Multiple Factors. The factors that the department will consider include, but are not limited to:

i. the average daily census (ADC) of the main hospital and/or any off-site campus(es);

ii. the average length of stay (ALOS) of patients at the main hospital and/or any off-site campus(es);

iii. the number of off-site campus outpatient locations operated by the entity;

iv. the number of provider-based emergency departments for the entity;

v. the number of inpatient beds related to the size of the entity and the scope of the services offered;

vi. the volume of outpatient surgical procedures compared to the inpatient surgical procedures (if surgical services are provided);

vii. staffing patterns; and

viii. patterns of ADC by day of the week.

4. Notwithstanding any other provision of this rule, an entity shall not be considered to be primarily engaged in providing inpatient hospital services to inpatients of a hospital if a main hospital or a main hospital's off-site campus(es) has an ADC of less than two, or an average length of stay of less than two. For purposes of determining whether a main hospital and its off-site campus(es) are primarily engaged, the ADC and the average length of stay shall be made independently for each entity.

5. Hospitals are not required to have a specific inpatient bed to outpatient bed ratio in order to meet the definition of primarily engaged.

a. If the hospital has an emergency department (ED), the number of hospital inpatient beds shall be greater than the number of ED beds, with a ratio of not less than 2:1.

D. Except as otherwise provided herein, hospitals shall provide directly or under arrangements the following professional departments, services, facilities and functions which are essential to establish whether a facility is primarily engaged in providing inpatient hospital services:

1. organization and general services:

2. nursing services;

3. pharmaceutical services;

4. radiological services;

5. laboratory services;

6. nutritional and therapeutic dietetic services;

7. medical record services;

8. quality assessment and improvement;

9. physical environment;

10. infection control;

11. respiratory care services.

E. Except as otherwise provided herein, hospitals may provide the following optional services directly or under arrangements:

1. surgical services;

2. anesthesia services;

3. nuclear medicine services;

4. outpatient services;

5. rehabilitation services;

6. psychiatric services;

7. obstetrical and newborn services;

8. pediatric services;

9. emergency services.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2399 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1474 (October 2019), LR 46:1682 (December 2020).

§9303. Definitions

A. The following definitions of selected terminology are used in connection with Chapter 93.

Accredited—the approval by the Joint Commission on Accreditation of Healthcare Organizations, American Osteopathic Association, or Det Norske Veritas.

Administrator—(see Chief Executive Officer).

Anesthesiologist—a physician, dentist, or osteopath physician, who has successfully completed an *approved* residency program in anesthesiology, or who is a diplomat of either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or who was made a Fellow of the American College of Anesthesiology before 1972.

Approved—acceptable to the authority having jurisdiction.

Authority Having Jurisdiction—an organization, office, or individual responsible for approving equipment, an installation, or a procedure.

Average Daily Census (ADC)—calculated by adding the midnight daily census of the main hospital or its off-site campus(es), independent of one another, for each day of the 12-month period and dividing the total number by the number of days in the year. In calculating the ADC for purposes of determining whether an entity meets the requirements of primarily engaged, LDH may utilize a period of between three months and 12 months.

Average Length of Stay (ALOS)—the average of the number of inpatient days a person is in the main hospital or its off-site campus(es). ALOS is calculated by dividing the total inpatient days by the total discharges during a specified period of time, which results in an average number of days in the main hospital or its off-site campus(es) for each person admitted. In calculating ALOS, LDH may utilize a period of between three months and 12 months. For purposes of calculating the ALOS of the main hospital or its off-site campus(es), each facility shall be considered an independent entity.

Certified Nurse Midwife—an advanced practice registered nurse as defined by R.S. 37:913.

Certified Registered Nurse Anesthetist—an advanced practice registered nurse as defined by R.S. 37:913.

Cessation of Business—when a hospital stops providing services to the community.

Chief Executive Officer (CEO)/Administrator—the person responsible for the operation of the hospital commensurate with the authority conferred by the governing body.

Clinical Nurse Specialist—an advanced practice registered nurse as defined by R.S. 37:913.

Crisis Receiving Center—a specialty unit of a hospital that shall receive, examine, triage, refer or treat an individual who is experiencing a behavioral health crisis.

Department—Louisiana Department of Health.

Food Delivery Services—the transportation of the nutritional and therapeutic dietetic services by a food management company that is delivered to the hospital and served to the patients of the hospital.

Food Management Company—an off-site vendor who provides nutritional and therapeutic dietetic services to the hospital through a contractual agreement and that is required to meet the same standards for food and dietetic services as provided by the hospital directly.

Governing Body—the board of trustees, owner or person(s) designated by the owner with ultimate authority and responsibility (both moral and legal) for the management, control, conduct and functioning of the hospital.

Hospital—any institution, place, building, or agency, public or private, whether for profit or not, maintaining and operating facilities, 24 hours a day, seven days a week, having a minimum of 10 licensed beds, having staff and equipment sufficient to meet patient needs, and providing hospital services, care and treatment for injured, disabled or sick persons who are admitted with the expectation that he or she will require hospital care that is expected to span at least two midnights. Except as otherwise noted in these licensing regulations, a hospital shall be primarily engaged in providing inpatient services to inpatients, by or under the supervision of licensed physicians. The term hospital does not include the following:

a. physicians' offices, clinics or programs where patients are not kept as bed patients for 24 hours or more;

b. nursing homes providing intermediate and/or skilled care as defined by and regulated under the provisions of R.S. 40:2009-2009.23;

c. persons, schools, institutions, or organizations engaged in the care and treatment of children with intellectual disabilities and which are required to be licensed by the provisions of the Developmental Disability Law, R.S. 28:451.1 et seq.;

d. hospitalization or care facilities maintained by the state at any of its penal or correctional institutions;

e. hospitalization or care facilities maintained by the federal government or agencies thereof;

f. infirmaries or clinics maintained solely by any college or university exclusively for treatment of faculty, students and employees; or

g. an urgent care clinic.

Note: Free standing emergency departments (or an entity that holds itself out to the public mainly as a free standing emergency department) shall not be licensed as a hospital.

Hospital Record—a compilation of the reports of the various clinical *departments* within a hospital, as well as reports from health care providers, as are customarily catalogued and maintained by the hospital medical records department. *Hospital records* include reports of procedures such as X-rays and electrocardiograms, but they do not include the image or graphic matter produced by such procedures, according to state law.

Immediate and Serious Threat—a crisis situation in which the health and safety of patients is at risk. It is a deficient practice which indicates the operator's inability to furnish safe care and services, although it may not have resulted in actual harm. The threat of probable harm is real and important and could be perceived as something which will result in potentially severe temporary or permanent injury, disability or death.

Inpatient—a person who admitted to a hospital with the status of inpatient for purposes of receiving hospital services with the expectation that he/she will require hospital care expected to span at least two nights and occupy a bed even though it is later determined that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. Persons in hospital observation status are not inpatients.

Inpatient Hospital Services or Inpatient Service—includes, but is not limited to, the following services provided to inpatients of the hospital as either: diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

a. bed and board;

b. 24-hour nursing services and other related services;

c. use of hospital facilities;

d. medical social services;

e. drugs, biologicals, supplies, appliances, and equipment;

f. certain other diagnostic or therapeutic services;

g. medical or surgical services provided by certain interns or residents-in-training; and

h. transportation services, including transport by ambulance.

License Under Suspensive Appeal—a full or provisional license against which the department has taken a licensing action and the hospital has filed an administrative appeal.

Licensed Bed—an adult and/or pediatric bed set up or capable of being set up within 24 hours in a hospital for the use of patients, based upon bedroom criteria expressed in these standards. Labor, delivery, newborn bassinets, emergency and recovery room beds are excluded.

Licensed Independent Practitioner—a person who is *approved* by his board for independent practice and who is *approved* by the medical staff and credentialed and *approved* by the Governing Board.

Licensed Nuclear Medicine Technologist—any person licensed to practice nuclear medicine technology by the Louisiana State Radiologic Technology Board of Examiners.

Licensed Practical Nurse (LPN)—a person licensed to practice practical nursing by the Louisiana State Board of Practical Nurse Examiners and is practicing within his/her scope of practice, training, experience, and competency.

Licensed Radiation Therapy Technologist—any person licensed to practice radiation therapy technology by the Louisiana State Radiologic Technology Board of Examiners.

Licensed Radiographer—any person licensed to practice general radiography by the Louisiana State Radiologic Technology Board of Examiners.

Minor Alteration—repair or replacement of building materials and equipment with materials and equipment of a similar type that does not diminish the level of construction beyond that which existed prior to the alteration. This does not include any alteration to the "functionality" or original design of the construction. (For example, normal maintenance, re-roofing, painting, wallpapering, asbestos removal, and changes to the electrical and mechanical systems.)

Monolithic Ceiling Construction—a continuous membrane ceiling composed of plaster or gypsum wallboard, but not moveable or "lay-in" ceiling tiles.

Neonatal—newborn immediately succeeding birth and continuing through the first 28 days of life.

New Construction—any of the following started after March 1, 1995:

a. new buildings to be used as a hospital;

b. additions to existing buildings to be used as a hospital;

c. conversions of existing buildings or portions thereof for use as a hospital;

d. alterations other than *minor alterations* to an existing hospital;

Nurse Practitioner—an advanced practice registered nurse as defined by R.S. 37:913.

Nurses Call System—a system that audibly transmits calls electronically from its place of origin (the patient's bed) to the place of receipt (the nurses' station).

Nutritional and Therapeutic Dietetic Services—the provision of a nourishing, palatable, well-balanced diet that meets the patient's daily nutritional and special dietary needs in accordance with the licensed practitioner's prescribed plan of care, and taking into consideration the preferences of each patient.

Observation Bed/Unit—outpatient service in which patients are admitted for a period of no longer than 24 hours for observation. After 24 hours, the patient must be admitted, transferred or discharged. This outpatient unit must not provide acute care nursing. A registered nurse must be on site while there are patients in this unit.

Office of the Secretary—office of the person serving as the Secretary of the Department of Health.

Off-Site Campus—all premises on which hospital services (inpatient and/or outpatient) are provided and that are not adjoining to the main hospital buildings or grounds. Each off-site campus of a hospital shall be licensed as a part of the main hospital. An off-site campus shall be located within 50 miles of the main hospital campus.

a. Exception. If a state-owned or operated hospital ceases to do business and surrenders its license, the offsite campus(es) of that hospital which provided outpatient services may be licensed as an off-site campus(es) of another state-owned and/or operated hospital, provided that the off-site campus(es) is located within 100 miles of the main hospital campus of the state-owned and/or operated hospital.

Organ—a human kidney, liver, heart, lung or pancreas.

Primarily Engaged—a hospital is directly providing inpatient hospital services to inpatients, by or under the supervision of licensed physicians. Inpatient hospital services are services defined in this licensing rule and are provided to inpatients of the hospital as one of the following:

a. diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or

b. rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Note: Having the capacity or potential to provide inpatient hospital services is not the equivalent of actually providing such care.

Radiologist—a doctor of medicine or osteopathy who is qualified by education and experience in radiology.

Registered Dietitian—a dietitian who is qualified based on registration by the Commission on Dietetic Registration of the American Dietetic Association and licensing by the Louisiana Board of Examiners in Dietetics and Nutrition.

Registered Nurse—any person licensed to practice nursing by the Louisiana State Board of Nursing.

Unit Definition—a licensed patient room.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2400 (November 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:513 (March 2010), LR 37:3028 (October 2011), LR 38:1413 (June 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1475 (October 2019).

§9305. Licensing Process

A. Procedures for Initial Licensing. The Department of Health and Hospitals is the only authority for hospitals in the state of Louisiana.

1. Any person, organization or corporation desiring to operate a hospital shall make application to the Department of Health and Hospitals (DHH) on forms prescribed by the department. Such forms may be obtained from: Hospital Program Manager, Department of Health and Hospitals, Health Standards Section (HSS), Post Office Box 3767, Baton Rouge, LA 70821.

2. An initial applicant shall as a condition of licensing:

a. submit a completed initial hospital packet and other required documents;

b. submit the required nonrefundable licensing fees by certified check or money order. No application will be reviewed until payment of the application fee. Except for good cause shown, the applicant must complete all requirements of the application process within 90 days of initial submission of the application material. Upon 10 days prior notice, any incomplete or inactive applications shall be closed. A new application will be accepted only when accompanied by a nonrefundable application fee.

3. When the required documentation for licensing is approved and the building is approved for occupancy, a survey of the facility by representatives of HSS shall be conducted at the department's discretion to determine if the facility meets the standards set forth in this Chapter 93.

4. Representatives of the HSS shall discuss the findings of the survey, including any deficiencies found, with representatives of the hospital facility.

5. The hospital shall notify the HSS in writing when the deficiencies, if any, have been corrected. Following review of the hospital's Plan of Correction (POC), HSS may schedule a survey of the facility prior to occupancy.

6. No new hospital facility shall accept patients until the hospital has written approval and/or a license issued by HSS.

7. No licensed bed shall be placed in a room that does not meet all patient room licensing criteria and which has not been previously approved by HSS.

8. The hospital shall accept only that number of inpatients for which it is licensed unless prior written approval has been secured from the department.

B. Issuance of a License

1. The agency shall have authority to issue two licenses as described below:

a. full license-issued only to those hospitals that are in substantial compliance with the rules, the standards governing hospitals and the hospital law. The license shall be issued by the department for a period of not more than 12 months for the premises named in the application, as determined by the department;

b. if a hospital is not in substantial compliance with the rules, the standards governing hospitals and the hospital law, the department may issue a provisional license up to a period of six months if there is no immediate and serious threat to the health and safety of patients.

2. The department also has discretion in denying, suspending or revoking a license where there has been substantial noncompliance with these requirements in accordance with the hospital law. If a license is denied, suspended or revoked, an appeal may be made as outlined in the hospital law (R.S. 40:2110).

a. Suspensive Appeal. A hospital that appeals the action of the department in denying, suspending or revoking the license may file a suspensive appeal from the action of the department.

b. A renewal license shall not be issued, nor will any changes be processed to a hospital's existing license, during the pendency of an administrative suspensive appeal of the department's decision to deny, suspend or revoke a hospital's license for substantial non-compliance. There is no additional administrative remedy to the hospital for the non-renewal of a license.

c. The license for a hospital that is suspensively operating during the pendency of the appeal process shall be considered a license under suspensive appeal.

3. The hospital license is not assignable or transferable and shall be immediately void if a hospital ceases to operate or if its ownership changes.

4. Licenses issued to hospitals with off-site locations shall be inclusive of the licensed off-site beds. In no case may the total number of inpatient beds at the off-site location exceed the number of inpatient beds at the primary campus.

C. Licensing Renewal. Licenses must be renewed at least annually. The renewal packet shall be sent by the Department to the hospital 45 days prior to the expiration of its license. The packet shall contain all forms required for renewal of the license. A hospital seeking renewal of its license shall:

1. complete all forms and return them to the department at least 15 days prior to the expiration date of its current license;

2. submit the annual fees or the amounts so specified by state law. All fees shall be submitted by certified check or money order and are nonrefundable. All state-owned facilities are exempt from fees.

D. Display of License. The current license shall be displayed in a conspicuous place in the hospital at all times.

E. Bed Increases

1. The hospital will notify the department in writing 14 days prior to the bed increase.

2. The hospital will complete the required paperwork and submit the appropriate documents.

3. A fee of $25 plus $5 per licensed unit being added or the amounts so specified by state law in the future shall be submitted to the department. This shall be a certified check or money order.

4. At the discretion of the department, signed and dated attestations to compliance with these standards may be accepted in lieu of an on-site survey.

5. Written approval of the bed increase must be obtained before patients can be admitted to these additions.

6. No licensed bed shall be placed in a room that does not meet all patient room licensing criteria and which has not been previously approved by HSS.

F. Eliminating and/or Relocating Beds

1. The hospital will notify the department in writing 14 days prior to the bed decrease or relocation.

2. The hospital will complete the required paperwork and submit the appropriate documents.

3. A fee of $25 or the amounts so specified by state law in the future shall be submitted to the Department. This remittance shall be a certified check or money order.

4. No licensed bed shall be placed in a room that does not meet all patient room licensing criteria and which has not been previously approved by HSS.

G. Adding or Eliminating Services

1. Prior to the addition or deletion of a service or services, the hospital shall notify the department in writing 45 days prior to implementation, if plan review is required, and 15 days prior to implementation if no plan review is necessary.

2. The department will determine the required documents, if any, to be provided for a new service.

3. No service shall be instituted that does not meet all licensing criteria and which has not been previously approved by the department.

H. Adding Off-Site Campuses

1. Individual licenses shall not be required for separate buildings and services located on the same or adjoining grounds or attached to the main hospital if they are operated as an integrated service of the hospital. An applicant shall as a condition of licensing:

a. submit a completed off-site campus packet and other required documents;

b. submit the required nonrefundable licensing fees by certified check or money order.

2. Except for good cause shown, all incomplete and inactive applications shall be closed 90 days after receipt of the initial off-site campus application. A new application will be accepted only when accompanied by a nonrefundable application fee.

3. At the discretion of the department, signed and dated attestations to the compliance with these standards may be accepted in lieu of an on-site survey.

4. The off-site campus will be issued a license which is a subset of the hospital's main license.

I. Closing Off-Site Campuses. The hospital is to notify the HSS in writing within 14 days of the closure of an off-site campus with the effective date of closure. The original license of the off-site campus is to be returned to HSS.

J. Duplicate and Replacement Licenses. A $5 processing fee or the amount so specified by state law in the future shall be submitted by the hospital for issuing a duplicate facility license with no change.

K. Changes to the License. When changes to the license, such as a name change, address change or bed reduction are requested in writing by the hospital, a fee of $25 or the amounts so specified by state law in the future, shall be submitted.

L. Facility within a Facility

1. If more than one health care provider occupies the same building, premises or physical location, all treatment facilities and administrative offices for each health care provider shall be clearly separated from each other by a clearly delineated and recognizable boundary.

a. Treatment facilities shall include, but not be limited to consumer beds, wings and operating rooms.

b. Administrative offices shall include, but not be limited to record rooms and personnel offices.

c. There shall be clearly identifiable and distinguishable signs.

2. If more than one health care provider occupies the same building, premises or physical location, each such health care provider shall have its own entrance. The separate entrance shall have appropriate signs and shall be clearly identifiable as belonging to a particular health care provider. Nothing prohibits a health care provider occupying the same building, premises or physical location as another health care provider from utilizing the entrance, hallway, stairs, elevators or escalators of another health care provider to provide access to its separate entrance.

3. Staff of the hospital within a hospital shall not be co-mingled with the staff of the host hospital for the delivery of services within any given shift.

4. The provisions and requirements of §9305.L are in addition to and not excluding any other statutes, laws and/or rules that regulate hospitals, as set forth in R.S. 40:2007.

M. Change of Ownership

1. Definition. *Change of Ownership (CHOW*)—the sale or transfer whether by purchase, lease, gift or otherwise of a hospital by a person/corporation of controlling interest that results in a change of ownership or control of 30 percent or greater of either the voting rights or assets of a hospital or that results in the acquiring person/corporation holding a 50 percent or greater interest in the ownership or control of the hospital. Examples of actions which constitute a change of ownership (R.S. 40:2115.11 et seq.).

a. Unincorporated Sole Proprietorship. Transfer of title and property to another party constitutes a change of ownership.

b. Corporation. The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes a change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership.

c. Partnership. In the case of a partnership, the removal, addition or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable state law, constitutes a change of ownership.

d. Leasing. The lease of all or part of a provider facility constitutes a change of ownership of the leased portion.

2. No later than 15 days after the effective date of the CHOW, the prospective owner(s) or provider representative shall submit to the department a completed application for hospital licensing, the bill of sale, and a licensing fee consistent with state law. Hospital licensing is not transferable from one entity or owner(s) to another.

N. Plan Review. A letter to the Department of Health and Hospitals, Division of Engineering and Architectural Services, shall accompany the floor plans with a request for a review of the hospital plans. The letter shall include the types of services offered, number of licensed beds and licensed patient rooms, geographical location, and whether it is a relocation, renovation, and/or new construction. A copy of this letter is to be sent to the Hospital Program Manager.

1. Submission of Plans

a. New Construction. All new construction shall be done in accordance with the specific requirements of the Office of State Fire Marshal and the Department of Health and Hospitals, Division of Engineering and Architectural Services. The requirements cover new construction in hospitals, including submission of preliminary plans and the final work drawings and specifications to each of these agencies. Plans and specifications for new construction shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer and shall include scaled architectural plans stamped by an architect.

b. New Hospitals. No new hospital shall hereafter be licensed without the prior written approval of, and unless in accordance with plans and specifications approved in advance by the DHH, Division of Engineering and Architectural Services and the Office of State Fire Marshal. This includes any change in hospital type (e.g., acute care hospital to psychiatric hospital) or the establishment of a hospital in any healthcare facility or former healthcare facility. The applicant must furnish one complete set of plans and specifications to the Division of Engineering and Architectural Services and one complete set of plans and specifications to the Office of State Fire Marshal, together with fees and other information as required. Plans and specifications shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer and shall include scaled architectural plans stamped by an architect. The review and approval of plans and specifications shall be made in accordance with the publication entitled *Guidelines for Construction and Equipment of Hospital and Medical Facilities*, Current Edition, published by the American Institute of Architects Press and the *Standard Plumbing Code*.

c. Change(s) in Service(s)/Hospital Type. Preliminary plans, final work drawings and specifications shall be submitted prior to any change in hospital type (e.g., acute care hospital to psychiatric hospital). The review and approval of plans and specifications shall be made in accordance with the publication entitled *Guidelines for Construction and Equipment of Hospital and Medical Facilities*, Current Edition, published by the American Institute of Architects Press and the *Standard Plumbing Code*. The applicant must furnish one complete set of plans and specifications to the Department of Health and Hospitals, Division of Engineering and Architectural Services and one complete set of plans and specifications to the Office of State Fire Marshal, together with fees and other information as required.

d. Major Alterations. No major alterations shall be made to existing hospitals without the prior written approval of, and unless in accordance with plans and specifications approved in advance by DHH, Division of Engineering and Architectural Services and the Office of State Fire Marshal. The applicant must furnish one complete set of plans and specifications to the Division of Engineering and Architectural Services and one complete set of plans and

specifications to the Office of State Fire Marshal, together with fees and other information as required. Plans and specifications shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer and shall include scaled architectural plans stamped by an architect. The review and approval of plans and specifications shall be made in accordance with the publication entitled *Guidelines for Construction and Equipment of Hospital and Medical Facilities*, Current Edition, published by the American Institute of Architects Press and the *Standard Plumbing Code*.

2. Approval of Plans

a. Notice of satisfactory review from the Division of Engineering and Architectural Services and the Office of State Fire Marshal constitutes compliance with this requirement if construction begins within 180 days of the date of such notice. This approval shall in no way permit and/or authorize any omission or deviation from the requirements of any restrictions, laws, ordinances, codes or rules of any responsible agency.

b. In the event that submitted materials do not appear to satisfactorily comply with the *Guidelines for Construction and Equipment of Hospital and Medical Facilities*, Current Edition, and the *Standard Plumbing Code*, the Division of Engineering and Architectural Services shall furnish a letter to the party submitting the plans which shall list the particular items in question and request further explanation and/or confirmation of necessary modifications.

3. Waivers

a. The secretary of the department may, within his sole discretion, grant waivers to building and construction guidelines. The facility must submit a waiver request in writing to the Division of Engineering and Architectural Services. The facility shall demonstrate how patient safety and the quality of care offered is not compromised by the waiver. The facility must demonstrate their ability to completely fulfill all other requirements of the service. The Department will make a written determination of the request. Waivers are not transferable in an ownership change and are subject to review or revocation upon any change in circumstances related to the waiver.

b. The secretary, in exercising his discretion, must at a minimum, require the applicant to comply with the edition of the building and construction guidelines which immediately preceded the most current edition of the *Guidelines for Construction and Equipment of Hospital and Medical Facilities.*

O. Fire Protection. All hospitals required to be licensed by the law shall comply with the rules, established fire protection standards and enforcement policies as promulgated by the Office of State Fire Marshal. It shall be the primary responsibility of the Office of State Fire Marshal to determine if applicants are complying with those requirements. No license shall be issued or renewed without the applicant furnishing a certificate from the Office of State Fire Marshal stating that the applicant is complying with their provisions. A provisional license may be issued to the applicant if the Office of State Fire Marshal issues the applicant a conditional certificate.

P. Sanitation and Patient Safety. All hospitals required to be licensed by the law shall comply with the Rules, Sanitary Code and enforcement policies as promulgated by the Office of Public Health. It shall be the primary responsibility of the Office of Public Health to determine if applicants are complying with those requirements. No initial license shall be issued without the applicant furnishing a certificate from the Office of Public Health stating that the applicant is complying with their provisions. A provisional license may be issued to the applicant if the Office of Public Health issues the applicant a conditional certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 16:971 (November 1990), LR 21:177 (February 1995), LR 29:2401 (November 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1413 (June 2012).

§9307. Hospital Closure

A. A cessation of business is deemed to be effective with the date on which the hospital stopped providing services to the community.

1. The hospital must notify the department in writing 30 days prior to the effective date of closure.

2. The hospital shall submit a written plan for the disposition of patient medical records for approval by the department. The plan shall include the following:

a. provisions that comply with state laws on storage, maintenance, access and confidentiality of the closed hospital's patient medical records;

b. an appointed custodian who shall provide physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction;

c. public notice on access in the newspaper, with the largest circulation, in close proximity of the closing hospital, at least 15 days before the effective date of closure;

d. the effective date of closure.

3. The hospital must return the original license to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2404 (November 2003).

§9309. Exceptions

A. Exceptions to these Rules and standards governing hospitals are as follows.

1. If a hospital does not provide an optional service or department, those relating requirements shall not be applicable.

2. If a hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association, the Department shall accept such accreditation in lieu of its annual on-site re-survey. This accreditation will be accepted as evidence of satisfactory compliance with all provisions except those expressed in §9305.O and P.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2404 (November 2003).

§9311. Enforcement

A. The department shall have the authority to interpret and enforce this Chapter 93 as authorized by and in accordance with the Health Care Facilities and Services Enforcement Act, R.S. 40:2199.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2404 (November 2003).

Subchapter B. Hospital Organization and Services

§9317. Governing Body

A. The hospital must have either an effective governing body or individual(s) legally responsible for the conduct of the hospital operations. No contracts/arrangements or other agreements may limit or diminish the responsibility of the governing body.

B. The governing body shall:

1. establish hospital-wide policy;

2. adopt bylaws;

3. appoint a chief executive officer or administrator;

4. maintain quality of care;

5. determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff; and

6. provide an overall institutional plan and budget.

C. The governing body and/or their designee(s) shall develop and approve policies and procedures which define and describe the scope of services offered. They shall be revised as necessary and reviewed at least annually.

D. There shall be an organizational chart that delineates lines of authority and responsibility for all hospital personnel.

E. In addition to requirements stated herein, all licensed hospitals shall comply with applicable local, state, and federal laws and regulations.

F. All off-site campuses operating under the license of a single provider institution (i.e., a hospital with a main facility and off-site campuses) are subject to the control and direction of one common governing body that is responsible for the operational decisions of the entire hospital enterprise.

1. The off-site campus is subject to the bylaws and operating decisions of the provider's governing body.

2. The provider has final responsibility for administrative decisions, final approval for personnel actions and final approval for medical staff appointments at the off-site campus.

3. The off-site campus functions as a department of the provider.

4. The off-site campus is included under the accreditation of the provider, if the provider is accredited by a national accrediting body, and the accrediting body recognizes the off-site campus as part of the provider.

5. The off-site campus director is under the day-to-day supervision of the provider, as evidenced by:

a. patients treated at the off-site campus are considered patients of the provider and shall have full access to all appropriate provider services;

b. the off-site campus is held out to the public as part of the hospital, i.e., patients know they are entering the provider and will be billed accordingly;

c. the off-site campus director or the individual responsible for the day-to-day operations at the site maintains a daily reporting relationship and is accountable to the provider's chief executive officer and reports through that individual to the provider's governing body; and

d. the administrative functions of the off-site campus, (i.e., QI, infection control, dietary, medical records, billing, laundry, housekeeping and purchasing) are integrated with those of the provider, as appropriate to that off-site campus.

6. All components of a single provider institution must comply with applicable state licensing laws.

G. If emergency services are not provided at the hospital, the governing body shall assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment and transfer as appropriate.

1. These policies and procedures shall address at a minimum the following:

a. needed emergency equipment and drugs to include but not limited to, suction, oxygen and ambu bag;

b. competence of staff appropriate to the approved use of emergency equipment and drugs;

c. determining when an emergency exists;

d. rendering life saving first aid;

e. making appropriate referrals to hospitals that are capable of providing needed services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2405 (November 2003).

§9319. Patient Rights and Privacy

A. Every patient shall have the following rights, none of which shall be abridged by the hospital or any of its staff. The hospital administrator shall be responsible for developing and implementing policies to protect patient rights and to respond to questions and grievances pertaining to patient rights. These rights shall include at least the following:

1. every patient, or his/her designated representative, shall whenever possible, be informed of the patient's rights and responsibilities in advance of furnishing or discontinuing patient care;

2. the right to have a family member, chosen representative and/or his or her own physician notified promptly of admission to the hospital;

3. the right to receive treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay or source of payment;

4. the right to be treated with consideration, respect and recognition of their individuality, including the need for privacy in treatment;

5. the right to be informed of the names and functions of all physicians and other health care professionals who are providing direct care to the patient. These people shall identify themselves by introduction and/or by wearing a name tag;

6. the right to receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and the hospital's health care personnel;

7. the right to participate in the development and implementation of his/her plan of care;

8. every patient or his or her representative (as allowed by state law) has the right to make informed decisions regarding his or her care;

9. the patient's rights include being informed of his/her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate;

10. the right to be included in experimental research only when he or she gives informed, written consent to such participation, or when a guardian provides such consent for an incompetent patient in accordance with appropriate laws and regulations. The patient may refuse to participate in experimental research, including the investigations of new drugs and medical devices;

11. the right to be informed if the hospital has authorized other health care and/or educational institutions to participate in the patient's treatment. The patient shall also have a right to know the identity and function of these institutions, and may refuse to allow their participation in his/her treatment;

12. the right to formulate advance directives and have hospital staff and practitioners who provide care in the hospital comply with these directives;

13. the right to be informed by the attending physician and other providers of health care services about any continuing health care requirements after his/her discharge from the hospital. The patient shall also have the right to receive assistance from the physician and appropriate hospital staff in arranging for required follow-up care after discharge;

14. the right to have his/her medical records, including all computerized medical information, kept confidential;

15. the right to access information contained in his/her medical records within a reasonable time frame;

16. the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff;

17. the right to be free from all forms of abuse and harassment;

18. the right to receive care in a safe setting;

19. the right to examine and receive an explanation of the patient's hospital bill regardless of source of payment, and may receive upon request, information relating to financial assistance available through the hospital;

20. the right to be informed in writing about the hospital's policies and procedures for initiation, review and resolution of patient complaints, including the address and telephone number of where complaints may be filed with the department;

21. the right to be informed of his/her responsibility to comply with hospital rules, cooperate in the patient's own treatment, provide a complete and accurate medical history, be respectful of other patients, staff and property, and provide required information regarding payment of charges;

22. except in emergencies, the patient may be transferred to another facility only with a full explanation of the reason for transfer, provisions for continuing care and acceptance by the receiving institution; and

23. the right for each inpatient or, if applicable, the patient's legal guardian, to have one opportunity to designate an uncompensated caregiver following the patient's inpatient admission into a hospital and prior to the patient's discharge, for provision of the patient’s post hospital aftercare at the patient’s residence.

B. The policies on patient rights and responsibilities shall also provide that patients who receive treatment for

mental illness or developmental disability, in addition to the rights listed herein, have the rights provided in the Louisiana Mental Health Law.

C. Hospital staff assigned to provide direct patient care shall be informed of and demonstrate their understanding of the policies on patient rights and responsibilities through orientation and appropriate in service training activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2405 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 43:74 (January 2017).

§9321. Medical Staff

A. The medical staff develops and adopts bylaws and rules for self-governance of professional activity and accountability to the governing body. In addition to physicians and dentists, the medical staff membership shall include licensed independent practitioners as appropriate to adequately meet the needs of the patients served by the hospital. The bylaws and rules shall contain provisions for at least the following.

1. The medical executive committee shall:

a. develop the structure of the medical staff and categories of membership;

b. develop and implement a mechanism to review credentials, at least every two years, and delineate individual privileges;

c. develop and implement a mechanism for determining that all medical staff hold current Louisiana licenses;

d. make recommendations for membership to medical staff, for approval by the governing body, with initial appointments and reappointments not to exceed two years;

e. develop and implement a mechanism for suspension and/or termination of membership to the medical staff;

f. develop and implement a mechanism for fair hearings and appellate reviews for both potential (new) applicants and current members of the medical staff;

g. define the required functions of the medical staff to include:

i. basic medical record review, drug usage review, pharmacy and therapeutics review, infection control and utilization review;

ii. if applicable, surgical and other invasive procedures and blood usage.

2. The medical staff shall provide a mechanism to monitor and evaluate the quality of patient care and the clinical performance of individuals with delineated clinical privileges.

3. Each person admitted to the hospital shall be under the care of a member of the medical staff and shall not be admitted except on the recommendation of a medical staff member.

4. There shall be a member of the medical staff on call at all times for emergency medical care of hospital patients.

5. The medical staff bylaws shall include specifications for orders for the care or treatment of patients which are given to the hospital verbally or transmitted to the hospital electronically, whether by telephone, facsimile transmission or otherwise. Such bylaws may grant the medical staff up to 10 days following the date an order is transmitted verbally or electronically to provide the signature or countersignature for such orders.

6. There shall be a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of all the offsite facilities operating under the license of the hospital.

7. There shall be total integration of the organized medical staff as evidenced by these factors:

a. all medical staff members have privileges at all off-site campuses;

b. all medical staff committees are responsible for their respective areas of responsibility at all off-site campuses of the hospital; and

c. the medical director of the off-site campus (if the off-site campus has a medical director) maintains a day-to-day reporting relationship to the chief medical officer or other similar official of the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2406 (November 2003).

§9323. Administration

A. There shall be a chief executive officer or administrator who is responsible for the operation of the hospital commensurate with the authority conferred by the governing body. All administrative authority shall flow through the chief executive officer who exercises control and surveillance over the administrative activities of the hospital and of all off-site campuses. (This does not preclude the establishment of assistant executive officer positions in any off-site campus as long as the individuals are under the authority of and report to the chief executive officer.)

B. The chief executive officer or administrator of the hospital shall have at least one of the following qualifications:

1. a master's degree and at least three years of full-time experience in progressively responsible management positions in healthcare;

2. a baccalaureate degree and at least five years of full-time experience in progressively responsible management positions in healthcare; or

3. at least 10 years of full-time experience in hospital administration;

a. hospital chief executive officers and administrators employed in Louisiana licensed hospitals at the time the final regulations are adopted and become effective shall be deemed to meet the qualifications as long as the individual holds their current position. If the individual leaves their current position as hospital administrator/chief executive officer, they must meet one of the qualifications above to be re-employed into such a position.

C. There shall be sufficient qualified personnel to properly operate each department of the hospital and provide quality patient care and related services.

D. All new employees, including volunteer workers, prior to or at the time of employment and annually thereafter shall be verified to be free of tuberculosis in a communicable state.

E. The hospital shall have policies and procedures that define how the facility will comply with current regulations regarding healthcare screenings of hospital personnel.

F. The hospital shall have policies and procedures and require all personnel to immediately report any signs or symptoms of a communicable disease or personal illness to their supervisor or administrator as appropriate for possible reassignment or other appropriate action to prevent the disease or illness from spreading to other patients or personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2407 (November 2003).

§9325. Staff Orientation, Training, Education and Evaluation

A. New employees, including contract employees, shall have an orientation program of sufficient scope and duration to inform the individual about his/her responsibilities and how to fulfill them.

B. The orientation program shall include, at least, a review of policies and procedures, job descriptions, competency evaluation and performance expectations prior to the employee performing his/her responsibilities.

C. A staff development program shall be conducted by educationally competent staff and/or consultants and planned based upon annual employee performance appraisals, patient population served by the hospital, information from quality assessment and improvement activities, and/or as determined by facility staff.

D. The hospital shall document appropriate training and orientation prior to reassignment of currently employed staff.

E. Records shall be maintained that indicate the training content, time, names of employees in attendance and the name of the presenter.

F. At least annually the performance of all hospital and contract employees shall be evaluated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2407 (November 2003).

§9327. Emergency Services

A. If emergency services are provided, the emergency services shall be on a 24-hour/seven-day basis in an emergency care area. The hospital shall have at least 1 physician available to the emergency care area within 30 minutes through a medical call roster.

B. Organization

1. Emergency services shall have written policies and procedures which:

a. define and describe the scope of services offered;

b. assures the integration of emergency services with other hospital services, delineating when the hospital shall divert emergency patients, the criteria for the diversion, and the notification of local emergency medical services and hospitals of the diversion; and

c. governs referrals if a clinical specialty service is not provided.

2. The emergency services shall be organized under the direction of a qualified member of the medical staff and a roster of on-call medical staff with service specialties shall be maintained. The services shall be integrated with other departments of the hospital. Ancillary services routinely available at the hospital for inpatients shall be available to patients presenting with emergency medical conditions.

3. The emergency service area shall be supplied with:

a. basic trauma equipment and drugs;

b. suction and oxygen equipment; and

c. cardiopulmonary resuscitation equipment.

C. All licensed hospitals shall comply with current provisions of the Emergency Medical Treatment and Active Labor Act (EMTALA).

D. In accordance with R.S. 40:2113.6, no officer or member of the medical staff of a hospital licensed by the department shall deny emergency services available at the hospital to a person diagnosed by a licensed physician as requiring emergency services because the person is unable to establish his ability to pay for the services or his race, religion or national ancestry. In addition, the person needing the services shall not be subjected to arbitrary, capricious or unreasonable discrimination based on age, sex, physical condition or economic status. Emergency services are services that are usually and customarily available at the hospital and that must be provided immediately to stabilize a medical condition which if not stabilized could reasonably be expected to result in the loss of life, serious permanent

disfigurement or loss or impairment of the function of a bodily member or organ, or for the care of a woman in active labor if the hospital is so equipped. If not so equipped, the hospital must provide treatment to allow the patient to travel to a more appropriate facility without undue risk of serious harm.

E. Personnel

1. The emergency services shall make provisions for physician coverage at all hours and a qualified member of the medical staff shall be designated to supervise emergency services. There shall be a registered nurse and other nursing service personnel qualified in emergency care to meet written emergency procedures and needs anticipated by the hospital. All registered nurses working in emergency services shall be trained in advanced cardiac life support, pediatric trauma and pediatric advanced life support.

2. There are specific assigned duties for emergency care personnel with a clear chain of command.

F. The hospital shall maintain an emergency service register on every individual seeking care. At a minimum, the register shall contain the following data:

1. name, age and sex of patient;

2. date, time and means of arrival;

3. nature of complaint;

4. disposition;

5. time of departure;

6. name of the on-call or treating physician.

G. Trauma Center. In addition to the requirements above, all hospitals that request official designation by the Department as a "Trauma Center" must meet the requirements provided under state law (R.S. 40:2171).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2407 (November 2003).

§9329. After Life Care

A. The hospital shall establish and implement written policies and procedures governing after life care that are reviewed annually and revised as needed. These policies shall delineate the responsibilities of the medical staff, nursing and morgue staff, and shall include procedures for at least the following:

1. identifying the body;

2. safe and proper handling to prevent damage to the body;

3. safeguarding the personal effects of the deceased and release of personal effects to the appropriate individual;

4. handling of toxic chemicals by morgue and housekeeping staff;

5. infection control, including disinfecting of equipment;

6. identifying and handling high-risk and/or infectious bodies in accordance with Centers for Disease Control guidelines and in compliance with Louisiana law;

7. release of the body to the funeral director;

8. release of the body to the coroner upon his request for autopsy;

9. policy for autopsy requests by the physician or family and physician communication to family members regarding the autopsy requests/results;

10. availability of autopsy reports, including reports of microscopic autopsy findings, to physicians and in the medical records within specified time frames; and

11. completion of the autopsy, including microscopic and other procedures, within specified time frames.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2408 (November 2003).

§9331. Organ or Tissue Donation

A. The hospital shall have policies and procedures for organ and tissue donation and requests for donation, approved by the governing body.

B. The hospital shall have an agreement with the designated organ procurement agency for the state and at least one tissue bank and one eye bank, if the organ procurement agency does not include these services.

C. When death is imminent or has occurred in a hospital, to a person determined to be a suitable candidate for organ or tissue donation, based on accepted medical standards, the hospital administrator or designated representative shall request the appropriate person described herein to consent to the gift of any part of the decedent's body as an anatomical gift.

D. No request shall be required when the requesting person has actual notice of contrary intention by the decedent or those persons described in this regulation according to the priority stated therein, or reason to believe that an anatomical gift is contrary to the decedent's religious beliefs.

E. Upon approval of the donation, the OPO or retrieval organization shall be notified and shall cooperate in the procurement of the anatomical gift. When a request is made, the person making the request shall complete a certificate of request for an anatomical gift on a form approved by the Department of Health and Hospitals.

F. The certificate shall include the following:

1. a statement indicating that a request for an anatomical gift was made;

2. the name and affiliation of the person making the request;

3. an indication of whether consent was granted and, if so, what organs and tissues were donated;

4. the name of the person granting or refusing the request, and his relationship to the decedent.

G. A copy of the certificate of request shall be included in the decedent's medical records.

H. The following persons shall be requested to consent to a gift, in the order of priority stated:

1. the spouse if one survives; if not:

a. an adult son or daughter;

b. either parent;

c. an adult brother or sister;

d. the curator or tutor of the decedent at the time of death;

e. any other person authorized or under obligation to dispose of the body.

I. Upon the arrival of a person who is dead or near death, a reasonable search for a document of gift or other information which may indicate that a person is a donor or has refused to make such a donation shall be made by the hospital.

J. If a person at or near death has been admitted or is in transit to a hospital and has been identified as a donor of his body, organs, tissue or any part thereof, the hospital shall immediately notify the named recipient if one is named and known, and if not, the OPO federally approved organ procurement agency.

K. The hospital shall cooperate in the implementation of the anatomical gift, including the removal and release of organs and tissue, or any parts thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2408 (November 2003).

§9333. Specialty Units

A. Specialty units are designated areas in a hospital organized and dedicated to providing a specific, concentrated service to a targeted group of patients.

B. Each unit shall be organized and function as a physically identifiable section with beds that are not commingled with other hospital beds.

C. Each unit shall be staffed with professional and support personnel, appropriate to the scope of services provided. Central support services such as dietary, housekeeping, maintenance, administration and therapeutic services may be shared with the rest of the hospital.

D. There shall be written policies and procedures that define and describe the scope of services offered, including admission criteria. The policies and procedures shall be developed and approved by the governing body. They shall be reviewed at least annually and revised as necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2409 (November 2003).

§9335. Emergency Preparedness

A. The hospital shall have an emergency preparedness plan designed to manage the consequences of natural disasters or other emergencies that disrupt the hospital's ability to provide care and treatment or threatens the lives or safety of the hospital patients and/or the community it serves. The emergency preparedness plan shall be made available, upon request or if mandated to do so, to local, parish, regional and/or state emergency planning organizations, DHH and the Office of the State Fire Marshal.

B. As a minimum, the plan shall include the following:

1. identification of potential hazards that could necessitate an evacuation, including internal and external disasters such as a natural disaster, acts of bio-terrorism, weapons of mass destruction, labor work stoppage, or industrial or nuclear accidents;

2. emergency procedures for evacuation of the hospital;

3. comprehensive measures for receiving and managing care for a large influx of emergency patients. At a minimum, these measures shall include the following roles:

a. the emergency department/services;

b. surgical suite; and

c. patient care units;

4. comprehensive plans for receiving patients who are being relocated from another facility due to a disaster. This plan shall include at least an estimate of the number and type of patients the facility would accommodate;

5. procedures in the case of interruption of utility services in a way that affects the health and safety of patients;

6. identification of the facility and an alternate facility to which evacuated patients would be relocated;

7. the estimated number of patients and staff that would require relocation in the event of an evacuation;

8. the system or procedure to ensure that medical charts accompany patients in the event of a patient evacuation and that supplies, equipment, records and medications would be transported as part of an evacuation; and

9. the roles and responsibilities of staff members in implementing the disaster plan.

C. The hospital shall assure that patients receive nursing care throughout the period of evacuation and while being returned to the original hospital.

D. The hospital shall ensure that evacuated patients, who are not discharged, are returned to the hospital after the emergency is over, unless the patient prefers to remain at the receiving facility or be discharged instead of being returned to the original hospital.

E. Any staff member who is designated as the acting administrator shall be knowledgeable about, and authorized to implement the hospital's plans in the event of an emergency.

F. The hospital administrator shall appoint an individual who shall be responsible for disaster planning for the hospital.

G. While developing the hospital's plan for evacuating patients, the disaster planner shall communicate with the facility or facilities designated to receive relocated patients.

H. The hospital shall conduct at least one evacuation drill each year, either simulated or using selected patients. An actual evacuation shall be considered a drill, if it is documented.

I. The hospital shall conduct at least one drill each year, in which a large influx of emergency patients is simulated. An actual emergency of this type shall be considered a drill, if it is documented.

J. In case of an emergency, the hospital shall have a policy for supply of food and water.

K. The hospital shall have a policy for the provision of emergency sources of critical utilities such as electricity, natural gas, water and fuel during any period in which the normal supply is temporarily disrupted.

L. The hospital's plan shall be developed in coordination with the local/parish office of emergency preparedness, utilizing community wide resources.

M. A hospital may temporarily exceed its licensed capacity in emergency situations, such as natural disasters or disease related emergencies. Such hospitals shall notify DHH in writing of the situation within 24 hours or as soon as practical thereafter.

N. Effective immediately, upon declaration of the secretary and notification to the Louisiana Hospital Association, all hospitals licensed in Louisiana shall file an electronic report with the EMSystem, or a successor operating system during a declared emergency, disaster or public health emergency.

1. The electronic report shall be filed twice daily at 7:30 a.m. and 2:30 p.m. throughout the duration of the disaster or emergency event.

2. The electronic report shall include, but not be limited to the following:

a. status of operation (open, limited or closed);

b. availability of beds by category (medical/surgery, intensive care unit, pediatric, psychiatric, etc.);

c. other resources that may be needed by a hospital in an emergency (blood products, fuel, pharmaceuticals, personnel, etc.);

d. generator status;

e. evacuation status; and

f. shelter in place status.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), amended LR 29:2409 (November 2003), LR 35:245 (February 2009).

§9336. Visitation by Members of the Clergy during a Declared Public Health Emergency

A. For purposes of this Section, a public health emergency (PHE) is a declaration made pursuant to the Louisiana Health Emergency Powers Act, R.S. 29:760 et seq.

B. A licensed hospital shall comply with any federal law, regulation, requirement, order, or guideline that is more restrictive than this Section regarding visitation in hospitals during a declared PHE issued by any federal government agency.

C. For purposes of this Section, clergy shall be defined as follows:

1. a minister, priest, preacher, rabbi, imam, Christian Science practitioner; or

2. other similar functionary of a religious organization; or

3. an individual reasonably believed so to be by the person consulting him.

D. The provisions of this Section regarding visitation by members of the clergy shall apply to all hospitals licensed by the Department of Health, except for a licensed hospital that is designated as a forensic facility.

E. Subject to compliance with the requirements of this Section, each hospital shall allow members of the clergy to visit patients of the hospital during a declared PHE when a patient, or his legal or designated representative, requests a visit with a member of the clergy, subject to the following conditions and requirements:

1. each hospital shall have a written policy and procedure addressing visitation by members of the clergy. A copy of the written policy and procedure shall be available, without cost, to the patient and his legal or designated representative, upon request. The hospital shall provide a link to an electronic copy of the policy and procedure to a member of the clergy, upon request;

2. a hospital’s policy and procedure regarding clergy visitation may adopt reasonable time, place, and manner restrictions, provided that such restrictions are implemented by the hospital, in consultation with appropriate medical personnel, for the purpose of mitigating the possibility of transmission of any infectious agent or infectious disease or

for the purpose of addressing the medical condition or clinical considerations of an individual patient;

3. a hospital's policy and procedure on clergy visitation shall, at a minimum, require the following:

a. that the hospital give special consideration and priority for clergy visitation to patients receiving end-of-life care;

b. that a clergy member will be screened for infectious agents or infectious diseases, utilizing at least the current screening or testing methods and protocols recommended by the Centers for Disease Control and Prevention, as applicable;

c. that a clergy member not be allowed to visit a hospital patient if such clergy member has obvious signs or symptoms of an infectious agent or infectious disease, or if such clergy member tests positive for an infectious agent or infectious disease;

d. that a clergy member not be allowed to visit a hospital patient if the clergy member refuses to comply with the provisions of the hospital's policy and procedure or refuses to comply with the hospital's reasonable time, place, and manner restrictions;

e. that a clergy member be required to wear personal protective equipment as determined appropriate by the hospital, considering the patient's medical condition or clinical considerations. At the hospital's discretion, personal protective equipment may be made available by the hospital to clergy members;

f. that a hospital's policy and procedure include provisions for compliance with a state health officer (SHO) order limiting visitation during a declared PHE; and

g. that a hospital's policy and procedure include provisions for compliance with any federal law, regulations, requirements, orders, or guidelines regarding visitation in hospitals during a declared public health emergency issued by any federal government agency that are more restrictive than this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 29:760.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:1580 (June 2022).

§9337. Smoking Prohibition

A. Smoking shall be prohibited in all areas of the hospital that are heated and air-conditioned. At the discretion of the hospital's governing body, smoking may be permitted in patient rooms, but only:

1. upon the consent of the patient's primary treating physician;

2. with the consent of all patients in the room;

3. in accordance with all standards established by the Joint Commission on Accreditation of Health Care Organizations and all other applicable state and federal laws.

B. Notwithstanding the provisions of the above, the hospital's governing body may designate a well-ventilated area for smokers. Additionally, the governing body of a psychiatric hospital shall establish policies to reasonably accommodate inpatients that smoke.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40: 2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2410 (November 2003).

Subchapter C. Nursing Services

§9343. Organization and Staffing

A. There shall be an organized nursing service that provides 24-hour nursing services. The nursing services shall be under the direction and supervision of a registered nurse licensed to practice in Louisiana, employed full time, 40 hours per week. There shall be a similarly qualified registered nurse to act in the absence of the director of nursing services.

B. Written nursing policies and procedures shall define and describe the patient care provided. There shall be a written procedure to ensure that all licensed nurses providing care in the hospital have a valid and current Louisiana license to practice, prior to providing any care.

C. Nursing services are either furnished or supervised and evaluated by a registered nurse.

D. There shall be at least one registered nurse on duty at all times, assigned to each inpatient nurse's station.

E. A registered nurse shall assign the nursing service staff for each patient in the hospital. Staffing shall be planned in accordance with the nursing needs of the patients, as demonstrated by a specific assessment process, specialized qualifications and competence of the nursing staff available.

F. The nursing staff shall be assigned clinical and/or management responsibilities according to education, experience and assessment of current competency and applicable laws.

G. There shall be at least two hospital employees, one of whom shall be a registered nurse, physically present in the hospital when there is one or more hospitalized patients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2410 (November 2003).

§9345. Delivery of Services

A. A registered nurse shall perform an initial assessment of the patient upon admission and identify problems for each patient. The registered nurse may delegate part(s) of the data collection to other nursing personnel, however the registered nurse shall by signature validate the assessment.

B. A nursing plan of care shall be developed based on identified nursing diagnoses and/or patient care needs and patient care standards, implemented in accordance with the Louisiana Nurse Practice Act, and shall be consistent with the plan of all other health care disciplines.

C. Isolation precautions shall be instituted when appropriate to prevent the spread of communicable diseases within the hospital.

D. All drugs and biologicals shall be administered in accordance with the orders of the practitioner(s) responsible for the patient's care and accepted standards of practice.

E. Blood transfusions and intravenous medications shall be handled, labeled and administered according to state law and approved medical staff and nursing service policies and procedures.

F. Blood and blood products shall be refrigerated separately from food, beverages and laboratory specimens.

G. An appropriate patient consent form shall be signed prior to blood transfusion administration.

H. There shall be policies and procedures for reporting transfusion reactions, adverse drug reactions and errors in the administration of drugs. It shall include immediate oral reporting to the treating physician, a written report to the director of pharmacy and the appropriate hospital committee, and an appropriate entry in the patient's record.

I. Safety policies and procedures shall be established for the care of patients, who because of their condition, are not responsible for their acts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2410 (November 2003).

Subchapter D. Pharmaceutical Services

§9349. General Provisions

A. The hospital shall provide pharmaceutical services that meet the needs of the patients. The hospital shall have a pharmacy directed by a registered pharmacist or a drug storage area supervised by a registered pharmacist. The hospital pharmacy shall have a permit, issued by the Louisiana Board of Pharmacy, allowing the ordering, storage, dispensing and delivering of legend prescription orders. The hospital shall have a current controlled dangerous substance (CDS) license to dispense controlled substances to patients in the hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2411 (November 2003).

§9351. Organization and Staffing

A. Pharmaceutical services shall be directed by a registered pharmacist, licensed to practice in Louisiana on either a full-time, part-time or consulting basis. The director of pharmacy shall be responsible for the procurement, storage, dispensing, supervision and management of all legend and non-legend drugs for the hospital, and shall maintain complete and accurate records of all drug transactions by the pharmacy. There shall be an adequate number of personnel to ensure quality services, including emergency services, 24 hours per day, seven days per week. A pharmacist shall be on call after hours, whenever the pharmacy does not provide 24-hour service.

B. Hospital pharmacies that are not staffed on a 24-hour basis shall have an adequate security detection device.

C. Hospital pharmacies that are not open after regular working hours shall make drugs available for the staff by use of a night drug cabinet. The hospital pharmacy shall maintain an inventory and a list of these drugs, which are approved by the pharmacy director and the appropriate hospital committee.

D. Each off-site campus shall have a site specific controlled dangerous substance (CDS) license if they will be dispensing controlled dangerous substances.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2411 (November 2003).

§9353. Delivery of Services

A. All compounding, packaging, and dispensing of drugs, biologicals, legend and controlled substances shall be accomplished in accordance with Louisiana law and Board of Pharmacy regulations and be performed by or under the direct supervision of a registered pharmacist currently licensed to practice in Louisiana.

B. Dispensing of prescription legend or controlled substance drugs direct to the public or patient by vending machines is prohibited.

C. Current and accurate records shall be maintained on the receipt, distribution and dispensing of all scheduled drugs in such a manner as to facilitate complete accounting for the handling of these controlled substances. An annual inventory, at the same time each year, shall be conducted for all schedule I, II, III, IV and V drugs.

D. A hospital outpatient pharmacy shall maintain all records and inventory separate and apart from that of the inpatient pharmacy, and shall require a separate pharmacy permit to operate.

E. Medications are to be dispensed only upon written orders, electromechanical facsimile, or oral orders from a physician or other legally authorized prescriber, and be taken by a qualified professional.

F. All inpatient drug containers shall be labeled to show at least the patient's full name, room number, the chemical or generic drug's name, strength, quantity and date dispensed unless a unit dose system is utilized. Appropriate accessory and cautionary statements as well as the expiration date shall be included. Floor stock containers shall contain the name and strength of the drug, lot and control number or equivalent, and the expiration date. In unit dose systems, each single unit dose package shall contain the name and strength of the drug, lot and control number or equivalent, and expiration date. Outpatient drug containers shall be labeled to show at least the patient's full name, the prescriber's name, the chemical or generic drug's name, directions, name of the pharmacy and pharmacist, prescription number, and appropriate accessory and cautionary statements. Outdated, mislabeled or otherwise unusable drugs and biologicals shall be separated from useable stock, shall not be available for patient or other use and shall be returned to an authorized agency for credit or destroyed according to current state or federal laws as applicable.

G. Drugs and biologicals not specifically prescribed as to time or number of doses shall automatically be stopped after a reasonable time that is predetermined by the medical staff.

H. The director of pharmacy shall develop and implement a procedure that in the event of a drug recall, all employees involved with the procurement, storage, prescribing, dispensing and administering of recalled drugs in the facility will be notified to return these drugs to the pharmacy for proper disposition.

I. Drug administration errors, adverse drug reactions, and incompatibilities shall be immediately reported to the attending physician, pharmacist and, if appropriate, to the hospital-wide quality assessment and improvement program. An entry shall be made in the patient's record.

J. Abuses and losses of controlled substances shall be reported to the individual responsible for pharmaceutical services, the chief executive officer, the Louisiana Board of Pharmacy, and to the Regional Drug Enforcement Administration (DEA) office, as appropriate.

K. Information relating to drug interactions, drug therapy, side effects, toxicology, dosage, indications for use and routes of administration shall be available to the staff.

L. A formulary system shall be established by the appropriate hospital committee to assure quality pharmaceuticals at reasonable costs, subject only to the restrictions of R.S. 37:1226.1 and LAC 46:LIII.1109.B.6.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2411 (November 2003).

§9355. Environment

A. All drugs and biologicals shall be kept in a locked, well illuminated clean medicine cupboard, closet, cabinet, or room under proper temperature controls and accessible only to individuals authorized to administer or dispense drugs. A list of authorized individuals shall be developed in cooperation with the medical, nursing, administrative and pharmaceutical staff. Compartments appropriately marked shall be provided for the storage of poisons and external use drugs and biologicals, separate from internal and injectable medications.

B. All controlled substances shall be kept separately from other non-controlled substances in a locked cabinet or compartment. Exceptions may be made, if listed in the pharmacy policy and procedures manual and deemed necessary by the director of pharmacy, to allow some abusable nonscheduled drugs to be maintained in the same locked compartment.

C. Drugs and biologicals that require refrigeration shall be stored separately from food, beverages, blood and laboratory specimens.

D. The area within the pharmacy used for the compounding of sterile parenteral preparations shall be separate and apart, shall meet the requirements of the Board of Pharmacy regulation §2541 and be designed and equipped to facilitate controlled aseptic conditions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2412 (November 2003).

Subchapter E. Radiologic Services

§9361. General Provisions

A. The hospital shall maintain, or have available through written contract, radiologic services according to the needs of the patients. If therapeutic services are also provided, they, as well as the diagnostic services, shall meet professionally approved standards for safety and personnel qualifications. The hospital shall comply with periodic inspections by the Department of Environmental Quality, Radiation Protection Division and shall promptly correct any identified hazards.

B. Radiologic services shall be supervised by a qualified radiologist on either a full-time, part-time or consulting basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2412 (November 2003).

§9363. Safety

A. The radiologic services, particularly ionizing radiology, shall adopt written policies and procedures to provide for the safety and health of patients and hospital personnel. The policies and procedures shall be available to all staff in the radiology department. At a minimum, the policies and procedures shall cover the following:

1. shielding for patients, personnel and facilities;

2. storage, use and disposal of radioactive materials;

3. periodic inspection of equipment and handling of identified hazards;

4. periodic checks by exposure meters or test badges on radiation workers;

5. radiologic services provided on the orders of practitioners with clinical privileges or other practitioners authorized by the medical staff and the governing body to order the service; and

6. managing medical emergencies in the radiologic department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2412 (November 2003).

§9365. Personnel

A. A qualified full-time, part-time, or consulting radiologist must supervise the ionizing radiology services and must interpret only those radiologic tests that are determined by the medical staff to require a radiologist's specialized knowledge. The radiologist shall have clinical privileges delineated by the medical staff.

B. Only personnel who are registered and/or licensed in the appropriate radiologic technology modality or category by the Louisiana State Radiologic Technology Board of Examiners and designated as qualified by the medical staff may use the radiologic equipment and administer procedures under the direction of a physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2413 (November 2003).

§9367. Records

A. Radiologic reports shall be signed by the practitioner who reads and interprets them.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 13:246 (April 1987), amended LR 21:177 (February 1995), LR 29:2413 (November 2003).

Subchapter F. Laboratory Services

§9371. Organization and Staffing

A. The hospital shall provide laboratory services or make contractual arrangements with a laboratory certified in accordance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988 to perform services commensurate with patient needs as determined by the medical staff on a 24-hour basis. Laboratory services shall be directed by an individual who meets appropriate qualifications of a director and is credentialed by the medical staff.

B. There shall be sufficient licensed qualified clinical laboratory scientists with documented training and experience to supervise the testing and sufficient numbers of licensed clinical laboratory scientists and supportive technical staff to perform the tests required of the clinical laboratory services.

C. The hospital shall have policies and procedures that address the administration of potentially HIV infectious blood or blood products, and the notification of patient, legal representative or relative within a specified time frame.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2413 (November 2003).

§9373. Equipment and Records

A. There shall be sufficient supplies, equipment and space to perform the required volume of work with optimal accuracy, precision, efficiency, timeliness and safety.

B. The laboratory shall ensure that satisfactory provisions are maintained for an instrumentation preventive maintenance program, an acceptable quality control program and an approved proficiency testing program covering all types of analysis performed by the laboratory services. Records and reports shall be maintained, retrievable, and as appropriate, filed in the patient's medical record.

C. The hospital shall make adequate provisions for the immediate pathological examination of tissue specimens by a pathologist.

D. The hospital shall make provisions for the procurement, storage and transfusion of blood and blood products.

E. The administration of blood shall be monitored to detect any adverse reaction as soon as it occurs. Prompt investigation of the cause of an adverse reaction shall be instituted. The results of all tests performed in the evaluation of an actual or suspected blood transfusion reaction shall be a permanent part of the patient's medical record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2413 (November 2003).

Subchapter G. Nutritional and Therapeutic Dietetic Services

§9377. General Provisions

A. There shall be an organized dietary service that provides nutritional and therapeutic dietetic services to patients. All hospital contracts or arrangements for off-site food preparation shall be with a provider who is licensed by

the department's healthcare division or operating under the authority of the federal government.

B. A hospital may meet the requirements of §9377.A through a contractual agreement with a provider who is licensed by the department's Health Standards Section or through a contract with an outside food management company. If the hospital has a contract with an outside food management company, the following requirements shall be met.

1. The hospital shall provide written notices to the department's Health Standards Section and to the department's Office of Public Health within 10 calendar days of the effective date of the contract.

2. The outside food management company must possess a valid Department of Health, Office of Public Health retail food permit and meet all of the requirements for operating a retail food establishment that serves a highly susceptible population, in accordance with the most current version of the provisions found in Title 51, *Public Health—Sanitary Code*.

3. Either the hospital or the food management company shall employ or contract with a registered dietician who serves the hospital on a full-time, part-time, or consultant basis to ensure that the nutritional needs of the patients are met in accordance with the licensed practitioners' orders and acceptable standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2413 (November 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1413 (June 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1476 (October 2019).

§9379. Organization and Staffing

A. Nutritional and therapeutic dietetic services shall be under the supervision of a registered dietitian, licensed to practice in Louisiana, who is employed either full time, part time or on a consulting basis. If the registered dietitian is not full time, there shall be a full time dietary manager.

B. The dietary manager shall:

1. be a qualified dietitian; or

2. be a graduate of a dietetic technician program, correspondence program or otherwise approved by the American Dietetics Association; or

3. have successfully completed a course of study, by correspondence or classroom, which meets the eligibility requirements for certification by the Dietary Manager's Association; or

4. have successfully completed a training course at a state approved school, vocational or university, which includes course work in foods and food service, supervision and diet therapy. Documentation of an eight-hour course of formalized instruction in diet therapy conducted by the employing facility's qualified dietitian is permissible if the course meets only the foods, food service and supervision requirements.

a. Exception. Hospitals with 25 or fewer beds that do not have on site food preparation for patient meals and contract for food services, another full-time employee, i.e., RN or LPN, will be allowed to carry out the responsibilities of the dietary manager. The RN or LPN must be qualified by training and experience and employed full time. The director of nursing shall not hold this position.

C. The registered dietitian shall be responsible for assuring that quality nutritional and therapeutic dietetic services are provided to patients. This shall be accomplished by providing and supervising the nutritional aspects of patient care including nutritional screening, nutritional assessments of patients at nutritional risk, patient education related to nutritional intake and diet therapy, and recording information in the medical record regarding the nutritional status and care of the patient and the patient's response to the therapeutic diet.

D. The hospital shall employ sufficient support personnel, competent in their respective duties, to carry out the function of the dietary service adequate to meet the nutritional and therapeutic dietetic needs of the patients in accordance with the prescribed plan of care.

E. For hospitals that provide dietary services in accordance with §9377 above, a registered dietician shall be employed or under contract to assure proper dietary services are being provided in accordance with §9379.B.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2413 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1476 (October 2019).

§9381. Menus and Therapeutic Diets

A. Menus shall be prepared in advance, meet the nutritional needs of the patients in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, or as modified in accordance with the orders of the practitioner(s) responsible for the care of the patient, and followed as planned.

B. Therapeutic diets shall be prescribed by the licensed practitioner(s) responsible for the care of the patient. Therapeutic diets, and laboratory tests to monitor the effectiveness of the dietary plan, may be prescribed by a licensed dietitian/nutritionist subject to the approval of, and authorization by, the facility's medical staff or bylaws and in accordance with state law. Each patient's nutritional intake shall be documented in the patient's medical record. Nutritional intake includes both enteral and parenteral nutrition.

C. There shall be a procedure for the accurate transmittal of dietary orders to the dietary service and for informing the dietary service when the patient does not receive the ordered diet, or is unable to consume the prescribed diet.

D. There shall be a current therapeutic diet manual, which shall be the guide used for ordering and serving diets and other nutritional intake. The manual shall be approved by the dietitian and medical staff and be readily available to all medical, nursing and food service personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2414 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 43:74 (January 2017).

§9383. Sanitary Conditions

A. Food shall be in good condition, free from spoilage, filth, or other contamination and shall be safe for human consumption. All food shall be procured from sources that comply with all laws and regulations related to food and food labeling. The use of food in hermetically sealed containers that was not prepared in a food processing establishment is prohibited.

B. All food shall be transported, stored, prepared, distributed and served under sanitary conditions to prevent food borne illness. This includes keeping all readily perishable food and drink at or below 41 degrees Fahrenheit, except when being prepared and served. Refrigerator temperatures shall be maintained at 41 degrees Fahrenheit or below, freezers at 0 degrees Fahrenheit or below.

1. For those hospitals that contract with a food delivery service for nutritional and therapeutic dietary services, food shall be transported only via vehicles designed, equipped, and maintained solely for the purpose of the transportation and delivery of food by the food management company.

C. Hot foods shall leave the kitchen or steam table at or above 140 degrees Fahrenheit, and cold foods at or below 41 degrees Fahrenheit. In-room delivery temperatures shall be maintained at 120 degrees Fahrenheit or above for hot foods and 50 degrees Fahrenheit or below for cold items, except for milk which shall be stored at 41 degrees Fahrenheit. Food shall be transported to the patients' rooms in a manner that protects it from contamination, while maintaining required temperatures.

1. For those hospitals who contract with a food management company for nutritional and therapeutic dietary services, transportation and delivery of such food shall be transported and served in accordance with §9383.A-C.

D. All equipment and utensils used in the preparation and serving of food shall be properly cleansed, sanitized and stored. This includes maintaining a water temperature in dish washing machines at 140 degrees Fahrenheit during the wash cycle (or according to the manufacturer's specifications or instructions) and 180 degrees Fahrenheit for the final rinse. Low temperature machines shall maintain a water temperature of 120 degrees Fahrenheit with 50 parts per million (ppm) of hypochlorite (household bleach) on dish surfaces. For manual washing in a 3 compartment sink, a wash water temperature of 75 degrees Fahrenheit with 50 ppm of hypochlorite or equivalent, or 12.5 ppm of iodine; or a hot water immersion at 170 degrees Fahrenheit for at least 30 seconds shall be maintained. An approved lavatory shall be convenient and equipped with hot and cold water tempered by means of a mixing valve or combination faucet for dietary services staff use. Any self-closing, slow-closing, or metering faucet shall be designed to provide a flow of water for at least 15 seconds without the need to reactivate the faucet. Effective with the promulgation of these requirements, an additional lavatory shall be provided in the dishwasher area in newly constructed hospitals or in existing hospitals undergoing major dietary alterations.

1. For those hospitals that contract nutritional and therapeutic dietary services, such shall be conducted in accordance with the *State Sanitary Code* for the preparing, cleaning, sanitation, and storage of equipment and utensils.

E. Dietary staff shall not store personal items within the food preparation and storage areas.

F. Dietary staff shall use good hygienic practices. Staff with communicable diseases or infected skin lesions shall not have contact with food, if that contact will transmit the disease.

G. Toxic items such as insecticides, detergents, polishes and the like shall be properly stored, labeled and used.

H. Garbage and refuse shall be kept in durable, easily cleanable, insect and rodent-proof containers that do not leak and do not absorb liquids. Containers used in food preparation and utensil washing areas shall be kept covered after they are filled.

I. The physical environment in which all food preparation takes place shall be kept clean and in operating condition.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2414 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1476 (October 2019).

Subchapter H. Medical Record Services

§9387. Organization and Staffing

A. There shall be a medical records department that has administrative responsibility for maintaining medical records for every person evaluated or treated as an inpatient, outpatient or emergency patient. Medical records for patients at off-site campuses shall be integrated into the unified records system of the provider.

B. Medical records shall be under the supervision of a medical records practitioner (i.e., registered record administrator or accredited record technician) on either a full-time, part-time or consulting basis.

C. Medical records shall be legibly and accurately written in ink, dated and signed by the recording person or, if a computerized medical records system is used, authenticated, complete, properly filed and retained, and accessible.

D. If a facsimile communications system (fax) is used, the hospital shall take precautions when thermal paper is used to ensure that a legible copy is retained as long as the medical record is retained.

E. Written orders signed by a member of the medical staff shall be required for all medications and treatments administered to patients. There shall be a reliable method for personal identification of each patient. The medical staff bylaws shall include specifications for orders for the care or treatment of patients which are given to the hospital verbally or transmitted to the hospital electronically, whether by telephone, facsimile transmission or otherwise. The bylaws may grant the medical staff up to ten days following the date an order is transmitted verbally or electronically to provide the signature or countersignature for such order.

F. If rubber stamp signatures are authorized for physician use, the administrative office shall have on file a signed statement from the medical staff member whose stamp is involved that ensures that he/she is the only one who has the stamp and uses it. The delegation of their use by others is prohibited.

G. If electronic signatures are used, the hospital shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of any computer generated signature.

H. There shall be adequate medical record personnel to ensure prompt completion, filing and retrieval of records.

I. The hospital shall have a system of coding and indexing medical records. The system shall allow for timely retrieval by diagnosis and procedure, in order to support quality assessment and improvement evaluations.

J. The hospital shall ensure that all medical records are completed within 30 days following discharge.

K. A patient or his/her personal representative shall be given reasonable access to the information contained in his/her hospital record. The hospital shall, upon request in writing signed and dated by either the patient or personal representative initiating the request, furnish a copy of the hospital record as soon as practicable, not to exceed 15 days following the receipt of the request and written authorization and upon payment of the reasonable cost of reproduction in accordance with Louisiana R.S. 40:1299.96. However, the hospital may deny the patient access if a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the patient or another person.

L. A hospital record may be kept in any written, photographic, microfilm, or other similar method or may be kept by any magnetic, electronic, optical or similar form of data compilation which is approved for such use by the department. No magnetic, electronic, optical or similar method shall be approved unless it provides reasonable safeguards against erasure or alteration.

M. A hospital may at its discretion, cause any hospital record or part to be microfilmed, or similarly reproduced, in order to accomplish efficient storage and preservation of hospital records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2415 (November 2003).

§9389. Content

A. The medical record shall contain the following minimum data:

1. unique patient identification data;

2. admission and discharge dates;

3. complete history and physical examination, in accordance with medical staff policies and procedures;

4. provisional admitting diagnosis and final diagnosis;

5. medical staff orders;

6. progress notes;

7. nursing documentation and care plans;

8. record of all medical care or treatments; and

9. discharge summary.

B. The medical record shall contain the following when applicable:

1. clinical laboratory, pathological, nuclear medicine, radiological and/or diagnostic reports;

2. consultation reports;

3. pre-anesthesia note, anesthesia record, and post-anesthesia notes;

4. operative reports;

5. obstetrical records, including:

a. record of mother's labor, delivery, and postpartum period;

b. separate infant record containing date and time of birth, condition at birth, sex, weight at birth if condition permits weighing, and condition of infant at time of discharge;

c. autopsy reports; and/or

d. any other reports pertinent to the patient's care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2415 (November 2003).

§9391. Registers and Reports

A. The hospital shall have the following registers and reports, where applicable, which may be computer generated:

1. patients' register;

2. emergency room register;

3. birth register;

4. delivery room register;

5. operating room register;

6. death register;

7. analysis of hospital service via the quality assessment and improvement program, based on patient statistics; and

8. daily census report of admissions, births, discharges and deaths.

B. All hospitals licensed by the Department of Health that provide emergency treatment, due to complications following an abortion as defined in R.S. 40:1061.9 shall:

1. ensure proper electronic coding and tracking of post-abortion complications;

2. submit to the department, on a form provided by the department, a report on patients who present for post-abortion complication emergency treatment. The report shall:

a. be confidential;

b. be exempt from disclosure pursuant to the Public Records Law, R.S. 44:1 et seq.;

c. not contain the name or address of the patient;

d. include the following:

i. the date of the abortion;

ii. the name and address of the facility where the abortion was performed or induced;

iii. the nature of the abortion complication diagnosed or treated;

iv. the name and address of the facility where the post-abortion care was performed; and

3. ensure that a staff member of the hospital attempts to obtain the information required in this section from any patient prior to the patient's discharge from the hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:1061.9.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2416 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1581 (June 2022).

§9393. Confidentiality

A. The hospital shall ensure the confidentiality of patient records, including information in a computerized medical record system, in accordance with the HIPAA Privacy Regulations (Title 45, Part 164, Subpart E of the Code of Federal Regulations) and any Louisiana state laws and regulations which provide a more stringent standard of confidentiality than the HIPAA Privacy Regulations. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records shall not be released outside the hospital unless under court order or subpoena or in order to safeguard the record in the event of a physical plant emergency or natural disaster. Psychiatric medical records shall be segregated to ensure confidentiality.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2416 (November 2003).

§9395. Retention

A. Hospital records shall be retained by the hospital in their original, microfilmed or similarly reproduced form for a minimum period of 10 years from the date a patient is discharged.

B. Graphic matter, images, x-ray films, nuclear medicine reports and like matter that were necessary to produce a diagnostic or therapeutic report shall be retained, preserved and properly stored by the hospital in their original, microfilmed or similarly reproduced form for a minimum period of three years from the date a patient is discharged. (Note: Medicare and/or Medicaid participating hospitals must maintain copies of reports and printouts, films, scans and other image records for at least five years). Such graphic matter, images, x-ray film and like matter shall be retained for longer periods when requested in writing by any one of the following:

1. an attending or consulting physician of the patient;

2. the patient or someone acting legally in his/her behalf;

3. legal counsel for a party having an interest affected by the patient's medical records.

C. A hospital that is closing shall notify the department in writing at least 30 days prior to cessation of operation for approval of their plan for the disposition of patients' medical records. The plan shall contain provisions that comply with state laws on the storage, maintenance, access and confidentiality of the closed hospital's patient medical records. It shall consists of an appointed custodian who shall provide physical and environmental security that protects against fire, water, intrusion, unauthorized access, loss and destruction. The plan shall also provide public notice on access in the newspaper, with the largest circulation, in close proximity of the closing hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2416 (November 2003).

Subchapter I. Quality Assessment and Improvement

§9399. General Provisions

A. The governing body shall ensure that there is an effective, written, ongoing, hospital-wide program designed to assess and improve the quality of patient care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2416 (November 2003).

§9401. Clinical Plan

A. There is a written plan for assessing and improving quality that describes the objectives, organization, scope and mechanisms for overseeing the effectiveness of monitoring, evaluation, and improvement activities. All organized services related to patient care, including services furnished by a contractor, shall be evaluated. Nosocomial infections and medication therapy shall be evaluated. All medical and surgical services and other invasive procedures performed in the hospital shall be evaluated as they relate to appropriateness of diagnosis and treatment. The services provided by each practitioner with hospital privileges shall be periodically evaluated to determine whether they are of an acceptable level of quality and appropriateness.

B. Each department or service of the hospital shall address:

1. patient care problems;

2. cause of problems;

3. documented corrective actions; and

4. monitoring or follow-up to determine effectiveness of corrective actions taken.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2416 (November 2003).

§9403. Implementation

A. Each department or service of the hospital, through its governing body, shall take and document appropriate remedial action to address deficiencies found through the quality assessment and improvement program. The hospital shall document the outcome of all remedial actions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2417 (November 2003).

§9405. Patient Care Services

A. The hospital shall have an on-going plan, consistent with available community and hospital resources, to provide or make available social work, psychological and educational services to meet the medically related needs of its patients.

B. The hospital shall also have an effective, on-going discharge planning program that facilitates the provision of follow-up care. Each patient's record shall be annotated with a note regarding the nature of post hospital care arrangements. Discharge planning shall be initiated in a timely manner. Patients, along with necessary medical information (e.g., the patient's functional capacity, nursing and other care requirements, discharge summary, referral forms) shall be transferred or referred to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care.

1. If a patient has designated an uncompensated caregiver for aftercare, a hospital shall make a good faith attempt to notify the patient's designated caregiver of the patient's discharge to the patient's residence as soon as possible prior to the patient's discharge. If the hospital is unable to contact the designated caregiver, the lack of contact may not interfere with, delay or otherwise affect the medical care provided to the patient, or an appropriate discharge of the patient.

a. For purposes of §9405.B.1-3, a residence does not include any rehabilitation facility, hospital, nursing home, assisted living facility or group home.

2. As soon as practicable prior to the patient's discharge, the hospital shall make a reasonable effort to consult with the designated caregiver along with the patient, taking into account the capabilities and limitations of the caregiver, to accomplish the aftercare tasks that may be included in a discharge care plan that describes the patient's aftercare needs at his residence.

3. The hospital shall educate and instruct the caregiver concerning the aftercare needs of the patient in a manner that is consistent with the discharge plan and is based on the learning needs of the caregiver. In addition, the hospital shall also provide an opportunity for the caregiver and patient to ask questions and receive explanations about the aftercare tasks.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2417 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 43:74 (January 2017).

Subchapter J. Physical Environment

§9409. General Provisions

A. The hospital shall be constructed, arranged and maintained to ensure the safety and well being of the patient.

B. Hospitals with specialty units such as psychiatric or rehabilitative units must also comply with the physical environment requirements as expressed within those particular chapters.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2417 (November 2003).

§9411. Buildings

A. The buildings shall reflect good housekeeping and shall by means of an effective pest control program, be free of insects and rodents.

B. The hospital shall maintain hospital-wide ventilation, lighting and temperature controls.

C. There shall be a provision of emergency sources of critical utilities such as electricity, natural gas, water and fuel during any period in which the normal supply is temporarily disrupted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2417 (November 2003).

§9413. Nursing Units

A. A nurses' station equipped with a telephone and a nurse call system shall be provided in a suitable location on each nursing unit.

B. An adequate and properly equipped utility space or area shall be provided on each nursing unit for the preparation, cleaning and storage of nursing supplies and equipment used on the nursing unit. This utility space shall be so arranged as to provide for separation of clean and soiled supplies and equipment.

1. Grab bars properly located and securely mounted shall be provided at patient bathing facilities and toilet bowl with accessories.

2. A lavatory basin shall be provided in or convenient to every toilet bowl with accessories.

3. Paper towels in a satisfactory dispenser or some other acceptable type of single use towel and a satisfactory receptacle for used towels shall be provided at all lavatories.

C. Areas for the isolation of patients with communicable diseases may be established on a temporary basis as the need arises. A private room or a corridor wing may be used provided appropriate isolation techniques are enforced, including identifying signs to warn and restrict the public.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2417 (November 2003).

§9415. Patient Rooms

A. Except as provided for in intensive care units, all patient rooms shall be outside rooms with a window area of clear glass of not less than 12 square feet.

B. In hospitals constructed prior to November 20, 1990 single rooms shall contain at least 80 square feet and multi-bed rooms shall contain at least 70 square feet per bed. In hospitals constructed subsequent to November 20, 1990 single rooms must contain at least 100 square feet and multi-bed rooms shall contain at least 80 square feet per bed, exclusive of fixed cabinets, fixtures, and equipment, in accordance with *Guidelines for Construction and Equipment of Hospital and Medical Facilities*, 1987 Edition. In hospitals constructed subsequent to March 1, 1995, single rooms must contain at least 120 square feet and multi-bed rooms shall contain at least 100 square feet per bed, exclusive of fixed cabinets, fixtures, and equipment, in accordance with *Guidelines for Construction and Equipment of Hospitals and Medical Facilities*, *Current Edition.* Any patient room shall not contain more than four beds. Rooms shall have at least a 7 1/2 foot ceiling height over the required area.

C. There shall be at least 3 feet between beds.

D. Rooms shall be arranged so as to permit the movement of a wheeled stretcher to the side of each bed.

E. There shall be sufficient and satisfactory separate storage space for clothing, toilet articles and other personal belongings of patients.

F. Every patient room shall have a lavatory. This lavatory is not necessary in rooms with an adjoining toilet or bathroom that has a lavatory. In new construction, lavatory requirements will be directed by *Guidelines for Construction and Equipment of Hospitals and Medical Facilities Current Edition.*

G. There shall be at least one toilet bowl with accessories, lavatory basin and bathing facility reserved for patient use on each patient floor and additional toilets, lavatories, and bathing facilities to adequately meet the needs of employees, professional personnel and patients on each nursing unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2417 (November 2003).

§9417. Patient Room Furnishings

A. A hospital type bed with suitable mattress, pillow and necessary coverings shall be provided for each patient. There shall be a bedside stand, chair, and wardrobe, locker, or closet suitable for hanging full-length garments and storing personal effects for each patient.

B. A nurses call system, within easy reach of each bed, shall be provided. The call system shall also be provided in each patient toilet and bathing area.

C. Each bed in multi-bed rooms shall have approved ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. A properly designed lamp or over-bed light, which can be operated by the patient, shall be provided at each bed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2418 (November 2003).

§9419. Equipment

A. Equipment shall be clean and in good repair for the safety and well-being of the patients.

B. Therapeutic, diagnostic and other patient care equipment shall be maintained and serviced in accordance with the manufacturer's recommendations.

C. All patients, when appropriate due to diagnosis, shall be provided with patient care items such as a bedpan, washbasin, emesis basin, drinking glass and soap dish. These supplies and equipment shall be properly cleaned and in appropriate cases shall be sterilized between use for different patients if disposable items are not used.

D. Methods for cleaning, sanitizing, handling and storing of all supplies and equipment shall be such as to prevent the transmission of infection through their use.

E. After discharge of a patient, the bed, mattress, cover, bedside furniture, and equipment shall be properly cleaned. Mattresses, blankets and pillows assigned to patients shall be in a sanitary condition. The mattress, blankets and pillows used for a patient with an infection shall be sanitized in an acceptable manner before they are assigned to another patient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2418 (November 2003).

Subchapter K. Infection Control

§9423. Organization and Policies

A. The hospital shall provide a sanitary environment to avoid sources and transmission of infections and communicable diseases.

B. There shall be an effective infection control program for the prevention, control, investigation and reporting of communicable disease and infections. The infection control program shall meet or exceed the latest criteria established by the following:

1. Centers for Disease Control;

2. Occupational Safety and Health Administration; and

3. *Sanitary Code* of the state of Louisiana.

C. A person or persons qualified by education and experience and competent in infection control practices shall be designated as infection control officer(s). This individual(s) shall be responsible for the development and implementation of a hospital-wide infection control program.

D. The infection control officer(s) shall develop, with approval of the medical director and governing body, policies and procedures for identifying, reporting, investigating, preventing and controlling infections and communicable diseases of patients and hospital personnel. The infection control officer(s) shall maintain a log of incidents related to infections and communicable diseases.

E. Employees with symptoms of illness that have the potential of being communicable (i.e. diarrhea, skin lesions, respiratory symptoms) shall be either evaluated by hospital staff or restricted from patient care activities during the infectious stage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2418 (November 2003).

§9425. Responsibilities

A. The chief executive officer or administrator, the medical staff and the director of nursing services shall ensure that the hospital-wide quality assessment and improvement program and training programs address problems identified by the infection control officer(s). They shall be responsible for the implementation of successful corrective action plans in affected problem areas. Infection control activities or programs conducted or instituted in different departments of the hospital shall have the approval of the infection control officer(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003).

§9427. Laundry Services

A. A supply of clean linen, sufficient to meet the requirements of the patients, shall be provided by a laundry service either in-house, contracted with another healthcare facility or in accordance with an outside commercial laundry service. All linens shall be handled, cleaned, sanitized, stored and transported in such a way as to prevent infection.

B. Clean linen shall be delivered in such a way as to minimize microbial contamination from surface contact or airborne deposition. Soiled linen shall be collected in such a manner as to minimize microbial dissemination into the environment. All linen shall be laundered between patient use.

C. Contaminated laundry shall be specially handled according to the hospital's written protocol, which is approved by the infection control officer(s). If laundry chutes exist, linen shall be bagged and the chutes shall empty into an enclosed collection room.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health

Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003).

§9429. Central Supply

A. Space shall be provided for the preparation, storage, handling and distribution of sterile supplies and other patient care items. Functional design shall provide for the separation of soiled and contaminated supplies from those that are clean and sterile. All central supply departments shall adhere to strict traffic control in their departments. Air circulation systems in central supply shall be negative pressure in decontamination and ethylene oxide areas and positive pressure in all clean areas.

B. Hand washing facilities shall be provided in all work areas. There shall be written policies and procedures for the decontamination and sterilization of supplies and equipment, shelf life of all stored sterile items and reuse of disposable items in accordance with the latest criteria established by the Centers for Disease Control.

C. All steam sterilizing equipment shall have live bacteriological spore monitoring performed at least weekly and with each load containing an implantable device. If tests are positive, a system shall be in place to recall supplies.

D. All ethylene oxide sterilizing equipment shall have live bacteriological spore monitoring performed with each load. There shall be ventilation of the room used for this sterilization to the outside atmosphere and there shall be a system in place to monitor trace gases of ethylene oxide at least monthly.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003).

§9431. Isolation

A. The hospital shall have appropriate facilities and procedures for infection control and the isolation of patients as necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003).

§9433. Waste and Hazardous Materials Management

A. The hospital shall have a written and implemented waste management program that identifies and controls wastes and hazardous materials. The program shall comply with all applicable laws and regulations governing wastes and hazardous materials.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003).

Subchapter L. Surgical Services (Optional)

§9437. General Provisions

A. Surgical services are provided. The services shall be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered, the services shall be consistent in quality with inpatient care in accordance with the complexity of services offered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003).

§9439. Organization and Staffing

A. Surgical services shall be under the medical direction of a qualified physician who is a member of the medical staff and appointed by the governing body.

B. Surgical privileges shall be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The surgical services shall maintain a roster of practitioners specifying the surgical privileges of each practitioner.

C. The surgical suite shall be supervised by a registered nurse experienced and competent in the management of surgical services.

D. A qualified registered nurse shall perform circulating duties for surgical procedures performed. In accordance with the needs of patients and the complexity of services performed, licensed practical nurses and operating room technicians may assist in circulatory duties under the supervision of a registered nurse who is immediately available to respond to emergencies. Licensed practical nurses and operating room technicians may perform scrub functions under the supervision of a registered nurse.

E. The operating room register shall be complete and up-to-date. It shall include at least the following:

1. patient's name;
2. patient's hospital identification number;
3. date of the operation;
4. inclusive or total time of the operation;
5. name of the surgeon and any assistant(s);
6. name of nursing personnel (scrub and circulating);
7. type of anesthesia used;
8. name of the person administering the anesthesia; and
9. operation performed.

F. An operative report describing techniques, findings, and tissue removed or altered shall be written or dictated

immediately following surgery and signed by the surgeon. It shall include at least:

1. the name and hospital identification number of the patient;

2. date of surgery;

3. name of the surgeon and assistant(s);

4. pre-operative and post-operative diagnoses;

5. name of the specific surgical procedure(s) performed;

6. type of anesthesia administered;

7. complications, if any;

8. a description of techniques, findings, and the tissues removed or altered; and

9. prosthetic devices or implants used, if any.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003).

§9441. Delivery of Service

A. There shall be a complete history and physical work-up in the chart of every patient prior to surgery, except in emergency surgery. If the history and physical has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the practitioner who admitted the patient.

B. A properly executed informed consent form for the procedure must be in the patient's chart before surgery, except in emergencies. The consent form shall contain at least the following:

1. name of the patient;

2. hospital and patient identification number;

3. name of the procedure(s) or operation;

4. the reasonably foreseeable risks and benefits involved;

5. name of the practitioner(s);

6. signature of the patient or legal guardian;

7. date and time the consent is obtained; and

8. signature and professional designation of the person witnessing the consent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2420 (November 2003).

§9443. Surgery Suite and Equipment

A. The surgical suite shall be appropriately equipped and consist of a clear floor area to accommodate the equipment and personnel required, allowing for aseptic technique.

B. The surgical suite(s) shall be located in a segregated area out of the line of traffic of visitors and personnel from other departments and arranged so as to prevent traffic through them.

C. There shall be scrub-up facilities in the surgical suite providing hot and cold running water and equipped with knee, foot or elbow faucet controls.

D. There shall be a provision for washing instruments and equipment, which are to be cleaned within the surgical suite. If an autoclave is present, the same operating requirements referenced in Subchapter K, Infection Control shall be implemented.

E. There shall be policies and procedures, approved by the Infection Control Committee that addresses terminal cleaning of the operating room as well as cleaning of the room between surgical cases.

F. The emergency equipment in the surgical suite shall include:

1. a communication system that connects each operating room with a control center;

2. cardiac monitor;

3. resuscitator;

4. defibrillator;

5. aspirator; and

6. tracheotomy set.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2420 (November 2003).

§9445. Post-Operative Area

A. There shall be a post-operative care area (recovery room) which is a separate area of the hospital, unless provisions are made for close observation of the patient until they have regained consciousness (e.g., direct observation by an RN in the patient's room). Access shall be limited to authorized personnel. There shall be policies and procedures which specify transfer requirements to and from the post-operative area.

B. There shall be at least two health care personnel, one of which is a registered nurse, present whenever there is a patient. There shall be emergency equipment and monitoring equipment in the immediate area of the post-operative area. The equipment shall be commensurate with the surgical procedure and the medical requirements of the patient. That equipment shall include, but not be limited to, the following:

1. EKG/ECG monitor;

2. pulse oxymeter monitor;

3. temperature monitoring equipment;

4. equipment to administer oxygen;

5. equipment necessary to monitor vital signs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2420 (November 2003).

Subchapter M. Anesthesia Services (Optional)

§9449. General Provisions

A. If anesthesia services are provided, which is mandatory when surgical or obstetric services are provided, they must be provided in a well organized manner under the direction of a qualified doctor of medicine or osteopathy.

B. The standards in this Chapter apply to services for all patients who:

1. receive general, spinal, or other major regional anesthesia; or

2. undergo surgery or other invasive procedures when receiving general, spinal, or other major regional anesthesia and/or intravenous, intramuscular, or inhalation sedation/analgesia, including conscious sedation, that, in the manner used in the hospital, may result in the loss of the patient's protective reflexes.

C. Invasive procedures include, but are not limited to, percutaneous aspirations and biopsies, cardiac and vascular catheterization, and endoscopies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2421 (November 2003).

§9451. Organization and Staffing

A. Anesthesia services shall be administered by practitioners with appropriate clinical privileges obtained through a mechanism that assures that each practitioner provide only those services for which they have been licensed, trained and deemed to be competent to administer anesthesia within the scope of their practice. Those practitioners include:

1. a qualified anesthesiologist;

2. a doctor of medicine or osteopathy;

3. a dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under state law;

4. a certified registered nurse anesthetist (CRNA) licensed by the Louisiana State Board of Nursing who is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed as defined in the medical staff bylaws; or

5. a bona fide student enrolled in a school of nurse anesthesia accredited by the Council on Accreditation of Nurse Anesthesia educational programs whose graduates are acceptable for certification by a nationally recognized certifying body may administer anesthesia as related to such course of study under the direct supervision of a certified registered nurse anesthetist or an anesthesiologist.

B. The individual administering the anesthesia shall be present throughout its administration and attending the patient until the patient is under the care of post-anesthesia staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2421 (November 2003).

§9453. Delivery of Service

A. Policies on anesthesia procedures must include the delineation of pre-anesthesia and post-anesthesia responsibilities. As a minimum, they shall address:

1. the qualifications, responsibilities and supervision required of all personnel who administer anesthesia;

2. patient consent for anesthesia;

3. infection control measures;

4. safety practices in all anesthetizing areas;

5. protocol for supportive life functions, e.g., cardiac and respiratory emergencies;

6. reporting requirements;

7. documentation requirements;

8. inspection and maintenance reports on all supplies and equipment used in anesthesia; and

9. trace gas reports.

B. The policies must also ensure that the following are provided for each patient:

1. a pre-anesthesia evaluation performed and recorded within 48 hours prior to surgery by an individual qualified to administer anesthesia;

2. a reevaluation of each patient immediately prior to induction of anesthesia;

3. an intra-operative anesthesia record that records monitoring of the patient during anesthesia and documentation of at least the following:

a. prior to induction of the anesthesia, all anesthesia drugs and equipment to be used have been checked and are immediately available and are determined to be functional by the practitioner who is to administer the anesthetic;

b. dosages and total dosages of all drugs and agents used;

c. type and amount of all fluid administered, including blood and blood products;

d. technique(s) used;

e. unusual events during the anesthesia period;

f. the status of the patient at the conclusion of anesthesia;

g. a post-anesthesia follow-up report written within 48 hours after surgery on inpatients and prior to discharge for patients undergoing one-day/same-day surgery by the individual who administers the anesthesia or another fully qualified practitioner within the anesthesia section; and

h. a post-anesthesia evaluation on outpatients for proper anesthesia recovery performed in accordance with policies and procedures approved by the medical staff.

C. The anesthesia policy and procedure manual shall ensure that the following are provided for each patient undergoing:

1. general anesthesia:

a. the use of an anesthesia machine that provides the availability and use of safety devices including, but not limited to, an oxygen analyzer, pressure and disconnect alarm, pin-index safety system, gas-scavenging system, and oxygen pressure interlock system;

b. continuous monitoring of the patient's temperature and vital signs, as well as the continuous use of an EKG/ECG , pulse oximeter monitor, end tidal carbon dioxide volume monitor, and peripheral nerve stimulator monitor;

2. regional anesthesia (major nerve blocks):

a. all equipment listed in the above list for general anesthesia shall be immediately available and in the operating room where the procedure is being performed; and

b. continuous monitoring of the patient's vital signs, and temperature, as well as the continuous use of an EKG/ECG, and pulse oximeter monitor; and

c. monitored by the practitioner who administered the regional anesthetic or individuals identified as a practitioner listed in §9451.A;

3. local anesthesia (infiltration or topical). There shall be:

a. continuous monitoring of the patient's vital signs and temperature as well as the continuous use of an EKG/ECG, and pulse oximeter monitor; and

b. monitoring by the practitioner who administered the local anesthetic or a practitioner listed within §9451.A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2421 (November 2003).

Subchapter N. Nuclear Medicine Services (Optional)

§9457. General Provisions

A. If the hospital provides nuclear medicine services or contracts for the services, those services must meet the needs of the patients in accordance with acceptable standards of practice and be provided in a safe and effective manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2422 (November 2003).

§9459. Organization and Staffing

A. The organization of the nuclear medicine services shall be appropriate to the scope and complexity of the services offered. There shall be a director who is a doctor of medicine or osteopathy qualified in nuclear medicine and named in the Department of Environmental Quality, Radiation Protection Division radioactive material license as authorized to use radioactive materials in humans.

B. Nuclear medicine services shall be ordered only by a practitioner whose scope of federal or state licensing and defined staff privileges allow such referrals.

C. The performance of nuclear medicine diagnostic procedures and the administration of radioactive material to humans may be accomplished only by the licensed physician practitioner or by the licensed nuclear medicine technologist.

AUTHORITY NOTE: promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2422 (November 2003).

§9461. Delivery of Service

A. Radioactive materials shall be prepared, labeled, used, transported, stored and disposed of in accordance with acceptable standards of practice.

B. In-house preparation of radiopharmaceuticals shall be by, or under the supervision of an appropriately trained registered pharmacist or a doctor of medicine or osteopathy whose use of radioactive materials is authorized in the facility's Department of Environmental Quality, Radiation Protection Division radioactive material license.

C. There shall be proper storage and disposal of radioactive materials. If clinical laboratory tests are performed in the nuclear medicine service, the service shall meet the requirements for clinical laboratories with respect to management, adequacy of facilities, proficiency testing and quality control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2422 (November 2003).

§9463. Facilities

A. Equipment and supplies shall be appropriate for the types of nuclear medicine services offered and shall be maintained for safe and efficient performance.

B. The equipment shall be maintained in safe operating condition, and inspected, tested, and calibrated at least annually by qualified personnel. The nuclear medicine service shall have and follow a preventive maintenance schedule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2422 (November 2003).

§9465. Records

A. The hospital shall maintain signed and dated reports of nuclear medicine interpretations, consultations and procedures. The hospital shall maintain copies of nuclear medicine reports in accordance with the retention requirement specified in Subchapter H, Medical Record Services.

B. The practitioner approved by the medical staff and authorized by the facility's Department of Environmental Quality, Radiation Protection Division radioactive material license to interpret diagnostic procedures shall sign and date the interpretations of these tests.

C. The hospital shall maintain records of the receipt and disposition of radiopharmaceuticals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2422 (November 2003).

Subchapter O. Outpatient Services (Optional)

§9469. General Provisions and Organization

A. If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice.

B. Outpatient services shall be appropriately organized, integrated with and provided in accordance with the standards applicable to the same service provided by the hospital on an inpatient basis.

1. Outpatient services shall be provided only under conditions stated in Subparagraphs a, b, or Clauses b.i.-ii below.

a. Outpatient services may be provided by a hospital if that hospital provides inpatient services for the same area of service. For example, a hospital may provide psychiatric outpatient services if that hospital provides psychiatric services on an inpatient basis.

b. Outpatient services may be provided by a hospital that does not provide inpatient services for the same area of service only if that hospital has a written policy and procedure to ensure a patient's placement and admission into an inpatient program to receive inpatient services for that area of service. The policy and procedure must ensure that the hospital is responsible for coordination of admission into an inpatient facility and must include, but not be limited to, the following:

i. the hospital personnel and/or staff responsible for coordination of placement and admission into an inpatient facility; and

ii. the procedure for securing inpatient services for that patient.

2. For all outpatient services, there shall be established methods of communication as well as established procedures to assure integration with inpatient services that provide continuity of care.

3. When patients are admitted, pertinent information from the outpatient record shall be provided to the inpatient facility so that it may be included in the inpatient record.

C. Any room designated for procedures or treatment involving conscious sedation shall have policies and procedures established by the medical staff to insure quality of care and safety of patients. Such guidelines shall include at a minimum:

1. pre-procedure preparation;

2. patient monitoring;

3. discharge criteria; and

4. staff competency requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2423 (November 2003), LR 33:284 (February 2007).

§9471. Personnel

A. The hospital shall assign an individual to be responsible for the outpatient services. There shall be appropriate professional and non-professional personnel available.

B. There must be a registered nurse on the observation unit as long as there are patients admitted to the unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2423 (November 2003).

§9473. Facilities

A. All outpatient facilities shall be accessible to and usable by handicapped employees, staff, visitors and patients. Where appropriate, there shall be at least:

1. a receptionist desk;

2. waiting space;

3. an examination room equipped with a lavatory and nurse call system;

4. public toilet facilities;

5. public telephone; and

6. drinking fountain.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2423 (November 2003).

Subchapter P. Rehabilitation Services (Optional)

§9477. General Provisions

A. If the hospital provides a range of rehabilitation services, including but not limited to physical therapy, occupational therapy, audiology or speech pathology services, the services shall be organized, operated and staffed in accordance with the provisions of this Subchapter P to ensure the health and safety of patients.

B. A rehabilitation unit or facility is defined as a designated unit or hospital that primarily provides physiological rehabilitation services to inpatients and/or outpatients.

C. For rehabilitation services that have multiple geographic locations, each geographical site shall meet the requirements in §9483.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2423 (November 2003).

§9479. Organization and Staffing

A. The organization of services shall be appropriate to the scope of the services offered. The rehabilitation service shall employ and define the leadership structure in accordance with the facility administration. The medical director of rehabilitation services shall:

1. be a doctor of medicine or osteopathy;

2. be licensed to practice medicine or surgery in accordance with state law;

3. have completed a one year hospital internship; and

4. have had at least two years of training or experience, within the last five years, in the medical management of patients requiring rehabilitation services.

B. Medical Director

1. It is expected that the experience and training of the medical director of rehabilitation services will be sufficient to provide the expertise to perform all of the functions within the service.

2. The medical director of rehabilitation services will be responsible to ensure that the objectives of each of the therapeutic disciplines of the rehabilitation program are efficiently conducted within the stated mission of the program and in accordance with current standards of rehabilitation medicine.

C. Physical therapy, occupational therapy, psychology/neuropsychology, speech therapy and audiology services shall be provided by staff that meet the qualifications in accordance with Louisiana law. All rehabilitation staff shall be duly licensed to practice in the areas in which they provide service.

D. A rehabilitation unit in a general hospital shall employ a full-time registered nurse as director of rehabilitation nursing services who is not shared with any other hospital department and who has three years clinical nursing experience, one of which shall be in providing rehabilitative nursing care. The unit shall provide 24-hour registered nurse coverage with an adequate number of licensed nurses and rehabilitative workers to provide the nursing care necessary under each patient's active treatment program.

E. In a rehabilitation hospital, the director of nursing services shall be a full-time registered nurse who has three years clinical nursing experience, one of which shall be in providing rehabilitative nursing care. In addition to the director of nursing services, the hospital shall provide 24-hour registered nurse coverage with an adequate number of licensed nurses and rehabilitative workers to provide the nursing care necessary under each patient's active treatment program.

F. If provided, psychological services shall be provided by or supervised by a psychologist licensed by the Louisiana State Board of Examiners of Psychologists.

G. Social services shall be provided by a licensed clinical social worker and shall meet the needs of the patients.

H. If the hospital provides a range of rehabilitation services, the services must define criteria for admission to the inpatient rehabilitation program and discharge from the inpatient program.

I. There shall be an interdisciplinary team which should include, but not be limited to:

1. a registered nurse with rehabilitation experience on each shift;

2. restorative nursing assistants and/or certified nursing aides;

3. a physical therapist;

4. an occupational therapist;

5. a psychologist/neuropsychologist;

6. a physician experienced in rehabilitation medicine;

7. a social worker;

8. a speech-language pathologist.

J. The program should provide or make arrangements for:

1. audiology services;
2. driver assessment;
3. driver education;
4. medical nutrition therapy;
5. orthotic services;
6. prosthetic services;
7. rehabilitation resources (independent centers);
8. vocational rehabilitation;
9. durable medical equipment;
10. specialty consultants;
11. other services consistent with the criteria for admission.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2423 (November 2003).

§9481. Delivery of Services

A. Rehabilitation services shall be furnished in accordance with a written plan of treatment based upon an assessment performed by the qualified professional. The written plan of treatment shall be established prior to the beginning of treatment. The plan of treatment shall consist of at least the treatment goals, type, amount, frequency and duration of services.

B. Rehabilitation services shall be given in accordance with the orders of practitioners who are authorized by the medical staff to order the services. The orders shall be incorporated in the patient's medical record.

C. The patient's progress shall be documented on a timely and regular basis in accordance with written policies and procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2424 (November 2003).

§9483. Facilities—Physical Space

A. Space and equipment shall be appropriate for the types of rehabilitation services offered and shall be maintained for safe and efficient performance and in accordance with the Rehabilitation Chapter and General Hospital Chapter of the *AIA Guidelines for Design and Construction of Hospital and Health Care Facilities*, 2001 (or most recent edition).

B. The Activities of Daily Living (ADL) room is in addition to the licensed bed capacity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2424 (November 2003).

Subchapter Q. Respiratory Care Services (Mandatory)

§9487. General Provisions

A. The hospital shall provide respiratory care services. The services shall meet the needs of the patients in accordance with acceptable standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2424 (November 2003).

§9489. Organization and Staffing

A. The organization of the respiratory care services shall be appropriate to the scope and complexity of the services offered. There shall be a director of the service who shall have the administrative authority and responsibility for implementing the hospital's policies. The director shall be a doctor of medicine or osteopathy with the knowledge, experience and capabilities to supervise and administer the services properly. The director may serve on either a full-time or part-time basis.

B. There shall be adequate numbers of respiratory therapists, respiratory therapy technicians and other personnel who meet the qualifications specified by the medical staff and approved by the governing body, consistent with Louisiana law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2424 (November 2003).

§9491. Delivery of Services

A. Respiratory care services shall be delivered in accordance with medical staff directives and incorporated in the patient's medical record. The order shall specify the type, frequency and duration of treatment, and as appropriate, the type and dose of medication, type of diluent, and the oxygen concentration. All respiratory care services provided shall be documented in the patient's medical record, including the type of therapy, date and time of administration, effects of therapy, and any adverse reactions.

B. Personnel qualified to perform specific procedures and the amount of supervision required for personnel to carry out specific procedures shall be designated in writing.

C. If blood gases or other clinical laboratory tests are performed in the respiratory care unit, the unit shall meet the requirement for clinical laboratories with respect to management, adequacy of facilities, proficiency testing and quality control as set forth in Subchapter F of these requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2425 (November 2003).

Subchapter R. Psychiatric Services (Optional)

§9495. General Provisions

A. These requirements are applicable to those hospitals which are primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons or have organized a physically and functionally distinct part unit within the hospital to provide these services. Pediatric and adolescent psychiatric units shall be physically separated from adult psychiatric units. Facilities without separate pediatric and adolescent units shall have policies and procedures that prevent adult patients from co-mingling with pediatric and/or adolescent psychiatric patients.

B. For psychiatric services/facilities that have multiple geographic locations, each geographical site shall meet the requirements in §9497, §9499 and §9501.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2425 (November 2003).

§9497. Facilities

A. The layout, design of details, equipment and furnishings shall be such that patients shall be under close observation and shall not be afforded opportunities for hiding, escape or injury to themselves or others. The environment of the unit shall be characterized by a feeling of openness with emphasis on natural light and exterior views. Interior finishes, lighting and furnishings shall suggest a residential rather than an institutional setting while conforming with applicable fire safety codes. Security and safety devices shall not be presented in a manner to attract or challenge tampering by patients.

B. Windows or vents shall be arranged and located so that they can be opened from the inside to permit venting of combustion products and to permit occupants direct access to fresh air in emergencies. The operation of windows shall be restricted to inhibit possible escape or suicide. Where windows or vents require the use of tools or keys for operation, the tools or keys shall be either located on the same floor in a prominent location accessible to staff or carried by every staff member. With hospitals that have approved engineered smoke control systems, the windows may be fixed. Where glass fragments pose a hazard to certain patients, safety glazing and/or other appropriate security features shall be used. There shall be no curtain or venetian blind chords.

C. Where grab bars are provided, they shall be institutional type, shall not rotate within their fittings, be securely fastened with tamper-proof screw heads, and shall be free of any sharp or abrasive elements. If grab bars are mounted adjacent to a wall, the space between the wall and the grab bar shall be 1 1/2 inches.

D. Where towel racks, closet and shower curtain rods are provided, they shall be the breakaway type.

E. Plastic bags and/or trash can liners shall not be used in patient care areas.

F. Electrical receptacles shall be of the safety type or protected by 5-milliampere ground-fault-interrupters.

G. There shall be outdoor space for patient recreation.

H. Patient Rooms

1. A nurses call system is not required, but if it is included, provisions shall be made for easy removal, or for covering call button outlets. A hospital shall have written policies and procedures to address call where no electronic system is in place.

2. Bedpan-flushing devices may be omitted from patient room toilets in psychiatric nursing units.

3. Visual privacy (e.g., cubicle curtains) in multi-bed rooms is not required.

4. Free standing closets shall be secured to the wall.

5. Electric patient beds are not to be used.

I. Service Areas

1. A secured storage area controlled by staff shall be provided for patients' belongings that are determined to be potentially harmful (e.g., razors, nail files, cigarette lighters).

2. Drugs and biologicals shall be stored in locked compartments under proper temperature controls, and only authorized personnel shall have access to the keys.

3. Food service may be one or a combination of the following:

a. a nourishment station;

b. a kitchenette designed for patient use with staff control of heating and cooking devices;

c. a kitchen service including a hand washing fixture, storage space, refrigerator, and facilities for meal preparation.

4. Storage space for stretchers and wheelchairs may be outside the psychiatric unit, provided that provisions are made for convenient access as needed for handicapped patients.

5. A separate charting area shall be provided with provisions for acoustical privacy. A viewing window to permit observation of patient areas by the charting nurse or physician may be used if the arrangement is such that patient files cannot be read from outside the charting space.

6. At least two separate social spaces, one appropriate for noisy activities and one for quiet activities shall be provided. The combined area shall be at least 40 square feet per patient with at least 120 square feet for each of the two spaces. This space may be shared by dining activities.

7. Space for group therapy shall be provided. This may be combined with the quiet space noted above when the unit accommodates not more than 12 patients, and when at least 225 square feet of enclosed private space is available for group therapy activities.

8. An automatic washer and dryer shall be provided for patient laundry.

9. Room(s) for examination and treatment with a minimum area of 120 square feet shall be provided within or in close proximity to the unit.

10. Separate consultation room(s) with minimum floor space of 100 square feet each, provided at a room-to-bed ratio of one consultation room for each 12 psychiatric beds shall be provided within the unit for interviews with patients and their families. The room(s) shall be designed for acoustical and visual privacy and constructed to achieve a noise reduction of at least 45 decibels.

11. Psychiatric hospitals or units shall provide 15 square feet of separate space per patient for occupational therapy, with a minimum total area of at least 200 square feet, whichever is greater. This space shall include provision for hand washing, work counter(s), storage and displays. Occupational therapy areas may serve more than one nursing unit. When the psychiatric nursing unit(s) contain fewer than 12 beds, the occupational therapy functions may be performed within the noisy activities area, if at least an additional 10 square feet per patient served is included.

12. A conference and treatment planning room for use by the psychiatric unit shall be provided. This room may be combined with the charting room.

J. Seclusion Treatment Room

1. There shall be at least one seclusion room for up to 24 beds or a major fraction thereof. It is intended for short-term occupancy by violent or suicidal patients and provides for patients requiring security and protection. The room(s) shall be either located for direct nursing staff supervision or observed through the use of electronic monitoring equipment.

2. If electronic monitoring equipment is used, it shall be connected to the hospital's emergency electrical source.

3. Each room shall be for single occupancy and contain at least 60 square feet. It shall be constructed to prevent patient hiding, escape, injury or suicide.

4. Where restraint beds are required by the functional program, 80 square feet shall be required.

5. If a facility has more than one psychiatric unit, located at the same geographical address, the number of seclusion rooms shall be determined by the total number of psychiatric beds at that location. However, if there are psychiatric units located at multiple and different geographical addresses, there shall be a seclusion room that meets these requirements at each off-site campus that offers inpatient psychiatric services.

6. Special fixtures and hardware for electrical circuits shall be used.

7. The minimum ceiling height shall be 9 feet.

8. Doors shall be 3 feet 8 inches wide, and shall permit staff observation of the patient while also maintaining provisions for patient privacy.

9. Seclusion rooms shall be accessed by an anteroom or vestibule which also provides direct access to a toilet room.

K. Ceiling construction in psychiatric patient rooms and seclusion room(s) shall be monolithic or tamper proof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2425 (November 2003).

§9499. Supplies and Equipment

A. Restraint equipment shall be immediately available and accessible to staff.

B. Recreational supplies and therapy equipment shall be available and in locked storage.

C. Locked storage areas shall be available for safekeeping of patient luggage and contraband items.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2426 (November 2003).

§9501. Staffing

A. The hospital or unit shall provide qualified professional, technical and consultative personnel to evaluate patients, formulate written individualized comprehensive treatment plans, provide active treatment measures and engage in discharge planning.

B. The hospital or unit shall employ a clinical director, who meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology, or the American Osteopathic Board of Neurology and Psychiatry. The clinical director shall monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

C. The hospital or unit shall employ a full-time registered nurse as director of psychiatric nursing services, who is not shared with any other hospital department and who has:

1. a master's degree in psychiatric or mental health nursing; or

2. a master's degree in a related field such as psychology or nursing education and five years nursing experience and three years providing nursing care to the mentally ill; or

3. a bachelor's, associate degree or diploma in nursing with documented evidence of educational programs focused on treating psychiatric patients, which has occurred at intervals sufficient enough to keep the nurse current on psychiatric nursing techniques. In addition, the nurse shall

have at least five years of nursing experience, three years of which were providing nursing care to the mentally ill, or receive regular, documented supervision/consultation from a master's prepared psychiatric nurse.

D. In addition to the director of psychiatric nursing service, the hospital or unit shall provide 24-hour registered nurse coverage with an adequate number of licensed nurses and mental health workers to provide the nursing care necessary under each patient's active treatment program.

E. Psychological services shall be provided by or supervised by a psychologist licensed by the Louisiana State Board of Examiners of Psychologists.

F. Social services shall be provided by a director who is a licensed clinical social worker and is experienced in the social service needs of the mentally ill.

G. Therapeutic activities shall be clinically supervised and provided by therapeutic recreational therapists adequate in number to respond to the therapeutic activity needs of the patient population being served.

1. An individual who clinically supervises therapeutic recreation activities shall meet the following qualifications:

a. have a degree in therapeutic recreation therapy from an accredited post-secondary institution; or

b. have a degree in another field of study and has also attained certification in accordance with the National Council for Therapeutic Recreation Certification requirements.

2. An individual who provides therapeutic recreational services shall have the following qualifications:

a. a degree in therapeutic recreation from an accredited post-secondary institution; or

b. a degree in another field of study and has also attained certification in accordance with the National Council for Therapeutic Recreation Certification requirements; or

c. a minimum of 10 years' experience providing therapeutic recreational services; or

d. be currently employed as a therapeutic recreational specialist 2 per Louisiana Civil Service requirements.

3. Individuals currently providing therapeutic recreational services who do not meet the qualifications of §9501.G.1-2.d, shall have two years from the effective date of this Rule to qualify as therapeutic recreational therapists.

4. Licensed hospitals providing therapeutic recreational services pursuant to §9501 and whose staff do not meet the qualifications of §9501.G.2.a-d within the time frame provided for in §9501.G.3, shall submit to the department documentation which:

a. clearly indicates why the qualifications have not been met; and

b. provides evidence of a barrier to access of such services in the hospital's service area.

5. No hospital shall submit the documentation allowed for in §9501.G.4 more than once and the submission shall cover a period of no more than 12 months from the date of receipt by the department.

6. Recreational therapy shall be designed to:

a. restore, remediate and rehabilitate a person's level of functioning and independence in life activities;

b. promote health and wellness; and

c. reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition.

NOTE: Examples of intervention modalities include, but are not limited to, creative arts (e.g., crafts, music, dance, drama, among others), sports, adventure programming, dance/movement, and leisure education.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2426 (November 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1489 (August 2015).

Subchapter S. Obstetrical and Newborn Services (Optional)

§9505. General Provisions for Hospitals Licensed as of January 1, 2022

A. Sections 9505-9509 shall be effective immediately upon publication of these provisions for existing hospitals licensed as of July 1, 2022, and shall remain in effect through November 30, 2023. Such hospitals must be in compliance with Sections 9511-9517 beginning December 1, 2023.

1. The level of care of the neonatal intensive care unit (NICU) is not required to match or exceed the level of obstetrical care for each level of obstetrical service.

2. For facilities that change the level of care and services of the facility's NICU unit, either decreasing or increasing the level provided, the facility shall submit an attestation of this change to the department's Health Standards Section (HSS) in writing and on the appropriate state neonatal services Medicaid attestation form. Such notice shall be submitted to the HSS within 90 days of the facility's change in NICU level provided. For facilities that change the level of care and services of a facility's obstetrical unit, by either decreasing or increasing the level provided, the facility shall submit written notice of this change to HSS within 90 days of such change.

B. For purposes of this Subchapter, hospital privileges are such privileges that are unrestricted and approved by the medical staff committee and the governing body that allows the practitioner to perform all duties within their scope of practice and certification(s) at the hospital in which the privileges are granted and such duties are performed.

1. The requirements for privileges, such as active privileges, inpatient privileges or full privileges, shall be

defined in hospital policy and approved by each hospital's governing body.

C. In accordance with R.S. 40:2109, a hospital located in a parish with a population of 250,000 people or less shall not be required to maintain personnel in-house with credentials to administer obstetric anesthesia on a 24-hour basis in order to qualify for Medicaid reimbursement for level III, neonatal or obstetric medical services, or as a prerequisite for licensure to provide such services. Personnel with such credentials may be required to be on staff and readily available on a 24-hour on-call basis and demonstrate ability to provide anesthesia services within 20 minutes.

NOTE: The provisions of §9505.C shall not apply to any hospital with level IIIS, IIIR or IV obstetrical and neonatal services.

D. For purposes of this Subchapter, the requirements for hospital staff and/or equipment as being immediately or readily available shall be defined by hospital policy and approved by each hospital's governing body.

E. Any transfer agreements shall be in writing and approved by the hospital medical staff and by each hospital's governing body. Transfer agreements shall be reviewed at least annually and revised as needed.

F. For those hospitals providing transports, the qualifications of the transport team shall be in writing, defined by hospital policy and approved by each hospital's governing body. Such qualifications shall be reviewed at least annually and revised as needed.

G. The hospital shall have data collection and retrieval capabilities in use, and shall cooperate and report the requested data to the appropriate supervisory agencies to review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2427 (November 2003), amended LR 33:284 (February 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 43:75 (January 2017), LR 46:1087 (August 2020), LR 48:2569 (October 2022).

§9507. Obstetrical Units

A. These requirements are applicable to those hospitals which provide obstetrical and neonatal services.

B. Levels of Care Units. There are five established obstetrical levels of care units:

1. obstetrical level I unit;
2. obstetrical level II unit;
3. obstetrical level III unit;
4. obstetrical level III regional unit; and
5. obstetrical level IV.

C. Obstetrical services shall be provided in accordance with acceptable standards of practice as delineated in the 2014 *AAP/ACOG Guidelines for Perinatal Care*. Each advanced level of care unit shall provide all services and meet the personnel requirements of the lower designated units, as applicable, i.e., a level IV unit must meet the requirements of a level I, II, III and III regional unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2427 (November 2003), amended LR 33:284 (February 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 43:75 (January 2017).

§9509. Obstetrical Unit Functions

A. Obstetrical Level I Unit

1. General Provisions

a. Care and supervision for low risk pregnancies greater or equal to 35 weeks gestation shall be provided.

b. There shall be a triage system present in policies and procedures for identification, stabilization and referral of high risk maternal and fetal conditions beyond the scope of care of a level I unit.

c. There shall be protocols and capabilities for massive transfusion, emergency release of blood products, and management of multiple component therapy available on-site.

d. Postpartum care facilities shall be available on-site.

e. There shall be capability to provide for resuscitation and stabilization of inborn neonates.

f. The hospital shall have a policy for infant security and an organized program to prevent infant abductions.

g. The hospital shall have a program in place to address the needs of the family, including parent-sibling-neonate visitation.

h. The hospital shall have a written transfer agreement with another hospital that has an approved appropriate higher level of care.

2. Personnel Requirements

a. Obstetrical services shall be under the medical direction of a qualified physician who is a member of the medical staff with obstetric privileges. The physician shall be board certified or board eligible in obstetrics/gynecology or family practice medicine. The physician has the responsibility of coordinating perinatal services with the pediatric chief of service.

b. The nursing staff shall be adequately trained and staffed to provide patient care at the appropriate level of service. Registered nurse to patient ratios may vary in accordance with patient needs.

c. The unit shall provide credentialed medical staff to ensure the capability to perform emergency Cesarean delivery within 30 minutes of the decision to operate (30 minutes from decision to incision).

d. Anesthesia, radiology, ultrasound, electronic fetal monitoring (along with personnel skilled in the use of these)

and laboratory services shall be available on a 24-hour basis. Anesthesia services shall be available to ensure performance of a Cesarean delivery within 30 minutes as specified in Subparagraph c above.

e. At least one credentialed physician or certified registered nurse midwife shall attend all deliveries, and at least one individual who is American Academy of Pediatrics (AAP) certified in neonatal resuscitation and capable of neonatal resuscitation shall attend all deliveries.

f. The nurse manager shall be a registered nurse (RN) with specific training and experience in obstetric care. The RN manager shall participate in the development of written policies, procedures for the obstetrical care areas, and coordinate staff education and budget preparation with the chief of service. The RN manager shall name qualified substitutes to fulfill duties during absences.

g. A facility shall have at least one individual with additional education in breastfeeding who is available for support, counseling and assessment of breastfeeding mothers.

h. A facility shall have ability to initiate education and quality improvement programs to maximize patient safety, and/or collaborate with higher-level facilities to do so.

3. Physical Plant

a. Obstetrical patients shall not be placed in rooms with non-obstetrical patients.

b. Each room shall have at least one toilet and lavatory basin for the use of obstetrical patients.

c. The arrangement of the rooms and areas used for obstetrical patients shall be such as to minimize traffic of patients, visitors, and personnel from other departments and prevent traffic through the delivery room(s).

d. There shall be an isolation room provided with hand washing facilities for immediate segregation and isolation of a mother and/or baby with a known or suspected communicable disease.

e. For any new construction or major alteration of the obstetrical unit/suite, the hospital shall ensure that the OB unit has a Cesarean delivery room (surgical operative room) to perform Cesarean deliveries at all times.

B. Obstetrical Level II Unit

1. General Provisions

a. The role of an obstetrical Level II unit is to provide care for most obstetric conditions in its population, but not to accept transports of obstetrical patients with gestation age of less than 32 weeks or 1,500 grams if delivery of a viable infant is likely to occur.

b. Women with conditions that would result in the delivery of an infant weighing less than 1,500 grams or less than 32 weeks gestation shall be referred to an approved level III or above unit unless the attending physician has documented that the patient is unstable to transport safely. Written transfer agreements with approved obstetrical level III and above units for transfer of these patients shall exist for all obstetrical level II units.

c. Ultrasound equipment shall be on site, in the hospital, and available to labor and delivery 24 hours a day.

2. Personnel Requirements

a. The chief of obstetric services shall be a board-certified obstetrician or a board eligible candidate for certification in obstetrics. This obstetrician has the responsibility of coordinating perinatal services with the neonatologist in charge of the neonatal intensive care unit (NICU).

b. A board-certified radiologist and a board-certified clinical pathologist shall be available 24 hours a day. Specialized medical and surgical consultation shall be readily available.

c. There shall be a continuous availability of qualified RNs with the ability to stabilize and transfer high-risk women.

d. A board-certified or board eligible OB-GYN physician shall be available 24 hours a day.

EXCEPTION: For those hospitals whose staff OB-GYN physician(s) do not meet the provisions of §9509.B(2)d, such physician(s) may be grandfathered as satisfying the requirement of §9509.B(2)d when the hospital has documented evidence that the OB-GYN physician(s) was granted clinical staff privileges by the hospital prior to the effective date of this Rule. This exception applies only to the physician at the licensed hospital location and is not transferrable.

e. A licensed physician board-certified in maternal fetal medicine (MFM) shall be available 24 hours a day for consultation onsite, by telephone, or by telemedicine, as needed.

f. Anesthesia services shall be available 24 hours a day to provide labor analgesia and surgical anesthesia.

g. A board-certified anesthesiologist with specialized training or experience in obstetric anesthesia shall be available 24 hours a day for consultation.

h. Medical and surgical consultants shall be available 24 hours a day to stabilize obstetric patients who have been admitted to the facility or transferred from other facilities.

C. Obstetrical Level III Unit

1. General Provisions

a. Women with conditions requiring a medical team approach not available to the perinatologist in an obstetrical level III unit shall be transported to a higher-level unit.

b. The unit shall have written cooperative transfer agreements with approved higher level units for the transport of mothers and fetuses requiring care unavailable in an obstetrical level III unit or that are better coordinated at a higher level unit.

c. The hospital shall have advanced imaging services available 24 hours a day which will include

magnetic resonance imaging (MRI) and computed topography (CT).

d. The hospital shall have medical and surgical ICUs to accept pregnant women and have qualified critical care providers available as needed to actively collaborate with MFM physicians 24 hours a day.

e. Participation is required in a statewide quality collaborative and database selected by the Medicaid Quality Committee, Maternity Subcommittee, with a focus on quality of maternity care. Proof of such participation will be available from the LDH website.

f. Equipment and qualified personnel, adequate in number, shall be available onsite to ventilate and monitor women in labor and delivery until they can be safely transferred to the ICU.

g. This unit shall accept maternal transfers as deemed appropriate by the medical staff and governing body.

2. Personnel Requirements

a. The delivery of safe and effective perinatal nursing care requires appropriately qualified registered nurses in adequate numbers to meet the nursing needs of each patient. The hospital shall develop, maintain and adhere to an acuity-based classification system based on nationally recognized staffing guidelines and shall have documentation of such.

b. A board-certified or board-eligible MFM physician with inpatient privileges shall be available 24 hours a day, either onsite, by telephone, or by telemedicine.

c. The director of MFM services shall be a board-certified or board eligible MFM physician.

d. The director of obstetric service shall be a board-certified OB-GYN with active staff privileges in obstetrical care.

e. Anesthesia services shall be available 24 hours a day onsite.

f. A board-certified anesthesiologist with specialized training or experience in obstetric anesthesia shall be in charge of obstetric anesthesia services and shall be available onsite as needed.

g. A full complement of subspecialists, including subspecialists in critical care, general surgery, infectious disease, urology, hematology, cardiology, nephrology, neurology, neonatology and pulmonology shall be available for inpatient consultations.

h. A lactation consultant or counselor shall be on staff to assist breastfeeding mothers as needed.

i. The lactation consultant or counselor shall be certified by a nationally recognized board on breastfeeding.

i. A nutritionist and a social worker shall be on staff and available for the care of these patients as needed.

D. Obstetrical Level III Regional Unit

1. General Provisions

a. This unit shall provide care for the most challenging of perinatal conditions. Women with such conditions requiring a medical team approach not available to the MFM physician in an obstetrical level III Regional unit shall be transported to a level IV unit.

b. This unit shall have written cooperative transfer agreements with a level IV unit for the transport of mothers and fetuses requiring care that is unavailable in the level III regional unit or that is better coordinated at a level IV.

c. This unit shall accept maternal transfers as deemed appropriate by the medical staff and hospital governing body.

2. Personnel Requirements

a. This unit shall have a board-certified or board-eligible OB/GYN available onsite 24 hours a day.

b. The director of MFM services for this unit shall be board-certified in MFM.

c. This unit shall have an anesthesiologist qualified in the delivery of obstetric anesthesia services available to be onsite 24 hours a day.

E. Obstetrical Level IV Unit

1. General Provisions

a. This unit shall provide onsite medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and postpartum care.

2. Unit Requirements

a. This unit shall have perinatal system leadership, including facilitation of maternal referral and transport, outreach education for facilities and health care providers in the region and analysis and evaluation of regional data, including perinatal complications and outcomes and quality improvement.

b. Participation is required in the department's designated statewide quality collaborative program.

NOTE: The hospital shall acquire and maintain documented proof of participation.

3. Personnel

a. This unit shall have a MFM care team with the expertise to assume responsibility for pregnant women and women in the postpartum period who are in critical condition or have complex medical conditions. This includes co-management of ICU-admitted obstetric patients. The MFM team members shall have full privileges and shall be available 24 hours per day for onsite consultation and management. This team shall be led by a board-certified MFM physician.

b. The director of obstetric services for this unit shall be a board-certified MFM physician.

c. This unit shall have qualified subspecialists on staff to provide consultation in the care of critically ill pregnant women in the following areas:

i. cardiothoracic surgery;

ii. neurosurgery;

iii. endocrinology; and

iv. gastroenterology.

d. Obstetrical Medical Subspecialties

Table 1—Obstetrical Medical Subspecialties				
Each higher level obstetrical unit shall meet the requirements of each lower level obstetrical unit.				
Level I	**Level II**	**Level III**	**Level III Regional**	**Level IV**
Board Certified or Eligible OB/GYN or Family Practice Physician	Board Certified/Eligible OB/GYN §9509.B(2)d -See Exception	Board Certified/Eligible Anesthesiologist	Board Certified/Eligible Anesthesiologist	Board Certified/Eligible Anesthesiologist
Anesthesia services	Anesthesia services*	Board Certified OB/GYN	Board Certified OB/GYN	Board Certified OB/GYN
Radiology services	Clinical Pathologist[1]	Board Certified/Board Eligible MFM[1]**	Board Certified/Board Eligible MFM**	Board Certified MFM**
Ultrasonography	Clinical Radiologist	Clinical Pathologist[1]	Clinical Pathologist[1]	Clinical Pathologist[1]
Laboratory services	MFM[1]**	Clinical Radiologist[1]	Clinical Radiologist[1]	Clinical Radiologist[1]
Electronic fetal monitoring	Lactation Consultant/Counselor See §9509.B(h.i)	Critical Care[1]	Critical Care[1]	Critical Care[1]
		General Surgery[1]	General Surgery[1]	General Surgery[1]
		Infectious Disease[1]	Infectious Disease[1]	Infectious Disease[1]
		Urology[1]	Urology[1]	Urology[1]
		Hematology[1]	Hematology[1]	Hematology[1]
		Cardiology[1]	Cardiology[1]	Cardiology[1]
		Nephrology[1]	Nephrology[1]	Nephrology[1]
		Neurology[1]	Neurology[1]	Neurology[1]
		Neonatology[1]	Neonatology[1]	Neonatology[1]
		Pulmonology[1]	Pulmonology[1]	Pulmonology[1]
		Lactation Consultant/Counselor	Lactation Consultant/Counselor	Lactation Consultant/Counselor
		Nutritionist	Nutritionist	Nutritionist
		Social Worker	Social Worker	Social Worker
				Cardiothoracic Surgery[1]
				Gastroenterology[1]
				Endocrinology[1]
[1] physician shall be available in person on site as needed by the facility.				Neurosurgery[1]
*Anesthesia services shall be available 24 hours a day to provide labor analgesia and surgical anesthesia. A board-certified/eligible anesthesiologist with specialized training or experience in obstetric anesthesia shall be available 24 hours a day for consultation.				
**Licensed MFM shall be available for consultation onsite, by telephone, or by telemedicine, as needed.				

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2427 (November 2003), amended LR 33:284 (February 2007).

§9511. General Provisions for Hospitals Licensed After January 1, 2022, and for Existing Hospitals Beginning July 1, 2023

A. Sections 9511-9517 shall be effective immediately upon publication of these provisions for hospitals licensed after January 1, 2022.

1. Sections 9511-9517 shall be effective for existing hospitals (those licensed by or before January 1, 2022) beginning July 1, 2023.

B. The level of care of the neonatal ICU is not required to match or exceed the level of obstetrical care for each level of obstetrical service.

C. For facilities that change the level of care and services of the facility's NICU unit, either decreasing or increasing the level provided, the facility shall submit an attestation of this change to the department's HSS in writing and on the appropriate state neonatal services Medicaid attestation form. Such notice shall be submitted to the HSS within 90 days of the facility's change in NICU level provided. For facilities that change the level of care and services of a facility's obstetrical unit, by either decreasing or increasing the level provided, the facility shall submit written notice of this change to HSS within 90 days of such change.

D. For purposes of this Subchapter, the requirements for hospital staff and/or equipment as being physically present at all times specifies the person and/or equipment shall be on-site in the location 24 hours a day, 7 days a week.

E. For purposes of this Subchapter, the requirements for hospital staff and/ or equipment as being readily available at all times specifies the person shall be available, as approved by hospital policy, 24 hours a day, 7 days a week.

F. Any transfer agreements shall be in writing and approved by the hospital medical staff and by each hospital's governing body. Transfer agreements shall be reviewed at least annually and revised as needed.

G. For those hospitals providing transports, the qualifications of the transport team shall be in writing, defined by hospital policy and approved by each hospital's governing body. Such qualifications shall be reviewed at least annually and revised as needed.

H. The hospital shall have data collection and retrieval capabilities in use, and shall cooperate and report the requested data to the appropriate supervisory agencies to review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2428 (November 2003), amended LR 33:286 (February 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 43:78 (January 2017), LR 48:2569 (October 2022).

§9513. Organization and Staffing

A. For purposes of this Subchapter, hospital privileges are such privileges that are unrestricted and approved by the medical staff committee and the governing body that allows the practitioner to perform all duties within their scope of practice and certification(s) at the hospital in which the privileges are granted and such duties are performed.

1. The requirements for privileges, such as active privileges, inpatient privileges or full privileges, shall be defined in hospital policy and approved by each hospital's governing body.

B. In accordance with R.S. 40:2109, a hospital located in a parish with a population of 250,000 people or less shall not be required to maintain personnel in-house with credentials to administer obstetric anesthesia on a 24-hour basis in order to qualify for Medicaid reimbursement for level III, neonatal or obstetric medical services, or as a prerequisite for licensure to provide such services. Personnel with such credentials may be required to be on staff and readily available on a 24-hour on-call basis and demonstrate ability to provide anesthesia services within 20 minutes.

NOTE: The provisions of §9513.B shall not apply to any hospital with level IIIS, IIIR or IV obstetrical and neonatal services.

C. For purposes of this Subchapter, the requirements for hospital staff and/or equipment as being physically present at all times means that the person and/or equipment shall be on-site in the location 24 hours a day, 7 days a week.

D. For purposes of this Subchapter, the requirements for hospital means that the person shall be available 24 hours a day, 7 days a week.

E. Any transfer agreements shall be in writing and approved by the hospital medical staff and by each hospital's governing body. Transfer agreements shall be reviewed at least annually and revised as needed.

F. For those hospitals providing transports, the qualifications of the transport team shall be in writing, defined by hospital policy and approved by each hospital's governing body. Such qualifications shall be reviewed at least annually and revised as needed.

G. The hospital shall have data collection and retrieval capabilities in use, and shall cooperate and report the requested data to the appropriate supervisory agencies to review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2429 (November 2003), amended LR 33:286 (February 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 43:78 (January 2017), LR 43:1979 (October 2017), LR 48:2569 (October 2022).

§9515. Obstetrical Units

A. These requirements are applicable to those hospitals which provide obstetrical and neonatal services.

B. Levels of Care Units. These are five established obstetrical levels of care units:

1. obstetrical level I unit;
2. obstetrical level II unit;
3. obstetrical level III unit;
4. obstetrical level III regional unit; and
5. obstetrical level IV.

C. The guidance for these standards is based on *Obstetric Care Consensus: Levels of Maternal Care* published in August 2019. Each advanced level of care unit shall provide all services and meet the personnel requirements of the lower designated units, as applicable, i.e., a level IV unit shall meet the requirements of a level I, II, III and III regional unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2429 (November 2003), amended LR 33:288 (February 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 43:82 (January 2017), LR 48:2570 (October 2022).

§9517. Obstetrical Unit Functions

A. Obstetrical Level I Unit (Basic Care)

1. General Provisions

a. Care and supervision for low risk pregnancies greater or equal to 35 weeks gestation and postpartum patients who are generally healthy and do not have medical, surgical, or obstetrical conditions that present a significant risk of maternal morbidity or mortality, shall be provided.

b. Participation in the state perinatal quality collaborative, which is under the authority of the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality, is required and defined as reporting national perinatal measures determined by the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality.

c. There shall be a triage system present in policies and procedures for identification, stabilization and referral of high risk maternal and fetal conditions beyond the scope of care of a level I unit, including situations where an infant will require a higher level of care than what may be provided by the neonatal level of care of the facility.

d. Postpartum care facilities shall be available on-site.

e. There shall be capability to provide for resuscitation and stabilization of inborn neonates.

f. The hospital shall have a policy for infant security and an organized program to prevent infant abductions.

g. The hospital shall have a program in place to address the needs of the family, including parent-sibling-neonate visitation.

h. The hospital shall have a written transfer agreement with another hospital that has an approved appropriate higher level of care.

i. The hospital shall have the capability to screen, provide brief intervention and refer to treatment through consultation with appropriate personnel for behavioral health disorders, including depression, and substance use disorder.

j. Social services, pastoral care and bereavement services shall be provided as appropriate to meet the needs of the patient population served.

2. Personnel Requirements

a. Obstetrical services shall be under the medical direction of a qualified physician who is a member of the medical staff with obstetric privileges. The physician shall be board certified or board eligible in obstetrics/gynecology or family practice medicine. The physician has the responsibility of coordinating perinatal services with the pediatric chief of service.

b. The nursing staff shall be adequately trained and staffed to provide patient care at the appropriate level of service. Registered nurse to patient ratios may vary in accordance with patient needs.

c. The unit shall provide credentialed medical staff to ensure the capability to perform emergency cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits.

d. The maternal care providers, including midwives, family physicians or obstetricians, shall be readily available at all times.

e. Anesthesia, radiology, ultrasound, electronic fetal monitoring (along with personnel skilled in the use of these) and laboratory services shall be readily available at all times.

f. At least one credentialed physician or certified registered nurse midwife shall attend all deliveries, and at least one individual who is American Academy of Pediatrics (AAP) certified in neonatal resuscitation and capable of neonatal resuscitation shall attend all deliveries.

g. The nurse manager shall be a registered nurse (RN) with specific training and experience in obstetric care. The RN manager shall participate in the development of written policies, procedures for the obstetrical care areas, and coordinate staff education and budget preparation with the chief of service. The RN manager shall name qualified substitutes to fulfill duties during absences.

h. A facility shall have at least one individual with additional education in breastfeeding who is available for support, counseling and assessment of breastfeeding mothers.

i. A facility shall have ability to initiate education and quality improvement programs to maximize patient safety, and/or collaborate with higher-level facilities to do so.

3. Physical Plant

a. Laboring and postpartum patients shall not be placed in rooms with non-obstetrical patients.

b. Each room shall have at least one toilet and lavatory basin for the use of obstetrical patients.

c. The arrangement of the rooms and areas used for obstetrical patients shall be such as to minimize traffic of patients, visitors, and personnel from other departments and prevent traffic through the delivery room(s).

d. There shall be an isolation room provided with hand washing facilities for immediate segregation and isolation of a mother and/or baby with a known or suspected communicable disease.

e. For any new construction or major alteration of the obstetrical unit/suite, the hospital shall ensure that the OB unit has a cesarean delivery room (surgical operative room) to perform cesarean deliveries at all times.

4. Program Functions and Services

a. Laboratory and Blood Bank Services

i. There shall be protocols and capabilities for massive transfusion with process to obtain more blood and component therapy as needed, emergency release of blood products and management of multiple component therapy available on-site.

b. Medical Imaging Services

i. Ultrasound equipment shall be physically present at all times in the hospital and available during labor and delivery.

ii. Basic ultrasound imaging for maternal or fetal assessment including interpretation, shall be readily available at all times.

c. Obstetrical Services

i. Ensure the availability and interpretation of non-stress testing and electronic fetal monitoring.

ii. A trial of labor for patients with prior cesarean delivery may be attempted only if the necessary personnel to perform a cesarean delivery and perform maternal

resuscitation are physically present. This personnel includes, all credentialed medical staff needed to perform an emergency cesarean delivery.

iii. The facility shall have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity and/or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols shall address at a minimum:

(a). massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination with the blood bank, including management of unanticipated hemorrhage and/or coagulopathy;

(b). hypertensive disorders in pregnancy;

(c). sepsis and/or systemic infection in the pregnant or postpartum patient; and

(d). venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, and early diagnosis and treatment.

B. Obstetrical Level II Unit (Specialty Care)

1. General Provisions

a. the role of an obstetrical level II unit is to provide care for pregnant and postpartum patients with medical, surgical and/or obstetrical conditions that present a moderate risk of maternal morbidity or mortality; and

b. women with high risk of morbidity or mortality or conditions that would result in the delivery of an infant weighing less than 1,500 grams or less than 32 weeks gestation that will require a higher level of care than what may be provided by the neonatal level of care of the facility, shall be referred to an approved level III or above unit unless the attending physician has documented that the patient is unstable to transport safely. Written transfer agreements with approved obstetrical level III and above units for transfer of these patients shall exist for all obstetrical level II units.

2. Personnel Requirements

a. Obstetric Service Leadership

i. The physician obstetric leader shall be a board-certified obstetrician or a board eligible candidate for certification in obstetrics. This obstetrician has the responsibility of coordinating perinatal services with the neonatal healthcare provider in charge of the neonatal intensive care unit (NICU).

b. Personnel

i. A board-certified or board eligible OB-GYN physician shall be readily available at all times.

EXCEPTION: For those hospitals whose staff OB-GYN physician(s) do not meet the provisions of §9517.B.2.b.i, such physician(s) may be grandfathered as satisfying the requirement of §9517.B.2.b.i when the hospital has documented evidence that the OB-GYN physician(s) was granted clinical staff privileges by the hospital prior to the effective date of this Rule. This exception applies only to the physician at the licensed hospital location and shall not be transferrable.

ii. A licensed physician board-certified or board eligible in maternal fetal medicine (MFM) shall be readily available at all times for consultation on-site, by telephone or by telemedicine, as needed. Timing and need to be on-site or available by telemedicine shall be directed by the urgency of the clinical situation.

iii. Anesthesia services shall be readily available at all times to provide labor analgesia and surgical anesthesia. A board-certified anesthesiologist with specialized training or experience in obstetric anesthesia shall be readily available at all times for consultation.

iv. A board-certified radiologist and a board-certified clinical pathologist shall be readily available at all times. Internal or family medicine physician(s) and general surgeon(s) shall be readily available at all times for consultation to stabilize obstetric patients who have been admitted to the facility or transferred from other facilities.

v. There shall be a continuous availability of qualified RNs with the ability to stabilize and transfer high-risk women.

vi. A lactation consultant or counselor shall be on staff to assist breastfeeding mothers as needed.

vii. The lactation consultant or counselor shall be certified by a nationally recognized board on breastfeeding. If individuals with such certification are not on staff, services may be obtained from certified providers through the use of telehealth, subject to requirements of any licensing board(s).

3. Program Functions and Services

a. Medical Imaging Services

i. Computed tomography (CT) scan, magnetic resonance imaging (MRI), non-obstetric ultrasound imagining and maternal echocardiography with interpretation shall be readily available at all times.

ii. Specialized obstetric ultrasound and fetal assessment with interpretation shall be readily available at all times.

C. Obstetrical Level III Unit (Subspecialty Care)

1. General Provisions

a. This unit shall provide care for moderate to high-risk perinatal conditions. Women with such conditions requiring a medical team approach not available to the perinatologist in an obstetrical level III unit shall be transported to a higher-level unit.

b. The unit shall have written cooperative transfer agreements with approved higher level units for the transport of mothers and fetuses requiring care unavailable in an obstetrical level III unit or that are better coordinated at a higher level unit.

c. The hospital shall have advanced imaging services readily available at all times which shall include MRI and CT.

d. The hospital shall have medical and surgical ICUs to accept pregnant women and women in the

postpartum period and, shall have qualified critical care providers readily available at all times to actively collaborate with MFM physicians.

e. Equipment and qualified personnel, adequate in number, shall be available on-site to ventilate and monitor women in labor and delivery until they can be safely transferred to the ICU.

f. This unit shall accept maternal transfers as deemed appropriate by the medical staff and governing body.

2. Personnel Requirements

a. Obstetric Leadership

i. The physician obstetric leader shall be a board-certified OB-GYN with active staff privileges in obstetrical care.

ii. A board-certified anesthesiologist with specialized training or experience in obstetric anesthesia shall be in charge of obstetric anesthesia services.

iii. The director of MFM services shall be a board-certified or board eligible MFM physician.

b. Personnel

i. This unit shall have a board-certified or board-eligible OB-GYN readily available at all times and available to be physically present within 20 minutes of request to be on-site.

ii. This unit shall have a board-certified or a board-eligible anesthesiologist qualified in the delivery of obstetric anesthesia services readily available at all times. Personnel with such credentials shall be required to be on staff and readily available on a 24-hour on-call basis, and demonstrate the ability to provide anesthesia services within 20 minutes.

iii. A board-certified or board-eligible MFM physician with inpatient privileges shall be readily available at all times, either on-site, by telephone or by telemedicine.

iv. A full complement of subspecialists, including subspecialists in critical care, general surgery, infectious disease, urology, hematology, cardiology, nephrology, neurology, gastroenterology, internal medicine, behavioral health, neonatology and pulmonology shall be readily available at all times for inpatient consultations.

v. Anesthesia services shall be physically present at all times, unless otherwise provided by R.S. 40:2109(B)(6).

vi. The delivery of safe and effective perinatal nursing care requires appropriately qualified registered nurses in adequate numbers to meet the nursing needs of each patient. The hospital shall develop, maintain and adhere to an acuity-based classification system based on nationally recognized staffing guidelines and shall have documentation of such.

vii. A nutritionist and a social worker shall be on staff and available for the care of these patients as needed.

D. Obstetrical Level III Regional Unit (Regional Transfer Unit).

1. General Provisions

a. This unit shall provide care for the most challenging of perinatal conditions. Women with such conditions requiring a medical team approach not available to the MFM physician in an obstetrical level III regional unit shall be transported to a level IV unit.

b. This unit shall have written cooperative transfer agreements with a level IV unit for the transport of mothers and fetuses requiring care that is unavailable in the level III regional unit or that is better coordinated at a level IV.

c. This unit shall accept maternal transfers as deemed appropriate by the medical staff and hospital governing body.

2. Personnel Requirements

a. This unit shall have a board-certified or board-eligible OB-GYN physically present at all times.

b. The director of MFM services for this unit shall be a board-certified MFM physician.

c. This unit shall have an anesthesiologist qualified in the delivery of obstetric anesthesia services physically present at all times.

E. Obstetrical Level IV Unit (Regional Subspecialty Perinatal Health Care Centers)

1. General Provisions

a. This unit shall provide on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and postpartum care.

2. Unit Requirements

a. This unit shall have perinatal system leadership, including facilitation of maternal referral and transport, outreach education for facilities and health care providers in the region and analysis and evaluation of regional data, including perinatal complications and outcomes and quality improvement.

3. Personnel

a. Obstetric Leadership

i. The physician obstetric leader for this unit shall be a board-certified MFM physician.

b. Personnel

i. This unit shall have a MFM care team with the expertise to assume responsibility for pregnant women and women in the postpartum period who are in critical condition or have complex medical conditions. This includes co-management of ICU-admitted obstetric patients. The MFM team members shall have full privileges and shall be available 24 hours per day for on-site consultation and management. This team shall be led by a board-certified MFM physician.

ii. This unit shall have qualified subspecialists on staff, readily available at all times, to provide consultation and treatment as needed on-site in the care of critically ill pregnant women in the following areas:

(a). cardiothoracic surgery and

(b). neurosurgery.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:2570 (October 2022).

§9519. Neonatal Intensive Care [Formerly LAC 48:I.9511]

A. This §9519 is applicable to those hospitals which provide obstetrical and neonatal services.

B. Levels of Care. There are five established neonatal levels of care units:

1. neonatal level I unit;
2. neonatal level II unit;
3. level III NICU unit;
4. level III surgical NICU; and
5. level IV NICU unit.

C. Each advanced level of care unit shall provide all services and meet the personnel requirements of the lower designated units, as applicable, i.e., a level III surgical unit must meet the requirements of the level I, II, and III units.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:2573 (October 2022).

§9521. Neonatal Unit Functions [Formerly LAC 48:I.9513]

A. Level I Neonatal Unit (Well Newborn Nursery)

1. General Provisions

a. This unit shall have the capability for resuscitation and stabilization of all inborn neonates in accordance with Neonatal Resuscitation Program (NRP) guidelines. The unit shall stabilize unexpectedly small or sick neonates before transfer to the appropriate advanced level of care.

b. The unit shall stabilize and provide care for infants born at 35 weeks or greater gestation and who remain physiologically stable. The requirements for maternal transport at lesser gestations for transfer to a higher level of care shall be determined by the medical staff and approved by the hospital governing body.

c. This unit shall have the capability to stabilize newborns born at less than 35 weeks gestational age for transfer to higher level of care.

d. This unit shall maintain consultation and written transfer agreements with an approved level II or III as appropriate.

e. This unit shall have a defined, secured nursery area with limited public access and/or secured rooming-in facilities with supervision of access.

f. Parent and/or sibling visitation/interaction with the neonate shall be provided.

2. Personnel Requirements

a. The unit's chief of service shall be a physician who is board-certified or board-eligible in pediatric or family practice medicine.

b. The nurse manager shall be a registered nurse with specific training and experience in neonatal care. The RN manager shall participate in the development of written policies and procedures for the neonatal care areas, and coordinate staff education and budget preparation with the chief of service. The RN manager shall name qualified substitutes to fulfill duties during absences.

c. Registered nurse to patient ratios may vary in accordance with patient needs. If couplet care or rooming-in is used, a registered nurse who is responsible for the mother shall coordinate and administer neonatal care. If direct assignment of the nurse is also made to the nursery to cover the newborn's care, there shall be double assignment (one nurse for the mother-neonate couplet and one for just the neonate if returned to the nursery). A registered nurse shall be available 24 hours a day, but only one may be necessary as most neonates will not be physically present in the nursery. Direct care of neonates in the nursery may be provided by ancillary personnel under the registered nurse's direct supervision. Adequate staff is needed to respond to acute and emergency situations.

B. Neonatal Level II Unit (Special Care Nursery)

1. General Provisions

a. This unit shall provide care for infants born at more than 32 weeks gestation and weighing more than 1,500 grams.

i. infants who have medical problems that are expected to resolve rapidly and are not anticipated to need emergent subspecialty services from a higher level NICU as determined by the attending medical staff.

b. This unit shall have the capability to provide mechanical ventilation and/or CPAP for a brief duration (less than 24 hours) for infants born at more than 32 weeks and weighing more than 1,500 grams.

c. Neonates requiring greater than 24 hours of continuous ventilator support shall be transferred to a higher-level neonatal intensive care facility.

d. This unit shall have the ability to stabilize infants born before 32 weeks gestation and/or weighing less than 1,500 grams until transfer to a higher level neonatal intensive care facility.

e. Neonates requiring transfer to a higher-level neonatal intensive care facility may be returned to a level II unit for convalescence.

2. Personnel Requirements

a. A board-certified neonatologist shall be the chief of service.

NOTE: This unit shall have continuously available medical staff defined as available 24 hours per day/7 days per week/365 days per year on call for consultation as defined by medical staff bylaws.

b. Registered nurse to patient ratios may vary in accordance with patient needs.

c. This unit shall have at least one full-time social worker to be available as needed to assist with the socioeconomic and psychosocial problems of high-risk mothers, sick neonates, and their families.

d. This unit shall have at least one occupational or physical therapist to be available as needed to assist with the care of the newborn.

e. This unit shall have at least one registered dietitian/nutritionist to be available as needed who can plan diets as required to meet the special needs of mothers and high-risk neonates.

f. This unit shall have staff available 24 hours per day who have the demonstrated knowledge, skills, abilities and training to provide the care and services to infants in this unit, such as but not limited to:

i. nurses;

ii. respiratory therapists;

iii. radiology technicians; and

iv. laboratory technicians.

3. Equipment Requirements

a. This unit shall have hospital based equipment to provide care to infants available 24 hours per day, such as but not limited to:

i. portable x-ray machine;

ii. blood gas analyzer.

C. Level III NICU

1. General Provisions

a. There shall be a written neonatal transport agreement with an approved level III surgical unit or level IV unit.

b. This unit shall have either a neonatologist or a neonatal nurse practitioner or a neonatology fellow in-house 24 hours per day.

c. The staffing of this unit shall be based on patient acuity and consistent with the recommended staffing guidelines of the 2012 Seventh Edition of the *AAP Guidelines for Perinatal Care*. For medical sub-specialty requirements, refer to Table 1, Neonatal Medical Subspecialties and Transport Requirements.

NOTE: All provisions of level III NICUs are required of level IIIS and IV NICUs.

2. Personnel Requirements

a. The chief of service of a level III NICU shall be a board-certified neonatologist.

EXCEPTION: In 1995, those physicians in existing units who were designated as the chief of service of the unit and who were not neonatal or perinatal board-certified, were granted a waiver by written application to the Office of the Secretary, Department of Health. This waiver shall be maintained as it applies only to the hospital where that chief of service's position is held. The physician cannot relocate to another hospital nor can the hospital replace the chief of service for whom the exception was granted and retain the exception.

b. This unit shall have at least one full-time social worker available as needed who has experience with the socioeconomic and psychosocial problems of high-risk mothers and fetuses, sick neonates, and their families. For units with greater than 30 patients, the social worker staffing ratios shall be at least one social worker to 30 patients (additional social workers may be required in accordance with hospital staffing guidelines.

c. This unit shall have at least one occupational or physical therapist available as needed with neonatal expertise and at least one individual skilled in evaluation and management of neonatal feeding and swallowing disorders (e.g., speech-language pathologist).

d. This unit shall have at least one registered dietitian/nutritionist available as needed who has training or experience in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates.

e. Delivery of safe and effective perinatal nursing care requires this unit to have qualified registered nurses in adequate numbers to meet the nursing needs of each patient. To meet the nursing needs of this unit, hospitals shall develop and adhere to an acuity based classification system based on nationally recognized staffing guidelines and have documentation available on such guidelines.

f. This unit shall have the following support personnel immediately available as needed to be on-site in the hospital, including but not limited to:

i. licensed respiratory therapists or registered nurses with specialized training who can supervise the assisted ventilation of neonates with cardiopulmonary disease.

3. Equipment Requirements

a. This unit shall have the following support equipment, in sufficient number, immediately available as needed in the hospital that includes, but is not limited to:

i. advanced imaging with interpretation on an urgent basis (computed tomography, ultrasound (including cranial ultrasound), MRI, echocardiography and electroencephalography); and

ii. respiratory support that allows provision of continuous mechanical ventilation for infants less than 32 weeks gestation and weighing less than 1,500 grams.

4. Transport

a. It is optional for level III NICUs to provide transports. If the unit performs transports, the unit shall have a qualified transport team and provide for and coordinate neonatal transport with level I and level II units throughout the state.

b. Transport shall be in accordance with national standards as published by the American Academy of Pediatrics' section on neonatal and pediatric transport and in accordance with applicable Louisiana statutes.

5. Quality Improvement Collaborative

a. Facilities with level III NICUs and above shall participate in a quality improvement collaborative and a database selected by the Medicaid quality committee, neonatology sub-committee.

b. Proof of current participation by the facility will be available from the LDH website.

D. Level III Surgical NICU

1. General Provisions

a. This unit shall have a transport team and provide for and coordinate neonatal transport with level I, level II units and level III NICUs throughout the state as requested. Transport shall be in accordance with national standards as published by the American Academy of Pediatrics' section on neonatal and pediatric transport and in accordance with applicable Louisiana statutes.

NOTE: All provisions of level III NICUs are required of level IIIS and IV NICUs.

2. Personnel Requirements

a. For medical sub-specialty requirements refer to Table 1–Neonatal Medical Subspecialties and Transport Requirements.

EXCEPTION: Those hospitals which do not have a member of the medical staff who is a board certified/eligible pediatric anesthesiologist but whose anesthesiologist has been granted staff privileges to perform pediatric anesthesiology, such physician(s) may be grandfathered as satisfying the requirement of §9521.2.a when the hospital has documented evidence that the anesthesiologist was granted clinical staff privileges by the hospital prior to the effective date of this Rule. This exception applies only to such physician at the licensed hospital location and is not transferrable.

3. Equipment Requirements

a. This unit shall have the following support equipment, in sufficient number, immediately available as needed in the hospital that includes, but is not limited to:

i. a full range of respiratory support that incudes high frequency ventilation and inhaled nitric oxide.

E. Level IV NICU

1. General Provisions

a. This unit shall be located within an institution with the capability to provide surgical repair of complex conditions (e.g., congenital cardiac malformations that require cardiopulmonary bypass with or without extracorporeal membrane oxygenation).

2. Personnel Requirements

a. for medical sub-specialty requirements, refer to Table 1–Neonatal Medical Subspecialties and Transport Requirements;

NOTE: All provisions of level IIIS NICUs are required of level IV NICUs.

b. Neonatal Medical Subspecialties and Transport Requirements;

Table 1—Neonatal Medical Subspecialties and Transport Requirements

Text denoted with asterisks (*) indicates physician shall be available in person on-site as needed by the facility. Each higher level NICU unit shall meet the requirements of each lower level NICU unit.

Level I (Well Nursery)	Level II	Level III	Level IIIS	Level IV
Board Certified/Eligible Pediatric or Family Practice Physician	Board Certified/Eligible Pediatric or Family Practice Physician	Pediatric Cardiology[1]	Pediatric Surgery[4]	Pediatric Surgery[4]
	Board Certified Neonatologist	Ophthalmology[2]	Pediatric Anesthesiology[5] §9513(2)a—See Exception	Pediatric Anesthesiology[5]
	Social Worker		Neonatal Transport	Neonatal Transport
	Occupational Therapist	Social Worker Ratio 1:30	Ophthalmology[2*]	Ophthalmology[2*]
	Physical Therapist	OT or PT/neonatal expertise	Pediatric Cardiology*	Pediatric Cardiology*
	Respiratory Therapists	RD/training in perinatal nutrition	Pediatric Gastroenterology*	Pediatric Cardiothoracic Surgery*
	Registered dietician/nutritionist	RT/training in neonate ventilation	Pediatric Infectious Disease*	Pediatric Endocrinology*
	Laboratory Technicians	Neonatal feeding/swallowing-SLP/ST	Pediatric Nephrology*	Pediatric Gastroenterology*
	Radiology Technicians		Pediatric Neurology[3*]	Pediatric Genetics*
			Pediatric Neurosurgery*	Pediatric Hematology-Oncology*
			Pediatric Orthopedic Surgery*	Pediatric Infectious Disease*
			Pediatric Otolaryngology[6*]	Pediatric Nephrology*
			Pediatric Pulmonology*	Pediatric Neurology[3*]
				Pediatric Neurosurgery
				Pediatric Orthopedic Surgery

Table 1—Neonatal Medical Subspecialties and Transport Requirements				
Text denoted with asterisks (*) indicates physician shall be available in person on-site as needed by the facility. Each higher level NICU unit shall meet the requirements of each lower level NICU unit.				
Level I (Well Nursery)	**Level II**	**Level III**	**Level IIIS**	**Level IV**
				Pediatric Otolaryngology[7*]
				Pediatric Pulmonology*
				Pediatric Radiology*
				Pediatric Urologic Surgery*
			Transport note:	
[1]There shall be at least one board certified or board eligible pediatric cardiologist as a member of medical staff. For Level III facilities, staff using telemedicine shall be continuously available.			Transport shall be in accordance with national standards as published by the American Academy of Pediatrics' Section on neonatal and pediatric transport and in accordance with applicable Louisiana statutes.	
[2]There shall be at least one board certified or board eligible ophthalmologist with sufficient knowledge and experience in retinopathy or prematurity as a member of the medical staff. An organized program for monitoring retinotherapy of prematurity shall be readily available in Level III and for treatment and follow-up of these patients in Level IIIS and IV facilities.				
[3]There shall be at least one board certified or board eligible pediatric neurologist as a member of medical staff.				
[4]For pediatric surgery, the expectation is that there is a board certified or eligible pediatric surgeon who is continuously available to operate at that facility.				
[5]There shall be at least one board certified or board eligible pediatric anesthesiologist as a member of the medical staff.				
[6]Board eligible or certified in Otolaryngology; special interest in Pediatric Otolaryngology or completion of Pediatric Otolaryngology Fellowship.				
[7]Board eligible or certified in Otolaryngology; completion of Pediatric Otolaryngology Fellowship.				
For specialties listed above staff shall be board eligible or board certified in their respective fields with the exception of otolaryngology as this field has not yet pursued certification.				

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:2573 (October 2022).

§9523. Additional Support Requirements [Formerly LAC 48:I.9515]

A. A bioethics committee shall be available for consultation with care providers at all times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:2576 (October 2022).

Subchapter T. Pediatric Services (Optional)

§9525. General Provisions

A. Pediatric services shall be under the medical direction of a qualified physician who is a member of the medical staff with pediatric privileges and appointed by the governing body. Hospitals admitting children shall have proper facilities for their care apart from adult patients and the newborn. Children under 14 years of age shall not be placed in rooms with adult patients.

B. In hospitals with a separate designated pediatric unit in existence prior to March 1, 1995, the maximum number of beds permitted in each pediatric room shall be eight and shall meet the same spatial standards as specified in Subchapter J of these requirements. In hospitals with a separate designated pediatric unit subsequent to March 1, 1995, the maximum number of beds permitted in each pediatric room shall be four and shall meet the same spatial standards as specified in Subchapter J of these requirements. Patient rooms containing cribs shall provide at least 60 square feet minimum clear floor area for each crib, with no more than six cribs in each room. Provisions for hygiene, toilets, sleeping and personal belongings shall be included where the program indicates that parents are allowed to remain with pediatric patients. Equipment and supplies shall be readily available and appropriate for pediatric services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2431 (November 2003).

§9527. Personnel

A. Every registered nurse who works in the pediatric unit shall be trained in an emergency pediatric nursing course that includes training in pediatric trauma and pediatric advanced life support and that has been conducted pursuant to guidelines established by the Louisiana State Board of Nursing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2431 (November 2003).

§9529. Pediatric Intensive Care Units

A. There are two levels of pediatric care units: Level I; and Level II. If pediatric intensive care services are provided, the hospital shall satisfy the Level II PICU requirements.

B. Levels I and II units shall have a PICU Committee established as a standing committee of the hospital. It shall be composed of at least physicians, nurses, respiratory therapists and other disciplines as appropriate to the specific hospital unit. The committee shall participate in the delineation of privileges for all personnel (both MD and non-MD) within the unit. Policies and procedures shall be established by the medical director and the registered nurse manager in collaboration with the committee and with approval of the medical staff and the governing body. These written policies and procedures shall include, but not be limited to, safety procedures infection control, visitation, admission and discharge criteria, patient monitoring and record keeping, equipment preventive maintenance and repair.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2431 (November 2003).

§9531. Facilities

A. The Levels I and II shall be distinct, separate units within the hospital. There shall be clean and soiled utility rooms, isolation room capabilities, medication and a conference area available on the units.

B. Level I units shall be located in the Category 1 facility as defined by the American Academy of Pediatrics.

C. The Emergency Department (ED) shall have a separate covered entrance. Two or more areas within the ED shall have the capacity and equipment to resuscitate any pediatric patient with any medical, surgical or traumatic illness within facilities with Level I units. Hospitals with Level II units only need one such area. The emergency room shall be staffed 24 hours a day in facilities with either Level I of II units.

D. There shall be an operating suite with one room available within 30 minutes and a second room within 45 minutes, 24 hours a day. Hospitals with Level I units must have the capability of providing cardiopulmonary bypass, pediatric bronchoscopy and radiography.

E. Clinical Laboratories

1. Clinical laboratories shall have microspecimen capability and the capability to perform clotting studies with one-hour turn around. There must also be the capability to perform:

a. complete blood cell count;

b. differential count;

c. platelet count;

d. urinalysis;

e. electrolytes;

f. blood urea nitrogen;

g. creatinine;

h. glucose calcium;

i. prothrombin time;

j. partial thromboplastin time; and

k. cerebrospinal fluid cell counts.

2. Preparation of gram stains and bacteriologic cultures shall be available 24 hours per day. Blood gas values must be available within 15 minutes. Results of drug screening and levels of serum ammonia, serum and urine osmolarity, phosphorus and magnesium shall be available within three hours for Level I units.

F. There must be a blood bank able to provide all blood components 24 hours a day in both Levels I and II. Cross matching shall allow for transfusions within one hour unless some unusual antibody is encountered.

G. Hospitals with Level I units must have radiology services capable of radiography, fluoroscopy, computerized tomography scanning, ultrasonography and nuclear scanning angiography.

H. Diagnostic cardiac and neurologic studies shall be available to both Levels I and II unit facilities.

I. A catheterization laboratory or angiography suite must be present in facilities with Level I units.

J. Level I units shall have the capability to provide hemodialysis 24 hours a day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2431 (November 2003).

§9533. Patient Rooms

A. The head of each bed and/or crib shall be rapidly accessible for emergency airway management.

B. Electrical power, oxygen, medical compressed air and vacuum outlets shall be available at each bed/crib.

C. There shall be walls or curtains available at each bedside to provide for full visual privacy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2432 (November 2003).

§9535. Medical Staff

A. The medical director in Level I units shall be:

1. board certified in pediatrics and board certified or in the process of board certification in pediatric critical care medicine (certification must be completed within five years);

2. board certified in anesthesiology with practice limited to infants and children with special qualifications (as defined by the American Board of Anesthesiology) in critical care medicine; or

3. board certified in pediatric care medicine (as defined by the American Board of Surgery). A Level II medical director shall meet the same criteria of Level I except the board certification in Pediatric Critical Medicine is not required. The medical director shall name a qualified alternate to serve in his or her absence.

B. In existing units, consideration will be given to waiving this requirement for board certified pediatricians with a minimum of five years experience in pediatric care who are currently serving as medical directors of Levels I and II units. The request for waiver shall be made in writing to the Office of the Secretary.

C. Levels I and II units must have at least one physician of at least the postgraduate year two assigned to the PICU in-house 24 hours per day.

D. Other physicians including the attending physician or designee shall be available within 30 minutes.

E. Level I units shall have on staff a pediatric anesthesiologist, surgeon, cardiothoracic surgeon, neurosurgeon, intensivist, cardiologist, neurologist, pulmonologist, hematologist/oncologist, endocrinologist, gastroenterologist, allergist or immunologist, as well as a radiologist, pathologist, and psychiatrist or psychologist. Level II units shall meet the above medical staffing requirements, except the cardiothoracic surgeon and the pediatric subspecialties. There shall be a five-year phase in period with regard to staffing requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2432 (November 2003).

§9537. Staffing

A. Levels I and II shall have a unit manager dedicated to the unit who is a registered nurse with specific training and experience in pediatric critical care. The Level I manager shall be certified in critical-care nursing. The registered nurse manager shall name a qualified alternate to act in his/her absence.

1. The staff to patient ratio shall vary with the acuity of the patients; however, the minimum shall be 1:3.

2. There shall be an organized written orientation program as well as an ongoing in-service/continuing education program.

B. For the Level I units the respiratory therapy staff assigned to a unit shall be in-house 24 hours per day.

1. Biomedical technicians shall be available within one hour, 24 hours a day.

2. The unit clerk shall be readily available to the unit 24 hours a day.

3. A pharmacist and licensed radiographer shall be in-house 24 hours per day.

4. Social workers, physical therapists and nutritionists shall be assigned to the unit as applicable.

C. For Level II Units the respiratory therapist shall be in-house 24 hours a day.

1. The biomedical technician shall be available within one hour, 24 hours a day.

2. The pharmacist and radiologist shall be on call 24 hours a day.

3. Unit clerks, social workers, physical therapists and nutritionists shall be available as applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2432 (November 2003).

§9539. Supplies and Equipment

A. There shall be lifesaving, therapeutic and monitoring equipment present in Level I and II units. There shall be a complete "code" or "crash" cart available on both Level I and II units. The cart contents available on Level I and II units should include, but not be limited to, approved medications, a defibrillator/cardioverter, automated blood pressure apparatus devices. All equipment shall be of proper size for infants and children. Oxygen tanks are needed for transport and backup for both Levels I and II units.

B. There shall be additional equipment available to meet the needs of the patient population.

C. Level I units shall have the capability of ventilator support.

D. There shall be bedside monitoring in Level I and II PICUs with the capability for continuously monitoring heart rate and rhythm, respiratory rate, temperature and one hemodynamic pressure. Level I units shall also have the ability to monitor systemic arterial, central venous, pulmonary arterial and intracranial pressures. The monitors must have alarms with both high and low settings and they must also have both audible and visible capability. There shall be a maintenance and calibration schedule maintained for all monitoring devices.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2432 (November 2003).

§9541. Miscellaneous

A. PICUs shall be integrated with the regional EMS system as available. Rapid access to a poison control center is essential. Each PICU shall have or be affiliated with a transport system and team to assist other hospitals in arranging safe patient transport.

B. Each Level I PICU shall offer pediatric critical care education for EMS providers, emergency department and transport personnel as well as for the general public. The staff nurses and respiratory therapists must also have basic life support certification.

C. Level I PICUs offering a fellowship program in pediatric critical care will possess sufficient patient volume, teaching expertise, and research capability to support such a fellowship. Programs providing sub-specialty training in critical care must possess approval by the residency review committee of the Accreditation Council on Graduate Medical Education. Research is essential for improving our understanding of the pathophysiology affecting vital organ systems. Such knowledge is vital to improve patient care techniques and therapies and thereby decrease morbidity and mortality.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2433 (November 2003).

Subchapter U. Alternative Birthing Units

§9551. General Provisions

A. An alternative birthing unit (ABU) is a unit that is housed within a licensed hospital that provides both obstetrical and neonatal intensive care unit (NICU) level one status at that location. The ABU shall be its own designated unit, separate and apart from any other unit within the hospital.

B. An ABU shall be in compliance with the:

1. American Midwifery Certification Board;

2. American Academy of Pediatrics; and

3. American College of Obstetrics and Gynecology guidelines.

C. An ABU shall be in compliance with all federal, state and local statutes, laws, rules, regulations and ordinances as applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1099 (June 2014).

§9553. Definitions

Active Labor—contractions resulting in progressive effacement and dilation of the cervix.

Alternative Birthing Unit (ABU)—a unit located within a hospital in which delivery is expected following a low risk, normal, and uncomplicated pregnancy. Care and services provided prior to, during, and following childbirth are under the direction of a certified nurse midwife.

Antepartum Care (Prenatal Care)—occurring or existing before birth. The prenatal period (also known as antenatal care) refers to the regular medical and nursing care recommended for women during pregnancy. Prenatal care is a type of preventative care with the goal of providing regular check-ups that allow doctors or certified nurse midwives to treat and prevent potential health problems throughout the course of the pregnancy.

Certified Nurse Midwife (CNM)—an advanced practice registered nurse educated in the disciplines of nursing and midwifery and certified according to a nationally recognized certifying body, such as the American College of Nurse Midwives Certification Council, as approved by the Board, and who is authorized to manage the nurse midwifery care

of newborns and women in the antepartum, intrapartum, postpartum and/or gynecological periods pursuant to Title 46, Part XLVII, Chapter 45, §4503.B.1 et seq.

Complications—any condition as defined by the medical staff/governing body that contraindicates continued care in the alternative birthing center.

Doula—a nonmedical person, certified by Doula of North America (DONA) who assists a woman before, during or after childbirth, as well as her partner and/or family, by providing information, physical assistance and emotional support.

Family—individuals selected by the pregnant woman to be present and/or in attendance during her admission to the ABU.

Intrapartum—the period beginning with active labor to the expulsion of the placenta.

Licensed Practitioner—for purposes of this Rule refers to a licensed physician and/or a certified nurse midwife.

Low Risk Pregnancy—a normal uncomplicated term pregnancy as determined by a generally accepted course of prenatal care. The expectation of a normal uncomplicated birth as shall be defined by the medical staff/governing body.

Medical Director—a physician licensed to practice medicine by the Louisiana State Board of Medical Examiners (LSBME), who is board certified as an obstetrician and gynecologist (OB/GYN) and credentialed and privileged for the hospital's obstetrical/gynecological services.

Postmature—gestational age of greater than 42 weeks.

Postpartum—the period beginning immediately after childbirth.

Preterm—prior to the thirty-seventh week of gestation.

Term—gestational age of greater or equal to 37 weeks.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1099 (June 2014).

§9555. Program Requirements

A. An ABU shall have policies/procedures and written criteria for the evaluation of risk status, admission, transfer, discharge, and complications requiring medical or surgical intervention. The policies/procedures and written criteria shall be developed, implemented, enforced, monitored, and reviewed annually by the clinical staff and approved by the governing body.

1. In order for a pregnant woman to be admitted to an ABU, the following admission requirements must be met.

a. The pregnancy shall be deemed low-risk by the licensed practitioner with the expectation of a singleton, vertex, and spontaneous vaginal birth at term without complication.

b. The pregnant woman shall have had consistent prenatal care which began no later than 28 weeks gestation with consistent prenatal screening.

c. A maternal/fetal assessment performed by the CNM shall be completed and documented within one hour of admission to the ABU.

2. The facility shall have policies and procedures readily available in the event the condition of the mother and/or newborn require transfer to an acute care unit within the hospital or emergent transfer to another hospital.

3. The facility shall have policies and procedures for discharge planning of the mother and newborn.

B. A patient who meets any of the following criteria/conditions shall not be admitted for delivery in an ABU:

1. females below 18 years of age;

2. a patient with any of the below documented condition(s) in the maternal medical history, based on an assessment by a licensed practitioner:

a. cardiovascular disease;

b. pulmonary disease and/or history of pulmonary embolus;

c. renal disease;

d. insulin-dependent diabetes;

e. bleeding disorder or hemolytic disease;

f. fetal malpresentation;

g. placenta previa;

h. preeclampsia;

i. oligohydramnios;

j. polyhydramnios;

k. ruptured membranes greater than 18 hours prior to onset of labor;

l. previous Rh sensitization;

m. vaginal birth following C-section (VBAC);

n. multiple births;

o. preterm labor;

p. post-maturity; or

q. fetal abnormality; or

3. a patient with a high risk pregnancy as determined by a licensed practitioner.

C. The following services shall be prohibited in the ABU:

1. general, intravenous, and/or conductive analgesia/anesthesia to include spinal and epidural analgesia/anesthesia;

2. conscious sedation;

3. caesarean sections and operative obstetrics to include tubal ligations;

4. stimulation or augmentation with chemical agents, e.g., oxytocin during the first and second stages of labor; and

5. vacuum extractors and/or forceps.

D. Prenatal Screening Requirements

1. Pregnant women shall be screened by either/or an OB/GYN, a certified nurse midwife (CNM), or an advanced practice registered nurse (APRN). Documentation of the screening shall include, but not be limited to:

a. social, family, medical, reproductive, nutritional, drug and alcohol use;

b. violence screen, depression screen and mental health history;

c. physical examination to include Papanicolaou smear and assessment for sexually transmitted diseases as determined by a licensed practitioner;

d. a prenatal laboratory profile to include a:

i. complete blood count, blood type and Rh antibody screen;

ii. glucose tolerance test;

iii. urinalysis; and

iv. other diagnostic testing as medically indicated; and

e. a repeat evaluation of the hemoglobin or hematocrit between 28 and 36 weeks gestation.

E. Newborn Requirements. The ABU shall be in compliance with current state laws, rules and regulations for screening of newborn health conditions.

F. Patient and/or Patient's Family Educational Requirements. The following educational programs are required to be completed by the patient and/or patient's family as determined by the policy and procedures of the ABU prior to discharge:

1. anticipated physiological and psychological changes during pregnancy;

2. fetal development;

3. normal nutrition;

4. warning signs of pregnancy complications;

5. self-care to include:

a. information on the dangers of smoking, alcohol and substance abuse; and

b. the need for dental care;

6. stages of labor;

7. non-pharmacologic techniques to promote comfort and relaxation during labor;

8. delivery process;

9. newborn care;

10. normal postpartum;

11. bonding;

12. breast-feeding;

13. importance of immunization;

14. criteria for discharge from the center;

15. child safety to include the use of car seats and safe sleeping practices;

16. directions for obtaining laboratory tests for newborns as required by the Department of Health and Hospitals;

17. instruction as to the clothing/supplies needed at the time of discharge from the center; and

18. a family instructional program.

G. In order for the family to participate in the birth process in the ABU, the following requirements shall be met.

1. The number of individuals/family members present at the time of birth shall be determined by the ABU's policy which takes into account room size and the need for infection control.

2. Individuals/family members shall abide by the facility's infection control policies.

3. An adult not involved in the birthing process shall be in charge of all minor children.

4. Only service animals shall be allowed in the ABU.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1099 (June 2014).

§9557. Policies and Procedures

A. An ABU shall develop, implement, enforce, monitor, and review annually the policies and procedures specific to the care and services of the mother and newborn. The policies and procedures shall be jointly developed by the medical director and professional staff and adopted by the governing body. These policies and procedures shall include, but are not limited to:

1. staffing;

2. admission criteria;

3. educational services;

4. consent for medical treatment and care;

5. initial and continuing risk assessment by the CNM;

6. criteria for consultation with collaborative physicians;

7. water birth;

8. external fetal monitoring (EFM);

9. nursing assessments;

10. medication administration;

11. laboratory and diagnostic services;

12. dietary services;

13. obstetric and pediatric consultation services;

14. newborn care, including:

a. pulse oximetry heart disease screening; and

b. circumcision of a male newborn by a licensed OB/GYN or other qualified physician as determined by the governing body;

15. emergency procedures for the mother and/or newborn, including:

a. maternal emergent care policy;

b. newborn emergent care policy;

c. maternal transfer to an acute care unit within the hospital or transfer to another hospital;

d. newborn transfer to an acute care unit within the hospital or transfer to another hospital;

e. precipitous delivery; and

f. newborn abduction;

16. family support and participation, including:

a. criteria for labor and delivery attendance; and

b. doula;

17. unique identification for mother and newborn;

18. delivery log;

19. mother/baby couplet aftercare, including:

a. lactation support services;

b. social services; and

c. home health care services, if applicable;

20. maternal and newborn discharge, including:

a. length of stay; and

b. child passenger restraint system;

21. follow-up postpartum and newborn care; and

22. hospital staff on call policy and procedure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1101 (June 2014).

§9559. Physical Environment

A. An ABU shall submit, meet, and obtain approval for facility plan review from the Office of State Fire Marshall prior to construction.

1. An ABU shall:

a. consist of a minimum of two birthing rooms and one examination room;

b. be located to ensure privacy;

c. be located out of the path of unrelated traffic; and

d. be under the direct supervision of the unit staff.

2. Birthing rooms shall:

a. be single occupancy;

b. have a minimum clear floor area of 200 square feet, including the newborn care area and a minimum clear dimension of 12 feet;

c. have an outside window;

d. have windows or doors within a normal sightline that would permit observation into the room and shall be arranged or draped as necessary for mother and newborn privacy;

e. have a hands-free hand-washing station; and

f. have direct access to a private bathroom that includes a:

i. hand-washing station;

ii. toilet; and

iii. shower or tub.

B. The newborn care area shall be a separately located area within the birthing room.

C. The reception and administration area shall be located as to control and monitor traffic flow/access to the ABU.

D. The staff work area shall:

1. be provided for the ABU staff;

2. have space for counters and storage; and

3. have convenient access to hand-washing facilities.

E. Hand-washing stations shall be readily accessible to families, visitors, and staff.

F. Medication Preparation Location

1. Provisions shall be made for the distribution of medications from a medicine preparation room or area, from a self-contained medicine dispensing unit, or by another approved system.

2. The medication preparation room or area shall:

a. be under the visual control of the staff; and

b. contain the following:

i. a work counter;

ii. a hand-washing station;

iii. a lockable refrigerator; and

iv. a locked storage for controlled drugs.

3. When a medication preparation room or area is to be used to store self-contained medication dispensing units, the room shall be designed with adequate space to prepare medicines with the self-contained medicine-dispensing units present.

G. Self-Contained Medication-Dispensing Unit

1. The location of a self-contained medicine-dispensing unit shall be permitted in the clean workroom or in an alcove, provided the ABU has adequate security for medications and adequate lighting to easily identify drugs.

2. The self-contained medicine-dispensing unit shall provide convenient access to hand-washing stations.

H. Nourishment Area

1. A nourishment area shall have the following:

a. a sink;

b. a work counter;

c. a refrigerator;

d. storage cabinets;

e. equipment for hot and cold nourishment;

f. provisions and space for separate temporary storage of unused and soiled dietary trays not picked up during meal time; and

g. immediate accessible hand-washing stations in or near the nourishment area.

2. Ice-making equipment shall:

a. be provided for treatments and nourishment;

b. be permitted in the clean workroom or the nourishment room; and

c. ice intended for human consumption shall be provided in the nourishment station and shall be served from self-dispensing ice-makers.

I. A clean workroom shall be separate from and have no direct connection with soiled workrooms or soiled holding rooms.

1. If the room is used for preparing care items for mothers and newborns, it shall contain:

a. a work counter;

b. a hand-washing station; and

c. storage facilities for clean and sterile supplies and equipment.

2. Storage for hazardous cleaning solutions, compounds, and substances shall be labeled and kept in an enclosed storage area or approved cabinet separate from other cleaning materials.

J. A soiled workroom or soiled holding room shall be separate from and have no direct connection with clean work rooms or clean supply rooms.

1. A soiled workroom or soiled holding room shall contain:

a. a clinical sink (or equivalent flushing rim fixture) and a hand-washing station; and

b. a work counter and space for separate covered container for soiled linen and a variety of waste types.

2. Omission of the clinical sink and work counter shall be permitted in rooms used only for temporary holding of soiled material. If the flushing-rim clinical sink is not provided, the facilities for cleaning bedpans shall be provided in the mothers' toilet rooms.

K. Environmental Services Room. An environmental services room shall be provided for the exclusive use of the ABU and include:

1. a service sink or floor receptor; and

2. a space for storage of supplies, housekeeping equipment, and housekeeping carts.

L. Examination Rooms. An examination room shall:

1. preserve patient privacy from outside observation;

2. be located convenient to nursing the station;

3. have a bathroom immediately accessible that includes:

a. ventilation with a minimum of 10 air changes per hour; and

b. have an exhaust;

4. have a hand-washing station;

5. have the following space requirements:

a. a minimum clear floor area of 80 square feet;

b. a minimum continuous clearance of 2 feet 8 inches at each side of the examination table; and

c. have counter and shelf space;

6. have ventilation with a minimum of six air changes per hour;

7. have lighting with fixed and portable features; and

8. have an examination table with access to at least two duplex receptacles.

M. Support areas provided for staff shall include:

1. a changing room;

2. a lounge;

3. a bathroom; and

4. securable lockers, closets and cabinet compartments.

N. Engineering and maintenance services shall have sufficient space for mechanical and electrical equipment and for the proper maintenance of equipment.

O. Building Codes and Architectural Details

1. The facility shall meet the business occupancy provisions of applicable life safety and building codes.

2. Corridors shall have a minimum corridor width of 5 feet and minimum height of 7 feet 8 inches.

3. Ceilings shall have a minimum height of 7 feet 10 inches with the following exceptions:

a. ceilings heights for storage rooms, toilet rooms, etc. shall not be less than 7 feet 8 inches; and

b. rooms containing ceiling mounted equipment/light fixtures shall be of sufficient height to accommodate the equipment or fixtures and normal movement.

4. Birthing Room Surfaces. Birthing room surfaces shall have:

a. finishes selected to facilitate cleaning and to resist strong detergents; and

b. finishes in the dietary area to ensure the ability to be cleaned and disinfected.

P. Building Systems

1. Heating, ventilation and air-conditioning, electrical, plumbing and related systems shall meet state and local building codes.

2. Heating, ventilation and air-conditioning systems in the environmental services (housekeeping) room shall be exhausted at a rate consistent with approved infection control guidelines.

Q. Electrical Systems

1. Lighting shall:

a. provide both subdued indirect lighting and special lighting capable of providing at least 70 foot-candles in the delivery and newborn care area(s); and

b. have emergency lighting available.

R. Oxygen and vacuum outlets shall be available.

1. Use of portable equipment shall be permitted.

S. Security systems shall be designed for active and passive security systems. Locking arrangements, security alarms, and monitoring devices shall be placed not to interfere with the life safety feature necessary to operate and maintain a healthy and functional environment.

T. Elevators shall be equipped with a cab with minimum dimensions of 5 feet 8 inches wide by 7 feet 6 inches deep.

U. Corridors, attics, and passageways shall be free of storage. Exits shall not be blocked by storage of furniture or equipment at any time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1101 (June 2014).

§9561. Equipment

A. The governing body and medical staff shall specify the types of equipment that is required for an ABU. This shall include at a minimum:

1. emergency equipment including:

a. an adult emergent care cart labeled and stocked accordingly; and

b. a neonatal emergent care cart labeled and stocked accordingly;

2. equipment and supplies used for labor and delivery including:

a. fetal heart rate doppler, fetoscope, and/or external fetal monitor;

b. a birthing tub; and

c. a bed;

3. equipment and supplies used for the newborn including:

a. a newborn crib, bassinet or newborn examination unit; and

b. calibrated newborn scales;

4. oxygen and supplies;

5. pulse oximetry supplies;

6. suction and supplies for mother and newborn;

7. maternal and newborn airways;

8. a wall clock synchronized with hospital system;

9. supplies for unique identification of mother and newborn;

10. a secure medication dispensing system;

11. emergency call and lighting systems; and

12. ancillary support equipment as needed.

B. The facility shall have a newborn abduction emergency alert system.

C. All hand-washing facilities shall be equipped with hands-free handles, disposable soap dispenser, paper towel dispenser and trash receptacle.

D. Vertical and horizontal transport systems shall be operated and maintained in a manner to provide for safe transport.

E. The facility shall have functional emergency communication, including:

1. telephone;

2. nurse call; and

3. internal/external paging system.

F. An ABU shall have storage for hazardous cleaning solutions, compounds, and substances.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1103 (June 2014).

§9563. Services

A. The ABU shall have patient care services policies that delineate the organization of the unit, qualifications of the staff and requirements for staff to patient ratio.

B. Unit Organization

1. Care in an ABU shall be under the direction of a CNM.

a. A CNM and a registered nurse shall be available per hospital on call policy to ensure 24-hour coverage for patient care.

b. Qualified professional clinical staff shall monitor the patient's progress in labor with ongoing assessments of maternal/fetal reactions to the process of labor, within accepted professional standards.

2. Authority and responsibilities of all patient care staff shall be clearly defined in written policies.

3. The functions of the ABU shall be under the direction of perinatal services. These functions shall include, but are not limited to:

a. the development, implementation, enforcement, monitoring, and annual review of policies and procedures related to patient care;

b. the orientation and training of qualified staff for provision of care; and

c. provisions for current educational and reference materials.

C. Staff Qualifications

1. The CNM shall provide documentation of current licensure and certification, as required by the Louisiana State Board of Nursing (LSBN). The documentation shall be maintained as part of the credential file for each CNM.

2. Licensed nursing personnel shall practice in accordance with the Louisiana State Nurse Practice Act and demonstrate current licensure by LSBN.

3. All clinical staff of the ABU shall be required to provide documentation of training and continued competence in Adult Basic Cardiopulmonary Life Support (BCLS) and Neonatal Resuscitation Program (NRP) or its equivalent.

4. Documented, dated, and signed demonstration of skills competencies shall be maintained in the personnel file for each staff member.

D. Requirements for Staff to Patient Ratio

1. A CNM must be present at all times while a laboring patient is in the ABU.

2. A registered nurse (RN) shall provide 1:1 maternal care during labor, delivery and post-delivery.

3. There shall be sufficient professional and support staff on duty and on call to meet the following patient's needs:

a. for services routinely provided;

b. to assure patient safety and satisfaction; and

c. to ensure that no patient in active labor is left unattended.

4. During the second stage of labor, 2:1 patient care is required, with one of the clinical staff being a CNM and one other RN.

5. Staffing per shift shall be based on acuity and census of the ABU.

6. Each RN shall be responsible for 1:1 labor care and/or 1:2 couplet care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1103 (June 2014).

§9565. Medical Records Requirements

A. The medical record of the mother and newborn shall include, but not be limited to, the following documentation:

1. informed consent signed by the patient and the CNM;

2. demographic and patient information;

3. family, medical, social, reproductive, nutrition and behavioral history;

4. initial maternal assessment and examination;

5. evaluation of maternal/fetal risk factors;

6. written orders for maternal/fetal and newborn care;

7. laboratory and/or diagnostic test results;

8. documentation of maternal/fetal and newborn monitoring;

9. postpartum assessments;

10. physical assessment of newborn, e.g., Apgar score, weights, measurements;

11. labor and discharge summaries; and

12. educational instructions for postpartum and newborn home care, follow ups, and referrals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1103 (June 2014).

§9567. Pharmaceutical Services

A. The ABU shall follow hospital policies and procedures for pharmaceutical services regarding the

procurement, storage, distribution and control of all medications. The ABU shall be in compliance with all local, state, and federal regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1104 (June 2014).

Subchapter V. Newborn Safety Devices

§9573. General Provisions

A. In accordance with the Louisiana Children's Code (La. Ch. Code 1149 et seq.), a parent may leave an infant in a newborn safety device (NSD) that is physically located inside a facility which is licensed as a hospital in accordance with R.S. 40:2100 et seq., and has an emergency department that is staffed 24 hours per day.

B. Each NSD shall meet all of the following specifications:

1. voluntarily installed in the designated hospital;

2. installed in a location that ensures the anonymity of the relinquishing parent;

3. installed in a climate-controlled environment consistent with the internal temperature of the hospital;

4. installed by a licensed contractor in accordance with manufacturer's recommendations;

5. have an access door that locks automatically upon closure when an infant is in the device;

6. have a supporting frame that is anchored so as to align the bed portion of the NSD directly beneath the access door and prevent movement of the unit as a whole; and

7. feature a safe sleep environment which includes a firm, flat bassinet mattress and a sheet that fits snugly on and overlaps the mattress, and is free of pillows, bumpers, blankets and other bedding.

C. The hospital shall post appropriate signage approved by the Department of Children and Family Services at the site of the NSD that clearly identifies the NSD, and provides both written and pictorial instruction to the relinquishing parent to open the access door, place the infant inside the NSD and close the access door to engage the lock. The signage shall also clearly indicate all of the following:

1. the maximum age of the infant who may be relinquished in accordance with the Louisiana Children's Code;

2. that the infant must not have been previously subjected to abuse or neglect; and

3. that by placing an infant in the NSD, a parent is foregoing all parental responsibilities with response to the infant, and is giving consent for the state to take custody of the infant.

D. The hospital shall be responsible for:

1. the cost of the installation of the NSD;

2. installation of an adequate dual alarm system that shall be connected to the physical location of the NSD. The hospital shall ensure all of the following with respect to the alarm system:

a. the alarm system generates an audible alarm at a central location within the facility 60 seconds after the opening of the access door to the NSD;

b. the alarm system generates an automatic call to 911 if the alarm is activated and not turned off from within the hospital less than 60 seconds after the commencement of the initial alarm;

c. the alarm system is tested at least one time per week to ensure that it is in working order; and

d. the alarm system is visually checked at least two times per day to ensure that it is in working order.

3. obtaining Department of Health (LDH), Health Standards Section (HSS) approval prior to the use of the NSD; and

4. submission of written notification to the LDH, HSS of the hospital's intent to implement the use of the device.

E. Prior to use of the NSD, an onsite survey shall be conducted by the LDH, HSS.

F. The hospital shall ensure that the device is checked at least daily for debris and is cleaned and sanitized with a hospital-quality disinfectant at least weekly and after any infant relinquishment into the NSD.

G. The hospital shall maintain documentation of the testing of the alarm system and the cleaning and sanitation of the NSD.

H. The hospital shall install a cardholder adjacent to the NSD and shall keep the cardholder stocked with safe haven informational cards and other safe haven informational materials produced in accordance with La. Ch. Code 1160 and required by the Department of Children and Family Services.

I. The hospital shall develop and implement written policies and procedures that include, but are not limited to, receiving an infant who has been relinquished into the NSD, the use of an adequate NSD alarm system, testing of theNSD alarm system, cleaning of the NSD, documentation, and training of staff responsible for implementing the policies and procedures of the NSD, in accordance with La. Ch. Code 1149 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:498 (March 2022).

Chapter 96. Hospitals—Crisis Receiving Centers

Subchapter A. General Provisions

§9601. Introduction

A. A hospital crisis receiving center is a specialty unit of a hospital that provides health care services to individuals who are experiencing a behavioral health crisis.

B. Crisis receiving centers shall receive, examine, triage, refer or treat individuals that present to the unit and are in need of assistance with a behavioral health crisis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:513 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:554 (April 2019).

§9603. Licensure Requirements

A. All crisis receiving center specialty units shall be licensed by the department and shall comply with the provisions of §9333 of these hospital licensing standards.

B. A crisis receiving center specialty unit (CRC-SU) shall have approval from the Office of Behavioral Health (OBH) and/or the appropriate human service district or authority before applying to become licensed as part of the hospital.

C. Prior to securing licensure and operating the CRC-SU, the hospital shall submit architectural plans of the CRC-SU to the Office of the State Fire Marshal (OSFM) for licensing approval.

D. A CRC-SU shall not operate until it has been licensed by the Health Standards Section (HSS) as a specialty unit of the hospital. No retroactive licenses shall be granted.

E. A CRC-SU shall be located in a designated area of the hospital or offsite campus of the hospital. The CRC-SU shall not relocate to another location, even within the hospital, without prior written approval from HSS.

F. If the CRC-SU is located at the main campus of the hospital, the hospital shall have a dedicated emergency department which shall comply with all Emergency Medical Treatment and Active Labor Act (EMTALA) regulations.

G. If the CRC-SU is located at an offsite campus or is at a free-standing psychiatric hospital which does not have a dedicated emergency department, the CRC-SU shall be considered a dedicated emergency department. The CRC-SU shall comply with all EMTALA regulations if the unit meets one of the following criteria:

1. the entity is licensed by the state as an emergency department of the hospital;

2. holds itself out to the public as providing emergency care; or

3. during the preceding calendar year, the entity provided at least one-third of its outpatient visits for the treatment of emergency medical conditions.

H. The following levels of a CRC-SU may be licensed as an optional service of the hospital:

1. Level I CRC-SU only; or

2. Level I CRC-SU and Level II CRC-SU.

I. A CRC-SU shall maintain compliance with the:

1. Office of Public Health (OPH) regulations; and

2. Office of State Fire Marshal regulations.

J. The CRC-SU shall develop and implement policies and procedures regarding the segregation of child and adolescent patients from adult patients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

ISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:513 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:554 (April 2019).

§9605. Licensing Process

A. The hospital shall submit the following items to the department in order to add a CRC-SU to its existing license:

1. a licensing application on the department's designated form;

2. the required licensing fee, if applicable;

3. a copy of the prerequisite approval from OBH and/or the appropriate human service district or authority; and

4. other documentation as required by the department, including a current Office of Public Health (OPH)/Sanitation approval and Office of State Fire Marshal approval for occupancy and licensing plan review.

B. Following receipt of the completed licensing application, the department shall conduct an on-site survey and inspection to determine compliance with the licensing laws, regulations, and standards.

1. For a Level I CRC-SU, the department may, in its sole discretion, allow a verified attestation by the licensed hospital to substitute for an on-site survey and inspection.

C. If the on-site inspection determines that the hospital is compliant with the requirements and licensing standards for a CRC-SU, the department shall issue the hospital a sub-license/certificate indicating that the CRC-SU is licensed as a specialty unit of the hospital.

1. The sub-license/certificate shall designate the level of the CRC-SU and the licensed capacity of the CRC-SU.

2. The sub-license/certificate shall be posted in a conspicuous place in the designated CRC-SU.

D. A hospital shall not operate a CRC-SU at a level higher than what has been licensed and designated by the department on the sub-license/certificate.

E. The expiration date of the sub-license/certificate shall coincide with the expiration date of the hospital license. The CRC-SU sub-license/certificate shall be renewed at the time the hospital's license is renewed. The licensing agency may perform an on-site survey and inspection for an annual renewal.

F. The sub-license/certificate shall be valid only for the designated geographic location and shall be issued only for the person/premises named in the application. The geographic location of the CRC-SU shall not be moved, changed, or relocated without notification to HSS, approval by HSS, and the re-issuance of the sub-license/certificate.

G. The department may conduct on-site surveys and inspections at the CRC-SU as necessary to ensure compliance with these licensing standards.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:513 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:555 (April 2019).

§9607. Discharges, Referrals or Transfers

A. Patients who are discharged home from the CRC-SU shall be given verbal and written discharge instructions and any referral information, including information for appointments regarding follow-up care and treatment.

B. If it is deemed necessary that the patient be admitted for inpatient behavioral health services, the CRC-SU shall provide an appropriate and immediate mechanism for transporting the individual to such inpatient facility. Copies of pertinent patient information shall be transferred to the treating facility.

C. The CRC-SU shall establish and implement a standard method of follow-up to ensure that the patient has been received and engaged in the referred service(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:514 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:555 (April 2019).

§9609. Training Requirements

A. A CRC-SU shall ensure that all staff providing direct patient care has documentation of successful completion of crisis services and intervention training in accordance with this Chapter.

B. Crisis services and intervention training shall include, but is not limited to the following:

1. an organized training program that includes an initial 40 hours of training to be completed upon hire and a minimum of 12 hours of training to be completed annually thereafter. Required training includes, but is not limited to the following areas:

a. components of the crisis cycle;

b. recognizing the signs of anxiety and escalating behavior;

c. therapeutic communication;

d. high-risk behavior assessment techniques;

e. verbal de-escalation techniques;

f. positive behavior management and limit-setting;

g. nonviolent physical intervention techniques;

h. establishing a therapeutic rapport and professional boundaries;

i. levels of observation;

j. maintaining a safe and therapeutic milieu;

k. an overview of mental illness and substance abuse diagnoses and treatment;

l. safe application of physical and mechanical restraints;

m. physical assessment of the restrained individual;

n. statutes, regulations, standards and policies related to seclusion and restraint;

o. confidentiality and Health Insurance Portability and Accountability Act (HIPAA) regulations; and

p. an overview of behavioral health settings and levels of care.

C. All formal training shall be provided by a licensed mental health professional (LMHP) or other qualified licensed behavioral health personnel with extensive experience in the field in which they provide training. Nonviolent physical interventions shall be taught by a trainer with documented current certification by a nationally established crisis intervention program (e.g. Crisis Prevention and Intervention, Tactical Crisis Intervention, Crisis Intervention Training, etc.).

1. An LMHP is an individual who is currently licensed to practice independently and in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts, and the individual's professional license, as one of the following:

a. medical psychologist;

b. licensed psychologist;

c. licensed clinical social worker (LCSW);

d. licensed professional counselor (LPC);

e. licensed marriage and family therapist (LMFT);

f. licensed addiction counselor (LAC);

g. advance practice registered nurse (APRN); or

h. licensed rehabilitation counselor (LRC).

D. In addition to the initial 40 hour crisis services and intervention training, nurses shall receive 24 hours of training focused on psychotropic medications, their side

effects and adverse reactions as part of their initial training. At least four hours of nurses' annual training shall focus on psychopharmacology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:514 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:555 (April 2019).

Subchapter B. Level I Crisis Receiving Centers

§9615. General Provisions

A. A Level I CRC-SU shall operate 24 hours per day, seven days per week.

B. The length of a patient stay for a Level I CRC-SU shall not exceed 24 hours, unless there is documented evidence of the CRC-SU's measures taken to transfer the patient to the appropriate level of needed care and the reasons the transfer of the patient exceeds 24 hours.

C. Services required of a Level I CRC-SU include, but are not limited to:

1. 24-hour telephone hotline;

2. triage and screening services;

3. assessment services, including medication management;

4. brief intervention and stabilization; and

5. linking and referral services.

D. The Level I CRC-SU shall develop and implement policies and procedures for instituting an increased level of supervision for patients at risk for suicide and other self-injurious behaviors.

E. The CRC-SU Level 1 shall comply with the provisions of the state Mental Health Law regarding the execution of emergency certificates pursuant to R.S. 28:53, or a successor law.

F. The CRC-SU shall maintain a policy manual that outlines the procedures to access CRC services and procedures for managing voluntary and involuntary commitments with specific focus on ensuring the patient's civil rights.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:514 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:555 (April 2019).

§9617. Level I Services

A. 24-Hour Telephone Hotline

1. A Level I CRC-SU shall either maintain a telephone hotline that operates 24 hours per day, seven days per week or enter into a formal cooperative agreement with an existing 24-hour hotline as specified in the region's crisis response systems plan.

2. The hotline shall be staffed at all times by trained crisis workers.

a. A trained crisis worker is one who is:

i. trained in the assessment and management of crisis phone calls;

ii. able to assess the priority of the call; and

iii. able to provide interventions that are appropriate to the level of acuity of the caller.

b. The trained crisis worker shall have resource data available whenever calls are answered in order to facilitate crisis intervention.

c. The trained crisis worker shall have the ability to provide active intervention (i.e. contacting emergency medical services, police, fire department, etc.) in life-threatening situations.

3. The CRC-SU shall have written procedures for handling crisis calls.

4. The telephone settings shall be set up so as to protect the confidentiality of callers.

5. The CRC-SU shall have well written procedures to expand the facility's capacity to handle multiple calls coming into the CRC-SU simultaneously.

B. Triage and Screening

1. The Level I CRC-SU shall conduct a triage/screening of each individual who applies for crisis assistance or is under an order for involuntary examination.

2. The triage/screening shall be available 24 hours per day and shall be conducted within 15 minutes of the individual presenting to the unit. The CRC-SU shall have procedures to prioritize imminently dangerous patients and to differentiate between medical emergencies and behavioral health emergencies.

3. Until a patient receives triage/screening, he or she shall wait in a location with restricted access and egress with constant staff observation and monitoring.

4. The triage/screening shall include:

a. an evaluation of the existence of a medical emergency;

b. an evaluation of imminent threat of harm to self or others;

c. an evaluation for the presence or absence of cognitive signs suggesting delirium or dementia;

d. an evaluation of the need for an immediate full assessment;

e. an evaluation of the need for an emergency intervention; and

f. a medical screening including at a minimum, vital signs and a medical history, as soon as the patient's condition permits.

5. The triage/screening shall be conducted by licensed professionals in the medical or behavioral health fields that have the training and experience to triage/screen individuals for both behavioral and medical emergent needs in accordance with the scope of practice of their licensed discipline.

6. When emergency medical services are not available onsite at the Level I CRC-SU, the staff shall be prepared to render first-responder healthcare (basic cardiac life support, first aid, etc.) at all times. A CRC-SU shall also ensure that access to emergency transportation services to the nearest emergency department is available.

7. A Level I CRC-SU shall have procedures in place to ensure that based on the triage/screening, patients are prioritized for further assessment and services according to their risk level, or they are referred to other resources for care.

C. Assessments

1. After the triage/screening is completed, patients who have not been referred to other resources shall receive a full assessment.

2. Assessments shall be conducted based on the priority level determined by the triage/screening. Every patient under the age of 18 shall be assessed by staff with appropriate training and experience in the assessment and treatment of children and adolescents in a crisis setting.

3. The assessment shall be initiated within two hours of the triage/screening evaluation and shall include:

a. a full psychiatric assessment;

b. a physical health assessment; and

c. an assessment for possible abuse and/or neglect.

4. A full psychiatric assessment shall include:

a. patient interviews by board certified/eligible licensed psychiatrist(s) or psychiatric nurse practitioner(s) trained in emergency psychiatric assessment and treatment;

b. a review of the medical and psychiatric records of current and past diagnoses, treatments, medications and dose response, side-effects and compliance, if available;

c. contact with current behavioral health providers whenever possible;

d. a psychiatric diagnostic assessment;

e. identification of social, environmental, and cultural factors that may be contributing to the crisis;

f. an assessment of the patient's ability and willingness to cooperate with treatment;

g. a general medical history that addresses conditions that may affect the patient's current state (including a review of symptoms) and is focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of recent physical trauma; and

h. a detailed assessment of substance use, abuse/ and misuse; and

i. an assessment for possible abuse and neglect; such assessment shall be conducted by an LMHP trained in how to conduct an assessment to determine abuse and neglect. The CRC-SU shall ensure that every patient is assessed for sexual, physical, emotional, and verbal abuse and/or neglect.

5. All individuals shall be seen by a licensed psychiatrist or a licensed APRN within eight hours of the triage/screening. The board certified/eligible psychiatrist or APRN shall formulate a preliminary psychiatric diagnosis based on review of the assessment data collected.

a. The APRN must be a nurse practitioner specialist in adult psychiatric and mental health, family psychiatric and mental health, or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, or child-adolescent mental health and may practice to the extent that services are within the APRN's scope of practice.

6. A physical health assessment shall be conducted by a licensed physician, licensed advanced nurse practitioner, or a licensed physician's assistant and shall include the following:

a. vital signs;

b. a cognitive exam that screens for significant cognitive or neuropsychiatric impairment;

c. a neurological screening exam that is adequate to rule out significant acute pathology;

d. medical history and review of symptoms;

e. pregnancy test in all women of child-bearing age, as applicable;

f. urine toxicology evaluation;

g. blood levels of psychiatric medications that have established therapeutic or toxic ranges; and

h. other testing or exams as appropriate and indicated.

D. Brief Intervention and Stabilization

1. If an assessment reveals that immediate stabilization services are required, the Level I CRC-SU shall provide behavioral health interventions and stabilization which may include the use of psychotropic medications.

2. Following behavioral health interventions and stabilization measures, the Level I CRC-SU shall assess the patient to determine if referral to community based behavioral health services is appropriate or a higher level of care is required.

E. Linking/Referral Services

1. If an assessment reveals a need for emergency or continuing care for a patient, the Level I CRC-SU shall make arrangements to place the patient into the appropriate higher level of care. Patients in a Level I CRC-SU shall be transitioned out of the Level I CRC-SU within 24 hours unless there is documented evidence of the CRC-SU's measures taken to transfer the patient to the higher level of needed care and the reasons the transfer of the patient exceeds 24 hours.

2. If the assessment reveals no need for a higher level of care, the Level I CRC-SU shall provide:

a. referrals, and make appointments where possible, to appropriate community-based behavioral health services for individuals with developmental disabilities, addiction disorders, and mental health issues; and

b. brief behavioral health interventions to stabilize the crises until referrals to appropriate community-based behavioral health services are established or contact is made with the individual's existing provider and a referral is made back to the existing provider in the form of a follow-up appointment or other contact.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:515 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:556 (April 2019).

§9619. Staffing Requirements

A. A Level I CRC-SU shall be under the direction of a qualified member of the medical staff of the hospital.

B. A Level I CRC-SU shall have the following staff on duty at all times:

1. a registered nurse in charge of the unit who meets the following criteria:

a. currently licensed in Louisiana and in good standing;

b. has one year of experience in the field of behavioral health; and

c. has documented crisis services and intervention training in accordance with the provisions of this Chapter; and

2. at least one additional worker with documented crisis services and intervention training.

C. A Level I CRC-SU shall have the following staff on call at all times and available to be onsite at the CRC-SU within one hour and who meets the following criteria:

1. is a licensed mental health professional (LMHP) who has one year of documented crisis services and intervention experience; or

2. a licensed practical nurse (LPN) or RN who meets the following criteria:

a. currently licensed in Louisiana and in good standing;

b. has one year of experience in the field of behavioral health; and

c. has documented crisis services and intervention training in accordance with this Chapter.

D. A psychiatrist shall be on call at all times to fulfill these licensing requirements and to meet the needs of the patient(s).

E. A Level I CRC-SU shall have sufficient numbers and types of qualified staff on duty and available at all times to provide necessary care and safety, based on the acuity of the patients, the mix of the patients present in the Level I CRC-SU, and the need for extraordinary levels of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:516 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:556 (April 2019).

§9621. Physical Environment

A. A Level I CRC-SU shall be located in an exterior area of the hospital which is easily accessible to patients seeking CRC-SU services. Patients shall not be required to go through other areas of the hospital to get to a Level I CRC-SU. The CRC-SU may share an entrance with an emergency department.

1. A Level I CRC-SU may also be located in a licensed offsite location of the hospital.

B. The CRC-SU shall give special design considerations to prevent injury and suicide in all patient care areas.

C. The layout, design details, equipment, and furnishings shall be such that patients shall be under continuous visual observation at all times and shall not be afforded opportunities for hiding, escape or injury to themselves or others.

D. Interior finishes, lighting, and furnishings shall conform to applicable fire safety codes. Security and safety devices shall not be presented in a manner to attract or challenge tampering by patients.

E. Grab bars, if provided, shall meet the following specifications:

1. of an institutional type;

2. shall not rotate within their fittings;

3. shall be securely fastened with tamper-proof screw heads;

4. shall be free of any sharp or abrasive elements; and

5. if mounted adjacent to a wall, the space between the wall and the grab bar shall be filled completely to prevent a cord or string being tied around the grab bar and used for hanging.

F. Towel racks, closet and shower curtain rods are not permitted.

G. Plastic bags and trash can liners shall not be used in patient care areas.

H. Electrical receptacles shall be of the safety type or protected by 5 milli ampere ground-fault-interrupters.

I. A Level I CRC-SU shall have at least two rooms that afford privacy for the triage/screening and/or assessment of individuals presenting to the unit. Rooms for triage/screening, and/or assessment shall have:

1. a minimum area of 120 square feet and shall be located within the CRC-SU unit; and

2. doors to these rooms shall swing outward or be double hinged.

J. A Level I CRC-SU shall have at least one designated area for the holding and monitoring of patients who are in the process of being triaged/screened, assessed and awaiting referral.

K. A Level I CRC-SU shall have at least one seclusion room. The seclusion room shall be intended for the short-term occupancy by violent or suicidal patients and provide an area for patients requiring security and protection. The seclusion room shall:

1. enable direct staff supervision of the patient by direct visualization or through the use of electronic monitoring;

a. if electronic monitoring equipment is used, it shall be connected to the hospitals' emergency electrical source;

2. be designated for single occupancy and contain at least 80 square feet;

3. be constructed to prevent patient hiding, escape, injury or suicide;

4. contain a restraint bed;

5. have a minimum ceiling height of 9 feet;

6. have ceiling construction that is monolithic or tamper proof;

7. be located in close proximity to a toilet room;

8. not contain protruding edges or corners;

9. have doors that:

a. are 3 feet, 8 inches wide;

b. swing out; and

c. permit staff observation of the patient while also maintaining provisions for patient privacy; and

10. not have electrical switches and receptacles.

L. There shall be a locked storage area to secure a patient's personal items and to secure contraband.

1. The CRC-SU shall have policies and procedures for the handling of such items.

2. The locked storage area shall be accessible only to authorized personnel.

M. The CRC-SU shall have a minimum of two single-use toilet rooms accessible to patients and at least one toilet room for CRC-SU staff.

1. All toilet rooms shall contain a toilet and a lavatory.

2. All plumbing and piping connections to fixtures shall be enclosed and not accessible to tampering by patients.

3. The doors on the bathroom/toilet rooms shall swing out or be double hinged.

4. If mirrors are located in the toilet rooms, they shall be fabricated with laminated safety glass or protected by polycarbonate laminate or safety screens.

5. Bathroom/toilet room hardware and accessories shall be of special design to give consideration to the prevention of injury and suicide.

N. The CRC-SU shall have at least one single-use shower facility for the use of patients within the confines of the CRC-SU.

1. Shower sprinkler heads shall be recessed or of a design to minimize patient tampering.

O. All windows in the CRC-SU shall be fabricated with laminated safety glass or protected by polycarbonate laminate or safety screens.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:516 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:556 (April 2019).

Subchapter C. Level II Crisis Receiving Centers

§9631. General Provisions

A. A Level II CRC-SU is an intermediate level of care unit that provides for:

1. an increased opportunity for observation;

2. improved diagnostic accuracy;

3. brief interventions;

4. psychotropic medications;

5. the ability to denote response to intervention; and

6. an appropriate referral and coordination of care for extended services as necessary

B. The goal of a Level II CRC-SU is to stabilize the patient and prevent the need for admission to a higher level of psychiatric care.

C. A Level II CRC-SU shall meet all of the requirements of a Level I CRC-SU and shall operate 24 hours per day, seven days per week.

D. The length of a patient stay at a Level II CRC-SU shall not exceed 72 hours.

E. The Level II CRC-SU shall be located adjacent to the Level I CRC-SU.

F. The licensed capacity in a Level II CRC-SU shall not be licensed as hospital beds and shall not be counted in the aggregate number of licensed hospital beds.

G. A Level II CRC-SU shall not be included, considered or certified as a portion or part of a distinct part psychiatric unit.

H. Patients may be directly admitted to a Level II CRC-SU from:

1. a Level I CRC-SU after the triage/screening and assessment has been completed;

2. an emergency department of a hospital, provided that the patient has undergone an emergency medical screening; or

3. an outpatient setting, provided that the outpatient setting has within the previous 24-hour period completed a triage/screening and assessment that meets the established criteria under the Level I CRC-SU provisions of this Chapter.

NOTE: If the required components of triage/screening and/or assessment have not been completed by the transferring hospital or outpatient setting, then immediately upon entry, the Level II CRC-SU shall conduct the additional components of the assessment prior to admitting the patient.

I. The Level II CRC-SU shall develop and implement policies and procedures for the use of psychotropic medications and pharmacy services.

J. The Level II CRC-SU shall develop and implement policies and procedures to utilize behavior management and therapeutic interventions to stabilize the behavioral health crisis in the least restrictive manner.

K. The Level II CRC-SU shall develop and implement policies and procedures on seclusion and restraint in accordance with federal requirements. All staff shall be trained on seclusion and restraint policies and procedures, and shall utilize the least restrictive method.

1. Policies shall include procedures and performance improvement measures to minimize the use of seclusion and restraints.

L. The Level II CRC-SU shall develop and implement policies and procedures for instituting an increased level of supervision for patients at risk for suicide and other self-injurious behaviors.

M. When a Level II CRC-SU receives a patient with a properly executed emergency certificate, the CRC-SU shall immediately notify the coroner's office.

1. If an emergency certificate is issued by appropriately licensed personnel of the CRC-SU, the CRC-SU shall immediately notify the coroner's office or physician as applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:517 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:557 (April 2019).

§9633. Level II Services

A. In addition to the services required in §9617 of this Chapter, the Level II CRC-SU shall provide the following services.

1. A Level II CRC-SU shall provide continuous observation of the patient in order to determine the following:

a. adherence to the initial service plan;

b. response to medications;

c. response to therapeutic interventions; and

d. evidence of deterioration or stabilization of behaviors.

2. The Level II CRC-SU shall assure access to necessary medical supports and services in order to stabilize acute medical conditions.

3. The Level II CRC-SU shall provide therapeutic milieu that encompasses:

a. a calming physical environment;

b. staff members knowledgeable of therapeutic communication; and

c. an atmosphere conducive to enhancing the mental health of the patients being served.

4. The Level II CRC-SU shall conduct a psychosocial assessment on each patient within 24 hours of admission. This assessment shall be conducted by a licensed LMHP who has one year of documented crisis services and intervention experience:

5. The Level II CRC-SU shall develop an initial service plan for each patient admitted based on their individual needs that includes, but is not limited to the following:

a. continued reassessments;

b. brief behavioral health interventions;

c. family or support system involvement;

d. substance abuse treatment and relapse prevention, as indicated;

e. peer support services;

f. psychotropic medications; and

g. discharge planning and referral.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:518 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:557 (April 2019).

§9635. Staffing Requirements

A. A Level II CRC-SU shall meet all of the staffing requirements of the Level I CRC-SU in addition to the following requirements.

1. A Level II CRC-SU shall have an RN in charge of the unit at all times. This RN may be the same nurse in charge of the Level I CRC-SU, providing he/she is not assigned to provide patient care to patients in the Level II CRC-SU.

2. The Level II CRC-SU shall have sufficient numbers and types of qualified staff on duty and available at all times to provide necessary care, services, treatment and safety, based on the acuity of the patients, the mix of the patients present in the CRC-SU, the need for extraordinary levels of care and to meet the needs of the patient throughout the length of any patient stay in the CRC-SU.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:518 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:557 (April 2019).

§9637. Physical Environment

A. A Level II CRC-SU shall meet the physical requirements of a Level I CRC-SU unless otherwise specified herein.

B. A Level II-CRC-SU may be located in an interior area of the hospital provided that it is immediately adjacent to the Level I CRC-SU.

1. A Level II CRC-SU may be located in a licensed offsite location of the hospital.

C. A Level II CRC-SU shall not be required to have the triage/screening rooms within the area of the Level II CRC-SU.

D. The Level II CRC-SU shall have patient rooms that meet the following requirements:

1. single occupancy rooms;

2. minimum of 100 square feet of space;

3. monolithic or tamper-proof ceilings;

4. have closet or storage space for personal belongings; and

5. electrical receptacles shall be of the safety type or protected by 5 milli ampere ground-fault-interrupters; and

6. doors that swing outward or are double hinged.

E. Electric patient beds shall not be used.

F. An electronic nurse call system is not required, but if it is included, provisions shall be made for easy removal and for covering call button outlets. The CRC-SU shall have policies and procedures to address calls where no electronic system is in place.

G. Bathrooms

1. The Level II CRC-SU shall have a minimum of two bathrooms that contain all of the following:

a. toilet;

b. shower; and

c. lavatory;

i. if the lavatory is in the patient room and not contained within the bathroom, the lavatory shall be adjacent to the bathroom.

2. If the Level II CRC-SU has more than a capacity for 12 patients, there shall be one additional bathroom for each additional capacity for four patients.

3. The bathrooms shall be outfitted as follows.

a. All plumbing and piping connections to fixtures shall be enclosed and not accessible to tampering by patients.

b. The doors on the toilet rooms shall swing out or be double hinged.

c. If mirrors are located in the toilet rooms, they shall be fabricated with laminated safety glass or protected by polycarbonate laminate, or safety screens.

d. Bathroom/toilet room hardware and accessories shall be of special design to give consideration to the prevention of injury and suicide.

4. Shower sprinkler heads shall be recessed or of a design to minimize patient tampering.

H. The Level II CRC-SU shall have a separate bathroom and a break room designated for staff use.

I. Separate and apart from the seclusion room required in a Level I CRC-SU, the Level II CRC-SU shall have a minimum of one seclusion room for each capacity for 12 patients.

1. The seclusion room in the Level II CRC-SU shall meet the same requirements specified for the seclusion room in the Level I CRC-SU.

2. The patient rooms in the Level II CRC-SU may be used as seclusion rooms provided they meet the same requirements as specified for the seclusion room in the Level I CRC-SU.

J. The Level II CRC-SU shall have separate consultation room(s) with a minimum floor space of 100 square feet each, provided at a room-to-bed ratio of one consultation room for each capacity for 12 patients. Consultation rooms within the unit shall be available for use for interviews with the patient and/or their families. The consultation room(s) shall be designed for acoustical and visual privacy.

K. The Level II CRC-SU shall have a room with a minimum of 225 square feet for group therapy, treatment team planning and conferencing.

L. The Level II CRC-SU shall have a room within the unit with a minimum of 120 square feet for examination and treatment of patients.

M. The Level II CRC-SU shall have an area for accommodation of charting, storage of records, and the storage and preparation of medications. Provisions shall be made for securing patient records and medications in this area.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:518 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:557 (April 2019).

Chapter 97. Nursing Facilities

Subchapter A. General Provisions

§9701. Definitions

Abuse—the willful infliction of injury or the causing of the deterioration of a resident by means including, but not limited to, physical, verbal, emotional, psychological, sexual abuse, exploitation, or extortion of funds or other things of value to such an extent that the resident's health, moral, or emotional well-being is endangered.

1. The determination of abuse shall not be mitigated by a resident's age, ability to comprehend or disability. Abuse determination shall be based on the reasonable person concept.

Administrator—any individual who is or may be charged with the general administration of a nursing facility and who has been licensed and registered by the Board of Examiners of Nursing Home Administrators in accordance with the provisions of *Louisiana Revised Statute* 37:2501.

Advanced Practice Registered Nurse (*APRN*)—a licensed registered nurse who is certified by a nationally recognized certifying body as having an advanced nursing specialty and who meets the criteria for an advanced practice registered nurse as established by the Louisiana State Board of Nursing. An advanced practice registered nurse shall include:

1. certified nurse midwife;
2. certified registered nurse anesthetist;
3. clinical nurse specialist; or
4. nurse practitioner.

Alzheimer's Special Care Unit—any nursing facility as defined in R.S. 40:2009.2, that segregates or provides a special program or special unit for residents with a diagnosis of probable Alzheimer's disease or related disorder so as to prevent or limit access by a resident to areas outside the designated or separated area, or that advertises, markets, or otherwise promotes the nursing facility as providing specialized Alzheimer/dementia care services.

Ancillary Service—a service such as, but not limited to:

1. podiatry;
2. dental;
3. audiology;
4. vision;
5. physical therapy;
6. speech pathology;
7. occupational therapy
8. psychological; and
9. social services.

Applicant—the legal entity that applies for the license to open, conduct, manage or maintain a nursing facility.

Biological—a preparation used in the treatment or prevention of disease that is derived from living organisms or their by-product.

Change of Information (*CHOI*)—any change in facility information required by regulation or statute to be submitted to the department that does not change the ownership structure and/or respective ownership interests held by stakeholders of the current legal entity.

Change of Ownership (*CHOW*)—any change in the legal entity responsible for the operation of the nursing facility. Management agreements are generally not changes of ownership if the former owner continues to retain policy responsibility and approve or concur in decisions involving the nursing facility's operation. However, if these ultimate legal responsibilities, authorities and liabilities are surrendered and transferred from the former owner to the new manager, then a change of ownership has occurred. Examples of actions that constitute a change of ownership include, but are not limited to:

1. *unincorporated sole proprietorship*—transfer of title and property of another party constitutes change of ownership;

2. *corporation*—the merger of the provider's corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation, constitutes change of ownership:

a. transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership. Admission of a new member to a nonprofit corporation is not a change of ownership;

3. *limited liability company*—the removal, addition or substitution of a member in a limited liability company does not constitute a change of ownership; or

4. *partnership*—in the case of a partnership, the removal, addition or substitution of a partner, unless the partners expressly agree otherwise as permitted by applicable state law, constitutes a change of ownership.

Charge Nurse—an individual who is licensed by the state of Louisiana to practice as an RN or LPN and designated as a charge nurse by the nursing facility.

Chemical Restraint—a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms.

Controlled Dangerous Substance—a drug, substance or immediate precursor in schedule I through V of R.S. 40:964.

Coronavirus Disease 2019 (COVID-19)—a communicable, contagious, and infectious disease/virus (more specifically, a coronavirus) identified as the cause of an outbreak of respiratory illness first detected in Wuhan, China. COVID-19 is a new disease, caused by a novel (or new) coronavirus that has not previously been seen in humans. Persons with COVID-19 have had a wide range of symptoms reported-ranging from mild symptoms to severe illness.

Culture Change—the common name given to the national movement for the transformation of older adult services, based on person-directed values and practices where the voices of elders and those working with them are considered and respected. Core person-directed values are:

1. choice;
2. dignity;
3. respect;
4. self-determination; and
5. purposeful living.

Designated Contact—resident's legal representative or interested family member.

Dietary Manager—a person who:

1. is a licensed dietitian;
2. is a graduate of a dietetic technician program;
3. has successfully completed a course of study, by correspondence or classroom, which meets the eligibility requirements for certification by the Dietary Manager's Association;
4. has successfully completed a training course at a state approved school (vocational or university) which includes course work in foods, food service supervision and diet therapy. Documentation of an eight-hour course of formalized instruction in diet therapy conducted by the employing nursing facility's qualified dietitian is permissible if the course meets only the foods and food service supervision requirements; or
5. is currently enrolled in an acceptable course of not more than 12 months which will qualify an individual upon completion.

Director of Nursing (*DON*)—a registered nurse, licensed by the state of Louisiana, who directs and coordinates nursing services in a nursing facility.

Drug Administration—an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails:

1. removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container);
2. verifying the dose with the physician's orders;
3. giving the individual dose to the proper resident;
4. monitoring the ingestion of the dose; and
5. promptly recording the time and dose given.

Drug Dispensing—an act which entails the interpretation of an order for a drug or biological and, pursuant to the order, the proper selection, measuring, labeling, packaging, and issuance of the drug or biological for a resident or for a service unit of the nursing facility by a licensed pharmacist, physician or dentist.

Legal Representative—a resident's legal guardian or other responsible person as determined by the specific legally recognized status of the relationship (e.g., full interdiction, partial interdiction, continuing tutorship, competent major, or other legally recognized status).

Licensed Bed—a bed set up, or capable of being set up, within 24 hours in a nursing facility for the use of one resident.

Licensed Dietitian—a dietitian who is licensed to practice by the Louisiana Board of Examiners in Dietetics and Nutrition.

Licensed Practical Nurse (*LPN*)—an individual currently licensed by the Louisiana State Board of Practical Nurse Examiners to practice practical nursing in Louisiana.

Locked Unit or Specialized Care Unit—a restricted section or area of the nursing facility which limits free access of residents suffering from severe dementia, Alzheimer's or other disease process or condition which severely impairs their ability to recognize potential hazards. Such units shall not be established for the sole purpose of housing individuals with mental illness.

Louisiana Department of Health (*LDH*)–the 'department', previously known as the Department of Health and Hospitals or DHH.

LSC Appeal—equivalent method of compliance related to *Life Safety Code* (LSC) requirements for participation, granted or approved by state and/or federal certification agencies.

Major Alteration—any repair or replacement of building materials and equipment which does not meet the definition of minor alteration.

Medication Attendant Certified (*MAC*)—a person certified by LDH to administer medications to nursing facility residents.

Medical Director—a physician licensed in Louisiana who directs and coordinates medical care in a nursing facility.

Minor Alteration—repair or replacement of building materials and equipment with materials and equipment of a similar type that does not diminish the level of construction below that which existed prior to the alteration. This does not include any alteration to the function or original design of the construction.

Misappropriation—taking possession of a resident's personal belongings without the resident's permission to do so, or the deliberate misplacement, exploitation or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.

Neglect—the failure to provide the proper or necessary medical care, nutrition or other care necessary for a resident's well-being, unless the resident exercises his/her right to refuse the necessary care.

Nursing Facility—any private home, institution, building, residence or other place, serving two or more persons who are not related by blood or marriage to the operator, whether operated for profit or not, and including those places operated by a political subdivision of the state of Louisiana which undertakes, through its ownership or management, to provide maintenance, personal care, or nursing services for persons who, by reason of illness or physical infirmity or age, are unable to properly care for themselves. The term does not include the following:

1. a home, institution or other place operated by the federal government or agency thereof, or by the State of Louisiana;

2. a hospital, sanitarium or other medical institution whose principal activity or business is the care and treatment of persons suffering from tuberculosis or from mental diseases;

3. a hospital, sanitarium or other medical institution whose principal activity or business is the diagnosis, care and treatment of human illness through the maintenance and operation of organized facilities;

4. any municipal, parish or private child welfare agency, maternity hospital or lying-in home required by law to be licensed by some department or agency;

5. any sanitarium or institution conducted by and for Christian Scientists who rely on the practice of Christian Science for treatment and healing;

6. any nonprofit congregate housing program which promotes independent living by providing assistance with daily living activities such as cooking, eating, dressing, getting out of bed and the like to persons living in a shared group environment who do not require the medical supervision and nursing assistance provided by nursing facilities. No congregate housing program, except those licensed or operated by the state of Louisiana, shall:

a. use the term "nursing facility" or any other term implying that it is a licensed health care facility; or

b. administer medications or otherwise provide any other nursing or medical service; or

7. any adult residential care facility.

Physical Restraint—any physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

Physician—an individual currently licensed by the Louisiana State Board of Medical Examiners to practice medicine and/or surgery in Louisiana.

Physician Assistant—a person who is a graduate of a program accredited by the Council on Medical Education of the American Medical Association or its successors, or who has successfully passed the national certificate examination administered by the National Commission on the Certification of Physicians' Assistants, or its predecessors, and who is approved and licensed by the Louisiana Board of Medical Examiners to perform protocol services under the supervision of a physician or group of physicians approved by the board to supervise such assistant.

Reasonable Person Concept—the degree of actual or potential harm one would expect a reasonable person in a similar situation to suffer as a result of alleged abuse, neglect or misappropriation of a resident's funds.

Registered Nurse (*RN*)—an individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

Registered Pharmacist—an individual currently licensed by the Louisiana Board of Pharmacy to practice pharmacy in Louisiana.

Resident—an individual admitted to the nursing facility by, and upon, the recommendation of a physician, and who is to receive the medical and nursing care ordered by the physician.

Resident Activities Director—an individual responsible for directing or providing the activity services of a nursing facility.

Resident Communication System—a system that registers calls electronically from its place of origin (the resident's bed, toilet or bathing facility) to the place of receivership.

Restorative Care—activities designed to resolve, diminish or prevent the needs that are inferred from the resident's problem; includes the planning, implementation and evaluation of said activities.

Sheltering in Place—the election to stay in place rather than evacuate when an executive order or proclamation of emergency or disaster is issued for the parish in which the nursing facility is located and a voluntary or mandatory evacuation has been declared for its geographic location.

Social Service Designee—an individual responsible for arranging or directly providing medically-related social services in the facility to assist in attaining and maintaining the highest practicable physical, mental, and psychosocial well-being of each resident.

Specialized Mental Health Services—for the purposes of pre-admission screening and resident review (PASRR), specialized services means any service or support recommended by an individualized level II determination that a particular nursing facility resident requires due to mental illness, intellectual disability or related condition, that supplements the scope of services that the nursing facility must provide under reimbursement as nursing facility services.

Specialized Rehabilitative Services—include, but are not limited to:

1. physical therapy;
2. speech language pathology;
3. occupational therapy; and
4. mental health rehabilitative services.

Sponsor—an adult relative, friend or guardian of a resident who has an interest or responsibility in the resident's welfare.

State Fire Marshal (*OSFM*)—Louisiana Department of Public Safety and Corrections, Office of the State Fire Marshal.

Written Notification-notification in hard copy or electronic format.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1891 (November 2016), amended LR 46:1393 (October 2020).

§9703. Licensing Process

A. All nursing facilities shall be licensed by the department. It shall be unlawful to operate a nursing facility without possessing a current, valid license issued by the department. The department is the only licensing authority for nursing facilities in Louisiana. Each nursing facility shall be separately licensed.

B. An institution that is primarily for the care and treatment of mental diseases cannot be a skilled nursing facility or nursing facility.

C. A nursing facility shall be in compliance with all required federal, state and local statutes, laws, ordinances, rules, regulations and fees.

D. A nursing facility license shall:

1. be issued only to the person or entity named in the license application;

2. be valid only for the nursing facility to which it is issued and only for the specific geographical address of that nursing facility;

3. be valid for up to one year from the date of issuance, unless revoked, suspended, modified or terminated prior to that date, or unless a provisional license is issued;

4. expire on the expiration date listed on the license, unless timely renewed by the nursing facility;

5. not be subject to sale, assignment, donation or other transfer, whether voluntary or involuntary; and

6. be posted in a conspicuous place on the licensed premises at all times.

E. A separately licensed nursing facility shall not use a name which is substantially the same as the name of another such nursing facility licensed by the department, unless such nursing facility is under common ownership with other nursing facilities.

F. No branches, satellite locations or offsite campuses shall be authorized for a nursing facility.

G. No new nursing facility shall accept residents until the nursing facility has written approval and/or a license issued by the department.

H. Notice of Fees. Fees shall be required for:

1. a replacement license for changes such as:

a. name;

b. address; or

c. bed capacity;

2. a duplicate license; and

3. a change in licensee or premises.

I. Plan Review. Construction documents (plans and specifications), plan review application and applicable plan review fees as established by the Office of State Fire Marshal (OSFM) are required to be submitted, reviewed and found to be acceptable for licensure by the OSFM as part of the licensing procedure prior to obtaining an initial license.

J. Construction Document Preparation. Construction documents shall be submitted to OSFM in accordance with OSFM requirements.

K. Any increase in licensed bed capacity requires facility need review approval (FNR) and a plan review, as applicable by state law.

L. LSC Appeal Request Equivalent Methods of Compliance. OSFM may accept equivalent methods of compliance with the physical environment provisions of these rules in consultation with LDH.

1. If a *Life Safety Code* (LSC) appeal is requested, the nursing facility shall:

a. submit the LSC appeal request and applicable fees as established by OSFM to OSFM;

b. demonstrate how patient safety and quality of care offered is not compromised by the LSC appeal request;

c. demonstrate the undue hardship imposed on the nursing facility if the LSC appeal request is not granted; and

d. demonstrate its ability to completely fulfill all other requirements of service.

2. The OSFM will make a written determination of the requests.

a. LSC appeal request determinations are subject to review in any change in circumstance and are subject to review or revocation upon any change in circumstances related to the LSC appeal determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1893 (November 2016).

§9705. Initial Licensing Application Process

A. An initial application for licensing as a nursing facility shall be obtained from the department. A completed initial license application packet for a nursing facility shall be submitted to and approved by the department prior to an applicant providing nursing facility services. The completed initial licensing application packet shall include:

1. a completed nursing facility licensure application and the non-refundable licensing fee as established by statute. All fees shall be submitted by certified or company check or U.S. Postal money order only, made payable to the department. All state owned nursing facilities are exempt from fees;

2. a copy of the released architectural plan review project report for the nursing facility from OSFM;

3. a copy of the on-site inspection report with determination as acceptable for occupancy by OSFM;

4. a copy of the health inspection report with approval of occupancy from the Office of Public Health (OPH);

5. a disclosure of the name and address of all individuals with 5 percent or more ownership interest, and in the instance where the nursing facility is a corporation or partnership, the name and address of each officer or director, and board members;

6. a disclosure of the name of the management firm and employer identification number, or the name of the lessor organization, if the nursing facility is operated by a management company or leased in whole or in part by another organization;

7. if applicable, clinical laboratory improvement amendments (CLIA) certificate or CLIA certificate of waiver;

8. a floor sketch or drawing of the premises to be licensed; and

9. any other documentation or information required by the department for licensure.

B. If the initial licensing packet is incomplete when submitted, the applicant will be notified of the missing information and will have 90 days from receipt of the notification to submit the additionally requested information. If the additionally requested information is not submitted to the department within 90 days, the application will be closed. After an initial licensing application is closed, an applicant who is still interested in becoming a nursing facility must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

C. Once the initial licensing application packet has been approved by the department, notification of the approval shall be forwarded to the applicant. Within 90 days of receipt of the approval notification, the applicant must notify the department that the nursing facility is ready and is requesting an initial licensing survey. If an applicant fails to notify the department within 90 days, the initial licensing application shall be closed. After an initial licensing application has been closed, an applicant who is still interested in becoming a nursing facility must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

D. Applicants shall be in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the nursing facility will be issued an initial license to operate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1894 (November 2016).

§9707. Types of Licenses

A. The department shall have the authority to issue the following types of licenses.

1. Full Initial License. The department shall issue a full license to the nursing facility when the initial licensing survey finds that the nursing facility is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations and fees. The initial license shall specify the capacity of the nursing facility. The license shall be valid for a period of 12 months unless the license is modified, revoked, suspended, or terminated.

2. Provisional Initial License. The department may issue a provisional initial license to the nursing facility when the initial licensing survey finds that the nursing facility is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the residents or participants. The provisional license shall be valid for a period not to exceed six months.

a. At the discretion of the department, the provisional initial license may be extended for an additional period not to exceed 90 days in order for the nursing facility to correct the noncompliance or deficiencies.

b. The nursing facility shall submit a plan of correction to the department for approval and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional initial license.

c. A follow-up survey shall be conducted prior to the expiration of the provisional initial license.

i. If all such noncompliance or deficiencies are determined by the department to be corrected on a follow-up survey, a full license may be issued.

ii. If all such noncompliance or deficiencies are not corrected on the follow-up survey, the provisional initial license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee if no timely informal reconsideration or administrative appeal of the deficiencies is filed pursuant to this Chapter.

3. Annual Renewal License. The department may issue a full license that is annually renewed to an existing licensed nursing facility, which is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations.

a. The nursing facility shall submit:

i. a completed application;

ii. appropriate fees; and

iii. any other documentation or information that is required by the department for license renewal.

b. The license shall be valid for a period of 12 months unless the license is modified, revoked, suspended, or terminated.

4. Provisional License. The department, in its sole discretion, may issue a provisional license to an existing licensed nursing facility for a period not to exceed six months.

a. At the discretion of the department, the provisional license may be extended for an additional period not to exceed 90 days in order for the nursing facility to correct the noncompliance or deficiencies.

b. When the department issues a provisional license to an existing licensed nursing facility, the provider shall submit a plan of correction to the department for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license.

c. The department shall conduct an on-site follow-up survey at the nursing facility prior to the expiration of the provisional license.

i. If the on-site follow-up survey determines that the nursing facility has corrected the deficient practices and has maintained compliance during the period of the provisional license, the department may issue a full license for the remainder of the year until the anniversary date of the nursing facility license.

ii. If the on-site follow-up survey determines that the nursing facility has not corrected the deficient practices or has not maintained compliance during the period of the provisional license, the provisional license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee if no timely informal reconsideration or administrative appeal of the deficiencies is filed pursuant to this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1895 (November 2016).

§9709. Changes in Licensee Information

A. Any change regarding the nursing facility name, "doing business as" name, mailing address, phone number or any combination thereof, shall be reported in writing to the department within five days of the change. Any change regarding the nursing facility name or "doing business as" name requires a change to the nursing facility license and shall require the appropriate fee for the issuance of an amended license.

B. A change of ownership (CHOW) of the nursing facility shall be reported in writing to the department at least five days prior to the change of ownership.

1. The license of a nursing facility is not transferable or assignable. The license cannot be sold.

2. In the event of a CHOW, the new owner shall submit the legal CHOW document, all documents required for a new license, and the applicable licensing fee. Once all of the application requirements are completed and approved by the department, a new license shall be issued to the new owner.

3. A nursing facility that is under license revocation, provisional licensure or denial of license renewal may not undergo a CHOW.

C. Any request for a duplicate license shall be accompanied by the appropriate fee.

D. A nursing facility that intends to change the physical address of its geographic location is required to have OSFM approval for plan review and approval for occupancy of the new location, Office of Public Health approval, compliance with other applicable licensing requirements, and an on-site licensing survey prior to the occupancy of the new location to be licensed.

1. Written notice of intent to relocate shall be submitted to HSS at the time plan review request is submitted to OSFM.

2. Relocation of the nursing facility's physical address results in a new anniversary date and the full licensing fee shall be paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1895 (November 2016).

§9711. Renewal of License

A. To renew a license, a nursing facility shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the

current license. The licensure application packet shall include:

1. the license renewal application;

2. a copy of the current onsite inspection report with approval of occupancy from OSFM and the Office of Public Health;

3. the licensure renewal fee; and

4. any other documentation required by the department.

B. the department may perform an onsite survey and inspection upon annual renewal of a license.

C. Failure to submit a completed license renewal application packet prior to the expiration of the current license shall result in the voluntary non-renewal of the nursing facility license.

D. The renewal of a license does not in any manner affect any sanction, civil fine, or other action imposed by the department imposed against the nursing facility.

E. If an existing licensed nursing facility has been issued a notice of license revocation, suspension, or termination, and the nursing facility license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1896 (November 2016).

§9713. Licensing Surveys

A. Prior to the initial license being issued to the nursing facility, an initial licensing survey shall be conducted on-site at the nursing facility to assure compliance with licensing standards. The nursing facility shall not provide services to any resident until the initial licensing survey has been performed and the nursing facility found in compliance with the licensing standards. The initial licensing survey shall be an announced survey.

B. Once an initial license has been issued, the department may conduct licensing and other surveys at intervals deemed necessary by the department to determine compliance with licensing standards and regulations, as well as other required statutes, laws, ordinances, rules, regulations and fees. These surveys shall be unannounced.

C. A follow-up survey may be conducted for any survey where deficiencies have been cited to ensure correction of the deficient practices. The department shall issue written notice to the provider of the results of the follow-up survey.

D. An acceptable plan of correction shall be required for any survey where deficiencies have been cited.

E. If deficiencies have been cited during a licensing survey, the department may issue appropriate sanctions, including but not limited to:

1. civil fines;

2. directed plans of correction;

3. denial of license renewal;

4. provisional licensure;

5. license revocation; or

6. any other sanctions or actions authorized under state law or regulation.

F. Surveyors and staff, on behalf of the department, shall be:

1. given access to all areas of the nursing facility and all relevant files during any licensing survey or other survey; and

2. allowed to interview any facility staff, resident, or participant as necessary to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1896 (November 2016).

§9715. Statement of Deficiencies

A. Notice to nursing facility of statement of deficiencies. When the department has reasonable cause to believe through an on-site survey, a complaint investigation, or other means that there exists or has existed a threat to the health, safety, welfare or rights of a nursing facility resident, the department shall give written notice of the deficiencies.

B. The survey team shall conduct an exit conference and give the nursing facility administrator or his/her designee the preliminary finding of fact and the possible deficiencies before leaving the nursing facility.

C. The department shall send confirmed written notice to the nursing facility administrator.

D. The department's written notice of deficiencies shall be consistent with the findings delineated at the conference and shall:

1. specify the deficiencies;

2. cite the legal authority which established such deficiencies; and

3. inform the administrator that the nursing facility has 10 calendar days from receipt of written notice within which to request a reconsideration of the proposed agency action.

E. Any statement of deficiencies issued by the department to the nursing facility shall be posted in a conspicuous place on the licensed premises.

F. In accordance with R.S. 40:2010.10, all nursing facilities shall provide notification to the applicant during the admission process that the applicant may receive a copy of the annual licensing survey as well as the telephone number to report complaints, and the applicant shall sign stating they have been so notified.

G. Any statement of deficiencies issued by the department to a nursing facility shall be available for disclosure to the public 14 days following the date the statement of deficiency is made available to the nursing facility.

H. Unless otherwise provided in statute or in this licensing rule, a provider shall have the right to an informal reconsideration of any deficiencies cited as a result of a survey or investigation.

1. Correction of the violation, noncompliance or deficiency shall not be the basis for the reconsideration.

2. The provider's written request for informal reconsideration shall be considered timely if received within 10 calendar days of facility's receipt of the statement of deficiencies.

3. The request for informal reconsideration of the deficiencies shall be made to the department's Health Standards Section.

4. Except as provided for complaint surveys pursuant to R.S. 40:2009.13 et seq., and as provided for license denials, revocations, and denial of license renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies. There is no administrative appeal right of such deficiencies.

5. The provider shall be notified in writing of the results of the informal reconsideration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1896 (November 2016).

§9717. Initial License Denial, Revocation or Denial of Renewal of License

A. The department also may deny, suspend or revoke a license where there has been substantial noncompliance with these requirements in accordance with R.S. 40:2009.1 et seq., the nursing home licensing law. If a license is denied, suspended, or revoked, an appeal may be requested.

B. The department may deny an application for a license, may deny a license renewal or may revoke a license in accordance with the provisions of the Administrative Procedure Act.

C. Denial of an Initial License. The department may deny an initial license in the event that the initial licensing survey finds that the nursing facility is noncompliant with any licensing laws or regulations that present a potential threat to the health, safety, or welfare of the residents.

1. The department shall deny an initial license in the event that the initial licensing survey finds that the nursing facility is noncompliant with any other required statutes, laws, ordinances, rules or regulations that present a potential threat to the health, safety or welfare of the residents.

2. The department shall deny an initial license for any of the reasons in this Rule that a license may be revoked or non-renewed.

D. Voluntary Non-Renewal of a License. If a provider fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the provider.

E. Revocation of License or Denial of License Renewal. A nursing facility license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the nursing facility licensing laws, rules and regulations;

2. failure to be in substantial compliance with other required statutes, laws, ordinances, rules, or regulations;

3. failure to be in substantial compliance with the terms and provisions of a settlement agreement;

4. failure to uphold resident rights whereby deficient practices may result in harm, injury, or death of a resident;

5. failure to protect a resident from a harmful act of an employee or other resident including, but not limited to:

a. abuse, neglect, exploitation, or extortion;

b. any action posing a threat to a resident's health and safety;

c. coercion;

d. threat or intimidation; or

e. harassment;

6. failure to notify the proper authorities of all suspected cases of neglect, criminal activity, mental or physical abuse, or any combination thereof;

7. knowingly making a false statement, or providing false, forged or altered information or documentation to LDH employees or to law enforcement in any of the following areas, including but not limited to:

a. application for initial license or renewal of license; or

b. matters under investigation by the department or the Office of the Attorney General;

8. the use of false, fraudulent or misleading advertising;

9. fraudulent operation of a nursing facility by the owner, administrator or manager;

10. an owner, officer, member, manager, administrator or person designated to manage or supervise participant care has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court;

a. for purposes of this paragraph, conviction of a felony means a felony relating to the violence, abuse, or negligence of a person, or a felony relating to the misappropriation of property belonging to another person;

11. failure to comply with all reporting requirements in a timely manner as required by the department;

12. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview facility staff or residents individually as necessary to conduct the survey;

13. failure to allow or refusal to allow access to records by personnel authorized by LDH; or

14. bribery, harassment, or intimidation of any residents designed to cause that resident to use the services of any particular nursing facility.

F. In the event a nursing facility license is revoked or renewal is denied any owner, officer, member, manager, director or administrator of such nursing facility may be prohibited from owning, managing, directing or operating another nursing facility for a period of two years from the date of the final disposition of the revocation or denial action.

1. For any of the above positions affected by employment prohibitions, the department shall consider the involvement, responsibilities and authority of the individual(s) affected by such employment prohibition, as well as associated circumstances involving license revocation or denial of license renewal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1897 (November 2016).

§9719. Notice and Appeal of Initial License Denial, License Revocation and Denial of License Renewal

A. Notice of an initial license denial, license revocation or denial of license renewal shall be given to the provider in writing.

B. The provider has a right to an informal reconsideration of the initial license denial, license revocation, or denial of license renewal. There is no right to an informal reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The provider's request for informal reconsideration shall be considered timely if received within 15 calendar days of the notice of the initial license denial, license revocation, or denial of license renewal. The request for informal reconsideration shall be in writing and shall be forwarded to the department's Health Standards Section.

2. The request for informal reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an informal reconsideration is received by the Health Standards Section, an informal reconsideration shall be scheduled and the provider will receive written notification.

4. The provider shall have the right to appear in person at the informal reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the initial license denial, revocation or denial of license renewal shall not be a basis for reconsideration.

6. The informal reconsideration process is not in lieu of the administrative appeals process.

7. The provider will be notified in writing of the results of the informal reconsideration.

C. The provider has a right to an administrative appeal of the initial license denial, license revocation, or denial of license renewal.

1. The provider shall request the administrative appeal within 30 days of the receipt of the results of the informal reconsideration. The provider may forego its rights to an informal reconsideration, and if so, the provider shall request the administration appeal within 30 days of the receipt of the notice of the initial license denial, license revocation, or denial of license renewal. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law (DAL).

2. The request for administrative appeal shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the DAL, the administrative appeal of the license revocation or denial of license renewal shall be suspensive, and the provider shall be allowed to continue to operate and provide services until such time as the department issues a final administrative decision.

a. If the secretary of the department, or his/her designee, determines that the violations of the nursing facility pose an imminent or immediate threat to the health, welfare or safety of a participant, the imposition of the license revocation or denial of license renewal may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the nursing facility shall be notified in writing.

4. Correction of a violation or a deficiency which is the basis for the initial license denial, revocation or denial of license renewal, shall not be a basis for the administrative appeal.

D. If an existing licensed provider has been issued a notice of license revocation and the provider's license is due for annual renewal, the department shall deny the license renewal application. The denial of the license renewal application does not affect in any manner the license revocation.

E. If a timely administrative appeal has been filed by the provider on an initial license denial, denial of license renewal, or license revocation, the DAL shall conduct the hearing in accordance with the Administrative Procedure Act.

1. If the final decision is to reverse the initial license denial, the denial of license renewal, or the license revocation, the provider's license will be re-instated or granted upon the payment of any licensing or other fees due to the department.

F. There is no right to an informal reconsideration or an administrative appeal of the issuance of a provisional initial license to a new provider. An existing provider who has been issued a provisional license remains licensed and operational and also has no right to an informal reconsideration or an administrative appeal of the issuance of the provisional license. The issuance of a provisional license to an existing provider is not considered to be a denial of initial licensure, a denial of license renewal, or a license revocation.

1. A follow-up survey shall be conducted prior to the expiration of a provisional initial license to a new provider or the expiration of a provisional license to an existing provider.

2. A new provider that is issued a provisional initial license or an existing provider that is issued a provisional license shall be required to correct all noncompliance or deficiencies at the time the follow-up survey is conducted.

3. If all noncompliance or deficiencies have not been corrected at the time of the follow-up survey, or if new deficiencies that are a threat to the health, safety, or welfare of residents are cited on the follow-up survey, the provisional initial license or provisional license shall expire on its face.

4. The department shall issue written notice to the provider of the results of the follow-up survey.

5. A provider with a provisional initial license or an existing provider with a provisional license who has deficiencies cited at the follow-up survey shall have the right to an informal reconsideration and the right to an administrative appeal of the deficiencies cited at the follow up survey.

a. The correction of a violation, noncompliance or deficiency after the follow-up survey shall not be the basis for the informal reconsideration or for the administrative appeal.

b. The informal reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

c. The facility's written request for informal reconsideration shall be considered timely if received within five calendar days of the notice of the results of the follow-up survey from the department.

d. The provider shall request the administrative appeal within 15 calendar days of the notice of the results of the follow-up survey from the department.

e. The provider with a provisional initial license or an existing provider with a provisional license that expires under the provisions of this section shall cease providing services unless the DAL issues a stay of the expiration. The stay shall only be granted by the DAL in accordance with the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1898 (November 2016).

§9721. Cessation of Business

A. Except as provided in Section §9767.K-M of these licensing regulations, a license shall be immediately null and void if a facility ceases to operate.

B. A cessation of business is deemed to be effective the date on which the nursing facility stopped offering or providing services to the community.

C. Upon the cessation of business, the nursing facility shall immediately return the original license to the department.

D. Cessation of business is deemed to be a voluntary action on the part of the nursing facility. The provider does not have a right to appeal a cessation of business.

E. The nursing facility shall notify the department in writing 30 days prior to the effective date of the closure or cessation. In addition to the notice, the provider shall submit a written plan for the disposition of patient medical records for approval by the department. The plan shall include the following:

1. the effective date of the closure.;

2. provisions that comply with federal and state laws on storage, maintenance, access and confidentiality of the closed provider's patients medical records;

3. an appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the patient or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing nursing facility, at least 15 days prior to the effective date of closure.

F. Failure to comply with the provisions concerning submission of a written plan for the disposition of patient medical records to the department may result in the provider

being prohibited from obtaining a license for any provider type issued by the department.

G. Once the nursing facility has ceased doing business, the nursing facility shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1899 (November 2016).

§9723. Complaint Process

A. Any person who has knowledge of any of the following circumstances that could affect the health and well-being of a nursing facility resident may submit a complaint regarding the matter in writing or by telephone to the Louisiana Department of Health, Health Standards Section:

1. the alleged abuse or neglect of a nursing facility resident;

2. violation of any state law, licensing rule or regulation, or federal certification rule pertaining to a nursing facility; or

3. that a nursing facility resident is not receiving the care and treatment to which he is entitled under state or federal laws.

B. Prohibition Against Retaliation. No discriminatory or retaliatory action shall be taken by a nursing facility against any person or resident who provides information to the department or any other governmental agency, provided the communication was made for the purpose of aiding the department in carrying out its duties and responsibilities.

1. Any person, who in good faith, submits a complaint pursuant to this Section, shall have immunity from any civil liability that otherwise might be incurred or imposed because of such complaint. Such immunity shall extend to participation in any judicial proceeding resulting from the complaint.

C. Notice of Complaint Procedure. Notices of how to lodge a complaint with the department, the Office of Civil Rights, the Americans with Disabilities Act, and/or the Medicaid Fraud Control Unit shall be posted conspicuously in the nursing facility in an area accessible to residents. The notices shall include the addresses and toll-free complaint telephone numbers for the Health Standards Section (HSS) and other governmental agencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1899 (November 2016).

§9725. Complaint Surveys

A. The department shall conduct complaint surveys in accordance with R.S. 40:2009.13 et seq.

B. Complaint surveys shall be unannounced surveys.

C. An acceptable plan of correction shall be submitted to the department for any complaint survey where deficiencies have been cited.

D. An on-site follow-up survey or a desk review may be conducted for any complaint survey where deficiencies have been cited to ensure correction of the deficient practices.

E. For deficiencies cited for non-compliance with any complaint survey, the department may issue appropriate sanctions, including but not limited to:

1. civil fines;

2. directed plans of correction;

3. denial of license renewal;

4. provisional licensure;

5. license revocation; or

6. any other sanctions or actions authorized under state law or regulation.

F. LDH surveyors and staff shall be given access to all areas of the nursing facility and all relevant files during any complaint survey. LDH surveyors and staff shall be allowed to interview any facility staff or resident, as necessary or required to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1899 (November 2016).

§9727. Incident Reporting Requirements

A. A nursing facility shall have written procedures for the reporting and documentation of actual and suspected incidents of abuse, neglect, misappropriation of property/funds and suspicious death. Major injuries of unknown origin (e.g., fractures, burns, suspicious contusions, head injuries, etc.) for which the nursing facility is unable to determine the cause and could possibly be the result of abuse or neglect shall also be reported. Such procedures shall ensure that:

1. a resident is protected from harm during an investigation;

2. immediate verbal reporting is made and a preliminary written report within 24 hours of the incident is submitted to the administrator or his/her designee;

3. notification, as required by HSS, is submitted to HSS within 24 hours of occurrence or discovery of the incident. The nursing facility shall utilize the LDH online tracking incident system (OTIS) or current LDH required database reporting system to provide notification;

NOTE: The nursing facility is required to maintain internet access and to keep the department informed of an active e-mail address at all times.

4. appropriate authorities are to be notified according to state law;

5. immediate, documented attempts are made to notify the resident's legal representative;

6. immediate attempts are made to notify other involved agencies and parties as appropriate; and

7. immediate notification is made to the appropriate law enforcement authority whenever warranted.

B. The initial written notification submitted to the LDH HSS within 24 hours of occurrence or discovery of the incident shall include:

1. the name of the alleged victim;

2. the name of the accused (if known);

3. the incident category (if applicable);

4. the date and time the incident occurred, if known, and the date and time the incident was discovered;

5. a description of the alleged abuse, neglect, misappropriation of property, and incident of unknown origin from the victim and/or the reporter;

6. documentation of any action taken to protect the resident during the investigation; and

7. any other relevant information available at the time the report is submitted.

C. The nursing facility shall have evidence that the alleged violations are thoroughly investigated and shall ensure protection of the resident from further potential abuse, neglect, and misappropriation of property/funds while the investigation is in progress.

D. A final report with the results of all investigations shall be reported to HSS within five working days of the incident through the use of OTIS or current LDH required database reporting system. The report shall include:

1. the alleged victim's name, date of birth, and a complete description of the physical harm, pain or mental anguish;

2. the name, date of birth, address and telephone number of the accused. If the accused is a nursing facility employee, include the Social Security number.

3. the date and time the incident occurred, if known, and the date and time the incident was discovered;

4. a description of the alleged abuse, neglect, misappropriation of property, and incident of unknown origin;

5. a detailed summary of the entity's investigation including all witness' information and all facts that lead to the determination of substantiated, unsubstantiated or unable to verify:

a. immediate action taken to protect the alleged victim during the investigation; and

b. any action taken toward the accused; and

6. nursing facility administrator/CEO finding.

E. If an alleged violation is verified, the nursing facility shall take appropriate corrective action.

F. If the investigation substantiates abuse, neglect, and/or misappropriation of property against a CNA, the following shall be available, if requested, by HSS:

1. a copy of the NAT-7 verifying termination;

2. the nursing facility abuse policy signed by the CNA;

3. the date and time the incident occurred;

4. the date and time the incident was discovered;

5. a copy of the CNA's statement (signed and dated);

6. a copy of the resident's statement (signed and dated);

7. witness statements (signed and dated); and

8. a copy of the time card for the date and time of the incident.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1900 (November 2016).

§9729. Sanctions and Appeal of Sanctions

A. Any nursing facility found to be in violation of any state or federal statute, regulation or any department rule, adopted in accordance with the Administrative Procedure Act, governing the administration and operation of the nursing facility may be sanctioned as provided for in LAC 48:I.Chapter 46.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1900 (November 2016).

§9731. Suspensive Appeal of Revocation of License

A. The secretary of the Department of Health, or his/her designee, may deny an application for a license or refuse to renew a license or may revoke an outstanding license when an investigation reveals that the applicant or licensee is in nonconformance with or in violation of the provisions of R.S.40:2009.6, provided that in all such cases, the Secretary shall furnish the applicant or licensee 30 calendar days written notice specifying reasons for the action.

B. The secretary or designee, in a written notice of denial, denial of renewal or revocation of a license, shall notify the applicant or licensee of his right to file a suspensive appeal with the DAL within 30 calendar days from the date the notice, as described in this Subchapter. This appeal or request for a hearing shall specify in detail reasons why the appeal is lodged and why the appellant feels aggrieved by the action of the secretary.

C. When any appeal as described in this Subchapter is received by the DAL, the hearing shall be conducted in accordance with R.S. 40:2009.17 and the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1901 (November 2016).

§9733. Approval of Plans

A. Plans and specifications for new construction of, or to, a nursing facility, and for any major alterations or renovations to a nursing facility, shall be submitted to the Department of Public Safety, Office of the State Fire Marshal (OSFM) for review in accordance with R.S. 40:1563(L), R.S. 40:1574 and LAC 55:V.Chapter 3.

1. Plans and specifications for new construction, major alterations and major renovations shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer where required by Louisiana architecture and engineering licensing laws of R.S. 37:141 et seq., and R.S. 37:681 et seq., and respective implementing regulations.

2. No residential conversions shall be considered for a nursing facility license.

B. The plans and specifications shall comply with all of the following:

1. LDH nursing facility licensing requirements and the Office of Public Health's (OPH) nursing home regulations (see LAC 51:XX); and

2. The OSFM's requirements for plan submittals and compliance with all codes required by that office.

C. Notice of satisfactory review from the department and OSFM constitute compliance with this requirement, if construction begins within 180 days of the date of such notice. This approval shall in no way permit and/or authorize any omission or deviation from the requirements of any restrictions, laws, regulations, ordinances, codes or rules of any responsible agency.

D. Fire Protection. All nursing facilities licensed by the department shall comply with the rules, laws, codes and enforcement policies as promulgated by OSFM.

1. It shall be the primary responsibility of OSFM to determine if applicants are complying with those requirements.

2. No initial license shall be issued without the applicant furnishing acceptable written proof from OSFM that such applicant is complying with their provisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1901 (November 2016).

§9735. Sanitation and Patient Safety

A. All nursing facilities licensed by the department shall comply with the rules, sanitary code and enforcement policies as promulgated by the Office of Public Health (OPH).

1. It shall be the primary responsibility of OPH to determine if applicants are complying with those requirements.

2. No initial license shall be issued without the applicant furnishing an approval from OPH that such applicant is complying with their provisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1901 (November 2016).

§9737. Alzheimer's Special Care Disclosure

A. Any provider offering a special program for persons with Alzheimer's disease or a related disorder shall disclose the form of care or treatment that distinguishes it as being especially applicable to or suitable for such persons. For the purpose of this section, a related disorder means progressive, incurable dementia.

B. Prior to entering into any agreement to provide care, a provider shall make the disclosure to:

1. any person seeking services within an Alzheimer's special care program; or

2. any person seeking such services on behalf of a person with Alzheimer's disease or a related disorder within an Alzheimer's special care program. A provider shall make the disclosure upon characterizing programs or services as especially suited for persons with Alzheimer's disease or a related disorder. Additionally, a provider shall give copies of current disclosure forms to all designees, representatives or sponsors of persons receiving treatment in an Alzheimer's special care program.

C. A provider shall furnish the disclosure to the department when applying for a license, renewing an existing license, or changing an existing license. Additional disclosure may be made to the state ombudsman. During the licensure or renewal process, the department will examine all disclosures to verify the accuracy of the information. Failure to provide accurate or timely information constitutes noncompliance with this section and may subject the provider to standard administrative penalties or corrective actions. Distributing an inaccurate or misleading disclosure form constitutes deceptive advertising and may subject a provider to prosecution under R.S. 51:1401 et seq. In such instances, the department will refer the matter to the Attorney General's Division of Consumer Protection for investigation and possible prosecution.

D. Within seven working days of a significant change in the information submitted to the department, a provider shall furnish an amended disclosure form reflecting the change to the following parties:

1. the department;

2. any clients with Alzheimer's disease or a related disorder currently residing in the nursing facility;

3. any designee, representative or sponsor of any such client;

4. any person seeking services in an Alzheimer's special care program; and

5. any person seeking services on behalf of a person with Alzheimer's disease or a related disorder in an Alzheimer's special care program.

E. The provider's Alzheimer's special care disclosure documentation shall contain the following information:

1. a written statement of the overall philosophy and mission of the Alzheimer's special care program which reflects the needs of residents afflicted with dementia;

2. a description of the criteria and process for admission to, transfer, or discharge from the program;

3. a description of the process used to perform an assessment as well as to develop and implement the plan of care, including the responsiveness of the plan of care to changes in condition;

4. a description of staff training and continuing education practices;

5. a description of the physical environment and design features appropriate to support the functioning of cognitively impaired adult residents;

6. a description of the frequency and types of resident activities;

7. a statement of philosophy on the family's involvement in care and a statement on the availability of family support programs; and

8. a list of the fees for care and any additional program fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1901 (November 2016).

Subchapter B. Organization and General Services

§9751. Delivery of Services

A. A nursing facility shall be administered in a manner that promotes the highest level of physical, mental and psychosocial functioning and well-being of each resident.

B. A nursing facility shall be in compliance with all required federal, state and local statutes, laws, ordinances, rules, regulations and fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1902 (November 2016).

§9753. Governing Body

A. The nursing facility shall have a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the nursing facility. The governing body shall develop and approve policies and procedures which define and describe the scope of services offered. The policies and procedures shall be revised as necessary and reviewed at least annually.

B. The governing body shall be responsible for the operation of the nursing facility.

C. The governing body shall appoint in writing a licensed administrator responsible for the management of the nursing facility.

D. The governing body of the nursing facility shall appoint a facility designee charged with the general administration of the nursing facility in the absence of a licensed administrator.

E. The governing body shall notify the department in writing when a change occurs in the administrator position within 30 calendar days from the date the change occurs. The notice shall include the identity of the individual and the specific date the change occurred.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1902 (November 2016).

§9755. Administration

A. Facility Administrator. Each nursing facility shall have a full time administrator. The administrator shall be licensed by the Louisiana Board of Examiners of Nursing Facility Administrators.

1. The administrator is the person responsible for the onsite, daily implementation and supervision of the nursing facility's overall operation commensurate with the authority conferred by the governing body.

2. The nursing facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

B. A full-time employee functioning in an administrative capacity shall be authorized in writing to act in the administrator's behalf when he/she is absent or functioning as a full-time administrator for two facilities.

C. Administrator Responsibilities and Restrictions

1. No individual shall function as a full-time administrator for more than two nursing facilities. When an individual functions as a full-time administrator of two nursing facilities, the department shall consider such factors including but not limited to size and proximity with regard to the administrator's ability to sufficiently manage the affairs of both nursing facilities.

a. The response time to either nursing facility shall be no longer than one hour. The administrator's response to either of the facilities shall include communication, either telephonic or electronic and\or by physical presence at the

facility. Any consideration requiring administrator's response shall be reviewed on a case-by-case basis.

b. If an individual functions as an administrator of two nursing facilities, he/she shall spend 20 hours per week at each nursing facility.

2. The administrator, or his designee, is responsible, in writing, for the execution of all policies and procedures.

3. The administrator is responsible for ensuring the nursing facility has a plan to conduct comprehensive risk assessments to determine the potential adverse impact of equipment, supplies and other factors relating to the health, safety and welfare of residents. Results of the risk assessments shall be used to develop and implement procedures to address the potential adverse impact and safety risk in the entire facility including but not limited to locked or specialized care units.

4. Written notice shall be provided to HSS for any personnel change in the administrator position. This notice shall be provided within 30 calendar days from the date of change by the facility administrator or, in the absence of an administrator, by the governing body of the nursing facility at the time the change occurs.

a. Notice shall include the identity of all individuals involved and the specific changes which have occurred.

b. The department shall allow nursing facilities 30 days from the date of the change in the position to fill the resulting vacancy in the administrator position. There shall be no exemption to the administrator position requirement.

c. Failure to either fill a vacancy, or to notify the department in writing within 30 days from the date of the change may result in a class C civil fine.

D. Assistant Administrator. A nursing facility with a licensed bed capacity of 161 or more beds shall employ an assistant administrator. An assistant administrator shall be a full-time employee and function in an administrative capacity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1902 (November 2016).

§9757. Personnel

A. There shall be sufficient qualified personnel to properly operate the nursing facility to assure the health, safety, proper care and treatment of the residents.

1. Time schedules shall be maintained which indicate the numbers and classification of all personnel, including relief personnel, who works on each tour of duty. The time schedules shall reflect all changes so as to indicate:

a. staff persons who actually worked;

b. in what capacity staff worked; and

c. percentage of time staff persons worked in each of the following capacities:

i. housekeeping;

ii. laundry;

iii. food service;

iv. CNA; and

v. nurse.

2. If the nursing facility's system of care (such as in the culture change environment) is such that nursing personnel perform services in addition to nursing care, such as housekeeping, laundry and food preparation as part of a plan wherein tasks and routines are organized and carried out to maximally approximate a facility environment, the nursing facility shall ensure:

a. sufficient nursing staff hours for the care of the resident;

b. nursing services shall not be neglected in order to provide the additional non-nursing services; and

c. nurse aides shall be properly trained in food preparation safety and infection control before being allowed to provide this service to residents.

B. Personnel records shall be current and available for each employee and shall contain sufficient information to assure that they are assigned duties consistent with his or her job description and level of competence, education, preparation and experience.

C. CNA Work History Reporting Requirements

1. If a nursing facility hires certified nursing assistants to provide care and services, the administrator or designee shall complete and submit the appropriate notice to the nurse aide registry to verify employment and termination of that certified nurse aide, within five working days of the action.

2. The administrator or designee shall reconcile with the nurse aide registry, at least monthly, the certified nurse aides employed and those terminated.

3. Accuracy of the work history held by the registry is the responsibility of the nursing facility (owner, administrator or designee).

a. When a change of ownership (CHOW) occurs, the new owner and/or administrator or designee shall ensure that all notifications of employment and termination of certified nurse aides have been sent to the registry, at the point that the change occurs.

b. In the event that a request for verification of work history is received after the CHOW occurs, the new owner and/or administrator or designee shall be responsible for compliance. The notification shall be sent to the registry within five working days of the request.

c. The administrator or designee shall ensure that all notifications of employment and termination of certified nurse aides, employed through staffing agencies, are sent to the registry monthly.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1903 (November 2016).

§9759. Criminal History Provisions and Screening

A. Nursing facilities shall have statewide criminal history checks performed on non-licensed personnel to include CNAs, housekeeping staff, activity workers, social service personnel and any other non-licensed personnel who provide care or other health related services to the residents in accordance with R.S. 40:1300.51 et seq.

B. All personnel requiring licensure to provide care shall be currently licensed to practice in the state of Louisiana. Credentials of all licensed full-time, part-time and consultant personnel shall be verified on an annual basis in writing by a designated staff member.

C. All personnel, including routine unpaid workers, involved in direct resident care, shall adhere to the *Title 51, Public Health—Sanitary Code*, Chapter 5 requirements for health examinations and tuberculosis (TB) testing for employees and volunteers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1903 (November 2016).

§9761. Policies and Procedures

A. There shall be written policies and procedures:

1. available to staff, residents and legal representatives governing all areas of care and services provided by the nursing facility;

2. ensuring that each resident receives the necessary care and services to promote the highest level of physical, mental and psychosocial functioning and well-being of each resident;

3. developed with the advice of a group of professional personnel consisting of at least a currently licensed physician, the administrator and the director of nursing services;

4. revised as necessary, but reviewed by the professional personnel group referenced in A.3 at least annually;

5. available to admitting physicians;

6. reflecting awareness of, and provision for, meeting the total medical and psychosocial needs of residents, including admission, transfer and discharge planning; and the range of services available to residents, including frequency of physician visits by each category of residents admitted; and

7. approved by the governing body.

B. The nursing facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.

1. The nursing facility shall not use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion.

2. The nursing facility shall develop and operationalize policies and procedures for screening and training employees, protection of the residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment and misappropriation of property.

C. The administrator or his designee is responsible, in writing, for the execution of such policies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1903 (November 2016).

§9763. Assessments and Care Plans

A. An initial assessment of the resident's needs/problems shall be performed and documented in each resident's clinical record by a representative of the appropriate discipline.

B. The assessment, including the PASRR level II recommendations, if applicable, shall be used to develop the resident's plan of care.

C. The assessment shall be completed within 14 days of admission and the care plan shall be completed within 7 days of the completion of the assessment or by the twenty-first day of admission.

D. The care plan shall be revised as necessary and reviewed at least annually by the professionally licensed personnel directly involved in the care of the resident.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1904 (November 2016).

§9765. Staff Orientation, Training and Education

A. New employees shall have an orientation program of sufficient scope and duration to inform the individual about his/her responsibilities and how to fulfill them.

B. The orientation program shall include at least a review of policies and procedures, job description and performance expectations prior to the employee performing his/her responsibilities.

C. A staff development program shall be conducted by competent staff and/or consultants and planned based upon employee performance appraisals, resident population served by the nursing facility and as determined by nursing facility staff. All employees shall participate in staff development programs which are planned and conducted for the development and improvement of their skills.

D. Training shall include, at a minimum, problems and needs common to the age, physical, mental and bio-psychosocial needs of the residents, and discharge planning

of those being served, prevention and control of infections, fire prevention and safety, emergency preparedness, accident prevention, confidentiality of resident information and preservation of resident dignity and respect, including protection of privacy and personal and property rights.

E. The nursing facility's training shall be sufficient to ensure the continuing competence of the staff. Nursing assistants shall be provided a minimum of 12 hours of training per year.

F. Records of training shall be maintained indicating the content, date, time, names of employees in attendance, and the name of the individual(s) who conducted the training.

G. Dementia Training

1. All employees shall be trained in the care of persons diagnosed with dementia and dementia-related practices that include or that are informed by evidence-based care practices.

2. Nursing facility staff who provide care on a regular basis to residents in Alzheimer's special care units shall meet the following training requirements.

a. Staff who provide nursing and nursing assistant care to residents shall be required to obtain at least eight hours of dementia-specific training within 90 days of employment and five hours of dementia-specific training annually. The training shall include the following topics:

i. an overview of Alzheimer's disease and related dementias;

ii. communicating with persons with dementia;

iii. behavior management for persons with dementia;

iv. promoting independence in activities of daily living for persons with dementia; and

v. understanding and dealing with family issues for persons with dementia.

b. Staff who have regular communicative contact with residents, but who do not provide nursing and nursing assistant care, shall be required to obtain at least four hours of dementia-specific training within 90 days of employment and one hour of dementia training annually. This training shall include the following topics:

i. an overview of dementias; and

ii. communicating with persons with dementia.

c. Staff who have only incidental contact with residents shall receive general written information provided by the nursing facility on interacting with residents with dementia.

3. Nursing facility staff who are not regularly assigned to the Alzheimer's special care unit shall meet the following training requirements:

a. Staff who are not regularly assigned to the Alzheimer's special care unit, but still provide nursing assistant care in the facility shall be required to obtain four hours of dementia-specific training within 90 days of employment and two hours of dementia training annually.

b. Unlicensed staff who are not regularly assigned to the Alzheimer's special care unit and who have regular communicative contact with residents but do not provide nursing assistant care in the facility shall be required to obtain four hours of dementia-specific training within 90 days of employment and one hour of dementia training annually. The training shall include the following topics:

i. an overview of dementias; and

ii. communicating with persons with dementia.

c. Staff who have only incidental contact with residents shall receive general written information provided by the nursing facility on interacting with residents with dementia.

4. Staff delivering approved training will be considered as having received that portion of the training that they have delivered.

5. Any dementia-specific training received in a nursing or nursing assistant program approved by the Department of Health or the Department of Children and Family Services may be used to fulfill the training hours required pursuant to this Section.

6. Nursing facility providers shall offer an approved complete training curriculum themselves or shall contract with another organization, entity, or individual to provide the training.

7. The dementia-specific training curriculum shall be approved by the department. To obtain training curriculum approval, the organization, entity, or individual shall submit the following information to the department or its designee:

a. a copy of the curriculum;

b. the name and qualifications of the training coordinator;

c. a list of all instructors;

d. the location of the training; and

e. whether the training will be web-based.

8. A provider, organization, entity or individual shall submit any content changes to an approved training curriculum to the department, or its designee, for review and approval.

9. If a provider, organization, entity or individual, with an approved curriculum, ceases to provide training, the department shall be notified in writing within 30 days of cessation of training. Prior to resuming the training program, the provider, organization, entity, or individual shall reapply to the department for approval to resume the program.

10. Disqualification of Training Programs and Sanctions. The department may disqualify a training curriculum offered by a provider, organization, entity, or individual that has demonstrated substantial noncompliance with training requirements, including, but not limited to:

a. the qualifications of training coordinators; or

b. training curriculum requirements.

11. Compliance with Training Requirements. The review of compliance with training requirements shall include, at a minimum, a review of:

a. the existence of an approved training curriculum; and

b. the provider's adherence to established training requirements.

12. The department may impose applicable sanctions for failure to adhere to the training requirements outlined in this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1904 (November 2016).

§9767. Emergency Preparedness

A. The nursing facility shall have an emergency preparedness plan which conforms to the format and specifications of the Louisiana Model Nursing Home Emergency Plan and the licensing regulations promulgated herein. The plan shall be designed to manage the consequences of all hazards, declared disasters or other emergencies that either have the potential to disrupt and/or actually disrupt the nursing facility's ability to provide care and treatment or threatens the lives or safety of the residents. The nursing facility shall follow and execute its emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency.

1. All nursing facilities located in the parishes named in R.S. 40:2009.25(A) shall submit their emergency preparedness information and documentation to the department for review. Upon request, all other nursing facilities shall forward their emergency preparedness information and documentation to the Department of Health (LDH) for review.

2. All nursing facilities' emergency preparedness information and documentation shall, at a minimum, include:

a. a copy of the nursing facility's emergency preparedness plan;

b. updates, amendments, modifications or changes to the nursing facility's emergency preparedness plan;

c. the current census and number of licensed beds; and

d. the nursing facility location, physical street address with longitude and latitude, and current nursing facility contact information.

3. After reviewing the nursing facility's plan, if the department determines that the plan does not comply with the current minimum licensing requirements or does not promote the health, safety and welfare of the nursing facility's residents, the nursing facility shall, within 10 days of notification, respond with an acceptable plan of correction to amend its emergency preparedness plan.

B. A nursing facility shall enter current nursing facility information into Mstat or into the current LDH emergency preparedness webpage or electronic database for reporting.

1. The following information shall be entered or updated into Mstat or into the current LDH emergency preparedness webpage or electronic database for reporting before the fifteenth of each month:

a. operational status;

b. census;

c. emergency contact and destination location information;

d. emergency evacuation transportation needs categorized by the following types:

i. red—high risk patients will need to be transported by advanced life support ambulance due to dependency on mechanical or electrical life sustaining devices or very critical medical condition;

ii. yellow—residents who are not dependent on mechanical or electrical life sustaining devices, but cannot be transported using normal means (buses, vans, cars), may need to be transported by an ambulance. However, in the event of inaccessibility of medical transport, buses, vans or cars may be used as a last resort; or

iii. green—residents who need no specialized transportation may be transported by car, van, bus or wheelchair accessible transportation.

2. A nursing facility shall also enter or update the nursing facility's information upon request, or as described per notification of an emergency declared by the secretary. Emergency events include, but are not limited to hurricanes, floods, fires, chemical or biological hazards, power outages, tornados, tropical storms and severe weather.

3. Effective immediately, upon notification of an emergency declared by the secretary, all nursing facilities shall file an electronic report with Mstat or into the current LDH emergency preparedness webpage or electronic database for reporting.

a. The electronic report shall be filed, as prescribed by the LDH, throughout the duration of the emergency declaration.

b. The electronic report shall include, but is not limited to, the following:

i. status of operation;

ii. availability of beds;

iii. generator status;

iv. evacuation status;

v. shelter in place status; and

vi. other information requested by the department.

NOTE: The electronic report shall not be used to request resources or to report emergency events.

C. The emergency preparedness plan shall be individualized and site specific. All information included in the plan or submitted with the plan shall be current and correct. At a minimum, the nursing facility shall have a written emergency plan that addresses:

1. the procedures and criteria used for determining when the nursing facility will evacuate, including a listing of specific evacuation determinations for those procedures and criteria;

2. the procedures and criteria used for determining when the nursing facility will shelter in place, including a listing of specific sheltering in place determinations for those procedures and criteria;

3. a primary sheltering host site(s) and alternative sheltering host site(s) outside the area of risk;

a. these host sites shall be verified by written agreements or contracts that have been signed and dated by all parties;

b. these agreements or contracts shall be verified in writing annually; and

c. the nursing facility shall accept only that number of residents for which it is licensed unless prior written approval has been secured from the department or if the nursing facility is acting as a host site during a declared emergency;

4. the policies and procedures for mandatory evacuations shall provide that if the state, parish, or local Office of Homeland Security and Emergency Preparedness (OHSEP) orders a mandatory evacuation of the parish or area in which the nursing facility is located, the nursing facility shall evacuate unless the nursing facility receives a written exemption from the ordering authority prior to the mandated evacuation;

5. the monitoring of emergency alerts or notifications including weather warnings and watches as well as evacuation orders from local and state emergency preparedness officials:

a. this monitoring plan shall identify who will perform the monitoring, what equipment will be used for monitoring, and who should be contacted if needed; and

b. the nursing facility shall have plans for monitoring during normal daily operations, when sheltering in place or during evacuations;

6. the delivery of essential care and services to residents, whether the residents are housed in the nursing facility, at an off-site location, or when additional residents are housed in the nursing facility during an emergency;

7. the provisions for the management of staff, including provisions for sufficient qualified staff as well as for distribution and assignment of responsibilities and functions, either within the nursing facility or at another location;

8. an executable plan for coordinating transportation services that are sufficient for the resident census and staff. The vehicles required for evacuating residents to another location that are equipped with temperature controls shall be used when available. The plan shall include the following information:

a. a triage system to identify residents who require specialized transportation and medical needs including the number of residents who need:

i. red—high risk patients will need to be transported by advanced life support ambulance due to dependency on mechanical or electrical life sustaining devices or very critical medical condition;

ii. yellow—residents who are not dependent on mechanical or electrical life sustaining devices, but cannot be transported using normal means (buses, vans, cars), may need to be transported by an ambulance. However, in the event of inaccessibility of medical transport, buses, vans or cars may be used as a last resort; or

iii. green—residents who need no specialized transportation may be transported by car, van, bus or wheelchair accessible transportation;

b. a written transportation contract(s) for the evacuation of residents and staff to a safe location outside the area of risk that is signed and dated by all parties. Vehicles that are owned by, or are at the disposal of the nursing facility, shall have written usage agreements that are signed, dated and shall include verification of ownership; and

i. the number and type of vehicles;

ii. the capacity of each vehicle;

iii. a statement of whether each vehicle is equipped with temperature controls; and

c. plans to prevent and treat heat related medical illnesses due to the failure of, or the lack of, temperature controls during transport.

NOTE: A copy of a vehicle's title or registration will be sufficient for verification of ownership.

9. the procedures to notify the resident's family or responsible representative of the nursing facility's intent to either shelter in place or evacuate. The nursing facility shall have a designee(s) who is responsible for this notification. If the nursing facility evacuates, notification shall include:

a. the date and approximate time that the nursing facility is evacuating;

b. the place or location to which the nursing facility is evacuating, including the:

i. name;

ii. address; and

iii. telephone number;

c. a telephone number that the family or responsible representative may call for information regarding the nursing facility's evacuation; and

d. notification to the resident's family, legal representative, or designated contact shall be made as far in advance as possible, but at least within 24 hours of the determination to shelter in place or after evacuation when communication is available;

10. the procedures or methods that will be used to directly attach identification to the nursing facility resident. The nursing facility shall designate a staff person to be responsible for this identification procedure. This identification shall remain directly attached to the resident during all phases of an evacuation and shall include the following minimum information, including but not limited to:

a. current and active diagnosis;

b. medications, including dosage and times administered;

c. allergies;

d. special dietary needs or restrictions; and

e. next of kin, including contact information;

11. the nursing facility shall designate a staff person who is responsible for ensuring that a sufficient supply of the following items accompanies residents on buses or other transportation during all phases of evacuation:

a. water;

b. food;

c. nutritional supplies and supplements;

d. medication(s); and

e. other necessary supplies;

12. the procedures for ensuring that all residents have access to licensed nursing staff and that appropriate nursing services are provided during all phases of the evacuation, including transport of residents:

a. for buses or vehicles transporting 15 or more residents, licensed nursing staff shall accompany the residents on the bus or vehicle;

b. a licensed therapist(s) or paramedic may substitute for licensed nursing staff;

13. staffing patterns for sheltering in place and for evacuation, including contact information for such staff;

14. a plan for sheltering in place if the nursing facility determines that sheltering in place is appropriate:

a. if the nursing facility shelters in place, the nursing facility's plan shall ensure that seven days of necessary supplies are on hand or have written agreements, including timelines, to have supplies delivered prior to the emergency event. Supplies should include, but are not limited to:

i. drinking water or fluids, a minimum of 1 gallon per day per person sheltering at the nursing facility;

ii. water for sanitation;

iii. non-perishable food, including special diets;

iv. medications;

v. medical supplies;

vi. personal hygiene supplies; and

vii. sanitary supplies;

b. if the nursing facility shelters in place, the nursing facility's plan shall provide for a posted communications plan for contacting emergency services and monitoring emergency broadcasts. The nursing facility shall designate a staff person to be responsible for this function. The communication plan shall include:

i. the type of equipment to be used;

ii. back-up equipment to be used if available;

iii. the equipment's testing schedule; and

iv. the power supply for the equipment being used;

c. the nursing facility's plan shall include a statement indicating whether the nursing facility has a generator for sheltering in place. If the nursing facility has such a generator, the plan shall provide for a seven day supply of fuel, either on hand or delivered prior to the emergency event. If the nursing facility has such a generator, the plan shall provide a list of the generator's capabilities including:

i. its ability to provide cooling or heating for all or designated areas in the nursing facility;

ii. the ability to power an OPH approved sewerage system;

iii. the ability to power an OPH approved water system;

iv. the ability to power medical equipment;

v. the ability to power refrigeration;

vi. the ability to power lights; and

vii. the ability to power communications;

d. an assessment of the integrity of the nursing facility's building to include, but not be limited to:

i. wind load or ability to withstand wind;

ii. flood zone and flood plain information;

iii. power failure;

iv. age of building and type of construction; and

v. determinations of, and locations of interior safe zones;

e. plans for preventing and treating heat related medical illnesses due to the failure of or the lack of air conditioning while sheltering in place;

f. the nursing facility's plan shall include instructions to notify OHSEP and LDH of the nursing facility's plan to shelter in place; and

g. the nursing facility shall provide to LDH a list of residents sheltering in place;

15. those nursing facilities that are subject to the provisions of R.S. 40:2009.25(A) shall perform a risk assessment to determine the nursing facility's integrity. The integrity of the nursing facility and all relevant and available information shall be used in determining whether sheltering in place is appropriate. All elevations shall be given in reference to sea level or adjacent grade as appropriate. The assessment shall be reviewed and updated annually. The risk assessment shall include the nursing facility's determinations and the following documentation:

a. the nursing facility's latitude and longitude;

b. flood zone determination for the nursing facility and base flood elevation, if available:

i. the nursing facility shall evaluate how these factors will affect the building;

c. elevations of the building(s), heating ventilation and air conditioning (HVAC) system(s), generator(s), fuel storage, electrical service, water system and sewer motor, if applicable:

i. the nursing facility shall evaluate how these factors will affect the nursing facility considering projected flood and surge water depths;

d. an evaluation of the building to determine its ability to withstand wind and flood hazards to include:

i. the construction type and age;

ii. roof type and wind load;

iii. windows, shutters and wind load;

iv. wind load of shelter building; and

v. location of interior safe zones;

e. an evaluation of each generator's fuel source(s), including refueling plans, fuel consumption rate and a statement that the output of the generator(s) will meet the electrical load or demand of the required (or designated) emergency equipment;

f. the determinations of an evaluation of surroundings, including lay-down hazards or objects that could fall on the building and hazardous materials, such as:

i. trees;

ii. towers;

iii. storage tanks;

iv. other buildings;

v. pipe lines;

vi. chemical and biological hazards; and

vii. fuels;

g. sea, lake and overland surge from hurricanes (SLOSH) modeling using the maximum's of the maximum envelope of waters (MOM) for the nursing facility's specific location and the findings for all categories of hurricanes. The nursing facility's plan shall include an evaluation of how this will or will not affect the nursing facility;

16. the nursing facility's plan shall provide for an evaluation of security risks and corresponding security precautions that will be taken for protecting residents, staff and supplies during and after an emergency event;

17. the nursing facility's plan shall include clearly labeled and legible floor plan(s) of the nursing facility's building(s). The nursing facility's plan shall include the following:

a. the areas being used as shelter or safe zones;

b. the supply and emergency supply storage areas;

c. the emergency power outlets;

d. the communications center;

e. the location of the posted emergency plan:

i. the posted location shall be easily accessible to staff; and

f. a pre-designated command post.

D. Emergency Plan Activation, Review and Summary

1. The nursing facility's shelter in place plan and evacuation plan shall each be activated at least annually, either in response to an emergency or in a planned drill. The nursing facility's performance during the activation of the plan shall be evaluated and documented. The plan shall be revised if a need is indicated by the nursing facility's performance during the emergency event or the planned drill.

2. Nursing facilities subject to the provisions of R.S. 40:2009.25(B) shall submit a summary of the updated plan to the department's nursing facility emergency preparedness manager by March 1 of each year. If changes are made during the year, a summary of the amended plan shall be submitted within 30 days of the modification. All agreements and contracts shall be verified by all parties annually and submitted.

E. The nursing facility's plan shall be submitted to the parish or local OHSEP annually. Any recommendations by the parish or local OHSEP regarding the nursing facility's plan shall be documented and addressed by the nursing facility.

1. For nursing facilities, the following requirements shall be met.

a. The nursing facility's plan shall include verification of its submission to the parish or local OHSEP.

b. A copy of any and all response(s) by the nursing facility to the local or parish OHSEP recommendations shall be forwarded to LDH nursing facility emergency preparedness manager.

F. The plan shall be available to representatives of the Office of the State Fire Marshal and the Office of Public Health.

G. The nursing facility's plan shall follow all applicable laws, standards, rules or regulations.

H. Evacuation, Temporary Relocation or Temporary Cessation

1. The following applies to any nursing facility that evacuates, temporarily relocates or temporarily ceases operation at its licensed location due to an emergency.

a. The nursing facility shall immediately give written notice to HSS by hand delivery, facsimile or email of the following information:

i. the date and approximate time of the evacuation;

ii. the sheltering host site(s) to which the nursing facility is evacuating; and

iii. a list of residents being evacuated, which shall indicate the evacuation site for each resident.

b. Within 48 hours, the nursing facility shall notify the HSS of any deviations from the intended sheltering host site(s) and shall provide HSS with a list of all residents and their locations.

c. If there was no damage to the licensed location due to the emergency and there was no power outage of HVAC (either through regular service or generator) of more than 48 hours at the licensed location due to the emergency event, the nursing facility may reopen at its licensed location and shall notify HSS within 24 hours of reopening. The nursing facility shall comply with OPH and OSFM and have clearance from the local office of emergency preparedness.

d. For all other evacuations, temporary relocations, or temporary cessation of operations due to an emergency event, a nursing facility shall submit to Health Standards a written request to reopen, prior to reopening at the licensed location. That request shall include:

i. damage report;

ii. extent and duration of any power outages;

iii. re-entry census;

iv. staffing availability;

v. access to emergency or hospital services; and

vi. availability and/or access to food, water, medications and supplies.

2. Upon receipt of a reopening request, the department shall review and determine if reopening will be approved. The department may request additional information from the nursing facility as necessary to make determinations regarding reopening.

3. After review of all documentation, the department shall issue a notice of one of the following determinations:

a. approval of reopening without survey;

b. surveys required before approval to reopen will be granted. This may include surveys by the OPH, OSFM and HSS; or

c. denial of reopening.

4. The purpose of the surveys referenced above is to assure that the nursing facility is in compliance with the licensing standards including, but not limited to, the structural soundness of the building, the sanitation code, staffing requirements and the execution of emergency plans.

a. The Health Standards Section, in coordination with state and parish OHSEP, will determine the nursing facility's access to the community service infrastructure, such as hospitals, transportation, physicians, professional services and necessary supplies.

b. The Health Standards Section will give priority to reopening surveys.

5. Upon request by the department, the nursing facility shall submit a written summary attesting how the nursing facility's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

a. pertinent plan provisions and how the plan was followed and executed;

b. plan provisions that were not followed;

c. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

d. contingency arrangements made for those plan provisions not followed; and

e. a list of all injuries and deaths of residents that occurred during execution of the plan, evacuation and temporary relocation including the date, time, causes and circumstances of the injuries and deaths.

I. Sheltering in Place. If a nursing facility shelters in place at its licensed location during an emergency event, the following will apply.

1. Upon request by the department, the nursing facility shall submit a written summary attesting how the nursing facility's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

a. pertinent plan provisions and how the plan was followed and executed;

b. plan provisions that were not followed;

c. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

d. contingency arrangements made for those plan provisions not followed; and

e. a list of all injuries and deaths of residents that occurred during the execution of the plan, including the date, time, causes and circumstances of these injuries and deaths.

J. Unlicensed Sheltering Sites

1. In the event that a nursing facility evacuates, temporarily relocates or temporarily ceases operations at its licensed location due to an emergency event, the nursing facility shall be allowed to remain at an unlicensed sheltering site for a maximum of five days. A nursing facility may request one extension, not to exceed 15 days, to remain at the unlicensed sheltering site.

a. The request shall be submitted in writing to HSS and shall be based upon information that the nursing facility's residents will return to its licensed location, or be placed in alternate licensed nursing facility beds within the extension period requested.

b. The extension shall only be granted for good cause shown and for circumstances beyond the control of the nursing facility.

c. This extension shall be granted only if essential care and services to residents are ensured at the current sheltering facility.

2. Upon expiration of the five days or upon expiration of the written extension granted to the nursing facility, all residents shall be relocated to a licensed nursing facility and HSS and OHSEP shall be informed of the residents' new location(s).

K. Inactivation of License due to Declared Disaster or Emergency

1. A licensed nursing facility in an area or areas which have been affected by an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766 may seek to inactivate its license for a period not to exceed two years, provided that the following conditions are met:

a. the licensed nursing facility shall submit written notification to HSS within 60 days of the date of the executive order or proclamation of emergency or disaster that:

i. the nursing facility has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

ii. the licensed nursing facility intends to resume operation as a nursing facility in the same service area; and

iii. includes an attestation that the emergency or disaster is the sole causal factor in the interruption of the provision of services;

NOTE: Pursuant to these provisions, an extension of the 60 day deadline may be granted at the discretion of the department.

b. the licensed nursing facility resumes operating as a nursing facility in the same service area within two years of issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766;

i. A nursing facility may request one extension, not to exceed an additional six months for good cause shown by the facility. This request for an extension may be granted at the sole discretion of the department.

c. the licensed nursing facility continues to pay all fees and costs due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties and/or civil fines; and

d. the licensed nursing facility continues to submit required documentation and information to the department, including but not limited to cost reports.

2. Upon receiving a completed written request to inactivate a nursing facility license, the department shall issue a notice of inactivation of license to the nursing facility.

3. Upon completion of repairs, renovations, rebuilding or replacement of the facility, a nursing facility which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met:

a. the nursing facility shall submit a written license reinstatement request to the licensing agency of the department within two years of the Executive Order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

b. the license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing survey; and

c. the license reinstatement request shall include a completed licensing application with appropriate licensing fees.

4. Upon receiving a completed written request to reinstate a nursing facility license, the department shall conduct a licensing survey. If the nursing facility meets the requirements for licensure and the requirements under this Subsection, the department shall issue a notice of reinstatement of the nursing facility license. The licensed bed capacity of the reinstated license shall not exceed the licensed bed capacity of the nursing facility at the time of the request to inactivate the license.

5. No change of ownership in the nursing facility shall occur until such nursing facility has completed repairs, renovations, rebuilding or replacement construction and has resumed operations as a nursing facility.

6. The provisions of this Subsection shall not apply to a nursing facility which has voluntarily surrendered its license and ceased operation.

7. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the nursing facility license.

L. Inactivation of License due to Non-Declared Emergency or Disaster

1. A licensed nursing facility in an area or areas which have been affected by a non-declared emergency or disaster

may seek to inactivate its license, provided that the following conditions are met:

a. the licensed nursing facility shall submit written notification to the Health Standards Section within 30 days of the date of the non-declared emergency or disaster stating that:

i. the licensed nursing facility has experienced an interruption in the provisions of services as a result of events that are due to a non-declared emergency or disaster;

ii. the licensed nursing facility intends to resume operation as a nursing facility in the same service area;

iii. the licensed nursing facility attests that the emergency or disaster is the sole causal factor in the interruption of the provision of services; and

iv. the licensed nursing facility's initial request to inactivate does not exceed one year for the completion of repairs, renovations, rebuilding or replacement of the facility;

NOTE: Pursuant to these provisions, an extension of the 30 day deadline for initiation of request may be granted at the discretion of the department.

b. the licensed nursing facility continues to pay all fees and costs due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties and/or civil fines; and

c. the licensed nursing facility continues to submit required documentation and information to the department, including but not limited to cost reports.

2. Upon receiving a completed written request to temporarily inactivate a nursing facility license, the department shall issue a notice of inactivation of license to the nursing facility.

3. Upon facility's receipt of the department's approval of request to inactivate the facility's license, the facility shall have 90 days to submit plans for the repairs, renovations, rebuilding or replacement of the facility to the OSFM and the OPH as required.

4. The licensed nursing facility shall resume operating as a nursing facility in the same service area within one year of the approval of renovation/construction plans by OSFM and OPH as required.

Exception: If the facility requires an extension of this timeframe due to circumstances beyond the facility's control, the department will consider an extended time period to complete construction or repairs. Such written request for extension shall show facility's active efforts to complete construction or repairs and the reasons for request for extension of facility's inactive license. Any approvals for extension are at the sole discretion of the department.

5. Upon completion of repairs, renovations, rebuilding or replacement of the facility, a nursing facility which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met:

a. the nursing facility shall submit a written license reinstatement request to the licensing agency of the department;

b. the license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing or physical environment survey; and

c. the license reinstatement request shall include a completed licensing application with appropriate licensing fees.

6. Upon receiving a completed written request to reinstate a nursing facility license, the department may conduct a licensing or physical environment survey. The department may issue a notice of reinstatement if the facility has met the requirements for licensure including the requirements of this Subsection.

NOTE: The licensed bed capacity of the reinstated license shall not exceed the licensed bed capacity of the nursing facility at the time of the request to temporarily inactivate the license.

7. No change of ownership in the nursing facility shall occur until such nursing facility has completed repairs, renovations, rebuilding or replacement construction and has resumed operations as a nursing facility.

8. The provisions of this Subsection shall not apply to a nursing facility which has voluntarily surrendered its license and ceased operation.

9. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the nursing facility license.

M. Temporary Inactivation of Licensed Nursing Facility Beds Due to Major Alterations

1. A licensed nursing facility which is undergoing major alterations to its physical plant may request a temporary inactivation of a certain number of licensed beds providing that:

a. the nursing facility submits a written request to the licensing agency of the department seeking temporary inactivation of a certain number of its licensed bed capacity. Such written request shall include the following:

i. that the nursing facility has experienced or will experience a temporary interruption in the provisions of services to its licensed bed capacity as a result of major alterations;

ii. an attestation that the renovations are the sole causal factor in the request for temporary inactivation of a certain number of its licensed beds;

iii. the anticipated start date of the temporary inactivation of a certain number of licensed beds;

iv. the anticipated end date of the temporary inactivation of a certain number of licensed beds; and

v. the number of licensed beds requested to be inactivated temporarily;

b. the nursing facility ensures the health, safety and welfare of each resident during the major alterations; and

c. the nursing facility continues to provide, and each resident continues to receive, the necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, in accordance with each resident's comprehensive assessment and plan of care.

2. Upon receiving a completed written request for temporary inactivation of a certain number of the licensed bed capacity of a nursing facility, the department shall issue a notice of temporary inactivation of a certain number of the nursing facility's licensed beds.

3. No change of ownership in the nursing facility shall occur until such nursing facility has completed the major alterations and has resumed operating at prior approved licensed bed capacity.

4. Upon completion of the major alterations and receiving a completed written request to reinstate the number of licensed beds of a nursing facility, the department may conduct a physical environment survey. If the nursing facility meets the requirements for licensure and the requirements under this Subsection, the department may issue a notice of reinstatement of the nursing facility licensed bed capacity.

NOTE: The licensed bed capacity after major alterations are completed shall not exceed the licensed bed capacity of the nursing facility at the time of the request to temporarily inactivate a certain number of its licensed bed capacity prior to renovations.

5. The provisions of this Subsection shall not apply to a nursing facility which has voluntarily surrendered its license and ceased operation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1905 (November 2016), amended LR 48:1290 (May 2022).

§9769. Visitation by Members of the Clergy During a Declared Public Health Emergency

A. For purposes of §9769 and §9771, a public health emergency (PHE) is a declaration made pursuant to the Louisiana Health Emergency Powers Act, R.S. 29:760 et seq.

B. For purposes of §9769 and §9771, clergy shall be defined as follows:

1. a minister, priest, preacher, rabbi, imam, Christian Science practitioner; or

2. other similar functionary of a religious organization; or

3. an individual reasonably believed by a resident to be such a clergy member.

C. For purposes of §9769 and §9771, immediate family member shall mean the following of a resident in a nursing facility:

1. spouse;

2. natural or adoptive parent, child, or sibling;

3. stepparent, stepchild, stepbrother, or stepsister;

4. father-in-law, mother-in-law, daughter-in-law, son-in-law, brother-in-law or sister-in-law;

5. grandparent or grandchild;

6. spouse of a grandparent or grandchild; or

7. legal or designated representative of the resident.

D. For purposes of §9769 and §9771, resident shall mean a resident of a licensed nursing facility in Louisiana or the legal or designated representative of the resident.

E. A licensed nursing facility shall comply with any federal law, regulation, requirement, order, or guideline regarding visitation in nursing facilities issued by any federal government agency during a declared public health emergency. The provisions of the licensing rules in §9769.F-I shall be preempted by any federal statute, regulation, requirement, order, or guideline from a federal government agency that requires a nursing facility to restrict resident visitation in a manner that is more restrictive than the rules.

F. Nursing facilities shall comply with any Louisiana state health officer (SHO) order or emergency notice regarding visitation in nursing facilities during a declared PHE.

G. Nursing facilities shall comply with any executive order or proclamation issued by the governor of the state of Louisiana regarding visitation in a nursing facility during a declared PHE.

H. The provisions of this Section regarding visitation by members of the clergy shall apply to all nursing facilities licensed by the Department of Health.

I. Subject to the requirements of §9769.E-G, each nursing facility shall allow members of the clergy to visit residents of the nursing facility during a declared public health emergency (PHE) when a resident, or his legal or designated representative, requests a visit with a member of the clergy, subject to the following conditions and requirements:

1. Each nursing facility shall have a written policy and procedure addressing visitation by members of the clergy. A copy of the written policy and procedure shall be available, without cost, to the resident and his legal or designated representative, upon request. The nursing facility shall provide a link to an electronic copy of the policy and procedure to a member of the clergy, upon request.

2. A nursing facility's policy and procedure regarding clergy visitation may adopt reasonable time, place, and manner restrictions, provided that such restrictions are implemented by the nursing facility, in consultation with appropriate medical personnel, for the purpose of mitigating the possibility of transmission of any infectious agent or infectious disease or for the purpose of addressing the

medical condition or clinical considerations of an individual resident.

3. A nursing facility's policy and procedure on clergy visitation shall, at a minimum, require the following:

a. that the nursing facility give special consideration and priority for clergy visitation to residents receiving end-of-life care;

b. that a clergy member will be screened for infectious agents or infectious diseases, utilizing at least the current screening or testing methods and protocols recommended by the Centers for Disease Control and Prevention, as applicable; if there is a current Louisiana SHO order or emergency notice that requires more rigorous screening or testing methods and protocols, then the nursing facility shall utilize those methods and protocols;

c. that a clergy member not be allowed to visit a nursing facility resident if such clergy member has obvious signs or symptoms of an infectious agent or infectious disease, or if such clergy member tests positive for an infectious agent or infectious disease;

d. that a clergy member not be allowed to visit a nursing facility resident if the clergy member refuses to comply with the provisions of the nursing facility's policy and procedure or refuses to comply with the nursing facility's reasonable time, place, and manner restrictions; and

e. that a clergy member be required to wear personal protective equipment as determined appropriate by the nursing facility, considering the resident's medical condition or clinical considerations; at the nursing facility's discretion, personal protective equipment may be made available by the nursing facility to clergy members.

f. that a nursing facility's policy and procedure include provisions for compliance with any Louisiana SHO order or emergency notice and with any governor's executive order or proclamation limiting visitation during a declared PHE; and

g. that a nursing facility's policy and procedure include provisions for compliance with any federal law, regulations, requirements, orders, or guidelines regarding visitation in nursing facilities issued by any federal government agency during a declared public health emergency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1309 (September 2021).

§9771. Visitation by Immediate Family Members and Other Designated Persons during a Declared Public Health Emergency

A. A licensed nursing facility shall comply with any federal law, regulation, requirement, order, or guideline regarding visitation in nursing facilities issued by any federal government agency during a declared public health emergency. The provisions of the licensing rules in §9771.B-E shall be preempted by any federal statute, regulation, requirement, order, or guideline from a federal government agency that requires a nursing facility to restrict resident visitation in a manner that is more restrictive than the rules.

B. Nursing facilities shall comply with any Louisiana state health officer (SHO) order or emergency notice regarding visitation in nursing facilities during a declared PHE.

C. Nursing facilities shall comply with any executive order or proclamation issued by the governor of the state of Louisiana regarding visitation in a nursing facility during a declared PHE.

D. The provisions of this Section regarding visitation by immediate family members of the resident and other designated persons shall apply to all nursing facilities licensed by the Department of Health.

E. Subject to the requirements of §9771.A-C, each nursing facility shall allow immediate family members and other designated persons to visit a resident of the nursing facility during a declared public health emergency (PHE) when a resident, or his legal or designated representative, requests a visit with immediate family members and other designated persons, subject to the following conditions and requirements:

1. Each nursing facility shall have a written policy and procedure addressing visitation by immediate family members and other designated persons. A copy of the written policy and procedure shall be available, without cost, to the resident and his legal or designated representative, upon request. The nursing facility shall provide a link to an electronic copy of the policy and procedure to immediate family members and other designated persons, upon request.

2. A nursing facility's policy and procedure regarding visitation by immediate family members and other designated persons may adopt reasonable time, place, and manner restrictions, provided that such restrictions are implemented by the nursing facility, in consultation with appropriate medical personnel, for the purpose of mitigating the possibility of transmission of any infectious agent or infectious disease or for the purpose of addressing the medical condition or clinical considerations of an individual resident.

3. A nursing facility's policy and procedure on visitation by immediate family members and other designated persons shall, at a minimum, require the following:

a. that the nursing facility give special consideration and priority for visitation by immediate family members and other designated persons to residents receiving end-of-life care;

b. that visitation by immediate family members of the residents and other designated persons will be screened for infectious agents or infectious diseases and will pass such screening prior to each visitation, utilizing at least the

current screening or testing methods and protocols recommended by the Centers for Disease Control and Prevention, as applicable; if there is a current Louisiana SHO order or emergency notice that requires more rigorous screening or testing methods and protocols, then the nursing facility shall utilize those methods and protocols;

c. that an immediate family member or other designated person not be allowed to visit a nursing facility resident if such immediate family member or other designated person has obvious signs or symptoms of an infectious agent or infectious disease, or if such immediate family member or other designated person tests positive for an infectious agent or infectious disease;

d. that an immediate family member or other designated person not be allowed to visit a nursing facility resident if the immediate family member or other designated person refuses to comply with the provisions of the nursing facility's policy and procedure or refuses to comply with the nursing facility's reasonable time, place, and manner restrictions;

e. that immediate family members and other designated persons be required to wear personal protective equipment as determined appropriate by the nursing facility, considering the resident's medical condition or clinical considerations; at the nursing facility's discretion, personal protective equipment may be made available by the nursing facility to immediate family members and other designated persons;

f. that a nursing facility's policy and procedure include provisions for compliance with any Louisiana SHO order or emergency notice and with any governor's executive order or proclamation limiting visitation during a declared PHE;

g. that a nursing facility's policy and procedure include provisions for compliance with any federal law, regulations, requirements, orders, or guidelines regarding visitation in nursing facilities issued by any federal government agency during a declared public health emergency; and

h. that includes provisions for off-site visitation, allowing an immediate family member or other designated person to visit a nursing facility resident away from the facility campus.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1310 (September 2021).

Subchapter C. Resident Rights

§9775. Transfer and/or Discharge of the Resident

A. Voluntary Individual Transfer or Discharge. The nursing facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the nursing facility to the receiving entity. The information in the transferred and/or discharged resident's care plan, MDS, any mental health and/or psychosocial assessments and/or evaluations and discharge plan shall be submitted to the individual or institution into whose care the resident is being discharged

B. Involuntary Transfer or Discharge. The nursing facility shall permit each resident to remain in the nursing facility, and shall not transfer or discharge the resident from the nursing facility unless:

1. the transfer or discharge is necessary for the resident's welfare and/or the resident's needs cannot be met in the nursing facility;

2. the transfer or discharge is appropriate because the resident's health has improved sufficiently such that the resident no longer needs the services provided by the nursing facility;

3. the safety and health of individuals in the nursing facility is endangered by the resident to be transferred or discharged;

4. the resident has failed, after reasonable and appropriate notice, to pay for services rendered by the nursing facility;

5. the nursing facility ceases to operate.

C. Notice before Involuntary Transfer or Discharge. Before a nursing facility involuntary transfers or discharges a resident, the nursing facility shall:

1. notify the resident, and if known, a family member or legal representative of the resident, of the transfer or discharge and the reasons for the move in writing and in a language and manner easily understood;

2. record the reasons in the resident's clinical record;

3. timing of the notice. The notice of transfer or discharge shall be made by the nursing facility at least 30 days before the resident is transferred or discharged;

4. notice may be made as soon as practicable before transfer or discharge when:

a. the safety and health of the individuals in the nursing facility would be endangered;

b. the resident's health improves sufficiently to allow a more immediate transfer or discharge;

c. an immediate transfer or discharge is required by the resident's urgent medical needs; or

d. a resident has not resided in the nursing facility for 30 days;

NOTE: In nursing facilities not certified to provide services under Title XVIII or Title XIX of the Social Security Act, the advance notice period may be shortened to fifteen days for nonpayment of a bill for a stay at the nursing facility.

5. contents of the notice. The written notice to the resident and/or resident's representative (if applicable) of involuntary discharge or transfer shall include the following information:

a. the reason for transfer or discharge;

b. the effective date of transfer or discharge;

c. the location to which the resident is to be transferred or discharged;

d. a statement that the resident has the right to appeal the action to the state. The address, phone number and hours of operation of the Division of Administrative Law or its successor;

e. the name, address and telephone number of the state long term care ombudsman;

f. for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities; and

g. for nursing facility residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of individuals with mental illness established under the Protection and Advocacy for Mentally Ill Individuals Act;

6. the nursing facility shall transmit a copy of the involuntary transfer/discharge notice to the local long-term care ombudsman program.

D. Transfer. The nursing facility shall ensure that the transfer or discharge is effectuated in a safe and orderly manner. The resident and his/her legal representative or interested family member, if known and available, shall be consulted in choosing another nursing facility if nursing facility placement is required.

E. Appeal of Involuntary Discharge or Transfer. The resident, or his/her legal representative or designated contact, if known and available, has the right to appeal any transfer or discharge to the Division of Administrative Law, which shall provide a fair hearing in all such appeals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1911 (November 2016).

§9777. Statement of Rights and Responsibilities

A. In accordance with R.S. 40:2010.6 et seq., all nursing facilities shall adopt and make public a statement of the rights and responsibilities of the residents residing therein and shall treat such residents in accordance with the provisions of the statement. The statement shall assure each resident the following:

1. the right to civil and religious liberties, including but not limited to:

a. knowledge of available choices;

b. the right to independent personal decision; and

c. the right to encouragement and assistance from the staff of the nursing facility in the fullest possible exercise of these civil and religious rights;

2. the right to private and uncensored communications, including but not limited to:

a. receiving and sending unopened correspondence;

b. access to a telephone;

c. visitation with any person of the resident's choice; and

d. overnight visitation outside the nursing facility with family and friends in accordance with nursing facility policies, and physician orders without the loss of his bed:

i. nursing facility visiting hours shall be flexible, taking into consideration special circumstances such as out of town visitors and working relatives or friends;

ii. with the consent of the resident and in accordance with the policies approved by the Department of Health, the facility shall permit recognized volunteer groups, representatives of community based legal, social, mental health, and leisure and planning programs, and members of the clergy access to the facility during visiting hours for the purpose of visiting with and providing services to any resident;

3. the right to be granted immediate access to the following:

a. any representative of the secretary of the United States Department of Health and Human Services;

b. any representative of the state acting pursuant to his duties and responsibilities under state or federal law;

c. the resident's individual physician;

d. the state long term care ombudsman;

e. the agency responsible for the protection and the advocacy system for individuals with developmental disabilities;

f. the agency responsible for the protection and the advocacy system for individuals with mental illness;

g. immediate family members, other relatives of the resident, and the resident's clergy subject to the resident's right to deny or withdraw consent at any time;

h. others who are visiting with the consent of the resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time;

i. reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

j. reasonable restrictions imposed by the nursing facility, Department of Public Safety and Corrections, or the court that protect the welfare and safety of all the nursing facility's residents. The nursing facility may change the location of visits to assist care giving or protect the privacy of other residents;

4. the right to present grievances on behalf of himself or others to the nursing facility's staff or administrator, to

governmental officials, or to any other person; to recommend changes in policies and services to nursing facility personnel; and to join with other residents or individuals within or outside the facility to work for improvements in resident care, free from restraint, interference, coercion, discrimination or reprisal. This right includes access to the resident's sponsor and the Department of Health; and the right to be a member of, to be active in, and to associate with advocacy or special interest groups;

5. the right to be fully informed, in writing and orally, prior to or at time of admission and during his stay, of services not covered by the basic per diem rates and of bed reservation and refund policies of the facility;

6. the right to be fully informed, in a language that he or she can understand, of his or her total health status, including but not limited to, his or her medical conditions and proposed treatment, to participate in the planning of all medical treatment, including the right to refuse medication and treatment, and to be informed of the consequences of such actions;

7. the right to receive adequate and appropriate health care and protective and support services, including services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules promulgated by LDH;

8. the right to refuse treatment and to refuse to participate in experimental research;

9. the right to formulate an advanced directive and to address life-sustaining procedures, the purpose of which is to assure that all residents have the fundamental right to control the decisions relating to their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances where such persons are diagnosed as having a terminal and irreversible condition. This purpose may be fulfilled by the following, non-exclusive means:

a. an advance directive executed pursuant to the provisions of R.S. 40:1151 et seq., defined as a declaration by a resident which instructs his/her physician to withhold or withdraw life-sustaining procedures or designates another to make the treatment decision and to make such a declaration for him;

b. Louisiana physician order for scope of treatment (LaPOST), executed pursuant to the provisions of R.S. 40:1155.1 et seq., which documents the wishes of a qualified patient in a physician order; or

c. any other means of documenting written instructions or directives, including but not limited to, a living will, durable power of attorney for health care, a medical power of attorney, a pre-existing medical order for do not resuscitate (DNR) or another document that directs the resident's health care choices related to life-sustaining treatments;

NOTE: A resident's choice to document wishes relative to withholding or withdrawal of medical treatment or life-sustaining procedures is voluntary and the provisions herein shall not be construed to compel a resident to do so and shall not be a condition of admission to a nursing facility.

10. the right to have privacy in treatment and in caring for personal needs:

a. to have closed room doors, and to have nursing facility personnel knock before entering the room, except in case of an emergency;

b. to have confidentiality in the treatment of personal and medical records;

c. to be secure in storing and using personal possessions, subject to applicable state and federal health and safety regulations and the rights of other residents; and

d. the right to privacy of the resident's body during, but not limited to toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance;

11. the right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and oral explanations of the services provided by the facility, including statements and explanations required to be offered on an as needed basis;

12. the right to be free from mental and physical abuse; and the right to be free from any physical or chemical restraint imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms:

a. in case of an emergency, restraint may only be applied by a qualified licensed nurse, who shall set forth in writing the circumstances requiring the use of the restraint, and, in case of a chemical restraint, the attending physician shall be consulted immediately thereafter;

b. restraints shall not be used in lieu of staff supervision or merely for staff convenience or resident punishment, or for any reason other than resident protection or safety;

13. the right of the resident or his or her legal representative:

a. upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and

b. after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard, photocopies of the records or any portions of them upon request and two working days advance notice to the nursing facility;

14. the right to select a personal physician; to obtain pharmaceutical supplies and services from a pharmacy of the resident's choice, at the resident's own expense or through title XVIII or title XIX of the Social Security Act; and to obtain information about, and to participate in, community based activities and programs, unless such participation would violate infection control or quarantine laws or regulations;

15. the right to retain and use personal clothing and possessions as space permits, unless to do so would infringe

upon the rights of other residents' health and safety. Clothing need not be provided to the resident by the facility except in emergency situations. If provided, it shall be of reasonable fit;

16. the right to have copies of the nursing facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable rules and regulations of the nursing facility and of his responsibility to respect the personal rights and private property of other residents;

17. the right to be informed of the bed reservation policy for a hospitalization:

a. the nursing facility shall inform a private pay resident and his sponsor that his bed shall be reserved for any single hospitalization for a period up to 30 days, provided the nursing facility receives reimbursement;

b. notice shall be provided within 24 hours of the hospitalization;

18. the right to receive a prompt response to all reasonable requests and inquiries;

19. the right to refuse to serve as a medical research subject without jeopardizing access to appropriate medical care;

20. the right to use tobacco at his own expense under the facility's safety rules and under applicable laws and rules of the state, unless the nursing facility's written policies preclude smoking in designated areas;

21. the right to consume a reasonable amount of alcoholic beverages at his own expense, unless:

a. not medically advisable as documented in his medical record by the attending physician;

b. alcohol is contraindicated with any of the medications in the resident's current regime; or

c. expressly prohibited by published rules and regulations of a nursing facility owned and operated by a religious denomination which has abstinence from the consumption of alcoholic beverages as a part of its religious belief;

22. the right to retire and rise in accordance with the resident's personal preference; and

23. the right to have any significant change in health status immediately reported to the resident and his/her legal representative or interested family member, if known and available, as soon as such a change is known to the facility's staff.

B. A sponsor may act on a resident's behalf to assure that the nursing facility does not deny the resident's rights under the provisions of R.S. 40:2010.6 et seq., and no right enumerated therein may be waived for any reason whatsoever.

C. Each nursing facility shall provide a copy of the statement required by R.S. 40:2010.8(A) to each resident and sponsor upon or before the resident's admission to the facility and to each staff member of the facility. The statement shall also advise the resident and his sponsor that the nursing facility is not responsible for the actions or inactions of other persons or entities not employed by the nursing facility, such as the resident's treating physician, pharmacists, sitter, or other such persons or entities employed or selected by the resident or his sponsor. Each facility shall prepare a written plan and provide appropriate staff training to implement the provisions of R.S. 40:2010.6 et seq., including, but not limited to, an explanation of the following:

1. the residents' rights and the staff's responsibilities in the implementation of those rights; and

2. the staff's obligation to provide all residents who have similar needs with comparable services as required by state licensing standards.

D. The nursing facility shall inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the nursing facility. The nursing facility shall provide such notification prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, shall be acknowledged in writing.

E. The nursing facility shall inform each resident before or at the time of admission, and periodically in the nursing facility and of charges for those services, including any charges for services not covered under Medicare or by the nursing facility's per diem rate.

F. The nursing facility shall notify the resident and the resident's legal representative or sponsor when there is a change in room or roommate assignment. Notification shall be given at least 24 hours before the change and a reason for the move shall be given to all parties. Documentation of this shall be entered in the medical record.

G. Involuntary Admittance. Residents shall not be forced to enter or remain in a nursing facility against their will unless they have been judicially interdicted.

H. Room-to-Room Transfer (Intra-Nursing Facility). The resident or curator and responsible party shall receive at least a 24-hour notice before the room of the resident is changed. A reason for the move will be given to resident and curator/responsible party.

1. Documentation of all of this information will be entered in the medical record.

2. A resident has the right to receive notice when their roommate is changed.

NOTE: The resident has the right to relocate prior to the expiration of the 24 hours' notice if this change is agreeable to the resident.

I. Any violations of the residents' rights set forth in R.S. 40:2010.6 et seq., shall constitute grounds for appropriate action by the Department of Health.

1. Residents shall have a private right of action to enforce these rights, as set forth in R.S. 40:2010.9. The state courts shall have jurisdiction to enjoin a violation of residents' rights and to assess fines for violations not to exceed $100 per individual violation.

2. In order to determine whether a facility is adequately protecting residents' rights, inspection of the facility by LDH shall include private, informal conversations with a sample of residents to discuss residents' experiences within the facility with respect to the rights specified in R.S. 40:2010.6 et seq., and with respect to compliance with departmental standards.

J. Any person who submits or reports a complaint concerning a suspected violation of residents' rights or concerning services or conditions in a home or health care facility or who testifies in any administrative or judicial proceedings arising from such complaint shall have immunity from any criminal or civil liability therefore, unless that person has acted in bad faith with malicious purpose, or if the court finds that there was an absence of a justifiable issue of either law or fact raised by the complaining party.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1912 (November 2016).

§9779. Resident Personal Fund Account

A. The resident has the right to manage his/her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

B. Upon written authorization of a resident, the facility shall hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility.

C. Deposit of Funds

1. Funds in Excess of $50. The facility shall deposit any residents' personal funds in excess of $50 in an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account.

2. Funds Less Than $50. The facility shall maintain a resident's personal funds that do not exceed $50 in a non-interest-bearing account, interest-bearing account, or petty cash fund.

D. Resident Access to Personal Funds Held by Facility. A resident shall have access to facility held funds on an on-going basis and be able to arrange for access to larger funds.

1. Requests for less than $50 shall be honored within the same day.

2. Requests for $50 or more shall be honored within three banking days.

E. Accounting and Records. The facility shall establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

1. The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

2. The individual financial record shall be available through quarterly statements and on request to the resident or his or her legal representative.

F. Conveyance upon Transfer or Discharge. Upon discharge or transfer of a resident from the facility, the provider shall not withhold personal fund account monies in lieu of payment for any outstanding balance owed by a resident unto the provider.

G. Conveyance upon Death of a Resident. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.

H. Assurance of Financial Security. The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of residents deposited with the facility.

I. Account Agreement

1. A nursing facility resident, with a personal fund account managed by the nursing facility, may sign an account agreement acknowledging that any funds deposited into the personal fund account by, or on the resident's behalf, are jointly owned by the resident and his legal representative or next of kin. The account agreement shall state that the:

a. funds in the account shall be jointly owned with the right of survivorship;

b. funds in the account shall be used by, for, or on behalf of the resident;

c. resident or the joint owner may deposit funds into the account; and

d. resident or joint owner may endorse any check, draft or other instrument to the order of any joint owner, for deposit into the account.

2. If a valid account agreement has been executed by the resident, upon the resident's death, the nursing facility shall transfer the funds in the resident's personal fund account to the joint owner within 30 days of the resident's death. This provision only applies to personal fund accounts not in excess of $2,000.

3. If a valid account agreement has not been executed, or if the personal fund account is in excess of $2,000, upon the resident's death, the nursing facility shall comply with the federal and state laws and regulations regarding the disbursement of funds in the account and the properties of the deceased.

4. The provisions of this section shall have no effect on federal or state tax obligations or liabilities of the

deceased resident's estate. If there are other laws or regulations which conflict with these provisions, those laws or regulations will govern over and supersede the conflicting provisions.

J. Nursing Facility Residents' Burial Insurance Policy. With the resident's permission, the nursing facility administrator or designee may assist the resident in acquiring a burial policy, provided that the administrator, designee, or affiliated persons derive no financial or other benefit from the resident's acquisition of the policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1914 (November 2016).

§9781. Virtual Visitation

A. Each nursing facility licensed by the Department of Health shall comply with the provisions of the Nursing Home Virtual Visitation Act of 2018 enacted by the Louisiana Legislature, and any such amendments enacted thereafter.

B. The term *monitoring device*, as used in this Section, shall have the same meaning as defined in the Nursing Home Virtual Visitation Act of 2018.

C. Capacity to Consent to Virtual Visitation

1. A resident's capacity to consent to the authorization for installation and use of a monitoring device is presumed if the resident has not been interdicted and has no current documented medical diagnosis affecting capacity.

2. Any question as to capacity of a non-interdicted resident to consent to the authorization for installation and use of a monitoring device shall be determined by any one of the following persons in the following order of priority, if there is no person in a prior class who is reasonably available and willing to make such determination:

a. the resident's personal physician;

b. the resident's admitting physician; or

c. the medical director of the nursing facility.

NOTE: Such determination shall be documented in the resident's medical record.

3. The nursing facility shall have a policy regarding capacity to consent to the authorization for installation and use of a monitoring device in a resident's room; such policy shall include, at a minimum, the provisions of §9781.C.1 and §9781.C.2; further, the policy shall be in compliance with the provisions of the Nursing Home Visitation Act of 2018 enacted by the Louisiana Legislature, and any such amendments enacted thereafter.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and 40:1193.1-1193.11.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 46:345 (March 2020).

Chapter 98. Nursing Facilities

Subchapter A. Physician Services

§9801. Medical Director

A. The nursing facility shall designate, pursuant to a written agreement, a physician currently holding an unrestricted license to practice medicine by the Louisiana State Board of Medical Examiners to serve as medical director.

B. The medical director is responsible for coordinating medical and behavioral health care and assisting to develop, implement and evaluate resident care policies and procedures that reflect current standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1915 (November 2016).

§9803. Physician Supervision

A. A resident shall be admitted to the nursing facility only with an order from a physician licensed to practice medicine in Louisiana.

1. Each resident shall remain under the care of a physician licensed to practice medicine in Louisiana and shall have freedom of choice in selecting his/her attending physician.

2. The nursing facility shall be responsible for assisting in obtaining an attending physician with the resident's or sponsor's approval when the resident or sponsor is unable to find one.

B. Another physician supervises the medical care of residents when their attending physician is unavailable.

C. Any required physician task may also be satisfied when performed by an advanced practice registered nurse or physician assistant who is not an employee of the nursing facility but who is working under the direction and supervision of a physician and/or in collaboration with a physician.

D. The nursing facility shall provide or arrange for the provision of physician services 24 hours a day, seven days a week, in case of emergency.

E. The name and telephone numbers of the attending physicians and the physicians to be called in case of emergency when the attending physician is not available shall be readily available to nursing personnel. Upon request, the telephone numbers of the attending physician or his/her replacement in case of emergency shall be provided to the resident, resident's representative, if applicable and/or sponsor, guardian, or designated contact.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1915 (November 2016).

§9805. Physician Visits and Responsibilities

A. Admissions

1. At the time each resident is admitted, the nursing facility shall have attending physician orders for the resident's immediate care. At a minimum, these orders shall consist of dietary, pharmacy, and routine nursing care to maintain or improve the resident's functional abilities.

2. If the orders are from a physician other than the resident's attending physician, they shall be communicated to the attending physician and verification shall be entered into the resident's clinical record by the nurse who took the orders.

3. A physical examination shall be performed by the attending physician within 72 hours after admission unless such examination was performed within 30 days prior to admission with the following exceptions:

a. if the physical examination was performed by another physician, the attending physician may attest to its accuracy by countersigning it and placing a copy in the resident's record; or

b. if the resident is transferring from another nursing facility with the same attending physician, a copy of all previous examinations may be obtained from the transferring nursing facility with the attending physician initialing its new date. The clinical history and physical examination, together with diagnoses shall be in the resident's medical record;

c. the physical examination shall include TB testing/screening as required by the current LAC *Title 51, Public Health—Sanitary Code*, Chapter 5 for all persons admitted to nursing facilities.

B. Each resident shall be seen by his/her attending physician at intervals to meet the holistic needs of the resident but at least annually.

C. At each visit, the attending physician shall write, date and sign progress notes.

D. The physician's treatment plan (physician's orders) shall be reviewed by the attending physician at least once annually.

E. Physician telephone/verbal orders shall be received only by physicians, pharmacists, licensed nurses, or licensed therapists, who within the scope of their practice, are allowed to receive physician's orders. These orders shall be reduced to writing in the resident's clinical record and signed and dated by the authorized individual receiving the order. Telephone/verbal orders shall be countersigned by the physician within seven days.

F. Use of signature stamps by physicians is allowed when the signature stamp is authorized by the individual whose signature the stamp represents. The administrative office of the nursing facility shall have on file a signed statement to the effect that the physician is the only one who has the stamp and uses it. There shall be no delegation of signature stamps to another individual.

G. At the option of the nursing facility attending physician, any required physician task in a nursing facility may also be satisfied when performed by an advanced practice registered nurse in collaboration with a physician, or physician assistant who is working under the direction and supervision of an attending physician, pursuant to his/her licensing board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1916 (November 2016).

§9807. Standing Orders

A. Physician's standing orders are permissible but shall be individualized, taking into consideration such things as drug allergies and the pertinent physical condition of the resident.

B. Utilization of over-the-counter drugs shall be documented on the physician's standing orders.

C. Controlled or prescription drugs shall not be on standing orders, and shall be an individual order reduced to writing on the physician's order sheet as either a routine or pro re nata (PRN) order. Each order shall include the following:

1. name of the medication;

2. strength of the medication;

3. specific dose of the medication (not a dose range);

4. route of administration;

5. reason for administration;

6. time interval between doses for administering the medication;

7. maximum dosage or number of times to be administered in a specific time frame; and

8. when to notify the attending physician if the medication is not effective.

D. Standing orders shall be signed and dated by the attending physician initially and at least annually thereafter.

E. A copy of the standing orders shall be maintained in the resident's active clinical record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1916 (November 2016).

Subchapter B. Nursing Services

§9821. General Provisions

A. The nursing facility shall have sufficient nursing staff to provide nursing and related services that meet the needs of each resident. The nursing facility shall assure that each resident receives treatments, medications, diets and other health services as prescribed and planned, all hours of each day.

B. Release of a Body by a Registered Nurse. In the absence of a physician in a setting other than an acute care facility, when an anticipated death has apparently occurred, registered nurses may have the decedent removed to the designated funeral home in accordance with the standing order of a medical director/consultant setting forth basic written criteria for a reasonable determination of death. This is not applicable in cases where the death was unexpected.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1916 (November 2016).

§9823. Nursing Service Personnel

A. The nursing facility shall provide a sufficient number of nursing service personnel consisting of registered nurses, licensed practical nurses, medication attendants certified, and certified nurse aides to provide nursing care to all residents in accordance with resident care plans 24 hours per day.

1. At a minimum, the nursing facility shall provide 2.35 hours of care per patient per day. The director of nursing (DON), the assistant director of nursing (ADON), and nursing department directors may be counted towards the minimum staffing requirements only for the time spent on the shift providing direct and/or hands on resident care services. A maximum of eight ward clerk hours per day can be utilized in the calculation of care hours per resident day.

2. The facility shall post the following information on a daily basis:

a. the facility name;

b. the current date;

c. the resident census; and

d. the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

i. registered nurses;

ii. licensed practical nurses; and

iii. certified nurse aides.

3. The facility shall post the nurse staffing data specified above on a daily basis at the beginning of each shift. The data shall be posted:

a. in a clear and readable format; and

b. in a prominent place readily accessible to residents and visitors.

4. The facility shall, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

5. Nursing service personnel shall be assigned duties consistent with their education and experience, and based on the characteristics of the resident census and acuity, and nursing skills required to provide care to the residents.

6. Licensed nurse coverage shall be provided 24 hours per day in the nursing facility. The facility shall develop a policy regarding the nursing services provided by licensed nurses. The policy shall be developed in consideration of the following:

a. the physical layout of the nursing facility;

b. the acuity of the residents; and

c. the resident census.

B. Director of Nursing

1. The nursing facility shall designate a registered nurse to serve as the director of nursing services on a full-time basis during the day-tour of duty.

2. The director of nursing services may serve as charge nurse only when the nursing facility has an average daily occupancy of 60 or fewer residents.

3. The director of nursing services shall have responsibilities which include, but are not limited to:

a. supervising the functions, activities, and training of all nursing personnel;

b. developing and maintaining standard nursing practice, nursing policy and procedure manuals and written job descriptions for each level of nursing personnel;

c. coordinating nursing services with other resident services;

d. designating the charge nurses pursuant to this section;

e. ensuring that duties of all nursing personnel are clearly defined and assigned in accordance with the level of education, preparation, experience, and licensure; and

f. supervision of documentation by nursing personnel.

C. If the director of nursing services has non-nursing administrative responsibilities for the nursing facility on a regular basis, there shall be another registered nurse designated to assist in providing direction of care delivery to residents.

D. The director of nursing may serve in such capacity for only one nursing facility.

E. Charge Nurse. A registered nurse, or a qualified licensed practical nurse, shall be designated as charge nurse by the DON for each tour of duty and is responsible for supervision of the total nursing activities in the nursing facility during each tour of duty.

1. The charge nurse delegates responsibility to nursing personnel for the direct nursing care of specific residents during each tour of duty on the basis of staff qualifications, size/physical layout of the nursing facility, characteristics of resident census and acuity, and emotional, social, and nursing care needs of the residents.

F. In building complexes or multi story buildings, each building or floor housing residents shall be considered a

separate nursing unit and separately staffed, exclusive of the director of nursing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1917 (November 2016).

§9825. Nursing Care

A. Each resident shall receive personal attention and nursing care and services in accordance with his/her condition and consistent with current acceptable standards of nursing practice. Each resident shall receive a comprehensive assessment, and a plan of care shall be developed to meet his/her needs. The plan of care shall be developed within 21 days of admission of the resident to the nursing facility and revised as needed to meet the initial and ongoing needs of the resident.

B. Each resident shall be kept clean, dry, well groomed, and dressed appropriately for the time of day and the environment, recognizing the resident's rights and wishes. Proper body and oral hygiene shall be maintained. Skin care shall be provided to each resident as needed to maintain skin integrity and prevent dryness, scaling, irritation, itching and/or pressure sores.

C. Residents unable to carry out activities of daily living shall receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene.

D. Other Nursing Services. Nursing services shall be provided to the resident to ensure that the needs of the resident are met. These services include the following.

1. Drug Administration. Medications shall be administered only by a licensed physician, licensed/applicant nurse, or the resident (with the approval of the interdisciplinary team as documented in the comprehensive care plan).

2. The nursing facility shall be cognizant of the mental status of the resident's roommate(s), or other potential problems which could result in abuses of any drugs used by the residents for self-administration.

3. Medications shall be administered in accordance with the nursing facility's established written procedures and the written policies of the pharmaceutical services committee to ensure the following criteria are met:

a. Drugs to be administered are checked against physician's orders.

b. The resident is identified before administering the drug.

c. All medications/treatments are administered and properly charted in accordance with standards of nursing practice. For any medications/treatments not administered, the reason for each medication/treatment omission shall be recorded in the resident's active medical record.

i. The drug dosage shall be prepared, administered and recorded by the same person.

ii. Medications prescribed for one resident shall not be administered to any other person.

iii. Medication errors and adverse drug reactions shall be immediately reported to the attending physician and recorded in the medical record.

iv. Current medication reference texts or sources shall be kept in all nursing facilities.

E. Restorative nursing care shall be provided for the residents requiring such care.

F. Assistance with eating shall be provided as needed.

G. The nursing facility shall provide the necessary care and services to prevent avoidable pressure ulcers.

H. The nursing facility shall promptly inform the resident, consult with the resident's attending physician, and if known, notify the resident's legal representative, sponsor or designated contact and maintain documentation when there is an accident which results in injury and requires physician intervention, or significant change in the resident's physical, mental or psychosocial status.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1917 (November 2016).

Subchapter C. Dietetic Services

§9831. General Provisions

A. The nursing facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and dietary needs of each resident.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1918 (November 2016).

§9833. Dietary Service Personnel

A. The nursing facility shall employ a licensed dietitian either full-time, part-time or on a consultant basis. A minimum dietary consultation time of not less than eight hours per month shall be required to ensure nutritional needs of residents are addressed timely. There shall be documentation to support that the consultation time was given.

B. If a licensed dietitian is not employed full-time, the nursing facility shall designate a full-time person to serve as the dietary manager.

C. Residents at nutritional risk shall have a complete nutritional assessment conducted by the consulting dietitian.

D. The nursing facility shall employ sufficient competent support personnel to carry out the functions of the dietary services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1918 (November 2016).

§9835. Menus and Nutritional Adequacy

A. Menus shall be planned, approved, signed and dated by a licensed dietitian prior to use in the nursing facility to ensure that the menus meet the nutritional needs of the residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council and the National Academy of Sciences, taking into account the cultural background and food habits of residents. Residents' preferences shall be taken into consideration in the development of menus.

1. Menus shall be written for any therapeutic diet ordered.

2. If cycle menus are used, the cycle shall cover a minimum of three weeks and shall be different each day of the week.

3. Each day's menu shall show the actual date served and shall be retained for six months.

4. Menus for the current week shall be available to the residents and posted where food is prepared and served for dietary personnel. Portion sizes shall be reflected either on the menu or within the recipe used to prepare the meal.

B. All diets shall be prescribed by a licensed practitioner. Each resident's diet order shall be documented in the resident's clinical record. There shall be a procedure for the accurate transmittal of dietary orders to the dietary service and for informing the dietary service when the resident does not receive the ordered diet or is unable to consume the diet, with appropriate action taken.

1. The nursing facility shall maintain a current list of residents identified by name, room number and diet order and such identification shall be accessible to staff during meal preparation and service.

2. A current therapeutic diet manual, approved by a registered dietitian, shall be readily available to attending physicians, nursing staff and dietetic service personnel.

C. The nursing facility shall provide to each resident:

1. at least three meals daily, at regular times comparable to normal mealtimes in the community;

2. food prepared by methods that conserve nutritive value, flavor, and appearance;

3. food that is palatable, attractive and at the proper temperature;

4. food prepared in a form designed to meet individual needs; and

5. substitutes offered of similar nutritional value to residents who refuse food or beverages served.

D. A list of all menu substitutions shall be kept for 30 days.

E. There shall be no more than 14 hours between a substantial evening meal and breakfast the following day. A substantial evening meal is defined as an offering of three or more menu items at one time, one of which includes a high-quality protein such as meat, fish, eggs, or cheese.

F. When a nourishing snack is provided at bedtime, there shall be no more than 16 hours between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

G. Bedtime nourishments shall be available nightly to all residents.

H. If residents require assistance in eating, food shall be maintained at appropriate serving temperatures until assistance is provided.

I. There shall be a procedure for the accurate documentation, monitoring and reporting of the resident's oral and parenteral intake in the resident's clinical record and incorporation of dietary orders/lab test monitoring into the nutritional plan of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1918 (November 2016).

§9837. Feeding Assistants

A. Prior to assisting nursing facility residents with feeding, the assistant shall have successfully completed the state-approved training course published by the American Health Care Association, *Assisted Dining: The Role and Skills of Feeding Assistants*.

1. Licensed personnel qualified to teach the course include:

a. registered nurses;

b. licensed practical nurses;

c. dieticians; and

d. speech therapists.

2. The competency of feeding assistants shall be evaluated by course instructors and supervisory nurses.

3. If feeding assistants transfer between nursing facilities, the receiving nursing facility shall assure competency.

B. Volunteers shall complete the training course except in cases where a family member or significant other is feeding the resident.

C. The clinical decision as to which residents are fed by a feeding assistant shall be made by a registered nurse (RN) or licensed practical nurse (LPN). Such decision shall be based upon the individual nurse's assessment and the resident's latest assessment and plan of care.

1. A physician or speech therapist may override the nurse's decision, if in their professional opinion, it would be contraindicated.

D. The use of a feeding assistant shall be noted on the plan of care.

E. There shall be documentation to show that the residents approved to be fed by feeding assistants have no complicated feeding problems.

1. Feeding assistants may not feed residents who have complicated feeding problems such as difficulty swallowing, recurrent lung aspirations and tube or IV feedings.

F. There shall be documentation of on-going assessment by nursing staff to assure that any complications that develop are identified and addressed promptly.

G. A feeding assistant shall work under the supervision of a licensed RN or LPN and the resident's clinical record shall contain entries made by the supervisory RN or LPN describing services provided by the feeding assistant.

H. Facilities may use feeding assistants at mealtimes or snack times, whenever the nursing facility can provide the necessary supervision.

1. A feeding assistant may feed residents in the dining room or another congregate area.

I. Nursing facilities may use their existing staff to feed residents as long as each non-licensed staff member successfully completes the state-approved training course.

J. Facilities shall maintain a record of all individuals used as feeding assistants who have successfully completed the training course.

K. Residents have the right to refuse to be fed by a feeding assistant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1919 (November 2016).

§9839. Equipment and Supplies

A. Special eating equipment and utensils shall be provided for residents who need them. At least a one-week supply of staple food with a three-day supply of perishable food conforming to the approved menu shall be maintained on the premises.

B. An approved lavatory shall be convenient and properly equipped for dietary services staff use.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1919 (November 2016).

§9841. Sanitary Conditions

A. All food shall be procured, stored, prepared, distributed and served under sanitary conditions to prevent food borne illness. This includes keeping all readily perishable food and drinks according to the LAC *Title 51, Public Health—Sanitary Code*.

B. Refrigerator temperatures shall be maintained according to the LAC *Title 51, Public Health—Sanitary Code*.

C. Hot foods shall leave the kitchen or steam table according to the LAC *Title 51, Public Health—Sanitary Code*.

D. In room delivery temperatures shall be maintained according to the LAC *Title 51, Public Health—Sanitary Code*.

E. Food shall be transported to residents' rooms in a manner that protects it from contamination while maintaining required temperatures.

F. Refrigerated food which has been opened from its original package shall be covered, labeled and dated.

G. All food shall be procured from sources that comply with all laws and regulations related to food and food labeling.

H. Food shall be in sound condition, free from spoilage, filth or other contamination and shall be safe for human consumption.

I. All equipment and utensils used in the preparation and serving of food shall be properly cleansed, sanitized and stored. This includes:

1. maintaining a water temperature in dishwashing machines at 140 degrees Fahrenheit during the wash cycle (or according to the manufacturer's specifications or instructions) and 180 degrees Fahrenheit for the final rinse;

2. maintaining water temperature in low temperature machines at 120 degrees Fahrenheit (or according to the manufacturer's specification or instructions) with a minimum of 50 ppm (parts per million) of hypochlorite (household bleach) on dish surfaces; or

3. maintaining a wash water temperature of 75 degrees Fahrenheit, for manual washing in a three-compartment sink, with a minimum of 25 ppm of hypochlorite or equivalent, or a minimum of 12.5 ppm of iodine in the final rinse water; or a hot water immersion at 170 degrees Fahrenheit for at least 30 seconds shall be maintained.

J. Dietary staff shall not store personal items within the food preparation and storage areas.

K. A commercial kitchen in a nursing facility shall not be used for resident dining.

L. Dietary staff shall use good hygienic practices.

M. Dietary employees engaged in the handling, preparation and serving of food shall use effective hair restraints to prevent the contamination of food or food-contact surfaces.

N. Staff with communicable diseases or infected skin lesions shall not have contact with food if that contact will transmit the disease.

O. There shall be no use of tobacco products in the dietary department.

P. Toxic items such as insecticides, detergents, polishes and the like shall be properly stored, labeled and used.

Q. Garbage and refuse shall be kept in durable, easily cleanable, insect and rodent-proof containers that do not leak and do not absorb liquids. Containers used in food preparation and utensil washing areas shall be kept covered when meal preparation is completed and when full.

R. All ice intended for human consumption shall be free of visible trash and sediment.

1. Ice used for cooling stored food and food containers shall not be used for human consumption.

2. Ice stored in machines outside the kitchen shall be protected from contamination.

3. Ice scoops shall be stored in a manner so as to protect them from becoming soiled or contaminated between usage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1919 (November 2016).

Subchapter D. Pharmaceutical Services

§9851. General Requirements

A. The nursing facility shall provide pharmaceutical services in accordance with accepted professional standards and all appropriate federal, state and local laws and regulations. Only licensed medical personnel shall be allowed to receive and sign for delivery of controlled drugs.

B. The nursing facility is responsible for ensuring the timely availability of drugs and biologicals for its residents.

C. Prescription drugs not covered by Medicaid or Medicare shall be at the expense of the resident. However, attempts should be made to get the attending physician to order a covered medication before the resident incurs any expense.

D. The nursing facility shall provide emergency drugs and biologicals to its residents as necessary and as ordered by a licensed practitioner.

E. The nursing facility shall have an emergency drug kit.

F. The nursing facility shall obtain a permit from the Board of Pharmacy for each emergency drug kit.

G. The most current edition of drug reference materials shall be available.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1920 (November 2016).

§9853. Consultant

A. If the nursing facility does not employ a licensed pharmacist, it shall have a designated consultant pharmacist that provides services in accordance with accepted pharmacy principles and standards. The minimum consultation time shall not be less than one hour per quarter which shall not include drug regimen review activities.

B. There shall be documentation to support that the consultation time was given.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1920 (November 2016).

§9855. Labeling

A. All drug and biological containers shall be properly labeled by a licensed pharmacist following the guidelines established by the state Board of Pharmacy.

B. The label on prepackaged (unit dose) containers shall follow the established guidelines of the state Board of Pharmacy.

C. Over-the-counter (non-prescription) medications and biologicals, may be purchased in bulk packaging and shall be plainly labeled with the medication name and strength and any additional information in accordance with the nursing facility’s policies and procedures. Over-the-counter medications specifically purchased for a resident shall be labeled as previously stipulated to include the resident’s name. The manufacturer's labeling information shall be present in the absence of prescription labeling.

D. The nursing facility shall develop procedures to assure proper labeling for medications provided a resident for a temporary absence.

E. Labeling of Drugs and Biologicals

1. The labeling of drugs and biologicals is based on currently accepted professional principles and includes:

a. the resident's full name;

b. physician's name;

c. full name of pharmacist dispensing;

d. prescription number;

e. name and strength of drug;

f. date of issue and expiration date of all time-dated drugs;

g. name, address, and telephone number of pharmacy issuing the drug; and

h. appropriate accessory and cautionary instructions.

2. Non-legend or over-the-counter drugs may be labeled by the nursing facility with resident's full name and room number not to obscure lot number and expiration date.

F. Medication containers which have soiled, damaged, incomplete, illegible or makeshift labels are to be returned to the issuing pharmacist or pharmacy for relabeling or disposal. Containers which have no labels are to be destroyed in accordance with state and federal laws.

G. The nursing facility shall have a procedure for the proper identification and labeling of medication brought into the nursing facility from an outside source.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1920 (November 2016).

§9857. Storage and Preparation

A. All drugs and biologicals shall be stored in a locked area/cabinet and kept at proper temperatures and lighting. The medicine room or medication preparation area shall have an operable sink with hot and cold water, paper towels and a soap dispenser.

1. In nursing facilities with drugs and biologicals stored in a locked area/cabinet in the resident’s room, the lavatory located in the room or immediately adjacent shall be deemed acceptable under this provision.

B. Access to drug storage areas shall be limited to licensed nursing personnel, the licensed nursing facility administrator and the consultant pharmacist as authorized in the nursing facility's policy and procedure manual. Any unlicensed, unauthorized individual (e.g., housekeepers, maintenance personnel, etc.) needing access to drug storage areas shall be under the direct visual supervision of licensed authorized personnel.

1. In nursing facilities with drugs and biologicals stored in a locked area/cabinet in the resident(s) room, residents who have been determined by the interdisciplinary team to be able to safely self-administer drugs shall be allowed to access the drugs.

C. Medication requiring refrigeration shall be kept separate from foods in separate containers within a refrigerator and stored at a temperature range of 36 to 46 degrees Fahrenheit.

1. Laboratory solutions or materials awaiting laboratory pickup shall not be stored in refrigerators with food and/or medication.

2. Medication for “external use only” shall be stored separate from other medication and food.

D. Separately locked, permanently affixed compartments shall be provided for storage of controlled drugs listed in schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse.

E. Medications of each resident shall be kept and stored in their originally received containers and transferring between containers is forbidden.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1921 (November 2016).

§9859. Disposition

A. Prescription and over-the-counter (OTC) medications and biologicals are to be disposed of in the following manner:

1. if medication(s) and/or biological(s) are discontinued, or the resident is discharged to the hospital, the nursing facility will retain the medication(s) for up to 60 days and then be destroyed as described in §9859.C.2. Such medications shall be stored in a locked storage area approved by the DON and consultant pharmacist.

2. If the resident is deceased, the medication will be disposed of as described in §9859.C.2, unless there is a written order of the attending physician specifying otherwise.

3. If the resident is transferred to another facility, the medication will accompany the resident to the receiving facility on the written order of the attending physician.

4. If the resident is discharged to facility, the remaining supply of ordered and filled medication, including controlled drugs, will accompany the resident facility on the written order of the attending physician.

B. If the resident, designated contact and/or legal representative receives the medications or biologicals, upon written order of the physician, documentation containing the name and the amount of the medication or biological to be received shall be completed and signed by the resident, designated contact and/or legal representative their receipt. This document shall be placed in the resident's clinical record.

C. Expired medication shall not be available for resident or staff use. They shall be destroyed on-site by nursing facility personnel no later than 90 days from their expiration/ discontinuation date utilizing the following methods.

1. Controlled drugs shall be destroyed on-site by a licensed health care professional, and witnessed by at least one other licensed health care professional or in accordance with DEA provisions.

a. All controlled substances to be destroyed shall be inventoried and documented on a form developed by the nursing facility’s staff, with input from the consultant pharmacist and medical director. The form shall include, at a minimum:

i. the resident’s name;

ii. medication name;

iii. strength and quantity of the drug destroyed;

iv. prescription number;

v. method and date of destruction; and

vi. signatures of the licensed health care professionals destroying the medication and the name of the licensed health care professional witnessing the destruction for each controlled drug destroyed.

b. This form shall be maintained on the nursing facility's premises for 24 months and archived for a minimum of 36 months. These drugs shall also be listed on the resident's individual accumulative drug destruction record.

2. For non-controlled drugs, there shall be documentation of:

a. the resident's name;

b. strength and quantity of the drug destroyed;

c. prescription number;

d. method and date of destruction; and

e. signatures of at least two individuals (which shall be either licensed nurses who are employees of the nursing facility or the consultant pharmacist) witnessing the destruction.

D. Medications of residents transferred to a hospital may be retained until the resident's return. Upon the resident's return, the physician's order shall dictate whether or not the resident is to continue the same drug regimen as previously ordered.

E. Nothing herein, shall preclude a nursing facility from donating unused medications to a provisional pharmacy or to the Department of Corrections or other statutorily approved programs. Medications not donated shall be destroyed using the procedures outlined above.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1921 (November 2016).

§9861. Administration

A. Drugs and biologicals shall not be administered to residents unless ordered by a practitioner duly licensed to prescribe drugs. Such orders shall be in writing and shall include the practitioner's signature. Each order shall include the following:

1. name of the medication;

2. strength of the medication;

3. specific dose of the medication (not a dose range);

4. route of administration;

5. reason for administration;

6. frequency of administration; and

7. maximum dosage or number of times to be administered in a specific time frame when applicable.

B. Drugs and biologicals shall be administered only by medical personnel or licensed nurses authorized to administer drugs and biologicals under their practice act or as allowed by statutorily designated medication attendants certified (MACS).

C. Drugs and biologicals shall be administered as soon as possible after doses are prepared, not to exceed two hours. They shall be administered by the same person who prepared the doses for administration.

D. If the policies and procedures of a licensed only nursing facility allows for the self-administration of drugs, an individual resident may self-administer drugs if an interdisciplinary team has determined that this practice is safe. The team shall also determine who will be responsible for storage and documentation of the administration of drugs. The resident's care plan shall reflect approval to self-administer medications. If the nursing facility's policy and procedures do not allow self-administration of drugs, this information shall be disclosed prior to admission.

E. All medication errors shall be reported immediately to the resident's attending physician by a licensed nurse and an entry made in the resident's record.

F. All adverse drug reactions shall be reported immediately to the resident's attending physician by a licensed nurse and an entry made in the resident's record.

G. Medications not specifically prescribed as to time or number of doses, such as pro re nata (PRN) medications, shall automatically be stopped after a reasonable time that is predetermined by the nursing facility's written policy and procedures. The attending physician shall be notified of an automatic stop order prior to the last dose so that he/she may decide if the administration of the medication is to be continued or altered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1922 (November 2016).

§9863. Drug Regimen Review

A. The drug regimen of each resident shall be reviewed as often as dictated by the resident's condition. Drug irregularities shall be reported, in writing, to the resident's attending physician and director of nursing, and these reports shall be acted upon.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1922 (November 2016).

§9865. Medication Record Keeping

A. General Records

1. All medication administered to residents shall be recorded on a medication administration record (MAR). Each medication shall be documented to include:

a. name, strength and dosage of the medication;

b. method of administration to include site, if applicable;

c. time of administration. The time of administration is defined as one hour before to one hour after the ordered time of administration; and

d. the initials of persons administering the medication along with a legend of the initials.

2. Medication errors and drug reactions shall be reported immediately to the resident's attending physician by a licensed nurse and an entry made in the resident's record.

B. Controlled Drugs

1. The nursing facility shall establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate accounting of all controlled drugs received, administered and destroyed or otherwise disposed.

2. Control records of schedule II drugs shall be maintained. The individual resident records shall list each type and strength of drug and the following information:

a. date;

b. time administered;

c. name of resident;

d. dose;

e. physician's name;

f. signature of person administering the dose; and

g. the balance on hand.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1922 (November 2016).

Subchapter E. Activity Services

§9871. Activities Program

A. A nursing facility shall provide for an ongoing program of diverse and meaningful activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident.

B. The activities program shall be designed to allow and encourage each resident's voluntary participation and choice of activities based upon his/her specific needs and interest.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1923 (November 2016).

§9873. Activity Service Personnel

A. The activities program shall be directed by a resident activities director (RAD). The resident activities director shall be responsible to the administrator or his/her designee for administration and organization of the activities program.

B. Responsibilities of the RAD include the following tasks:

1. scheduling and coordinating group activities and special events inside and outside the nursing facility;

2. developing and using outside resources and actively recruiting volunteers to enhance and broaden the scope of the activities program;

3. posting monthly activity calendars in places of easy viewing by applicants/residents and staff; and

4. planning and implementing individual and group activities designed to meet the applicants/residents' needs and interests.

C. Activities Assessments

1. Within 14 days after admission, the RAD shall complete a written assessment of each resident's interests and hobbies and note any illnesses or physical handicaps which might affect participation in activities.

2. The activities assessment shall:

a. become the basis for the activities component of the plan of care;

b. be signed, dated, and filed with other elements in the medical record;

c. identify specific problem/need areas along with specific approaches formulated to meet the problems/needs; and

d. be included in the interdisciplinary staffing.

D. Activity Services Progress Notes. Activity services progress notes shall:

1. be written to document the services provided and/or changes in activity needs or approaches at least every 90 days (quarterly); and

2. document the activity level of residents, specifically describing their day to day activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1923 (November 2016).

Subchapter F. Social Services

§9877. Social Services

A. A nursing facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

B. It is the responsibility of the nursing facility to identify the medically-related social service needs of the resident and assure that the needs are met by the appropriate disciplines.

C. A nursing facility with more than 120 beds shall employ a qualified psychosocial worker on a full-time basis.

1. Qualifications of a Social Worker. A qualified social worker shall have:

a. a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to: sociology, special education, rehabilitation counseling, and psychology; and

b. one year of supervised social work experience in a health care setting working directly with individuals.

D. A nursing facility with 120 beds or less shall designate at least one staff member as social services designee (SSD). The SSD is responsible for assuring that the medically-related social services needs of each resident are identified and met by the appropriate disciplines.

1. The individual responsible for provision of social services shall:

a. arrange for social services from outside sources or by furnishing the services directly;

b. integrate social services with other elements of the plan or care; and

c. complete a social history.

E. Social History. The SSD shall complete, date, and sign a social history on applicants/residents within seven days after their admission. The history shall include but shall not be limited to the following information:

1. background:

a. age, sex, and marital status;

b. birthplace;

c. religion;

d. cultural and ethnic background;

e. occupation;

f. education;

g. special training or skills; and

h. primary language; and

2. social functioning:

a. living situation and address before admission;

b. names and relationships with family and friends;

c. involvements with organizations and individuals within the community; and

d. feelings about admission to the nursing facility.

F. Social Needs Assessment

1. The SSD shall also identify and document the needs and medically related social/emotional problems within 14 days after admission.

2. The social services assessment shall become a component of the plan of care written in conjunction with other disciplines and shall be filed in the active medical record.

3. If the initial social assessment concludes that there are no problems or unmet social needs, the social assessment shall state that no social services are required.

G. Participation in Interdisciplinary Staffing. The SSD shall participate in the interdisciplinary staffing.

H. Social Services Progress Notes. Social services progress notes shall:

1. be recorded as often as necessary to document services provided, but at least every 90 days (quarterly) in nursing facilities and as often as necessary to describe changes in social conditions;

2. document the degree of involvement of family and friends, interaction with staff and other residents, and adjustment to the nursing facility and roommate(s);

3. reflect the social needs and functioning;

4. document services in the plan of care are actually being provided; and

5. remain in the active medical chart for three to six months.

I. Vision and Hearing. The nursing facility shall assist the resident in:

1. making appointments;

2. arranging for transportation to and from appointments; and

3. locating assistance from community and charitable organizations when payment is not available through Medicaid, Medicare, or private insurance.

J. Dental

1. The nursing facility shall provide or obtain from an outside resource, the following dental services to meet the needs of each resident:

a. routine dental services to the extent covered under the state plan; and

b. emergency dental services.

2. The nursing facility shall, if necessary, assist the resident:

a. in making appointments;

b. in arranging for transportation to and from the dentist's office; and

c. by promptly referring residents with lost or damaged dentures to a dentist.

K. The nursing facility shall establish policies and procedures for ensuring the confidentiality of all social information. Records shall reflect each referral to an outside agency and shall include the applicant/resident's written consent to release the information.

L. The same qualifications apply to Medicare skilled nursing facilities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1923 (November 2016).

Subchapter G. Rehabilitation Services

§9881. Delivery of Services

A. Rehabilitative services, when provided in the nursing facility, shall be delivered in a safe and accessible area. Rehabilitation services shall be provided under the written order of the resident's attending physician. These services shall be provided by appropriately credentialed individuals.

B. Specialized services shall be specified in the resident's plan of care. The nursing facility shall verify that the resident is receiving the specialized services as determined by the level II authority.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1924 (November 2016).

§9883. Record Keeping

A. An initial assessment established by the appropriate therapist and a written rehabilitation plan of care shall be developed. The resident's progress shall be recorded by the therapist at the time of each visit. This information shall be maintained in the resident's clinical record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1924 (November 2016).

Subchapter H. Resident Clinical Records and Financial Information

§9887. General Provisions

A. The nursing facility shall maintain a clinical record on each resident in accordance with accepted professional standards and practices. Each resident's clinical record shall be complete, accurately documented, readily accessible and systematically organized to facilitate retrieving and compiling information.

B. Each resident's personal financial information shall be protected in compliance with all applicable federal, state and local laws, rules and regulations.

C. Resident records that are created, modified, maintained archived, retrieved or transmitted in an electronic format shall be in compliance with all applicable federal, state and local laws, rules and regulations.

D. Availability of Records. The nursing facility shall make necessary records available to appropriate state and federal personnel at reasonable times. Records shall include but shall not be limited to the following:

1. personal property and financial records;

2. all medical records; and

NOTE: This includes records of all treatments, drugs, and services for which vendor payments have been made, or which are to be made, under the Medical Assistance Program. This includes the authority for and the date of administration of such treatment, drugs, or services. The nursing facility shall provide sufficient documentation to enable LDH to verify that each charge is due and proper prior to payment.

3. all other records which LDH finds necessary to determine a nursing facility's compliance with any federal or state law, rule, or regulation promulgated by the Department of Health and Human Services (DHHS) or by LDH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1924 (November 2016).

§9889. Maintenance of Records

A. The overall supervisory responsibility for the resident record service shall be assigned to a responsible employee of the nursing facility.

B. All hand-written or typed entries in the clinical record shall be legible, dated and signed.

C. If electronic signatures are used, the nursing facility shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of any computer generated signature.

D. If a facsimile communications system (fax) is used, the nursing facility shall take precautions when thermal paper is used to ensure that a legible copy is retained as long as the clinical record is retained.

E. A nursing facility record may be kept in any written, photographic, microfilm or other similar method or may be kept by any magnetic, electronic, optical or similar form of data compilation which is approved for such use by the department.

F. No magnetic, electronic, optical or similar method shall be approved unless it provides reasonable safeguards against erasure or alteration.

G. A nursing facility may, at its discretion, cause any nursing facility record or part to be microfilmed, or similarly reproduced, in order to accomplish efficient storage and preservation of nursing facility records.

H. Upon an oral or written request, the nursing facility shall give the resident or his/her legal representative access to all records pertaining to himself/herself including current clinical records within 24 hours excluding weekends and holidays. After receipt of his/her records for inspection, the nursing facility shall provide upon request and two working days' notice, at a cost consistent with the provisions of R.S. 40:1299(A)(2)(b), photocopies of the records or any portions thereof.

I. The nursing facility shall ensure that all clinical records are completed within 90 days of discharge, transfer or death. All information pertaining to a resident's stay shall be centralized in the clinical record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1924 (November 2016).

§9891. Content

A. The clinical record shall contain sufficient information to identify the resident clearly, to justify the diagnosis and treatment, and to document the results accurately.

B. At a minimum, each clinical record shall contain:

1. sufficient information to identify the resident;

2. physician orders;

3. progress notes by all practitioners and professional personnel providing services to the resident;

4. a record of the resident's assessments;

5. the plan of care;

6. entries describing treatments and services provided; and

7. reports of all diagnostic tests and procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1925 (November 2016).

§9893. Confidentiality

A. The nursing facility shall safeguard clinical record information against loss, destruction or unauthorized use. The nursing facility shall ensure the confidentiality of resident records, including information in a computerized record system, except when release is required by transfer to another health care institution, law, third party payment contract or the resident. Information from, or copies of, records may be released only to authorized individuals, and the nursing facility shall ensure that unauthorized individuals cannot gain access to or alter resident records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1925 (November 2016).

§9895. Retention

A. Clinical records shall be retained for a minimum of five years following a resident's discharge or death, unless the records are pertinent to a case in litigation. In such instance, they shall be retained indefinitely or until the litigation is resolved.

B. A nursing facility which is closing shall notify the department of their plan for the disposition of residents' clinical records in writing at least 14 days prior to cessation of operation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1925 (November 2016).

Chapter 99. Nursing Facilities

Subchapter A. Ancillary Services

§9901. Radiology and other Diagnostic Services

A. The nursing facility shall arrange for the provision of radiology and other diagnostic services to meet the needs of its residents. The nursing facility is responsible for the quality and timeliness of the services and shall:

1. arrange for the provisions of radiology and other diagnostic services only when ordered by the attending physician;

2. promptly notify the attending physician of the findings;

3. assist resident in making transportation arrangements to and from the source of service as needed;

4. file in the resident's clinical record signed and dated reports of X-ray and other diagnostic services.

B. If the nursing facility provides its own diagnostic services, the services shall meet the applicable conditions of participation of hospitals contained in 42 CFR 482.26.

C. If the nursing facility does not provide diagnostic services, it shall have an agreement to obtain these services from a provider or supplier that is approved to provide these services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1925 (November 2016).

§9903. Laboratory Services

A. The nursing facility shall arrange for the provision of clinical laboratory services to meet the needs of the residents. The nursing facility is responsible for the quality and timeliness of the services and shall:

1. provide or obtain laboratory services only when ordered by the attending physicians;

2. promptly notify the attending physician of the findings; and

3. assist resident in making transportation arrangements to and from the services as needed.

B. A nursing facility performing any laboratory service or test shall have appealed to CMS or received a certificate of waiver or a certificate of registration.

C. An application for a certificate of waiver may be needed if the nursing facility performs only the following tasks on the waiver list:

1. dipstick or table reagent urinalysis;

2. fecal occult blood;

3. erythrocyte sedimentation rate;

4. hemoglobin;

5. blood glucose by glucose monitoring

6. devices cleared by Food and Drug Administration (FDA) specifically for home use;

7. spun micro hematocrit;

8. ovulation test; and

9. pregnancy test.

D. Appropriate staff shall file in the residents' clinical record signed and dated reports of clinical laboratory services.

E. If the nursing facility provides its own laboratory services, the services shall meet the applicable conditions for coverage of services furnished by independent laboratories.

F. If the nursing facility provides blood bank and transfusion services it shall meet the applicable conditions for independent laboratories and hospital laboratories and hospital laboratories at 42 CFR 482.27.

G. If the nursing facility laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be approved for participation in the Medicare Program either as a hospital or an independent laboratory.

H. If the nursing facility does not provide laboratory services on site, it shall have an agreement to obtain these services from a laboratory that is approved for participation in the Medicare Program either as a hospital or as an independent laboratory.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1925 (November 2016).

Subchapter B. Physical Environment

§9911. General Provisions

A. The nursing facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.

B. The nursing facility shall provide a safe, clean, orderly, homelike environment.

C. If the nursing facility determines that a licensing provision of this Subchapter B prohibits the provision of a culture change environment, the nursing facility may submit a written waiver request to the Health Standards Section (HSS) of the Department of Health (LDH), asking that the provision be waived and providing an alternative to the licensing provision of this subchapter. The department shall consider such written waiver request, shall consider the health and safety concerns of such request and the proposed alternative, and shall submit a written response to the nursing facility within 60 days of receipt of such waiver request.

D. Any construction-related waiver or variance request of any provision of the LAC *Title 51, Public Health—Sanitary Code* shall be submitted in writing to the state health officer for his/her consideration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1926 (November 2016).

§9913. Nurse/Care Team Work Areas

A. Each floor and/or household of a nursing facility shall have a nurse/care team work area in locations that are suitable to perform necessary functions. These nurse/care team work areas may be in centralized or decentralized locations, as long as the locations are suitable to perform necessary functions.

1. Each centralized nurse/care team area shall be equipped with working space and accommodations for recording and charting purposes by nursing facility staff with secured storage space for in-house resident records.

a. Exception. Accommodations for recording and charting are not required at the central work area where decentralized work areas are provided.

2. Each decentralized work area, where provided, shall contain working space and accommodations for recording and charting purposes with storage space for administrative activities and in-house resident records.

3. The nurse/care team work areas shall be equipped to receive resident calls through a communication system from resident rooms, toileting and bathing facilities.

a. In the case of an existing centralized nurse/care team work area, this communication may be through audible or visible signals and may include wireless systems.

b. In those facilities that have moved to decentralized nurse/care team work areas, the facility may utilize other electronic systems that provide direct communication from the resident to the staff.

B. There shall be a medicine preparation room or area. Such room or area shall contain a work counter, preparation sink, refrigerator, task lighting and lockable storage for controlled drugs.

C. There shall be a clean utility room on each floor designed for proper storage of nursing equipment and supplies. Such room shall contain task lighting and storage for clean and sterile supplies.

D. There shall be a separate soiled utility room designed for proper cleansing, disinfecting and sterilizing of equipment and supplies. At a minimum, it shall contain a clinical sink or equivalent flushing-rim sink with a rinsing hose or bed pan sanitizer, hand washing facilities, soiled linen receptacles and waste receptacle. Each floor of a nursing facility shall have a soiled utility room.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1926 (November 2016).

§9915. Resident Rooms

A. Resident bedrooms shall be designed and equipped for adequate nursing care, comfort, and privacy of residents. Each resident bedroom shall have a floor, walls, and ceilings in good repair and so finished as to enable satisfactory cleaning.

B. Each resident's bedroom shall have a floor at or above grade level, shall accommodate a maximum of two residents, and be so situated that passage through another resident's bedroom is unnecessary.

1. Exception. Resident bedrooms in existing nursing facilities shall be permitted to accommodate no more than four residents unless the cost of renovations to the existing nursing facility exceeds the values stipulated by R.S. 40:1574.

C. Private resident bedrooms shall measure at least 121 square feet of bedroom area, exclusive of wardrobes, closet space, vestibules or toilet rooms, and shall have a clear width of not less than 11 feet.

D. Double occupancy resident bedrooms containing two beds shall measure at least 198 square feet of bedroom area, exclusive of wardrobes, closet space, vestibules or toilet rooms, and shall have a clear width of not less than 11 feet.

E. In existing nursing facilities, or portions thereof, where plans were approved by the department and the Office of the State Fire Marshal prior to January 20, 1998, there shall be at least three feet between the sides and foot of the bed and any wall, other fixed obstruction, or other bed, unless the furniture arrangement is the resident's preference and does not interfere with service delivery.

F. Each resident's bedroom shall have at least one window to the outside atmosphere with a maximum sill height of 36 inches. Windows with sills less than 30 inches from the floor shall be provided with guard rails.

1. Each resident's bedroom window shall be provided with shades, curtains, drapes, or blinds.

2. Operable windows shall be provided with screens.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1926 (November 2016).

§9917. Resident Room Furnishings

A. Each resident shall be provided with an individual bed of proper size and height for the convenience of the resident and equipped with:

1. a clean supportive frame in good repair;

2. a clean, comfortable, well-constructed mattress at least 5 inches thick with waterproof ticking and correct size to fit the bed;

3. a clean, comfortable pillow shall be provided for each bed with extra pillows available to meet the needs of the residents;

4. adequate bed rails, when necessary, to meet the needs of the resident; and

5. sheets and covers appropriate to the weather and climate.

B. Screens or noncombustible ceiling-suspended privacy curtains which extend around the bed shall be provided for each bed in multi-resident bedrooms to assure resident privacy. Total visual privacy without obstructing the passage of other residents either to the corridor, closet, lavatory or adjacent toilet room, nor fully encapsulating the bedroom window shall be provided.

C. Each resident shall be provided with a call device located within reach of the resident.

D. Each resident shall be provided a bedside table with at least two drawers. As appropriate to resident needs, each resident shall have a comfortable chair with armrests, waste receptacle, and access to mirror unless medically contraindicated.

1. Each resident who has tray service to his/her room shall be provided with an adjustable overbed table positioned so that the resident can eat comfortably.

E. Each resident shall be provided an individual closet that has minimum dimensions of 1 foot 10 inches in depth by 2 feet 6 inches in width. A clothes rod and shelf shall be provided that is either adjustable or installed at heights accessible to the resident. Accommodations shall be made for storage of full-length garments. The shelf may be omitted if the closet provides at least two drawers. The following exceptions may apply.

1. Individual wardrobe units having nominal dimensions of 1 foot 10 inches in depth by 2 feet 6 inches in width are permitted. A clothes rod and shelf shall be provided that is either adjustable or installed at heights accessible to the resident. Accommodations shall be made for storage of full-length garments. The shelf may be omitted if the unit provides at least two drawers.

2. In existing nursing facilities, or portions thereof, where plans were approved by the department and OSFM prior to January 20, 1998, each resident shall be provided an individual wardrobe or closet that has nominal dimensions of 1 foot 10 inches in depth by 2 feet in width.

F. Each resident shall be provided with a bedside light or over-the-bed light capable of being operated from the bed.

1. In nursing facilities, or portions thereof, where plans were approved by the department and OSFM prior to May 1, 1997 shall be exempt from this provision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1927 (November 2016).

§9919. Specialized Care Units, Restraints, and Seclusion

A. Specialized Care Units

1. Nursing facilities may establish a distinct unit that benefits residents living with severe dementia, Alzheimer's disease, or other disease process or condition which severely impairs their ability to recognize potential hazards. Such units shall not be established for the sole purpose of housing individuals with mental illness.

2. Specialized care units may involve locking mechanisms provided that such locking arrangements are approved by OSFM and satisfy the requirements established by OSFM.

3. Nursing facilities providing care and services on a specialized care unit shall develop admission and discharge criteria. There shall be documentation in the resident's record to indicate the unit is the least restrictive environment possible, and placement in the unit provides a clear benefit to the resident.

4. Guidelines for admission and discharge shall be provided to the resident, the resident's family, and/or the resident's legal representative.

5. Specialized care units shall be designed and staffed to provide the care and services necessary for the resident's needs to be met.

a. The unit shall have designated space for dining and/or group and individual activities that is separate and apart from the resident bedrooms and bathrooms.

b. The dining space shall contain tables for eating within the unit.

c. The activities area(s) shall contain seating, and be accessible to the residents within the unit.

6. There shall be sufficient staff to respond to emergency situations in the unit at all times.

7. The facility shall ensure that admission to the specialized care unit imposes restrictions on residents' exercise of their rights only to the extent absolutely necessary to protect the health and safety of themselves and other residents.

8. Care plans shall address the reasons for the resident being in the unit and how the nursing facility is meeting the resident's continuing needs.

9. All staff designated to provide care and services on specialized care units shall have training regarding unit policies and procedures, admission and discharge criteria, emergency situations and the individual and special needs of the residents on the unit.

10. Admission to a specialized care unit shall be in compliance with R.S. 40:1299.53 and 40:2010.8.

B. Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

C. Seclusion. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1927 (November 2016).

§9921. Hand-Washing Stations, Toilet Rooms and Bathing Facilities

A. A hand-washing station shall be provided in each resident room.

1. Omission of this station shall be permitted in a single-bed or two-bed room when a hand-washing station is located in an adjoining toilet room that serves that room only.

B. Each resident shall have access to a toilet room without having to enter the corridor area. In nursing facilities built prior to August 26, 1958, each floor occupied by residents shall be provided with a toilet room and hand-washing station.

1. One toilet room shall serve no more than two residents in new construction or no more than two resident rooms in renovation projects. In nursing facilities built prior to August 26, 1958, toilets and hand-washing stations shall each be provided at a rate of 1 per 10 beds or fraction thereof.

2. Toilet rooms shall be easily accessible, conveniently located, well lighted, and ventilated to the outside atmosphere. Fixtures shall be of substantial construction, in good repair and of such design to enable satisfactory cleaning.

3. Separate male and female toilet rooms for use by staff and guests shall be provided.

4. Each toilet room shall contain a toilet, hand-washing station and mirror.

5. Doors to single-use resident toilet rooms shall swing out of the room.

6. Doors to single-use resident toilet rooms shall be permitted to utilize privacy locks that include provisions for emergency access.

7. In multi-use toilet rooms provisions shall be made for resident privacy.

C. Each floor occupied by residents shall be provided with a bathing facility equipped with a toilet, hand-washing station, and bathing unit consisting of a bathtub, shower, or whirlpool unit.

1. A minimum of one bathtub, shower, or whirlpool unit shall be provided for every 20 residents, or fraction thereof, not otherwise served by bathing facilities in resident rooms. In nursing facilities built prior to August 26, 1958, showers or tubs shall each be provided at a rate of 1 per 15 beds or fraction thereof.

2. Bathing facilities shall be easily accessible, conveniently located, well lighted and ventilated to the outside atmosphere. Fixtures shall be of substantial construction, in good repair, and of such design to enable satisfactory cleaning.

3. Tub and shower bottoms shall be of nonslip material. Grab bars shall be provided to prevent falling and to assist in maneuvering in and out of the tub or shower.

4. Separate bathing facilities shall be provided for employees who live on the premises.

5. In multi-use bathing facilities provisions shall be made for resident privacy.

6. Wall switches for controlling lighting, ventilation, heating or any other electrical device shall be so located that they cannot be reached from a bathtub, shower, or whirlpool.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1928 (November 2016).

§9923. Dining and Resident Activities

A. The nursing facility shall provide one or more areas designated for resident dining and activities.

B. Smoking is not permitted in the dining room and other public areas as specified by R.S. 40:1300.256(B)(11).

C. Dining room(s) or dining area(s) shall be sufficient in space and function to accommodate the needs of the residents without restriction. Dining areas shall be adequately furnished, well lighted, and well ventilated. Dining areas shall be sufficient in space to comfortably accommodate the persons who usually occupy that space, including persons who utilize walkers, wheelchairs and other ambulating aids or devices.

D. There shall be at least one well lighted and ventilated living/community room with sufficient furniture.

E. There shall be sufficient space and equipment to comfortably accommodate the residents who participate in group and individual activities. These areas shall be well lighted and ventilated and be adequately furnished to accommodate all activities.

F. Areas used for corridor traffic or for storage of equipment shall not be considered as areas for dining or activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1928 (November 2016).

§9925. Linen and Laundry

A. The nursing facility shall have available, at all times, a quantity of bed and bath linen essential for proper care and comfort of residents.

B. All linen shall be in good condition.

C. All used linen shall be bagged or enclosed in appropriate containers for transportation to the laundry.

D. Soiled linen storage areas shall be ventilated to the outside atmosphere.

E. Linen from residents with a communicable disease shall be bagged, in readily identifiable containers distinguishable from other laundry, at the location where it was used.

F. Linen soiled with blood or body fluids shall be placed and transported in bags that prevent leakage.

G. If hot water is used, linen shall be washed with detergent in water at least 160 degrees Fahrenheit for 25 minutes. If low-temperature (less than or equal to 158 degrees Fahrenheit) laundry cycles are used, chemicals suitable for low-temperature washing, at proper use concentration, shall be used.

H. Clean linen shall be transported and stored in a manner to prevent its contamination.

I. Nursing facilities providing in-house laundry services shall have a laundry system designed to eliminate crossing of soiled and clean linen.

J. Nursing facilities that provide in house laundry services and/or household washers and dryers shall have policies and procedures to ensure safety standards, infection control standards and manufacturer’s guidelines are met.

K. There shall be hand washing facilities available for use in any designated laundry area.

L. Provisions shall be made for laundering personal clothing of residents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1929 (November 2016).

§9927. Equipment and Supplies

A. The nursing facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition.

B. Therapeutic, diagnostic, and other resident care equipment shall be maintained and serviced in accordance with the manufacturer's recommendations.

C. Wheelchairs shall be available for emergency use by residents who are not fully ambulatory.

D. Equipment for taking vital signs shall be maintained.

E. At least one oxygen tank or resource of oxygen shall be readily accessible for emergency use.

F. An adequate number of battery-generated lamps or flash lights shall be available for staff use in case of electrical power failure.

G. There shall be at least one telephone adapted for use by residents with hearing impairments at a height accessible

to bound residents who use wheelchairs and be available for resident use where calls can be made without being overheard.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1929 (November 2016).

§9929. Other Environmental Conditions

A. A hard surfaced off-the-road parking area to provide parking for one car per five licensed beds shall be provided. This is a minimum requirement and may be exceeded by local ordinances. Where this requirement would impose an unreasonable hardship, a written request for a lesser amount may be submitted to the department for waiver consideration.

B. The nursing facility shall make arrangements for an adequate supply of safe potable water even when there is a loss of normal water supply. Service from a public water supply shall be used, if available. Private water supplies, if used, shall meet the requirements of the LAC *Title 51, Public Health—Sanitary Code*.

C. An adequate supply of hot water shall be provided which shall be adequate for general cleaning, washing, and sterilizing of cooking and food service dishes and other utensils, and for bathing and laundry use. Hot water supply to the hand washing and bathing faucets in the resident areas shall have automatic control to assure a temperature of not less than 100 degrees Fahrenheit, nor more than 120 degrees Fahrenheit, at the faucet outlet. Supply system design shall comply with the Louisiana state Plumbing Code and shall be based on accepted engineering procedures using actual number and types of fixtures to be installed.

D. The nursing facility shall be connected to the public sewerage system, if such a system is available. Where a public sewerage is not available, the sewerage disposal system shall conform to the requirements of the LAC *Title 51, Public Health—Sanitary Code*.

E. The nursing facility shall maintain a comfortable sound level conducive to meeting the need of the residents.

F. All plumbing shall be properly maintained and conform to the requirements of the LAC *Title 51, Public Health—Sanitary Code*.

G. All openings to the outside atmosphere shall be effectively screened. Exterior doors equipped with closers in air conditioned buildings need not have screens.

H. Each room used by residents shall be capable of being heated to not less than 71 degrees Fahrenheit in the coldest weather and capable of being cooled to not more than 81 degrees Fahrenheit in the warmest weather.

I. Lighting levels in all areas shall be adequate to support task performance by staff personnel and independent functioning of residents. A minimum of 6 foot to 10 foot candelas over the entire stairway, corridors, and resident rooms measured at an elevation of 30 inches above the floor and a minimum of 20 foot to 30 foot candelas over areas used for reading or close work shall be available.

J. Corridors used by residents shall be equipped on each side with firmly secured handrails, affixed to the wall. Handrails shall comply with the requirements of the state adopted accessibility guidelines.

K. There shall be an effective pest control program so that the nursing facility is free of pest and rodent infestation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1929 (November 2016).

Subchapter C. Infection Control and Sanitation

§9941. Organization

A. A nursing facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

B. No later than September 1 of each year, the nursing facility shall provide information from the LDH website to the residents on the risks associated with pneumonia and the availability of the pneumococcal immunization.

C. No later than September 1 of each year, the nursing facility shall provide information from the LDH website to the residents on the risks associated with zoster, also known as shingles, and how to protect oneself against the varicella-zoster virus.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1930 (November 2016).

§9943. Infection Control Program

A. An infection control committee shall be established consisting of the medical director and representatives from at least administration, nursing, dietary and housekeeping personnel.

B. The committee shall establish policies and procedures for investigating, controlling and preventing infections in the nursing facility, and monitor staff performance to ensure proper execution of policies and procedures.

C. The committee shall approve and implement written policies and procedures for the collection, storage, handling, and disposal of medical waste.

D. The committee shall meet at least quarterly, documenting the content of its meetings.

E. Reportable diseases as expressed in the LAC Title 51, Public Health—Sanitary Code shall be reported to the local parish health unit of OPH and other agencies as required by state and/or federal laws, statutes, and ordinances.

F. Coronavirus Disease 2019 (COVID-19) Reporting. The facility, in addition to any state and/or local reporting, shall:

1. electronically report information about COVID-19 in the standardized format, and at the frequency, required by the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC); and

2. inform residents, their representatives, and families of those residing in facilities, of the conditions of residents in the facility, within the timeframe and requirements as specified by CMS regulations and CDC reporting guidelines.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.
HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1930 (November 2016), amended LR 46:1393 (October 2020).

§9945. Employee Health Policies and Procedures

A. Nursing facility employees with a communicable disease or infected skin lesions shall be prohibited from direct contact with residents or their food, if direct contact will transmit the disease.

B. The nursing facility shall require staff to wash their hands after each direct resident contact for which hand washing is indicated. An antimicrobial gel or waterless cleaner may be used between resident contact, when appropriate. The nursing facility shall follow the current Centers for Disease Control's *Guideline for Hand Washing*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.
HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1930 (November 2016).

§9947. Isolation

A. When the infection control program determines that a resident needs isolation to prevent the spread of infection, the nursing facility shall isolate the resident according to the most current Centers for Disease Control's recommendations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.
HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1930 (November 2016).

§9949. Housekeeping and Maintenance

A. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and safe interior shall be provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.
HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1930 (November 2016).

§9951. Nursing Care Equipment

A. Bedpans, urinals, emesis basins, wash basins and other personal nursing items shall be thoroughly cleaned after each use and sanitized as necessary. Water pitchers shall be sanitized as necessary.

B. All catheters, irrigation sets, drainage tubes or other supplies or equipment for internal use, and as identified by the manufacturer as one time use only, shall be disposed of in accordance with the manufacture's recommendations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.
HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1930 (November 2016).

§9953. Waste and Hazardous Materials Management

A. The nursing facility shall have a written and implemented waste management program that identifies and controls wastes and hazardous materials. The program shall comply with all applicable laws and regulations governing wastes and hazardous materials.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.
HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1930 (November 2016).

Chapter 100. Nurse Aide Training and Competency Evaluation Program

Subchapter A. General Provisions

§10001. Definitions

Abuse—

1. the willful infliction of physical or mental injury;

2. causing deterioration by means including, but not limited to:

a. sexual abuse;

b. exploitation; or

c. extortion of funds or other things of value to such an extent that the resident's health, moral or emotional well-being is endangered; or

3. the willful infliction of injury, unreasonable confinement, intimidation or punishment which results in or which could reasonably be expected to result in physical or mental harm, pain or mental anguish. Lack of awareness or knowledge by the victim of the act which produced or which could have reasonably been expected to produce physical or mental injury or harm shall not be a defense to the charge of abuse.

Approved Setting—a provider entity licensed and regulated by the department, a school serving children with special needs, or a correctional facility in which the certified nurse aide performs nursing or nursing-related duties.

Certified Nurse Aide—an individual who has completed a nurse aide training and competency evaluation program (NATCEP) approved by the state as meeting the requirements of 42 Code of Federal Regulations (CFR)

483.151-483.154, or has been determined competent as provided in 42 CFR 483.150(a) and (b), and is listed as certified and in good standing on Louisiana's nurse aide registry.

Department—the Louisiana Department of Health and Hospitals.

Misappropriation—taking possession without the permission of the resident who owns the personal belongings, or the deliberate misplacement, exploitation or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.

Neglect—the failure to provide goods and services to the resident that are necessary to avoid physical harm, mental anguish or mental illness.

Nursing Homes or Nursing Facilities—any entity or facility serving two or more persons, who are not related to the operator by blood or marriage, that undertakes to provide maintenance, personal care or nursing for persons who are unable to properly care for themselves by reason of illness, age or physical infirmity.

Trainee—an individual who is at least 16 years old and is enrolled in a nurse aide training and competency evaluation program, whether at a nursing facility or educational facility, with a goal of becoming a certified nurse aide.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2074 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1242 (May 2012).

Subchapter B. Training and Competency Requirements

§10011. General Provisions

A. All nurse aide training and competency evaluation programs shall be approved by the department.

B. Training and competency evaluation programs may be provided by:

1. community colleges;

2. vocational-technical programs; and

3. other educational entities.

C. Nursing facilities may provide the classroom and clinical training portion of the program but the competency evaluation shall be administered by an entity approved by the department.

D. Each training and competency evaluation program shall:

1. maintain qualified, approved personnel for classroom and clinical instruction;

2. protect the integrity of the competency evaluations by keeping them secure;

3. utilize a pass rate of a least 70 percent for each individual student; and

4. assure the curriculum meets federal and state requirements.

E. Clinical instruction shall be conducted in a nursing home or a hospital-based skilled nursing facility unit.

F. Training programs that do not meet the minimum standards and cannot provide an acceptable plan for correcting deficiencies shall be eliminated from participation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2075 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1242 (May 2012).

§10013. Certification Criteria for Nursing Professionals, Nursing Students and Military Personnel

A. Individuals applying for nurse aide certification shall complete the application form designated by the department and submit documentation as deemed necessary by the department to determine eligibility.

B. Registered nurses (RNs) and licensed practical nurses (LPNs) who have completed online courses shall provide an official transcript to determine eligibility to test.

C. Registered nurse (RN) and licensed practical nurse (LPN) students shall provide an official transcript and any other documentation needed to determine eligibility.

D. Registered nurses (RNs) and licensed practical nurses (LPNs) who trained in other countries, and are requesting certification to the registry, shall be required to test.

E. RN and LPN students who have completed a nursing course, or have completed sufficient course content to meet eligibility criteria for certification, shall be required to test if their request for certification is received within three years of taking the nursing course.

F. An individual who trained in another state but did not test, shall test and certify to the registry in that state before transferring to Louisiana, or shall retrain and test in Louisiana.

G. Military personnel shall provide a copy of their military transcript and any other documentation needed to determine eligibility.

H. Licensed nurses on probation or suspended status shall provide documentation as deemed necessary by the department to determine eligibility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2075 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1242 (May 2012).

§10015. Training Curriculum/Program Approval

A. Training Curriculum

1. Providers applying to have a training program after the effective date of this Rule shall use one of the state approved curriculums or any subsequent editions issued by the publisher or any future state approved curriculums.

2. The curriculum shall be a minimum of 80 hours in length, which includes 40 classroom hours and 40 clinical hours.

3. Each additional unit objective added to the approved curriculum, above the minimum 80 hours, shall be behaviorally-stated for each topic of instruction. Each objective shall state performance criteria which are measurable and shall serve as a basis for the competency evaluation.

a. The unit objectives shall be reviewed with the trainees at the beginning of each unit so each trainee will know what is expected of him/her in each part of the training.

B. Curriculum Goals and Content

1. The goal of the nurse aide training and competency evaluation program is the provision of quality services to residents by nurse aides who are able to:

a. communicate and interact competently on a one-to-one basis with residents as part of the team implementing resident care;

b. demonstrate sensitivity to the emotional, social and mental health needs of resident's through skillful, directed interactions;

c. assist residents in attaining and maintaining functional independence;

d. exhibit behavior to support and promote the rights of residents; and

e. demonstrate proficiency in the skills needed to support the assessment of the health, physical condition and well-being of residents.

2. Facility and non-facility based training programs shall provide at least 16 hours of instruction prior to a trainee's direct involvement with a resident. The 16 hours of instruction shall be devoted to areas listed in Subsection C of this Section.

C. The training program shall be conducted to ensure that each nurse aide, at a minimum, is able to demonstrate competencies in the following areas:

1. basic nursing skills including, but not limited to:

a. bed-making;

b. taking vital signs;

c. measuring height and weight;

d. caring for the resident's environment;

e. measuring fluid and nutrient intake and output;

f. assisting in the provision of proper nutritional care;

g. ambulating and transferring residents;

h. using body mechanics;

i. maintaining infection control and safety standards;

j. understanding the protocols in facility policy for the performance of and attaining/maintaining proficiency in basic cardio-pulmonary resuscitation including one hour of in-service training that shall be provided by the facility annually;

k. caring for residents when death is imminent;

l. recognizing abnormal signs and symptoms of common diseases and conditions; and

m. caring for residents suffering from Alzheimer's disease or dementia;

2. personal care skills including, but not limited to:

a. bathing, including mouth care;

b. grooming and dressing;

c. toileting;

d. assisting with feeding and hydration; and

e. skin care;

3. mental health and social service needs including, but not limited to:

a. modifying his/her own behavior in response to a resident's behavior;

b. identifying developmental tasks associated with the aging process and using task analysis to increase independence;

c. providing training in and the opportunity for self-care according to a resident's capabilities;

d. demonstrating principles of behavior modification by reinforcing appropriate behavior and causing inappropriate behavior to be reduced or eliminated;

e. demonstrating skills which support age-appropriate behavior by allowing the resident to make personal choices;

f. providing and reinforcing behavior consistent with maintaining a resident's dignity; and

g. utilizing a resident's family as a source of emotional support;

4. basic restorative services including, but not limited to:

a. the use of assistive devices in ambulation, eating and dressing;

b. maintenance of range of motion;

c. proper turning and positioning in a bed and a chair;

d. transferring a resident;

e. bowel and bladder training; and

f. care and use of prosthetic devices, such as hearing aids, artificial eyes or artificial limbs;

5. maintaining a resident's rights including, but not limited to:

a. assisting a resident to vote;

b. providing privacy and maintaining confidentiality;

c. allowing the resident to make personal choices to accommodate individual needs;

d. giving assistance in resolving grievances;

e. providing needed assistance in getting to, and participating in, resident and family groups and other activities;

f. maintaining reasonable care of a resident's personal possessions;

g. providing care which frees the resident from abuse, mistreatment or neglect and reporting any instances of poor care to appropriate facility staff; and

h. maintaining the resident's environment and care so as to minimize the need for physical and chemical restraints;

6. communication and interpersonal skills;

7. safety and emergency procedures;

8. promoting residents' independence; and

9. the Heimlich maneuver.

D. Program Approval

1. All training programs shall meet the guidelines established by the department.

2. To get a nurse aide training program approved, the facility or school shall submit to the department the application, completed in its entirety, which denotes the state approved curriculum that shall be used and all required documentation stipulated in the nurse aide training packet.

3. All schools applying for approval shall identify the physical locations used for classroom instruction and for the clinical experience. Non-facility based programs shall also submit clinical contracts which meet the guidelines established by the department.

4. Approval to provide nurse aide training is granted specifically for the provider who submitted the application. There is no provision for subcontracting the training program.

5. If an approved program ceases to provide a nurse aide training and competency evaluation program for a two year period, the program shall be closed. The provider must reapply if they wish to provide training at a later date.

6. All approved providers shall maintain a current address, telephone and fax number, and e-mail address. The provider shall report to the department any changes in this information or other aspects of the approved program within five working days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2075 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Financing LR 38:1242 (May 2012), repromulgated LR 38:1410 (June 2012).

§10017. Coordinators, Instructors and Trainers

A. Program Coordinator. Every nurse aide training program shall have a program coordinator who provides general supervision of the training received by the nurse aide trainees.

1. The program coordinator shall be a registered nurse (RN) and shall have the following experience and qualifications:

a. a minimum of two years of nursing experience, of which at least one year must be in caring for the elderly or chronically ill, obtained through employment in any of the following:

i. a nursing facility/unit;

ii. a geriatrics department;

iii. a chronic care hospital;

iv. other long-term care setting; or

v. experience in varied responsibilities including, but not limited to, direct resident care or supervision and staff education; and

b. completion of VTIE, CTTIE, "train-the-trainer" type program or a master's degree or higher.

2. The program coordinator shall supervise no more than two nurse aide training programs simultaneously and shall be on the premises where the program is being conducted for at least 50 percent of the duration of the program.

B. Instructors. Instructors shall be RN's or LPN's and shall hold a current Louisiana nursing license. Licensed practical (vocational) nurses, under the general supervision of the coordinator, may provide classroom and clinical skills instruction and supervision of trainees if they have two years of experience in caring for the elderly and/or chronically ill of any age or have equivalent experience.

1. Such experience is normally obtained through employment in:

a. a nursing facility;

b. a geriatrics department;

c. a chronic care hospital; or

d. other long-term care setting.

2. Experience in resident care, supervision and staff education is preferred.

3. The ratio of instructors to trainees in clinical training shall not exceed 1:10 and the ratio of instructors to trainees in the classroom shall not exceed 1:23.

C. Program Trainers. Qualified resource personnel from the health field may participate as program trainers as needed for discussion or demonstration of specialized care procedures.

1. Qualified resource personnel shall have a minimum of one year of experience in their field and shall be licensed, registered and/or certified, if applicable, and may include:

a. registered nurses;

b. licensed practical/vocational nurses;

c. pharmacists;

d. dietitians;

e. social workers;

f. sanitarians;

g. fire safety experts;

h. nursing home administrators;

i. gerontologists;

j. psychologists;

k. physical and occupational therapists;

l. activities specialists; and

m. speech/language/hearing therapists.

2. All program trainers shall have a minimum of one year of current experience in caring for the elderly and/or chronically ill of any age or have equivalent experience.

3. The training program may utilize other persons such as residents, experienced aides and ombudsmen as resource personnel if these persons are needed to meet the planned program objectives or a specific unit of training.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2076 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1244 (May 2012).

§10019. Training Program Responsibilities

A. Each nurse aide trainee shall be at least 16 years old.

B. Each nurse aide trainee shall be clearly identified as a trainee at all times during clinical training. Identification shall be recognizable to residents, family members, visitors and staff.

C. Each nurse aide training program shall provide all trainees with an orientation of the clinical training site of at least four hours that is not included in the required 80 hours of core curriculum. The orientation shall include but is not limited to:

1. an explanation of the facility's organizational structure;

2. the facility's policies and procedures;

3. discussion of the facility's philosophy of care;

4. description of the resident population;

5. employee rules; and

6. what constitutes abuse, neglect, and misappropriation, including the consequences imposed if found guilty of such.

D. The facility/school shall not accept a nurse aide trainee into a training program until the facility or school conducts a statewide criminal history background check which includes a check of the national sex offender public registry.

1. A trainee shall not be eligible to participate in a training program if convicted or found guilty by a court of law of:

a. abusing, neglecting or mistreating the elderly or infirm as defined by R.S. 40:2009.20;

b. misappropriating a resident's property; or

c. has not had a finding of abuse, neglect, mistreatment or misappropriation of a resident's property placed on the Nurse Aide Registry or the Direct Service Worker Registry.

2. If a criminal history background check cannot be legally obtained by a training program, trainees may obtain a certified copy of their criminal history from the Louisiana State Police by requesting that a "right to review" be conducted.

E. Trainees shall not be prohibited from completing training due to:

a. criminal history that is not related to abuse, neglect or misappropriation; or

b. the Louisiana State Police not being able to complete a criminal history check due to the age of the trainee.

F. For facility-based training programs, the facility shall assure that trainees do not perform any care and services for which they have not trained and been found proficient by the instructor. Trainees providing services to residents shall be under the general supervision of a licensed nurse approved to work in a nurse aide training program.

1. Trainees enrolled in facility-based training programs, shall complete training and test within 60 days of hire.

2. Nursing facilities may provide the classroom instruction and clinical instruction but the competency evaluation shall be administered by an entity approved by the department.

3. A class roster as well as the beginning and ending dates of each training class shall be available for review by the department at all times. This shall be available for both classroom and clinical instruction.

G. Providers shall issue a certificate of completion to nurse aide trainees who successfully complete a training and competency evaluation program. The certificate shall contain the following:

1. the name of the nurse aide training program or school;

2. the date the program began;

3. the date the program ended;

4. the notation that this is a "DHH Approved Program;"

5. the name of the instructor; and

6. the signature of the coordinator and the date signed

H. Any entity responsible for the nurse aide training and competency evaluation program shall report to the Nurse Aide Registry within 30 days the names of all individuals who have satisfactorily passed the competency evaluation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2077 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1244 (May 2012).

§10021. Competency Evaluation

A. Written or oral examinations shall be provided by an entity or organization approved by the department. The examination shall reflect the content and emphasis of the training program and shall be developed in accordance with accepted educational principles.

B. The written evaluation component shall be given in English unless the aide will be working in a facility in which the predominant language is something other than English. In this case, the examination may be taken in the written predominant language used in the facility, dependent upon the availability of a translator who shall maintain the integrity of the examination.

C. A substitute examination, including an oral component, shall be developed for those nurse aides with limited literacy skills. This examination shall contain all of the content that is included in the written examination and shall include a written reading comprehension portion that shall determine competency to read job-related information.

D. Trainees of non-facility based programs shall take the competency evaluation (through skills demonstration and either written or oral examination) within 30 days after completion of the training program.

E. Trainees shall be provided a maximum of three opportunities within one year following completion of the training program to successfully complete the competency evaluation.

F. The evaluation program shall be developed and conducted to ensure that each nurse aide, at a minimum, is able to demonstrate competencies listed in §10015.C.

G. For the skills training component of the evaluation program, each nurse aide training program shall develop a performance record of duties/skills taught which shall verify proficiency attained.

1. The performance record shall consist of, at a minimum:

a. a listing of the duties/skills expected to be learned in the program; and

b. space to note satisfactory or unsatisfactory performance of each task including:

i. the date of the performance; and

ii. the name of the instructor supervising the performance.

2. At the completion of the nurse aide training program, the nurse aide and his/her employer shall receive a copy of this record. If the individual did not successfully perform all duties/skills on this performance record, he/she shall receive training for all duties and skills not satisfactorily performed until satisfactory performance is confirmed.

H. The skills demonstration of the competency evaluation program shall consist of a minimum performance of five tasks, all of which are included in the performance record. These five tasks shall be selected for each aide from a pool of evaluation tasks which have been ranked according to degree of difficulty. A random selection of tasks shall be made with at least one task from each degree of difficulty being selected. Such evaluation tasks may include, but are not limited to:

1. making an occupied bed;

2. taking and recording a resident's blood pressure, temperature, pulse and respirations;

3. orienting a new resident to the facility;

4. performing a range of motion exercises;

5. giving a bed bath;

6. positioning a resident on his/her side; and

7. responding to a demented resident who is calling out, yelling or indicating distress or anger.

I. Task-related evaluation items shall be developed to evaluate communication and psychosocial skills. The skills demonstration portion of the competency evaluation may be held in either a nursing facility or in a laboratory equipped for this purpose.

J. In the case of nursing facilities that provide their own training programs, the facility shall contact an approved entity to administer competency evaluation. The clinical portion of the competency evaluation shall be given in a nursing facility, but shall be administered by personnel not associated with the facility. The competency evaluation may

be proctored by facility personnel if the competency evaluation is:

1. secured from tampering;

2. standardized;

3. scored by a testing, educational or other organization approved by the state or scored by the state itself; and

4. not administered or scored by facility personnel.

K. The examiner conducting the clinical competency evaluation for any individual trainee shall be approved by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2077 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1245 (May 2012).

§10023. Compliance with Federal and State Regulations

A. The department shall review all components of a training and competency evaluation program for compliance with federal and state regulations.

B. Programs not meeting minimum requirements may be terminated if the program does not provide an acceptable plan for correcting deficiencies.

C. Programs not accessible or refusing to permit unannounced visits by the department shall be terminated.

D. A program that has not conducted training or certified trainees to the registry within a two year period shall be closed.

E. Operational Requirements

1. In order to be considered operational and retain approval to conduct a training program, providers shall have at least one employee on duty at the business location during the hours of operation reported on the training program application submitted to the DHH Health Standards Section.

2. All nurse aide training providers (facility based and non-facility based) shall maintain a current, operational telephone number, fax number and e-mail address and shall keep the department informed of any changes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2078 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Financing, LR 38:1246 (May 2012).

§10025. Nurse Aide Responsibilities

A. A nurse aide shall be responsible for notifying the registry of current contact information such as address, telephone number, and e-mail address.

B. A nurse aide shall perform at least eight hours of nursing or nursing-related services in an approved setting during every consecutive 24-month period for pay after completion of a training and competency evaluation program to maintain certification.

C. If a nurse aide does not have proof of the required eight hours of paid employment in an approved setting in a 24-month period needed for recertification, he/she may retest with the two years immediately following the expiration. If the nurse aide fails to retest within the allotted time period, they shall retrain.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2078 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1246 (May 2012).

Subchapter C. Nurse Aide Registry

§10033. General Provisions

A. The Department of Health and Hospitals shall develop and maintain a registry for individuals who have successfully completed a nurse aide training and/or competency evaluation program. Each individual listed on the registry will have the following information maintained and retrievable:

1. name;

2. address;

3. Social Security number;

4. phone number;

5. place of employment;

6. date of employment;

7. date employment ceased;

8. state certification number;

9. documentation of any investigation including codes for specific findings of a resident's:

a. abuse;

b. neglect;

c. misappropriated property; and

d. an accurate summary of findings only after actions on findings are final;

10. current e-mail address; and

11. status of certification, which includes the:

a. certified date;

b. recertified date; and

c. expiration date.

B. The registry shall renew certification in accordance with the provisions of §10025 of this Chapter.

C. Employers shall use the registry to determine if a prospective hire is a certified nurse aide and if there is a

finding placed on the registry that he/she has abused or neglected a resident or misappropriated a resident's property or funds.

D. If there is a final and binding administrative decision to place a finding on the registry or if there is a final conviction, guilty plea or no contest plea to a crime(s) by a nurse aide against the elderly, infirmed or a nursing facility resident, the department shall place the adverse finding on the registry. Record of the occurrence and associated findings shall remain permanently on the registry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2078 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1246 (May 2012).

§10035. Certification by Reciprocity

A. Nurse aides may become certified by reciprocity from other states. Applicants shall, at a minimum, submit to the Nurse Aide Registry the following information either on forms or via electronic submissions approved by the department:

1. his/her name;
2. his/her Social Security number;
3. the certification number in the other state;
4. the address of the other state's registry;
5. his/her former place of employment;
6. the date of employment and termination;
7. his/her e-mail address;
8. a copy of his/her social security card; and
9. a copy of his/her official Louisiana identification, such as a driver's license, identification card, etc.

B. After verification of certification in the other state, the registry shall certify the aide in Louisiana. Likewise, the registry will be responsible for granting reciprocity to other states.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2079 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1246 (May 2012).

Subchapter D. Provider Participation

§10045. Employer Responsibilities

A. A person shall not be employed as a nurse aide or nurse aide trainee by a nursing facility or hospital based SNF unit for more than 60 days unless he/she has satisfactorily completed an approved training and competency evaluation program.

B. A person shall not be employed as a nurse aide or nurse aide trainee if there is a final administrative or judicial court decision that the nurse aide or trainee has:

1. committed abuse, neglect or mistreatment of the elderly, infirm or nursing facility resident;
2. misappropriated a resident's property; or
3. as specified in R.S 40:1300.53.

C. The provider shall complete and send the appropriate form or approved electronic submission to the registry to verify employment or termination of a certified nurse aide. Failure to send notification to the registry within five working days of employment or termination may result in further adverse action against the provider. The provider shall maintain documentation to verify compliance.

D. All facilities shall continue to provide on-going training on a routine basis in groups and, as necessary in specific situations, on a one-to-one basis.

1. Each nurse aide shall receive and be compensated for 12 hours of on-going training per year.

2. Training may be conducted in the unit as long as it is:

a. directed toward skills improvement;

b. provided by appropriately trained staff; and

c. documented.

E. When a change of ownership (CHOW) occurs, the new owner or the administrator/designee is responsible for ensuring that all reporting of employment and termination to the registry is current. In the event that a request for verification of work history is received after the CHOW occurs, the current owner is responsible for compliance.

F. The facility administrator/designee is responsible for reporting employment and termination to the registry for nurse aides employed by staffing agencies. This shall be done at least monthly.

G. No nurse aide who is employed by, or who has received an offer of employment from a facility on the date on which the aide begins a nurse aide competency evaluation program may be charged for any portion of the program.

H. If an individual who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide competency evaluation program, the state shall provide for the reimbursement of costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide.

I. If a training program is facility based, the administrator or their designee shall reconcile with the nurse aide registry at least monthly, their CNA's that are currently employed or have been terminated. Accuracy of the information held by the registry is dependent upon the information received from the facility. Failure to maintain current data shall result in adverse action by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2079 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1247 (May 2012).

Subchapter E. Violations

§10055. Disqualification of Training Programs

A. The department prohibits nursing facilities from offering nurse aide training programs when the facilities have:

1. been determined to be out of compliance by the Medicaid or Medicare Programs until the end of a two-year period during which time no survey or investigation finds any deficiencies; or

2. operated under a waiver granted on the basis of a demonstration that the facility is unable to provide RN coverage in excess of 48 hours during a week.

B. The department may prohibit nursing facilities from offering nurse aide training programs when the facilities have been sanctioned with:

1. civil monetary penalties of $5,000 or more;

2. termination of vendor payments;

3. a ban on new admissions;

4. placement under temporary management or closure of a facility with transfer of residents; or

5. extended or partial extended survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2079 (November 2006), amended LR 38:1247 (May 2012).

§10057. Allegations of Nurse Aide Wrong-Doing

A. The department, through its Division of Administrative Law or successor entity, has provided for a process for the review and investigation of all allegations of wrong-doing by nurse aides employed in nursing facilities. Certified nurse aides and nurse aide trainees must not:

1. use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion on a resident in a nursing facility; nor

2. neglect a resident or commit misappropriation of a resident's property or funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2079 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1247 (May 2012).

§10059. Notice of Violation

A. When there are substantiated charges against the nurse aide, either through oral or written evidence, the department shall notify the individual(s) implicated in the investigation of the following information by certified mail:

1. the nature of the violation(s) and the date and time of each occurrence;

2. the department's intent to report the violation(s) to the Nurse Aide Registry; and

3. the right to request an informal dispute resolution and/or the right to an administrative hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2079 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1247 (May 2012).

§10061. Informal Dispute Resolution

A. When a nurse aide feels that he/she has been wrongly accused, the following procedure shall be followed.

1. The nurse aide may request an informal dispute resolution (IDR) within 15 calendar days of the receipt of the agency's notice of violation. The request for an IDR must be made to the department in writing.

2. The IDR is designed:

a. to provide an opportunity for the nurse aide to informally review the situation;

b. for the agency to offer alternatives based on corrections or clarifications, if any; and

c. for the nurse aide to evaluate the necessity for seeking an administrative hearing.

3. An IDR meeting shall be arranged within 20 days of the request.

4. During the IDR, the nurse aide shall be afforded the opportunity to:

a. talk with agency personnel involved in the situation;

b. review pertinent documents on which the alleged violation is based;

c. ask questions;

d. seek clarifications; and

e. provide additional information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2080 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1247 (May 2012).

Subchapter F. Administrative Hearings

§10071. General Provisions

A. Within 30 calendar days after receipt of the department's notice of violation or the notice of the results of an informal dispute resolution, the nurse aide may request an administrative hearing.

1. The request for an administrative hearing must be made in writing to the department's Division of Administrative Law or successor entity.

2. The request shall contain a statement setting forth the specific charges with which the nurse aide disagrees and the reasons for this disagreement.

3. Unless a timely and proper request is received by the Division of Administrative Law or successor entity, the findings of the department shall be considered a final and binding administrative determination.

a. Notification of the finding of abuse, neglect and/or misappropriation shall then be sent to the Nurse Aide Registry to be recorded.

B. When an administrative hearing is scheduled, the Division of Administrative Law or successor entity shall notify the nurse aide, his/her representative and the agency representative in writing.

1. The notice shall be mailed no later than 15 calendar days before the scheduled date of the administrative hearing and shall contain the:

a. date of the hearing;

b. time of the hearing; and

c. the place of the hearing.

C. The administrative hearing shall be conducted by an administrative law judge from the Division of Administrative Law or successor entity as authorized by the Administrative Procedure Act, R.S. 49:950 et seq., and according to the following procedures.

1. An audio recording of the hearing shall be made.

2. A transcript shall be prepared and reproduced at the request of a party to the hearing, provided he bears the cost of the copy of the transcript.

3. Testimony at the hearing shall be taken only under oath, affirmation or penalty of perjury.

4. Each party shall have the right to:

a. call and examine parties and witnesses;

b. introduce exhibits;

c. question opposing witnesses and parties on any matter relevant to the issue, even though the matter was not covered in the direct examination;

d. impeach any witness regardless of which party first called him to testify; and

e. rebut the evidence against him/her.

5. Any relevant evidence shall be admitted if it is the sort of evidence upon which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make the admission of such evidence improper over objection in civil or criminal actions.

a. Documentary evidence may be received in the form of copies or excerpts.

6. The administrative law judge may question any party or witness and may admit any relevant and material evidence.

7. Each party has the burden of proving whatever facts he/she must establish to sustain his/her position.

a. The burden of producing evidence to substantiate the written allegation(s) shall be on the department and the provider of services.

b. When the charge of abuse, neglect or misappropriation is substantiated, the nurse aide may not rest on the mere denial in his/her testimony and pleading(s) but must set forth specific facts and produce evidence to disprove or contest the charge(s).

D. Any party may appear, and be heard, at any appeals proceeding through an attorney or a designated representative. The representative shall have a written authorization to appear on behalf of the provider.

1. A person appearing in a representative capacity shall file a written notice of appearance on behalf of a provider identifying:

a. his/her name;

b. address;

c. telephone number; and

d. the party being represented.

E. At the conclusion of the administrative hearing, the administrative law judge shall:

1. take the matter under advisement; and

2. shall prepare a written proposed decision which will contain:

a. findings of fact;

b. a determination of the issues presented;

c. a citation of applicable policy and regulations; and

d. an order.

F. The written proposed decision is provided to the secretary of the department. The secretary may:

1. adopt the proposed decision;

2. reject the proposed decision based upon the record; or

3. remand the proposed decision to the administrative law judge to take additional evidence:

a. If the proposed decision is remanded, the administrative law judge shall submit a new proposed decision to the secretary.

G. The decision of the secretary shall be final and binding upon adoption, subject only to judicial review by the courts. A copy of the decision shall be mailed to the nurse aide at his/her last known address and to any representative thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2080 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1248 (May 2012).

§10073. Preliminary Conferences

A. Although not specifically required, the Division of Administrative Law or successor entity may schedule a preliminary conference. The purposes of the preliminary conference include, but are not limited to:

1. clarification, formulations and simplification of issues;

2. resolution of controversial matters;

3. exchange of documents and information;

4. stipulations of fact to avoid unnecessary introduction of evidence at the formal review;

5. the identification of witnesses; and

6. other matters as may aid disposition of the issues.

B. When the Division of Administrative Law or successor entity schedules a preliminary conference, all parties shall be notified in writing. The notice shall direct any parties and their attorneys to appear on a specific date and at a specific time and place.

C. When the preliminary conference resolves all or some of the matters in controversy, a summary of the findings agreed to at the conference shall be provided by the administrative law judge. When the preliminary conference does not resolve all of the matters in controversy, an administrative hearing shall be scheduled on those matters still in controversy.

1. The hearing shall be scheduled within 30 calendar days following the completion of the preliminary conference or at a time mutually convenient to all parties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2081 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1248 (May 2012).

§10075. Witnesses and Subpoenas

A. Each party shall arrange for the presence of their witnesses at the hearing.

B. A subpoena to compel the attendance of a witness may be issued by the administrative law judge:

1. upon written request by a party and a showing of the need for such action; or

2. on his own motion.

C. An application for subpoena duces tecum for the production by a witness of books, papers, correspondence, memoranda or other records shall be made in writing to the administrative law judge. The written application shall:

1. give the name and address of the person or entity upon whom the subpoena is to be served;

2. precisely describe the material that is desired to be produced;

3. state the materiality thereof to the issue involved in the proceeding; and

4. include a statement that, to the best of the applicant's knowledge, the witness has such items in his possession or under his control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2081 (November 2006).

§10077. Continuances or Further Hearings

A. The administrative law judge may continue a hearing to another time or place, or order a further hearing on his own motion or at the request of any party who shows good cause.

B. Where the administrative law judge, at his/her discretion, determines that additional evidence is necessary for the proper determination of the case, he/she may:

1. continue the hearing to a later date and order the party(s) to produce additional evidence; or

2. close the hearing and hold the record open in order to permit the introduction of additional documentary evidence:

a. any evidence submitted shall be made available to both parties and each party shall have the opportunity for rebuttal.

C. Written notice of the time and place of a continued or further hearing shall be given. When a continuance of further hearing is ordered during an administrative hearing, oral notice of the time and place of the continued hearing may be given to each party present.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2081 (November 2006).

§10079. Failure to Appear at Administrative Hearings

A. If a nurse aide fails to appear at an administrative hearing, a notice/letter of abandonment may be issued by the Division of Administrative Law or successor entity dismissing the appeal. A copy of the notice shall be mailed to each party.

B. Any dismissal may be rescinded upon order of the Division of Administrative Law or successor entity if the nurse aide:

1. makes written application within 10 calendar days after the mailing of the dismissal notice; and

2. provides evidence of good cause for his/her failure to appear at the hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and P.L. 100-203.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2081 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1248 (May 2012).

Subchapter G. Medication Attendant Certified

§10080. Definitions

Abuse—

1. the willful infliction of injury;

2. unreasonable confinement;

3. intimidation; or

4. punishment with resulting physical harm, pain, or mental anguish.

Department—the Louisiana Department of Health (LDH).

LBP—the Louisiana Board of Pharmacy.

LSBN—the Louisiana State Board of Nursing.

LSBPNE—the Louisiana State Board of Practical Nurse Examiners.

Licensed Nurse—a licensed registered nurse or a licensed practical nurse or a RN or LPN practicing in the state under a multistate license from a compact state with a privilege to practice (PTP) in Louisiana in accordance with applicable state statutes and regulations.

Licensed Practical Nurse—a person licensed by the LSBPNE to practice practical nursing in Louisiana or a RN or LPN practicing in the state under a multistate license from a compact state with a PTP in Louisiana.

Medication Attendant Certified (MAC)—a person certified by LDH to administer medications to nursing facility residents, hereafter referred to as a MAC.

Nurse Aide—an individual who has completed a nurse aide training and competency evaluation program (NATCEP) approved by the state as meeting the requirements of 42 Code of Federal Regulations (CFR), §§483.151-483.154, or has been determined competent as provided in 42 CFR, §483.150(a) and (b), and is listed as certified and in good standing on Louisiana's nurse aide registry.

Nursing Facility—an institution licensed pursuant to R.S. 40:2009.1-2009.10.

Nursing Home—an institution licensed pursuant to R.S. 40:2009.1-2009.10.

Registered Nurse (RN)—a person licensed by the LSBN to practice professional nursing in Louisiana or practicing in Louisiana under a PTP.

Registered Pharmacist—an individual currently licensed by the Louisiana Board of Pharmacy to practice pharmacy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1413 (July 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 46:29 (January 2020).

§10081. General Provisions

A. The Department of Health (LDH) establishes provisions for the use of medication attendants certified (MACs) in licensed nursing facilities. The department shall maintain a registry of individuals who have, at a minimum, successfully:

1. completed a state-approved MAC training course;

2. passed a competency evaluation administered by a state-approved testing source; and

3. passed drug screening/testing and a statewide criminal background/security check conducted by the Louisiana State Police, or its designee.

B. The MAC registry shall contain the following items:

1. a list of individuals who have successfully completed an approved MAC training curriculum and competency evaluation. Each individual listed shall have the following information maintained on the registry:

a. name;

b. address;

c. Social Security number;

d. telephone number;

e. place of employment;

f. date of employment;

g. date employment ceased;

h. state issued certification number;

i. documentation of any investigation, if applicable, including findings of:

i. abuse;

ii. neglect;

iii. extortion;

iv. exploitation and misappropriation of property; and

v. an accurate summary of findings after action on findings are final and after any appeal is ruled upon or the deadline for filing an appeal has expired;

j. information relative to training and registry status which will be available through procedures established by the department; and

k. a current, monitored e-mail address.

C. Registry. Employers shall use the registry to determine if a prospective hire is a MAC and if there is a finding that he/she has abused or neglected an individual being supported or misappropriated the individual's property or funds.

D. Change of Information. A certificate holder shall notify the department as soon as possible but no later than 30 days after changing his or her address, telephone number, e-mail address, or name.

E. Arrest. A MAC, or his or her employer, if aware, shall immediately notify the department of any arrest in any state.

F. Reciprocity. A person who holds a valid license, registration or certificate as a medication attendant issued by another state shall also be certified in Louisiana if the transferring state's training program is at least 120 hours or more and the applicant passes the state-approved MAC competency examination.

1. The applicant shall submit a request for reciprocity to the registry.

2. The application shall include a certified copy of the license or certificate for which the reciprocal certificate is requested.

3. The department shall contact the issuing agency to verify the applicant's status with the agency.

G. When issued, an initial certificate shall be valid for 12 months from the date of issue. The registry will renew the certificate if:

1. a certificate holder has completed four hours of state-approved continuing education administered by an approved institution focusing on medication administration prior to expiration of the certificate; and

2. a certificate holder has worked at least 400 hours per year in a licensed nursing facility.

H. Denial of Renewal. The department shall deny renewal of the certificate of a MAC who is in violation of this Chapter at the time of the application renewal.

I. A person whose certificate has expired shall not engage in activities that require a certificate until the certificate has been renewed.

J. A MAC shall function under the direct supervision of a licensed registered or practical nurse on duty at the nursing facility. Although the performance of selected medication administration tasks are delegated to the MAC by the registered nurse, the registered nurse retains the accountability for the total nursing care of the resident, regardless of whether the care is provided solely by the registered nurse or by the registered nurse in conjunction with other licensed or unlicensed assistive personnel. The MAC shall:

1. function in accordance with applicable laws and rules relating to administration of medication and operation of a nursing facility; and

2. comply with the department's rules applicable to such personnel used in a nursing facility.

K. Persons employed as MACs in a nursing facility shall comply with the requirements relating to nurse aides as set forth in the Omnibus Budget Reconciliation Act of 1987, Public Law 100-203 and minimum licensure standards for nursing facilities or subsequent amendments. Requirements are met if the individual is:

1. a student enrolled in an accredited school of practical nursing or program for the education of vocational nurses who is administering medications as part of the student's clinical experience; or

2. a trainee in a medication assistant training program approved by the department under this Chapter who is administering medications as part of the trainee's clinical experience.

L. Restriction. While on duty, a MAC's sole function shall be to administer medications to residents. Persons employed as medication attendants in a nursing facility may not be assigned additional responsibilities. If medication administration has been completed, they may assist in other areas.

M. Nursing facilities may count the MAC in required nursing hours.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1413 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1248 (May 2012), repromulgated LR 38:1412 (June 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:30 (January 2020).

§10082. General Requirements

A. Prior to application for a certificate under this Chapter, all persons shall:

1. be proficient in reading, writing, speaking, and understanding the English language at a minimum eighth grade level as evidenced by the MAC training program's required entry placement test scores.

2. be a citizen of the United States or a legal alien with appropriate documentation from the U.S. Department of Homeland Security;

3. be at least 18 years of age;

4. complete a required health and physical examination;

5. be a graduate of high school or have a general equivalency diploma;

6. be currently employed in a facility as a certified nurse aide (CNA) on the first official day of an applicant's medication attendant training program or be a graduate of a nursing program;

7. have a minimum of one year experience in a nursing home as a CNA or be a graduate of a nursing program; and

8. successfully pass a statewide criminal background/security check conducted by the State Police, or its designee, within 90 days of an applicant starting the MAC program and be free of abused substances as evidenced by periodic drug testing in accordance with the NF's policies and procedures. Verification of these resultsmust be received by the training entity, documented, and maintained in the personnel file.

B. A MAC may not administer medication to a resident in a nursing facility unless he/she:

1. holds a current certificate issued by the department under this Chapter and acts under the supervision of a person who holds a current license under state law which authorizes the licensee to administer medication; or

2. is currently enrolled in a state approved training course and is acting under the direct supervision of faculty.

C. All medication attendant training and competency evaluation programs must be approved by the department.

D. Each training and competency evaluation program shall:

1. maintain qualified, approved registered nurses and licensed practical nurses for classroom and clinical instruction;

2. protect the integrity of the competency evaluations by keeping them secure;

3. utilize a pass rate of at least 80 percent for each individual student; and

4. assure the curriculum meets state requirements.

E. Clinical instruction shall be conducted in an approved nursing facility with a ratio of no more than 5:1 under the direct supervision of the instructor.

F. Training programs that do not meet the minimum standards and cannot provide an acceptable plan for correcting deficiencies shall be eliminated from participation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1414 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1249 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:30 (January 2020).

§10083. Coordinators, Instructors, and Trainers

A. Program Coordinator. Every MAC training program shall have a program coordinator who provides general supervision of the training received by the MAC trainees.

1. The program coordinator shall be a registered nurse (RN) and shall have the following experience and qualifications:

a. a minimum of two years of nursing experience, of which at least one year must be in caring for the elderly or chronically ill, obtained through employment in any of the following:

i. a nursing facility/unit;

ii. a geriatrics department;

iii. a chronic care hospital;

iv. other long-term care setting; or

v. experience in varied responsibilities including, but not limited to, direct resident care or supervision and staff education; and

b. completion of Vocational Trade and Industrial Education (VTIE) or Career and Technical Trade and Industrial Education (CTTIE) licensure, "train the trainer" type program, or a master's degree or higher.

2. The program coordinator shall supervise no more than two MAC training programs simultaneously and shall be on the premises where the program is being conducted for at least 50 percent of the duration of the program.

B. Instructors. Instructors shall be RNs or LPNs in a ratio such that not less than 50 percent of the instructors are RNs and shall hold a current, unencumbered Louisiana nursing license or PTP. Licensed practical (vocational) nurses, under the direct supervision of the coordinator, may provide classroom and clinical skills instruction and supervision of trainees if they have two years of experience in caring for the elderly and/or chronically ill of any age or have equivalent experience.

1. Such experience may be obtained through employment in:

a. a nursing facility;

b. a geriatrics department;

c. a chronic care hospital; or

d. another long-term care setting.

2. Experience in resident care, supervision and staff education is preferred.

3. The ratio of instructors to trainees in clinical training shall not exceed 1:5 and the ratio of instructors to trainees in the classroom shall not exceed 1:15.

C. Program Trainers. Qualified resource personnel from the health field may participate as program trainers as needed for discussion or demonstration of specialized medication procedures.

1. Qualified resource personnel shall have a minimum of one year of experience in their health care field and shall be licensed, registered and/or certified, if applicable, and may include:

a. registered nurses;

b. licensed practical/vocational nurses;

c. pharmacists;

d. dietitians;

e. nursing home administrators;

f. gerontologists;

g. physical therapists and occupational therapists;

h. activities specialists; and

i. speech/language/hearing therapists.

2. All program trainers shall have a minimum of one year of current experience in caring for the elderly and/or chronically ill of any age or have equivalent experience.

3. The training program may utilize other persons such as residents, experienced aides, and ombudsmen as resource personnel if these persons are needed to meet the planned program objectives or a specific unit of training.

D. Trainees

1. Each medication attendant trainee shall be clearly identified as a trainee during all clinical portions of the training. Identification should be recognizable to residents, family members, visitors and staff.

2. Trainees shall take the competency evaluation (through skills demonstration and written examination) within 30 days after completion of the training program. Trainees will be given a maximum of two opportunities within 90 days following completion of the training program to successfully complete the competency evaluation program.

3. If a trainee fails to successfully complete the competency evaluation program, he or she shall re-enroll in a training program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1415 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1249 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:31 (January 2020).

§10084. Training Curriculum

A. The goal of the medication attendant training and competency evaluation program is the provision of safe, effective and timely administration of medication to residents by medication attendants who are able to:

1. communicate and interact competently on a one-to-one basis with residents as part of the team implementing resident care;

2. demonstrate sensitivity to the resident's emotional, social and mental health needs through skillful, directed interactions;

3. exhibit behavior to support and promote the rights of residents; and

4. demonstrate proficiency in the skills related to medication administration.

B. Each medication attendant training program shall provide all trainees with a nursing facility orientation that is not included in the required minimum 120 hours of core curriculum. The orientation program shall include, but is not limited to:

1. an explanation of the facility's organizational structure;

2. the facility's policies and procedures;

3. discussion of the facility's philosophy of care;

4. a description of the resident population; and

5. employee policies and procedures.

C. Core Curriculum. The curriculum content for the training program must include material which provides a basic level of knowledge and demonstrable skills for each individual completing the program. The content should include the needs of populations which may be served by an individual nursing facility.

1. The core curriculum shall be a minimum of 120 hours in length with a minimum of 45 clinical hours.

2. Each unit objective shall be behaviorally-stated for each topic of instruction. Each objective must state performance criteria which are measurable and will serve as the basis for the competency evaluation.

D. Minimum Curriculum. The training program shall be developed and conducted to ensure that each medication attendant, at a minimum, is able to demonstrate competency in the following areas including, but not limited to:

1. the basic principles of medication administration and the responsibilities of the medication attendant including:

a. the role and functions of a MAC;

b. the professional relationship between the MAC and the residents and their families; and

c. prohibited functions or duties;

2. definition of nurse delegation;

3. definition of the basic terms used in medication administration, including identification of the abbreviations

used in medication orders and on the medication administration records;

4. review of the various forms of medications;

5. methods of medication administration including:

a. proper positioning of resident for various medication administrations; and

b. the value of good body alignment prior to and after medication administration;

6. requirements for proper storage and security of medications;

7. proper methods for disposal of drugs;

8. infection control;

9. basic anatomy and physiology;

10. the functions of the gastrointestinal, musculoskeletal, integumentary, nervous, sensory, renal and urinary, reproductive, cardiovascular, respiratory, and endocrine systems;

a. description of the common disorders associated with these systems; and

b. the effect of aging on these systems;

11. definition of pharmacology including:

a. medication classifications,

b. a description of a controlled drug and how administration of these drugs differ;

c. the cycle of a drug in the body; and

d. side effects of medications;

12. the safe administration of all forms of oral medication including;

a. a description of the difference among all forms of oral medication; and

b. special precautions observed when administering timed-release capsules, enteric-coated tablets and oral suspensions;

13. appropriate procedures to follow when the resident is NPO “nothing by mouth”, dysphagic, refuses the medication, vomits the medication, or has allergies;

14. application of topical medications and the standard precautions utilized in administering a topical medication;

15. the safe instillation of ophthalmic drops and ointments;

16. the safe administration of nose drops;

17. proper technique for administration of inhalant medications including:

a. a description of when the MAC may administer an inhalant;

18. the safe administration of a rectal suppository;

19. the safe administration of a vaginal medication;

20. developing proficiency in measuring liquid medications in a medicine cup or syringe;

21. measuring apical pulse and/or blood pressure (B/P) prior to medication administration;

22. the importance of the "chain of command;"

23. developing effective communication and interpersonal skills;

24. maintaining communication with the licensed nurse including:

a. a description of the situations that must be reported to the nurse;

25. the purpose of the clinical record and the importance of timely, clear and complete documentation in the medication administration record;

26. methods for avoiding medication errors:

a. reporting and documentation requirements when medication errors occur;

27. a resident's rights related to medication administration;

28. a discussion of the "rights" of medication administration;

29. the application and certification; and

30. violations of the laws and rules that may result in disciplinary action and/or loss of certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1415 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1250 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:31 (January 2020).

§10085. Competency Evaluation

A. A competency evaluation shall be developed by the training entity and conducted to ensure that each trainee, at a minimum, is able to demonstrate competencies taught in each part of the training curriculum.

B. Written examinations shall be provided by the training entity or organizations approved by the department. The examination shall reflect the content and emphasis of the training curriculum and will be developed in accordance with accepted educational principles.

C. The entity responsible for the training and competency evaluation shall report to the registry the names of all individuals who have satisfactorily completed the curriculum after the training is completed. Within 15 days after a MAC has successfully completed the training and competency evaluation, the training entity shall notify the registry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1416 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1250 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:32 (January 2020).

§10086. Authorized Duties

A. The MAC may perform certain duties and functions under the direct supervision of a licensed nurse. These authorized duties shall apply to medication attendant trainees under the supervision of the clinical instructor. The ratio of MACs to licensed nurses shall not exceed two medication attendants to one licensed nurse at any given time.

B. MACs may:

1. observe and report to the licensed nurse a resident's adverse reaction to a medication;

2. administer medications which require vital signs only with direct authorization from the licensed nurse prior to administration;

3. take and record vital signs prior to the administration of medication that could affect or change the vital signs;

4. in an emergency only, administer oxygen at 2 liters per minute per nasal cannula and immediately after the emergency, verbally notify the licensed nurse on duty and appropriately document the action and notification;

5. administer regularly prescribed medication only after personally preparing (setting up) the medications to be administered;

6. deliver and administer certain prescribed medications ordered by an authorized prescriber by the following methods:

a. orally;

b. topically (to intact skin only);

c. drops and sprays for the eye, ear or nose;

d. vaginally;

e. rectally;

f. transdermally;

g. by metered dose oral inhalation; or

h. sublingually;

7. record medications administered in the resident's chart and/or medication administration record;

8. chart medication effects and side effects;

9. administer medications which require vital signs, only with direct authorization from the licensed nurse prior to administration:

a. the results of the vital signs must be documented in the clinical record;

10. administer pro re nata (prn), as needed medications only with direct authorization of the licensed nurse;

11. measure prescribed liquid medication only if verified by the licensed nurse prior to administration; and

12. crush prescribed medications only if ordered by the physician and verified by the licensed nurse.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1416 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1250 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:32 (January 2020).

§10087. Prohibited Duties

A. Medication attendants certified shall not:

1. administer any controlled dangerous substances (schedules II through V) as set forth by the Drug Enforcement Agency or the Louisiana Board of Pharmacy;

2. administer any medications by the following parenteral routes:

a. intramuscular;

b. intravenous;

c. subcutaneous;

d. intradermal; or

e. other routes restricted in department rules;

3. administer any medication used for intermittent positive pressure breathing (IPPB) treatments;

4. administer an initial dose of a medication that has not been previously administered to a resident as determined by the clinical record;

5. calculate medication doses for administration;

6. administer medications or feedings by way of a tube inserted in a cavity of the body;

7. receive or assume responsibility for writing any verbal or telephone order from an authorized prescriber;

8. order new medications or medications whose directions have changed from the pharmacy;

9. apply topical medications that involve the treatment of skin that is broken;

10. steal, divert or otherwise misuse medication;

11. violate any provision of this Chapter;

12. procure or attempt to procure a certificate by fraudulent means;

13. neglect to administer prescribed medications in a responsible and timely manner;

14. perform a task involving the administration of a medication which requires:

a. an assessment of the patient's physical status;

b. an assessment of the need for the medication;

c. a calculation of the dose of the medication; or

d. the conversion of the dose;

15. perform a task involving the administration of a medication if the patient is unstable or has changing nursing needs, unless the supervising nurse is able to monitor the patient and the effect of the medication on the patient; or

16. administer medications if he/she is unable to do so with reasonable skill and safety to the resident if the resident is impaired by reason of excessive use of mood altering drugs, narcotics, chemicals or any other type of material.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1416 (July 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 46:32 (January 2020).

§10088. Provider Participation and Responsibilities

A. A nursing facility with a license that is in good standing with the department may apply to the department to utilize MACs. Upon receipt of a facility's application, the department shall review the facility's compliance history.

B. If a facility is non-compliant with program regulations, the department shall take into consideration the findings that resulted in the facility's noncompliance before making a determination whether or not to allow the facility to utilize MACs. Emphasis shall be placed on deficiencies cited in the area of medication administration such as significant medication errors, medication error rates and repeat deficiencies of such.

C. The department may deny a facility's request to use MACs if it is determined that, based upon the compliance history, the safety and well-being of residents would be jeopardized. If the facility is denied participation, the facility may ask for a reconsideration and review of the circumstances which contributed to the denial of the application.

D. The following information shall be provided prior to acceptance in the program:

1. the number of beds for the entire nursing facility and beds per unit;

2. the type of nursing facility;

3. the plan for orientation and utilization of MACs, including orientation of all staff to the role of MACs;

4. the number and type of medication errors in the year prior to the utilization of MACs; and

5. a statement that the nursing facility will utilize the MACs in accordance with the department's rules and regulation and will provide evaluation information as indicated.

E. A facility's application that is not complete within 90 days of receipt by the department shall be considered null and void.

F. The department may sanction a facility and/or revoke a facility's participation in the MAC program if it is determined by the department that, based upon the facility's compliance history, the safety and well-being of residents is jeopardized by the facility's non-compliance with licensing standards. If the facility's participation is revoked, the facility may ask for a reconsideration and review of the circumstances which contributed to the revocation of participation in the MAC program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1417 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1250 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:32 (January 2020).

§10089. Allegations of Medication Attendant Certified Wrong-Doing

A. The department, through its Division of Administrative Law or successor entity, has provided for a process of the review and investigation of all allegations of resident abuse, neglect or misappropriation of residents' property or funds by MACs.

B. In the event of an allegation of wrong-doing, MACs shall be bound by the department's established:

1. reporting requirements;

2. informal dispute resolution policies; and

3. appeal and administrative hearing provisions:

a. the formal hearing shall be conducted according to formal hearing procedures set forth in the Administrative Procedure Act.

C. Through the formal hearing process, determinations will be made on both the certificate for medication attendant and the certificate for nurse aide practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1417 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1250 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:33 (January 2020).

§10090. Suspension, Revocation or Denial of Renewal

A. The department may revoke, suspend or deny renewal of a certificate or reprimand a certificate holder for a violation of this Chapter.

B. The following are grounds for disciplinary actions:

1. stealing, diverting or otherwise misusing medication;

2. procuring or attempting to procure a certificate by fraudulent means; or

3. violating any provision of this Chapter.

C. Prior to institution of formal proceedings to revoke or suspend a certificate, the department shall give written notice to the certificate holder of the facts or conduct alleged to warrant revocation, suspension or rescission. The certificate holder shall be given an opportunity to participate in an informal dispute resolution process.

D. If denial, revocation or suspension of a certificate is proposed, the department shall give written notice that the certificate holder must submit a written request for a formal hearing within 30 days of receipt of the notice. If not, the right to a hearing shall be waived and the certificate shall be denied, revoked or suspended.

E. If the department suspends a MAC's certificate, the suspension shall remain in effect until the department:

1. determines that the reason for suspension no longer exists;

2. revokes the certificate; or

3. determines not to renew the certificate.

F. The department shall investigate prior to making a final determination on a suspended certificate. During the time of suspension, the suspended certificate holder shall return his certificate to the department.

1. If a suspension overlaps a certificate renewal date, the suspended certificate holder shall be subject to the renewal procedures pursuant to the provisions of this Subchapter. However, the department shall not renew the certificate until it determines that the reason for suspension no longer exists.

G. If the department revokes or denies renewal of a certificate, a person may reapply for a certificate by complying with the provisions of this Chapter at the time of reapplication. The department may refuse to issue a certificate if the reason for revocation or denial of renewal continues to exist.

1. If a certificate is revoked or denied renewal, the certificate holder shall immediately return the certificate to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1417 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1250 (May 2012), amended by the Department ofHealth, Bureau of Health Services Financing, LR 46:33 (January 2020).

Title 48
PUBLIC HEALTH—GENERAL
Part I. General Administration
Subpart 5. Health Planning

Chapter 101. Introduction

§10101. Introduction

A. This health planning document was first developed in 1980. Since that time it has been revised periodically to reflect changing conditions in the state. It is, then, a document in transition. In its current form, it contains health need priorities which were first developed for the 1982-87 State Health Plan, but were extensively revised in 1986 with input from 1,576 state, parish and local organizations representing public, private, voluntary and professional organizations involved in the planning and delivery of health care. Resource goals contained in this document were also revised in 1986 and are, in fact, updated each year. An original feature of the State Health Plan, "Louisiana Medical Facilities Inventory," has not been retained, as the frequency of change in this inventory results in almost immediate obsolescence. To maintain a current inventory requires constant updating which is carried out by the Division of Policy, Planning and Evaluation. Current inventories are available from this source upon request.

B. This document is the result of a planning effort involving many agencies and organizations throughout Louisiana. It is intended to serve as a basis for policy decisions and actions of state government and other public and private entities concerned with health matters in the state. Most important, the plan reflects the policies, programs and priorities of the state of Louisiana in those areas which affect the health of the state's citizens and the system through which health needs are met.

C. The State Health Plan was produced by the Louisiana Statewide Health Coordinating Council with the support of the Division of Policy, Planning and Evaluation which performs the health planning functions mandated in P. L. 93-641 (as amended) for the Department of Health and Human Resources. It is not an authoritarian mandate to force changes in consumer or provider behavior. It is simply a document intended to promote a better understanding of the health problems of the people of Louisiana, to encourage dialogue among those who receive health services and those who provide them, and, hopefully, to develop agreements on what should be done to provide these services in as effective and efficient a manner as possible within the expected resource capabilities of the state.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256 (b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§10103. Background

A. Planning for health care is not new either to Louisiana or to the nation as a whole. Since the earliest days of our nation, federal and state governments have concerned themselves with matters affecting the health and welfare of the American people. However, this health planning activity has intensified dramatically in the recent past, more specifically since the 1960's. During this time, attention has been directed to health problems, health care patterns and attitudes, needed resources and other issues related to health care. This increased intensity of health planning activity brought with it the need for coordination of effort.

B. On January 4, 1975, President Ford signed into law the National Health Planning and Resources Development Act (P.L. 93-641), thereby bringing together in one package many of the federal government's concerns about health matters. The new law set up a hierarchy of planning efforts at the local, regional, state, and federal levels to stimulate needed changes in the financing, development, and organization of health resources and services. This program is administered by the United States Department of Health and Human Services.

C. P.L. 93-641 combines and redirects the efforts of a number of federally- supported state and local activities involved in the planning and development of health resources across the nation. Many of these programs go back many years and, despite some shortcomings, have contributed much to improving the availability of health services to the American people. A brief history of some of the more important of these past efforts is helpful to an understanding of the goals and aspirations of P.L. 93-641 and the directions and emphasis outlined in this planning document.

D. The Hill-Burton Act, passed by Congress in 1946, made available federal loans and grants for hospital construction to overcome shortages stemming from the depression of World War II years. Later amendments to the Act made similar funds available for nursing homes, rehabilitation and ambulatory care facilities, chronic disease hospitals, and the replacement and modernization of existing facilities. Under the Hill-Burton Program, the Louisiana State Department of Health and Human Resources developed and revised, on an annual basis, a State Facilities Plan. This Plan was used to develop priorities and objectives for the allocation of available federal funds for construction of health facilities throughout the state.

E. Additional federally-supported health planning activities began in 1964, when the Hill-Burton Act was amended to provide for federally recognized area-wide

health planning agencies. These area-wide agencies functioned on a voluntary basis and were expected to deal with broad based planning for health facilities in their areas. The program was essentially a reaction to the over-construction resulting from the Hill-Burton program. This legislation was replaced in 1966 by P. L. 92-603, the Comprehensive Health Planning Program (more commonly known as the "Partnership for Health Act").

F. This "Partnership for Health Act" broadened the area-wide planning concept to include health services and manpower development, as well as facilities construction. An important part of the Act was its emphasis on eliminating unnecessary duplication of health care facilities and equipment. The program established state agencies and local comprehensive health planning agencies to plan for and to promote the rational and orderly development of health resources and services in their respective areas.

G.. The Regional Medical Program, enacted in 1965, also had a planning component, but its primary focus was on the development of cooperative arrangements among health care institutions, medical schools, and research bodies as an essential first step in diffusing throughout the health care system the latest improvements in technology and knowledge for the treatment of heart disease, cancer, and stroke, then and now, the three leading killers of Americans. As the Program developed, its emphasis shifted from its original orientation on the three major disease groupings to more broadened concerns with the planning and development of health services. It was inevitable that many of its activities and programs paralleled those which the Partnership for Health (CHP) Program was attempting to carry out.

H. In 1971, the Experimental Health Services Delivery System (EHSDS) program was initiated. The EHSDS's were federally funded development efforts directed in a handful of designated states and communities. They were demonstrations of health services management systems under a local, public non-profit corporate structure. Emphasis was placed upon collection of data and the initiation of a management information system for health providers at the community level. These experimental efforts were found to be insufficiently structured to avoid some overlap and supplication of the RMP and CHP efforts.

I. In 1972, the Social Security Act was amended to include Section 1122 of the Act. This Section allowed the Federal government to withhold Medicare and Medicaid reimbursements to a hospital or other type of health care facility for any of the facility's capital expenditures totaling over $100,000 unless a designated state health planning agency (the CHP "a" agency of the state) had given its prior approval. This 1972 amendment to the Social Security Act was utilized in many areas of the nation to discourage unneeded facilities and duplication of services.

J. Despite all this activity and interest, it became increasingly evident to concerned individuals and groups, both in and out of government, that all was not well in the health field: costs of health services had been rising rapidly; health resources were, in many instances, limited or lacking and often inappropriately or inefficiently utilized; and the quality of services did not always meet acceptable standards, particularly in areas where health resources were often most limited. But it was also becoming increasingly evident that the major constraint to improving health services was economic. It was these concerns that led to the enactment of P.L. 93-641. And it is the provisions of this law that have given rise to the preparation f this health plan for Louisiana and to the accomplishments that promise to follow from it.

K. An important provision of P.L. 93-641 was the establishment of a network of local health systems agencies (HAS's) throughout the United States. In Louisiana, three agencies were designated as HAS's and began local planning efforts in 1976. However, in 1981, congress modified section 1536 of the Act, permitting governors to request that mandated health planning functions be conducted at the state level only, with the assurance that local input into the state health planning process would be maintained. In December, 1981, Governor David Treen elected to exercise this option for the state of Louisiana. The secretary of the Department of Health and Human Services granted this request and, effective April 30, 1982, the State Health Planning and Development Agency was designated to carry out health planning functions in Louisiana.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§10105. Statutory Authority

A. Public Law 93-641, the National Health Planning and Development Act of 1974 amends the Public Health Services Act in order to assure the development of a national health policy and effective state and area health planning and resource development programs.

B. Public Law 93-641 states that:

1. "The achievement of equal access to quality health care at a reasonable cost is a priority of the federal government. The massive infusion of federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources. The many and increasing responses to these problems by the public sector on federal, state, and local levels and the private sector have not resulted in a comprehensive, rational approach to the present [specifically there is:]

a. lack of uniformly effective methods of delivering health care;

b. maldistribution of health care facilities and manpower; and

c. increasing cost of health care.

2. Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of

appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care. Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels. Large segments of the public are lacking in basic knowledge regarding proper health care and methods of effective use of available health services."

C. In recognition of the magnitude of the problems described in the law and the urgency placed upon their solution, it is the purpose of the National Health Planning and Resources Development Act of 1974 to facilitate the development of recommendations for a national health planning policy; to augment areawide and state planning for health services, manpower, and facilities; and to authorize financial assistance for the development of resources to further that policy.

D. The Act also requires the designation of a State Health Planning and Development Agency to perform within each state the health planning and development function prescribed by the Act; and stipulates that the designated State Health Planning and Development Agency be advised by a Statewide Health Coordinating Council.

E. Governor's Executive Order No. 79-02 of 1979 designated the Department of Health and Human Resources as the State Health Planning and Development Agency (SHPDA). This agency is organizationally located in the Division of Policy, Planning and Evaluation of the Office of Management and Finance within the Department of Health and Human Resources.

F. The governor also authorized the creation and establishment of the Statewide Health Coordinating Council in conformance with regulations published by the secretary of the Department of Health and Human Services. The Louisiana Statewide Health Coordinating Council is comprised of 31 persons, 30 of whom are appointed by the governor, and is inclusive of consumers and providers of health care and governmental officials. Membership composition should reflect the geographic and racial composition of the state as a whole.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§10107. Purposes of the Plan

A. Consistent with the nature of any plan, this document reflects present conditions, desired future conditions, and the means, resources, and strategies required to progress from the present conditions to the desired future conditions. Expressed in terms of health planning, this document sets forth the present health status and relevant demographics of Louisiana, existing health related policies and resources, desired health related goals, the prioritization of these goals, and the actions that must be taken in order to achieve these goals. It is best viewed as an instrument for bridging the gap between what exists today and what is desired in the future in areas affecting the health of Louisiana.

B. More specifically, the purposes of this State Health Plan are:

1. to develop and articulate the Louisiana State Government's health and health-related policies, programs, priorities, and goals;

2. to serve as an instrument for guiding state and federal resource allocations to meet existing and emerging state health needs and priorities;

3. to encourage the development of a coordinated approach to the identification and resolution of health problems throughout the state;

4. to guide the Louisiana State Health Planning and Development Agency and the Louisiana State Health Coordinating Council in carrying out mandated functions; and,

5. to promote needed changes in the provision of health services, in the development of health facilities, and in the supply and distribution of health manpower throughout the State of Louisiana.

C. Finally, the Plan is also intended to serve as a convenient source of information for guiding the decisions and actions of organizations and individuals concerned with planning, financing, and regulating health services in Louisiana or with providing or administering these services.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R. S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

Chapter 103. Overview of the State

Subchapter A. Physical Description

§10301. Geographic and Climatic Characteristics

A. Louisiana lies at the south end of the Mississippi River Valley, and with the exception of Florida and Texas, extends farther south than any other continental state in the United States. The state is bounded on the north by Arkansas, on the west by the Sabine river and Texas, on the east by the Pearl and Mississippi rivers and the state of Mississippi, and on the south by the Gulf of Mexico.

B. Louisiana ranks 31st in land size among the 50 states with 48,523 square miles of land and water. Over 4,000 square miles of this total area are water-3,500 square miles in lakes and 650 square miles in rivers, bayous, and streams. The state measures nearly 300 miles, at its widest part, from east to west, and about 275 miles from north to south. Diagonally, from the northwestern corner of Caddo parish to the mouth of the Mississippi, the distance is approximately 400 airline miles.

C. There is wide variation in land elevation and in soil types in Louisiana. The lowlands include plains along the

gulf coast, southwestern prairies, and land along major rivers. Rolling, hilly areas of the northwest and southwest are called the uplands.

D. There are three sections of Louisiana uplands, which range in altitude from lower levels of one hundred feet to higher levels of over 500 feet. The Florida parishes uplands lie east of the Mississippi river and north of Lake Pontchartrain. This area slopes from north to south and averages about 200 feet in altitude.

E. The uplands in the north and northwest sections of the state lie roughly between the Red and Ouachita river valleys. There are points in this area that reach over 500 feet. The west Louisiana uplands lie west of the Red river and north and northeast of the Calcasieu river. The entire area is crisscrossed with bluffs and ravines.

F. The lowland areas have an elevation normally less than 50 feet above sea level. This area may also be divided into three sections. The gulf coastal plain lies west of the Atchafalaya river. Coastal marshes of this area are protected from the Gulf of Mexico by beaches, composed of sand and soil held together by undergrowth and a few trees. The Mississippi river plain is narrow in the north, but widens as one moves southward. Higher portions of this plain are called frontlands, then backlands, and finally swamps. Throughout this area are numerous lakes, lagoons, and marshes. The third lowland area is the prairie section of southwest Louisiana. This section is fairly level, sparsely timbered, and cut by numerous streams and bayous.

G. The Mississippi is Louisiana's most important river and from the viewpoint of political history is the most important river of the Western Hemisphere. It has served to carry much of the inland commerce of the entire central portion of the United States.

H. The Red River is the second most important Louisiana waterway. Rising in northwestern Texas, it enters Louisiana near the northwestern corner of the state. It was an important water highway during the colonial period and greatly contributed to the economic and commercial life of the state.

I. At this time approximately 55 percent of the land area of the state is timberland. Furniture, lumber, and paper manufacture, all dependent on the state's forest resources, produce over 500 million dollars in revenue each year and employ over 40,000 workers.

J. An unusual combination of diversified natural resources occurs in Louisiana. Rich alluvial soils and a favorable climate produce a great variety of agricultural products and valuable forests; salt, sulfur, oil and natural gas are the primary mineral resources; lakes, rivers, and the Gulf provide fresh-water fish and seafood, as well as sand, gravel, and shells; game and fur-bearing animals abound.

K. Most of Louisiana has a semitropical climate. The average temperature is 60 degrees in the north and 71 degrees in the extreme southern part. Louisiana has frequent rains with the average yearly rainfall over 57.0 inches. But despite its rainfall, Louisiana is a "sunshine" state since over one-half of the days are sunny and warm. The growing season in the south is 320 days; in the north 220 days.

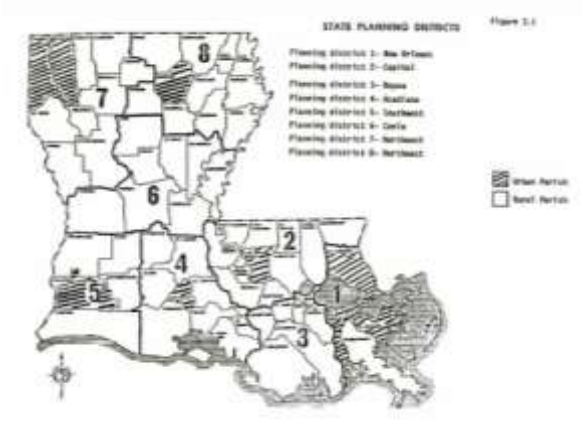
L. As with other coastal states, Louisiana has had its share of violent weather. Hurricanes form in the Caribbean Sea and the Gulf of Mexico, and such storms occasionally hit the coastal areas and carry for some distance inward.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance , LR 13:246 (April 1987).

§10303. Geographic Divisions for Planning

A. For governing purposes, Louisiana is divided into 64 parishes. In Executive Order 21, issued by the governor in February, 1973, eight planning regions were designated to be utilized by all state agencies for regional and local planning purposes. Figure 3.1 presents the eight planning regions.



B. The National Health Planning and Resources Development Act (P. L. 93-641) and its 1979 amendment (P. L. 96-79) require that health planning be done on a regional basis so that the peculiar and particular needs of relatively homogeneous geographical areas can be addressed. In Louisiana, a division of three health service areas was made which incorporated state planning districts one and three into health service area I; state planning districts two, four, and five into health service area II; and state planning districts six, seven, and eight into health service area III. See Figure 3.2.

Figure 3.2

I - New Orleans/Bayou-River Health System Area
II - Mid-Louisiana Health System Area
III - North Louisiana Health System Area

C. Section 1536 of the Health Planning and Development Act was modified in 1981 by Congress to permit governors to request that mandated health planning functions be conducted at the state level only. In December, 1981, the Secretary of the Department of Health and Human Services recognized Louisiana as a "1536 state," which effected the dismantling of the Health Systems Agency (HSA) Network in the state. Effective March 31, 1982, the Mid-Louisiana HSA ceased external operation, followed by the closure of the New Orleans/Bayou-River HSA and the North Louisiana HSA on April 30, 1982.

D. As a result of Louisiana's "1536" status, the Louisiana Health Planning and Development Agency must perform as though it is a health systems agency with the state being the health service area. However, local input must be included in the planning process.

E. In determining geographic health planning areas, it was found to now be advantageous to use nine health planning regions. Utilizing nine regions allows for a more logical geographic breakdown, consistent with the geographic/demographic characteristics of the state. Consequently, interpretation and analysis of data in this document will be made on the basis of nine Health Planning Areas (See map in Figure 3.1).

F. The ninth, planning region consists of St. Tammany, Tangipahoa and Washington parishes. This division appears to conform more closely to the natural regions of the state. It also reduces the undue influence of New Orleans bed resources on a population which must traverse a large lake to utilize health care services in the New Orleans area.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance , LR 13:246 (April 1987).

Subchapter B. Population Description

§10305. Population

A. The final population census of Louisiana as of April 1, 1980, was 4,205,991. This represents an increase of 561,334 or 15.4 percent over 1970 census figures. Population growth in the state was faster than expected and exceeded projections for the decade prepared in 1976 by the Division of Business and Economic Research at the University of New Orleans. In this earlier report, the Louisiana population projection for the year 2000 was 4,632,220. Revised projections will undoubtedly increase the year 2000 projection to nearly 5,500,000.

B. Louisiana's estimated population for 1985 is 4,527,545 as released by Vincent Maruggi and Paul Fletes of the University of New Orleans, in Population Projections for 1985. Population and its distribution are vital components of health planning since so many health service need indicators are based on average utilization patterns and prevalence rates which have been noted in defined segments of the general population. A great many of the health planning concepts presented in this document fall into the category of population-based planning. The 1985 population distribution as presented in Table 3.1 is the source of all planning projections which appear in this document, except where otherwise stated.

Table 3.1
Louisiana Population
1980, Percent Change from 1970 and 1990 Projections

	1990 Projections	1980	1970	Percent Change from 1970-1980
Louisiana	4,849,038	4,205,971	3,644,637	15.4%
Planning Districts				
1. New Orleans	1,331,661	1,171,436	1,008,110	16.2%
2. Capital	721,062	591,384	466,731	26.7%
3. Bayou	331,025	284,708	237,740	19.8%
4. Acadiana	547,825	476,339	469,721	1.4%
5. Southwest	293,849	259,809	226,845	14.5%
6. Cenla	393,875	356,241	287,305	24.0%
7. Northwest	530,544	471,632	488,695	-3.6%
8. Northeast	392,339	358,578	288,043	24.5%
9. Northshore	306,858	235,774	171,447	37.5%

Source: Population Projections for 1985 and 1990:
Vincent Maruggi and Paul Fletes
UNO - June 1983

C. In the decade from 1970 to 1980, the greatest population growth in the state occurred in the Northshore Health Planning District which grew in population by 37.5 percent. This district is composed of St. Tammany, Tangipahoa and Washington Parishes. The next largest increase occurred in the Capital Planning District which grew by 26.7 percent. The Acadiana District experienced the smallest increase in population of 1.4 percent. However, the Northwest District experienced a net loss in population of 3.6 percent, in part, a result of Lincoln parish being moved from the Northwest District into the Northeast District.

1. Projections for 1990 indicate the 1980 to 1990 decade will experience a similar growth in population as experienced in the previous decade (Population Projections to the year 2000). Projections indicate a 15.3 percent overall increase in the state's population. The Northshore district is projected to have the largest growth in population, a 30 percent increase, followed by a 22 percent increase in the Capital district. The Northwest district, which experienced a loss in population in the 1970-1980 decade, is projected to have a 12.5 percent growth in population. The Northeast district is projected to experience the smallest increase in population (9.4 percent).

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance LR 13:246 (April 1987).

§10307. Demographic Characteristics

A. Rural vs. Urban

1. In the last five years Louisiana has become an urban state. Eight geographic areas now meet the definition of a Metropolitan Statistical Area (MSA). The MSA's in Louisiana are listed in Figure 3.3.

Figure 3.3	
MSA	**Parish**
New Orleans-Orleans	
	Jefferson
	St. Tammany
	St. Bernard
	St. John
	St.Charles
Baton Rouge-East Baton Rouge	
	W. Baton Rouge
	Livingston
	Ascension
Shreveport-Caddo	
	Bossier
Lafayette-Lafayette	
	St. Martin
Houma-Thibodaux	
	Terrebonne
	Lafourche
Lake Charles-Calcasieu	
Monroe-Quachita	
Alexandria-Rapides	
Source: U.S. Department of Commerce, Bureau of the Census current Population Report (P-26 No 82-18-C, April 1984)	

2. Forty-five parishes meet the definition of rural. (See Figure 3.1). However, approximately 70 percent of the state's population reside in the state's eight MSA's according to 1985 estimates prepared by the U.S. Bureau of Census. The urban vs rural factor is important in health planning. Attempts must be made to assure that adequate emergency and primary health care services are available to residents of sparsely populated areas, while maintaining a cost effective and high quality health care system.

B. Per Capita Income

1. In 1983, Louisianians had a total personal income of nearly $45 billion dollars compared to $30.5 billion in 1979. While some areas of the state, particularly the southeastern portion of the state, experienced economic growth in the years between 1979 and 1983, Louisiana's per capita income remains far below the national average (see table 3.2).

2. In 1979, Louisiana's per capita income was 13.3 percent below that of the nation. In 1983, Louisiana's per capita income rose to $10,262 with the national average at $11,700. Thus, the difference in Louisiana's per capita income and that of the nation decreased to 12.3 percent in 1983.

3. According to the Division of Business Research at Louisiana State University the overall outlook suggests that the Louisiana economy will be restrained until the latter half of 1986. The State's unemployment rate of 13 percent is well above the national unemployment rate of 7 percent (Louisiana Labor Market Information, March 1986).

4. In 37 of the 64 parishes the per capita income is less than 75 percent of the national average. The poorer parishes are concentrated in the central and northern areas of the state. The parishes of the Cenla District have the lowest per capita income in the state with a per capita income of $7,789.

5. There are, however, five parishes that exceed the national average in per capita income: Lafayette, Jefferson, St. Charles, East Baton Rouge and St. Tammany (see Table 3.2).

Table 3.2 Per Capita Personal Income By District And Parish 1983			
Louisiana	$10,262	U.S.	$11,700
Planning District			
1. New Orleans	$11,675	6. Cenla	$ 7,789
Jefferson	12,449	776 miles	6,544
Orleans	11,271	Catahoula	6,980
Plaquemines	10,430	Concordia	8,766
St. Bernard	10,772	Grant	6,993
St. Charles	11,982	LaSalle	7,088
St. John	10,119	Natchitoches	7,498
Rapides	8,609		
2. Capital	$10,750	Vernon	7,360
Ascension	10,041	Winn	7,099
EBR	11,993		
E. Feliciana	7,398	7. Northwest	$10,133
Iberville	9,059	Bienvilie	8,376
Livingston	8,635	Bossier	9,639
Point Coupee	8,861	Caddo	11,370
St. Helena	6,338	Claiborne	8,589
WBR	9,331	DeSoto	8,660
W. Feliciana	6,252	Red River	7,054
		Sabine	5,933
3. Bayou	$10,122	Webster	9,289
Assumption	8,327		
Lafourche	9,943	8. Northeast	$ 8,246
St. James	10,663	Caldwell	6,930
St. Mary	10,658	E. Carroll	6,853
Terrebonne	10,230	Franklin	6,396

Table 3.2 Per Capita Personal Income By District And Parish 1983			
		Jackson	8,547
4. Acadiana	$ 9,313	Lincoln	8,971
Acadia	8,551	Madison	5,668
Evangeline	7,343	More House	7,828
Iberia	10,925	Ouachita	9,300
Lafayette	13,399	Richland	7,722
St. Landry	7,650	Tensas	7,242
St. Martin	8,116	Union	8,013
Vermilion	9,817	W. Carroll	6,105
5. Southwest	$ 9,749	9. Northshore	$ 9,676
Allen	6,950	St. Tammany	11,744
Beauregard	7,910	Tangipahoa	7,479
Calcasieu	10,679	Washington	8,035
Cameron	10,487		
Jeff Davis	8,197		

Source: "Survey of Current Business" April 1985: 52 Estimates of the Population of Louisiana Parishes, 1983, Bureau of the Census.

C. Poverty and Income Supports

1. Even though personal income in a few areas exceeds the national average, the state has a large population of low income residents who do not have sufficient income to meet the basic personal needs of household members. The extent to which this is true is revealed by data on the utilization of income support programs provided by the Offices of Family Security, Management and Finance, and Human Development. According to information obtained from these sources, approximately 230,672 of the state's 4,527,545 citizens received income assistance from the state in 1985 through the Aid to Families with Dependent Children program, at a cost of $12,970,920. State supplementation of the Federal Supplemental Security Income Program was paid to 8,046 persons at a cost of $76,293. Viet Nam and Cambodian Refugee Assistance was paid to 277 persons at a cost of $16,533. In 1985, 698 persons received general assistance at a cost of $61,757. Disaster Assistance to 1,492 persons cost the state $5,614,208 in 1985. The State Foster Care Program, including certified foster families, residential care and relative placements, served 5,603 persons in 1985 at a cost of $14,894,265. The total number of individuals supported totally or in part by these income maintenance programs in 1985 was over 246,000 or over 5 percent of the population. This does not include persons receiving employment related benefits, such as unemployment compensation or employee disability.

2. Recipients of income maintenance payments are also certified for Medicaid (Title XIX) benefits. In addition, the state provided Medicaid benefits to individuals found eligible for medical assistance on the basis of incurred medical costs which exceeded their resources (Medically Needy Program). In 1984, 316,581 individuals received benefits under the Medicaid program at a cost of $708,071,316.

3. Another income supplement program that is highly utilized by the citizens of the state is the Food Stamp Program. In 1985, approximately 215,442 households and 659,058 persons received food stamps at a cost of $32,125,082.

4. There is a large number of individuals at or below the poverty level who receive no benefits from income support programs. According to the Division of Policy, Planning and Evaluation, Research Bureau's 1984 Report, there are 216,405 families in Louisiana with incomes at or below the poverty level. Therefore, 19 percent of all Louisiana families have incomes at or below the poverty level, while 11.7 percent of all families in the U.S. have incomes at or below this level. Of the families in Louisiana with incomes at or below the poverty level, only 33.6 percent receive AFDC according to DPPE statistics. In looking at the U.S. as a whole, 51.5 percent of the families in poverty receive AFDC. These figures indicate that Louisiana has a significantly greater percentage of families with incomes at or below the poverty level than does the nation. However, the state provides income support to 18 percent fewer of its poor than does the nation.

5. Poverty areas are defined by the Bureau of Census as a census tract, a census parish division or a minor civil division in which 20 percent or more of the Poverty areas have incomes below the poverty level. Table 3.3 shows the proportions of parishes in which the percent of families with income less than poverty level exceeds 20.0 percent. There are 25 such parishes, according to 1980 census data.

Table 3.3 Proportion of Parishes in Which the Percent of Families with Income Less Than Poverty Level Exceeds 20.0x (1980) Louisiana			
Planning Districts			
1. New Orleans	1/6	6. Cenla	5/9
Jefferson	7.8%	Avoyelles	25.6%
Orleans	21.8%	Catahoula	25.8%
Plaquemines	12.2%	Concordia	21.7%
St. Bernard	7.4%	Grant	18.3%
St. Charles	11.9%	LaSalle	17.2%
St. John	12.1%	Natchitoches	21.8%
Rapides	15.4%		
2. Capital 3/9		Vernon	15.8%
Ascension	12.4%	Winn	21.6%
EBR	11.7%		
E. Feliciana	17.7%	7. Northwest	4/8
Iberville	18.7%	Bienville	20.9%
Livingston	11.3%	Bossier	10.2%
Point Coupee	23.1%	Caddo	13.1%
St. Helena	28.2%	Claiborne	20.9%
WBR	15.6%	DeSoto	20.3%
W. Feliciana	27.7%	Red River	22.8%
Sabine	18.9%	Webster	15.6%
3. Bayou	0/5		
Assumption	17.7%		
Lafourche	11.0%	8. Northeast	8/12
St. James	14.5%	Caldwell	21%
St. Mary	12.6%	E. Carroll	34.5%
Terrebonne	11.4%	Franklin	25.3%
4. Acadiana	2/7	Jackson	18.9%
Acadia	18.6%	Lincoln	14.7%
Evangeline	25.8%	Madison	32.9%
Iberia	11.8%	More House	25.8%
Lafayette	10.0%	Ouachita	16.2%
St. Landry	23.1%	Richland	28.6%
St. Martin	16.9%	Tensas	34.0%
Vermilion	14.1%	Union	17.5%

Table 3.3 Proportion of Parishes in Which the Percent of Families with Income Less Than Poverty Level Exceeds 20.0x (1980) Louisiana			
Planning Districts			
5. Southwest	0/5	West Carroll	29.5%
Allen	19.0%	9. Northshore	2/3
Beauregard	14.0%	St. Tammany	10.3%
Calcasieu	10.0%	Tangipahoa	21.4%
Cameron	11.0%	Washington	21.0%
Jeff Davis	15.3%		

Source: Bureau of The Census General Social and Economic Characteristics Table 181

6. The Northeast district (district eight) appears to have the largest percent of residents with incomes at or below the poverty level. More than 20 percent of the families have incomes that are less than the poverty level in eight out of the 12 parishes composing this district.

7. Poverty levels are important indicators for health planning purposes, since low income persons are usually not able to participate in the mainstream of the health care system. Lower socio-economic status is also correlated with higher incidences of disease and higher mortality rates. It is clear that there is a significant portion of Louisiana residents whose participation in the health care system is directly related to the availability of state or federally supported health care programs.

D. Age

1. The number of persons in the general population in specific age groups is important to health planning. Certain age groups are more likely than others to need certain types of health services (e.g., those over 65 years of age, infants and children), while some health services are needed exclusively by defined age groups (neonatal units and obstetrical services).

2. The 1980 Louisiana population by age is presented in Table 3.4. It is essential to identify the number of individuals age 65 and older in a population because of this group's significantly higher utilization of health care resources. The number of persons age 65 and over is represented in Table 3.5 broken down by district. Table 3.6 provides population projections for 1990 for the 65 + age group.

3. In 1980 11.3 percent of the U.S. population was 65 years of age or older. The 1980 Louisiana population of 65 + was 9.6 percent. However there are areas in Louisiana where the proportion of older people exceeds the national average.

4. In 1970 9.9 percent of the U.S. population was 65 years of age or older. This is an important benchmark, as this percentage was the basis, in part, for the establishment of the commonly accepted hospital bed need standard of 4 beds per 1,000 population. For that reason, in this planning document 9.9 percent of the population age 65 + is accepted as a standard against which the aged population in the State is evaluated. Where the population of persons age 65 + is more than 9.9 percent, those institutional health care services utilized heavily by this age group should be available in appropriately larger numbers.

5. As can be seen in Table 3.5, there are three planning districts with populations of persons age 65 + which exceed 9.9 percent, the Cenla, Northwest, and Northeast Districts. It is necessary that health planners and providers of health services give special consideration to the needs of the aged population in the three planning districts, where older people represent a disproportionately large segment of the population.

6. Another segment of the population requiring special attention by persons planning for and providing health services is that made up of children and youth between the ages of birth and 14 years. This age group requires substantially more primary care services than the 15-64 age group, in the form of periodic and developmental examinations, immunizations, and diagnostic and treatment services for relatively frequent episodes of acute illness and developmental problems.

7. According to 1980 census data, the Louisiana population under age 15 represents 25.7 percent of the overall population. This compares to the 1980 national average of 22.64 percent of the population 14 and under. The national average of persons under 15 was 28.49 percent in 1970, while the Louisiana average was 31.76 percent. The declining numbers of individuals in the age group under 15 years is reflective of the declining birth rate.

8. The Louisiana population under 15 years declined at a slightly faster rate (.25 percent) than in the U.S. as a whole during the decade 19701980. Even so, Louisiana still exceeds the U.S. by 3 percent in proportion of persons under 15 years of age. The number of Louisiana residents under 15 declined 6.6 percent between 1970 and 1980.

Table 3.4 Population By Age Group				
	1970		1980	
	Number	Percent	Number	Percent
Total	3,644,637	100.0	4,205,971	100.0
Under 15	1,156,439	31.8	1,079,462	25.7
15-64	2,179,491	59.8	2,722,230	64.7
65 or older	307,707	8.4	404,279	9.6
Median Age	24		27.4	

Source: Population Projections for 1985 and 1990:Vincent Maruggi and Paul Fletes UNO - June 1983

Table 3.5 Estimated Population 65 Years and Older, and Its Percentage within the Population			
	1980 Population 65 years and older	1980 Census Population	% of Persons 65 years and older
Louisiana	404,279	4,205,971	9.6
Planning Districts			
1. New Orleans	108,009	1,171,436	9.2
2. Capital	44,936	591,384	7.6
3. Bayou	20,396	284,708	7.2
4. Acadiana	43,651	476,339	9.2
5. Southwest	24,468	259,809	9.4

6. Cenla	39,619	356,241	11.1
7. Northwest	56,382	471,632	12.0
8. Northeast	44,737	358,578	12.5
9. Northshore	22,081	235,774	9.4

SOURCE: Population Projections for 1985 and 1990: Vincent Maruggi and Paul Fletes UNO - June 1983

Table 3.6
Interim Projections of Population Aged 65 and Over

	1980	1985	1990
Louisiana	404,279	441,235	472,049
Planning Districts			
1. New Orleans	108,009	120,847	133,971
2. Capital	44,937	49,615	54,586
3. Bayou	20,396	22,896	25,266
4. Acadiana	43,651	47,366	49,711
5. Southwest	24,468	27,146	29,366
6. Cenla	39,619	41,912	42,788
7. Northwest	56,382	59,351	61,191
8. Northeast	44,737	46,744	46,980
9. Northshore	22,081	25,358	28,190

SOURCE: Population Projection for 1985 and 1990: Vincent Maruggi and Paul Fletes UNO - June 1983

Table 3.6
Interim Projections of Population Aged 65 and Over
Louisiana 1980-1985

	1980	1981	1982	1983	1984	1985
Louisiana	403,939	410,354	416,770	423,185	429,600	436,020
HSA I(1,3)	132,313	134,719	137,125	139,531	141,937	144,344
HSA II (2,4,5)	132,240	134,799	137,358	139,917	142,476	145,041
HSA 111(6,7,8)	139,386	140,836	142,287	143,737	145,187	116,635
Planning Districts						
1. New Orleans	112,065	113,984	115,903	117,822	119,741	121,659
2. Capital	59,862	61,184	62,506	63,828	65,150	66,469
3. Bayou	20,248	20,735	21,222	21,709	22,196	22,685
4. Acadiana	48,076	48,918	49,760	50,602	51,444	52,293
5. Southwest	24,302	24,697	25,092	25,487	25,882	26,279
6. Cenla	33,915	34,344	34,773	35,202	35,631	36,059
7. Northwest	66,907	67,642	68,377	69,112	69,846	70,585
8. Northeast	38,564	38,850	39,137	39,423	39,710	39,991

SOURCE: Computed from Louisiana State Planning Office projections for 1980 and 1985

9. These statistics suggest a need to improve quality in health care services for the under 15 age group and to identify previously unmet health needs, such as those of primary care for this segment of the population in poor and/or rural areas of the state. Poverty and lack of accessibility to health care services are known to increase the risk of poor health. With declining numbers of children in rural areas, there is a need to develop innovative and cost effective means of delivering primary health services to this increasingly isolated, high risk age group in rural areas.

E. Race

1. Another characteristic of a population which is important for health planners is its ethnic composition. It has been observed that non-whites in the population are at greater risk for poorer health than whites. Trends Affecting the U.S. Health Care System, prepared by Cambridge Research Institute, January, 1976. The degree to which this factor is interrelated with other risk factors such as lower socio-economic status, living in areas of high population density, living in rural areas and high birth rate is not established. Nonetheless, it is important to consider the greater need for health services among the non-white population in planning the development of health system resources.

2. The Louisiana population by racial composition is depicted in Table 3.7. The state's population is 29.3 percent black, according to 1980 census data. The New Orleans, Northeast and Northwest Planning Districts have the largest black populations, 34.2 percent, 34.0 percent and 33.8 percent respectively.

Table 3.7
Louisiana Population by Race
1980

	Total	White/Other	Black	Percent Black
Louisiana	4,205,971	2,992,676	1,233,917	29.3%
Planning Districts				
1. New Orleans	1,171,436	770,681	400,755	34.2%
2. Capital	591,453	407,027	184,426	31.2%
3. Bayou	284,708	225,317	59,391	20.9%
4. Acadiana	476,339	358,861	117,478	25.7%
5. Southwest	259,809	207,716	52,093	20.1%
6. Cenla	356,241	264,358	91,883	25.8%
7. Northwest	471,633	312,230	159,403	33.8%
8. Northeast	358,578	236,860	121,718	34.0%
9. Northshore	235,774	184,310	51,464	21.8%

Table 3.7a
Louisiana Population By Race (Projections)
1990

	Total	White/Other	Black	Percent Black
Louisiana	4,849,328	3,396,045	1,452,995	30.0%
Planning Districts				
1. New Orleans	1,331,662	845,055	486,607	36.5%
2. Capital	721,062	495,588	225,474	31.3%
3. Bayou	331,025	263,271	67,754	20.5%
4. Acadiana	547,825	412,610	135,215	24.7%
5. Southwest	293,849	234,695	59,154	20.1%
6. Cenla	393,875	291,798	102,077	26.0%
7. Northwest	530,544	349,468	181,077	34.1%
8. Northeast	392,339	257,415	134,924	19.8%
9. Northshore	306,858	246,145	60,713	19.8%

Table 3.8
Percent Non-White Population, Louisiana,
Selected States and the U.S.
1930-1980

	1930	1940	1950	1960	1970	1980
Louisiana	37.3	36.1	33.1	32.1	30.2	30.8
U.S.	11.3	10.2	10.4	11.5	12.5	16.8
Alabama	35.8	34.8	31.5	30.1	26.4	26.2
Arkansas	25.8	24.8	22.5	21.9	18.6	17.3
Florida	29.5	27.2	21.9	17.9	15.8	16.0
Georgia	36.9	34.8	30.9	28.6	26.1	27.7
Mississippi	50.4	49.4	45.5	42.3	37.2	35.9

Table 3.8
Percent Non-White Population, Louisiana, Selected States and the U.S.
1930-1980

	1930	1940	1950	1960	1970	1980
Texas	26.5	14.5	12.8	12.6	13.2	21.3
The South	25.1	24.0	21.9	20.9	19.7	21.8

3. Table 3.8 depicts the changes in the non-white population of the State as compared to the U.S. and to selected other states in the South. There was a declining proportion of non-whites in the state over the period 1930-1970. This decline leveled off and was slightly reversed in the decade between 1970 and 1980.

F. Sex

1. The composition of a population by sex, race and age is important in health planning. For example, the number of females in a population group age 15-44 provides an estimate of the need for obstetrical and neonatal services and has an indirect bearing on needed pediatric inpatient and outpatient services.

2. Table 3.9 provides 1985 statistics on the composition of the Louisiana population by age and sex compared to the U.S.

Table 3.9
Louisiana
Population By Age & Sex 1980

	Both Sexes	%	Male	%	Female	%
Total	4,205,971	100.0	2,039,929	48.5	2,166,042	51.5
Under 15	1,079,214	25.7	548,447	13.0	530,767	12.6
15-44	1,977,551	47.0	978,843	23.3	998,708	23.7
45-64	744,927	17.7	350,046	8.3	394,881	9.4
65 and Older	404,279	9.6	162,593	3.9	241,686	5.7

Table 3.9a
Louisiana
Population by Age and Sex (Projections For 1990)

	Both Sexes	%	Male	%	Female	%
Total	4,849,038	100.0	2,372,187	48.9	2,476,851	51.1
Under 15	1,244,844	25.7	632,013	13.0	611,831	12.6
15-44	2,326,326	48.0	1,171,697	24.2	1,154,629	23.8
45-64	806,809	16.6	378,742	7.8	428,067	8.8
65 and Older	472,059	9.7	189,735	3.9	282,324	5.8

Table 3.10
Louisiana and U.S. Birth Statistics
1984

	Number and Percent of Births				Birth Rate Per 1000	
	Louisiana		U.S		LA	U.S.
Total	81,428	100	3,697,000	100	18.2	15.7
White	49,171	60.4	-	-	15.7	-
Nonwhite	32,257	39.6	-	-	24.0	-

1979

	Number and Percent of Births				Birth Rate Per 1000	
	Louisiana		U.S		LA	U.S.
Total	74,831	100	3,333,279	100	18.9	15.3
White	45,099	60.3	2,679,956	80.4	16.3	14.2
Nonwhite	29,732	39.7	653,323	19.6	24.8	22.1

Source: Louisiana Vital Statistics Report 1984 advance Final Report, PHS - 1984 Series No 2. Nov, 1985

G. Birth Rate

1. The birth rate of any population is the most dynamic component of its growth and is indicative of the fertility of the population. This, in turn, directly affects the age composition and size of the population group. Such rates have an immediate impact on the demand for hospital obstetric services, neonatal and pediatric units, with further long-range implications on other health care services.

2. As shown in Table 3.10, the Louisiana birth rate is 18.2 per 1,000 population as calculated from the 1984 Louisiana Vital Statistics Report. This breaks down to a 15.7 per 1,000 for whites and 24.0 per 1,000 for nonwhites. This significant difference in rates is important to note since

geographic areas with large percentages of non-whites have a higher utilization rate for obstetric beds and a disproportionate need for health care services related to maternal and child care. The U.S. birth rate is significantly lower than the Louisiana rate, due in part, but not completely, to a higher percentage of non-whites in the State's population.

3. Table 3.11 presents statistics depicting the Louisiana birth rate over the period 1940-1984. Since a peak of 30.6 births per 1,000 in 1954, the birth rate steadily declined until 1974, with a rate of 17.5 per 1,000. During the period between 1974 and 1979, there was an annual increase in the birth rate. However, 1980 statistics provided a break in this upward trend. Statistics for the period of 1984 indicate somewhat of a leveling off of the birth rate. Health planners and providers of obstetrical and related services will need to take special care in evaluating the birth rate during the 1987-1990 period. A continuing increase in the birth rate could find certain areas of the state seriously lacking in obstetrical services.

Table 3.11
Louisiana
Live Births and Birth Rate 1940-1980

Year	Number	Rate/ 1000	Year	Number	Rate/ 1000
1940	50,623	21.4	1960	90,126	27.7
1941	54,396	22.7	1961	88,892	26.8
1942	57,912	24.3	1962	88,005	26.1
1943	60,770	25.0	1963	85,334	24.9
1944	60,260	24.6	1964	86,060	24.7
1945	57,363	23.2	1965	79,533	22.5
1946	68,549	26.9	1966	77,223	21.5
1947	74,166	28.6	1967	75,199	20.7
1948	73,104	27.7	1968	74,098	20.2
1949	75,302	28.3	1969	74,770	20.1
1950	76,108	28.4	1970	74,615	20.5
1951	80,256	29.5	1971	73,014	19.8
1952	80,046	29.1	1972	68,340	18.3
1953	84,108	30.2	1973	66,413	17.6
1954	86,225	30.6	1974	65,880	17.5
1955	86,031	30.2	1975	67,792	17.9
1956	89,333	29.1	1976	69,998	18.1
1957	90,786	29.0	1977	74,989	19.1
1958	90,175	28.3	1978	74,831	18.9
1959	90,814	27.9	1979*	78,631	19.6
			1980*	81,268	19.3

SOURCES: L.S.U.N.O. Division of Business and Economic Research, Statistical Abstract of Louisiana, Sixth Edition 1977 Louisiana Department of Health and Human Resources, Louisiana Vital Statistics Report, 1976-1980 *Provisional Statistics

4. The declining birth rate of the 1960's and first half of the 1970's can be attributed to many reasons, including:

a. better and more widely available contraceptive and family planning methods;

b. an economy which requires an increasing number of women to work to provide sufficient income for the family and/or requires that the number of children be limited;

c. less restrictive abortion laws;

d. an increasing awareness of the need to restrain population growth in light of the finiteness of the earth's resources.

5. The increasing birth rate of the latter part of the 1970's is seen as a result of significant numbers of women who had postponed pregnancy until the latter part of their child-bearing years. Fluctuations in the economy also have substantial impact on the birth rate, with increased births in periods of economic recovery.

6. Although 1984 statistics indicate a reduction, Louisiana's birthrate continues to exceed the national average by 3.5 births per 1,000, according to the 1984 Louisiana Vital Statistics Report.

7. The fertility rate of a population is another means by which to analyze population growth patterns and to project health service needs. Birth rates are derived simply by averaging the number of births per 1000 general population. Fertility rates are developed by selecting only the population of females in child-bearing years, age 15-44, for analysis. This provides important information because of the variations in the numbers of females age 15-44 living in various sections of the state. "Age-race-specific fertility rates" are the number of live births per 1,000 females in the given age-race group and permit an even more accurate analysis of birth rates in a given locale.

8. Table 3.12 presents data on age-race-specific fertility rates in Louisiana and in the nine health planning districts for 1984. The fertility rate for the black population is significantly higher than the white population for all age groups, but particularly higher for females under age 20. Regions VII and VIII have the highest fertility rates in the 10-14 age group with 3.48 per 1,000 and 4.88 per 1,000 respectively. Regions VI and VII show the highest fertility rates in the 15-19 age group with 89.43 per 1,000 and 78.55 per 1,000 respectively. These statistics indicate a need to address the problems represented by teen-age pregnancies, such as the need for improved family planning and human sexuality education initiative

Table 3.12
Age-Race-Specific Fertility Rate* = of Live Births to Females in Given Age-Race Group/Total # of Females in Same Age-Race Group

	Age of Mother						
	10-14	15-19	20-24	25-29	30-34	35-39	40-44**
Louisiana	2.43	71.09	129.95	114.71	63.09	22.14	0.70
White	0.67	51.41	117.59	110.55	57.12	17.79	0.47
Black	1.68	106.53	155.09	124.26	78.24	33.99	1.35
Region I	2.07	67.15	116.02	107.00	63.14	22.94	0.71
White	0.55	39.12	91.51	99.07	56.81	19.11	0.47
Black	3.97	104.05	154.11	121.11	75.29	30.55	1.33
Region II	0.90	2.16	60.98	117.35	112.27	65.38	22.73
White	0.62	44.59	110.15	108.87	58.66	18.34	0.52
Black	4.98	89.83	131.67	119.79	81.75	34.00	1.85
Region III	2.30	0.79	74.91	136.74	120.61	55.61	23.85
White	0.94	60.32	120.48	110.69	47.85	17.35	0.67
Black	6.53	120.23	193.28	158.64	85.68	50.44	1.33
Region IV	1.87	67.04	137.50	133.57	76.16	27.16	0.78

Table 3.12 Age-Race-Specific Fertility Rate* = of Live Births to Females in Given Age-Race Group/Total # of Females in Same Age-Race Group							
	Age of Mother						
	10-14	15-19	20-24	25-29	30-34	35-39	40-44**
White	0.97	53.83	131.00	129.68	70.62	21.83	0.53
Black	4.10	97.07	154.68	146.05	95.51	45.06	1.67
Region V	0.93	65.50	143.14	123.76	60.56	20.60	0.69
White	0.48	56.95	138.96	121.54	55.81	17.10	0.52
Black	2.43	93.39	157.46	131.93	80.14	36.83	1.53
Region VI	1.58	78.55	154.57	115.57	56.14	19.21	0.47
White	0.29	66.23	144.45	109.81	46.54	15.27	0.26
Black	4.65	105.91	179.10	131.30	86.55	33.72	1.18
Region VII	3.48	89.43	150.12	111.40	57.66	18.92	0.56
White	0.81	61.47	138.12	110.86	54.86	13.90	0.32
Black	7.26	127.90	169.76	112.43	63.49	30.40	1.15
Region VIII	4.88	77.90	120.21	101.93	57.58	18.22	0.65
White	0.58	51.14	110.07	97.01	47.85	14.11	0.53
Black	11.08	115.13	136.35	111.19	79.52	29.11	0.93
Region IX	3.30	70.06	139.17	132.67	68.93	21.93	0.69
White	0.87	52.20	128.50	133.93	67.52	18.68	0.62
Black	10.83	121.28	171.32	128.04	75.56	39.39	1.03

*Rate per 1000 females in same age and race group.
**40-44 rate contains all births to those 40 and older.

9. The effect of large numbers of early teen-age pregnancies on the state is seen in a variety of negative ways. Teen-age mothers are often unmarried and their children frequently must depend on the state and federal government for financial support. Illegitimate births to young teenagers also account for a disproportionate number of infants with birth defects and other difficulties associated with high risk pregnancy. Too, children of young, unwed mothers often do not receive appropriate early childhood health care and do not have access, because of poverty, to a full spectrum of health care.

10. The incidence of illegitimate births in Louisiana is depicted in Table 3.13. Of the children born in Louisiana in 1984, 26.6 percent were illegitimate. The incidence of illegitimate births was highest in North Louisiana and lowest in Central Louisiana. The incidence of illegitimacy is nine percent among whites and 54 percent among non-whites, with the highest rates seen among the non-white population of the predominantly rural, economically deprived Northwest and Northeast districts. In these areas there is an urgent need for improved family planning and health education programs among non-whites.

Table 3.13 Illegitimate Births by Place of Mother's Usual Residence and Race of Child Louisiana, 1980						
	Total		White		NonWhite	
	Illeg. Births	Ratio/1000 Live Births	Illeg. Births	Ratio/1000 Live Births	Illeg. Births	Ratio/1000 Live Births
Louisiana	19,043	234.3	3,485	70.3	15,558	490.7
HSA I (1,3)	6,992	243.8	1,175	70.3	5,817	485.9
HSA II (2,4,5)	6,232	204.4	1,442	72.1	4,790	456.8
HSA III (6,7,8)	5,819	263.3	868	67.5	4,951	535.6
1. New Orleans	5,876	265.0	899	73.5	4,977	500.7
Jefferson	1,213	147.8	406	64.5	807	422.5
Orleans	4,222	410.8	309	108.6	3,913	526.5
Plaquemines	101	175.3	38	92.5	63	381.8
St. Bernard	84	76.9	53	52.1	31	413.3
St. Tammany	256	126.6	93	55.9	163	454.0
2. Capital	3,128	225.7	489	58.5	2,639	479.9
Ascension	175	174.0	35	49.4	140	468.2
E. Baton Rouge	1,498	215.4	223	54.9	1,275	440.9
E. Feliciana	110	290.2	6	33.7	104	517.4
Iberville	240	350.4	32	102.6	208	557.6
Livingston	122	103.7	72	67.4	50	467.3
Pointe Coupee	124	262.7	7	30.0	117	489.5
St. Helena	50	340.1	2	36.4	48	521.7
Tangipahoa	483	289.0	69	74.4	414	557.2
Washington	180	221.9	26	52.7	154	484.3
W. Baton Rouge	105	251.2	14	55.3	91	551.5
W. Feliciana	41	290.8	3	42.3	38	542.9
3. Bayou	1,116	171.4	276	61.6	840	413.6
Assumption	121	251.6	15	54.2	106	519.6
Lafourche	258	152.1	83	61.2	175	516.2
St. Charles	148	208.2	28	62.1	120	461.5
St. James	111	250.6	8	41.5	103	412.0
St. John	151	198.4	15	37.5	136	376.7
Terrebonne	327	135.2	127	70.5	200	324.1
4. Acadiana	2,268	198.0	634	81.7	1,634	441.6
Acadia	236	202.4	91	103.1	145	512.4
Evangeline	122	192.7	31	72.3	91	446.1

Table 3.13 Illegitimate Births by Place of Mother's Usual Residence and Race of Child Louisiana, 1980						
	Total		White		NonWhite	
	Illeg. Births	Ratio/1000 Live Births	Illeg. Births	Ratio/1000 Live Births	Illeg. Births	Ratio/1000 Live Births
Iberia	314	215.4	84	89.8	230	439.8
Lafayette	526	169.7	157	69.9	369	433.1
St. Landry	383	215.0	73	72.7	310	399.0
St. Martin	201	220.2	48	87.9	153	416.9
St. Mary	303	217.2	73	80.8	230	467.5
Vermilion	183	180.8	77	95.1	106	524.8
5. Southwest	836	161.9	319	82.3	517	401.7
Allen	72	184.6	33	115.0	39	378.6
Beauregard	58	108.8	36	79.2	22	278.5
Calcasieu	553	163.5	187	76.0	366	396.5
Cameron	24	130.4	18	105.9	6	428.6
Jeff Davis	129	191.1	45	88.8	84	500.0
6. Cenla	1,138	191.2	267	67.3	871	439.5
Avoyelles	155	209.7	26	53.4	129	511.9
Catahoula	48	244.9	7	56.5	41	569.4
Concordia	137	417.7	23	143.8	114	678.6
Grant	51	190.3	19	91.8	32	524.6
LaSalle	40	149.3	21	90.5	19	527.8
Rapides	537	215.0	120	74.7	417	468.0
Vernon	104	76.7	46	47.7	58	148.0
Winn	66	221.5	5	26.6	61	554.5
7. Northwest	2,730	268.8	405	71.2	2,325	520.1
Bienville	82	263.7	10	65.4	72	455.7
Bossier	254	164.6	88	75.9	166	433.4
Caddo	1,521	306.3	194	77.5	1,327	538.6
Claiborne	91	303.3	3	23.8	88	505.7
DeSoto	141	295.0	11	43.3	130	580.4
Lincoln	148	271.6	13	47.6	135	496.3
Natchitoches	178	261.4	30	79.4	148	488.4
Red River	61	306.5	8	73.4	53	588.9
Webster	179	235.8	21	46.6	158	511.3
8. Northeast	1,951	325.7	196	61.3	1,755	628.6
Caldwell	27	174.2	9	73.2	18	562.5
E. Carroll	148	575.9	3	51.7	145	728.6
Franklin	140	324.8	17	69.1	123	664.9
Jackson	84	272.7	8	41.9	76	649.6
Madison	155	563.6	4	52.6	151	758.8
Morehouse	293	405.8	18	57.1	275	675.7
Ouachita	748	282.3	93	61.4	655	576.6
Richland	160	360.4	15	66.1	145	668.2
Tensas	67	458.9	1	22.7	66	647.1
Union	78	221.6	8	38.5	70	486.1
W. Carroll	51	203.2	20	101.5	31	574.1

SOURCE: Department of Health and Human Resources, Public Health Statistics, Louisiana Vital Statistics Report, Provisional Statistics, January-December, 1980

H. Summary of Demographic Characteristics

1. All of the demographic variables which have an impact on the need for and use of health care services should be considered when evaluating the health system and status of a geographic area. Factors which create a higher than average risk of death or illness are:

a. race—non-white

b. sex—male

c. residence—rural; or in area of high population density

d. age-65 + ; neonate

e. income—at or below poverty level.

2. Since Louisiana has a higher percentage of non-whites, neonates, poor, and rural individuals than the national average, there is a need for special efforts to be directed toward meeting the health needs of those at high risk of poor health. In part, inpatient and outpatient health care services at regional, state-supported general hospitals, and at parish health units are directed toward this large segment of the population considered to be "at risk". However, other services and other ways to bring this high

risk population into the mainstream of the health care system need to be developed. Underlining all goals and objectives established in this document is the sometimes unstated goal of giving priority to the needs of those who are at high risk.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance LR 13:246 (April 1987).

§10309. Health Status

A. Death, disease and disability patterns in a population provide insight into the health of that population. There is no single indicator through which to make totally valid observations about health status, but rather a number of indicators through which a composite picture is sketched of the health of the populace.

B. Mortality Statistics

1. Introduction

a. Statistics on death are essential tools for understanding the impact of disease, evaluating health programs, allocating health resources and establishing priorities for health improvement efforts. Death statistics are the most widely used group of health status indicators because of their availability, uniformity, reliability and low cost.

b. In the following sections of this document, a variety of mortality statistics is presented, including age-specific and age-adjusted rates, race and sex adjusted rates, disease-specific rates and infant mortality rates.

2. Age-Adjusted Mortality Rates

a. The concept of an age adjustment when analyzing mortality rates is an important one since crude mortality rates have little meaning. Adjusting mortality statistics by age means factoring the death rate within a specific age group by the percentage which that age group represents in a standard population. Thus, populations which are heavily weighted with persons 45 and over are not seen as more "unhealthy" because of having higher death rates than predominantly younger population groups.

b. In Table 3.14, the age-adjusted, 1984 death rates for Louisiana as compared to the United States are presented, both for the leading causes of death and for all causes. The Louisiana age-adjusted death rate in 1975 was 725.67 per 100,000 population. This decreased to 618.22 in 1984. However, Louisiana continues to have a significantly higher rate than the nation as a whole. The state's death rates exceed those of the nation in each category of leading causes of death, with the exception of influenza/pneumonia and liver disease. The most significant differences are in the categories of diseases of the heart and malignant neoplasms which are the two leading causes of death in the U.S. as well as in Louisiana. (See Chapter IX sections on Open Heart Surgery, Cardiac Catheterization and Radiation Therapy for more information about the incidence of heart disease and malignant neoplasm.)

c. It is significant to note that in the period between 1975 and 1984, the state showed a decrease in death rates in each category of leading causes of death with the exception of suicide and malignant neoplasm which showed slight increases.

Table 3.14
Age Adjusted Death Rates * of Louisiana and the U.S. for Major Diseases, 1984

Disease	Age Specific Death Rate: Louisiana Age Adjusted Rate											
	11	1-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	LA	USA
Disease of Heart	34.8	1.4	5.5	10.1	50.6	203.2	573.1	1269.4	2932.5	6989.9	212.42	183.3
Malignant Neoplasm	2.5	3.2	5.4	12.5	57.3	182.4	497.4	882.2	1383.4	1692.3	144.55	133.1
Cerebrovascular	5.0	.5	1.0	3.2	11.6	36.3	69.6	216.5	674.5	1801.2	39..61	33.9
Motor Vehicle Accidents	7.5	7.9	41.8	26.1	19.2	17.3	16.2	13.0	30.0	11.5	21.22	19.2
Suicide	0.0	0.1	12.9	20.4	15.9	16.8	22.6	21.0	20.2	22.9	13.10	11.6
Homicide & Legal	9.9	1.5	16.1	26.2	20.1	13.5	9.1	7.1	9.0	14.3	13.34	8.2
Prtherosclerosis	0.0	0.0	0.0	0.0	1.1	1.0	5.5	24.4	113.9	578.4	5.51	4.1
Influenza, Pneumonia	27.3	1.1	0.4	3.1	2.8	6.1	19.5	53.7	201.6	715.9	12.01	12.2
Chronic Liver Disease	3.7	0.1	0.1	2.2	7.6	20.6	31.4	35.6	28.5	11.5	8.70	9.8
All Causes											618.22	547.7

* Rates per 100,000 population

** Source: Monthly Vital Statistics Report, Vol. 33, No. 13, September 26, 1986

d. Table 3.14 allows us to compare age adjusted death rates in specific age categories. An important factor to consider is that, while heart disease and malignant neoplasms are the leading causes of death in most age categories, motor vehicle accidents and homicide are the leading causes of death for persons 1 year of age through 34 years of age (Vital Statistics Report 1985).

3. Crude Mortality Rates—a comparison of neighboring states and planning districts within the state

a. A comparison of Louisiana to the neighboring states of Mississippi, Arkansas and Texas is seen in table 3.15. Louisiana's death rates for specified leading causes of death are lower than those of Mississippi and Arkansas from diseases of the heart, malignant neoplasms, and

cerebrovascular disease and is lower than each of its neighboring states in deaths from motor vehicle accidents.

Table 3.15 Death and Death Rates for Specified Leading Causes of Death - 1983*								
	Disease of Heart		Malignant Neoplasms		Cerebrovascular Dis.		Motor Vehicle Accidents	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
U.S.	770,432	329.8	442,986	189.3	155,598	66.5	44,452	19.0
Louisiana	13,266	298.8	7,670	172.7	2,115	47.6	980	22.1
Mississippi	8,425	326.4	4,592	177.9	2,076	80.4	716	27.7
Arkansas	8,617	370.6	4,902	210.8	1,162	50.0	565	24.3
Texas	39,973	253.3	23,282	147.6	7,253	46.0	3,868	24.5

SOURCE: NCHS. Monthly Vital Statistics. Advance Report of Final Mortality Statistics, 1983 V34, No.6, Supp (2) September 26, 1985.

b. Another comparison of death rates may be made within the state. Table 3.16 provides data on principal causes of deaths by planning district. The Northwest district has the highest death rate from diseases of the heart and malignant neoplasms and the second highest from pneumonia/influenza, homicide and suicide. The New Orleans district has the highest death rates from homicide, suicide and chronic liver diseases. The Northeast district has the highest death rates from cerebrovascular diseases and pnemonia/influenza and the second highest from disease of the heart. Although these death rates are not adjusted for age, the statistics indicate the need for improved health care initiatives in the New Orleans, Northeast, and Northwest districts.

Table 3.16 Principal Causes of Deaths by Planning Districts Louisiana/U.S. 1984										
	Disease of Heart		Malignant Neoplasms		Cerebrovascular Arterios Disease		Cronic Pnemonia and Influenza		Accidents and Adverse Effects Homicide Suicide	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
1. New Orleans	3,509	283.9	2,338	189.2	677	54.8	510	41.3	203	16.4
2. Capital	1,403	218.2	846	131.6	273	42.5	229	35.6	100	15.6
3. Bayou	711	234.6	463	152.7	131	43.2	194	64.0	33	10.9
4. Acadiana	1,419	281.2	946	187.5	276	54.7	258	51.1	91	18.0
5. Southwest	808	295.0	474	173.0	195	71.2	137	50.0	48	17.5
6. Cenla	1,283	345.2	609	163.9	237	63.8	179	48.2	79	21.3
7. Northwest	1,815	366.4	1,015	204.9	352	71.1	213	46.6	112	22.6
8. Northeast	1,341	360.6	691	185.8	290	78.0	145	39.0	120	32.3
9. Northshore	769	291.4	416	157.6	175	66.3	157	59.5	40	15.2

SOURCE: Louisiana Vital Statistics. 1984 Advance Final Data. PHS. 1984 Series

c. The Capital district has fewer deaths per 100,000 from diseases of the heart malignant neoplasms, cerebrovascular diseases, accidents and adverse effects, and suicide than other areas of the state. The Bayou district has the lowest death rate from pnemonia/influenza and chronic liver disease.

4. Age, Race, Sex and Disease—Specific Mortality

a. Another way of looking at mortality statistics is the examination of disease-specific causes of death by age group. Table 3.17 presents such statistics for Louisiana according to 1984 mortality data. These data reveal that perinatal diseases are the leading cause of death of persons under one year of age. Congenital anomalies constitute the second leading cause of death in this age group. This group of diseases remains among the top five leading causes of death in the 1 year to 4 year age group, but is not found among the top five causes of death in age groups above four years. Motor vehicle accidents appears as a leading cause of death in the 1-4 year age group and remains ranked among the top five until the 55-64 year age group. In this age group chronic pulmonary disease and diabetes mellitus are introduced among the five leading causes of death. Pneumonia and influenza appear as a leading cause in the 75-84 year age group and atherosclerosis appears in the 85 and over age group.

b. An interesting analysis of death rates is provided by a breakdown of the death rate by sex, race and age. Such a statistical analysis is given in Table 3.18. The significance in such a comparison lies in premature deaths, that is in age groups below 75 but especially in the 15-64 age groups. The variation by race and sex is quite substantial.

Table 3.17
Rank Order of 5 Leading Calms of Death Stage Group and Miser of Deaths—Louisiana, 1984

Age Group	Rank 1	Rank 2	Rank3	Rank4	Rank5	Total Deaths
Under1	Perinatal Diseases 481	Congenital Anomalies 202	Cardiovascular Dis. 34	Pneumonia and Influenza 22	All Other Accidents 15	979
1-4	All Other Accidents 63	Motor Vehicle Accidents 40	Congenital Diseases 14	Malignant Neoplasm 14	Pneumonia and Influenza 10	212
5-14	All Other Accidents 56	Motor Vehicle Accidents 43	Malignant Neoplasm 19	Homicide 13	Cardiovascular Disease 11	191
15-24	Motor Vehicle Accidents 343	All Other Accidents 178	Homicide 132	Suicide 106	Cardiovascular Disease 54	947
25-34	All Other Accidents 210	Homicide 206	Motor Vehicle Accidents 206	Suicide 160	Cardiovascular Disease 111	1,144
35-44	Cardiovascular Disease 353	Malignant Neoplasm 310	All Other Accidents 124	Homicide 109	Motor Vehicle Accidents 104	1,367
45-54	Cardiovascular Disease 968	Malignant Neoplasm 718	Cerebrovascular 143	All Other Accidents 112	Motor Vehicle Accidents 68	2,459
55-64	Cardiovascular Disease 2,418	Malignant Neoplasm 1,807	Cerebrovascular 253	Chronic Pulmonary 151	Diabetes Mellitus 135	5,576
65-74	Cardiovascular Disease 4,172	Malignant Neoplasm 2,351	Cerebrovascular 577	Chronic Pulmonary 303	Diabetes Mellitus 237	8,477
75-84	Cardiovascular Disease 5,073	Malignant Neoplasm 1,846	Cerebrovascular 900	Chronic Pulmonary 304	Pneumonia and Influenza 269	9,110
85 and Over	Cardiovascular Disease 3,337	Cerebrovascular Disease 629	Malignant Neoplasm 591	Pneumonia and Influenza 250	Arteriosclerosis 202	5,191

Source: Louisiana Vital Statistics Report, 1984 advance Final Report, PHS-1984 Series No. 2, Nov, 1985

Table 3.18
Age Race Sex Specific Death Rates
- All Causes - of LA Residents Over 14 Years
1984
Age at Death

	15-24	25-34	35-44	45-54	55-64	65 and over
Louisiana	115.4	145.7	252.5	624.7	1535.0	5251.3
WM	117.3	108.7	191.5	497.1	1410.8	6360.3
WF	108.9	124.6	203.6	511.7	1269.0	4208.2
NWM	117.5	255.7	473.9	1153.6	2539.7	6994.0
NWF	122.0	199.1	380.7	884.1	1939.7	4954.0

SOURCE: La. Vital Statistics Report, Public Health Statistics, 1984, series: No. #2, November, 1985

c. Premature death rates are strongly correlated with non-whites as a group. As the above chart indicates, non-white males are at substantially greater risk of premature death than others in all age ranges over 24. The death rate for non-white females is substantially greater than whites in all age ranges and greater than that for non-white males in the age group 15-24. It is significant to note, that in the past the death rate among white females was consistently below that of the population in general by as much as 50 percent. However, according to 1984 vital statistics data, in the age range 25-54 the white female death rate now exceeds the white male rate.

d. Planning districts do not show significant variations in the numbers of males and females in specific age groups within the population. Therefore, the correlation of higher premature death rates with males does not, in itself, have implications in the identification of special local and regional health care needs. However, racial correlations with higher death rates are significant for local planning, since there is some variation in the racial composition of regional populations.

e. Of interest in comparing race and sex differentials in the death rates is a parallel comparison of utilization patterns of health care services and facilities. Current data are not available for Louisiana on the race/sex variations in utilization; however, several studies at the national level provide data which permit extrapolation. A National Ambulatory Medical Care Survey (NAMCS) conducted by the Department of Health Education and Welfare (DHEW) in 1975 provided statistics on the numbers of persons in the U.S. who visited general and family practitioners during the survey years. Female patients accounted for 59.2 percent of the total number of reported visits in 1975, while representing 51.3 percent of the population. (Pregnancy exams accounted for 2.4 percent of the visits.) Whites accounted for 88.5 percent of the patients making the physician visits, nonwhites 11.5 percent. The population ratio of whites to non-whites in the surveyed population was 85.5 to 14.5. From these statistics it could be observed that the female utilization rate for these general outpatient health services was 31.1 percent higher than for males, with pregnancy-related examinations accounting for only 4.1 percent of this differential and the difference in the

male-female ratio in the population accounting for 5.19 percent. The utilization rate for whites was 87 percent higher than for the non-white population, with 83 percent of this difference being accounted for by population differences of the races.

f. A local study which seems to support these statistics regarding sex and race variables in health services utilization is the Mid-Louisiana HSA Hospital Patient Abstract Study. A random 5 percent sample of hospital discharges during 1977-78 was taken. Almost 60 percent of all discharges in the study were female, while 51.2 percent of the population was female. Here a 35 percent higher utilization rate was seen for women, with 20 percent of their discharges being for services related to obstetrical care. Whites accounted for 75 percent of the discharges, while representing 72.2 percent of the area population; non-whites comprised 25 percent of the discharges, with a 27.8 percent representation in the area. Thus, non-whites were 14 percent less likely than whites to use general hospital facilities.

g. Excluding obstetrical services, females in these studies were about 25 percent more likely to receive general outpatient care than males and about 15 percent more likely to receive general inpatient care. The same approximate variables applied to whites versus non-whites, that is whites were about 25 percent more likely than non-whites to receive general outpatient care and about 15 percent more likely to receive general inpatient care. Similarly, the observation can be made that white females are over 40 percent more likely than white males and non-white females to receive general outpatient services and over 80 percent more likely to receive such services than non-white males. White females are over 20 percent more likely to receive non-OB-related general hospital care than white males and non-white females and over 40 percent more likely to receive such services than non-white males. It can be observed that there are close parallels between this health service utilization pattern and death rates when analyzed by sex and race variables. There is not sufficient data to draw definite conclusions; however, it may be postulated that higher utilization of some health care services correlates with lower premature death rates and that differentials in sex and race variables in the death rate may not be related to sexual or racial characteristics but rather to patterns and attitudes toward health care. Such observations underline the need for health planners and health care service providers to focus on activities related to health promotion, prevention and early detection of disease, and primary care.

h. In a 1974 NAMCS survey (U.S.), respondents with no regular place of care stated more frequently (54.2 percent) that the main reason for not having a regular source of medical care was that, as far as they could determine, they did not need one. People in lower income groups confronted cost, transportation and knowledge barriers to care disproportionately more often than in higher income family groups. The most frequently identified reason that people felt they were not getting all the medical care they needed was the high cost of care. Implications again revolve around a need to emphasize health education, prevention and promotion and to target such efforts in poverty areas. A lack of Medicaid coverage for preventive health care for adults makes screening and preventive personal health care services a commodity which a large segment of the population in Louisiana may not be able to afford.

5. Percent of years of life lost between ages one and 65.

a. Another method of examining mortality statistics is through percent of years of life lost. In this method, the number of years between 1 and 65 lost as a result of each cause of death is computed and compared to the number of years of life between one and 65 for the population as a whole. Breaking this information down to a cause specific analysis permits a better understanding of the impact that the various causes of death have on the population in terms of percent of productive years of life lost.

b. Table 3.19 presents such data for Louisiana residents based on 1984 deaths. Louisianians exceeded national percentages of productive years of life lost in several cause-specific categories. Louisiana exceeds the U.S. average by the greatest amount in non-motor vehicular accidents and homicides. In deaths due to malignant neoplasm, Louisiana is significantly lower than the nation as a whole, inspite of higher age adjusted death rates. One possible explanation for this is that cancer mortality tends to be lower in Louisiana among the very young who have many years of life to lose and higher in the more advanced age groups with fewer years of life to lose. For most other causes of death, there is little deviation between U.S. and Louisiana statistics in terms of percentage of years of life lost.

Table 3.19
Percent of All Years of Life Lost Between Ages 1 and 65 for Selected Causes of Death, Louisiana and U.S., 1984

	LA	US
Malignant Neoplasms	17.0	19.5
Diabetes Mellitus	1.2	1.3
Heart Disease	17.1	16.5
Cerebrovascular Disease	3.2	2.8
Arteriosclerosis	0.2	0.1
Diseases of Arteries	0.3	NR
Influenza and Pneumonia	1.3	1.3
Bronchitis, Emphysema	1.1	1.3
Cirrhosis of Liver	1.7	2.5
Congenital Anomalies	1.2	1.5
Accidents	11.7	9.4
Motor Vehicle Accidents	15.3	15.0
Suicide	6.8	7.1
Homicide	8.7	6.2
Hypertension	0.2	NR
All Other Causes	13.1	15.7

SOURCE: Louisiana Department of Health and Human Resources, Louisiana Vital Statistics Report, Provisional Statistics, January-December, 1984
National Center for Health Statistics Monthly Vital Statistics Report: V33, No. 13, September 26, 1985

6. Infant Mortality Rates

a. The rate of infant deaths per 1,000 live births provides insight into the relative health status of pregnant women and their newborns, as well as into the relative responsiveness of the health care system in meeting the needs of pregnant women and newborns.

b. Figure 3.3 depicts the relationship between the U.S. and Louisiana infant mortality over the period 1950-1984. There is a significantly higher infant mortality rate among non-whites than whites. There is a noted trend of decreasing infant mortality in the U.S., as Figure 3.3 indicates. It also shows that Louisiana follows the national trend closely. The decrease is most pronounced for non-whites. However, in Louisiana the nonwhite infant mortality rate remains far above that of whites.

c. Table 3.20 presents infant mortality data by planning district. The 1984 infant mortality rates are highest in the Cenla district, for both whites and non-whites. The non-white infant mortality rate for the Cenla district is 21.3 per 1,000, which compares to 15 per 1,000 for whites. In comparing white and non-white infant mortality, the greatest range exists in the southwest district where the white mortality rate is 10.7 and the nonwhite rate is 19.9.

Table 3.20

Infant Deaths and Mortality Rates by Race and Planning Districts Louisiana - 1984

	Total		White		Non-White	
	Infant Deaths	Rate/ 1000	Infant Death	Rate/ 1000	Infant Deaths	Rate/ 1000
Louisiana	977	12.0	466	9.1	531	16.5
1. New Orleans	277	12.8	98	8.8	179	16.9
2. Capital	138	11.5	56	7.6	82	17.6
3. Bayou	54	9.2	30	7 5	24	12.6
4. Acadiana	111	11.0	65	9.4	46	14.4
5. Southwest	52	10.7	27	7.5	25	19.9
6. Cenla	102	15.0	51	11.6	51	21.3
7. Northwest	101	11.2	50	9.9	51	12.9
8. Northeast	80	12.9	34	10.3	46	16.0
9. Northshore	62	12.7	35	10.0	27	19.4

C. Morbidity Statistics

1. Issues in Obtaining Morbidity Statistics

a. Information on the distribution and types of diseases and disabilities afflicting the population is an essential health planning tool. Unfortunately, information on the incidence of disease within the state is incomplete and for the most part unavailable since there is no single indicator of morbidity and no uniform system through which such statistics are reported. The only exception is in the area of certain highly communicable diseases which are required to be reported to the Office of Preventive and Public Health Services.

b. Several indicators may be analyzed to estimate the effect of disease, illness and disability in a population. Hospital discharge diagnoses and diagnoses given by physicians on health insurance claims are the only diagnoses (other than communicable diseases) which flow into the general "information system" and which are presumably supported by clinical evidence of disease. Statistical analysis of such reported diagnoses provides some insights, but is made difficult by several factors.

c. First, clinical diagnosis nomenclature systems contain thousands of diagnoses, the use of which by clinicians is by no means uniform and often inexact. Many patients have multiple symptoms or diseases, and the reporting and sequence of primary, secondary, or tertiary diagnoses is often left to the discretion of a medical records clerk. Additionally, the existence of multiple diagnoses for a single patient's single medical service complicates and distorts the proper evaluation of such statistics.

d. Another problem in analyzing clinical diagnoses from hospital and physician service insurance claims is the fact that the population being measured is in fact not a random sample. The exercise is actually a comparison of the relative frequency of one diagnosis over another among a population of people who have sought medical care. Thus, there is no representation whatsoever of those in the population who are ill but may have not sought medical care or who may have been treated on an outpatient basis without the submittal of an insurance claim.

e. This problem ties in with another, that is the actual availability to health planners of the diagnostic information that has, in fact, been reported. At this time, there are no available data in Louisiana on the frequency of the various clinical diagnoses on insurance claims for physician services. This is because there is a reluctance on the part of third party payors to share such information, in part based on their need to preserve the confidentiality of medical records information and, in part, based on the expense of extracting diagnostic data from claims and sharing it with other entities in a way that permits comparisons. There are impediments in that various third party payors use different nomenclature systems for the classification of medical services or procedures. In some cases there are also different classification systems for diseases since there have not been timely or uniform changeovers to the use of updated disease classification systems (i.e. from ICDA-8 to ICD-9-CM).

f. At present, the only physician service claim information from which the State Health Planning and Development Agency might obtain information is that extracted from state Medicaid claims. As previously noted, such information will have the bias of the Medicaid eligible population, compounded by specialty and geographic variations in provider participation.

g. The only statistical information on diagnoses (other than communicable disease) which is available to this agency is:

i. that obtained by the Mid-Louisiana Health Systems Agency in their 1978-79 Hospital Patient Abstract Study; and

ii. that released by the federal Health Care Financing Administration (HCFA) in an analysis of the most frequently submitted diagnoses on Medicare hospital claims in 1977-78.

h. Both of these studies are biased in that only patients obtaining hospital care are included in the surveyed population. The Mid-Louisiana study is limited to the 24 parishes of that area. Though the HCFA study is statewide, the bias of the Medicare population is that all of the beneficiaries were age 65 + . So, with an understanding of the inherent limitations of the data, we present it and make some observations.

i. Mid-Louisiana Hospital Patient Abstract Study

(a). Data in this survey were provided by almost every hospital in the area and described a five percent sample of discharges. Analysis of raw data provided the following information.

(b). The most frequent discharge diagnoses were:

(i). Obstetrical and related diagnoses, including delivery, complications of pregnancy, live-born infant, perinatal morbidity and mortality, fetal deaths and abortions-20.67 percent;

(ii). Digestive System Diseases-11.55 percent;

(iii). Respiratory Disease, including respiratory system disease, flu and pneumonia-9.95 percent;

(iv). Genitourinary Diseases-9.32 percent;

(v). Circulatory System Diseases, including hypertension, ischemic heart and cerebro-vascular diseases and diseases of the arteries-8.78 percent;

(vi). External Causes of Injuries, including accidents, burns and violence-8.49 percent;

(vii). Symptoms and ill-defined conditions-4.95 percent;

(viii). Musculoskeletal System Diseases, includes bone joint diseases, arthritis and rheumatism-3.55 percent;

(ix). Infections-3.47 percent;

(x). Mental Diagnoses, includes mental disorders and retardation-3.09 percent;

(xi). Cancer (malignant neoplasms)-2.75 percent; All Other-11.81 Percent;

(xii). Total-100.00 percent.

(c). Those diagnoses accounting for the most patient days, (number of discharges times the length of stay,) were circulatory diseases, obstetrical and related diagnoses, digestive system diseases, external causes of injury, respiratory diseases, and genitourinary diseases. During 1978, the 24 parish area experienced a rate of 985.5 patient days per 1,000 population.

(d). Of interest in the analysis of morbidity is the high percentage of hospital discharges for reason of digestive, respiratory and genitourinary diseases. These disease categories do not appear in statistics depicting the leading five causes of mortality, but they were the leading disease-related causes for hospitalization in the mid-Louisiana area. This would seem to underscore the need for health planners to develop a methodology for measuring morbidity so that initiatives in the health care field may be directed more precisely toward treatment of illness and disease.

ii. HCFA Medicare Hospital Abstract

(a). Data in the HCFA study were obtained from a 20% sample of all Medicare (+ 65) inpatient hospital bills submitted during 197778. The 25 most frequently reported diagnoses were analyzed for participating hospitals in Louisiana.

(b). The most frequent discharge diagnoses were:

Number discharges reported in 20 percent sample.

(i). Circulatory System Diseases-13,750 Respiratory Diseases-3,046;

(ii). Digestive System Diseases-2,694 Eye Disease (cataract surgery)-1,641;

(iii). Endocrine Disease (diabetes)-1,505;

(iv). Genitourinary Disease (prostate surgery and other diseases of the urinary tract)-1,493;

(v). Musculoskeletal System Diseases (osteoarthritis and allied conditions; fracture of necks or femur) 1,124;

(c). The number of discharges with diagnoses other than the most frequent ones was not included in the HCFA report and thus relative percentages could not be included. Again, the high incidence of respiratory and digestive disease discharges is of note, and the incidence of circulatory and related diseases is, as would be expected among the 65 + population, quite pronounced.

2. Health Index

a. One of the most valuable tools for evaluating the incidence of morbidity in a population is a random survey of the residents. While clinical diagnoses cannot be obtained from the general population with any accuracy or validity, behavioral indicators of general health status can be obtained. Loss of functioning, days of restricted activity, special personal care requirements and use of health care services are all health status indicators which may be obtained from a survey of an area's households. These indicators are of particular importance in our current chronic disease-oriented environment in which concern is increasingly directed toward nonfatal illnesses and injuries which disable or, at the least, cause inconvenience and economic loss. Sampling the same population regularly, on an annual or biannual basis, provides the basis for a comparative health status index.

b. Such health status indicators are obtained on a national level in an annual survey performed under the

auspices of the National Center for Health Statistics. The sampling of individual states is too small to permit a statistically reliable projection of the indicators for the state as an entity in itself.

c. The Louisiana State Health Planning and Development Agency has recommended that an annual sample of 2,400 Louisiana households be undertaken to obtain reliable behavioral indicators of health status within the state. The State Health Planning Agency has not had sufficient funds to perform the survey (estimated 1982 cost to initiate survey: $25-30,000; cost in future years: $10,000 +). At such time as funds become available, the State Health Planning Agency would see this type of survey as a priority. Data that would be obtained could be used to develop a hierarchy of goals for forming governmental policies and in providing health care services.

3. Developmental Disability

a. It is important to identify the segment of the population with developmental disabilities (DD) since persons with these chronic conditions require special medical and social services if they are to function at as high a level as possible. The term "developmental disability" means a severe, chronic disability which:

i is attributable to a mental or physical impairment or combination of mental and physical impairments;

ii. is manifested before the person attains age 22;

iii. is likely to continue indefinitely;

iv. results in substantial functional limitations in three or more of the following areas of major life activity:

(a). self-care;

(b). receptive and expressive language;

(c). learning;

(d). mobility;

(e). self-direction

(f). capacity for independent living; and

(g). economic sufficiency; and

v. reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

b. The definition of developmental disability, as amended by P.L. 95-602, is a functional rather than a categorical definition. Specific disability categories are not cited; however, individuals with the following types of conditions originating in childhood could be included if the above criteria in the definition of developmental disabilities are met:

i. moderate, severe and profound levels of mental retardation;

ii. cerebral palsy;

iii. severe cases of epilepsy;

iv. autism;

v. severe emotional disturbances, particularly childhood psychosis and childhood schizophrenia;

vi. severe physical impairments associated with such disorders as spina bifida, muscular dystrophy, tuberous sclerosis, and osteogenesis imperfect;

vii. multiple handicaps such as deaf-blindness;

viii. severe learning disabilities.

c. It is estimated that at least 50 percent of the developmentally disabled persons have a major intellectual deficit.

d. The Louisiana State Planning Council on Developmental Disabilities has adopted the prevalence rate of 1.1 percent for developmental disabilities. This estimate has been developed nationally and does not reflect high risk factors in Louisiana, which may contribute to a higher prevalence of developmental disabilities in this state. Using the 1.1 percent prevalence rate, it is estimated that there are 46,244 persons with developmental disabilities in Louisiana, based on 1980 census figures.

e. Persons with developmental disabilities require a comprehensive coordinated system of services to participate as fully as possible in the community. Because of the developmentally disabled individual's need for continuing services, long term care services in the least restrictive and most cost effective settings are needed. Support of the family to maintain a developmentally disabled family member at home is critical. Residential programs are also needed, such as community homes, supervised apartment programs, independent living services and specialized adoptive and foster care. Finally, a range of community support services are required.

4. Mental Health and Substance Abuse

a. Problems related to mental health and substance abuse are serious impediments to good health and are a major cause of ill health in the U.S. as well as in Louisiana.

b. The National Institute of Mental Health estimates that 20 percent of Americans have a mild to severe psychiatric disorder and that 2 percent of the population will be hospitalized for mental illness at some point in their lives. Applying these percentages to 1980 Louisiana census data, it is estimated that 840,794 Louisianians suffer from mental health disorders, with over 84,000 persons hospitalized for mental illness. Survey data compiled by the Louisiana Office of Mental Health and Substance Abuse was the basis for an estimated prevalence rate of 6 percent for problems related to alcohol. Alcohol and drug abuse are recognized as serious primary illnesses which often overlap with each other and with other diseases and aggravate many other health and social problems. Health-related problems which are exacerbated or caused by alcohol and drug abuse are heart and liver disease, accidental death and injury, severe

psychiatric impairment, fetal and infant morbidity and mortality, homicide and other violence.

c. The incidence of significant mental health and substance abuse problems in the Louisiana population is at least 15 percent, or about 630,600 persons based on 1980 census data. With so large a segment of the population affected by these problems, it is critical that services directed toward ameliorating these health problems be given substantial attention. (See Chapter 115, sections on Chemical Dependency and Psychiatric Beds for further information.)

d. Statistical information provided by the Office of Prevention and Recovery of Alcohol and Drug Abuse, which highlights the health and social problems caused by alcohol and drug abuse is as follows:

i. the effects of alcoholism on members of the alcoholic's family is such that it is classified as a family illness. One out of eight Americans alive today (28.6 million) have been reared by a parent or parents who were alcoholics. Currently 6.6 million children under eighteen years of age live with an alcoholic parent;

ii. alcohol is estimated to be involved in 53 percent to 58 percent of fatal accidents resulting in approximately 22,500 traffic deaths in 1983. Louisiana ranks 11th in the nation in deaths from motor vehicle accidents;

iii. in the United States, cocaine use has increased fivefold in just ten years. Recent surveys show an estimated 22 million Americans have used cocaine and 4.2 million are considered current users;

iv. fifty-four percent of inmates had been drinking prior to committing the crimes for which they were convicted. Sixty-eight percent of those convicted of manslaughter, 62 percent of those convicted of assault, and 49 percent of those convicted of murder or attempted murder were drinking prior to committing the offense;

v. one fourth of all suicides are alcohol related;

vi. current research shows that one out of every 16 employees has or is developing a serious alcohol or drug problem. These employees yield a 25-50 percent loss in productivity;

vii. the estimated economic costs of alcohol and drug abuse to the state of Louisiana for 1980 was $2.5 billion;

viii. in 1984, Louisiana ranked 26th among states in alcohol consumption;

ix. an estimated 32 million Americans use marijuana each year;

x. marijuana and cocaine users are concentrated among our youth; 18-25 year olds have the highest drug use rates and 12 to 17 years olds have the second highest. There has been a 200 percent increase in cocaine-related deaths in the past 5 years, and a 500 percent increase in cocaine-related treatment admissions.

5. Physically Handicapped

a. Prevalence rates for the physical handicaps are inexact. The "Ridge Method" of calculating the prevalence of physical handicap in a state population was applied to Louisiana population characteristics and a prevalence rate of 18.53 percent among persons aged 18-64 was found.

b. 1970 census data indicated a prevalence rate for physical handicap of 10.6 percent of the population age 16-64, which is a significantly lower estimation than produced by the "Ridge Method".

c. Because 1980 census data do not have the age 18 as the bottom of an age range, it is not possible to calculate precisely the numbers of people age 18-64. Of the 1980 population 64.7 percent or 2,722,230 persons were age 15-64. We have used 12 percent of this population group as a prevalence indicator and estimate that 326,667 of the state's 1980 population age 15-64 are physically handicapped. This prevalence indicator does not include handicapped persons younger than 15 or older than 64.

d. See Chapter 115, section on Comprehensive Physical Rehabilitation Services for more information.

6. Communicable Disease and other Reportable Health Conditions

a. There are 32 health conditions which are to be reported by treating physicians. The incidence of most of these is minimal. For 1980 and 1984, statistics released by the Office of Preventive and Public Health Services revealed the following disease incidence in the state.

Table 3.21
Reportable Diseases

	1984	1980
Asceptic Meningitis	85	93
Diptheria	0	0
Encephalitis, Other and Unspecified	14	24
Encephalitis Arthropod Bone	0	N/A
Hepatitis A	322	-
Hepatitis, Unspecified	93	-
Hepatitis, NON A, NON B	31	-
Hepatitis B	336	313
Tuberculosis, Pulmonary	337	478
Tuberculosis, Other	40	N/A
AIDS	53	N/A
Pertussis	12	38
Rabies in Animals	63	19
Rubella	0	13
Severe Undernutrition	21	7
Shigellosis	113	233
Typhoid Fever	2	2
Other Salmonellosis	225	213
Tetanus	3	5
Measles	8	15
Gonorrhea	25,469	22,605
Syphilis, including primary and secondary	2,854	1,421
Brucellosis	3	N/A
H-Blue Meningitis	96	N/A
Legionellosis	4	N/A
Leprosy	4	N/A
Malaria	12	N/A
Mycobactoeriosis, Atypical	86	N/A
Botulism, Infant	3	N/A

Table 3.21 Reportable Diseases		
	1984	1980
Botulism	1	N/A
Food Poisoning	11	N/A
Leptospirosis	2	N/A

Source: La. Vital. Statistics Office

b. Venereal disease is the most prevalent of the communicable diseases and is a serious problem in the state. Rates of gonorrhea in Louisiana decreased during the 1950's and early 1960's after the widespread use of penicillin. However, the incidence level began rising in 1965. In 1974 the incidence well exceeded pre-penicillin levels. In 1980 there were 22,605 reported cases of gonorrhea. In 1984 the number of reported cases increased to 25,469. AIDS has recently been added to the reportable diseases list because of widespread concerns. In 1984 there were 53 reported cases of AIDS in the state.

c. Syphilis rates per 100,000 dropped from a 1950 high of 348.4 to 17.1 in 1977. There has been a sharp increase since 1977 in the syphilis incidence rate, with 72.6/100,000 noted in 1980. In 1984 the number of reported cases of syphilis was more than double the reported cases in 1980 or 2,854 reported cases.

D. Summary

1. Mortality statistics are the most reliable indicators of health status currently available for use. Using prevalence rates to estimate the incidence of some conditions is helpful in determining health service needs for certain well-defined segments of the population, such as the developmentally disabled and physically handicapped. On the other hand, morbidity statistics are quite limited in Louisiana and should be further explored. The use of hospital discharge diagnoses as a measure of morbidity is accurate only as a measure of the relative frequency of one discharge diagnosis over another discharge diagnosis. Such "relative frequency" data available in Louisiana hospital discharges indicates a higher frequency of hospital utilization for patients with digestive, respiratory and genitourinary disease than might be expected based on mortality indicators.

2. External causes of injury (non-motor vehicular and motor vehicular accidents, burns and violence) account for a substantial number of hospital discharges (8.5 percent, according to a Mid-Louisiana patient abstract study conducted in 1978-1979) and account for a significant number of productive years lost because of premature death. There is a correlation between injuries and death from accidents and violence and the incidence of alcohol and substance abuse. These problems are significant in evaluating the health status of Louisianians.

3. Perhaps the most distinct "risk factors" which can be identified are noted in examining race and sex variables in health status. The premature death rate for non-whites is substantially greater than whites. Nonwhite males have the highest level of premature death. The observation is made, on the basis of available information, that the utilization of medical care services is inversely proportional to the likelihood of premature death. The observation can also be made that treatment appears to be most often obtained for diseases not significantly related to mortality. These correlations suggest that much illness and premature death is preventable with improved access for regular primary health care. The target population for health system initiatives in this area should be non-whites.

4. The age-adjusted death rate in Louisiana suggests that Louisiana's population is in relatively poorer health than the national average and is particularly affected by higher incidences of circulatory diseases and cancer. Louisiana's higher incidence of disease-related deaths can be attributed, at least in part, to the state's higher percentage of non-whites. (Non-whites have a significantly higher age-adjusted death rate than whites).

5. The observation can be made that rural people have a higher crude death rate and more frequent and longer hospitalizations than urban residents. This correlation is primarily due to rural areas having higher percentages of persons over 65 years of age, non-whites and persons below poverty level. Thus ruralness in itself is not seen as a health risk factor but rather the location of high percentages of persons at risk because of other factors.

6. A health status indicator which seems particularly urgent is the rate of malignant neoplasm, or cancer, in the state. The age-adjusted mortality rate for cancer is increasing rather than decreasing. The state has an age-adjusted death rate from cancer which exceeds the national rate. The death rate for cancer is greatest in the northwest district, New Orleans district and Acadiana district. Risk factors which are generally associated with poor health care are age, low income, and accessibility and availability of health care resources. However, these factors do not explain the high incidence of cancer in some areas of the state. Identification of the risk factors involved in the increasing incidence of cancer in some districts of the state, warrants study by health care professionals.

7. Louisiana's overall health status does not fare well in comparison with the U.S. as a whole. Much can be done through initiatives and changes in the health care system to improve the health status of the citizens. Much which needs to be done is also in the province of those outside the health care system, that is, those concerned with safety and accident control, homicides and violence, control of narcotics and other addictive substances, environmental quality and health education in schools. Improvement of the health of Louisianians will require a mutual effort by all, including the participation and assumption of responsibility by every citizen for his or her own personal health habits.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance LR 13:246 (April 1987).

Chapter 105. Statewide Health Priorities

§10501. National and State Priorities

A. In Section 1523 of the National Health Planning and Resources Development Act of 1979 (Public Law 96-79), the United States Congress charged the State Health Planning and Development Agency with responsibility for determining the health needs of the state. In Section 1502 of the same Act, Congress outlined 17 national health priorities which were found to deserve special consideration in the development and operation of federal, state and area health planning and resources development programs. These national priorities are:

1. the provision of primary care services for medically underserved populations, especially those in rural or economically depressed areas;

2. the development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services);

3. the development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care;

4. the training and increased utilization of physician assistants, especially nurse clinicians;

5. the development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions;

6. the promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under part B of Title XI of the Social Security Act;

7. the development of health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis;

8. the promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services;

9. the adoption of uniform cost accounting, simplified reimbursement, utilization reporting systems, improved management procedures for health service institutions, and the development and use of cost saving technology;

10. the development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health service;

11. the promotion of an effective energy conservation and fuel efficiency program for health service institutions to reduce the rate of growth of demand for energy;

12. the identification and discontinuance of duplicative or unneeded services and facilities;

13. the adoption of policies which will (a) contain the rapidly rising costs of health care delivery, (b) insure more appropriate use of health care services, and (c) promote greater efficiency in the health care delivery system;

14. the elimination of inappropriate placement in institutions of persons with mental health problems and the improvement of the quality of care provided those with mental health problems for whom institutional care is appropriate;

15. assurance of access to community mental health centers and other mental health care providers for needed mental health services to emphasize the provision of outpatient as a preferable alternative to inpatient mental health services;

16. the promotion of those health services which are provided in a manner cognizant of the emotional and psychological components of the prevention and treatment of illness and the maintenance of health; and

17. the strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve to advance the purposes of quality assurance, cost effectiveness, and access.

B. All planning involves the setting of priorities because, for many obvious reasons, rarely is it possible to address all of the problems and issues one might identify. Even more rarely is it possible to find feasible, timely solutions to all of the problems or to develop necessary resources to carry out planning strategies. It is, therefore, essential to any plan that some goals be selected or ranked as more appropriate, more relevant, or more beneficial so that a hierarchy of goals and implementation strategies may be developed.

C. In consideration of this need to narrow the focus of this State Health Plan and in accordance with the Congressional mandate to establish health needs priorities for the State of Louisiana, three comprehensive areas within the broad spectrum of health-related issues have been selected as health priorities for the 1982-87 planning horizon. These priority areas have been adopted by the Louisiana Statewide Health Coordinating Council and by the Secretary of the Department of Health and Human Resources as the primary issues to which attention and initiative should be given.

1. Priority: High Costs of Health Care

a. Goal. The adoption of policies which will contain the rapidly rising costs of health care and promote greater efficiency in the health care delivery system.

i. Sub-goal: The development of policies and effective methods of public education directed at insuring

more appropriate (discriminating) use of available health care services.

ii. Sub-goal: The identification and discontinuance of duplicative or unneeded services and facilities.

iii. Sub-goal: The development of effective methods through which both public sector and private sector health care providers can coordinate and consolidate spedicalized institutional and clinic health services and share support services.

iv. Sub-goal: The training and increased utilization of physician's assistants, nurse practitioners and other non-M.D. health professionals for delivery of appropriate health care services not requiring the presence of an M.D.

v. Sub-goal: The development and use of cost-saving technology, including uniform cost accounting, simplified reimbursement, utilization reporting systems and improved management procedures.

vi. Sub-goal: The promotion of an effective energy conservation and fuel efficiency program for health service institutions.

vii. Sub-goal: The development of lower cost alternatives to inpatient services in acute care facilities available and accessible through the state, primarily ambulatory surgical centers and beds.

viii. Sub-goal: The curtailment of unnecessary medical procedures and excessively lengthy hospital stays.

ix. Sub-goal: The encouragement of the development by private industry of more appropriate health benefits packages for employees.

x. Sub-goal: The training of medical students regarding the cost implication of actions by treating physicians.

xi. Sub-goal: The encouragement of the development of prepaid medical group practices, health maintenance organizations and other organized systems for the provision of less costly health care.

2. Priority: Alternatives to Long Term Institutionalization

a. Goal: The development and promotion of a comprehensive array of services available at the community level directed toward preventing, postponing or terminating inappropriate and costly long term institutionalization of the functionally impaired. (Functionally impaired is defined as individuals with handicaps due to advancing age, chronic mental illness, physical or developmental disabilities and those recovering from mental illness, alcohol and drug abuse disorders.)

i. Sub-goal: A full range of accessible residential alternatives for the functionally impaired, including special living arrangements, foster care, supervised apartment living, community living developments and half-way housing, independent living and subsidized adoption.

ii. Sub-goal: A full range of personal and family support services for the non-institutionalized functionally impaired, including personal care, nutrition, home health/homemaker transportation, respite care, parent training, family counseling, and parent-to-parent support programs.

iii. Sub-goal: Day programs for the non-institutionalized functionally impaired, including day care, medical day care, education, training, sheltered employment and recreation.

iv. Sub-goal: Diagnostic and treatment services available and accessible to the non-institutionalized functionally impaired for needed medical, dental and physical therapy services.

v. Sub-goal: Availability of needed medical equipment, supplies and prescription drugs for the non-institutionalized functionally impaired.

vi. Sub-goal: Case Management services for the functionally impaired which assure the continuity and availability of appropriate, humane and efficient non-institutional care and placement, including services for identification, diagnosis and evaluation, information and referral, individual service plan development, and implementation, service authorization and placement, and monitoring of the plan.

3. Priority: Health Promotion

a. Goal: The availability of services at the community level directed toward informing, educating and motivating the public to accept responsibility for their own health, adopting lifestyles and nutritional practices which promote optimal health, avoiding health risks and making more appropriate use of available health care services.

i. Sub-goal: A populace more knowledgeable about the signs and symptoms, prevention and treatment of diseases which significantly affect the citizens of Louisiana, especially heart disease, stroke, cancer, respiratory disease, diabetes, veneral disease and mental and emotional disorders.

ii. Sub-goal: A more knowledgeable citizenry, motivated to avoid the abuse of alcohol and other drugs and the use of tobacco.

iii. Sub-goal: A population with increased knowledge and ability to select a diet most conducive to good health.

iv. Sub-goal: A more knowledgeable citizenry, motivated to participate in a program of appropriate, regular physical exercise.

v. Sub-goal: A population increasingly aware of practical methods to avoid safety hazards and accidents in the home, workplace and on the highway.

vi. Sub-goal: A population increasingly aware of the need to preserve, protect and improve the quality of the environment.

AUTHORITY NOTE: Promulgated in accordance with PI. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§10503. Priority Selection Methodology

A. The three issues of High Costs of Health Care, Alternatives to Long-Term Institutionalization and Health Promotion were determined to represent the priority health needs of Louisiana upon completion of the following priority selection process.

B. To facilitate the submission of recommendations respecting priority health issues, a mail-out survey was designed and sent to 1,576 individuals representing governmental health agencies, a wide range of public and private health care providers, consumer health advocacy organizations, the governing boards of the three Health System Agencies and the Statewide Health Coordinating Council. A listing of the individuals and groups surveyed can be found in Form A in the Appendix. The survey design involved presenting as many potential priority topics as could be identified to the surveyed population and requesting that they select the ten topics they believed most important. The ten topics were then to be ranked by respondents from one to ten in the order of priority they would assign. Respondents were asked to consider priority selection in the following ways:

1. Impact on Population of the State

a. The number of people and the degree to which the state as a whole is affected.

b. The pain, disability, discomfort or early death caused to the individual citizen.

2. Potential for Elimination-Benefits. The probability that substantial prevention, reduction or elimination of the problem can occur if something is done about it.

3. Future Impact-Urgency

a. The degree to which this problem will affect the state and its citizens if no changes are made in the health care system.

b. The total costs to the individual, the community and the state that will be incurred in the 1982-1987 period if something is not done.

C. In developing the list of possible priority areas for the survey, the Health Planning and Development Agency compiled a list of health issues which included:

1. national health planning priorities;

2. health systems agencies priorities;

3. leading causes of death in the state;

4. leading causes of morbidity in the state, indicated by hospital discharge diagnoses and statistics on communicable disease; and

5. qualitative statements about possible deficiencies in the state's health system resources in the areas of availability, accessibility, cost, quality or continuity of services.

D. This comprehensive list of issues was reduced to the twenty-two issues presented in the survey after related issues were grouped into broader issues and some issues were discarded because of a failure to meet the requirement of (a) broadness of scope; or (b) capability of DHHR to address the issue effectively; or (c) urgency of the problem because of a lack of current resources and a likelihood of a worsening in the status quo. In addition, the HSA's were given the opportunity to review and suggest recommendations which were incorporated into the survey. Refer to Form B in the Appendix for a copy of the survey and priorities.

E The survey also gave respondents the opportunity to write in additional priority areas of concern so that it could be determined if any major areas had been overlooked. Essentially, the State Health Planning and Development Agency is satisfied that the possible priority issues presented for consideration by respondents was comprehensive and represented significant health-related issues in Louisiana. Refer to Form C in the Appendix for a review of the comments received from respondents.

F. Nine hundred forty-six of the 1,576 surveys were returned. This represented 60 percent of the surveyed population, which is a statistically sound sampling. Surveys were returned from people in every parish of the state: 53 percent were public providers of health care; 20 percent were private providers and 27 percent classified themselves as consumers of health care. Residential distribution was 41 percent from rural areas or cities under 25,000; 21 percent from cities, population 25,000-100,000; 20 percent from cities, population over 100,000; and 18 percent from the New Orleans Metropolitan area. Female respondents comprised 53.5 percent; males 46.5 percent. Blacks comprised 8 percent of the respondents; Whites 91 percent; other, less than 1 percent. Age distribution of respondents was 5 percent age 65 + ; 84 percent age 31-64; and 11 percent age 18-30.

G. Respondents' answers were tabulated in two methods. Priorities were assigned a point value of ten for a first place ranking, down through one for a tenth place ranking. Results were then recomputed giving no value for a ranking of six to ten and assigning a value of five for a first place ranking and so on down to a value of one for a fifth place ranking. These two methodologies were used in order to compare any difference in ranking which might occur due to a particular issue being selected by a large number of people as a priority ranked 6-10 but by relatively fewer as a priority 1-5. This was considered significant since it was proposed that priority issues be limited to a small number which could be given significant attention.

H. The outcome of the rankings appears on Form D in the Appendix. It is noteworthy that the position of "Substance Abuse" falls from #5 to #12 when only the top

five priorities were tabulated. Otherwise, the rankings remained relatively stable.

I. The Health Planning and Development Agency recommended that the top three issues selected by survey respondents be accepted as priority health issues for focus during the 1982-87 planning horizon: High Costs of Health Care, Alternatives to Long Term Institutionalization, and Health Promotion. These three issues were adopted by the Statewide Health Coordinating Council as the statewide health needs deserving priority attention in the development of health-related planning by all concerned private and public organizations and provider groups. The Department of Health and Human Resources also adopted these three issues as their planning priorities for the 1982-87 period.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P. L. 96-79, and R.S. 36: 256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance LR 13:246 (April 1987).

§10505. Use of Statewide Health Priorities

A. The three priorities have been used extensively in the development of this State Health Plan and served as a guide for the selection of implementation strategies proposed by state health agencies. The priorities are seen to be reflective of the State of Louisiana and of the nation during the 1980's. Of the 17 national priorities, nine issues are directed toward containing or lowering the cost of health care, two toward the development of alternatives to long term institutionalization, and two toward the development of better methods of preventing ill health and promoting healthy lifestyles. The priorities selected for focus in Louisiana are bound together by a concept of reducing the costs of health care while bringing about improvements in the health status of the state's citizens and the health system.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of management and Finance, LR 13:246 (April 1987).

Chapter 107. Program Inventory: Priority Areas

§10701. Introduction

A. In order to properly evaluate the elements of a health system, it is helpful to know what components are already in place: to have an inventory of on-going programs and services. The development of such an inventory does not proceed without difficulty. To successfully accomplish the task, a clear and uniform taxonomy is needed so that agencies and organizations can classify their activities and programs into precise, well defined categories that permit comparisons.

B. The design of the required taxonomy is, in itself, a very demanding task. Many health system taxonomies have been proposed, but none has achieved the goal of permitting the comprehensive review of programs without problem. In each taxonomy there appears to be some amount of overlap among categories, ambiguity in definitions, and problems with syntax. Once developed, the application of a taxonomy is complicated by ambiguities in program descriptions, the fact that health system programs have multiple purposes, goals and target populations making precise classification difficult, and the fact that the programs are dynamic in nature causing initial classifications to become obsolete as program changes occur.

C. To develop a systematic inventory of existing health system programs in Louisiana, a very simple taxonomy was devised, consisting of the selected priorities broken down, where appropriate, by program type. Information on existing programs and services was obtained initially through a survey of state and non-governmental agencies and organizations. The review of state-administered programs was more comprehensive because the organizational structure of the bureaucracy permitted a more thorough survey. A Task Force composed of representatives from the state agencies providing health-related services was formed and developed an inventory of services and programs which were directed toward one or more of the state's priority areas and goals (Alternatives to Long Term Institutionalization, Health Promotion and High Costs of Health Care).

i. This inventory was as complete as the agency representatives were able to produce, and certainly depicted a substantial, if not exhaustive, record of what existed at the time within the state-administered health system in the established priority areas.

D. Initially, it was attempted to identify the amount of money spent in each service area; however, it became clear immediately that the task was not possible. Because of an inability to separate particular services and programs into discrete entities of a small enough denomination, the precise number of health dollars spent in priority areas is not known.

E. In February, 1986, a second survey of state agencies and organizations was conducted in an effort to update the inventory. The updated information is presented in this chapter. The first section of the chapter is devoted to a state agency inventory and the second section to a review of private sector initiatives.

F. There are a number of programs and services available in Louisiana directed toward helping people stay out of long term care facilities whenever possible. There are also substantial programs aimed at educating the public about ways to reduce their own health risks. Though there is a variety of such programs, there are not nearly enough to meet the needs of the state's population of over 4.5 million. As can be seen in the inventories of state and private agency programs, there are few initiatives directed toward containing health costs.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641, as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§10703. Inventories

A. The inventory of on-going programs underlines the gaps and insufficiencies of services in the identified areas.

B. Inventory of State-Administered Programs

C. In the left margin are initials designating which state agencies administer the described service. Initials are:

1. DHHR Department of Health and Human Resources;

2. OMR-DD Office of Mental Retardation—Developmental Disabilities (DHHR);

3. OMR Office of Mental Retardation;

4. OMH Office of Mental Health (DHHR);

5. OHD Office of Human Development (DHHR);

6. OH Office of Hospitals (DHHR);

7. OCHNO Office of Charity Hospital in New Orleans (DHHR);

8. OFS Office of Family Security (DHHR);

9. OPPHS Office of Preventive and Public Health Services (DHHR);

10. OPRADA Office of Prevention and Recovery from Alcohol and Drug Abuse (DHHR);

11. D. EDUC. Department of Education

D. Alternatives to Institutionalization

1. This is an inventory of services and programs administered by state agencies encompassing any inpatient or outpatient service which prevents, postpones or terminates long term institutionalization of the functionally impaired.

a. Supportive services, to enable individuals to function outside of long-term care institutions and to realize full potential for employment and/or independent living:

i. OMR-DD Independent Living Program—provides support services to developmentally disabled individuals; Statewide for physically handicapped (assessment and technical assistance only); Shreveport and New Orleans for MR adults; New Orleans for children and adolescents;

ii. OMH Community Living Skills—offered in New Orleans; provides training in living to individuals recently deinstitutionalized or in danger of institutionalization (chronically mentally ill);

iii. OMR-DD/ Supervised Apartment Living—the OMR-DD contracts with private OMH providers for supervised apartment living programs in seven of eight regions;

iv. OMR-DD Planning for Independent Living—offered in Lake Charles region; provides case management, counseling and advocacy training for the physically handicapped;

v. OMR-DD Adult Day Services—offered statewide through contracts with providers; provides sheltered employment, training, limited recreation and transportation for mentally retarded/developmentally disabled adults ages 22 years and older;

vi. OMR-DD Infant Intervention Services—offered statewide through contract with private providers who provide language stimulation, motor development and self-help skills in either a home-based or center-based setting to mentally retarded/developmentally disabled infants from birth—two years.

vii. OMR-DD Respite Care—provided directly by state staff at Opelousas Developmental Center and Southwest State School.

viii. OMR-DD Community Homes/Group Homes—group homes provide residential care and habilitation services to 7-15 mentally retarded/ developmentally disabled individuals. Community homes provide the same type of services, but in smaller residential settings (4-6). These homes are located statewide with the vast majority being privately operated serving 6 or fewer clients.

ix. OMR-DD Substitute Family Care—Substitute Family Care provides residential care, supervision, and training in individually recruited family homes. Such placements exist in every region of the state, although programs are actually operated out of six of the eight regions. Participants are adults and children who previously resided in institutional settings, or for whom institutional placement was being sought. The program is administered by OMR /DD state schools and community services regional offices.

x. OMR-DD Minor Home Renovation—services to enable a handicapped individual to continue to live at home through minor renovation to the client's residence.

xi. OHD Independent Living Program—New Orleans, Lake Charles and Shreveport-state operated center for disabled adults offering assistance with information, referral, support services of all types and home aide services. Approximately 910 clients are served annually at these centers at a cost of $200,000.

xii. OMH Community Living Program and Day Treatment/ Hospitalization Programs—psychiatric day care, including psycho-social treatment, rehabilitation and educational services, offered in 11 centers throughout the state, for adults, adolescents and children. Services are designed to meet the needs of persons who do not require full time hospitalization, and to assist with transition from institutionalization to community living.

xiii. OMH Transitional Living Units—Located at Southeast Louisiana Hospital and Central Louisiana State Hospital. Services are provided to assist psychiatric patients in autonomous living skills and to assist with outpatient transition, work and living arrangements after release from inpatient care.

xiv. OMH Adult Residential Services for the Chronically Mentally Ill—Transitional residential/rehabilitative services which include case management, socialization and pre-employment training for the adult mentally ill. Group home sites range in size from six to 15 beds. Locations of current programs are the New Orleans, Baton Rouge, Houma and Lafayette areas.

xv. OMH Fairweather Programs—Self-supported projects in congregate living available in Pineville and New Orleans for small groups of chronic, long-term hospitalized patients. Participants form a corporation and arrange to govern themselves, move out of the hospital setting as a group and earn sufficient money to provide for living expenses.

xvi. OHD Respite Care Program—contract services purchased with State funds to provide temporary care for functionally impaired individuals and relieve their families of the burden of on-going care of the severly impaired. Purchased services are available in-home or center-based up to a maximum of 720 hours of care every six months. Respite Care Centers are available regionally throughout the state.

xvii. OHD Halfway House for the Psychiatrically Disabled—four houses operated by OHD employees in New Orleans, Baton Rouge and Shreveport offer short-term housing for individuals in transition between psychiatric institutionalization and independent community living.

xviii. OPRADA Halfway House and other residential services for Recovering Substance Abusers—five contract programs involving purchase of service from private providers offering residential living services to individuals in substance abuse rehabilitation program.

xix. OHD /Non-emergency Transportation—services are available to Medicaid OFS eligibles to enable recipients without personal or public means of access to needed medical care to obtain transportation to medical treatment. Such services enable some individuals to remain in their own homes.

xx. OMH Psychosocial Clubhouses—Resource coordination, employment development, sheltered employment, socialization and daily living skills for the chronically mentally ill. Category includes Alliance House in Baton Rouge and Friends of the Psychologically Handicapped in New Orleans and other such programs in Monroe, Alexandria and Lafayette.

xxi. OMH Supervised Apartment Living/Clustered Apartment Living—Offered in New Orleans, Baton Rouge and Lafayette; provides structured support services to chronically mentally ill individuals living in the community.

xxii. OMH Adolescent Community Home Programs—Transitional residential services based upon a teaching family model of residential care for severely emotionally disturbed adolescents between 12 and 18 years of age. Project sites are in Shreveport, Pineville, Baton Rouge and Kenner.

xxiii. OFS Medical Day Care Services—available through Title XIX funds for Medicaid eligible persons; day care services for persons needing medical care to assist the family in keeping the individual at home to avoid or delay institutionalization.

xxiv. D. Educ. Special Education Services—mandated education services provided statewide for identified special education students, ages three through 21. These services include, but are not limited to: identification, referral, evaluation, and placement in a special education program.

b. Direct mental and physical health services which offer outpatient treatment or short-term hospitalization as a preferable alternative to long term institutionalization:

i. OH Tri-Med Services—short-term, acute medical treatment for individuals with alcohol or drug abuse problems, or mental illness; discharge planning and referral services offered at eight state-supported general hospitals.

ii. OPPHS Home Health Services—offered to residents, primarily over 60 years of age, in all parishes except Orleans and Plaque-mines who could not otherwise obtain/afford such needed services.

iii. OPRADA Outpatient Clinic Program—primary and specialty physician care to maintain health and prevent acute episodes requiring hospitalization, available at 16 contracted outpatient clinics and the operation of 24 outpatient clinics throughout the state by OPRADA. Services are directed toward preventing hospitalization and include screening, diagnosis, counseling, group therapy and referral.

iv. OMH/OFS Outpatient Mental Health Services—Consists of 45 full-time community mental health centers or clinics and 55 part-time outreach clinics operated throughout the state with services directed in part toward preventing hospitalization or re-hospitalization. Clinical outpatient services include: screening, evaluation and diagnosis, individual, group and family therapy; crisis care; medication administration and management; specialized services for identified target populations such as children and adolescents, the elderly, and criminal justice interface clients; and transportation services.

v. OCHNO Mental Health Crisis Intervention Unit-80 bed psychiatric and 37 bed chemical dependency units operated at New Orleans Charity Hospital offering immediate, community-based short-term services to individuals in crisis because of mental or substance abuse problems.

vi. OFS Home Health Services—covered under Title XIX for Medicaid eligibles (up to a maximum of 50 services per year)—services consist of physical therapy, part-time skilled nursing, home health aide service and medical supplies needed by recipients to enable them to remain in their own homes.

vii. OFS Durable Medical Equipment—Medical equipment, supplies,and appliances provided to title XIX

recipients who, in many cases, would otherwise be unable to function independently and live in their own homes.

viii. OPPHS Adult Health—services available in twelve parishes offering screening for chronic disease and illness. Program involves referral and some follow-up treatment; early diagnosis and treatment in elderly patients is directed toward maintaining health and postponing or preventing long-term care.

ix. OPPHS Tuberculosis Control Program—provides screening, diagnosis and treatment. Maintenance services provided by the Tuberculosis Control Program are responsible for preventing the long-term institutionalization of many of the state's residents who have been diagnosed as having tuberculosis.

x. OPRADA Inpatient Detoxification—purchase of substance abuse detoxification services from three contracted detox programs and the provision of detoxification services at one OPRADA operated detox program.

c. Direct rehabilitation services:

i. OH/OCHNO Physical Therapy and/or Occupational Therapy—In-patient and out-patient services for the physically handicapped (temporary and permanent), instruction to patient and families in P. T. exercises, and referrals appropriate to community service agencies for home follow-up, medical equipment (wheelchairs, braces, etc.), and vocational rehabilitation.

ii. OCHNO Louisiana Rehabilitation Institute—provides comprehensive rehabilitation services (physical therapy, speech therapy and occupational therapy) to physically handicapped, including spinal cord and paraplegic patients on an inpatient and outpatient basis. Services are directed toward reducing disability and restoring skills and abilities needed for independent living. Admissions are open on a space available basis.

iii. OFS Rehabilitation Services—services covered by Title XIX for Medicaid eligibles.

d. Indirect services—referrals, counseling and third party payment:

i. OHD Client Placement Services—evaluation, referral and placement services available to any functionally impaired individual of any age if mentally retarded, up to age 25 if mentally ill, with some exceptions for continuing care beyond age 25, if out-of-home care is required. This is a placement and third party reimbursement program, with emphasis on community rather than institutional placement, in the least restrictive environment. Placement services are rendered by OHD staff.

ii. OPPHS Health-related Social Services—social work counseling, case management and referral services available to clients receiving services through various OPPHS programs. Within the Handicapped Children's Program, these services are directed at assisting parents in maintaining handicapped children in their own homes and obtaining needed medical care. Services are funded through various available sources, according to the eligibility of the client.

iii. D. Educ. Regional Technical Assistance Specialists for Special Education — preschool coordinators and special education regional coordinators are based in each of the eight congressional planning districts to provide technical assistance to parents, school system personnel, and other service providers on how to best program for special education students in the least restrictive environment.

iv. D. Educ. Joint Project for Parent and Children Services—a special project designed to improve early identification, referral, and evaluation of high risk infants and handicapped youth in an 11 parish area (Region II).

E. Statewide Programs with full range of health-related services:

1. OHD Specialized Foster Care—offers specialized placement for foster children with medical problems, who would otherwise be placed in a larger, formalized institution.

2. OHD Subsidized Adoption—offers a subsidy to adoptive parents, when a foster child with special medical problems is adopted, and the family could not otherwise adopt the child because of medical costs.

3. OFS Medical Coverage for Children in Custody of the OHD (foster children, former ECA children, ete.)—costs of most medical care for these special children are paid through Title XIX funds, to encourage foster home placement for children who might otherwise be institutionalized.

4. OHD Title XX Contract Services—for eligible persons and other persons in need of services; family planning; general health care services; home delivered and congregate meals; homemaker services; information, referral, and placement services; medical transportation services.

5. OPPHS Handicapped Children's Program—medical and social services offered state-wide on a regional basis to children age 0-21 who have physical handicaps.

F. Health Promotion

1. Introduction. This is an inventory of services and programs administered by state agencies which are directed toward a goal of reducing the incidence of death, illness and disease among citizens through educating the public to be aware of health risks and symptoms and to take responsibility for preserving and enhancing their own health and preventing illness.

a. OH Patient Advisory Councils (PAC)—established in each of eight state-supported general hospitals provide an avenue for each facility to learn community needs and concerns and address them jointly.

b. OPPHS Community Health Protection and Promotion—activities of a regulatory nature offered statewide through OHSEQ, including:

i. retail food sanitation program;

ii. building and premises sanitation program;

iii. seafood sanitation;

iv. milk and dairy products inspection;

v. food, drug and cosmetic manufacturing and warehouse inspection;

vi. drinking water supply sampling and analysis.

c. OPPHS Maternal and Child Health—Programs offered statewide to promote wellness in newborns, infants, children and women of childbearing age.

i. Improved Pregnancy Outcome provides equipment and special training programs for parish health units, area professionals and patients.

ii. Preventive health care is offered to females of child-bearing age and children 0-21 years of age.

iii. Child Health Clinics are available at parish health units statewide offering screening, immunization and follow-up of children.

iv. School Health Programs offer screening and follow-up services for common health problems among school children.

d. OPPHS Family Planning—offered to all persons who voluntarily seek family planning services. The services are directed toward health and sex education, contraceptive services and family planning counseling.

e. OPPHS Supplemental Food Program for Women, Infants and Children (WIC Program)—offers food vouchers to low income pregnant, post-partum, and breast feeding women, infants and children determined to be nutritionally at risk by the parish health unit.

f. OPPHS Fluoridation of community drinking water supplies—offered to communities of 1,000 + population (to promote dental health).

g. OPPHS Refugee Health Program—integrates Indochinese refugees into the health system.

h. OPPHS Immunization Administration—immunization is available as needed against polio, diptheria, measles, tetanus, rubella, mumps and pertussis. Yellow fever vaccine is available to international travelers at a few metropolitan health units. Influenza vaccine is available to persons at high risk of developing serious complications from influenza infections. Immune serum globulin is given to household members where cases of hepatitis type A are reported.

i. OMH Community Education and Consultation—Staff at all mental health centers available for public speaking and education programs directed toward preventing mental illness and educating the public to take responsibility for maintaining health and reducing risk related to mental illness. In some areas, efforts involve regularly scheduled presentations via public media.

j. OPRADA Alcohol Prevention Services—Designs and implements strategies for preventing primary and secondary alcohol and drug abuse through education, community development and early casefinding. Coordinates substance abuse programs and activities with public and private school systems and with the Criminal Justice system.

k. OFS/OPPHS Early Periodic Screening, Diagnosis and Treatment Program - through Title XIX funds, eligible children under the age of 21 receive periodic medical screening, immunizations and referral services to prevent and detect disease and illness.

1. OCHNO Patient Education Programs—videotaped health education programs are shown in most areas of the hospital and in the emergency room to patients and their families. These are directed at improving health habits and teaching patients how to take personal responsibility for their health.

m. OPPHS Health Education—offers counseling, nutrition advice and educational health services to encourage patients to take responsibility for their own health (a part of all patient services rendered by OPPHS staff in all parish health units and special service sections).

n. OPPHS AIDS Prevention—The provision of sound information about AIDS/HTLV III infection and risk reduction counseling to the general public, especially to adolescents and young adults who are forming the life styles which will determine their long-term risk of contracting the disease.

o. OH/OCHNO Nutrition Programs—nutrition counseling is offered to patients at all nine state-supported acute care general hospitals.

p. OFS Monthly mailout notices on subjects related to health services sent to recipients eligible for Title XIX services. Notices inform the recipient population of available services and encourage appropriate use of health care services.

q. OCHNO Health Risk Appraisal—OCHNO has implemented the Health Risk Appraisal system for all employees—Programs to date have included a promotion of the use of seat belts and promotion of a one day moratorium on smoking.

r. OCHNO Multidisciplinary Case Conferences—OCHNO is holding regular multidisciplinary staff meetings in each hospital center to resolve patient's health problems.

s. OCHNO Hospital Satellite Network Staff Development—includes staff development programs for various employee groups, including employees in high risk situations.

G. High Costs of Health Care

1. Introduction

a. This is an inventory of programs and initiatives set in place within DHHR agencies which are directed toward a goal of reducing the overall costs of providing health care.

b. All programs addressed in Alternatives to Institutionalization can be considered as serving to reduce the costs of medical care, since costs related to an overnight stay or long term care placement in health care facilities are reduced. All programs addressed in Health Promotion also indirectly serve to reduce costs of health care through prevention and early detection of illness and disease.

2. Inventory

a. OH/OCHNO Unit Dose System—provides a system of dispensing drugs in quantities no larger than needed for a single dose. This system controls usage and minimizes waste and theft of prescription drugs.

b. OH/OCHNO Reduction of Patient Length of Stay—on-going initiatives to reduce the overall length of patient stays in the nine state-supported acute care hospitals have resulted in reductions in the average length of stay to 5.6 days in hospitals administered by the Office of Hospitals and 7.9 days in New Orleans Charity Hospital.

c. OH/OCHNO Inventory Control System—automated management control system for distributing supplies and material so that waste and theft are reduced. The system is active in New Orleans Charity Hospital and is slated for the future in other state-supported acute care hospitals. At present the material management system in other state-supported hospitals is manually operated.

d. OFS Medicaid Management Information System—Title XIX claims are processed through an automated claims processing system which monitors provider claims for duplicate billings, medical necessity of service, eligibility of recipient and many other factors which might be indicators of an ineligible or questionable claim.

e. OM and F Section 1122 Project Review (Bureau of Health Planning)—Section 1122 of the Social Security Act requires that a proposed health facility—related capital expenditure over $600,000 or a proposed change in services or number of beds in a health care facility obtain prior approval from the designated planning agency in order to be reimbursed by Medicare and Medicaid for costs related to the capital expenditure. The purpose of this provision is to assure that federal funds are not used to support unnecessary capital expenditures by health care facilities.

f. OH/OCHNO/OMH Quality Assurance and Utilization Review—as a requirement of accreditation by the Joint Commission on Accreditation of Hospitals, health services rendered in state-supported hospitals are reviewed for appropriateness of service and efficient use of technology and corrective action is planned and implemented on an on-going basis.

g. OPPHS Central Pharmacy—all drugs prescribed in parish health units throughout the state are dispensed through a central pharmacy in New Orleans which results in a substantial savings.

h. OPPHS Management Control System—a system of personnel management involving review of staffing levels and staffing mix. Information is used to improve efficiency in staff utilization and distribution.

i. OMR-DD Preventive Dentistry Program—provides preventive dentistry techniques, including screening, referrals and coordination of tooth brushing to developmentally disabled individuals in New Orleans and Lafayette.

j. OMR/DD Family Subsidy—services designed to provide financial assistance, to help parents offset the unusual costs of specific services for keeping their children at home.

k. OH/OCHNO Day Surgery Services—day surgery services available in all nine state-supported acute care general hospitals. Surgical procedures requiring anesthesia and recovery services, but not necessitating overnight stay, are performed in these units.

1. OH/OCHNO Minor Surgery Clinic—minor medical/surgical procedures not requiring anesthesia are performed in outpatient clinics at all nine state-supported acute care general hospitals.

m. OMHSA Mental Health Management Information System—incorporates measures of efficiency/effectiveness through reporting of data elements such as client/patient data, direct services data, indirect services data, and assessment data.

n. OCHNO Energy Conservation Measures—Increased energy conservation and/or fuel efficiency from:

i. replacing a steam turbine chiller with two electric chillers;

ii. replacing incandescent with fluorescent fixtures in the hospital warehouse; and

iii. recovering heat from hospital laundry waste water for use in preheating water.

o. OCHNO Promote Use of Alternative Health Delivery Systems for Employees—OCHNO encourages employees to attend open sessions on Health Maintenance Organizations as an alternative to Group Insurance.

p. OCHNO Expand Use of Orientation Sessions—includes hospital orientation for residents and orientations, in many hospital centers, to their policies and procedures. OCHNO plans to expand the use of this mechanism to all hospital centers.

H. Private Sector Initiatives in Priority Areas

1. Introduction

a. Data related to the private health care delivery and advocacy system is scarce. There is no central or uniform reporting required for private and voluntary agencies. Information about private agencies may or may not appear in community service directories or in public information published by the agency itself. This is unfortunate since the tradition of voluntary action in the organization of health care is very strong. Through cooperative efforts, voluntary private health agencies can

serve as valuable resources for the state's citizens and as allies to federal, state, and local government health care organizations.

b. A survey of private agencies and organizations was conducted by the Health Planning and Development Agency in the fall of 1981. The purpose was to elicit information from the private health-related agencies about their roles in the provision of services in the three established priority areas (Alternatives to Long-Term Institutionalization, Health Promotion and High Costs of Health Care). The survey instrument consisted of listing and describing types of services directed toward the priority areas. Open-ended questions regarding populations served and eligibility requirements were also used. The mailing list was composed of statewide private health agencies thought to be offering services in one of the priority areas. This list included private health agencies participating in the statewide priority survey, additional names supplied by those agencies initially surveyed and others taken from various parish directories. For those agencies that had many chapters located within the parishes (e.g. Red Cross, YMCA) a representative sample was used, since it was thought that all of these chapters would participate in the same common goals and objectives. All statewide private health agencies were not included since some were either unknown or unrecognized as functioning with the priority areas.

c. A total of 317 surveys were mailed out; 99 surveys were completed and returned, 21 were returned unopened by the Postal Service because of out-of-date addresses or discontinued service. There was, therefore, a return rate of 32.3 percent (n99 of 306).

Table 5.1
Agencies Reporting
Alternatives to Institutionalization Activities*

Activity or Service Areas	Percent Agencies
Chemical dependency and substance abuse	22.6
Elderly needs	5.7
Emotional and mental disorders	15.0
Physical disabilities and handicaps	35.8
Programs for specific diseases	22.6

* n . 53; 56.3%

Table 5.2
Agencies Reporting
Health Promotion Activities*

Activity or Service	Percent Agencies
Public Education (i.e. speakers, workshops, seminars, pamphlets, films, etc.)	76.0
Professional education	1.8
Public and Professional Education	21.8
Deaf/Blind	1.8
Dental	1.8
Disabilities (physical and mental)	16.4
Drug and Substance Abuse	16.4
Elderly	3.6
Nutrition and diet	5.4
Prenatal and Child care	7.3
Specific diseases and disorders (i.e. heart disease, cancer, arthritis, tuberculosis, etc.)	29.1
Youth	7.3

Table 5.2
Agencies Reporting
Health Promotion Activities*

Activity or Service	Percent Agencies
Multiservice (i.e. YMCA, Red Cross)	10.9

* n = 55; 58.5%

d. Approximately 56.3 percent of the responding health-oriented agencies stated they engaged in providing services which assisted in offering alternatives to long-term institutionalization; 58.5 percent reported that health promotion activities were a part of the services provided. Data collected on cost containment activities was not suitable for interpretation because of a general misunderstanding of what was meant by "cost containment". What was seen in the various agencies' reports was that major thrusts in cost containment are, in fact, initiatives in developing or providing alternatives to long-term institutionalization and in promoting good health and preventing illness.

e. An inventory of reported programs sponsored by private agencies follows this narrative. This should not be interpreted as being a comprehensive examination of on-going programs addressing the priority health areas, but rather as a representative sample of the types of programs which are in place in the state's health care system.

2. Inventory

a. Alternatives to Institutionalization

i. Supportive services, to assist individuals to function outside of long term care institutions and to realize full potential for employment and/or independent living:

(a). Desire Narcotic Rehabilitation Center, Inc.—Supportive services, including individual, group and family counseling, employment and academic counseling—Serves persons 18 years or older in the Orleans, Jefferson, St. Bernard and St. Tammany area.

(b) Education and Treatment Council, Inc.—Outpatient drug abuse counseling for adolescents and their families (in connection with the Mental Health Association)—Serves Calcasieu, Allen, Beauregard, Cameron and Jefferson Davis parishes.

(c). Alcoholics Anonymous—Group therapy, individual counseling and referrals, serving statewide population.

(d). Family Counseling and Children's Services—Individual, couple and family counseling for chemical dependency and mental disorders—Serves the Caddo-Bossier, Baton Rouge, and New Orleans areas.

(e). St. Martin, Iberia, Lafayette, Community Action Agency (SMILE, CAA)—Home delivered meals, homemaker services (including personal health care and transportation to health care facilities)—Serves persons over 60 years of age in the St. Martin, Iberia, and Lafayette areas.

(f). YWCA Senior Center—(New Orleans)—Resources for housing sites for the elderly and informal

health education and recreation within the community—Services persons over 60 years of age in the New Orleans area.

(g). Vermilion Association for Retarded Citizens—Day developmental training center offering training in self-help and community living skills, for persons 22 years of age and over who are evaluated as mentally retarded—Statewide.

(h). Ouachita Association for Retarded Citizens—Group home/work activity center serving planning district VIII.

(i). Calcasieu Hop Centers, Inc.—Adult program assists those with mental and developmental handicaps in independent living skills and self-care training; provides physical therapy and infant stimulation services—Serves Lake Charles and the Calcasieu parish area.

(j). Recovery, Inc.—Self-help programs and group sessions for persons over age 18 with mental or nervous disorders—Serves the New Orleans, Baton Rouge, Lafayette, and Shreveport areas.

(k). Mental Health Association of Louisiana—Social rehabilitation club for persons recovering from mental illness; and training in living skills for the chronically mentally ill.

(1). Lighthouse for the Blind—Provides training to blind individuals in those skills necessary for independent living—Serves the New Orleans area.

(m). Kingsley House—Adult day care, personal care and supervision, and social, recreational and educational services for persons 18 years of age or older with moderate physical or mental handicaps—Serves the New Orleans area.

(n). Goodwill Rehabilitation Center—Vocational rehabilitation, evaluation and training of handicapped individuals 16 years and over—Serves the New Orleans area.

ii. Direct mental and physical health services which offer outpatient treatment or short-term hospitalization as an alternative to longterm institutionalization:

(a). Insight Program—Detoxification and substance abuse clinic—Serves the Greater New Orleans area.

(b). Alcohol and Drug Detoxification Center—Detoxification services and outpatient treatment for the chemically dependent—Serves the Baton Rouge area.

(c). Drug Rehabilitation Clinic—Chemotherapy and methadone outpatient treatment for opiate and other drug users—Serves the Orleans, Jefferson and St. Bernard areas.

(d). Alcohol Recovery Unit (Metairie General Hospital—"One Day at a Time")-28 day inpatient chemical dependency treatment, and outpatient counseling—statewide.

(e). F. Edward Hebert Hospital (Chemical Dependency Unit—Outpatient treatment (intensive and primary therapy for drug and alcohol abuse) and aftercare, serving statewide population.

(f). Baton Rouge General Hospital 1) Adolescent Chemical Dependency Unit provides short term (6-7 week) inpatient treatment and a two year aftercare program. 2) Chemical Dependency Unit (adult) offers a 28 day inpatient program and aftercare.

(g). DePaul Community Health Center and DePaul Center for Psychotherapy—Aftercare services after institutionalization for chemical dependency, psychiatric disorders and emotional disturbances of children and adolescents—Serves the New Orleans area.

(h). Speech and Hearing Center of Southwest Louisiana, Inc.—Speech and hearing evaluation, screening, consultation and speech therapy for groups and individuals—Serves statewide population.

(i). Southwest Louisiana Health Couseling Services—Direct services, in-home counseling, and physical and occupational therapy for physically handicapped persons—Serves Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis parishes.

(j). Calcasieu Multi-Handicapped Center, Inc.—Individual discharge planning and rehabilitation for the institutionalized mentally and physically disabled—Serves statewide population.

(k). Visiting Nurses Association of Greater New Orleans—In-home nursing and homemaker services for the disabled and chronically ill—Serves the New Orleans area.

(1). Physical Therapy and Rehabilitation Center—Private physical therapy and chronic and acute pain treatment, particularly for crippled children and stroke victims. Services provided at the Center of in the client's home—Serves the Houma area, including Terrebonne, Lacfourche and St. Mary parishes.

(m). Opelousas Area Cerebral Palsy Treatment Center—Physical and speech therapy and home care for cerebral palsy clients aged 0-21 years—Serves St. Landry parish and the surrounding area.

(n). United Cerebral Palsy of Greater New Orleans—Medical, therapeutic and counseling services, continuing education and work activity—Serves Jefferson, New Orleans, St. Tammany and St. Bernard parishes.

(o). Muscular Dystrophy Association, Inc.—Five comprehensive outpatient clinics for diagnostic and follow-up care; orthopedic equipment use for home care; and physical and occupational therapy—Serves statewide population.

(p). National Society for Autistic Children—Direct services and in-home counseling, physical therapy, and occupational therapy—Serves statewide population.

(q). United Cerebral Palsy Association of Southwest Louisiana—Direct services and in-home counseling, physical therapy, and occupational therapy—Serves statewide population.

iii. Direct Care—(Home health and respite) to prevent longterm institutionalization.

(a). Ouachita Association for Retarded Citizens—Respite center and respite-in-home services—Serves Planning District VIII.

(b). St. Landry Area Agency on Aging—Professional home care services to persons over 60 years of age in St. Martin, Iberia and Lafayette parishes.

(c). Home Health Agency VNA of Southwest Louisiana—Professional home health services for persons residing in Calcasieu parish and parts of Jefferson Davis, Cameron and Beauregard parishes.

(d). Professional Home Health Services of Alexandria—In-home nursing—Serves patients in Rapides, Grant, LaSalle, and Natchitoches parishes.

(e). Home Health Services (2)—Skilled nursing, physical therapy, speech therapy, occupational therapy and home health aide services—Serves the Lake Charles area (Calcasieu, Beauregard, Cameron, Jefferson Davis parishes) and Jefferson and St. Bernard parishes.

(f). Professional Home Health Services of Allen—Home Health care (nursing, physical therapy)—Serves Allen, Evangeline, Vernon and Beauregard parishes.

(g). American Community Services, Inc.—Respite care in-home for those with long term handicaps not due to aging—Serves Franklin, Jackson, Ouachita, Richland, Rapides, and Winn parishes.

(h). Respite Services of Southwest Louisiana—In home respite care for persons with chronic disabilities—Serves Allen, Beauregard, Calcasieu, Cameron and Jefferson Davis parishes.

(i). Project HELP—Respite Care for the non-elderly disabled in Orleans, Jefferson, and St. Bernard parishes.

(j). Louisiana State Society for Autistic Children—Summer residential camps as respite for autistic children—Serves statewide population.

iv. Alternative Living Arrangements

(a). Volunteers of America—Group homes for mentally retarded and supervised apartment living for disabled adults—Serves statewide population between the ages of 18-40 years.

v. Indirect services—referrals, transportation, family counseling, etc.

(a). Easter Seal Society for Crippled Children and Adults of Louisiana, Inc.—Transportation services for handicapped and elderly adults, and equipment for home health care—Serves statewide population.

(b). Association of Deaf Counseling—Counseling to help families cope with the deaf/blind patient—Serves statewide population.

(c). Louisiana Chapter Arthritis Foundation—Arthritis clinics and information about home care—Serves statewide population.

(d). Charles and Elizabeth Wetmore Foundation—Financial assistance to people with tuberculosis for medical equipment for home care—Serves statewide population.

(e). American Cancer Society—Provision of equipment and supplies for the home care of cancer patients; financial assistance for transportation, medicine, and equipment; emotional support and counseling—Serves Greater Baton Rouge and Greater New Orleans area, East and West Baton Rouge, Livingston, East and West Feliciana, St. Helena, Pointe Coupee, Iberville and Ascension parishes. Different chapters are established statewide.

b. Health Promotion Activities

i. Deaf/Blind. La. Association of Deaf Counseling and Service Coordination Program for Deaf-Visually Impaired—Genetic counseling for Usher's syndrome, and vocational and consumer health counseling—Serves statewide deaf—blind population.

ii. Dental. Northeast Louisiana University—Dental hygiene clinic, instruction in dental prophylaxis—Serves Northeast Louisiana.

iii. Disabilities (physical and mental)

(a). Calcasieu Hope Centers, Inc.—Training in self care and living skills, films on personal hygiene—Serves Lake Charles, and Calcasieu parish.

(b). Mental Health Association of Louisiana—Mental health education activities including films and seminars—Serves statewide population (25 chapters).

(c). DePaul Community Health Center and DePaul Center for Psychotherapy—Community education on mental health and enhancement of mental health, effectiveness and communication training and stress management—Serves New Orleans.

(d). Professional Home Health Services of Allen—Education of patients and families on the benefits of proper diet, exercise, illness prevention and care—Serves Allen, Evangeline, Vernon, and Beauregard parishes.

(e). Home Health Services (2)—Skilled nurses teach home care skills to families of patients in the Lake Charles area (Calcasieu, Beauregard, Cameron, Jefferson Davis parishes,) and the New Orleans area (St. John the Baptist, Plaquemine, New Orleans, Jefferson, and St. Bernard parishes).

(f). Easter Seals Society for Crippled Children and Adults of Louisiana, Inc.—Health education and information on prevention of specific disabilities; screening and education on scoliosis—Serves statewide population.

(g). Southwest Louisiana Health Counseling Services—Community education on developmental disabilities and professional training and education—Serves Allen, Beauregard, Calcasieu, and Jefferson Davis parishes.

iv. Drug and Substance Abuse

(a). Insight Program—Lectures on drug use—Serves Greater New Orleans area.

(b). Alcohol and Drug Abuse Council of Greater Baton Rouge Area—Professional and corporate education, including speakers, workshops, seminars and films on alcohol and drugs—Serves Greater Baton Rouge area, East and West Baton Rouge, Ascension, Iberville, St. James, and Livingston parishes.

(c). Alcoholics Anonymous—Pamphlets, books, tapes, speakers on alcoholism and alcohol abuse—Serves Statewide.

(d). F. Edward Hebert Hospital-Chemical Dependency Unit—Presentations on drug abuse and chemical dependency to industries, schools and health-related social services—Serves statewide population.

(e). Louisiana A. Philip Randolph Institute of Drug Abuse—Job site substance abuse committees, awareness programs, seminars and speakers—Serves statewide population (mainly Union members).

(f). Community Organization for Drug Abuse Concerns (CODAC)—drug information program in Caddo-Bossier school system (alternative ways of dealing with stress, health hazards, associating with these who use drugs), serving the Caddo-Bossier parishes.

(g). Education and Treatment Council Inc. of Lake Charles—Drug Abuse Prevention Program-alternative actions—Serves Lake Charles area, Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis parishes.

(h). Committee on Alcohol and Drug Abuse for Greater New Orleans—Public education, information, referral on drug and alcohol abuse,—Serves Greater Metropolitan New Orleans, including Jefferson, St. Bernard and St. Tammany parishes.

(i). Alcohol Recovery Unit-Metairie General Hospital-One Day at a Time—Community and industry educational program on chemical dependency and effects, serving statewide population.

v. Elderly

(a). SMILE, Inc., Community Action Agency—Educates and counsels those over 60 years of age on medication and side effects and provides information on high blood pressure—serves St. Martin, Iberia and Lafayette parishes.

(b). YWCA Senior Center—Informal health education on the psychological and physical aspects of aging—Serves the New Orleans area.

vi. Nutrition and Diet

(a). Diet Counseling Service of Physicians and Surgeons Hospital—Patient and professional education seminars—Serves northwest Louisiana, and the Louisiana/Arkansas and Louisiana/Texas border areas.

(b). Southwest Louisiana Dietetic Association—Nutritional education and diets for preventive health (especially in hospitals and nursing homes)—Serves Calcasieu, and Beauregard parish areas.

(c). Hammond District Dietetic Association—Continuing nutritional education for members of the dietetic profession; community nutrition projects and research—Serves Livingston, Washington, St. Tammany and Tangipahoa parishes.

vii. Prenatal and Child Care

(a). Genetic Desease Center of Louisiana—Sickle cell anemia education, screening and counseling services, referral and follow-up,—Serves Metropolitan New Orleans (Southeast and south central parishes by request).

(b). Calcasieu Women's Shelter—Promotion of good health care and practices; personal hygiene, child care, and nutrition education—Serves Calcasieu, Beauregard, Jefferson Davis, and Cameron parishes (especially battered women and children).

(c). Ouachita Parenting and Childbirth Association (OPCA)—Public information program on pregnancy, child care, parenting, C-sections; prenatal education classes; consumer voice in obstetric and pediatric care—Serves the Northeast Louisiana area.

(d). March of Dimes Birth Defects Foundation—Educational programs on starting healthy families; films and pamphlets on alcohol and drug use during pregnancy, and nutrition practices—Serves statewide population.

viii. Specific Disorders and Diseases

(a). Cancer Association of Greater New Orleans—Public education programs on cancer; cooperation with Seventh Day Adventist church on "Stop Smoking" program—Serves statewide population.

(b). American Cancer Society (Louisiana Division, Inc.) (2)—Public education activities including "Quit Smoking" Clinics, breast self-exam information, information on the warning signals of cancer, health fairs, free screening, pamphlets, films, speakers, and educational programs for adults and youth—Serves Greater Baton Rouge (East Baton Rouge, West Feliciana, Iberville, Ascension, Livingston, West Baton Rouge, St. James), Greater New Orleans area and statewide.

(c). Louisiana Chapter of Arthritis Foundation—Health fairs, literature and group lectures on arthritis and rheumatism—Serves statewide population.

(d). United Cerebral Palsy Association of Greater New Orleans and southwest Louisiana—Health fairs, cerebral palsy information for the public, community and professional education—Serves New Orleans area including

Jefferson, St. Tammany and St. Bernard parishes, and the Louisiana area.

(e). American Diabetes Association (Louisiana Affiliate Inc. (3)—Public, professional and diabetic patient education on diabetes treatment, care, detection; activities include speakers, seminars and meetings—Serves statewide population (located in Baton Rouge, Shreveport and Houma)

(f). American Heart Association—Professional and public education on heart disease, CPR and heart attacks; community services—Serves Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Ouachita, Richland, Tensas, Union, West Carroll parishes.

(g). Greater New Orleans Ostomy Association (Chapter of United Ostomy Association, Inc.)—Emotional support and information to ostomy patients and families, public information on rehabilitative ostomy surgery, gastrointestinal and urological disorders and diseases, treatment and prevention—Serves Orleans, Jefferson, St. Bernard, St. Tammany and St. Charles parishes.

(h). National Association for Autistic Children—Counseling and professional and community education in autism—Serves Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis parishes.

(i). Muscular Dystrophy Association Inc.—Public health education and an intensive program one week per year for special emphasis on MD and neuromuscular disease—Serves statewide population.

(j). Southwestern Sickle Cell Anemia Foundation, Inc.—Patient support groups, genetic counseling, in-service training and public information including pamphlets—Serves Lake Charles and Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis parishes.

(k). Spina Bifida Association of Louisiana—Public and patient information on Spina Bifida, including literature and speakers—Serves statewide population.

(1). Charles and Elizabeth Wetmore Foundation—Education, including treatment information and films on medicine and lifestyle changes for those with tuberculosis—Serves Orleans, Jefferson, St. Bernard, Plaquemine, and St. Tammany parishes.

ix. Maternal and Child Health

(a). Children's Council of Region I.- Press releases on health topics related to child care—Serves Orleans, Jefferson, St. Bernard, St. Tammany and Plaquemines parishes.

(b). Children's Council of District V—Public awareness program to promote good health habits (in conjunction with public health clinics)—Serves Allen, Beauregard, Cameron, Calcasieu and Jefferson Davis parishes.

(c). Capital Area Regional Children's Council—Health education activities including public formums and activities to increase public awareness of legislation affecting mental and physical health—Serves East and West Baton Rouge, East and West Feliciana, Pointe Coupee, Iberville, Ascension, Livingston, Washington, Tangipahoa, and St. Helena parishes.

(d). Ouachita Multi-Purpose CAP Head Start—Comprehensive health services to preschool children and education services for families and children,—serves Ouachita parish (primarily for children 3-5 years).

x. Multiservice

(a). American Red Cross (Northwest Chapter)—public information, including courses on topics such as "You and the Aging" and "Preparation for Parenthood" and pamphlets on Family Health and Home Nursing Care—Serves Northwest Louisiana.

(b). American Red Cross (New Orleans Chapter)—Courses in first aid, emergency preparedness and CPR—Serves New Orleans and Tangipahoa, St. Tammany, St. John, and St. Charles parishes.

(c). American Red Cross—(Calcasieu—Cameron Chapter)—Courses in First Aid, Vital Signs, Home Nursing and CPR—Serves Calcasieu and Cameron parishes.

(d). Baranco—Clark Branch YMCA—Public education with an emphasis on preventive health care, controlling blood pressure, films on health related activities for the elderly population—Serves South Baton Rouge Area.

(e). YWCA—New Orleans—Physical fitness and exercise programs and information on proper nutrition—Serves Orleans, St. Tammany, St. Bernard, and Jefferson parishes.

(f). Baton Rouge Area YWCA—Encore support group for post-mastectomy patients; prenatal exercise classes; stress management, fitness and nutrition programs,—Serves the Greater Baton Rouge area, Ascension, Livingston St. James and Iberville parishes.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance. , LR 13:246 (April 1987).

Chapter 109. Implementation Strategies

Subchapter A. Developing the Implementation Plans

§10901. Introduction

A. The logical step, after 1) determining the priority health needs of the state and developing corresponding goals and 2) determining what programs or services are currently in place to meet the needs, is to determine what can be done to meet the unmet need remaining. The following section sets forth the objectives developed to move toward these priority goals, the costs of achieving these objectives (where available), and a target date for this achievement.

B. There is much uncertainty at this point about how the state's predicted revenue shortfall will affect the offices of the Department of Health and Human Resources. It appears quite possible that sizeable funding cuts will occur, resulting in losses of manpower, programs and services. Given the uncertain future, it is difficult to project a strategy for one year, much less for five years. For this reason, the implementation objectives in this State Health Plan, although ongoing in many instances, will emphasize FY 1986-87 activities. It is hoped that, when conditions become more stable, longer range objectives can be developed and published for the next revision of the Plan.

C. It is also expected that the next State Health Plan will reflect the increasing communication and cooperation with non-state agencies on Plan implementation. It is realized that no effort to meet the priority health needs of the state can succeed without the input and cooperation of local and non-public health related entities, but time and staff limitations precluded their inclusion in this Plan.

D. The first Section of this Chapter lists objectives which the Division of Policy, Planning and Evaluation hopes to achieve directly during the fiscal year. The second lists the objectives of other DHHR agencies under the priority goal to which they pertain most directly.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P. L .96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

Subchapter B. Implementation Plans

§10905. Division of Policy, Planning and Evaluation Implementation Activities

A. To assure that 100 percent of the applications for capital expenditure which are recommended for approval under §1122 are consistent with the criteria and standards in the State Health Plan, including the priority health care goals, in order to assure that unneeded health services and facilities are not approved.

1. Target completion date: June 30, 1987

2. Resource requirement: Approximately $429,000.

B. To implement a three year plan development cycle which will include the following activities in FY 1986-87:

1. increase contact with DHHR and other state-level health provider agencies in order to facilitate communication of needed information and technical assistance on plan development activities;

2. complete development and establishment of a local health planning network and hold the first meeting of this group to request local health information for plan development;

3. provide technical assistance to the agencies in the network;

4. identify and update obsolete sections of the Plan (this activity will include input from activities a and b);

5. target completion date: June 30, 1987;

6. resource requirement: approximately $76,000.

C. To implement a three year plan implementation cycle which will include the following activities in FY 1986-87:

1. increase contact with DHHR and other state level health provider agencies in order to coordinate implementation activities where needed, to monitor all such activities and to provide technical assistance on implementation;

2. utilize local health planning network to receive input on plan implementation in the local area;

3. provide technical assistance, coordinate where necessary, and monitor the implementation activities of the members of the local health planning network;

4. target completion date: June 30, 1987;

5. resource requirement: approximately $76,000.

D. Identify necessary health planning data (health care trends and health indicators, etc.) and gather these data through all available sources:

1. target completion date: June 30, 1987;

2. resource requirement: approximately $53,500.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S.36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§10907. Department of Health and Human Resources Health-Related Offices Implementation Activities

A. Development of services at the community level directed toward informing, educating and motivating the public to accept responsibility for protecting their health.

1. Office of Preventive and Public Health Services (OPPHS)

a. To motivate industries and groups to initiate health promotion activities for their employees and/or members. Planned activities include:

i. general Health Risk Appraisal (HRA) information to new requestors;

ii. HRA demonstration or orientation to a potential new user;

iii. follow-up HRA information or assistance to potential new user;

iv. HRA batch processing for client or potential new user group;

v. target completion date: June 30, 1987 (and ongoing);

vi. resource requirement: Continuation of state funding at standstill level.

b. To sponsor, assist and monitor new HRA users. Key activities to be recorded will include:

i. new HRA users sponsored or assisted;

ii. the number of formal training sessions for HRA and the number of individuals trained;

iii. HRA User Status Reports solicited from users to obtain baseline data that would provide direction for health promotion in the state;

iv. target completion date: June 30, 1987 (and ongoing);

v. resource requirement: State funding at standstill level.

c. To develop and print a statewide Health Education Resource Directory which provides resource information by region. Component activities will be:

i. to obtain Health Education Resource information from eight regions;

ii. format Health Education Resource information onto computer disc;

iii. to print a minimum of 500 directories;

iv. target completion date: February 28, 1987;

v. resource requirement: State funding at 100 percent level.

d. To provide health education resources, equipment and audiovisuals to DHHR, OPPHS Programs and selected target populations. These materials will include:

i. pamphlets, posters and artistic designs created for health promotion activities of OPPHS programs;

ii. audio-visual materials and equipment loaned to support program activities;

iii. target completion date: June 30, 1987 (and ongoing);

iv. resource requirement: State funding at standstill level.

e. To plan and implement educational/media campaigns for vari ous health promotion activities. These will include but not be limited to:

i. World Health Day;

ii. Great American Smoke-Out;

iii. Diabetes Awareness Campaign;

iv. Secretary's Health Promotion Awards;

v. component activities will include:

(a). developing, printing and distributing flyers;

(b). developing news articles and proclamations, and distributing media packets;

(c). assisting various DHHR Programs.

vi. target completion date: June 30, 1987 (and ongoing);

vii. resource requirement: State funding at standstill level.

f. Aids prevention:

i. to provide information, risk reduction counseling, and antibody testing for high-risk persons;

ii. to provide information and risk reduction counseling to adolescents and young adults who are forming the lifestyles that will determine their long-term risk of contracting the disease;

iii. to make information about AID/HTLV-III infection effectively available to the public;

iv. to collect epidemiological information from clients in our service programs;

v. benefits: approximately 200 new cases of AIDS are expected to occur in Louisiana during the coming year. Most of these will become the medical responsibility of the state. For each case prevented, approximately $100,000 in treatment costs will be saved; treatment costs which are increasing as survival time increases;

vi. target completion date: On-going (annual update).;

vii. resource requirement: $1,060,000 per year.

2. Office of Prevention and Recovery from Alcohol and Drug Abuse (OPRADA)

a. To coordinate national media campaign activities in Louisiana aimed at preventing alcohol and drug abuse ("The Chemical People," "Just Say No", "Fetal Alcohol Syndrome Awareness", "Drunk and Drugged Driving Week", etc.):

i. target completion date: June 30, 1987;

ii. resource requirement: Continuation of current funding.

b. To plan and coordinate a "Substance Abuse Awareness Week" in October of each year. This event, which will be proclaimed by the governor, will include media and community events to publicize deleterious effects of alcohol and drug abuse. The events will be geared toward the adult and youth population of Louisiana:

i. target completion date: June 30, 1987;

ii. resource requirement: Continuation of current funding.

c. To conduct a statewide media campaign to coincide with the governor's proclaimed "Fetal Alcohol Effects Awareness Week" in April, 1987. This event is designed to impact 1.5 million women.:

i. target completion date: June 30, 1987;

ii. resource requirement: Continuation of current funding.

d. To disseminate information on alcohol and drug abuse from state office, Regional Clearinghouses for Drug and Alcohol Information, and OPRADA clinics to all parts of the state. This will be a continuous process:

i. target completion date: June 30, 1987 (and ongoing);

ii. resource requirement: Continuation of current funding.

e. To coordinate the development of employee assistance programs for persons with alcohol or drug-related problems in each department of state government by the end of FY 87-88:

i. target completion date (first phase): June 30, 1987;

ii. resource requirement: Continuation of current funding.

f. To conduct one regional alcohol and drug abuse prevention workshop per quarter in FY 86-87 aimed at galvanizing communities to establish local comprehensive prevention programs:

i. target completion date: June 30, 1987;

ii. resource requirement: Continuation of current funding.

g. To continue interfacing with other state agencies to coordinate efforts for the prevention of alcohol and drug abuse, via cooperative and interagency agreements:

i. target completion date: June 30, 1987 (and ongoing);

ii. resource requirement: Continuation of current funding.

h. To establish, at the state and local levels in all regions, networks of agencies, groups, and individuals to stimulate planned, concerted actions to prevent alcohol and drug abuse, by the end of Fiscal Year 1986/87:

i. target completion date: June 30, 1987 (and ongoing);

ii. resource requirement: Continuation of current funding.

i. To facilitate the development of at least one privately funded new women's initiative to combat alcohol and drug abuse in Louisiana's major population centers (Baton Rouge, Monroe and New Orleans) by the end of FY 87:

i. target completion date: June 30, 1987;

ii. resource requirement: Continuation of current funding.

3. Office of Hospitals (OH)

a. To develop a primary health care model program to provide Health Maintenance Organization (HMO) services, including a wellness component, to the indigent and uninsured in Louisiana. If grant funding is secured, activities for the first year would include formulation of a small task force to study the relevant requirements for organizing and implementing the HMO and to develop written suggestions for its implementation:

i. target completion date: June 30, 1987;

ii. resource requirement: Robert Woods Johnson Foundation grant funds.

B. Goal 2: Containment of the Rapidly Rising Costs of Health Care and Promotion of Greater Efficiency in the Health Care Delivery System

1. Office of Preventive and Public Health Services (OPPHS)

a. To establish a home care system of services, in cooperation with the Office of Family Security and Children's Hospital, for families with ventilator dependent or assisted children, through:

i. obtaining a federal SPRANS grant for training of families and community outreach personnel (including Handicapped Children's Services (HCS) staff);

ii. planning for the future without a Medicaid Model Waiver;

iii. successfully placing 24 children at home;

iv. Target completion date: December 31, 1986;

v. Resource requirement: Medicaid Model Waiver questionable. An estimated $500,000 per year will be needed for training and case management of ongoing community networks.

b. To reduce the number of premature heart attacks, strokes, and kidney failures, and the state health expenditures by maintaining and improving the High Blood Pressure Control program available through the local health units:

i. target completion date: June 30, 1987 (and ongoing);

ii. resource requirement: $673,108 from Preventive Health Block Grant.

c. To develop and maintain a diabetes control program to provide:

i. demonstration projects to 1) assess needs, 2) develop and implement programs to meet these needs, 3) obtain funds from third party carriers for out-patient education programs and 4) evaluate program accomplishments;

ii. education for health professionals and patients which will enable better use of knowledge available on diabetes control and treatment. This is expected to reduce hospitalization and delay the onset of debilitating

complications which result in costly hospitalizations and disability;

iii. target completion date: June 30, 1987 (and ongoing);

iv. Resource requirement: Centers for Disease Control continuation funding.

d. To prevent or facilitate the prevention of health problems associated with medically indigent infants and children, promote their health and participate in efforts to reduce infant mortality and morbidity in Louisiana by:

i. provision of child health nursing services targeted to medically indigent children ages birth to five years;

ii. provision of limited child health physician services targeted to medically indigent children ages birth to five years;

iii. provision of nutrition services to indigent children and their parents;

iv. provision of lead poisoning screening, treatment and follow-up services for indigent young children at risk of or suffering from lead poisoning in areas with excessively high lead levels;

v. provision of audiological screening, vision screening, and diagnostic clinic services to pre-school and school age children and training for school nurses and other persons;

vi. provision of preventive and orthodontic dental services to handicapped and medically indigent children;

vii. provision of medical social services for a Sudden Infant Death Syndrome (SIDS) follow-up for high-risk medically indigent infants and young children;

viii. target completion date: June 30, 1987;

ix. resource requirement: Continuation of Maternal and Child Health (MCH) funding at FY 85-86 levels.

e. To prevent or facilitate the prevention of health problems of medically indigent pregnant women and adolescents, promote their health and participate in efforts to reduce infant and maternal mortality and the high rate of adolescent pregnancy in Louisiana through:

i. provision of targeted maternity nursing services to low-risk medically indigent women and adolescents in areas with 1983 infant mortality rates of 13.2 per 1000 births or higher where no other maternity services are available;

ii. provision of limited targeted maternity physician services to low-risk medically indigent women;

iii. provision of nutrition services to indigent pregnant women and adolescents;

iv. provision of medical social services to pregnant women and adolescents;

v. provision of comprehensive family planning services and health education in all regions of the State;

vi. target completion date: June 30, 1987 (and ongoing);

vii. resource requirement: Continuation of MCH and Family Planning funding at FY 85-86 levels.

2. Office of Prevention and Recovery from Alcohol and Drug Abuse (OPRADA)

a. Subgoal: To ameliorate the problems and reduce the costs associated with alcohol and drug abuse through the statewide provision of services including prevention, early intervention and provision of care to the substance abuser and his/her family.

i. To fund and implement at least one publicly financed treatment program for females in the northern and southern parts of the state, by the end of FY 87:

(a). target completion date: June 30, 1987;

(b). resource requirement: Continuation of current funding.

ii. To analyze the unmet need for substance abuse prevention and recovery services and develop proposals for meeting these needs in conjunction with the Louisiana Commission on Alcohol and Drug Abuse:

(a). target completion date: June 30, 1987;

(b). resource requirement: No additional funds.

iii. To provide geographically accessible screening, evaluation and treatment services to the approximately 200,000 substance abusers dependent on public treatment resources in order to provide services to clients with as little disruption to their lives as possible:

(a). target completion date: June 30, 1987;

(b). Resource requirement: $768,499.

iv. To provide for the special needs of addicted women through development of four 10 bed programs of social detoxification:

(a). target completion date: June 30, 1987;

(b). resource requirement: No additional funds.

3. Office of Hospitals (OH)

a. To evaluate the possibility of privatizing in-house functions in the Office of Hospitals system as a cost reduction measure. One such possibility is contracting with a private provider for laser dine technology in the medical records department:

i. target completion date: June 30, 1987;

ii. resource requirement: No additional funds.

C. Goal 3: Development and promotion of a comprehensive array of services directed toward preventing or postponing long term institutionalization and terminating inappropriate institutionalization.

1. Office of Preventive and Public Health Services (OPPHS)

a. To locate and provide habilitation or rehabilitation services to 20,000 handicapped children in order to prevent their institutionalization:

i. to develop a case management system for ventilator assisted children at home;

ii. to continue training of community based personnel for ventilator dependent children;

iii. to assist with planning for group homes as the least restrictive environment for ventilator dependent children;

iv. target completion date: June 30, 1987;

v. resource requirement: Approximately $500,000 a year for five years.

b. Maintain Genetics clinics in 10 locations (of them utilizing Handicapped Children's Services (HCS) clinics and staff):

i. hold specialty outpatient clinics;

ii. hospitalize when necessary;

iii. provide appliances to the HCS staff nurses assigned to hold Genetics clinics;

iv. target completion date: June 30, 1987 (and ongoing);

v. resource requirement: Maintain standstill budget for HCS program, and maintain Genetics program funding for staff.

c. To enable persons who are essentially confined to their homes and who currently have no insurance coverage to receive necessary nursing and related health care at home, in order to reduce the incidence of prolonged hospitalization, and prevent or postpone unnecessary costly institutionalization.

i. target completion date: June 30, 1987 (and ongoing);

ii. resource requirement: $250,000.

d. To maintain clinics for the treatment of children with Juvenile Rheumatoid Arthritis in 5 Handicapped Children's Districts:

i. target completion date: June 30, 1987 (and ongoing);

ii. resource requirement: Maintain Handicapped Children's Services Program standstill budget.

2. Office of Human Development (OHD)

a. To provide physically and/or mentally handicapped individuals with specialized services designed to (a) develop, enhance or create their employment potential and/or (b) assist them in acquiring personal skills to meet the demands of daily living:

i. target completion date: June 30, 1987;

ii. resource requirement: undetermined.

b. To provide adoption services to eligible children who are determined to be in need of such services and are available for adoption, and to increase by 36 percent the number of adoptive placements for children with special needs resulting from their age, race, nationality, physical/mental and/or emotional condition or from being a member of a sibling group which should not be separated. (There are 171 subsidized adoptive placements projected for 1986-87):

i. target completion date: June 30, 1987;

ii. resource requirement: $2,284,000. Services will be provided directly by OHD Division of Children, Youth and Family Services.

c. To provide eligible individuals with counseling to assist with their inter/intra-personal functioning, resolve problems, alleviate emotional/situational stresses, and change maladaptive behavior:

i. target completion date: June 30, 1987;

ii. resource requirement: $228,000. Service will be provided directly by OHD staff.

d. To assist eligible individuals to alleviate stressful family situations; to acquire or improve their self-care and social skills; to prepare for, secure, or maintain employment, or to recuperate from temporary disabilities by providing day care for children.

i. target completion date: June 30, 1987;

ii. resource requirement: $11,525,651. These services will be provided directly through vendor agreements with $9,592,605 and indirectly with $1,933,045 in purchase of services contracts with private providers.

e. To provide family services to eligible families determined by OHD to need such services:

i. to provide pre-placement or preventive or reunification services to 13,880 families determined eligible by OHD-DCYFS or DYS staff;

ii. to reduce the placement of children out of their homes as a result of abuse or neglect by 4 percent;

iii. to limit the number of children in long-term placements (over 24 months) to 55 percent of the total foster care population;

iv. target completion date: June 30, 1987;

v. resource requirement: $12,437,916. These services will be provided directly by OHD staff with $12,061,920 and indirectly with $375,996 in purchase of service contacts with private providers.

f. To allow eligible individuals and families to improve, maintain or develop the capacity for independent functioning in their own homes, family setting or other living arrangement by providing homemaker services:

i. target completion date: June 30, 1987;

ii. resource requirement: These services are to be provided directly by OHD staff, but the expenditures are included in Family Services and Protection for adults categories.

g. To assist individuals to locate, access and utilize Title XX and related services by providing information and referral services:

i. target completion date: June 30, 1987;

ii. resource requirement: These services will be provided directly by OHD staff to persons in need of emergency assistance with the cost being absorbed by all other services.

h. To enable eligible individuals to achieve their maximum potential for independent functioning so that they can remain in or move into the optimum environment in which they are able to function:

i. target completion date: June 30, 1987;

ii. resource requirement: $2,347,656. Services being provided directly by OHD staff. This dollar amount excludes the cost of room and board estimated $56.50 per day.

i. To provide respite care services to eligible disabled/handicapped individuals so their families can benefit from temporary relief from caregiving responsibilities. This serves to support the family as principal care-giver in order to prevent or delay placement of such disabled/handicapped individuals in restrictive settings:

i. target completion date: June 30, 1987;

ii. resource requirement: $1,076,629 in purchase of service contracts with private providers.

j. To provide temporary, but stable parenting, nurturing and/or oversight for eligible individuals (including those eligible for IV-E funded services) in foster family homes while permanent plans are being made for restoring the family unit, for adoptive placement or for independent living:

i. Target completion date: June 30, 1987;

ii. Resource requirement: $8,342,012. These services will be provided directly by OHD staff at a cost of $8,204,472. They will also be provided through purchase of service contracts with private providers with expenditures of $137,540. These dollar amounts exclude the cost of room and board estimated at $7.74 per day.

k. Transportation — Terminated 3. Office of Mental Health

a. Sub-Goal: Development and promotion of a comprehensive array of services directed toward preventing or postponing long term hospitalization or terminating inappropriate, long term hospitalization.

i. To provide acute day hospitalization care on a regional basis for all adults determined to be in need of this level of care:

(a). target completion date: June 30, 1987 (ongoing);

(b). resource requirement: With possible budget reductions and associated manpower reductions, this objective may require revision.

ii. To continue research into and development of residential programs which offer an alternative to long-term hospitalization, e.g, supervised boarding homes and substitute foster care:

(a). target completion date: Ongoing;

(b). resource requirement: No additional funds.

iii. To provide residential services in each region for all patients determined to be in need of:

(a). residential backup for acute day hospital services;

(b). transitional residential services during rehabilitation;

(c). long-term residential rehabilitation services (chronically mentally ill population); and

(d). respite care.

(e). target completion date: June 30, 1987 (ongoing);

(f). resource requirement: With possible budget reductions and associated manpower reductions, this objective may require revision.

iii. To provide case management services for every client determined to be in need assistance in:

(a). brokering services provided by other community caretakers;

(b). socialization/rehabilitation services so individualized they cannot be offered through other programmatic elements; and

(c). arranging transportation to essential services identified in individual treatment plans.

(d). target completion date: June 30, 1987 (ongoing);

(e). resource requirement: With possible budget reductions and associated manpower reductions, this objective may require revision.

iv. To provide essential outpatient mental health services to priority and target populations at the level possible with existing resources:

(a). to provide in at least one location in each OMH Region 24-hour telephone availability, 24-hour walk-in availability, on-call professional staff, medical staff back-up and inpatient availability;

(b). target completion date: June 30, 1987 (ongoing);

(c). resource requirement: With possible budget reductions and associated manpower reductions, this objective may require revision.

v. To provide adequate assessment, individualized treatment planning and treatment for all OMH patients through adequate staffing of all community mental health centers:

(a). target completion date June 30, 1987 (ongoing);

(b). resource requirement: With possible budget reductions and associated manpower reductions, this objective may require revision.

vi. To provide essential inpatient mental health services to priority and target populations at the level possible with existing resources:

(a). to provide short-term and acute inpatient care on a regional basis for all individuals determined to be in need of this level of care;

(b). target completion date: June 30, 1987 (ongoing);

(c). resource requirement: With possible budget reductions and associated manpower reductions, this objective may require revision.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

Chapter 111. Area Level Planning

§11101. Introduction

A. Most of the planning which appears throughout this document can be considered "area level planning" since analyses of the health status and the state's health system are presented with emphasis on area-specific differences and needs. Many of the implementation strategies planned for the 1982-87 period which appear in the preceding chapter are directed toward identified locales. In developing this look at area health needs, five core health system categories have been used along with the general category of health status and pertinent information from a number of sources synthesized. The Health System Plans and Annual Implementation Plans of the three Health System Agencies in the state were utilized, as well as planning documents of various state health-related agencies and organizations.

B. All recommended actions presented in this Section are not developed so specifically as to include identification of the change agent and the cost and manner through which change could be accomplished. Specific implementation planning is found in Chapter VI. Criteria through which health system resource goals will be implemented during 1122 review are found in Chapter IX. The recommended actions delineated in this chapter are needs which have been identified and to which attention should be drawn through all possible channels, public and private, individual and organizational. It is acknowledged that at this time resources are becoming scarcer and actions requiring excessive start-up costs or subsidy from tax-generated funds must be limited. It is not realistic or fair for this planning document to outline myriad desirable activities and programs and, by implication, point an accusing finger at those agencies and communities who may fail to accomplish the goals because of the unavailability of funds. The area level planning which appears in this Section is, therefore, a picture of ideal responses and initiatives of the health system.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11103. Acute Care

A. New Orleans/Bayou-River Health System Area

1. There are 34 general (non-federal) hospital facilities located in the New Orleans/Bayou-River area. Current patient bed to population ratio is 5.6/1,000 general population. The ratio in planning district I (New Orleans) is 6.26/1,000, while in planning district III (Bayou-River) is 2.90/ 1,000. Although there is a relatively large use of hospital beds in the New Orleans district by persons from outside the service area, only 5 of the 26 facilities in the district had occupancy rates during 1980 which reached 80 percent. No facility in the Bayou-River district reached 80 percent occupancy; 6 of the 9 facilities in that district had occupancy rates below 60 percent during 1980. Most of the facilities in the Bayou-River area are small hospitals which provide acute care accessibility to rural residents and cannot reasonably be expected to achieve 80 percent occupancy.

2. Three new general hospital facilities have been approved for construction in HSA I and 714 additional beds have been approved for existing facilities.

3. Planning objectives for acute care in HSA I:

a. by 1985 the ratio of non-federal short-term general hospitals beds to population should not exceed 5.0 beds per 1000 population in the five-parish New Orleans area;

b. by 1985 non-federal medical-surgical beds located within the New Orleans Standard Metropolitan Statistical Area should reflect an annual unit occupancy rate of at least 80 percent;

c. by 1985 medical-surgical beds located in the non-metropolitan parishes of Assumption, Lafourche, Plaquemines, St. Charles, St. James, St. John the Baptist and Terrebonne should reflect an annual unit occupancy rate of at least 70 percent except where the number of beds is less than 50 and where accessibility would otherwise be jeopardized;

d. by 1985 non-federal short-term obstetric beds and neo-natal beds located within the New Orleans SMSA should reflect an annual unit occupancy rate of at least 75

percent and should conform to other standards and goals established in the 1982-87 State Health Plan;

e. by 1984 non-federal short-term pediatric beds located within the New Orleans SMSA should reflect an annual unit occupancy rate of at least 70 percent and should conform to other standards and goals established in the 1982-87 State Health Plan.

4. Recommended actions:

a. local consumer groups, business leaders, and labor unions should assume an active role in increasing the public's understanding of the need to restrain rising hospital costs through local action;

b. District VI of the Louisiana Hospital Association, the Metropolitan Hospital Council of New Orleans, and individual hospital administrators in the New Orleans SMSA should institute coordinative agreements which will lead to voluntary reduction of excess hospital capacity through mergers, relocations and conversions of existing hospital services;

c. short-term general hospitals located in the New Orleans SMSA which have annual medical-surgical occupancy rates of less than 70 percent should convert underutilized capacity to new services such as, but not limited to: comprehensive primary care services; mental health services; immunization programs;

d. prenatal care programs, particularly aimed at high risk mothers; screening for early detection of cancer; habilitation and rehabilitation services; services for the developmentally disabled; and alternative maintenance services;

e. short-term general hospitals located in non-metropolitan parishes which have an annual medical-surgical occupancy rate of less than 70 percent should assess the feasibility of closure or conversion to alternative services, such as ambulatory care centers or skilled nursing facilities, except where such action would jeopardize accessibility to a rural population group;

f. obstetric units in the New Orleans SMSA which have fewer than 400 deliveries per year should be consolidated or closed;

g. pediatric units in Orleans Parish with fewer than 20 beds should be consolidated or closed.

B. Mid-Louisiana Health System Area

1. There are 57 general (non-federal) hospital facilities located in the Mid-Louisiana area. Current bed to population ratio is 3.9/1,000 general population. The ratio in planning district II (Capital) is 3.58/1,000; in planning district IV (Acadiana), it is 4.19/1,000; and in planning district 5 (Southwest), it is 4.36/1,000. Only 4 of the 21 facilities in the Capital district had occupancy rates during 1980 which reached 80 percent; only 3 of the 24 facilities in Acadiana district reached 80 percent occupancy during 1980; none of the 12 facilities in the Southwest district reached 80 percent occupancy. The need to provide accessibility for rural population groups is a factor which applies to many of the area's hospitals and keeps occupancy below 80 percent; however, 26 of the 57 facilities had annual occupancy rates which fell below 60 percent in 1980.

2. Two new general hospital facilities have been approved for construction in HSA II and 561 additional beds have been approved for existing facilities.

3. Planning objectives for acute care in HSA II:

a. Medical-Surgical Services. Through 1985, the total supply of all hospital beds in Mid-Louisiana should not exceed 4.0 licensed beds per 1000 Mid-Louisiana residents.

b. By 1985 medical surgical beds located in the non-metropolitan parishes of the area should reflect an occupancy rate of at least 70 percent annually except where the number of beds is less than 50 and accessibility would otherwise be jeopardized.

c. Obstetrical Services. Through 1985, the total supply of obstetrical beds should not exceed 354-370 beds and should conform to other standards and goals established in the 1982-87 State Health Plan.

d. Neo-natal services should conform to goals and standards established in the 1982-87 State Health Plan.

e. Pediatrics. Through 1985, the total supply of pediatric beds should not exceed 383-441 beds and should conform to other standards and goals established in the 1982-87 State Health Plan.

f. Cardiac care services should conform to goals and standards established in the 1982-87 State Health Plan.

4. Recommended Actions. Short-term general hospitals located in non-metropolitan parishes which have an annual medical-surgical occupancy rate of less than 70 percent should assess the feasibility of closure or conversion to alternative services, such as ambulatory care centers, except where such action would jeopardize accessibility to a rural population group.

C. North Louisiana Health System Area

1. There are 50 general (non-federal) hospitals located in the North Louisiana area. Current patient bed to population ratio is 5.06/1,000 general population. The resource goal in North Louisiana is 4.26/1,000, adjusted upward as necessary for small institutions needed in rural areas to accomodate accessibility.

2. The current patient bed to population ratio in the Cenla district is is 4.03/1,000; bed need goal adjusted for percentage of population 65 + is 4.11/1,000. The current patient bed to population ratio in the Northwest district is 6.06/1,000 and in the Northeast district is 4.56/1,000. In both the Northwest and Northeast district the age-adjusted bed need goal is 4.30.

3. Occupancy rates in the North Louisiana area are generally low. In Cenla district, 2 of 13 facilities had occupancy rates in 1980 which reached 80 percent. In the Northwest district, 3 of 20 facilities reached 80 percent

occupancy. In the Northwest district, none of the 17 facilities in that district reached 80 percent occupancy. Although small rural hospitals account for a significant proportion (66 percent) of the hospitals in the North Louisiana area, occupancy rates were below 60 percent in 1980 at 24 of the 50 facilities in the area. The Northwest and Northeast districts account for 10 facilities each in the below 60 percent category; the Cenla district had four facilities with occupancy rates below 60 percent.

4. Two new general hospital facilities have been approved for construction in HSA III. 530 additional patient beds have been approved for existing facilities.

5. Planning objectives for acute care in HSA III:

a. by 1985, the ratio of non-federal short-term general hospital beds to population should not exceed 5.0/1,000 in the Northwest district;

b. by 1985, the ratio of non-federal short-term general hospital beds to population should not exceed 4.3/1,000 in the Northeast district;

c. by 1985, medical-surgical beds located in the non-metropolitan parishes (outside Caddo, Bossier and Ouachita parishes) should reflect an annual unit occupancy rate of at least 70 percent, except where the number of beds is less than 50 and where accessibility would otherwise be jeopardized;

d. by 1985, medical-surgical beds located in the metropolitan parishes of Caddo, Bossier and Ouachita should reflect an annual unit occupancy rate of at least 80 percent;

e. obstetrical, neo-natal and pediatric services should conform to standards and goals established in the 1982-87 State Health Plan;

f. cardiac care services should conform to standards and goals established in the 1982-87 State Health Plan.

6. Recommended Actions

a. Local consumer groups, business leaders, and labor unions should assume an active role in increasing the public's understanding of the need to restrain rising hospital costs through local action.

b. The Louisiana Hospital Association and individual hospital administrators in the Northwest and Northeast districts should institute coordinative agreements which will lead to voluntary reduction of excess hospital capacity through mergers, relocations and conversions of existing hospital services.

c. Underutilized medical-surgical bed capacity should be converted to needed new services, such as comprehensive primary care services, mental health services, chemical dependency units, family planning and prenatal care programs; habilitation and rehabilitation services; services for the developmentally disabled; alternative maintenance services; and ambulatory surgical beds.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P. L. 96-79, and R. S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11105. Ambulatory Care

A. New Orleans/Bayou-River Health System Area

1. The New Orleans/Bayou-River area is predominantly urban, with a higher per capita income, more physicians and more hospital beds than elsewhere in the state. Yet the area has the highest mortality rate in the state. Mortality rates in the area which have particular significance for ambulatory care planning are those for heart disease, cancer and infants.

2. There is a shortage of primary care physicians in some of the rural sections of the area and in the poverty pockets of New Orleans. Dental services are also relatively inaccessible to some of the poorer residents of New Orleans.

3. Planning Objectives for Ambulatory Care in HSA I

a. ambulatory or mobile health care settings which provide low cost screening diagnosis and treatment or referral should be available and accessible to all residents of the area within 30 minutes travel time. Programs directed especially toward screening for heart disease, hypertension, cancer, tuberculosis, anemia, gonorrhea and syphilis are needed.

b. Primary care physician services should be available in Assumption Parish and in Northeastern St. Tammany Parish, Dulac, Desire/ Florida (N.O.), Teche and Lafitte by 1985.

c. Low-cost pre-natal care programs for the low-income population should be available within 30 minutes travel time for all residents of the area, with appropriate referral services for high risk patients.

d. Ambulatory or mobile dental services which provide low-cost screening and treatment should be available to all residents of the area within 30 minutes travel time, but especially in the poverty areas of New Orleans.

e. By 1987, 30 percent of all surgical procedures performed in the area should be performed on an ambulatory basis.

f. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for radiation therapy services.

g. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for computed tomography services.

h. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for end-stage renal disease services.

i. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for ambulatory surgical services.

j. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for preventive health services.

4. Recommended Actions

a. Primary care physicians, dentists and other ambulatory care providers should consider the cost-effectiveness of mobile or "no-frills" type services which can be offered at a lower consumer cost in underserved poverty areas.

b. The Medicaid Program should consider the feasibility of instituting coverage of adult dental services beyond the current denture program, with the possibility of implementing a "co-pay" coverage whereby the recipient would bear 50 percent of the costs.

c. Medicare, Medicaid and major health insurance companies should develop policies that promote the utilization of ambulatory surgical services when medically appropriate, such as patient rebate for same day discharge or cost incentives for hospitals for same day discharge.

d. Assistance from L. S. U. and Tulane Medical Schools and/or Louisiana State Board of Medical Examiners in locating primary care physicians willing to establish practice in the designated manpower shortage areas of the area.

B. Mid-Louisiana Health System Area

1. In Mid-Louisiana are several urban, economically sound areas with adequate physicians and other ambulatory health care. However, there is a significant number of rural sections in the area, some of which are relatively isolated, with ambulatory health care inaccessible to residents. Dental services are inaccessible to some of the poorer residents of Baton Rouge.

2. Mortality rates are high in Mid-Louisiana, as they are elsewhere in the state, but especially so in the 15-24 year old age group. Suicides and accidents are a major reason for the high mortality rate in this age group.

3. Planning Objectives for Ambulatory Care in HSA II

a. Ambulatory or mobile health care settings which provide low cost screening, diagnosis and treatment or referral should be available and accessible to all residents of the area within 30 minutes travel time. Programs directed toward screening for heart disease, hypertension, arteriosclerosis and cancer are especially needed.

b. Primary care physician services should be available in Ascension, Cameron, East and West Feliciana, Evangeline, Iberville, Jefferson Davis, Livingston, Pointe Coupee, St. Helena and West Baton Rouge Parishes; also in St. Martin, Eden Park (Baton Rouge), Merryville and North Lake Charles by 1985.

c. Ambulatory or mobile dental services which provide low-cost screening and treatment should be available to all residents of the area within 30 minutes travel time, with emphasis on providing services to residents of the Eden Park area in Baton Rouge.

d. A comprehensive effort to screen and refer young people with symptoms of mental health and/or chemical dependency problems should be initiated by ambulatory health care providers.

e. By 1987, 30 percent of all surgical procedures performed in the area should be performed on an ambulatory basis.

f. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for radiation therapy services.

g. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for computed tomography services.

h. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for end stage renal disease services.

i. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for ambulatory surgical services.

j. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for preventive health services.

4. Recommended Actions

a. Primary care physicians, dentists and other ambulatory care providers should consider the cost-effectiveness of mobile or "no-frills" type services which can be offered at a lower consumer cost in underserved poverty areas.

b. The Medicaid Program should consider the feasibility of instituting coverage of adult dental services beyond the current denture program, with the possibility of implementing a "co-pay" coverage whereby the recipient would bear 50 percent of the cost.

c. Primary care physicians and other providers of ambulatory health care should devote attention to the screening and referral of persons in the 15-24 age group who may have symptoms of mental health and/ or chemical dependency problems.

d. Medicare, Medicaid and major health insurance companies should develop policies that promote the utilization of ambulatory surgical services when medically appropriate, such as patient rebate for same day discharge or cost incentives for hospitals for same day discharge.

e. Assistance from L. S. U. and Tulane Medical Schools and/or Louisiana State Board of Medical Examiners in locating primary care physicians willing to establish practice in the designated manpower shortage areas of the area.

C. North Louisiana Health System Area

1. North Louisiana is a predominantly rural area of the state, with a larger geographic area and a smaller population than the other areas of the state. There is a higher level of poverty in the area, especially concentrated in the Cenla and

Northeast districts. This type of setting portends a shortage of ambulatory care, accessible within 30 minutes travel time, just as is found in the area. Creative planning and implementation activities are needed to improve the accessibility and availability of ambulatory care in the rural sections of North Louisiana.

2. There are designated primary care physician shortages in Bienville, Bossier, Caldwell, Catahoula, DeSoto, Grant, Jackson, Madison, Tensas, Vernon, Webster, West Carroll and Winn Parishes, and in Zwolle, West Union and a poverty area of Shreveport. There is also a designated shortage of primary care physicians for the state-operated hospital in Ouachita Parish, E.A. Conway Memorial Hospital.

3. There are designated dental manpower shortages in Bienville, Caldwell, Catahoula, Concordia, DeSoto, East and West Carroll, Franklin, Grant, Jackson, Lincoln, Madison, Morehouse, Natchitoches, Red River, Tensas, Union, and Vernon Parishes.

4. Despite the general lack of accessible primary care, the mortality rate in North Louisiana is lower than in other parts of the state except for motor vehicular accidents, cerebrovascular disease and infant mortality, which are the highest in the state. The area also has the highest rate of illegitimate births and the highest fertility rates for females age 10-19, who are at high risk for complicated pregnancy and neonatal illness.

5. The North Louisiana area has a very high percentage of persons over the age of 65 years (11.8 percent), making ambulatory care for the chronic diseases of the aged important, especially in light of the area's high utilization among the + 65 population of nursing home services.

6. Planning Objectives for Ambulatory Care in HSA III

a. Ambulatory or mobile health care settings which provide low cost screening, diagnosis and treatment or referral should be available and accessible to all residents of the area within 30 minutes travel time. Programs directed toward screening for cerebrovascular and heart disease and screening and treatment of chronic diseases of the aged (such as diabetes, respiratory disease, vision problems and eye disease) are especially needed.

b. Primary care physician services should be available in designated shortage areas by 1987, if not through permanent location, through mobile units or special placement of interns and residents.

c. Ambulatory or mobile dental services which provide low-cost screening and treatment should be available to all residents of the area within 30 minutes travel time, with emphasis on providing services to the residents of designated dental manpower shortage areas.

d. Increased visibility, availability and accessibility of health education and family planning services directed toward low-income females in the 10-19 year age group, especially in the Northeast district, should be implemented by 1985.

e. Low-cost pre-natal care programs for the low-income population should be available within 30 minutes travel time for all residents of the area, with appropriate referral services for high risk patients.

f. By 1987, 30 percent of all surgical procedures performed in the area should be performed on an ambulatory basis.

g. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for radiation therapy services.

h. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for computed tomography services.

i. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for end-stage renal disease services.

j. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for ambulatory surgical services.

k. By 1987, there should be conformity to goals and standards established in the 1982-87 State Health Plan for preventive health services.

7. Recommended Actions

a. Primary care physicians, dentists and other ambulatory care providers should consider the cost-effectiveness of mobile or "no-frills" type services which can be offered at lower consumer cost, especially in under-served, rural poverty areas.

b. The Medicaid Program should consider the feasibility of instituting coverage of adult dental services beyond the current denture program, with the possibility of implementing a "co-pay" coverage whereby the recipient would bear 50 percent of the cost.

c. Rural hospitals with occupancy rates less than 60 percent should research the feasibility of converting underutilized capacity to outpatient clinics and obtaining the services at least on a part-time basis of primary care physicians. Especially needed are prenatal services and care for the chronic diseases of the aged directed toward low-income groups.

d. The Office of Health Services and Environmental Quality should implement more effective outreach and delivery of family planning services in the North Louisiana area, especially in the Northeast district among the 10-19 age group.

e. Medicare, Medicaid and major health insurance companies should develop policies that promote the utilization of ambulatory surgical services when medically appropriate, such as patient rebate for same day discharge or cost incentives for hospitals for same day discharge.

f. Assistance from L. S.U. and Tulane Medical Schools and/or Louisiana State Board of Medical Examiners in locating primary care physicians willing to establish practice in the designated manpower shortage areas of the area.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11107. Long Term Care

A. Introduction. For the purpose of this planning analysis, long term care services are those direct services needed by persons functionally impaired by advancing age, physical or developmental disability, chronic disease, or recuperating from acute illness. Services are both institutional and non-institutional. Non-institutional long term care services are those which are primarily directed toward preventing or postponing institutionalization. Not included in this analysis are long term care services needed by persons impaired because of mental illness or substance abuse. These are covered in the subsequent area level planning section.

B. New Orleans/Bayou-River Health System Area

1. The percentage of persons 65 + in the New Orleans/Bayou-River health system area is 8.8 percent. The current nursing home bed (SNF, ICF I and II) to population ratio is 36.3 beds per 1,000 population age 65 + . This is significantly fewer beds than are available in the other parts of the state. In 1980, 90.1 percent of patient days were by persons age 65 + ; 3.9 percent were by persons with developmental disability; and 6.0 percent were utilized by other persons. The average occupancy in 1981 was 96 percent in the New Orleans district. The average 1981 occupancy in the Bayou district was 99 percent.

2. There is one intermediate care facility for the mentally retarded (ICF-MR) in the New Orleans/Bayou-River area, Belle Chasse State School, operating 604 beds at 88 percent occupancy. A state school in Thibodaux is under construction and will have a bed capacity of 75.

3. Planning Objectives for Long Term Care for HSA I

a. Through 1985, the proportion of skilled (SNF) beds should be maintained between 15 and 20 percent of the total number of nursing home beds located in the HSA.

b. Through 1987, the ratio of total nursing home beds to the population age 65 and over within the HSA should not exceed 65 beds per 1000 population age 65 and over.

c. Through 1985, the overall annual occupancy rate for nursing homes in HSA I should be maintained at least 95 percent.

d. By 1985, all nursing homes should provide the full range of rehabilitation and supportive services established by the federal guidelines for nursing home care and should be encouraged to seek Joint Commission on Accreditation of Hospitals (JCAH) accreditation.

e. By 1988, the development of small, community-based ICF/MR services should be initiated, in accordance with the goals and standards established in the State Health Plan 1982-87.

f. By 1985, valid and reliable data describing the scope, utilization, and cost of all home health and other community-based services provided to the functionally impaired population residing in the health service area should be accessible to those involved in the development and/or expansion of community-based services.

g. By 1985, accurate and complete information describing the availability of institutional and community-based long term care services should be accessible to the aged residents in the health service area.

h. By 1985, the development and expansion of the array of community-based long term care services including home health services, adult day care, day-hospital, respite care services, and alternative residential settings for the developmentally disabled, should be initiated.

i. 1987, Comprehensive Physical Rehabilitation Facility services should be available and accessible to the population, meeting goals and standards for CPRF services established in the State Health Plan 198287.

j. By 1987, Home Health services should be available and accessible to the population, meeting goals and standards for such services established in the State Health Plan 1982-87.

4. Recommended Actions

a. Existing providers of nursing home care should assess the feasibility of altering their services to include outpatient, mobile, or home-based services.

b. Existing and potential providers of ICF I and II nursing home care should assess the feasibility of conversion to or construction of skilled (SNF) care or day care.

c. General hospital facilities with underutilized medical/surgical beds should assess the feasibility of converting space to medical day care services or skilled nursing beds.

d. The Department of Health and Human Resources should assess the feasibility of securing an appropriation of funds to be used for low interest loans to persons willing to develop currently unavailable community-based services to the functionally impaired to prevent institutionalization.

e. The Department of Health and Human Resources should assess the feasibility of securing a recurring appropriation of funds through 1987 to be used for low interest loans to persons willing to develop small community-based residential services for the developmentally disabled.

f. The Department of Health and Human Resources, the Office of Elderly Affairs and the Legislative

Health and Welfare Oversight Committee should assess the feasibility of making at-home services economically accessible to persons not eligible for Medicaid reimbursed at-home services, but having potential eligibility for institutional long term care services. Alternatives to prevent costly institutionalization might be "co-pay" programs through which eligibles pay 25 percent of the cost of services. (Sliding scale payments are not recommended because of the cost of administration.)

C. Mid-Louisiana Health System Area

1. The percentage of persons 65 + in the Mid-Louisiana health system area is 8.7 percent. The current nursing home bed (SNF, ICF I and II) to population ratio is 67.2 beds per 1,000 population 65 + . Although the number of beds is well below the standard 80/1,000 population 65 + which is established as a benchmark for assessing service availability, it is still believed that the bed ratio could be significantly reduced if sufficient alternative services were available. If low-cost and subsidized alternative services are developed over the coming 5-year period, by 1990, a goal of 65 beds/1,000 population age 65 + could be feasible.

2. In 1980, 84.3 percent of patient days in Mid-Louisiana nursing homes were by persons age 65 + ; 4.9 percent were by persons with developmental disabilities; and 10.8 percent were utilized by other persons. The average occupancy in 1981 was 92 percent, which is 3 percent less than the 95 percent standard.

3. There are 3 intermediate care facilities for the mentally retarded (ICF/MR) in the Mid-Louisiana area, with an overall occupancy rate in 1981 of 97 percent for the 924 beds.

4. Planning Objectives for Long Term Care for HSA II

a. Through 1985, SNF beds complements should be encouraged to locate within acute care hospitals.

b. By 1987, the ratio of total nursing home beds to the population age 65 and over within the HSA should not exceed 80 beds per 1000 population age 65 and over.

c. Through 1985, the overall annual occupancy rate for nursing homes in HSA II should be maintained at least 95 percent.

d. By 1985, all nursing homes should provide the full range of rehabilitation and supportive services established by the federal guidelines for nursing home care and should be encouraged to seek Joint Commission on Accreditation of Hospitals (JCAH) accreditation.

e. Through 1985, the total number of existing and 1122-approved inpatient hospice beds in the Mid-Louisiana HSA should not exceed 41.

f. By 1985, the development of small, community-based ICF/MR services should be initiated, in accordance with the goals and standards established in the State Health Plan 1982-87.

g. By 1985, valid and reliable data describing the scope, utilization, and cost of all home health and other community-based services provided to the functionally impaired population residing in the health service area should be accessible to those involved in the development and/or expansion of community-based services.

h. By 1985, accurate and complete information describing the availability of institutional and community-based long term care services should be accessible to the aged residents in the health service area.

i. By 1985, the development and expansion of the array of community-based long term care services including home health services, adult day care, day-hospital, respite care services, and alternative residential settings for the developmentally disabled, should be initiated.

j. By 1987, Comprehensive Physical Rehabilitation Facility services should be available and accessible to the population, meeting goals and standards for CPRF services established in the State Health Plan 198287.

k. By 1987, Home Health services should be available and accessible to the population, meeting goals and standards for such services established in the State Health Plan 1982-87.

5. Recommended Actions

a. Existing providers of nursing home care should assess the feasibility of altering their services to include outpatient, mobile, or home-based services.

b. Existing and potential providers of ICF I and II nursing home care should assess the feasibility of conversion to or construction of medical day care units.

c. General hospital facilities with underutilized medical/surgical beds should assess the feasibility of converting space to medical day care services or skilled nursing beds.

d. The Department of Health and Human Resources should assess the feasibility of securing an appropriation of funds to be used for low-interest loans to persons willing to develop currently unavailable community-based services to the functionally impaired to prevent institutionalization.

e. The Department of Health and Human Resources should assess the feasibility of securing a recurring appropriation of funds through 1987 to be used to low interest loans to persons willing to develop small community-based residential services for the developmentally disabled.

D. North Louisiana Health Systems Area

1. The percentage of persons 65 + in the North Louisiana health system area is 11.8 percent. The current nursing home bed to population ratio is 80.1/1,000 population age 65 + . Although this is quite near the standard 80 bed/1,000 population 65 + which is established as a benchmark for assessing service availability, it is believed that the bed ratio could be significantly reduced if sufficient alternative services were available. If low-cost and subsidized alternative services, especially mobile and at-home services in rural areas, are developed over the coming

5 year period, by 1990, a goal of 75 beds/1,000 population age 65 + could be feasible.

2. In 1980, 85.2 percent of patient days in North Louisiana nursing homes were by persons age 65 + ; 6.5 percent were by persons with developmental disabilities; and 8.3 percent were utilized by other persons. The average occupancy in 1981 was 96 percent.

3. There are 11 intermediate care facilities for the mentally retarded in North Louisiana. There was a 93 percent occupancy in 1981 for the 2,853 beds.

4. Planning Objectives for Long Term Care for HSA III

a. By 1987, the ratio of total nursing home beds to the population age 65 and over within the HSA should not exceed 80 beds per 1000 population age 65 and over.

b. Through 1985, the overall annual occupancy rate for nursing homes in HSA III should be maintained at least 95 percent.

c. By 1985, all nursing homes should provide the full range of rehabilitation and supportive services established by the federal guidelines for nursing home care and should be encouraged to seek Joint Commission on Accreditation of Hospitals (JCAH) accreditation.

d. By 1987, there should be a reduction in patient days utilized by persons with developmental disability in SNF and ICF I and II beds from 6.5 percent to 4.5 percent.

e. By 1985, valid and reliable data describing the scope, utilization, and cost of all home health and other community-based services provided to the functionally impaired population residing in the health service area should be accessible to those involved in the development and/or expansion of community-based services.

f. By 1985, accurate and complete information describing the availability of institutional and community-based long term care services should be accessible to the aged residents in the health service area.

g. By 1985, the development and expansion of the array of community-based long term care services including home health services, adult day care, day-hospital, respite care services and alternative residential settings for the developmentally disabled should be initiated.

h. By 1987, Comprehensive Physical Rehabilitation Facility services should be available and accessible to the population, meeting goals and standards for CPRF services established in the State Health Plan 198287.

i. By 1987, Home Health services should be available and accessible to the population, meeting goals and standards for such services established in the State Health Plan 1982-87.

j. By 1985, ICF /MR services should be delivered in accordance with the goals and standards established in the State Health Plan 1982-87, with no additional ICF-MR services approved during 1122 review except for facilities with 8 or fewer beds.

5. Recommended Actions

a. Existing providers of nursing home care should assess the feasibility of altering their services to include outpatient, mobile, or home-based services.

b. Existing and potential providers of ICF I and II nursing home care should assess the feasibility of conversion to or construction of medical day care units.

c. General hospital facilities with underutilized medical/surgical beds should assess the feasibility of converting space to medical day care service or skilled nursing beds.

d. The Department of Health and Human Resources should assess the feasibility of securing an appropriation of funds to be used for low interest loans to persons willing to develop currently unavailable community-based services to the functionally impaired to prevent institutionalization.

e. The Department of Health and Human Resources should assess the feasibility of securing a recurring appropriation of funds through 1987 to be used to low interest loans to persons willing to develop small community-based residential services for the developmentally disabled.

f. The Department of Health and Human Resources, the Office of Elderly Affairs and the Legislative Health and Welfare Oversight Committee should assess the feasibility of making at-home services economically accessible to persons not eligible for Medicaid reimbursed at-home services, but having potential eligibility for institutional long term care services. Alternatives to prevent costly institutionalization might be "co-pay" programs through which eligibles pay 25 percent of the cost of services. (Sliding scale payments are not recommended because of the cost of administration.)

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11109. Mental Health/Substance Abuse

A. The following planning objectives for mental health and substance abuse apply to all areas of the state.

1. By 1985, information on the availability, accessibility, and appropriate use of primary mental health care services should be available to all residents of the state.

2. By 1987, mental health education services for the school-age population should be improved and extended throughout the state.

3. By 1985, mental health diagnosis and treatment services should be coordinated so that these services are available to all individuals within the health service area within one hour travel time.

4. By 1985, financial barriers to private mental health diagnosis and treatment services should be alleviated. The demand for services exceeds the treatment capacity of the public facilities, with a resultant strain on consumers and providers within the public system.

5. By 1987, mental health, alcohol and substance abuse services provided in short-stay inpatient settings should be consistent with the goals and standards established for inpatient psychiatric beds and chemical dependency beds in the State Health Plan 1982-87.

6. By 1987, the number of community-based small group homes and transitional residences appropriate for emotionally disturbed persons should be increased by 100 percent.

7. By 1987, day care, day treatment, education, training, and employment programs appropriate for the needs of emotionally disturbed persons should be available in ambulatory settings, within 1 hour travel time for rural residents and 30 minutes travel time for urban residents.

B. The following recommended actions apply to all areas of the state.

1. Organizational mechanisms should be established that will coordinate existing community mental health education programs, inventory available mental health education resources, and promote mental health education activities (both voluntary and governmental).

2. A plan to develop, maintain and evaluate mental health education programs should be developed by the Office of Mental Health and Substance Abuse.

3. A guide to all existing mental health services in the health service area should be developed by the Office of Mental Health and Substance Abuse in coordination with private mental health providers.

4. Efforts to increase reimbursement for mental health diagnosis and treatment costs by public and private insurance programs should be supported.

5. Encouragement of the development of needed health system resources should be undertaken by interested advocacy groups and by the state through subsidies, such as low-interest loans, and Medicaid coverage of special health-related ambulatory programs.

6. Conversion of an appropriate number of underutilized medical/ surgical beds in short stay general hospitals which may be better utilized as discrete units for the treatment of psychiatric or chemical dependency problems should be considered by appropriate facilities.

7. By 1984, the Office of Mental Health and Substance Abuse should have developed a quantifiably meaningful needs assessment for behavioral health services. This assessment should cover:

a. the full range of behavioral health services which should be provided in accordance with the needs of the population in the various districts of the state;

b. the number and type of behavioral health services that should be provided in each of the parishes, those which should be provided within the catchment, or service areas, and those which should be provided only within the planning districts;

c. the number and types of behavioral health services which are not being provided in the areas mentioned above;

d. changes needed in the local behavioral health system (i.e., new resources or changes in existing resources) in order to meet the needs of the people;

e. the resources required for implementing the changes; and

f. the persons, agencies, or groups who will take responsibility for implementing the changes.

C. New Orleans/Bayou-River Health System Area

1. Planning Objective for Mental Health/Substance Abuse Services in HSA I

a. By 1987, psychiatrists should be available in the designated manpower shortage parishes of Lafourche and Terrebonne.

2. Recommended Action

a. Assistance from the L.S.U. and Tulane Medical Schools and from the Louisiana State Board of Medical Examiners should be given to locate and/or place psychiatrists or psychiatric residents in Lafourche and Terrebonne parishes.

D. Mid-Louisiana Health System Area

1. Planning Objective for Mental Health/Substance Abuse Services in HSA II

a. By 1987, special inpatient acute treatment units for children and adolescents with psychiatric problems should be available in the Mid-Louisiana area in accordance with goals and standards established for inpatient psychiatric services in the State Health Plan 1982-87.

b. By 1987, small, community-based facilities providing intermediate and long-term psychiatric care for children and adolescents should be developed in accordance with the goals and standards established for psychiatric services in the State Health Plan 1982-1987.

c. By 1987, psychiatrists should be available in the designated manpower shortage parish of St. Mary.

2. Recommended Action

a. Underutilized medical/surgical beds in acute care general hospitals should be converted, in appropriate numbers, to discrete treatment units for children and adolescents with acute psychiatric problems.

b. Facilities providing intermediate and long-term inpatient psychiatric services for children and adolescents should be developed, especially small community-based group homes.

c. Assistance from the L.S.U. and Tulane Medical Schools and from the Louisiana State Board of Medical Examiners should be given to locate and/or place psychiatric residents in St. Mary Parish.

E. North Louisiana Health System Area

1. Planning Objectives for Mental Health/Substance Abuse Services in HSA III

a. By 1985, there should be a discrete chemical dependency unit available for the inpatient treatment of adolescents with chemical dependency problems in Shreveport and in Monroe.

b. By 1987, special inpatient acute care treatment units for children and adolescents with psychiatric problems should be available in the North Louisiana area in accordance with goals and standards established for inpatient psychiatric services in the State Health Plan 1982-87.

c. By 1987, small, community-based facilities providing intermediate and long-term psychiatric care for children and adolescents should be developed in accordance with the goals and standards established for psychiatric services in the State Health Plan 1982-87.

d. By 1987, psychiatrists should be available in the designated manpower shortage parishes of Caldwell, East and West Carroll, Franklin, Madison, Morehouse, Ouachita, Richland and Tensas.

2. Recommended Actions

a. Underutilized medical/surgical beds in acute care general hospitals should be converted, in appropriate numbers, to discrete treatment units for children and adolescents with acute psychiatric problems.

b. Facilities providing intermediate and long-term inpatient psychiatric services for children and adolescents should be developed, especially small community-based group homes.

c. Assistance from the L. S. U. and Tulane Medical Schools and from the Louisiana State Board of Medical Examiners should be given to locate and/or place psychiatrists or psychiatric residents in designated psychiatric manpower shortage areas.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11111. Emergency Medical Services

A. The following planning objectives for emergency medical services apply to all areas of the state:

1. By 1987, the resource goals for emergency medical services established in the State Health Plan 1982-87 should be met.

2. By 1985, mobile EMS resources conforming to the requirements. of Basic Life Support as defined by the United States Department of Transportation should be available and accessible to 95 percent of the population with 10 minutes in urban areas and within 30 minutes in non-urban areas.

3. Educational programs to increase public awareness of the available emergency medical services in the various areas and the public's potential for emergency medical self-help should be developed and implemented on a regional basis.

4. By 1985, all regional disaster plans should include EMS components.

5. By 1985, regionalized emergency medical services communication systems should be operational in all areas of the state.

6. By 1987, emergency transportation services for high risk groups such as high risk pregnancies, ill neo-nates, mentally disturbed individuals, and offshore personnel in need of emergency care should be developed.

7. By 1985, health care institutions and ambulance services should coordinate emergency medical patient transport from the scene to the critical care facility.

8. By 1983, public education strategies emphasizing the need for the following two components of the emergency care system should be developed:

a. legislation requiring minimum staffing, standard equipment and regular maintenance of equipment and vehicles;

b. a single access (or 911) emergency number with direct communication to a central ambulance dispatching center.

B. Recommended Actions

1. A universal telephone number should be operable where technically feasible to ensure access to emergency medical services.

2. Basic Life Support (VHF) base stations should be installed in health care institutions presently without two-way radio communications capability.

3. Basic Life Support Radio equipment should be installed in all emergency ambulances presently without two-way radio communications capability.

4. Advanced Life Support telecommunications equipment should be installed in large medical centers.

5. The Louisiana EMS Councils should coordinate efforts to develop a special bureau composed of persons interested in EMS activities. These persons would appear on radio and television talk shows and speak before groups about EMS activities.

6. The Louisiana EMS Councils should encourage health care institutions and ambulance services to sign written transfer and mutual aid agreements respectively.

7. The Louisiana EMS Councils should complete classification of critical care capabilities in area health care institutions. This information should be distributed to

appropriate EMS personnel, including vehicle dispatchers and ambulance attendants.

8. The Louisiana EMS Councils should contact all public safety and disaster planning agencies and urge them to consider the emergency medical needs of residents in their disaster planning efforts.

9. Local community groups should start their own campaigns for local passage of legislation (either city or parish ordinances) governing ambulances. The Bureau of EMS, the EMS councils, key hospital administrators, local medical societies, ambulance personnel, and the State Police could arrange group discussions of possible strategies for public education programs. The programs should emphasize the urgent need for passage of legislation requiring minimum requirements for ambulances. Local campaigns include such strategies as planning and organizing town meetings and developing public service announcements.

C. New Orleans/Bayou-River Health Systems Area

1. Planning Objectives for Emergency Medical Services in the New Orleans/Bayou-River Health System Area

a. By 1985, there should be a 50 percent increase in the number of Emergency Medical Technicians (EMT's) at all levels of training in the area.

b. By 1985, 50,000 additional residents of the area should receive medical self-help training.

2. Recommended Actions

a. The State Bureau of EMS should continue to offer numerous levels of EMT training classes in the area.

b. The State Bureau of EMS, Southeast Louisiana EMS Council, American Red Cross, and American Heart Association should expand their First Responder, Citizen CPR, and First Aid instruction programs in HSA I.

D. Mid-Louisiana Health System Area

1. Planning Objective for Emergency Medical Services in the Mid-Louisiana Health System Area

a. By 1983, a program should be designed to increase public awareness regarding use of automobile restraints and helmets to reduce fatalities and serious injuries from motor vehicular accidents.

2. Recommended Action

a. Interested advocacy groups should implement public education programs to reduce fatalities and serious injuries from motor vehicular accidents.

E. North Louisiana Health System Area

1. Planning Objective for Emergency Medical Services in the North Louisiana Health System Area

a. By 1983, a program should be designed to increase public awareness regarding use of automobile restraints and helmets to reduce fatalities and serious injuries from motor vehicular accidents.

2. Recommended action:

a. Interested advocacy groups should implement public education programs to reduce fatalities and serious injuries from motor vehicular accidents.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11113. Health Status

A. New Orleans/Bayou-River Health System Area

1. Planning goals for health status improvements in the New Orleans/Bayou-River area:

a. Cancer Mortality: To reduce the number of deaths attributable to cancer;

b. Premature Mortality from disease: To reduce the number of deaths due to cardiovascular and cerebrovascular disease, and diabetes mellitus;

c. Alcoholism and Drug Abuse: To contain alcoholism and drug abuse in the area and prevent increase beyond current levels;

d. Hypertension: To increase the percentage of people with high blood pressure who have been identified and are under treatment to a higher percentage than the national average;

e. Infant Mortality: To reduce the number of infant deaths by over 25 percent;

f. Accidental Deaths: To reduce the number of deaths from non-motor vehicular accidents among persons under 35—a high risk group—by 10 percent;

g. Preventable disease: To reduce the number of preventable diseases such as diptheria, measles, mumps, polio, or tetanus to as close to zero as possible;

h. Dental Disease and Tooth Loss: To reduce tooth decay among children, and tooth loss among adults;

i. Vision Problems and Loss of Sight: To reduce uncorrected vision problems among children and adults, and to reduce the number of people in the health service area who become blind;

j. Reportable Venereal Disease: To reduce the number of cases of gonorrhea and syphilis, particularly in Orleans and Jefferson Parishes.

B. Mid-Louisiana Health System Area

1. Planning Goals for Health Status Improvements in HSA II

a. Cancer Mortality: To reduce the age-adjusted mortality rate for the Mid-Louisiana Health Service Area to a low or lower rate than the rate for the United States.

b. Emergency Medical Services: To contain the accident mortality rate for the Mid-Louisiana Health Service area and not exceed the national rate.

c. Perinatal Care Services: To reduce the rates for perinatal mortality, neonatal mortality, fetal mortality and incidence of low birth weight infants and to make the rates more comparable with the corresponding annual rates for the United States, especially among non-whites in poor or rural areas.

d. Substance Abuse: To reduce the incidence and prevalence of alcohol and drug abuse in the HSA.

e. Disability: To reduce disability associated with acute and chronic conditions among the population of the HSA.

f. Mental Health: To improve the mental health status of the population of the HSA.

g. Suicide: To reduce the number of deaths from suicide in the area, especially in the 15-24 age group.

h. Institutionalization: To reduce the percentage of persons 65 + requiring care in a long term care facility.

i. Dental Disease and Tooth Loss: To reduce tooth decay among children, and tooth loss among adults.

j. Vision Problems and Loss of Sight: To reduce uncorrected vision problems among children and adults, and to reduce the number of people in the area who become blind.

C. North Louisiana Health System Area

1. Planning Goals for Health Status Improvements in HSA III

a. Accidents—Burn/Trauma Treatment: To reduce the number of deaths associated with accidents, especially motor vehicular accidents.

b. Long Term Care/Support System: To maintain the population most vulnerable to institutionalization at maximum levels of psychological, physical and social well-being and to reduce the percentage of persons age 65 + in long term care facilities by 6 percent by 1987; and to reduce the percentage of persons with developmental disabilities in long term care facilities by 3 percent by 1987.

c. Infant Mortality: To reduce the rate of deaths of infants from birth to one year of age to 14.5/1,000 live births by 1987.

d. Cardiovascular Diseases: To reduce the death rate from heart and cerebrovascular diseases.

e. Venereal disease: To reduce incidence of venereal diseases in North Louisiana by 5 percent by 1985; to reduce the gonorrhea rate from 643 per 100,000 persons in 1978 to 611 per 100,000; to reduce the syphilis rate from 19 per 100,000 in 1978 to 18 per 100,000.

f. Cancer: To reduce by 1987 the number of deaths attributable to cancer by 5 percent.

g. Respiratory diseases: To reduce by 1987 the number of deaths attributable to respiratory diseases in North Louisiana from 24.2/100,000 to 10.1/100,000 or a reduction of 17 percent.

h. Kidney disease: To increase by 1985 the referral rate (discovery rate) of patients developing End Stage Renal Disease by 70 percent while increasing the number of transplant procedures by 23 percent and reducing the corresponding dialysis care mortality by 2.1 percent.

i. Diabetes Mellitus: To reduce by 1984 the diabetic death rate in North Louisiana from 23.4/100,000 to 16.2/100,000.

j. Dental Disease and Tooth Loss: To reduce tooth decay among children, and tooth loss among adults.

k. Vision Problems and Loss of Sight: To reduce uncorrected vision problems among children and adults, and to reduce the number of people in the area who become blind.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

Chapter 113. State Health Policy Analysis

Subchapter A. Statutory Sources for Louisiana Health Policy

§11301. Introduction

A. A policy is a guiding principle or course of action adopted and pursued by a society through its government as well as by various societal groups such as voluntary associations and professional organizations. Social policy, as a type of policy, addresses three areas which are considered its common domain:

1. a society's overall quality of life;

2. the conditions of life directly experienced by individuals and groups such as the family; and

3. the quality of the relationships among various societal groups and individuals.

B. Health policy must be considered a major sub-area of social policy. The three areas previously identified as the domain of social policy are inseparable from health concerns. Can a society's overall quality of life be ascertained without considering mortality and morbidity rates? Similarly, can the conditions of life directly experienced by individuals not be affected by the availability, accessibility and quality of health care? It therefore becomes inevitably necessary for health related matters to be addressed in social policy.

C. Since health policy is defined as a sub-area of social policy it also becomes subject to all of the difficulties inherent in analyzing social policy. A major contributing factor to difficulties encountered in the analysis of social policy is the lack of definitional consensus on what social policy actually is. The literature on social policy reflects this definitional confusion by using the term in different ways.

Sometimes social policy refers to abstract principles, a philosophical stance that should guide decision-makers seeking solutions to social problems. Sometimes, it is perceived as a set of decisions telling us what is to be done about a particular social problem. This approach overlooks the "channeling functions" of social policy. Social policies shape our perceptions of what constitutes a social problem by labeling behavior, situations, or conditions problematic, therefore legitimizing and focusing our concern on the particular problem as well as legitimizing the allocation of resources to solve or contain the problem.

D. A third approach considers social policy to be an underlying process societal organizations use to maintain equilibrium and improve conditions for its members.

E. Finally, social policy is defined as a framework for action. This assumes the existence of clarity linked to the expectation that changes in values, structures, and conditions will ensue in the societal units affected by the policy. This last approach fuses the definition of policy as both process and product.

F. Given the lack of definitional consensus, perhaps the most useful approach, and the one adopted for the remainder of this analysis, begins by conceptualizing the "Social Policy" pursued by any society, as an interacting and interdependent system of policies, and by further conceptualizing those policies which make up the system, when they are public policies, as being expressed through legislative act.

G. Two considerations which add to the difficulties of social policy analysis bear on the evaluation of policy as conceptualized in the previous paragraph. First, each area of policy having developed over time has a history. Consequently policy is characteristically stratiform and, of necessity, in flux, since policy derives from societal structures which are themselves constantly in transition.

H. A second consideration, explained in part by the first, is the potential for inconsistency and conflict in the body of social policy. There may be clear interrelationships between policies but the stratiform character of policy development, compounded by conflicts of interest between societal groups, can create inconsistencies that may become quite problematic.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11303. Methodology

A. Health planning should emerge from the analysis and interpretation of health policy if policy, as a guiding principle, is considered to be a standing plan. However, analysis and interpretation are dependent upon some conclusion as to how to conceptualize that policy. Therefore based on considerations discussed in the "Introduction" Section of this Chapter, the following definition was adopted.

1. *State Health Policy*—a system of interacting and interdependent authoritative decisions relating to health care delivery, promotion of the public health, and protection of the public health, as codified in state legislation.

B. Based, on this definition the Louisiana Revised Statutes were considered to be the primary source of information on Louisiana State Health Policy. [For additional sources of information on health policy as articulated by state agencies see State Agency Documents Printed and Intended for Public Distribution.] Accordingly an inventory of state statutes relating to health care delivery, health promotion and protection was undertaken. As the following tables illustrate, and as was to be expected, given the stratiform character of policy development, the statutes related to health are many and varied, having developed over time and being reflective of the various and potentially conflicting philosophies which prevailed at different points in time.

C. Because of the number and diversity of the statutes related to health care, it became necessary to develop a framework within which to organize the subject matter. Within an analytic framework future analysis can be facilitated and any conflicts, inconsistencies, gaps, and other problems identified. The analytic framework developed and used in the following tables is derived from the conceptual model of social processes developed by David G. Gil. Gil delineates three universal categories which encompass all societal processes, and which all social policies should address:

1. Resource Development: This process involves the development of material and symbolic, life-sustaining and life enhancing resources, goods, and services and all decisions and courses of action concerning their type, quality and quantity. Decisions concerning the selective utilization and preservation of the natural environment are involved in this process, as are decisions concerning the acceptable levels of social, ecological, and economic costs of various productive activities.

2. Status Allocation: This process involves assignment of individuals and groups to specific tasks which must be performed in order to develop and distribute throughout society, the life-enhancing resources, goods and services and to ensure society's survival.

3. Rights Distribution: This process involves the distribution to individuals and groups, of specific rights to material and symbolic, life-sustaining and life-enhancing resources, goods, and services.

D. All Louisiana statutes regarding health care and health related matters were analyzed to determine into which of the three categories, as defined above, they should fall. In doing so each statute or group of statutes was reviewed in order to determine its broad objective or goal (see Table columns entitled "Objectives"). If the objective related to resource development, that statute was so categorized; if related to status allocation it was assigned to that category; and, if to rights distribution, accordingly. Statutes whose objective addressed more than one category were assigned to

the one to which they were determined to be primarily related. In making this determination the following assumptions were used:

1. that the general population of a state is its "Human Resource", and that, therefore, all statutes having an objective related to promotion of the public health or prevention of health problems should be assigned to the category "Resource Development";

2. that the licensing of health care professionals, while involving status allocation issues, is primarily a quality assurance measure aimed at preserving the quality of health care resources and protecting the human resource, and that statutes providing for such licensing should therefore be assigned to the category "Resource Development";

3. that statutes dealing with protection of the environment are concerned with issues related not only to how natural resources are to be used, but also with protection of the human resources of the state and should therefore be assigned to the category "Resource Development";

4. that statutes which create public facilities or services for specific population groups, while they do provide for additional health care resources, are primarily concerned with access to services as an entitlement for those groups, and should, therefore be assigned to the category "Rights Distribution".

E. The following tables were utilized to organize the statutes by "Key Process" categories. Within the tables the statutes are further organized by area of concern or problem (column entitled "Target Area") and, within the target area by its location in the statutes ("Statutory Reference"). For each statutory reference the broad objective or goal ("Objective") and how the objective is to be achieved and with what resources ("Statutory Provisions") is explained.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11305. Conclusion

A. Louisiana has a large body of Law devoted to providing health care, promoting health within its general population, and protecting the health of its citizens. This phase of analysis has attempted only to determine the broad objectives of each health related statute or group of statutes and to provide an inventory of those statutes organized within a framework from which additional analysis can be performed.

B. It appears from the analysis thus far performed, that health policy in Louisiana has been concerned primarily with the development of resources and with ensuring rights distribution. No statutes were found to be primarily related to status allocation as defined in the "Methodology" Section of this Chapter. This is not necessarily an indication that status allocation issues are not addressed in the statutes which have been categorized as relating primarily to the key process areas of resource development and rights distribution. In fact, an effective policy should address issues related to each of the three key societal processes. Consequently, a next phase of analysis might be to determine the extent to which statutes which are primarily concerned with resource development, also address rights distribution and status allocation issues; likewise, the extent to which rights distribution related statutes address resource development and status allocation.

C. Other types of analyses which the framework used herein may facilitate are:

1. an analysis of resources devoted to various state objectives within and among target areas of concern; and

2. inconsistencies among objectives within target areas.

D. The results of these further analyses should indicate which policies of the state can be expected to be most effective in dealing with areas of concern in Louisiana as well as identify necessary changes to legislation in order to maximize its effectiveness.

Table 8.1
Health Related Statutes Concerning Resource Development
Policy Area : Quality Assurance

Target Area	Statutory Reference	Objective	Statutory Provisions
Licensing of Health Care Professionals	R.S. 37:491	To provide a cosmetology licensing procedure.	Creates the Louisiana State Board of Cosmetology to regulate and license the field of cosmetology. Authorizes the Board to create the necessary rules and regulations comprising the licensing procedure.
	R.S. 37:753	To provide for the licensing of dentists and dental hy gienists.	Creates Louisiana Board of Dentistry to examine and license qualified applicants in the fields of den tistry and dental hygienics. Authorizes the Board to create the necessary rules and regulations compromising the licensing procedure.
	R.S. 37:611-612	To provide for the licensing of podiatrists.	Authorizes the Louisiana State Board of Medical Examiners to examine and license qualified candidates for the practice of podiatry. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing procedure.
	R.S. 37:831	To provide for the licensing of embalmers and funeral directors.	Creates the Louisiana State Board of Embalmers and Funeral Directors. Authorizes the Board to examine and license qualified applicants in embalming and funeral directing. Assigns to the Board the task of creating and enforcing the necessary rules and regulations comprising the licensing procedure. Authorizes the Board to regulate funeral homes and other places that care for the dead.
	R.S. 37:911-913	To provide for the licensing of registered and practical nurses.	Authorizes the Louisiana State Board of Nursing to examine and license qualified registered nurse applicants and approve schools of nursing in Louisiana. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing and approval procedure. Authorizes the Louisiana State Board of Practical Nursing to examine and license qualified practical nurse applicants and approve schools of practical nursing in Louisiana. Authorizes the Board to create the necessary rules and regulations comprising the licensing and accrediting procedure.
	R.S. 37:1021-1025	To provide non-licensed but trained medication attendants to facilities operated by the Office of Mental Retardation-Developmental Disabilities.	Establishes criteria necessary to qualify as a medication attendant in a facility operated by the Office of Mental Retardation-Development Disabilities.
	R.S. 37:1041-1042	To provide for the licensing of optometrists.	Creates the Louisiana State Board of Optometry Examiners to examine and license qualified candidates for the practice of optometry. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing procedure.
	R.S. 37:1184, 1204	To provide for the licensing of pharmacists.	Creates the Louisiana State Board of Pharmacy. Authorizes the Board to examine and license qualified candidates for the practice of pharmacy. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing function.
	R.S. 37:1261-1292	To provide for the licensing of physicians.	Creates the Louisiana State Board of Medical Examiners to examine and license qualified applicants for the practice of medicine in Louisiana. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing function.
	R.S. 37:1360.21-1360.27	To provide for the licensing of physician's trained assistants.	Authorizes the Louisiana State Board of Medical Examiners to create the necessary rules and regulations governing the certification of physician's trained assistants.
	R.S. 37:1518, 1520 ,1533	To provide for the licensing of veterinarians.	Authorizes the Board of Veterinary Medicine to examine and license qualified candidates for the practice of veterinary medicine. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing function.
	R.S. 37:2102	To provide for the licensing of sanitarians.	Creates the Louisiana State Board of Examiners for Sanitarians. Authorizes the Board to examine and license applicants wishing to become sanitarians. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing function.
	R.S. 37:2356, 2353, 2360	To provide for the licensing of psychologists.	Creates the Louisiana State Board of Examiners of Psychologists. Authorizes the Board to examine and certify qualified applicants for the practice of psychology. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing function.
	R.S. 37:2403	To provide for the licensing of physical therapists.	Authorizes the Louisiana State Board of Medical Examiners to examine and license qualified candidates for the practice of physical therapy. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing function. Directs that licensed physical therapists must work under the direction of a licensed physician.
	R.S. 37:2443	To provide for the licensing of hearing aid dealers.	Creates the Louisiana Board of Hearing Aid Dealers. Authorizes the Board to examine and license persons selling or maintaining any type of hearing aid.
	R.S. 37:2503, 2510	To provide for the licensing of nursing home administrators.	Creates Board of Examiners for Nursing Home Administrators. The Board is authorized to examine and license nursing home administrators.
	R.S. 37:2654	To provide for the licensing of speech pathologists and audiologists.	Creates Louisiana Board of Examiners of Speech Pathology and Audiology. Authorizes the Board to examine and license qualified

Table 8.1 Health Related Statutes Concerning Resource Development Policy Area : Quality Assurance			
Target Area	**Statutory Reference**	**Objective**	**Statutory Provisions**
			candidates for the practice of speech pathology or audiology. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing function.
	R.S. 37:2704	To provide for the licensing of social workers.	Creates the Louisiana State Board of Board Certified Social Work Examiners. Authorizes the Board to examine and license qualified candidates for the practice of social work. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing function.
	R.S. 37:2802, 2805	To provide for the licensing of chiropractors.	Creates Louisiana Board of Chiropractic Examiners. Authorizes the Board to examine and license qualified candidates for the practice of chiropractic medicine. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing function.
	R.S. 37:3004	To provide for the licensing of occupational therapists and assistants.	Authorizes the Louisiana State Board of Medical Examiners to examine and license candidates for practice as occupational therapist and occupational therapist assistant. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing function.
	R.S. 37:3071	To provide for the licensing of electrologists.	Creates the State Board of Electrolysis Examiners. Authorizes the Board to examine and license candidates for the practice of electrolysis. Authorizes the Board to create and enforce the necessary rules and regulations comprising the licensing function.
Licensing/ Regulation of Health Care Facilities and Services	R.S. 28:424(A)	To provide for the licensing of residential living options or mental retardation and disabilities services.	Requires that each application for licensure to provide residential living options or mental retardation and developmental disabilities services by a public or private provider shall be made to DHHR on forms furnished by the Division of Licensing and Certification and shall include information required for health planning.
	R.S. 28:567	To provide for the licensing of facilities for the men tally retarded.	Authorizes the Department of Health and Human Re sources to license facilities for the mentally retarded and to create the necessary rules and regulations that comprise the licensing procedure.
	R.S. 28:567	To provide for the licensing of mental health clinics.	Authorizes the Department of Health and Human Resources to license public or private mental health clinics and to create the necessary rules and regulations that comprise the licensing procedure. Forbids the operation of unlicensed mental health clinics.
	R.S. 40:1058.1	To provide for the licensing of comprehensive care and of component centers for alcoholic and drug dependent persons.	Authorizes the Department of Health and Human Resources to regulate and license comprehensive care and component centers. Authorizes the department to create and enforce the necessary rules and regulations comprising the licensing function.
	R.S. 40:1142, 1144	To provide for the certification of supervisors operating the water supply and sewage systems.	Authorizes the State Health Officer - Secretary of Department of Health and Human Resources to appoint a Committee of Certification whose function is the certification of supervisors operating water supply and sewage systems.
	R.S. 40:1231-1236	To provide for the establishment of occupational qualifications for ambulance operators and advanced emergency technicians.	Authorizes the Department of Health and Human Resources to certify ambulance operators. Establishes the qualifications that ambulance operators and persons employed in any capacity on any ambulance must meet. Establishes the minimum essential equipment that an ambulance is expected to carry. Defines the duties of advanced emergency technicians.
	R.S. 40:1299.31-34	To provide for the regulation and control of abortion.	Requires that abortions be performed only by physicians in hospitals or licensed abortion facilities. Requires physician completed reports on each performed or induced abortion.
	R.S. 40:1299.41-48	To provide for the regulation of malpractice claims.	Establishes a Medical Review Panel to oversee malpractice claims. Requires malpractice insurers to report to the relevant licensing board, information on malpractice claims paid by insurers.
	R.S. 40:2104, 2140, 2009.1-9	To provide for the regulation of nursing homes.	Authorizes the Department of Health and Human Resources to study federal regulations and standards with regard to nursing homes and promulgate rules and regulations for Louisiana that are consistent with the federal government's rules and regulations. Authorizes the Department to prescribe and publish minimum nursing home standards. Forbids nursing homes to operate without a license issued by the Department. Authorizes the Secretary of the Department of Health and Human Resources to promulgate and enforce rules for the regulation and licensing of home health agencies. Provides for denial of the application for initial licensure unless certain criteria, including documentation of need, are met.
	R.S. 40:2009.31-40	To provide for the licensure and regulation of home health agencies.	Authorizes the Secretary of the Department of Health and Human Resources to promulgate and enforce rules for the regulation and licensing of home health agencies. Provides for denial of the application for initial licensure unless certain criteria, including documentation of need, are met.
	R.S. 40:2017.3 and R.S.	To provide for the establishment and enforcement of minimum hospital standards.	Authorizes the Department of Health and Human Resources to prescribe through regulations and rules the minimum maintenance and operation

Table 8.1 Health Related Statutes Concerning Resource Development Policy Area : Quality Assurance			
Target Area	**Statutory Reference**	**Objective**	**Statutory Provisions**
	40:2017.6-7 R.S. 28:478		standards a hospital, which has received or may receive federal aid for construction, must meet. Authorizes DHHR to accept funds to carry out purposes of the Chapter and requires the department to notify each legislator whose district encompasses the proposed location of any facility scheduled for a public hearing to review the application for a finding of conformity pursuant to the provisions of Section 1122 of the Social Security Act prior to the public hearing. Authorizes the department to enforce all rules, standards, regulations, and orders it issues with regard to hospitals in Louisiana.
	R.S. 40:2109	To provide for the establishment and enforcement of hospital patient care standards, and of hospital construction, maintenance, and operation.	Authorizes the Department of Health and Human Resources to promulgate rules, regulations and minimum standards governing the operation and maintenance of hospitals.
	R.S. 40: 2018	To provide for the classification and licensing of obstetrical and neonatal units.	Establishes the Commission on Perinatal Care within the Department of Health and Human Resources. The Commission is authorized to develop a plan for upgrading perinatal care in Louisiana. The Commission is also to develop criteria for classifying and certifying obstetrical and neonatal units.
	R.S. 40: 2131-2141	To provide for the regulation and licensing of ambulatory surgical centers.	Authorizes the Department of Health and Human Resources to develop, establish, and enforce standards of care for individuals in ambulatory surgical centers. These centers provide surgical care which does not require an overnight inpatient admission. Authorizes the Department to license these centers and establish the requisite rules, regulations, and minimum standards. Specifies that confidentiality of information is not to include information on the licensing form.
Regulation of the Manufacture and Sale or Distribution of Goods	R.S. 37:1178	To provide for drug quality control.	Authorizes the Board of Pharmacy to inspect pharmacies and other places that sell drugs.
	R.S. 40:601-603, 621	To provide for regulation of the quality of food, drugs, and cosmetics.	Authorizes the Department of Health and Human Resources and the Department of Agriculture to regulate the quality of food, drugs, and cosmetics. Empowers these departments with the right to promulgate and enforce rules and regulations governing the manufacturing and provision of food, drugs, and cosmetics to the public. This authority includes the power to carry out investigations when the department deems it necessary.
	R.S. 40:951-2	To provide for the proper identification of poisons.	Requires that manufacturers and distributors of poison properly identify and label containers of poison.
	R.S. 40:961-1026	To provide for the regulation of controlled substances.	Authorizes the Department of Health and Human Resources to license and regulate the manufacturing, distributing, or dispensing of controlled dangerous substances. Establishes five schedules of controlled substances and provides specific penalties for the unlawful manufacturing and distribution of controlled substances.
	R.S. 51:915	To provide for the inspection of premises in which bedding, upholstered furniture, etc. is manufactured or repaired, and the licensing of persons involved.	Authorizes the Department of Health and Human Resources to inspect premises in which bedding or upholstered furniture is manufactured or repaired, and the licensing of persons involved. Authorizes the Department to create and enforce the necessary rules and regulations comprising the licensing function.
	R.S. 40:1241-1242	To provide for the regulation of public and private markets.	Authorizes the Department of Health and Human Resources to regulate the location and operation of all public and private markets and to carry out inspections as part of the regulation process.
	R.S. 40:1295	To provide for the regulation of the usage of shoe fitting machines.	Limits the use of such devices to persons licensed to use diagnostic or therapeutic radiation.
	R.S. 40:2271-2275	To provide for intrastate inspection of meat and poultry products so as to prevent the intrastate commerce of adulterated meat and poultry.	Authorizes the Commissioner of Agriculture to require antemortem inspection of all cattle. Authorizes the Commissioner to provide for postmortem examinations of animal carcasses that are to be used as food. Establishes sanitation rules governing meat and meat food product preparation.
Manpower	R.S. 17:1606-1607	To provide for physician manpower in correctional institutions and in the forensic unit of the state mental hospital system.	Provides for four year medical school scholarships at the Louisiana State University Medical School for persons agreeing to serve, upon graduation, as a physician in a correctional institution for a two year period. Provides for four year medical school scholarships to persons recommended by the director of the forensic unit at East Louisiana State Hospital at Jackson. These persons must agree to serve, upon graduation, as a physician at the forensic unit for a two year period.
	R.S. 37:1011	To provide for the upgrading of faculty at approved schools of nursing.	Creates a stipendiary educational program which provides stipends for nursing faculty seeking a or doctorate.
	R.S.	To provide an increased supply of health	Establishes a framework for the legal recognition and development of a

Table 8.1
Health Related Statutes Concerning Resource Development
Policy Area : Quality Assurance

Target Area	Statutory Reference	Objective	Statutory Provisions
	37:1360.21-1360.24	manpower.	new category of health professional to be known as a physician's trained assistant. Supervising physicians delegate certain health care tasks to these assistants.
	R.S. 37:2819-2825	To provide an adequate supply of chiropractors.	Creates annual chiropractic scholarships administered by the Louisiana Board of Chiropractic Examiners.
	R.S. 40:1231.1, 6, 7, 8, 9 R.S. 40:1232	To provide an adequate supply of emergency medical technicians.	Authorizes the Department of Health and Human Resources to provide an emergency medical technician training course.
	R.S. 40:2017.5	To provide for an adequate supply of nurses.	Authorizes the Department of Health and Human Resources to promote nurse education. This includes working with public and private agencies as well as establishing schools of nursing.
Health Facilities	R.S. 17:3051-3060	To provide for prompt and efficient medical care in modern well-equipped facilities. To promote physical and mental health education activities in various public and private medical institutions and organizations within Louisiana.	Creates Health Education Authority of Louisiana (H.E.A.L.) within the Department of Health and Human Resources. This Authority is empowered to plan, coordinate, finance, construct, and attract health facilities to a specific geographic area in New Orleans.
	R.S. 46:1077, 1055(8)	To provide for the administration and organization of parish hospitals. To provide for the general public health.	Authorizes parish police juries to create Hospital Districts which are to own and operate hospitals serving those in need of hospital care. These districts are to promote the general public health.
	R.S. 40:2017.2-2017.4	To provide a mechanism for carrying out the Federal Hospital Survey and Construction Act. To provide for the maintenance and operation of hospitals. To provide for additional hospitals when they are needed.	Authorizes the Department of Health and Human Resources to carry out the provisions of the Federal Hospital Survey and Construction Act. In addition, the department is authorized to develop and adopt a state plan for the construction of medical facilities. Authorizes the department to issue regulations prescribing minimum hospital maintenance and operation standards. These standards apply only to hospitals which have or which may receive federal construction aid under the federal act and the state hospital construction plan. Authorizes the department to assess through surveys, Louisiana's need for additional hospitals. Newly established hospitals should be designed and equipped to provide medical internships and residencies.
Health Care for the Poor	R.S. 33:7501 and R.S. 40:2017	To provide the poor with access to health care.	Authorizes and empowers municipalities to offer specialized and comprehensive neighborhood health service programs that include the provision of necessary physical facilities as well as alcohol abuse problems.
	R.S. 40:2113.1-2113.2	To promote medical research and training.	Authorizes the Department of Health and Human Resources to establish rules and regulations regarding arrangements, contracts, etc., between the department and state colleges and universities for the purpose of promoting medical research and training. Establishes a Research and Training account to fund the training of mental health specialists.
	R.S. 46:772	To promote medical education in Louisiana.	Provide the medical departments of Louisiana State University Medical School and Tulane University Medical School with free access to Charity Hospital at New Orleans, for teaching purposes.
	R.S. 46:922	To provide financial assistance to medical interns and residents for the purpose of furthering their education and training.	Establishes stipends available only to interns and residents at any Charity Hospital in Louisiana.
	R.S. 46:1051, 1053, 1055	To provide physicians to areas in the state with limited or no medical care.	Authorizes each parish hospital service district's Board of Commissioners to establish and administer a medical scholarship program. The program's purpose is to increase the educational opportunities available to medical students willing to practice in geographic areas where medical care is limited or unavailable.
	R.S. 46:1771-1775	To provide physician manpower planning.	Establishes the Louisiana Council for Statewide Planning for Physician Manpower. The Council advises the Governor on Louisiana's need for various types of physicians, manpower education, and the geographic distribution of physicians. The Council is to recommend ways to make Louisiana an attractive place to practice medicine, particularly to physicians who have been trained in Louisiana's medical schools.
State Vital Statistics Law	R.S. 40:33	To provide a central authority that collects vital records for Louisiana. To provide for the compilation, tabulation, and analysis of data necessary for health planning and for programmatic activities.	Establishes and defines the duties of the Division of Vital Records which is within the Department of Health and Human Resources. Authorizes the Division to compile, tabulate, and analyze the collected data that is to be used for health planning and other programmatic needs.
The Mentally and Physically Handicapped	R.S. 46:1721-1726	To improve services to the mentally and physically handicapped.	Creates Commission on the Mentally and Physically Handicapped to study and examine the factors pertaining to the mentally and physically handicapped. The Commission's mandate is to increase coordination between programs serving the handicapped, and, when possible, consolidate programs. The Commission is to be composed of members representing state agencies and offices with functions bearing on the handicapped. This includes the Department of Health and Human Resources and the Department of Education.

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Health Related Statutes Concerning Resource Development
Policy Area : Quality Assurance

Target Area	Statutory Reference	Objective	Statutory Provisions
Environmental Protection	R.S. 30:1061, 1079, 1149	To provide for environmental protection and regulation.	Creates the Department of Environmental Quality as the primary agency in the state concerned with environmental protection and regulation. Empowers the department with jurisdiction over matters affecting the regulation of air quality, noise pollution control, regulation of solid waste disposal, regulation and control of radiation and management of hazardous waste.
	R.S. 30:1061, 1082-1084, 1104	To provide for the regulation, control, and maintenance of Louisiana's air quality and regulation and control of radiation.	Creates the Office of Air Quality and Nuclear Energy within the Department of Environmental Quality. Authorizes the Office to administer and enforce the Louisiana Air Control Law, the Louisiana Nuclear Energy and Radiation Control Law and the Central Interstate Low-Level Radioactive Waste Compact.
	R.S. 30:1061, 1121-1124, 1131-1150	To provide for the disposal and utilization of solid waste. To provide the public with protection from hazardous waste.	Creates the Office of Solid and Hazardous Waste in the Department of Environmental Quality. Authorizes the Office to administer and enforce the Louisiana Solid Waste Management and Resource Recovery Law, the Louisiana Hazardous Waste Control Law and the Louisiana Resource Recovery and Development Law. Creates the Hazardous Waste Advisory Board.
	R.S. 30:1061, 1091-1094	To provide the public with protection against polluted waterways.	Creates the Office of Water Resources in the Department of Environmental Quality. Authorizes the Office to administer and enforce the Louisiana Water Control Law.
	R.S. 40:1131-1137	To provide the Port of New Orleans with protection from pollution.	Prohibits the disposal of garbage in the Port of New Orleans. Authorizes the Department of Health and Human Resources to promulgate and enforce the rules and regulations necessary to prevent the disposal of garbage into the Port and to establish guidelines for the retention and maintenance of garbage on vessels in the Port.
	R.S. 40:2321-2327	To provide additional funds for water pollution control.	Authorizes the state of Louisiana to make grants to parishes, municipalities, etc., to assist in theconstruction of those portions of water pollution control projects which qualify for federal aid and assistance under the Federal Water Pollution Act.
Protection of the Public Health	R.S. 40:2-4	To provide for a State Health Officer and the administration of the state sanitary code.	Authorizes the establishment of a State Health Officer and provides a job description. Empowers the State Health Officer to execute Louisiana's sanitary laws and enforce all rules, ordinances, and regulations contained in the state sanitary code. The State Health Officer has the authority to amend the sanitary code and to adopt new provisions.
	Sanitary Code Chapter II	To provide measures to control the incidence of communicable disease.	Requires that persons having knowledge of a case of a disease listed as reportable in the Sanitary Code or of any rare or exotic communicable disease or any outbreak shall report this to the State Health Officer. Provides for investigation and control measures which may be taken by the State Health Officer or a designee in such cases. Provides for specific tests to be included in a required health examination of employees and residents in day care centers and residential facilities.
	R.S. 40:1275-1278 Sanitary Code Chapter III	To provide for the control of rabies.	Authorizes the Department of Health and Human Resources to add to the sanitary code all provisions necessary to the control of rabies in animals. Authorizes the department to enforce the rabies provisions.
	R.S. 40:1299.20-29 Sanitary Code Chapter IV	To provide for the diagnosis and treatment of lead poisoning.	Authorizes the Department of Health and Human Resources to establish, in larger municipalities, programs to screen, diagnose, and treat cases of lead poisoning. This program should eliminate the sources of lead poisoning. Authorizes the systematicphysical examination of all children under the age of six and of all mentally retarded persons. Establishes a state laboratory for the detection of lead and lead poisoning. Restricts the sale and use of lead-based paint and coating materials.
	Sanitary Code Chapter V	To provide protection against diseases transmitted by insects, other arthropods and rodents,	Provides specific measures to control the population of disease-bearing animals, including mosquitoes, domestic flies and other arthropods of public health and rodents, importance and rodents.
	Sanitary Code Chapters VI, VII, VIII, IX, X, and XI.	To provide protection against disease caused by contaminated food, drugs and cosmetics.	Provides specific measures to regulate the selection and all handling of items intended for human consumption (including manufactured food items, baked goods and confections, bottled drinks, drugs, milk products, frozen desserts, seafood, and meat) and cosmetics.
	Sanitary Code Chapters XII, XIII, and XIV.	To provide the public with protection from disease caused by contaminated drinking water. To provide water facilities with protection from pollution and to regulate water supply and sewage systems.	Authorizes the State Health Officer - Secretary of the Department of Health and Human Resources to classify all water and sewage facilities. Authorizes the State Health Officer to supervise the operation of these facilities and to prevent their unlawful pollution.
	Sanitary Code Chapters XV and XVI	To provide the public with protection from disease which might be contracted and spread in inadequately constructed or badly run public lodgings and camps.	Provides specific measures to regulate the construction, level of sanitation and service provided in hotels, lodging and boarding houses and camps.

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Health Related Statutes Concerning Resource Development
Policy Area : Quality Assurance

Target Area	Statutory Reference	Objective	Statutory Provisions
	Sanitary Code Chapters XVII and XVIII	To provide individuals with protection from disease which might be contracted and spread in inadequately constructed or badly run public buildings and institutions.	Provide specific measures to regulate the construction, equipment, and level of sanitation in public buildings and governmental institutions, including schools and prisons.
	Sanitary Code Chapters XIX, XX, and XXI.	To provide individuals with protection from disease which might be contracted and spread in health care, residential and day care facilities.	Provides specific measures to regulate the construction, equipment and sanitation procedures in hospitals, ambulatory surgical centers, renal dialysis centers, nursing homes, residential facilities and day care centers.
	Sanitary Code Chapters XXII and XXIII	To provide individuals with protection from disease which might be contracted and spread by contaminated or spoiled food.	Provides specific measures to regulate the construction, equipment and sanitation procedures in retail food markets and eating and drinking establishments.
	Sanitary Code Chapter XXIV	To provide individuals with protection from disease which might be contracted and spread in public swimming facilities.	Provides specific measures to regulate the construction, equipment and sanitation procedures for all artificial swimming pools and natural or semi-artificial swimming or bathing places other than those associated with private, single family residences.
	Sanitary Code Chapters XXV	To provide individuals with protection from disease which might be contracted and spread at inadequately served mass gatherings.	Provides specific measures to assure that preparation for and operation of mass gatherings are adequate in terms of maintenance, clean, safe and sanitary condition of the grounds, sanitary facilities and other service equipment.
	Sanitary Code Chapter XXVI	To provide for the disposition of dead human bodies	Provides specific procedures for the burial, transportation, disinterment and other disposition of dead human bodies.
	R.S.40: 12-27	To provide for the administration and control of local sanitation matters.	Authorizes the establishment of local health units or departments to be known as parish health units. These units, administered by a local Parish Health Officer, control and administer all local matters of sanitation.
	R.S. 40: 1061-1068	To provide for the detection prevention, and treatment of venereal diseases.	Authorizes the Department of Health and Human Resources to examine persons suspected of being infected with venereal disease and to treat persons with such a disease. Makes it unlawful to infect or expose others to a venereal disease and requires that persons infected submit to treatment. Permits the treatment of minors for venereal disease without parental consent.
	R.S. 40: 1298	To provide for the prevention of death or serious injury at public swimming places.	Requires that at least one resuscitation unit, in working order, be present at each publicly supervised swimming place.
	R.S. 40:28	To provide for the diagnosis and treatment of tuberculosis.	Authorizes the Department of Health and Human Resources to make free clinics available for the diagnosis of tuberculosis. Physicians in private practice may have access to these clinics.
Health Promotion	R.S. 17: 2111-2	To provide for the detection of sight and hearing problems in children.	Authorizes the Department of Health and Human Resources and the Superintendent of Education to prepare and provide materials appropriate to the testing of sight and hearing among school pupils. Requires that all school pupils be tested and the results recorded. Parents are to be notified if a defect in sight or hearing, and/or a disease of the eyes and ears is discovered.
	R.S. 33:7501	To provide for the prevention of starvation and malnutrition.	Authorizes municipalities to provide emergency food and medical assistance to persons in need. This assistance is specifically aimed at preventing starvation and counteracting malnutrition.
	R.S. 40: 63-64	To provide for the improvement of maternal health and life.	Authorizes the compilation of abortion related data to be used in the improvement of maternal health and life. Requires that all induced pregnancy terminations in Louisiana be monitored and that data on maternal life and health related factors be recorded.
	R.S. 40:992	To provide for the prevention and deterrence of controlled dangerous substances' misuse and abuse.	Authorizes the Department of Health and Human Resources to carry out educational programs designed to prevent and deter the misuse and abuse of controlled dangerous substances. Requests that the department encourage research on misuse and abuse of controlled dangerous substances' patterns and their resulting social impact.
	R.S. 40:1051-1052	To provide long range strategies for the diagnosis, prevention, and treatment of narcotic addiction.	Authorizes the Department of Health and Human Resources to survey and analyze drug addiction related problems and to formulate a long range comprehensive plan to address these problems. Authorizes the department to establish and direct experimental pilot treatment and rehabilitation programs for narcotic addicts. Authorizes the department to disseminate informational, educational, and training materials on narcotic addiction to the relevant publics.
	R.S. 40: 1101-1107	To provide for the detection and treatment of blindness in newborns caused by Ophthalmia Neonatorum.	Authorizes the Department of Health and Human Resources to supervise the reporting, the investigating and the treating of all cases of Ophthalmia Neonatorum.
	R.S. 40: 1299.71	To provide prompt and suitable medical assistance to disabled persons.	Encourages persons with conditions such as diabetes to wear identifying tags. Encourages law enforcement and medical personnel to carefully search for identifying devices on the bodies of disabled persons.
	R.S. 40:1299.80-82	To provide for increased knowledge about cancer and cardiopulmonary diseases.	Establishes in the Department of Health and Human Resources a statewide cancer registry. The collected data will be used to assess the presence, extent, and possible causes of specific cancers in Louisiana. This program is

Table 8.1 Health Related Statutes Concerning Resource Development Policy Area : Quality Assurance			
Target Area	**Statutory Reference**	**Objective**	**Statutory Provisions**
			to promote cancer research and clinical investigation. Establishes the Louisiana Cancer and Lung Trust Fund Board within the Department of Health and Human Resources. The Fund is to be used solely for cancer research and research on cardio-pulmonary diseases.
	R.S. 46:971-972	To promote maternal and child health in Louisiana.	Authorizes the Department of Health and Human Resources to administer those parts of the federal Social Security Act, and any amendments, relating to maternal and child health services. The department is authorized to receive and expend federal monies for these services. The mandate is to extend and improve services that promote the health of mothers and children in Louisiana. Authorizes the department to establish a state plan for maternal and child health services. This plan should provide for the financing, administering, and supervising of these services.
	R.S. 40:2018	To provide for the upgrading of perinatal care in Louisiana.	Establishes a Commission on Perinatal Care within the Department of Health and Human Resources. The Commission is to plan for the upgrading of perinatal care and to develop criteria for classifying and licensing obstetrical and neonatal units. The Commission is mandated to develop and evaluate a pregnancy risk identification system applicable to the diverse maternal and child populations in Louisiana.
	R.S. 46:1601-1607	To provide adequate information on the welfare of the aged, including material of a health related nature.	Establishes a mechanism to create local voluntary councils on aging. These councils are to collect facts and statistics on the aged, including information on mental and physical health.
	R.S. 40:2451-2453	To provide for the promotion of physical fitness and sports participation.	Creates the Governor's Council on Physical Fitness and Sports within the Department of Health and Human Resources. The Council is to develop, foster, andcoordinate physical fitness and sports services and programs for the people of Louisiana. These programs are to be coordinated with medical, dental, and other similar professional societies with the goal of promoting personal health and physical fitness.
Mental Health Substance Abuse, and Mental Retardation	R.S. 28:21	To provide for hospital care for the mentally ill and the inebriated.	Designates the following facilities for the treatment of mental illness and inebriation: East Louisiana State Hospital at Jackson, Central Louisiana State Hospital at Pineville, Southeast Louisiana Hospital at Mandeville.
	R.S. 28:21.1	To provide for the treatment of persons suffering from alcoholism and to define alcoholism as a disease or illness.	Authorize the Department of Health and Human Services to treat poor and destitute persons suffering from alcoholism in state-supported hospitals. Recognizes alcoholism as a sickness or disease.
	R.S. 28:22.5	To provide for community care for the mentally ill and mentally defective (sic).	Provides for the creation and administration (by the Department of Health and Human Resources) of community mental health facilities for the care, treatment, and rehabilitation of the mentally ill and mentally defective (sic).
	R.S. 28:23	To provide emergency and temporary care for acute cases of mental illness.	Establishes departments providing for emergency and temporary care for acute cases of mental illness within state-owned general hospitals (administered by the Department of Health and Human Resources).

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

Chapter 115. Health Resource Requirements

Subchapter A. Introduction

§11501. Introduction

A. The State Health Planning and Development Agency is required to develop standards, criteria, and plans against which proposed capital expenditures are to be reviewed. Goals are established for institutional health care resources requiring 1122 review and for other important areas in the health care system.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11503. General Criteria and Standards for Section 1122 Review

A. In reviewing projects under Section 1122, DPPE shall use the following criteria:

1. the relationship of the proposal to the State Health Plan;

2. the relationship of the proposal to the long range development plan (if any) of the facility;

3. the need of the service area population for the proposed facility/services.

a. Delineation of the service area for the proposal the definition of "service area" will be governed by the State Health Plan's definition for each particular type of service or facility.

b. Current and projected availability of beds/services/facilities. DPPE will count as available:

i. all health care facilities, as defined in the applicable State Health Plan section;

ii. all health care facilities, as defined for Section 1122 Review purposes;

iii. all services and equipment in health care facilities;

iv. the division will consider as part of the review:

(a). number and distribution of similar facilities, services, or beds within the service area;

(b). bed to population ratio in the service area;

(c). comparison of bed to population ratio in the service area to that of other service areas in the state.

c. Physical accessibility of the target population to existing and proposed facilities/services.

d. Current and projected measures of utilization of existing facilities/services (i.e. occupancy or other appropriate utilization data).

e. Demographics of the service area for the proposal.

4. The availability or potential availability of less costly or more effective alternatives to the proposal.

5. The immediate and long-term financial feasibility of the proposal, and the availability of funds.

6. The relationship of the proposed facility/services to other health care providers in the service area; documentation of agreements between the applicant and other health care providers; the extent of cooperation with other facilities in the service area.

7. The relationship (including the organizational relationship) of the proposed services to ancillary or support services provided in the existing facility.

8. The availability of health manpower and management personnel for the provision of the proposed services, including:

a. availability and projected availability of physicians, nurses, and other personnel within the service area;

b. the adequacy of proposed staffing according to required standards.

9. Special needs and circumstances:

a. health maintenance organizations;

b. biomedical and behavioral research projects for which local conditions offer special advantages, and which are designed to meet a national need;

c. facilities which provide a substantial amount of services of resources to non-residents of the service area or of adjacent service areas (i.e. medical and health professional schools, specialty centers, multi-disciplinary clinics).

10. The cost and methods of the proposed construction, including energy provision.

11. The probable impact of the project on the cost of health services within the facility and the service area.

12. Evidence of ownership or legally executed option to acquire an appropriately zoned site.

13. Support or opposition to the proposal by the local community, including health related agencies and professional organizations.

14. Whether the project will foster cost containment or improved quality of care through improved efficiency and productivity or through increased competition between different health services delivery systems.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P. L. 96-79, and R. S. 36:256(b).

HISTORICAL NOTE Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

Subchapter B. Facility or Service—Specific Criteria and Standards

§11505. General Acute Care Hospital Beds

A. General Information, Criteria and Standards

1. Description

a. General acute care hospital beds are those short-term acute care beds available for the overnight care of patients hospitalized for any of a variety of medical reasons.

b. In Louisiana, general acute care hospital beds include but are not limited to: medical/surgical, obstetrics, pediatrics, intensive care/ coronary care, neonatal intensive care, pediatric intensive care, chemical dependency, hospital-based, Medicare certified skilled nursing beds and "swing" beds. All such types of hospital beds are included in the total bed complement of a hospital.

2. Hospital Bed Need

a. Determining how many general acute care hospital beds an area's population needs for proper health care is an important health planning function. An appropriate number of available beds, distributed equitably over the population, assures that the inpatient health care needs of the residents are met. Too many beds can mean higher costs and inefficient use of health care resources. Empty beds may inflate overall costs and encourage overutilization. Too few beds can mean waiting lists for admissions, reduced quality of care and unmet health care needs.

b. Surpluses of general hospital beds are believed by many to contribute significantly to rising hospital care costs as the result of a decision-making process which is predicated on a distorted reimbursement mechanism. The rapid growth during the 1960's and 1970's of health insurance plans and of the federally-financed Medicare and

Medicaid programs has created a health care system in which normal adverse market consequences of oversupply are felt primarily by third party payors rather than the hospitals themselves.

c. In addition, reimbursement by third party payors makes patients, physicians and other health care practitioners less aware of the cost of treatment and thus removes the economic deterrents to excess use of hospital facilities. Another factor to consider is the benefit structure of most health insurance plans, which provides substantial coverage for hospitalization, while allowing minimal coverage for the cost of outpatient health care and often no coverage for preventive health care. Patients and their treating physicians may opt for hospitalization in lieu of outpatient treatment to assure that costs of diagnostic tests and minor surgical procedures are reimbursable by third party payors.

3. Impact of Ruralness on Bed Need

a. Small hospitals in rural areas where the patient population cannot support a large facility meet many of the health care needs of patients in the surrounding area. Rural hospitals offer emergency services and inpatient care for a variety of health conditions. However, more complicated health conditions and those requiring special treatments and diagnostic examinations are best treated in larger facilities where the patient population can support high technology equipment and highly specialized health care staff.

b. Accessibility to health care services is a primary concern in planning and providing for the health care needs of sparsely populated areas of the state. Accessibility as related to general hospitals means that the majority of an area's residents are not more than 30 minutes travel time from a general hospital facility. Ensuring general hospital accessibility means that the hospital service need of an area's rural population may often best be met by the distribution of hospital beds over several small facilities rather than in one single larger facility.

4. Service Area. The service area for all general acute care hospital beds is the health planning district in which the facility or proposed facility is or will be located.

5. Resource Goals

a. Bed Supply: 4.0 beds/1,000 population in Health Planning Districts one through six, and nine; 4.26/1,000 population in Health Planning Districts seven and eight.

i. In determining the bed to population ratio for a proposal, Division of Policy, Planning and Evaluation will use population projections for the anticipated opening date (year) of the facility, which in no case shall exceed five years subsequent to the year in which the application is declared complete.

ii. In Louisiana, the 65 + population is 9.6 percent of the overall population(1980 census figures). The only planning districts where the percentage of persons over 65 exceeds 9.9 percent are Planning Districts 7 and 8. There is, therefore, no adjustment to be made to the bed supply goal except in Planning Districts 7 and 8, where persons 65 + represent 11.8 percent of the population.

iii. In the absence of state data, the national utilization rate of 34 percent (percentage of patient days utilized by persons age 65 +) is applied to the North Louisiana population age 65 + to determine the number of beds over 4.0 needed in that area to accommodate the disproportionately large population age 65 + . The North Louisiana population has 1.9 percent more persons age 65 + than the national average, so the national 1.36 65 + bed supply use rate is increased proportionately to 1.62 beds. This represents a .26 increase in the bed supply goal due to an increased number of persons age 65 + . The adjusted bed supply goal in North Louisiana (Planning District 7 & 8) is 4.26 beds per 1,000.

iv. The bed supply standards stated above will be used to determine the need for all general acute care hospital beds, including but not limited to medical/surgical, obstetrics, pediatric, pediatric intensive care, neonatal intensive care and intensive care/coronary care beds. Medicare certified and Section 1122 approved rehabilitation and psychiatric hospital beds are not counted in determining the number of general acute care hospital beds. In determining bed supply, beds which are counted are (1) licensed but not Section 1122 approved beds which are in use or could be put into use within 24 hours*, (2) 1122 approved and licensed beds which are in use or could be put into use within 24 hours and (3) 1122 approved beds which are not yet licensed.

v. Licensed hospital beds which are Medicare certified as skilled nursing beds are considered available for long term patients and not available for general acute care patients; therefore, such beds are not counted in determining the number of general acute care hospital beds and shall not be considered for the purposes of determining hospital occupancy.

b. Occupancy Rate: General acute care hospitals shall maintain annual occupancy rates relative to the number of beds in the facility:

0— 49-50%
50— 99-60%
100-199—70%
200 + —75%

i. In determining occupancy rates, beds used in the calculations include: (1) licensed but not Section 1122 approved beds which are in use or could be put into use within 24 hours*, and (2) 1122 approved and licensed beds which are in use or could be put into use within 24 hours*. This calculation shall not include general acute care hospital beds which are Medicare certified as skilled nursing beds.

ii. *Beds that can be brought into service within 24 hours shall be construed to mean the appropriate number of beds in rooms originally constructed and equipped as hospital rooms that either (1) have not been converted to other uses, or (2) retain all essential nonmovable equipment and connections necessary for patient care in accordance with licensing standards. Nonmovable equipment shall

include equipment which can be removed only through reconstruction or rennovation.

iii. For any additional general acute care hospital beds to be approved:

(a). the bed to population ratio shall not exceed 4.0 or 4.26 beds per 1000 population (4.26/1000 for Health Planning District 7 and 8);

(b). either optimal occupancy must be reached by all hospitals in all bed size categories or a 75 percent occupancy for the four most recent quarters of all hospitals in the health planning district must be attained.

c. Adjustment

i. An existing general acute care hospital which has operated at a level of 10 percent or more above its optimal occupancy, as determined by bed size category, for the four most recent quarters will be allowed to add a number of beds that would bring its occupancy down to the optimal occupancy level for its bed size. The occupancy rate for the 12 consecutive months shall be determined by Division of Policy, Planning and Evaluation from the four most recent quarters of data due to have been reported by the hospital to the Division of Licensing and Certification.

B. Obstetrical Services

1. Description

a. Institutional obstetrical services are those health-related services provided to pregnant women in specialized OB units in acute care hospitals. Services primarily involve health care during labor, delivery and post partum recovery; care and treatment of a medical condition (in a pregnant patient), related to or complicated by pregnancy; and special care rendered to the fetus during the prenatal period, during and immediately following labor and delivery. Institutional obstetrical services can also include health education and genetic counseling before and during the prenatal period, and performance of outpatient diagnostic examinations which may be necessary during the course of a pregnancy. Services rendered to newborns at delivery are a part of obstetrical unit services, although newborn nursery care, intermediate and intensive care services are considered neonatal services.

b. Facilities providing obstetrical services can be categorized into three types according to the level of technology and the spectrum of services offered. The existence of neonatal nursery services at a level commensurate with the level and quantity of obstetrical services offered is essential to the continuity and overall quality of obstetrical services.

i. Level I—A unit within a hospital designed to provide services for the uncomplicated maternity patient.

ii. Level II—A unit within a hospital designed to provide a full range of maternal services for uncomplicated patients and the majority of complicated obstetrical problems.

iii. Level III—A unit within a hospital designated to provide the full range of resources and expertise required for the management of any complication of pregnancy.

c. Obstetrical units consist of postpartum beds, labor beds, recovery beds and delivery rooms, for both normal and cesarean deliveries.

2. Location of OB Services

a. Obstetrical beds in hospitals are often part of a unit providing a combination of obstetrical and gynecological services (OB/GYN services). If occupancy levels in the unit rise above a specified optimum level, elective gynecological admissions may be postponed or GYN patients may be transferred to available general medical and surgical beds. Utilization of obstetrical beds in frequently not as efficient as it could be because of the randomness of birth, the number of unscheduled deliveries, fluctuations in length of OB stays and the need to maintain OB beds in facilities that are reasonably accessible to residents of sparsely populated geographic areas. Mixing obstetric and gynecology patients is a primary method of improving bed utilization within an obstetric unit. Other methods include construction of "swing" units, which can be partitioned as part of either OB/ GYN or medical/surgical units as the demand requires, and regional sharing of obstetrical facilities.

3. Regionalization of Services

a. Regional planning is an important factor in the location of obstetrical units and is an essential element in evaluating the feasibility of existing and proposed OB units. In determining the need for OB services in a health planning district, critical factors include the population base and the requirements for prenatal and perinatal services that the population base will generate. In planning for these needs, optimal deployment of scarce resources (such as money and personnel) must be a goal secondary only to an acceptable quality of obstetrical services.

b. An optimum occupancy level is conducive to high quality, efficiency and economy in hospital obstetrical care. The Perinatal Commission, because of the high risk nature of Louisiana's perinatal patients, recommends that a Level III regional Perinatal Center should serve an area with 6,000 to 10,000 births annually. A Level III regional OB and Perinatal Center with an annual rate of 6,000-10,000 live births can justify high technology equipment, better staffing and a more effective inservice program. As a result of these advantages, personnel in large obstetrical departments can maintain a higher level of proficiency in their duties, and the cost of highly specialized services may be spread over a larger population. The population base and the economic base must be adequate to support the large investment required for operation of a Level III regional facility.

c. Since the numbers of perinatal patients who are gravely ill or at extremely high risk are not large, most complication is of pregnancies and abnormalities of the newborn can be properly managed in units staffed and equipped to provide moderately complex care.

d. A concern in the regional approach to obstetrical care is the function of hospitals with small numbers of deliveries (Level I OB beds). In many instances, such hospitals must provide obstetrical services because of geographic, climatic and transportation factors which prevent patients from having access to fully staffed and equipped obstetrical facilties. An approach is to encourage the consolidation of multiple small obstetrical units into a larger service whenever such action is not impeded by geographic or other insurmountable problems. Another approach is to encourage Level I units to refer or transfer high risk obstetrical patients to Level II and III facilities.

e. Regional planning is critical for obstetrical services. Institutions offering OB care should develop and maintain a network of communication and coordinate service delivery and facility planning. All obstetrical units should have linkages with intermediate and intensive care (Level II and III) neonatal units to assure that transportation and beds are available to infants who are in need of immediate transfer to neonatal special care units. However, maternal transport is encouraged in preference to neonatal transport when high risk situations can be predicted (approximately 50 percent of the time). The Guidelines for Perinatal Transportation, prepared by the Sub-Committee on Perinatal Transportation of the Louisiana Perinatal Commission, address specific procedures, staffing patterns, and equipment for the transportation of high risk mothers and neonates.

f. Obstetrical units should also maintain communication with other obstetrical units in the health planning district so that resources, equipment and staff can best be utilized to meet the obstetrical care needs of the population. This is particularly necessary for appropriate referral, antenatal diagnosis and monitoring, counseling, scheduling of delivery, specialist attendance and monitoring of OB patients who are identified as having one or more antepartum high risk factors for perinatal and/or maternal mortality and morbidity.

4. Costs and Length of Stay

a. One of the current issues related to institutional obstetrical services is cost containment. Costs of basic obstetrical services are increased by the length of the patient's stay and the number and type of special diagnostic examinations and medical procedures which may be required because of complications arising from the pregnancy and delivery. According to the Perinatal Commission, several studies have shown that cost of basic obstetrical services are increased with the level of care regardless of the needs of the patient. This factor is important since it is among patients with an essentially uncomplicated delivery where a reduction in the length of stay is most possible.

b. Length of hospitalization for maternity patients (and other types of admissions) has been reduced substantially from the lengthy hospital stays of 50 years ago, when maternity patients were often "confined" in a hospital as long as two weeks after delivery. The reduced stays are in part due to the development of a theory that getting out of bed earlier helps recovery, and in part due to other changes in social and medical concepts concerning pregnancy and the post partum period.

c. Since the mid 1970's there have been numerous projects begun at hospitals across the nation to encourage OB patients with normal deliveries to leave the hospital soon after birth. Maternity day care units, providing a home-like environment, with husbands allowed to stay during labor and delivery, and with discharge within 24 hours of delivery, have been established partly in response to the women's movement and partly to reduce hospital costs.

d. The Perinatal Commission does not recommend early discharge (less than 24 hours after delivery) for uncomplicated deliveries unless provisions are made for appropriate follow-up of the mother and neonate on an out-patient basis. At the present time the public health nursing system in the state is not adequate to meet the needs of a follow-up system for non-private patients.

e. It has been noted that patients choosing maternity day care services have primarily been those without insurance coverage, who personally feel the financial impact of longer hospital stays. Because the motivation for shorter OB stays seems to be predominantly financial, a number of programs exist in which rebates and other benefits are offered by insurance companies to women who leave the hospital within 24 hours of an uncomplicated delivery.

f. Among the alternatives to traditional hospital deliveries are deliveries by certified nurse-midwives at alternative birthing centers or at home. The Perinatal Commission is vigorously opposed to home deliveries and also recommends that alternative birthing centers should come under the same vigorous standards and guidelines as hospital based obstetrical units.

g. According to the Perinatal Commission, the combination of private and charity beds into one overall plan is a desired goal, but is not realistic in present day Louisiana. Any plan for Perinatal Care in Louisiana must take full recognition that the charity and private systems operate separately, and that patients do not easily cross over This is especially true for charity patients in need of more intensive care who cannot find access (financial or physicial) into the private system that may have high technology beds available. As the charity system becomes more deluged by perinatal patients seeking services, the number of patients requiring high technological obstetrical and/or neonatal care will increase. The charity system cannot now adequately handle these high risk situations and private hospitals are reluctant to participate because of inadequate reimbursement. An improved reimbursement strategy will be necessary to allow patients to more easily cross over from the charity to private systems in order to meet the medical needs of this population.

5. Resource Goals

a. Note: Proposals for obstetrical services that include an increase in general acute care hospital beds must

meet the resource goals for both obstetrical services (1-12 below) and general acute hospital beds. Proposals for obstetrical services that do not include an increase in general acute care hospital beds must meet the resource goals for obstetrical services (2-12) below).

b. Obstetrical beds are considered general acute care hospital beds; therefore, the need for such beds is determined in accordance with the standards for general acute care hospital beds.

c. The Level I Unit must be able to provide emergency medical services competently. There must be a well-defined, efficient regional system of communication, consultation, and transport between the Level I Unit and other levels of care.

d. Level II units shall provide a full range of maternal services for uncomplicated patients and the majority of complicated obstetrical problems.

e. A Level II Obstetrical Service must be located in the same facility as a Level II or Level III Neonatal Unit.

f. Level III units must be able to provide the full range of resources and expertise required for the management of any complication of pregnancy. The Level III Obstetrical Unit should serve an area with approximately 6,000-10,000 deliveries per year. The unit should provide care for normal patients, preferably with an obstetrical base of greater than 1,500 inborn deliveries annually. The Level III Unit must be equipped to manage all types of maternal-fetal illnesses. They must be able to provide a full range of resources 365 days a year for the management of complicated perinatal conditions. This includes personnel and facility resources available continously in the medical, nursing, and ancillary health areas. The Level III Obstetrical Unit should be physically contiguous to the Level III Neonatal Unit.

g. In areas where two or more Level I units exist in close proximity, attention should be given to consolidation of obstetric services.

h. The average annual length of stay should not exceed current acceptable obstetrical practices.

i. Obstetrical services should be planned on a regional basis with linkages among obstetrical services and neonatal services. New obstetrical services should be located a distance of at least 30 miles from the nearest obstetrical unit.

j. All obstetrical units should have procedures for obtaining and effecting consultation and patient transfers between Level I, II and III units. Obstetrical facilities should have arrangements for referrals to services offered by physicians, acute care facilities, social service agencies, community mental health centers, public health and welfare agencies, and providers of home health care.

k. Hospital OB units should have a minimum of two delivery rooms. The ratio of delivery rooms to deliveries should be one for every 1,000 births. Every obstetrical unit performing deliveries should have the ability to perform cesarean sections in an appropriately equipped delivery room or surgical suite. One labor bed should be provided for each 250-350 deliveries performed annually.

1. Obstetrical services should be available to all residents in need of such services regardless of their ability to pay.

m. Level I, II, and III units should meet standards and guidelines for licensure developed by the Perinatal Commission.

C. Pediatric Beds

1. Definition/Description

a. Inpatient pediatric services are distinguished and treated separately from general or adult inpatient services because of the special needs of children to age 21.

b. Changes have occurred in the delivery of pediatric services as diagnosis and treatment of diseases have become more sophisticated. Advances in biomedical research and the behavioral sciences have enabled pediatricians to deal with more diseases in a more precise manner in their own offices, or on an outpatient basis, rather than to hospitalize children. As a result of this trend, and of the generally declining birth rate, children have proportionately fewer hospitalizations and shorter hospital stays than adults. Infants spend more time in the hospital than older children, and children in low income families are more likely to be hospitalized than children in middle and high income families.

2. Related Issues

a. Inpatient services should be organized and coordinated with other services within the same facility, and should be appropriately linked with other facilities in terms of working relationships, shared services, and agreements. Internal and external coordination are essential for the delivery of high quality, cost effective pediatric inpatient care. Note all hospitals can or should provide all services to all children; each community and hospital must evaluate the extent of pediatric inpatient services needed, and he capability for providing the services.

b. Regionalization, in its broadest sense, implies the development within a geographical area of a coordinated, cooperative system of health care which promotes efficiently, avoids unnecessary duplication, improves access to health care, achieves greater equity, enhances quality, and responds to consumer needs. The concentration in regional centers of pediatric inpatient services (including complex and expensive equipment and facilities and highly skilled personnel) would assure that children have access to needed services.

c. Unnecessary duplication of services should be avoided; however, because children have different hospital needs than adults, services which appear to be similar and duplicative to adult services may be necessary to provide optimal care for hospitalized infants and children. The proper care of a hospitalized child cannot be given simply by adopting adult inpatient philosophy, programs, or standards.

The National Guidelines for Health Planning, published by DHEW, recognize that two main differences exist: the need for hospitalized children to remain close to home, and the need for regulations providing different occupancy rates.

3. Resource Goals

a. Note: Proposals for pediatric services that include an increase in general acute care beds must meet resource goals for both pediatric services (1-3 below) and general acute care hospital beds. Proposals for pediatrics services that do not include an increase in general acute hospital beds must meet the resource goal for pediatric services. (2-3 below).

b. Pediatric beds are considered general acute care hospital beds; therefore, the need for such beds shall be determined in accordance with the standards for general acute care hospital beds.

c. Pediatric units in urban areas should maintain a minimum of 20 beds.

d. Pediatric units should be accessible. New pediatric services should be located a distance of at least 30 miles from the nearest facility providing pediatric beds/services.

D. Pediatric Intensive Care Units

1. Resource Goals

a. Bed supply: Pediatric intensive care unit beds are considered general acute care hospital beds and the need for such beds is determined in accordance with the standards for general acute care hospital beds.

E. Neonatal Intensive Care Unit (NICU) Beds 1. Commission on Perinatal Care

a. The Commission on Perinatal Care was established by an act of the legislature of the state of Louisiana in 1978 in Section 2018, title 40 of the Louisiana Revised Statutes of 1950. This act established the Commission on Perinatal Care within the Bureau of Personal Health Services, the Office of Preventive and Public Health Services of the Department of Health and Human Resources, and charged the Commission with certain functions, duties and services which include but are not limited to:

i. Development of a plan for upgrading perinatal are of Louisiana.

ii. Development of criteria for the classification of Level I, II and III centers and development of licensing standards for state-wide certification of obstetrical and neonatal units.

iii. Investigation, review, and study of all maternal deaths occurring within the State for the purpose of reducing the risk and incidence thereof.

b. In the past six years, the commission has accomplished these goals and developed a state-wide plan as well as criteria for classification of Level I, II, and III centers. The Perinatal Commission is composed of practicing physician representatives from all parts of the state, representatives of the medical schools, major health societies and gubernatorial appointees. The expertise of the commission members, the written perinatal plan for the state of Louisiana, and the neonatal and obstetrical guidelines were used as resources in the State Health Plan.

c. Over the past six years, the Commission on Perinatal Care has reviewed Louisiana's statistics on perinatal health with statistics of previous years and with national statistics. The commission has viewed the problems of increased perinatal morbidity and mortality in our state as both a social as well as a medical problem. The commission, after due consideration, decided that the national guidelines could not easily or correctly be applied to Louisiana because of the high rate of prematurity, increased numbers of non-whites births, the large number of hospitals delivering less than 1500 babies per year, and other logistic and social problems that are unique to our state. Moreover, the Commission has been extremely aware of the dual nature of the medical system in our state, with the charity and private hospital systems working in isolation rather than in cooperation. This is especially evident in the perinatal health field.

d. One theme consistently reiterated by the Perinatal Commission has been the voluntary aspect of regionalization of perinatal care. The commission believes that all hospitals should be encouraged to reach their highest level of care without regard for other need standards. The commission is also opposed to drawing lines georgraphically or requiring physicians to have certain referral patterns for high risk patients. The commission is opposed to any midwives other than Certified Nurse Midwives (CNM).

e. The Perinatal Commission has worked on coordinating efforts for transport of high risk patients and communication among physicians caring for perinatal patients. A standard transport form is used by a large majority of hospitals in the state, thus standardizing and documentating medical problems of referred perinatal care patients. The commission recommends that patients be referred and moved to the most appropriate facility, allowing financial and physical access to the best medical care possible to meet the needs of the patient. The patient should not be denied access to care because of economic or transportation deficits.

2. Louisiana Perinatal Foundation. The Louisiana Perinatal Foundation, a free-standing and completely independent foundation, serves as a source of funds for the advancement of quality perinatal care and a consequential improvement in the overall health of the people of Louisiana. The foundation is composed of concerned individuals and corporations who wish to assist in improving obstetrical and neonatal care. The main activity of the foundation is the support of educational and research owned and controlled by the community at large.

3. Definitions

a. *Birth* (live)—a birth that shows any sign of life after delivery.

b. *Birth Rate*—the number of live births per 1,000 population.

c. *Infant Death*—death of an infant under 365 days of age.

d. *Low Birth Weight*—less than 2500 grams at birth.

e. *Low Birth Weight Percentage*—the number of low birth weight births per 100 live births.

f. *Maternal Death*—a death attributable to complications of pregnancy, childbirth or the peurperium.

g. *Neonate*—an infant less than 28 days of age.

h. *Neonatal Death*—death occurring to a child under 28 days of age.

i. *Perinatal*—pertaining to or occurring in the period shortly before and after birth, generally considered to begin with completion of twenty-eight weeks of gestation and variously defended as ending one to four weeks after birth.

j. *Perinatal Care*—preventive and curative, direct and indirect services offered to maternal and neonatal patients.

4. Description

a. Neonatal intensive care units provide highly specialized medical care to the small percentage of infants who are born with or develop serious health impairments during the first weeks of life. Respiratory distress and asphyxia are the two most common conditions indicating the need for transfer of a newborn to a NICU. Other conditions which might indicate the transfer of a newborn to a NICU would be prematurity, significant congenital malformation, genetic disorder, intrapartum complications or injuries, or other disease or illness.

b. Neonatal intensive care consists primarily of higher sophisticated life-support systems, monitoring and intensive care techniques which compensate for the infants's lack of full or normal development. The most common technologies are respirators and positive pressure breathing devices for treatment of respiratory distress syndrome (RDS) which is responsible for nearly 20 percent of all neonatal deaths in the U.S. According to the Perinatal Commission, half of all neonatal deaths result from respiratory distress syndrome or its complications.

c. The hospital facilities delivering neonatal care are classified into three groups, depending on the sophistication and scope of the services provided. These levels of care and the definition of each are in accordance with standards and guidelines for Neonatal Intensive Care Units developed by the Commission on Perinatal Care.

i. *Level I Newborn Unit*—a unit within a hospital designed to provide services for the normal newborn infant.

ii. *Level II Neonatal Unit*—a unit within a hospital designed to provide a full range of neonatal services for uncomplicated patients and certain types for neonatal illnesses except those requiring consultation and facilities not available at that level.

iii. *Level III Neonatal Unit*—a specialized unit within a hospital specifically designed to provide a full range of health services to the high-risk neonate and which meets the guidelines established for the Level III unit with the exception of the transportation and out-reach education programs.

d. Unfortunately, neonatal services in may hospitals do not reflect the three defined levels of care. Factors such as the rapid advancement of medical technology, the rising costs of medical equipment, and training requirements for medical personnel have led to a diversity of neonatal services provided at various hospitals in the same region. As a result, the services provided in different hospitals classified at the same level can vary considerably, making a standard level of care difficult to determine in practice. According to the Perinatal Commission, although the standard of care does vary in hospitals classified at the same level, through adherence to guidelines and extensive education, neonatal services in hospitals should reflect the designated level of care. The American Academy of Pediatrics states that there is "considerable diversity of opinion about the definition of Level II (Neonatal) units and the functions these units should perform." Morever, the American Academy of Pediatrics Committee on the Fetus and the Newborn considers it undesirable for Level II units to provide neonatal cardiology and certain surgical procedures (subspecialist). The committee's final observation was that "the continued development of Level II (neonatal) units in both urban and rural locations throughout the country is essential, particularly for hospitals in which more than 1,000 infants are born annually." Dr. Auld, a Neonatologist, suggests that all community hospitals should approach the standards of care required for Level II units.

e. The increase in the overall birth rate in Louisiana since 1974 (from 17.5/1,000 in 1974 to 19.4/1,000 in 1980), caused mainly by a larger percentage of women of childbearing ages, has resulted in an increase in the number of ill newborns requiring special neonatal are. Continued increases in the overall number of births and in the number of newborns needing special care will expand the need for neonatal intensive care. It is extremely important to consider certain factors which have increased the Louisiana mortality rate, such as weight specific mortalities, almost 25 percent of births are to women who are not married, and a high percentage of birth are to teenage mothers. Not only does Louisiana have more infants born less than 2500 grams, but the state has more very low births weight infants, less than 1500 grams. If the number of infants in certain weight categories (i.e. 500-1,000 grams, 1,000-1,500 grams, etc.) are compared to other states, Louisiana's mortalities by weight specific groups are average for this country. The problem is that the state is higher than the national average of infants born in the low birth weight categories. Thus the goal in this area should be to decrease low birth weight infants by improving prenatal care and family planning.

5. Regionalization of NICU's

a. Health professionals nationwide and in Louisiana are in basic agreement that the best care can be given to critically ill newborns if NI-CU's are planned and developed on a regional basis, with a few adequately staffed and qualified units meeting the needs of the population of planning districts rather than a large number of units within many different hospitals. As affirmed by the American Academy of Pediatrics, properly conducted, early transfer of ill newborns to a qualified NICU results in better care than attempts to maintain them in inadequate units. This regionalized concept necessitates the development of level II and III units of sufficient size located in medical facilities which have available specialty staff. The availability of subspecialty consultative services and highly sophisticated equipment is necessary for Level III units.

b. Regionalized planning also requires appropriate linkages between neonatal units and obstetrical services, with communication and transportation systems. The majority of transport in this state are done by ground and fixed wing. Approximately 75 percent of all transports are done by ground ambulance and 25 percent by air. Of the air transport, almost 90 percent is done by fixed wing and probably less than 10 percent by helicopter. There is a state-wide transport system operative among a number of private institutions, but the charity system does not have an organized transport system. The major factor in limiting access to existing neonatal intensive care units is not the lack of transportation but the lack of financial resources to move charity patients into private institutions and pay for these services.

c. The Guidelines for Perinatal Transportation, prepared by the sub-committee on Perinatal Transportation of the Louisiana Perinatal Commission, provide specific guidelines regarding procedures, staffing patterns, and equipment for the transportation of high risk mothers and neonates.

6. Costs of NICU Services

a. The costs of neonatal intensive care are directly related to birthweight and prematurity—the lower the weight and/or the earlier the births, the higher the costs of care. The U.S. Congressional Office of Technology Assessment estimates that in 1978, the mean cost per patient in NICU (Level III) was $8,000 with an average length of stay of 13 days. It can be roughly estimated that for each dollar spent on neonatal intensive care over $4 is saved in future costs.

b. Another issue related to the cost of neonatal intensive care is the number of NICU patients whose costs cannot be borne by the family because of insufficient resources and lack of health insurance coverage for the newborn. Over 50 percent of low birthweight infants in Louisiana are born to blacks, who have a lower income level and who experience a high rate of births to unmarried women. Another factor contributing to the overall tendency of ill newborns to be born into families with limited resources is the high incidence of low birthweight babies among females under age 20. In the U.S. in 1978, 66.5 percent of low birthweight babies were born to females under 20 years of age.

c. The costs of caring for ill newborns, therefore, are often either left to be assumed by the hospital facilities and ultimately absorbed by other patients, or borne by state and federal taxpayers.

d. In terms of terminating care for hopelessly ill newborns, the Baby Doe law in the state of Louisiana plays a more important role than ethical or economic considerations. This law allows for very little leeway in parent or physician intervention that would shorten the suffering of a hopelessly and terminally ill neonate. The Perinatal Commission has discussed the present Baby Doe law as it now exists, and is opposed to its present wording.

7. Resource Goals

a. Note: Proposals for neonatal intensive care services that include an increase in general acute care beds must meet resource goals for both neonatal intensive care services (1-9 below) and general acute care hospital beds. Proposals for neonatal intensive care services that do not include an increase in general acute hospital beds must meet the resource goals for neonatal intensive care services (2-below).

b. Neonatal intensive care unit beds are considered general acute care hospital beds; therefore, the need for such beds is determined in accordance with the standards for general acute care hospital beds.

c. Level I Newborn Units shall provide services for normal newborn infants.

d. Level I Newborn Units shall have an active relationship with a Regional Center for the support of in-service education, patient and service consultation, and general support of newborn services.

e. Level II Neonatal Units shall provide a full range of neonatal services for uncomplicated patients and certain types of neonatal illnesses except those requiring consultation and facilities not available at that level.

f. Level II units shall be located in hospitals delivering more than 1,000 infants annually.

g. Level III Neonatal Units shall serve approximately 6,000 10,000 deliveries per year. These units must provide care for normal patients, preferably with an obstetrical base greater than 1,500 inborn deliveries annually.

h. The Regional Level III Neonatal Unit should have as a minimum 20 neonatal special care beds.

i. Neonatal care shall be planned on a regional basis with linkages to obstetrical services.

j. Level I, II, and III units shall meet the standards and guidelines for licensure developed by the Perinatal Commission.

NOTE: The Perinatal Commission has recognized that there is no shortage of neonatal intensive care beds in the private sector in the state of Louisiana. The shortage is in the charity system. With the advent of Medicaid target rates and Diagnostic Related Group prospective payment system, the access to private care beds for indigent perinatal patients will become even more limited in the next few years. The limited access to intensive care for the high risk mother and neonates in the charity sector will be one of the most difficult problems facing the state over the next 6 years.

E. Intensive Care Unit (ICU)/Coronary Care Unit (CCU)

1. Description

a. An intensive care/coronary care unit is defined as a unit in which especially intense surgical and medical care can be given to patients in the first few days after suffering from acute myocardial infarction (heart attack).

b. ICU's are used to support surgical patients postoperatively, to keep accident victims alive until surgery can be performed, and to enable premature infants to survive the first few days of life where neonatal intensive care units are not available. They also play a large part in the treatment of burns when the victims are critically ill and cannot undergo surgery until the crisis is over. The objectives of an ICU are the initiation of resuscitation, the administration of electrolytes and fluids, and the prevention of contamination and cross-infection.

c. As an aid to the main task of keeping the patient alive, ICU's are commonly equipped with a number of monitoring devices; these are designed to keep the medical and nursing staff informed of the status of the patient's heart by displaying his ECG in various ways. An ICU will commonly have facilities for inserting pacemakers in cases where arrhythmias occur, and catheterization of the heart for diagnostic purposes.

2. Resources Goals

a. Bed Supply: ICU/CCU unit beds are considered general acute care hospital beds and the need for such beds is determined in accordance with the standards for general acute hospital beds.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11507. Psychiatric Beds

A. Description

1. Psychiatric beds are located in general hospitals, psychiatric specialty hospitals, or other medical centers which are set up to provide inpatient medical care to persons with mental illness or disorders.

2. Chemical dependency services may be provided in psychiatric hospitals or in psychiatric units of general hospitals. Refer to the subsequent section of this Chapter for a discussion of Chemical Dependency Services.

3. Admissions to general hospitals for psychiatric reasons are usually for emergencies and acute psychiatric episodes; the patient's length of stay does not ordinarily exceed several weeks. Treatment of chronic and severe mental disorders is usually undertaken at psychiatric specialty hospitals, where the average length of stay may be much longer.

4. The role of inpatient psychiatric facilities is one of increasing importance as more becomes known about effective treatment methods. The availability of short-term beds in community-based facilities is essential for treatment of emergency and acute conditions. Therapeutic intervention at an early stage in mental health deterioration is vital for early recovery. Although it is important to have sufficient beds for the long-term care and treatment of the chronically mentally ill, active treatment and rehabilitation programs are needed to assure that patients do not remain institutionalized longer than necessary. Large patient-to-staff ratios have often been a problem in state-operated psychiatric hospitals and have created an impediment to goals aimed at reducing lengths of stay.

5. In any facility providing more than emergency care for persons with psychiatric disorders, small, discrete treatment units for special segments of the population are needed for the most effective therapy. Preschool and latency age, early and late adolescence, severe handicap and emotional disturbance are some of the variables which indicate a need for specialized treatment in separate units.

6. High quality, appropriate services are essential components of all inpatient mental health care if timely and successful recovery is to occur. The patient's length of stay should be as short as is therapeutically possible, for the humane aspect of brief and successful treatment, and for cost effectiveness. The cost of inpatient psychiatric care ranges from $80 a day at large state mental hospitals to $300 a day in private facilities. Outpatient care usually ranges from $50 to $180 per week.

7. Treatment techniques which have been successful in the rehabilitation of persons with mental illness include various types of therapeutic intervention by trained mental health professionals (psychiatrists, psychologist, social workers, psychiatric nurses and others); recreational, occupational and vocational therapy; group, family and individual therapy; and administration of psychotherapeutic drugs. Outpatient or ambulatory care is preferable to inpatient care when the patient's condition is stable enough to permit functioning in the community without endangering the patient, the community, or the course of recovery.

B. Bed Need

1. As of December, 1984, there are 4,999 licensed and approved psychiatric beds in Louisiana: 1166 are short-term beds (average length of stay less than 30 days); 3,707 are intermediate beds (average length of stay between 30 days and 180 days); 126 are long-term beds (average length of stay 182 + days).

2. Although a need for psychiatric beds has been identified in certain health service areas, the addition of beds to the current supply should be undertaken with caution.

With increasing impetus toward outpatient services as a preferable alternative to inpatient care, the utilization of inpatient psychiatric beds will eventually decline. Any addition of psychiatric beds to the existing supply should be made only after analysis of occupancy rates of facilities in the area.

3. Inpatient psychiatric services for which there is a recognized need include, but are not limited to:

a. intermediate and long-term treatment facilities for children and adolescents;

b. small, community-based facilities for short-term and intermediate treatment;

c. emergency and acute care psychiatric units in general hospitals, especially those converted from existing, underutilized medical/surgical beds;

d. facilities offering special programs to assist the chronically mentally ill with the transition from institutionalization to community living;

e. facilities providing special treatment units for persons with mental disorders aggravated by other adaptive disorders, such as emotional disturbance, severe handicap, developmental disability and addiction to alcohol or drugs;

f. facilities offering programs for partial hospitalization and psychiatric foster and/or home care.

C. Service Area. The service area for psychiatric beds is the health planning district in which the facility (or proposed facility) is or will be located.

D. Resource Goals

1. Bed Supply: 104.0 psychiatric beds per 100,000 population.

a. In determining the bed to population ratio for the proposal, DPPE will use population projections for the anticipated opening date (year) of the facility, which in no case shall exceed five years subsequent to the year in which the complete application was declared complete.

b. In determining bed supply, beds which are counted are (1) licensed, but not Section 1122 approved beds which are in use or could be put into use within 24 hours*, (2) 1122 approved beds which are not yet licensed, and (3) 1122 approved and licensed beds which are in use or could be put into use within 24 hours.*

2. Occupancy: Free-standing Psychiatric Hospitals

a. A free-standing psychiatric hospital shall maintain annual occupancy rates relative to the number of beds in the facility:

0— 49-50%
50— 99-60%
100-199-70%
200 + —75%

b. In determining occupancy rates, beds used in the calculations include (1) licensed but not Section 1122 approved beds which are in use or could be put into use within 24 hours*, and (2) 1122 approved and licensed beds which are in use or could be put into use within 24 hours.*

c. *Beds that can be brought into service within 24 hours shall be construed to mean the appropriate number of beds in rooms originally constructed and equipped as hospital rooms that either (1) have not been converted to other uses, or (2) retain all essential nonmovable equipment and connections necessary for patient care in accordance with licensing standards. Nonmovable equipment shall include equipment which can be removed only through reconstruction or renovation.

3. For any additional free-standing psychiatric beds to be approved:

a. the bed to population ratio shall not exceed 104.0 per 100,000 population; and

b. either optimal occupancy must be reached by all free-standing psychiatric hospitals in all bed size categories or a 75 percent occupancy of all psychiatric hospitals in the health planning district must be attained.

4. Occupancy: Psychiatric Units in General Hospitals

a. A psychiatric unit in a general hospital shall maintain annual occupancy rates relative to the number of beds in the facility:

0— 49-50%
50— 99-60%
100-199-70%
200 + —75%

b. In determining occupancy rates, beds used in the calculations include: (a) licensed but not Section 1122 approved beds which are in use or could be put into use within 24 hours*, and (b) 1122 approved and licensed beds which are in use or could be put into use within 24 hours*.

c. *Beds that can be brought into service with 24 hours shall be construed to mean the appropriate number of beds in rooms originally constructed and equipped as hospital rooms that either (1) have not been converted to other uses, or (2) retain all essential nonmovable equipment and connections necessary for patient care in accordance with licensing standards. Noranovable equipment shall include equipment which can be removed only through reconstruction or renovation.

5. For any additional psychiatric beds in a general hospital to be approved:

a. the bed to population ration shall not exceed 104.0 psychiatric beds per 100,000 population; and

b. either optimal occupancy must be reached by all psychiatric units of general hospitals in all bed size categories or a 75 percent occupancy of all psychiatric units of all general hospitals in the health planning district must be attained.

6. Adjustment:

a. An existing psychiatric hospital or psychiatric unit of a general hospital which has operated at a level of 10

percent or more above its optimal occupancy, as determined by bed size category, for a period of 12 consecutive months, will be allowed to add a number of beds that would bring its occupancy down to the optimal occupancy level for its bed size. The occupancy rate for the 12 consecutive months shall be determined by DPPE from the four most recent quarters of data due to have been reported by the hospital to the Division of Licensing and Certification.

b. Inpatient services should be provided in small units, with patients grouped according to specific treatment needs.

c. A facility should continually strive to reduce the average length of stay for psychiatric admissions.

AUTHORITY NOTE: Promulgated in accordance with P.L.93-641 as amended by P. L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11509. Chemical Dependency Services

A. Description

1. Chemical dependency services are provided in general acute care hospitals, in psychiatric hospitals, or in licensed free-standing substance abuse facilities. The only free standing facilities subject to section 1122 review are those licensed as hospitals or for which the expenditure is by or on behalf of a health care facility. The incidence of alcohol and drug abuse in the population has increased significantly in the past twenty years, particularly among adolescents and youth, and has stimulated public concern about substance abuse and its treatment.

2. A 28-day inpatient period is the average established treatment course, followed by outpatient or community-based after care. Treatments offered in chemical dependency units (CDU's) include detoxification, education, and individual, group, and family therapy.

B. Bed Need and Supply

1. Because of extreme differences in level of abuse, physical deterioration, emotional involvement and resource exhaustion associated with the illness, a variety of treatment models have evolved in the field of substance abuse. Among the clinical programs are detoxification services, acute medical care services, short and long term intermediate rehabilitation, and short term residential care. Nonclinical programs include social detoxification, half way houses and long term residential programs.

2. The average length of stay varies greatly among these treatment models. Among the clinical programs, it ranges from less than one week for detoxification to an excess of three weeks for short term residential care. It is this latter service, usually with detoxification, education, and individual, group, and family therapy components, which is offered in chemical dependency units (CDU's). While these programs are designed for approximately 28 days for adults and somewhat longer for adolescents, the average length of stay is usually shorter than this because of individual differences in programs, accommodation to unique requirements of patients and failure of some patients to remain for the full program. A recent survey conducted in Louisiana yielded an average length of stay of 27.44 days for this type of facility.

3. Although occupancy levels of existing CDU's in a region is the most reliable indicator of bed need at this time, there is a need to have a bed need determination methodology for planning purposes. Such a methodology can be used to project bed need estimates into regions not having established substance abuse facilities and, therefore, no occupancy data on which to base bed need. It can also be used to detect underserved areas of the state and to estimate the level of need for services.

4. To serve these several purposes, a methodology based on the prevalence of substance abuse would obviously be most appropriate. Unfortunately, there is no single, valid formula for estimating prevalence. A review of the literature turned up some 18 methods of estimating the prevalence of alcoholism alone.

5. Faced with this condition, a study committee organized by the plan development staff synthesized an algorithm for estimating bed need that is based on the Keller formula for estimating prevalence of alcohol abusers, the Massachusetts procedure for converting prevalence data to an estimate of residential bed need, and parameter values for Louisiana obtained from a survey of treatment facilities.

6. This algorithm follows:

a. determine the drinking age population (DAP) for the area (population 15 years old and older);

b. multiply DAP by 65 percent to obtain the number of drinkers;

c. multiply number of drinkers by 10.4 percent to estimate the number of abusers;

d. multiply number of abusers by 20 percent to estimate number in need of services;

e. multiply number in need of service by 7 percent to estimate the number needing short term inpatient rehabilitation;

f. divide number needing inpatient rehabilitation by 11.3 to determine number of beds needed for inpatients at 27.44 days average length of stay (AL OS) and 85 percent occupancy rate (The derivation of this factor is as follows: At 85 percent occupancy the patient days generated by 1 bed annually 310.25. At 27.4 days ALOS the average length of stay of 1 patient 1/11.3 of the annual patient days generated by 1 bed or 10.25-27.44);

g. multiply alcohol abuser population needing short term inpatient rehabilitation by 10 percent to estimate the drug abuser population requiring beds;

h. divide drug abuser population requiring beds by 11.3 to determine number of beds needed by this population;

i. add beds needed by alcohol and drug abuser populations.

7. Utilizing 1984 population data, the algorithm yields the following estimate of short term residential beds needed in the state for that year:

a. 3,338,569 = DAP - State population 15 years old and older;

b. X .65 = 2,179,069, Estimated number of drinkers;

c. X .104 = 225,687, Estimated number of alcohol abusers;

d. X .20 = 45,137, Estimated number in need of services;

e. X .07 = 3,160, Estimated number needing short term rehabilitation;

f. - 11.3 = 280, Estimated number of beds needed for alcohol abusers;

g. 3,160 X .10 = 316, Estimated number of non alcohol substance abusers requiring short term rehabilitation;

h. - 11.3 = 28, Estimated number of beds needed for non alcohol substance abusers;

i. + 280 = 308, Estimated number of short term residential beds needed.

8. The number of chemical dependency beds existing in the state in 1984 actually exceeded 308, but there were then and are now areas of the state in need of substance abuse services. The reasons for this apparent paradox are that: the 308 figure represents only one type of substance abuse bed need, the state was over-bedded in some districts while under-bedded in others, and the algorithm has not been sufficiently refined to be completely accurate.

9. In the case of specific substance abuse beds needed, the 308 figure represents only the need for short term residential beds. To have estimated the need for detoxification services a factor of .33 would have been used in step 5 of the algorithm; for medical recuperation, a factor of .03; for halfway house services, a factor of .08; for long term care, a factor of .02; and for ambulatory care, a factor of .8. Of course, appropriate adjustments would have had to have been made in step 6 also. These adjustments were not made in the present Health Plan because, at this time, new services are largely limited to short term residential beds.

10. Addressing the fact that the service need algorithm is not completely accurate, it is recognized that this accuracy cannot be achieved until there has been sufficient time to explore the relationship between estimates yielded by the algorithm and empirical utilization data. Consequently, it is assumed for Section 1122 review purposes at the present time, that the most valid indicator of level of need for chemical dependency services is the utilization experience of existing services.

C. Service Area. The service area for CDU services is the health planning district in which the facility (or proposed facility) is located.

D. Resource Goals

1. Proposals for chemical dependency services which would result in an increase in general acute care hospital beds or psychiatric hospital beds must meet the resource goals for the relevant hospital type and for chemical dependency services (below). Proposals for chemical dependency services which would not result in an increase in general acute care hospital beds or psychiatric hospital beds must meet only the resource goals for chemical dependency services (below).

a. Occupancy: 60 percent occupancy for the four complete quarters prior to the application being deemed complete in all free standing CDU facilities in the service area; or

b. 60 percent occupancy for the four complete quarters prior to the application being deemed complete in all CDU units of general acute care hospitals in the service area.

c. In determining occupancy rates, beds used in the calculations are those beds carried in the DPPE inventory of chemical dependency beds, which is composed of chemical dependency beds which are exempt from prospective payment by medicare or in free standing facilities for which the expenditure was by or on behalf of a health care facility.

AUTHORITY NOTE: Promulgated in accordance with P.L.93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11511. Open Heart Surgery

A. Definition/Description

1. Open heart surgery is the generic term for various surgical operations performed on the heart or major arteries of the heart. Open heart surgery procedures are defined as those which use a heart-lung bypass machine to perform the function of circulation during surgery.

2. The Inter-Society Commission on Heart Diseases Resources reports that there are over 1,000,000 deaths in the United States each year due to diseases of the heart and coronary arteries. A wide range of congenital and acquired disease and defects of the heart (and allied vessels) can be rectified with open heart surgery. This sophisticated procedure is used to preserve life and to improve the quality of life by repairing or replacing damaged portions of the heart and blood vessels to prevent the development of more serious problems, and to reduce disability.

3. Open heart surgery procedures, adult and pediatric, require costly, highly specialized personnel and facility resources, and supportive intensive care and cardiac care units. The total bill for open heart surgery can exceed $150,000. Thus, efforts should be made to limit unnecessary duplication of related resources.

4. Adult open heart surgical programs should have the capability of performing a full range of procedures, including but not limited to, the following: repair/replacement of heart valves: repair of congenital defects; cardiac revascularization; repair/reconstruction of intra-thoracic vessels; and treatment of cardiac trauma.

5. Open heart surgical programs should have the ability to implement and apply circulatory assist devices such as intra-aortic balloon, prolonged cardiopulmonary partial bypass, and a full range of diagnostic and support system services. Some of the services provided are cardiology, hematology, nephrology, general medicine, pathology, anesthesiology, radiology, neurology, cardiac catheterization, and social services.

B. Issues

1. Diagnosis and treatment are so closely linked that facilities for both should be included in the same center, to permit the closest possible liaison between professional and support personnel. Cardiac catheterization and open heart surgery both require careful planning, to facilitate close inter-

disciplinary coordination, to minimize unnecessary diagnostic studies, and to allow prompt intervention when life-threatening complications develop during diagnostic procedures.

2. Because open heart surgery is, at times, performed in emergency situations, all facilities providing open heart surgery services should have the capability of rapid mobilization of the surgical and support team for emergency procedures 24 hours a day, 7 days a week. However, most open heart surgery is elective, used by a small proportion of the total population. It is, therefore, neither feasible nor necessary to provide open heart surgical services in close proximity to every patient's community, as this could lead to low volume programs.

3. An adult open heart surgery facility should serve a population of 1,200,000 and a pediatric unit should service a population of 2,000,000.

4. Although research has correlated high volume and better quality for open heart surgery, the correlation is decreasing with time. Volume is only a measure of quality to the extent that it helps maintain physician and hospital team skills, and to the extent that it results from quality services which generate referrals. The maintenance of necessary skills of the surgical team reduces the danger to the patient.

5. An important issue related to the quality of care in open heart surgery is the relationship between surgical volume and mortality. In hospitals, mortality rates for open heart surgery should be no higher than 30/ 1000 procedures.

C. Service Area. The service area for open heart surgery procedures is the health planning district in which the facility or proposed facility is located.

D. Resource Goals

1. A minimum of 200 open heart procedures should be performed annually, within three years after initiation, in any institution in which open heart surgery is performed for adults.

2. A minimum of 100 pediatric heart operations should be performed annually, within three years after initiation, in any institution in which pediatric open heart surgery is performed, of which at least 75 should be open heart surgery.

3. No institution should have a surgeon and/or surgical team that performs fewer than 100 open heart procedures over a two year period.

4. Open heart surgical services should be available to the population in need of such services within 80 road miles one way.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-64 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11513. Cardiac Catheterization Units

A. Definition/Description of Service

1. Cardiac catheterization is a hospital-based diagnostic medical procedure, for examination of the heart and surrounding blood vessels. The "invasive" procedure involves the insertion of a catheter into the patient's arm or leg and into the chambers of the heart.

2. The term *cardiac catheterization* is used to describe a broad range of invasive cardiac diagnostic procedures, the most common of which are angiocardiography and coronary arteriography. These and other studies provide otherwise unavailable information in many types of heart diseases, and permit a definitive diagnosis of a number of heart and circulatory conditions affecting an age range from newborn to geriatric.

3. Patients are generally referred for catheterization after other noninvasive (and less serious) diagnostic tests have indicated or confirmed abnormal heart/circulatory function, but have not provided a precise diagnosis. Because it is sophisticated and expensive, and because of its invasive nature, it is not lightly chosen as a diagnostic technique.

4. In the United States, cardiovascular illness claims nearly one million lives each year. Heart disease is the nation's number one killer, accounting for half of all deaths recorded annually. In 1977, cardiovascular diseases alone cost the American people more than $27 billion, including physicians' fees, hospital costs, drugs, and lost wages.

B. Access to Coronary Care Units/Relationship to Open Heart Surgery

1. Because of the need for close interaction among the disciplines, there can be little justification for the development of highly specialized facilities unless expertise in cardiology, cardiovascular radiology, and cardiovascular surgery are immediately available. Ideally, therefore, cardiac

catheterization labs should be located only in institutions with well-organized and closely related programs of cardiovascular surgery, and with experienced personnel who have worked together as a team. Consultation is necessary between the cardiologist and the cardiac surgeon, and emergency situations often necessitate the availability of an open heart team.

2. There is a close relationship between cardiac catheterization and cardiac surgery. Cardiac catheterization is the primary procedure used in the evaluation of a potential candidate for open heart surgery, and the procedure is often predicated on the patient's suitability for surgery. For every four cardiac catheterizations, there is one open heart surgery performed. Because cardiac catheterization is essential to decision making for cardiac surgery, the number and complexity of cardiac catheterizations performed will increase as the number of procedures for repair and replacement of damaged coronary arteries increases. The increases in both services have resulted in the diffusion of cardiac catheterization laboratories and cardiovascular surgical programs to community hospitals throughout the country. Because of their complexity and costs, careful planning for both services is essential.

Cardiac catheterization units should be available to the population on a regional basis, with one adult unit per 300,000 population, and one pediatric unit per 30,000 live births annually.

C. Cost/Volume/Risk Relationships

1. Increases in numbers of cardiac catheterization units and in the complexity of procedures has led to concern regarding quality, cost, and continuity of services. The technique is costly and usually requires a two-night stay in the hospital. The cost is usually paid by a third party. The equipment used in catheterization and the radiation shielding required for the examination rooms generally place the initial costs of the laboratory in excess of $500,000.

2. There are substantial replacement and maintenance costs, since the life of the equipment is fairly short, and generally must be replaced every four to seven years. The financial situation with a catheterization laboratory corresponds to several other types of costly, sophisticated technology (linear accelerators used in cancer therapy have sizeable maintenance costs; CT scanners have a short useful life). However, there is an important difference in that many of these technologies have a substantially greater capacity for serving patients than do catheterization laboratories. Depending on the type of procedure, a cardiac catheterization study can last for several hours. The high fixed costs must therefore be carried over a smaller volume of patient procedures. Additionally, highly specialized personnel and staff are required to perform a catheterization, which adds considerably to the costs. Although this does not represent a cost to the catheterization laboratory, it adds costs to this form of diagnosis when compared to procedures that can be utilized on an outpatient basis.

3. There is the opinion within the medical profession that a certain minimal workload is essential to assure cost-effective, high quality, safe results. Because of its invasive nature, cardiac catheterization carries aslight mortality and complication risk: one of every 1,000 patients dies from the procedure. The Inter-Society Commission on Heart Disease Resources (ICHDR) recommends a 3 percent mortality rate in catheterization laboratories as a tolerance level above which the quality of care must be questioned and patients referred elsewhere.

4. The ICHDR recommends that 300 adult catheterizations or 150 pediatric catheterizations be performed per year, per team, to maintain skills to reduce risks to patients. The principal consideration is excellence in cardiovascular diagnosis obtained at minimum risk to the patient.

D. Service Area

1. The service area for cardiac catheterization units is the health planning district in which the facility or proposed facility is located.

E. Resource Goals

1. Within three years after initiation of a cardiac catheterization unit, there should be at least 300 adult or 150 pediatric procedures performed annually.

2. No unit should be operated in a facility not performing open heart surgery.

3. Adult cardiac catheterization services should be available to the population in need of such services within 80 road miles one way.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L.96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11515. Radiation Therapy

A. Definition/Description

1. Radiation therapy is a clinical medical specialty in which ionizing radiation is used to treat patients with cancer (and other tumors or neoplasms). The objective is to deliver a lethal dose of radiation to cancer cells, with minimal damage to surrounding healthy tissues. The therapy can selectively treat malignant tissues because cancer cells are more susceptible than other cells to the damaging effects of radiation.

2. Radiation therapy is increasingly referred to as "oncology" (the study of tumors), stressing the relationship of the specialty to the field of cancer management. There are three forms of treatment for cancer patients, all of which are used individually or in combination with one another: radiation therapy, chemotherapy, and surgery. Because of differences in degrees of responsiveness to radiation, some tumors can be equally well treated by surgery or by radiation, while others cannot be effectively treated by radiation and must be treated with surgery or chemotherapy. Because of its dual curative and palliative role, therapeutic radiation is sometimes used prior to surgery or after surgery.

3. Approximately 60 percent of all cancer patients require radiation therapy at some time during the course of their disease. Radiation therapy, alone or in combination with other forms of treatment, will be used by only 50 percent of the cancer patients because of limited access. Radiation therapy was not recognized as a medical specialty, apart from general radiology, until the late 1960's, when the American Medical Association recognized separate training programs for radiation therapists and radiologists. The trend of separating therapeutic and diagnostic radiology has continued.

4. The techniques used in clinical radiation therapy are external irradiation, local irradiation, and internal or systemic irradiation, ranging from low energy to megavoltage equipment. Megavoltage machines are more expensive than other types of equipment, because of their high initial cost and protective requirements for the treatment room. However, they offer significant clinical advantages in terms of patient comfort and long term survival and they have higher utilization capacity.

5. There are three types of facilities for radiation therapy. The least comprehensive provides basic services and may provide selected specialized services, using superficial and/or orthovoltage and cobalt equipment. Facilities equipped for major clinical radiation therapy, provide clinical research and training programs using superficial, orthovoltage, cobalt and small linear accelerator equipment. The most comprehensive type provides services of the other two types and, in addition, provides major training and clinical radiation therapy, with linear accelerators, computerized treatment planning, a treatment simulator, and access to a CT Scanner.

6. Over the years a vernacular has developed in the field of radiation therapy. Several definitions unique to the field are important to an understanding of utilization, need and resource goals. The more commonly needed terms are defined as follows:

a. *Cancer Case*—a patient treated with one course of radiation therapy regardless of the number of anatomical areas treated during the course or the number of fields involved.

b. *Course*—a prescribed number of treatments for a cancer case, usually averaging 25 for a curative patient and 14 for a palliative patient.

c. *Field*—the level of the beam used for irradiation. On the average a treatment involves between 2-25 fields.

d. *Megavoltage Unit*—a radiation therapy unit with a maximum beam energy at or in excess of one million volts. It will usually be a modern cobalt-60 machine or low energy linear accelerator (Linac).

e. *Treatment or Treatment Visit*—one irradiation regardless of the number of anatomical areas treated or the number of fields involved.

f. *Treatment Load*—the total number of treatments performed by a therapy unit per year.

B. Application/Issues

1. Louisiana's age-adjusted death rate for cancer consistently runs higher than the national rate. In 1970, it exceeded the national rate by 7 percent and by 10 percent in 1975. Utilizing 1984 projected populations for Louisiana and the nation, total reported deaths for Louisiana and a random 10 percent sample of deaths for the nation, and the direct method of computation, the age-adjusted cancer death rates for Louisiana and the nation for that year stood at 144.55 and 133.10 per 100,000 population respectively. Thus, in 1984, the age-adjusted death rate for cancer in Louisiana exceeded that in the nation as a whole by 7.92 percent. Because cancer claims the lives of thousands of persons each year, with no known absolute prevention or cure, radiation therapy will continue to make a substantial contribution to the care of cancer patients. Recent advances in cancer management and in radiation therapy have evidenced a potential for higher cure rates for certain types of cancer.

2. Radiation therapy is part of a multi-disciplinary approach to cancer management, requiring skills of a variety of specialists and services, prior to, during and following treatment. Although it is not feasible for every facility providing radiation therapy to have a total complement of cancer management services in-house, each institution should provide a broad range of services which are basic to cancer management and should establish a referral mechanism with agreements to provide a comprehensive, integrated range of cancer management services, from diagnosis through treatment and follow up.

3. Regionalization of radiation therapy services is a primary issue in terms of promoting efficient use of equipment and providing a coordinated comprehensive system of services which are accessible, of high quality, and at reasonable cost. Planning and delivery of radiation therapy services on a regional basis should reduce unnecessary duplication of equipment and assure sufficient utilization and revenues to meet expenses for each facility providing the service.

4. Accessibility is of particular concern for radiation therapy services because of costs and inconvenience associated with daily treatment over a period of several weeks. Without reasonable access to the services, patients can be forced temporarily to relocate, creating additional stress. Unless there is some clear therapeutic advantage, it is inadvisable to remove cancer patients from the support of their families and friends.

C. Cost/Volume Relationships

1. Even more than in most fields of medicine, radiation therapy performed with curative intent involves a balance of risks: the risk of not controlling the disease versus the risk of damaging healthy tissue. The treatment is made more difficult in that the disease is complex and variable. Results are not shown immediately, but often require many years to be demonstrated. Highly trained personnel are thus needed in this field, and they need sufficient patient loads to maintain their skills.

2. Volume figures also serve as indicators of need for a new service or expansion of an existing program. A certain volume is advised to ensure quality of care and to contain costs: a megavoltage radiation therapy unit should treat a minimum of 300-500 patients per year; each megavoltage therapy machine should perform at least 6000 treatments per year before another unit is added in the service area. This range of volume allows for differences among patients in terms of treatment required, and among facilities in terms of organization, staff, and equipment.

3. Radiation therapy patients usually receive daily treatment (five per week) over a period of three to eight weeks.

4. Studies have shown that underutilization of services can result in high operating costs for equipment, which are passed on to the patients, and that unrestricted proliferation of radiation therapy facilities can result in disadvantageous benefit/cost to the health care system. Benefits can only be maximized when optimum radiation therapy capacity is available. Therefore, a service should be initiated or expanded only if there is a need for additional capacity within the area and/or if there are special need considerations (e.g. accessibility) which justify the service or expansion.

D. Resource Goals

1. The following standards are necessary for effective and efficient planning of radiation therapy services.

a. There should be at least one megavoltage therapeutic radiology unit for each 150,000 to 250,000 persons.

b. Within three years after initiation, a megavoltage radiation therapy unit should treat at least 300 cancer cases annually.

c. Radiation therapy services should be accessible to the service area residents within 60 road miles one way.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11517. Computed Tomography

A. Description of Service

1. Computed tomography (CT) is a diagnostic service utilizing an X-Ray source, detector and computer to reconstruct from multiple projections a pictorial representation of the internal structure of an object. CT scanning is based upon the principle of conventional radiology: tissues may be distinguished by their respective densities, which are determined by the amount of radiation transmitted through the objects. CT scanning differs from conventional X-Ray in that numerous images are recorded as the X-Ray equipment traverses the body or head area. These images are reconstructed onto a screen or film in a representation of a selected slice of the body.

2. CT scanning is much more sensitive than conventional X-Ray to differenced in tissue density and thus more readily permits the identification of tumors and other soft tissue abnormalities. In addition to its superior diagnostic capability, CT scanning may reduce patient risk by replacing painful invasive diagnostic procedures, such as cerebral angiography and pneuoencephalography, and by reducing the need for exploratory surgery.

3. The evolution of CT has been extraordinarily rapid. The first brain scanner was introduced by EMI in 1972 following five years of development. Progress was quickly made toward the development of body scanners which showed organs such as the pancreas, kidneys and lungs. The speed and accuracy of scanning is now much advanced from the early stages of development.

B. Application and Effectiveness of CT Scanning

1. CT can help physicians determine the site, type and extent of head and body neoplasms and other diseases of soft tissue structure. In the case of malignancies, CT is superior as an aid in radiation treatment planning due to its capability to depict the size and location of tumors. CT is also useful in solving problems where there is conflicting information, either from several radiologic studies or between radiologic studies and the clinical status of the patient. In the head, CT can diagnose virtually all of the neurological disorders that are known to be associated with some physical abnormality of the brain. CT is applicable to the examination of the chest, including the pleura, mediastinum and lung. In the abdomen, CT can examine the retroperitoneum, liver, spleen, pancreas, kidneys, adrenal glands, uterus, ovaries, bladder and prostate. CT is also quite useful in diagnostic work-ups of trauma or accident victims, as well as in guiding biopsy of deep masses in the chest and abdomen.

2. Hundreds of studies of the effectiveness of CT have been conducted. Nearly all report that CT is safe and medically useful and indicate that it provides accurate diagnostic information, improves therapy and reduces the need for other diagnostic procedures.

C. Cost

1. The typical charge for all types of CT scans was estimated at $350 in 1984. It is, therefore, a relatively expensive methodology, but according to some studies, it reduces other diagnostic and therapeutic charges proportionately. Several costly diagnostic procedures are no longer required because of CT—e.g., radionuclide brain scanning, pneumoencephalography and polytomography. The use of many other imaging procedures has been markedly reduced—e.g. abdominal arteriography, lymphangiography and conventional x-ray tomography of many organs. In addition, CT has been shown to reduce hospital stays and to eliminate certain surgical procedures.

2. More clinical research is needed to identify the most cost-effective diagnostic uses. As with any expensive methodology, identifying and avoiding inappropriate use is important in containing the cost of health care. Studies have reported that CT is not cost effective when it is used to

evaluate persons with headaches and other chronic symptoms or to confirm diagnostic findings previously noted by other imaging or clinical tests.

3. The average proce of new CT scanners is approximately $1 million. As new scanners have been bought to replace older units, a secondary market has sprung up for used scanners which is supplying smaller hospitals with a more cost effective means to introduce CT capability.

D. Service Area. The service area for a fixed CT scanner is the health planning district in which the CT scanner is or will be located. The service area for a mobile CT scanner is the health planning district in which the applicant facility is located.

E. Resource Goals

1. The following criteria and standards are applicable to CT scanners for Section 1122 review, as a type of major medical equipment.

2. An initial CT scanner (if purchased or leased, when the expenditure is capitalized) is subject to full 1122 review, regardless of the cost of the equipment. An additional CT scanner, which is not a back-up or replacement scanner, is subject to expedited review.

3. The applicant must project that, within two years after initiation, an initial CT scanner (head or body) will operate at a minimum of 1000 medically necessary patient procedures a year. The applicant should document the anticipated caseload and the source of new patients expected to be served by the proposed CT scanner service. If the anticipated caseload assumes referrals from other facilities, documentation of the linkage agreements must be provided. The documentation shall be quantified and approved by the referring facility's governing body.

4. The applicant must document that the following personnel will be available to the institution:

a. a board-certified or board-eligible radiologist formally trained in the interpretation of CT scanning must be available when the unit is available for patient use and on call at other times;

b. a radiologic technologist trained in the operation of CT scanning equipment should be available when the unit is available for patient use and on call at other times;

c. facilities should document the availability of specialists in the following areas: neurology, general and orthopedic surgery, and internal medicine.

F. Back-up or Replacement Scanners

1. An applicant institution may request that an existing scanner be declared obsolete, even though it will be used as a back-up for a replacement unit. The existing scanner will only be considered as a backup CT unit for planning and review purposes if documentation is supplied to the effect that the existing scanner is subject to extraordinary down time or if other special circumstances apply.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P. L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11519. End Stage Renal Disease Services

A. Definition

1. End Stage Renal Disease services are diagnostic, therapeutic, maintenance, and rehabilitative services required for the care of patients with End State Renal Disease. End Stage Renal Disease (ESRD) is defined as renal impairment which is permanent and irreversible.

2. It is estimated that eight million persons in the United States have some form of kidney disease, and about 60,000 persons die each year from End State Renal Disease. The two major types of ESRD services are transplantation and dialysis.

B. Transplantation

1. Transplantation is a process by which a kidney is excised from a donor and implanted into an ESRD patient, and supportive care is furnished to the donor and to the recipient following implementation. Transplantation is, ideally, a one-time procedure; if the donated kidney functions properly, the patient can live a relatively normal life.

2. A Renal Transplantation Center is a hospital which is approved by the Social Security Administration to directly furnish transplantation and other medical and surgical services required for the care of ESRD transplant patients. The Transplantation Center also furnishes dialysis (a process which removes impurities from the blood), either directly or by arrangement. If transplantation is not successful, dialysis must be readily available to sustain life.

3. There were 73 transplantation procedures performed in the ESRD Network in Louisiana in 1980, and as of December, 1980, 139 dialysis patients were awaiting transplants. There are five ESRD facilities in Louisiana which perform transplants.

C. Dialysis

1. In general, dialysis is a procedure which removes impurities from the blood. One type of dialysis, Peritoneal Dialysis, is less common and is not subject to 1122 Review, since it does not require any special health care facility or equipment for its performance. Hemodialysis is the most common form of treatment for ESRD patients. Hemodialysis is a procedure which filters waste from the blood by circulating it through an artificial kidney machine by diffusion and returning the cleansed blood to the patient's body.

2. Hemodialysis requires from 4-6 hours per session, 2-3 times per week, throughout the patient's lifetime. it can be performed in the home, in a free-standing dialysis facility, or in a hospital dialysis center, and is classified by the level of patient participation. Home dialysis requires self-care with the assistance of a trained family member or other

person. Dialysis in a free-standing facility or in a hospital center can require full staff assistance, or varying degrees of self-care and professional assistance and instruction. Dialysis which is regularly furnished on an outpatient basis to ESRD patients, whether in a free-standing facility, hospital or at home, is referred to as Chronic Maintenance Dialysis.

D. Home Dialysis vs. Outpatient Dialysis

1. Home dialysis offers a number of advantages to ESRD patients. It enables the patient to set his own schedule and it eliminates travel time, whereas in other settings the time required for the procedure and for travel can curtail normal activities and often preclude employment. Home dialysis is less expensive for the patient, and offers certain psychological advantages for the patient's confidence and sense of independence. From a medical standpoint, the more familiar and knowledgeable a patient is about his care and condition, the better and more likely he is to take care of himself and to follow instructions. Home dialysis also reduces the danger of hepatitis and other infections. While facility-based dialysis provides easy access to professional help, home-based dialysis does not have this advantage. Home dialysis has certain requirements (such as physical space, electrical facilities, and the presence of another persons trained in dialysis) which can render it impossible for some patients.

E. Availability/Accessibility of ESRD Services

1. Accessibility to ESRD services is often restricted by lack of transportation. Facilities should assess the problems and patterns and assist the patients in arranging for transportation. Both accessibility and cost savings are increased when hemodialysis stations are operated for longer hours.

2. Distance to care is not a significant factor for transplantation services, since the procedure involves a shorter course of treatment than dialysis, and requires costly, sophisticated medical resources.

3. Routine dialysis services should be available to ESRD patients within two hours round trip (except in sparsely population areas), and patients should not have travel more than 100 miles round trip for services.

4. There are over 1100 patients receiving care in the ESRD network in Louisiana; 1050 are on hemodialysis, 13 are on self-dialysis in facilities, and 50 are on home hemodialysis. There are 43 ESRD facilities within the network, 5 of which perform transplants.

Louisiana Approved ESRD Facilities
February 22, 1985

Facility Name	City	Approved ESRD Stations*	File	Date of Approval	New 1122 Approvals
Louisiana - Total		490			17
Planning District 1		212			
Jefferson		27			6
Parish					
BMA of Marrero	Marrero	6			
BMA of Metairie	Metairie	11			
Dialysis Center of Kenner	Kenner	6			
West Jefferson Dialysis	Marrero	4			
Kenner Renal Center	Kenner		4086	06/06/84	6
			6027	08/21/84	
Orleans Parish		158			4
BMA of New Orleans	New Orleans	31			
BMA of New Orleans East	New Orleans	10			
Hotel Dieu Hospital	New Orleans	4			
Kidney Care	New Orleans	8			
Mid-City Dialysis	New Orleans	6			
New Orleans Charity	New Orleans	11			
Ochsner Clinic	New Orleans	11			
St. Charles Hospital	New Orleans	6			
St. Claude Dialysis Center	New Orleans	6			
Southern Baptist Hospital	New Orleans	18			
Touro Infirmary	New Orleans	14			
Tri-Parish Renal Center	New Orleans	8			
Tulane Medical Center	New Orleans	14			
Westbank Chronic Renal Center	New Orleans	11			
Ochsner Clinic	New Orleans		NSTR	12/14/84	4
St. Bernard Parish					
Chalmette Dialysis	Chalmette	11			
St. Tammany		16			
St. Tammany Dialysis Center	Slidell	8			
St.	Slidell	8			

Louisiana Approved ESRD Facilities February 22, 1985					
Facility Name	**City**	**Approved ESRD Stations***	**File**	**Date of Approval**	**New 1122 Approvals**
Tammany Renal Center					
Planning District 2					
East Baton Rouge Parish		39			
BMA of Baton Rouge	Baton Rouge	24			
BMA of Baton Rouge – Central	Baton Rouge	12			
Earl K. Long Hospital	Baton Rouge	3			
Caddo Parish		49			
BMA of Shreveport	Shreveport	12			
Louisiana State University Hospital	Shreveport	10			
Shreveport Regional Dialysis	Shreveport	18			
Willis Knighton Hospital	Shreveport	9			
Nachitoches Parish					
Nachitoches Dialysis	Nachitoches	6			
Planning District 8					
Ouachita Parish					
Northern Louisiana Dialysis	Monroe	25			

*Source: ESRD Network 12 Listing of approved stations, received 1/11/85, and verbal communication. (Mr. Armistead, 2/21/85)

F. Legislation/Funding/Cost

1. Section 2991 of Public Law 92-603, the 1972 Social Security Amendments, established a federal program to finance medical care for almost all ESRD patients. This was the first program in which the federal government assumed responsibility for treatment costs of cirtually an entire patient population. The legislation provided for ESRD patients to be defined as disabled, and therefore eligible for participation in the Medicare program. An individual can qualify if he suffers from permanent kidney failure, meets Social Security insured status or receives Social Security cash benefits, or is a spouse or dependent child of someone who has insured status or receives cash benefits. The only ESRD patients not eligible are teachers, government employees, college students over age 21, and others who have worked under the Social Security program.

2. Medicare reimburses 80 percent of all allowable costs for covered treatment services for eligible persons, in facilities and for the home training program. In Louisiana, approximately 93 percent of ESRD patients qualify for Medicare coverage. Prior to the legislation, costs for the average ESRD patient could range up to $30,000 a year for clinic services, or $10,000 a year for home dialysis.

3. In 1978, the Medicare ESRD Program Amendments were enacted, in order to encourage the use of lower-cost treatment modalities, specifically self-dialysis and transplatation, for the maximum number of patients who are medically, socially, and psychologically suitable for such treatments. In recognition of the fact that many patients are unable to dialyze at home, a provision was included to encourage the use of self-dialysis stations in dialysis facilities. Reimbursement for all forms of therapy was made approximately equal, thus allowing the patient and his physician the choice of the most acceptable form of therapy. Total costs are not equal, but cost to the patient is approximately the same regardless of the treatment modality.

4. The Medicaid (Title XIX) Program in Louisiana provides coverage for eligible persons for services received in free-standing ESRD facilities which are certified for medicare participation. Medicaid does not cover most pharmacy charges, or laboratory services not performed in the dialysis facility. Medicaid reimburses for dialysis treatment and routine lab services, medically necessary non-routine lab services, physician supervision of dialysis, dialysis training and counseling for home dialysis care, and medically necessary injections. In 1980, the Louisiana Medicaid program spent approximately $2,000,000 for ESRD services in free-standing centers, for 2375 ESRD patients.

5. Costs vary considerably among treatment types; for example, home dialysis is less expensive than facility-based dialysis. The initial cost of tranplantation is $15,000-$25,000, with annual follow-up costs ranging from $1,500 to $3,000. In the long run, transplantation is the least expensive form of treating ESRD. Home dialysis has an initial cost of approximately $2,000, with the cost per dialysis session $115-$130. Hemodialysis in a hospital-based facility is approximately $175 per session, and is slightly less expensive in a free-standing facility. A number of studies have estimated cost differences between home and facility dialysis to range from $7,900 to $13,400 after the first year.

6. The present cost of the federally funded ESRD program is over $20,000 per patient per year in Louisiana.

G. ESRD Network

1. The federal regulations for Medicare coverage of ESRD suppliers have the following objectives, which are carried out through a regional ESRD Network:

a. to assist SSI recipients with ESRD in receiving needed medical care;

b. to encourage the availability, accessibility, and appropriate use of ESRD treatment facilities while maintaining or improving the quality of care;

c. to provide the flexibility needed for physicians to efficiently deliver appropriate care.

2. Each network covers a specific geographical area designated by the Secretary of DHHR, and all facilities within the area must be part of the network. The network has a coordinating council, which represents each ESRD treatment facility in the area, and which serves as coordinator of ESRD activity within the network. Louisiana is served by ESRD Network Coordinating Council Number 12. The major functions of the council include:

a. establishing a medical review board to determine the appropriateness of ESRD care and services within the network;

b. establishing methods and procedures for the medical review board;

c. establishing working relationships with Professional Standards Review Organizations in the network;

d. reporting information to the secretary of DHHS on the ESRD activities within the network;

e. developing an annual plan which outlines the network's objectives;

f. conducting certification reviews and making recommendations to the State Health Planning and Development Agency (aSHPDA) and DHHS on each request for a new or expanded ESRD service.

3. The functions of the seven member medical review board are to develop ways of monitoring patient care, to review and coordinate facilities and physicians, to coordinate medical care evaluations, and to make written recommendations to facilities and physicians based on the evaluations.

H. Minimal Use Rates

1. Medicare-approved ESRD treatment facilities must meet certain federal regulations. Two of the requirements are that the facility must be a member of the network, and that it must meet minimum use rates for transplantation and dialysis.

2. The use rate status is defined in the regulations, and is summarized below. Institutions with high use will be given unconditional ratings and are thereby eligible for reimbursement. Institutions with lower ratings may be given conditional status, which means that they can be reimbursed until a specified time, after which payment terminates unless usage is within the unconditional range. Under special circumstances, institutions may be given exception status, which means that they do not have to meet usage requirements. (For example, if a facility serves a sparsely populated area where no other dialysis services are available, reimbursement would not be denied because of failure to meet use requirements.)

a. ESRD minimal utilization rates for dialysis facilities performing greater than 20 percent of their dialysis on outpatients in a Standard Metropolitan Statistical Area (SMSA) of 500,000 population or greater are:

i. Unconditional approval: six or more dialysis stations with an average of 4.5 or more dialyses per week.

ii. Conditional approval: six or more dialysis stations with an average of between 4.0 and 4.5 dialyses per station per week; or 4 or 5 dialysis stations with an average of 4.5 or more dialyses per station per week.

b. ESRD minimal utilization rates for dialysis facilities performing greater than 20 percent of the dialyses on outpatients in an SMSA of less than 500,000 or in an area not included in an SNSA are:

i. Unconditional approval: three or more dialysis stations with performance of an average of 4.0 or more dialyses per stations per week.

ii. Conditional approval: two dialysis stations with performance of an average of 4.0 ore more dialyses per station per week.

c. ESRD minimal utilization rates for renal dialysis centers performing 20 percent or less of their dialyses on outpatients are:

i. Unconditional approval: three or more dialysis stations with performance of an average of 4.0 or more dialyses per station per week.

ii. Conditional approval: two dialyses stations with performance of an average of 4.0 more dialyses per station per week.

d. Minimal utilization for a transplantation facility/center is 7 to 14 renal transplants performed annually during the first two years of operation, and 15 or more renal transplants performed annually during each succeeding year.

I. Resource Goals

1. For a system of ESRD services to best meet the needs of the ESRD patients in Louisiana, the following factors should be considered:

a. the projected number of people needing the service in an area;

b. the availability of enough services in the proper geographical distribution;

c. the ability of the people of travel to services;

d. the efficient utilization of facilities.

2. A facility should be considered fully utilized if there is a 75 percent utilization rate based on two patient shifts per day, 6 days per week.

3. Routine dialysis services should be available to ESRD patients within 2 hours round trip (except in sparsely populated areas), and patients should not have to travel more than 100 miles round trip for services.

4. Hemodialysis services should be available for two patient treatment shifts, 6 days per week.

J. Resource Goal Adjustment and Need Calculations

1. Methodology for determining need for chronic maintenance hemodialysis services within the service area

a. Factors to be included in the methodology for determining the need for hemodialysis services are:

i. The most recent available area-wide census of ESRD patients receiving in-facility maintenance hemodialysis for chronic renal failure.

ii. The projected annual incidence rate of chronic renal failure in the service area (new cases per million population per year).

iii. The number of renal transplant operations performed on residents of the service area for the most recent twelve month period available.

iv. The number of renal transplant operations performed on residents of the service area which did not result in a properly functioning kidney in the patient and did not result in the death of the patient.

v. The projected number of patients to receive home dialysis training in the forthcoming calendar year in the service area.

vi. The projected number of patients to begin peritoneal dialysis in the forthcoming calendar year.

vii. The mortality rate observed for the ESRD chronic maintenance hemodialysis patient population in the service area during the preceding year.

viii. Ten percent of the current area-wide census of patients receiving chronic maintenance hemodialysis at home in the service area.

ix. A factor of 80 percent of full utilization.

x. The service area's projected estimate of the population of the health service area in the year being considered.

2. Methodology Formula

(factor 1) + [(factor 10) (factor 2)]—(factor 3) + (factor 4)—(factor 5) - (factor 6)—[(factor 1) (factor 7)] + (factor 8) = The projected total number of ESRD patients needing in-facility chronic maintenance hemodialysis (factor 11)
(factor 11)—(factor 4) =
The projected total minimum number of in-facility chronic maintenance hemodialysis stations needed in the area assuming full utilization of all dialysis stations (factor 12)
[(factor 12)—(factor 9)] = The number of in-facility chronic hemodialysis stations needed in the area.

a. Additional factors which may influence the need for chronic hemodialysis stations may include transient patients and/or existing facilities operating on a three shift per day basis.

Methodology for Determining Need for In-facility Chronic Maintenance Hemodialysis Stations								
Current areawide census of patients receiving chronic maintenance hemodialysis in facilities	Projected number of new ESRD cases for the next year	-	The projected number of ESRD patients who will receive kidney transplants	+	The projected number of ESRD patients who will undergo kidney transplants and survive despite failure of grafted kidney to function properly	-	The projected number of patients who will be trained for home dialysis in the next year	-
The projected number of patients who will begin peritoneal dialysis in the next year	-	The projected number of ESRD patients receiving chronic maintenance hemodialysis who will die for any cause next year	+	Ten percent of the current areawide census of patients receiving chronic maintenance hemodialysis at home	=	The projected total number of ESRD patients needing in-facility chronic maintenance hemodialysis		
Full utilization is 12 treatments per week per station. Most hemodialysis patients require dialysis three times per week. Thus, full utilization is also about 4 patients per station. To determine the projected minimum number of in-facility chronic maintenance hemodialysis stations needed in the area assuming full utilization of all station, in the next year, the total from the equation above is divided by 4.								
Because full utilization is an unreasonable expectation as a result of: 1. Isolation requirements for hepatitis-positive patients and patients with other infectious diseaee; 2. Transient or emergency outpatients requiring temporary dialysis; and 3. Normal variation in the number of patients requiring chronic. maintenance hemodialysis, the optimal number of in-facility chronic maintenance hemodialysis stations is defined as that which would result in a utilization race equal to eighty percent of the projected minimum number of stations needed. Therefore, the minimum number of stations needed would be divided by 0.80 to calculate the optimal number.								

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11521. Emergency Medical Services A. Definition/Description

1. Title 40 of the Louisiana Revised Statutes established the Emergency Medical Services program within the Louisiana Department of Health & Human Resources. The department was granted the authority to adopt rules and

regulations pertaining to Emergency medical Services in Louisiana and to responsibility for coordinating the planning and implementation of the statewide Emergency Medical Services systems.

2. Emergency Medical Services (EMS) are services utilized in responding to a perceived need for immediate medical care to prevent death or aggravation of physiological or psychological illness or injury. The purpose of EMS is to respond to and care for people who have experienced a medical emergency, including care at the scene of the emergency, during transportation to a medical facility, and in the hospital emergency department or specialty care center.

3. For an EMS system to respond effectively, each element of the integrated system must be in place, so that assistance is summoned when needed and patients are transferred smoothly along the chain of emergency medical care. An EMS system should include an organized method for detecting, reporting, providing initial care, sorting or triage, transporting, caring for patients en route, giving acute definitive care to and providing linkage to continued care and rehabilitation for acutely ill or injured patients.

4. Although the development of multi-institutional systems for coordination or consolidation of health services such as EMS is a national health priority, there have been problems in successful community planning. Some of the obstacles have been the lack of clear federal guidelines, lack of coordination between agencies with program responsibilities, and lack of uniformity and reliability of data to indicate need for improvement.

5. The specific health status and environmental characteristics of the state or service area impact the development of an EMS system. An individual's residential and occupational settings greatly affect his degree of risk, of becoming an emergency victim, and of coming into contact with an emergency situation. Local occupational settings such as industrial or offshore workplaces carry high risk of life-threatening events and risk of medical attention not being readily available. In rural communities residents are separated from each other and from medical assistance by long distances. Low population density creates unique needs; sparsely populated areas have higher rates of traffic fatalities, and most emergency conditions are complicated by the increased response time to emergencies. In these areas there is a greater need for CPR programs due to high response time of emergency medical personnel and low utilization or lack of medical facilities and personnel. Population groups such as the poor and ethnic minorities are also at a higher risk for emergencies than the general population, as a result of poor health and inadequate economic access to medical care.

6. Heart disease is the leading cause of death in Louisiana. The majority of heart-related deaths are due to acute myocardial infarction, with death usually occurring before the patient reaches a hospital. It has been estimated that 10% of deaths attributable to heart disease and 15% of deaths attributable to accidents could be prevented if proper medical treratment were initiated at the scene of the incident and continued en route to a medical facility. Thus, the intent of an EMS system is to decrease current death and disability rates.

7. Elements of an EMS System

a. The key to saving emergency patients from unnecessary death, disability, and complications from injury involves careful evaluation of the patient's condition, followed by a stablization of the patient at the scene, with an expeditious and careful trip to a medical facility. The following emergency patient's needs can be met through an effective EMS system:

i. discovery and notification of accident/illness;

ii. pre-hospital emergency care;

iii. transportation to designated facility;

iv. initial care in appropriate critical care unit; v. secondary definitive care.

b. An EMS system should provide arrangement of personnel, facilities, and equipment for effective and coordinated delivery of emergency health care services in an appropriate geographical area. An ideal system should have well-developed plans for efficiently and effectively moving patients through the various parts of the system. The component parts of an EMS system are as follows:

i. Manpower—An EMS system shall include an adequate number of health professionals, allied health professionals, and other health personnel, including ambulance personnel, with appropriate training and experience. This means sufficient personnel to provide services on a 24-hour basis within the service area of the system. There are 4,000 Emergency Medical Technicians in Louisiana.

ii. Trained Personnel—An EMS system shall provide for its personnel appropriate training and continuing education programs which are coordinated with other programs in the system's service area.

iii. Communications—An EMS system shall join the personnel, facilities, and equipment of the system by a central communications systems.

iv. Transportation—An EMS system shall include an adequate number of necessary ground, air, and other transportation facilities to meet the individual characteristics of the service area.

v. Facilities—An EMS system shall include an adequate number of easily accessible emergency medical services facilities which are collectively capable of providing services on a continuing basis, have appropriate standards relating to capacity, location, personnel, and equipment, and which are coordinated with other health care facilities of the system.

vi. Critical Care Units—An EMS system shall provide access (including appropriate transportation) to

specialized critical medical care units in the system's service area or neighboring areas if necessary.

vii. Use of Public Safety Agencies—An EMS system shall provide for the effective utilization of personnel, facilities, and equipment of each public safety agency providing emergency services in the system's service area.

viii. Consumer Participation—An EMS system shall be organized in a manner that provides persons who reside in the service area, and who have no professional training or financial interest in health care, with an opportunity to participate in policymaking for the system.

ix. Accessibility to Care—An EMS system shall provide, without prior inquiry as to ability to pay, necessary emergency medical services to all patients requiring such services.

x. Transfer of Patients—An EMS system shall provide for transfer of patients to facilities and programs which offer such follow-up care and rehabilitation as is necessary to effect the maximum recovery of the patient.

xi. Standard Medical Record Keeping—An EMS system shall provide for a standardized patient record keeping system, covering treatment of the patient from initial entry into the system through discharge, and consistent with ensuing patient records used in follow-up care and rehabilitation of the patient.

xii. Consumer Information and Education—An EMS system shall provide programs of public information and education which disseminate information regarding appropriate methods of medical self-help and first-aid.

xiii. Independent Review and Evaluation—An EMS system shall provide for periodic, comprehensive, and independent review and evaluation of the extent and quality of the emergency health care services provided in the system's service area.

xiv. Disaster Linkage—An EMS system shall have a plan to assure that the system will be capable of providing emergency medical services in the system's service area during mass casualties, natural disasters, or national emergencies.

xv. Mutual Aid Agreements—An EMS system shall provide for appropriate arrangements with EMS systems in neighboring areas for the provision of services on a reciprocal basis, where access to such services would be more appropriate and effective in terms of the services available, time, and distance.

8. Communications

a. Development of an effective system of communication is essential to an EMS operation, since time is a critical factor and delay is costly. A regionalized emergency communications system should exist, linking all phases of the emergency system, including dispatchers, emergency vehicles, hospitals, and physicians. There should be a rapid, easy, universal method of telephone entry into the system (such as "911") which is easy to remember and to dial. Currently, two-thirds of Louisiana has access to the "911" number, and within five years, the number will be in use statewide.

b. Communications plays a key role during several phases of the EMS system's cycle, including notification, dispatch, transportation of resources, and transportation of patients to facilities. The success of the EMS system depends on the effectiveness of the communications system.

c. The essentials of a central communications center are that (1) all requests for system response are directed to the center; (2) all system resource response is directed from the center; and (3) all system liason with other public safety and emergency response systems is coordinated from the center. The primary functions of an EMS communications system are:

i. To provide a method of access for the public so that calls for emergency medical help can be quickly and easily placed.

ii. To provide a method that allows an ambulance to be dispatches to the scene of an emergency in response to a call for assistance.

iii. To provide a method that allows direct communication between the physician or nurse in the hospital and personnel at the scene of the emergency.

(a). Hospital-to-ambulance communication permits emergency medical personnel at the scene of an emergency to notify the hospital in advance of their arrival, giving the hospital time to prepare. With the use of paramedics providing advanced life support, hospital-ambulance communication assumes greater importance. Paramedics provide sophisticated treatment at the scene of an emergency, such as administering medications, requiring direct contact with a physician. Each of the seven regions in Louisiana's EMS program will have ambulance-hospital communications capabilities within two years; currently, three-fourths of the facilities have this capability.

9. Transportation

a. Emergency transportation of the sick and injured is one of the most critical areas of the EMS system. Transportation provides a connecting link between the EMS system components. It is the primary purpose of the ground or air transportation to transport qualified personnel and equipment to the scene, to initiate immediate care to the ill or injured, and then to transport the victim to the most appropriate medical facility.

b. All phases and modes of emergency transportation should be coordinated in order that response times are minimized, while high quality pre-hospital patient care is maintained. Ambulance service areas should be established and clearly defined to ensure that the closest, most appropriate units are dispatched to a call, that dispatchers can quickly determine which unit serves an area and who provides back-up services, and that response time

goals can be met. Factors which should be considered in defining service area size of units include:

i. response time goals—what is the farthest the unit can travel within that goal 90 percent of the time?;

ii. population distribution and call load estimates;

iii. population characteristics which may alter call load estimates (for example, a concentration of elderly residents could increase the frequency of calls from an area);

iv. topographic features and road conditions which may affect response times;

v. special features such as heavy industry, recreational areas, etc. which could affect frequency and type of call;

vi. traditional service area patterns where appropriate.

c. The placement of emergency medical vehicles involves both basic and advanced life support, frequency from several ambulance providers, often from non-ambulance providers, and often from non-ambulance emergency vehicles from other public safety agencies such as fire departments. If centers around the concept of response time:, which varies between urban and rural communities and between types of emergencies. Response time, the elapsed time from the receipt of a call for service to the arrival of that service, is used to measure the availability of emergency medical care. National guidelines indicate that maximum ambulance response times to 95 percent of the population should be 10 minutes in urban and 30 minutes in rural areas.

10. Regionalization/Accessibility

a. An EMS system must design a rational sequence of comprehensive program activities on a regional basis if the needs of all potential emergency patients are to be properly anticipated and adequately met. A regional EMS system is described geographically be existing natural patient care flow patterns. It must be large enough in size and population so that definitive care can be made available to most general emergency and critical patients. Where sophisticated medical resources are not available within the region, arrangements must be formalized for providing these patients care services in an adjoining region. When possible, EMS regions should coincide with existing service area boundaries. Critical patient origin and distribution patterns are the essential issues in defining the regional boundaries.

b. There are seven EMS regions in Louisiana: Southeast, Southwest, Northeast, Northwest, Acadiana, Greater New Orleans, and Capital/Central.

11. Critical Care

a. One of the major goals of an EMS program is the development of a network of care for critical patients. The critical care concept is based on the premise that a critically ill or injured person should get to the facility, that can provide the medical care most appropriate to his condition. Ideally, critical patients who are suffering from a life-threatening condition should be transported to those hospitals which have the intense concentration of resources necessary to care for those patients. Also, caring for critical patients at a small number of hospitals allows those hospitals to further develop their expertise in providing for the critical patient. There are several types of specialty centers for critical care patients: trauma, burn, spinal injuries, cardiac, poison, perinatal, and behavioral emergencies. (Refer to Chapter X, Louisiana Medical Inventory, Hospital Special Services.)

B. Resource Goals

1. Emergency medical transportation services should be available to 95 percent of the urban population within 10 minutes, on a 24-hour basis.

2. Emergency medical transportation services should be available to 95 percent of the non-urban population within 30 minutes, on a 24-hour basis.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R. S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11523. Long Term Care Beds

A. Skilled Nursing and Intermediate Care Facilities

1. Definition/Description

a. In the broadest sense, long term care includes the complete spectrum of institutional and non-institutional services which provide health care to persons with chronic disease or disability requiring care over an extended period of time, or to persons recovering from the an acute phase of illness requiring continuing care. Services range from those provided in the home to inpatient or residential services provided in public or private institutions. The goal of long term care is to provide persons of all ages with preventive, diagnostic, medical, rehabilitative, maintenance, or social services, to achieve optimal physical, social, and psychological functioning.

b. Long Term Care beds may be located in general acute care hospitals or in nursing homes. A licensed nursing home is a long term care facility which provides, in addition to food and shelter, professional attendant and nursing care, 24 hours a day, to the chronically ill, convalescent, disabled, and the elderly, with a full range of complementary services (therapeutic, dietary, social, etc.)

c. Nursing homes differ from hospitals in that they have no facilities for diagnostic services or for acute or emergency medical care (x-ray, laboratory, or surgical units); however, nursing homes provide the most complete care possible outside of a hospital, because services and manpower are located and delivered within the institution in which the patients reside.

d. Nursing homes are classified according to the type of care provided. A nursing home may be certified in one or more of the following levels of care:

2. Skilled Nursing Care Facility (SNF)

a. A skilled Nursing Facility provides intensive, frequent, and comprehensive nursing care and/or rehabilitation services ordered by and under the direction of a physician. Services are provided under the supervision of a registered nurse or licensed practical nurse on a 24 hour basis. Skilled nursing beds may be located in a general acute care hospital or in a nursing home.

b. Examples of services include therapy, administration of medication and I.V. fluids, tube feeding, post surgical convalescent care. Skilled care is also referred to as Extended Care.

3. Intermediate Care Facility—Level I (ICF-I). An Intermediate Care Facility, Level I, provides basic nursing services under the direction of a physician to persons who require a lesser degree of care than skilled services, but who need care and services beyond the level of room and board. Examples of services are administration of injections and medication, treatment and care of persons requiring tubes, appliances, surgical dressings, physical therapy, restraints, and personal care.

4. Intermediate Care Facility—Level II (ICF-II). An Intermediate Care Facility, Level II, provides supervised personal care and health related services, under the direction of a physician, to persons needing nursing supervision in addition to help with personal needs. Services can usually be provided by trained aides and orderlies. Examples of services are administration of routine oral medication, stimulation of activities in daily living, supervision or assistance with personal care.

5. Intermediate Care Facility for the Mentally Retarded (ICF-MR)

a. An Intermediate Care Facility for the Mentally Retarded provides residents with professionally developed individual plans to cared, supervision, and therapy, to attain or maintain optimal functioning.

b. (Refer to the section on ICF/MR)

6. Determination of Level of Care

a. The Office of Family Security evaluates the necessity for Skilled and Intermediate Care for Title XIX (Medicaid) recipients through admission review and medical certification. Admission review is based on assurance that the recipient's level of care is the most appropriate for his individual needs, and that there has been a medical and social evaluation and physician certification. As provided in the 1984 Deficit Reduction Act (P. L. 98-369), physician recertification is required every 30, 60 and 90 days after admission to the facility and every 60 days thereafter for recipients residing in Skilled Nursing Facilities. Recipients residing in Intermediate Care Facilities shall be recertified 60 and 180 days after admission, at 12, 18, and 24 months after admission, and annually thereafter. Recertification is authorized by a physician.

7. Payment to Nursing Homes

a. Payment is made to nursing homes according to the type of care provided, as described above.

b. A nursing home must be licensed by the state in order to operate, and must be certified according to federal standards in order to participate in the Medicare and Medicaid programs. Medicare is the federal hospitalization and medical insurance program for the aged and disabled, and Medicaid is the federal-state health care program for the financially needy. Medicare applies only to Skilled Nursing Care, and pays for up to 100 days of care in any single spell of illness, while Medicaid covers both Skilled and Intermediate care levels without limitation on the number of eligible days. Because of its restrictive definition and durational limits of coverage, Medicare covers a relatively small percentage of the total number of people currently in long term care facilities. Medicaid, the major source of nursing home support, pays 60 percent of the nation's total nursing home bill.

8. Alternatives

a. Alternatives to nursing home placement, which can delay or eliminate the need for nursing home placement, include the following: case management services, home health services, adult day medical care, homemaker services, personal care and habilitation services, hospice care, respite care, nutritional services (meals on wheels), volunteer services, transportation services, semi-institutional and semi-independent living arrangements.

b. Developing alternatives to nursing home placement is a priority health issue for this planning period, primarily because many of the aforementioned services are not available currently in all areas of the state. One reason that alternatives to nursing home care are not available to many of the state's citizens is cost. People who may qualify for Medicaid-reimbursed nursing home care often have sufficient income to remain in their own homes, but insufficient funds to pay for home-based services, such as homemakers, day care, etc. Because of eligibility criteria, many persons may not qualify for any subsidized services other than nursing home care. For these reasons, there is nearly twice as much utilization of nursing home services by people over 65 in the poor areas of rural North Louisiana health system care compared to the more urban and economically stable New Orleans/Bayou-River area.

9. Quality of Care

a. There are four quality control mechanisms now in existence for nursing homes:

i. Title XIX (Medicaid Program) conducts a Professional Medical Review (PMR) once yearly. A PMR team (which includes a physician) is located in each health planning district. Each team makes a site visit to review all medical records and patients in each facility, to determine if patients are receiving both quality care and appropriate care. Title XIX also conducts a Utilization Review, simultaneous with a PMR, in which each team determines whether a patient needs the level of care for which he is certified. Six months after the on-site visit the team reviews the treatment

plan and discharge plan of each patient to see if the needed level of care is being provided.

(a). Under state law, complaints are made to the secretary of the Department of Health and Human Resources, who reviews such complaints and who then may refer the matter to appropriate office or law enforcement agency for action (R.S. 40: 2009.13 et seq.).

ii. The Ombudsman Program, in the Governor's Office of Elderly Affairs, monitors patient care and assists residents with resolution of problems (R. S. 40:2010.0 et seq.)

iii. The State Licensing and Certification Office reviews each facility annually with its own team. This team has members which the PMR team does not; i.e., dietician, pharmacist. Their concern is with the physical plant and whether the facility is providing the care for which it is licensed. The team monitors a 15 percent sample of patients as to level of care needed/received. The facility is given a time limit to correct infractions.

iv. The Louisiana Nursing Home Association has a Peer Review Committee which conducts voluntary evaluations of the quality of nursing home care for the purpose of "maintaining high standards of excellence in meeting the total needs of the patients they serve." The association surveys each nursing home prior to accepting the facility as a member.

10. Service Area. The service area for a proposed or existing facility is designated as the parish in which the site is located with the following exceptions: The parishes of Ascension, Iberville, Plaquemines and St. John shall be considered to be divided by the Mississippi River into two separate service areas. Therefore, all east bank wards in these parishes will be considered as separate service areas and all west bank wards will be considered as another service area. This methodology identifies the resources and needs of persons most likely to utilize the nursing home beds. It allows the placement of beds in areas which are presently served only by distant or otherwise inaccessible nursing homes.

11. Resource Goals

a. The nursing home bed supply should not be more than 80 ICF I, II and SNF beds (combined) per 1,000 population age 65 + .

i. Beds which are counted include: (1) licensed but not Section 1122 approved beds, (2) 1122 approved and licensed beds,and (3) 1122 approved but not yet licensed beds. The calculation shall include licensed general acute care hospital beds which are Medicare certified as skilled nursing facility beds.

ii. In determining the bed to population ratio for the proposal, Division of Policy, Planning and Evaluation will use population projections for the anticipated opening date (year) of the facility, which shall not exceed two years from the date the application is declared complete.

b. The occupancy rate for the four most recent quarters due to have been reported to Division of Licensing and Certification in the service area should be at least 95 percent.

i. In determining this occupancy rate, beds used in the calculations include: (1) licensed but not 1122 approved beds and (2) 1122 approved and licensed beds. This calculation shall include licensed general acute care hospital beds which are Medicare certified as skilled nursing facility beds.

12. Adjustments to Resource Goals

a. Circumstances may exist or be created which cause a particular group (see Section on Health Care for Persons with Acquired Immunodeficiency Syndrome) or area to be underserved. When one of the following circumstances exists in a service area, an adjustment to the above resource goals may be justified:

i. Inaccessibility to Minority Groups

(a). It is recognized that certain factors may limit the accessibility of nursing home beds to minority groups. For this reason, a documented claim submitted by the applicant, of inaccessibility of nursing home beds to minority groups, may be considered a special circumstance in the determination of need in the service area. Inaccessibility refers only to situations where there is documented evidence of discrimination against a particular minority in a geographic area. This requirement will be deemed met only when the Title VI or Title VII agency has made a positive finding of systematic discrimination against a minority group on the part of an existing health care facility within the geographic area.

ii. Inaccessibility in High Occupancy Areas

(a). It is recognized that in certain areas of the state nursing home care may not be available. For this reason, a documented claim, submitted by the applicant that nursing home care is not available may be considered a special circumstance in the determination of need in the service area. This requirement shall be deemed met only when the adjusted occupancy rate for all facilities in the service area exceeds 95 percent. The adjusted occupancy rate is computed for each quarter for the four most recent quarters due to have been reported to the Division of Licensing and Certification and is calculated from a base bed inventory which includes licensed but not 1122 approved beds. 1122 approved but not yet licensed beds.

(b). This calculation shall include licensed general acute care beds which are Medicare certified as skilled nursing facility beds.

iii. Inaccessibility Due to Poor Quality Care

(a). It is recognized that in some areas of the state the nursing home care being provided may not be of the quality desired by the residents of that parish. Therefore, in these areas, a documented claim, submitted by the applicant, that nursing home care is not accessible due to the poor quality of care provided in the parish may be considered a

special circumstance in the determination of need in the service area. This requirement will be deemed met only when a facility in the service area has been disenrolled by the Office of Family Security as a Medicaid Provider or decertified or delicensed by the Division of Licensing and Certification and the adjusted occupancy rate for the other facilities in the service area is greater than 95 percent. The adjusted occupancy rate is computed for each quarter for the four most recent quarters due to have been reported to Division of Licensing and Certification and is calculated from a base bed inventory which includes licensed but not 1122 approved beds, 1122 approved and licensed beds and 1122 approved but not yet licensed beds.

(b). This calculation shall include licensed general acute care hospital beds which are Medicare certified as skilled nursing facility beds. The beds of the facility which was disenrolled, decertified or delicensed shall be excluded in computing the adjusted occupancy rate and the Section 1122 approval for such facility shall be revoked unless the facility obtains reenrollment, recertification and relicensure within 60 days of the loss of such approvals.

13. Applications for Proposals Based on Inaccessibility Adjustments

a. All applications for proposed or existing facilities based on the foregoing inaccessibility adjustments will be referred by the health planning staff to a committee of knowledgeable professionals who will review and provide written comments to Division of Policy, Planning and Evaluation on such applications. The following committee members are appointed by the governor: the assistant secretary of Office of Family Security, the administrator of Licensing and Certification, the chairman of the Statewide Health Coordinating Council (shall always be a consumer representative), the ombudsman coordinator of the governor's Office of Elderly Affairs, and the director of the Bureau of Civil Rights of DHHR.

b. Division of Policy. Planning and Evaluation shall forward copies of the applications to be reviewed to the above noted committee members as soon as such applications are declared complete. The transmittal will include the date of the public hearing and the decision due date. Division of Policy, Planning and Evaluation shall also forward a summary of the public hearing comments to the committee members.

c. Each committee members will forward individual comments and recommendations to the Division of Policy, Planning and Evaluation. Comments must be received by Division of Policy, Planning and Evaluation at least five working days prior to the decision due date. If available, such comments and recommendations will be included in the staff analysis and considered when a decision is rendered. The number of beds which may be approved in an area deemed inaccessible due to high occupancy shall not exceed the lesser of (1) the average of all the facilities in the service area or (2) 10 percent of the number of beds in the service area. For all other resource goal adjustments based on inaccessibility, the number of beds which may be approved shall not exceed the average of all the facilities in the service area.

NOTE: Specific requirements for meeting these exceptions shall be further established in Section 1122 Policies and Guidelines promulgated by the Division of Policy, Planning and Evaluation.

B. Intermediate Care Facilities for the Mentally Retarded

1. Definition/Description of Services

a. An Intermediate Care Facility for the Mentally Retarded (ICF/ MR) is one which serves individuals having disabilities attributable to mental retardation or related conditions. The definition of "related conditions" is hinged on legislative language contained in the Developmental Disabilities Services and Facilities Construction Act, P. L. 91-517. This Act, as amended by P.L. 95-602, contains the following definition of developmental disability.

i. The term developmental disability means a severe, chronic disability of a person which:

(a). is attributable to a mental or physical impairment or combination of mental and physical impairments;

(b). is manifested before the person attains age 22;

(c). is likely to continue indefinitely;

(d). results in substantial functional limitations in three or more of the following areas of major life activity:

(i) self-care;

(ii) receptive and expressive language;

(iii) learning;

(iv) mobility;

(v) self-direction;

(vi) capacity for independent living; and

(vii) economic self-sufficiency; and

(e). reflects the person's need for a combination and sequence of special inter-disciplinary, or generic care, treatment, or other services which are individually planned and coordinated.

b. The ICF/MR, referred to as an Intermediate Care Facility—Handicapped or ICF/H by the Office of Family Security, like other Intermediate Care Facilities, must fully meet the licensure requirements of the State. It provides, on a regular basis, health related services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require care and services above the level of room and board that can be made available only in institutional facilities. Among the conditions that might be served in an ICF/MR are: disabilities attributable to mental retardation, cerebral palsy,

epilepsy, autism and other conditions as defined in the paragraph above.

c. There is a wide range in the types of facilities which may meet licensing and Title XIX regulatory standards as ICF/MRs. At one end of this range are those facilities that provide domiciliary care. These facilities have a bed capacity of sixteen or more beds. Thus, they constitute the largest ICF/MR facilities and may be referred to as large residential facilities. These facilities exist in a network of publically owned State schools as well as in privately owned arrangements. Group homes and community homes comprise the community based services. The former consists of facilities with a bed capacity between seven and 15 beds while facilities in the latter category have between one and six beds. Elderly persons suffering from mental retardation or related conditions and unable to benefit from active treatment are provided care in nursing homes (SNF, ICF I and ICF II). As of January, 1986 there were 5,104 large residential facility beds, 183 group home beds, and 669 community home beds approved and licensed to serve those with mental retardation and related conditions. In addition, 125 community home beds and 48 residential facility beds were Section 1122 approved but not yet licensed.

2. Issues

a. There has been an ongoing commitment for over 10 years within the Office of Mental Retardation/Developmental Disabilities to reduce the populations of the large state institutions for the mentally retarded. There exists additional impetus at the national level to encourage the development of community-based ICF/MRs with a corresponding reduction in the population of large residential facilities.

b. Successful development of a variety of community-based programs for the developmentally disabled depends heavily on the existence of a stabilizing center for the coordination of activities and provisions of support and consultation services. The State School with its cadre of professional services provides the most efficient and economical base for a regional system of support services for the developmentally disabled.

3. Bed Need

a. According to 1980 census data, Louisiana had a population of 4,206,313. Projections for 1990 indicate a population of over 4,849,038. A three percent prevalence rate has generally been accepted to estimate the number of individuals with mental retardation existing in the general population. However, recent studies and experiences in Louisiana indicate that a one percent prevalence rate is more realistic. Therefore, a one percent prevalence rate was used to project the number of individuals with mental retardation in Louisiana. Hence, in 1980 it was estimated that there were 42,063 individuals with mental retardation, with a projection of 48,490 mentally retarded individuals in 1990. According to many experts, 70 percent of the mentally retarded individuals fall into the category of mild retardation. Fifteen percent are considered moderately retarded and 15 percent are considered severely and profoundly retarded.

b. The emphasis in bed need has shifted from traditionally large domiciliary care facilities to alternative living arrangements. The 1983-85 Developmental Disabilities State Plan delineated four priority areas to meet needs of developmentally disabled individuals, one of which is the development of alternatives to the large domiciliary care facility. Such alternative living arrangements include adoption homes, substitute family care homes, supervised apartments, and independent living services as well as such residential alternatives as community homes and group homes.

c. Under the subcategory of living arrangements outside of the family home, adoptive homes are needed by some developmentally disabled children whose families cannot or will not care for them any longer. Some who are returning from more restrictive placements and need a family-like living environment can benefit most from such arrangements. These specialized adoptive homes must have professional backup and support, and the adoptive parents should be well trained and able to carry out any in-home training specified in the child's individual habilitation plan (IHP).

d. Substitute family care homes are required for a number of disabled children and some adults who need a stable family-like environment when the natural family can no longer care for them or when the individual is returning from a more restrictive placement. Foster care is preferable when there is a chance that the natural family may accept the child back or permanent placement with a family is not feasible. The foster parents should be trained and under contract to provide any in-home training prescribed in the individual's IHP.

e. A larger proportion of developmentally disabled children and adults require temporary or permanent community home, or group home, living arrangements because they need round-the-clock supervision and intensive programming. These persons may be in need of this alternative if they are removed from the natural family for periods of time, are returning from an institution or are exhibiting severe behavioral problems. This alternative calls for a staff that has been trained in administering intensive programming, and for the availability of professional back-up support.

f. A number of developmentally disabled adults need supervised apartment or independent living alternatives, which usually entail obtaining necessary support services, such as training in independent living, attendant care, homemaker services, and supervision or assistance in locating accessible housing. These community supports are the key to successful independent living for the otherwise self-sufficient developmentally disabled individuals. The staff providing the supervision must have skills in understanding and meeting these service needs.

4. Types of Facilities Needed. In planning for the expansion of ICF/MR services for the mentally retarded and developmentally disabled, the emphasis will be on smaller, community-based facilities distributed throughout the state.

In addition, there is a need for special units or facilities for certain segments of the developmentally disabled population who have special needs because of adaptive difficulties, such as the mentally retarded/emotionally disturbed and the mentally retarded delinquent. In all cases, the facility should be the least restrictive setting for the clients it is designed to serve.

5. Elements of an ICF/MR

a. The following characteristics are required in ICF/MRs. The Office of Mental Retardation/Developmental Disabilities will evaluate proposed new or expanded programs based on these characteristics. In accordance with L. R. S. 28:420, OMR/DD shall approve the program model for the population to be served. Criteria for judging the program model will be based on Title XIX regulations, state licensing requirements and the OMR/DD law.

i. Program Characteristics

(a). Normalization—Care for the developmentally disabled in intermediate care facilities should be provided in a manner which facilitates the individual's training in developmental skills for restoring lost function, acquisition of new skills, or the maintenance of present skills. Therefore, proposals should delineate the manner in which residents will participate in such services as may be specified in their individual habilitation plans. Services must be designed to approximate as nearly as possible the normal patterns of life and conditions of those not developmentally disabled. Through normalization, individuals with disabilities should have available to them the options of everyday life which closely parallel the norms and patterns of the mainstream of society.

(b). Developmental Approach—It has been demonstrated that persons who are developmentally disabled are capable of change and can increase their self-sufficiency when provided with appropriate learning and experimental opportunities. Therefore, services should be offered which are designed to increase the person's ability to cope progressively with more complex situations, increase his/her control over these situations, and help the person live a normal life in the community. Care in such residential settings should be focused through developmental programming.

(c). Least Restrictive Setting—Individuals shall be provided services in ways and settings that are suitable and appropriate to their abilities while least restrictive to their liberties. Generic community resources can be used by most developmentally disabled persons. Specialized services shall be used by the developmentally disabled only when general service programs fail to meet needs appropriately.

(d). Individual Program Planning—Since developmentally disabled persons often have multiple disabilities in a variety of combinations and so are especially vulnerable to neglect, state and federal mandates require that individual program planning be made for each disabled person. The plan shall include: goals toward which a person should be directed; specific activities and services needed to achieve those goals; and evaluation measures to determine and adjust for goal achievement. The plan should cover all services needed by the client/family whether one or several agencies are required to provide all of those services.

(e). Interdisciplinary Program Planning—Diagnosis, evaluation, and individual program planning are best accomplished through a team effort of client, family or significant others, and professionals representing a variety of perspectives and disciplines. The clients and family members are included in the team as active participants in both the planning and decision-making process. The client's individual habilitation plan shall be implemented, followed up, monitored and revised periodically to ensure provision of appropriate quality services.

ii. Facility Characteristics

(a). Facility Types—there are two types of community residential facilities, the group home and the community home. The community home has a bed capacity of six or fewer beds while a group home has a capacity of 15 or fewer beds. ICF/MRs should be as small as possible to provide a home-like environment. Individuals who are severely retarded may be served appropriately in an ICF/MR. Moderately retarded persons with a secondary disability or extreme deficits in adaptive behavior may also be placed in an ICF/MR. In large residential facilities (16 beds and over), individuals of substantially different ages or developmental levels or having special needs, should be housed in small, separate physical units within the facility. Although persons should be provided with ICF/MR placements, services and programs in the region where their families or advocates reside, the individual's habilitative needs should be given priority in considering placement recommendations. Characteristics to be considered in making an ICF/MR placement are adaptive behavior, mobility, physical disability, behavior, medical needs, age range, and level of retardation.

(b). Facility Design—the physical environment should be home-like in terms of furnishings, equipment and availability of privacy. In a large residential facility (16 beds and over) the physical arrangement of the living environment should permit its occupants to be divided into smaller groups (up to 8 persons) in separate living units (apartments, cottages, etc.)

(c). Facility Location—the location of ICF /MRs is important. In order to assure that the location provides maximum support to the facility the following conditions should be present:

(i). the location should be in communities of sufficient size to permit integration of the clients into the community and there should be opportunities for the residents to establish patterns of normal everyday activities;

(ii). the location should provide access to recreational activities, shopping, public education programs, and sheltered workshops;

(iii).the location should be in an area capable of providing the required support services through a

qualified and experienced labor force and in settings outside of the residence to ensure separation of life functions;

(iv). in accordance with L. R.S. 28:478B, there shall be no community home placed within one thousand foot radius of another community home;

(v). the location of the ICF/MR site must be specific and must either be owned by or under an option to be bought, leased, or rented by the provider;

(vi). the capability of the receiving community to support the proposed ICF/MR should be evaluated by the State Office of Mental Retardation/Developmental Disabilities and a written assessment from this office shall be provided to the State Health Planning and Development Agency during project reviews.

iii. Community Support. Providers are encouraged to work with the Office of Mental Retardation/Developmental Disabilities to develop and implement strategies that will foster community acceptance. Prior to the development of a community home, a legal notice shall be published in the local newspaper of the community where the project is to be developed. The notice shall give the proposed site to be used.

iv. Staffing

(a). The following kinds of staff are considered appropriate to various types of ICF/MR programs. A qualified mental retardation professional (QMRP) is a person who has specialized training or one year of experience in treating or working with the developmentally disabled and is one of the following:

(i). Psychologist—Master's degree from an accredited program in psychology. Must have specialized training or one year of experience in treating the developmentally disabled and receive in-service training during the first year of employment in various specialty areas related to the needs of the clients in the facility.

(ii). Educator—Bachelor's degree in education with a minimum of one year of teaching preferred. Must have specialized training or one year of experience in educating the developmentally disabled and receive in-service training during the first year of employment in various specialty areas related to the needs of the clients in the facility.

(iii). Social Worker—Bachelor's or master's degree in social work from an accredited program and one year of experience in direct service with developmental disabilities. A QMRP in social work can also be an individual with a bachelor's degree in a field other than social work with at least three years of social work experience under the supervision of a qualified social worker. Must receive in-service training during the first year of employment in various specialty areas related to the needs of the clients in the facility.

(iv). Physical or Occupational Therapist—Appropriate degree from an accredited program. One year of experience in direct service with developmental disabilities. Must receive in-service training during first year of employment in various specialty areas related to the needs of the clients in the facility.

(v). Speech Pathologist or Audiologist—Degree with license and certification of clinical competence and one year of experience as speech pathologist. Must receive in-service training the first year of employment in various specialty areas related to the needs of the clients in the facility.

(vi). Rehabilitation Counselor—B.S. degree in counseling with one year of experience in counseling and must be certified by the Committee of Rehabilitation Counselor Certification. Must receive in-service training during first year of employment in various specialty areas related to the needs of the clients in the facility.

(vii). Registered Nurse—Licensed with a minimum of one year of experience in nursing. Experience in restorative or rehabilitative nursing preferred. Must receive in-service training during first year of employment in various specialty areas related to the needs of the clients in the facility.

(viii). Therapeutic Recreation Specialist—graduate of accredited program in recreation therapy. One year of experience in therapeutic training required. Must receive in-service training during the first year of employment in various specialty areas related to the needs of the clients in the facility.

[a]. While the administrator of an ICF/MR does not have to be a qualified mental retardation professional, he or she should be qualified in management.

Type of Facility	Staff
Developmental/Medical	Administrator/Program Director (QMRP)
	Registered nurse
	Paraprofessionals
Developmental/Family-Living	Administrator/Program Director (QMRP)
	Trained house-parents or shift staff serving as parent or peer models
Social/Vocational Programs	Administrator/Program Director (QMRP)
	Trained houseparents/shift staff serving as parent or peer models
Developmental/Behavioral Training	Administrator/Program Director (QMRP)
	Psychologist or educator (QMRP) with expertise in behavior modification training
	Houseparents or shift staff with behavior modification experience.

6. Distribution of ICF/MR Beds

a. The incidence of mental retardation does not occur uniformly throughout the population. Causes for mild and moderate retardation (nearly 85 percent of the mentally retarded population) often have socioeconomic implications. Because of the desirability of making client placements which will permit the return of mentally retarded clients to

the community where their families or advocates reside, ICF/MR beds should be distributed in a manner which parallels somewhat the distribution of the mentally retarded population.

b. At present, there is no data available to be used in sketching the actual geographic distribution of persons who are mentally retarded. Until such data is available, bed need projections will be based on prevalence rates and occupancy rates at existing facilities in the region.

7. Quality of Care

a. The following quality control mechanisms are in existence for ICF/MRs.

i. All Section 1122 applications for new or expanded ICF/MR projects are reviewed by the Office of Family Security (OFS) to determine if the proposed developer has had prior experience in the operation of an ICF/MR and, if so, has demonstrated an ability to provide quality care. The applications are reviewed by the Division of Licensing and Certification (DLC) to determine if the project appears in conformity with Title XIX regulations and state licensing laws. The application is reviewed by the Office of Mental Retardation/Developmental Disabilities (OMR/DD) to determine if the most appropriate program components are in place.

ii. All projects are monitored at least twice yearly by Department of Health and Human Resources review teams.

iii. The following Inter-Agency Agreement on Procedures Relative to Quality Assurance in ICF/MRs is to be followed.

(a). The Office of Family Security and Division of Licensing and Certification will forward to Office of Mental Retardation/Developmental Disabilities regional offices a copy of the monitoring reports on each provider, within 30 days.

(b). If deficiencies are identified, OMR/DD will meet with the provider to discuss their corrective action plan. OMR/DD regional offices will follow-up to the providers in writing with an offer of specific technical assistance with a carbon copy to OFS and DLC. OMR/DD regional offices will advise the central office of any technical assistance needs which exceed the resources of the region.

(c). OMR/DD regional offices will keep a record on each provider reflecting deficiencies noted in each monitoring report. The provider's record will also contain references to all technical assistance offered to the provider. Also noted in the record will be the provider's willingness to work with OMR/DD in correcting deficiencies. OFS and DLC will receive carbon copies of all relevant OMR/DD correspondence with providers.

(d). OFS and DLC will reflect in their subsequent monitoring reports the extent to which deficiencies were corrected and the extent to which OMR/DD was contacted for technical assistance. OFS will take appropriate action including sanctions if indicated.

8. Service Area. The service area for a proposed or existing facility is designated as the one of 8 OMR/DD planning regions in which the facility or proposed facility is or will be located.

9. Resource Goals

a. In accordance with the department's policy of least restrictive environment, there is no currently identified need for additional facilities with 16 or more beds. Beds may be transferred from one existing residential facility to another.

b. The bed to population ratio for community and group homes may at no time exceed .36 per 1000 population in each service area. In determining the bed to population ratio for a proposal, Division of Policy, Planning and Evaluation will use population projections for the anticipated opening date (year) of the facility which in no case shall exceed two years from the date the application is declared complete.

c. The occupancy rate for community homes in the service area must be 80 percent or greater in order for another community home to be approved.

d. The occupancy rate for group homes in the service area must be 85 percent or greater in order for another group home to be approved.

e. In determining the occupancy rate, beds used in the calculations are 1122 approved and licensed beds.

f. Community or group homes will be determined to meet the above resource goals where mandated by courts.

g. A distinct part of a publicly supported facility other than an intermediate care facility will be determined to meet the above resource goals provided that the distinct part:

i. meets all requirements for an intermediate care facility;

ii. is an identifiable unit, such as an entire ward or contiguous ward, a wing, floor, or building;

iii. consists of all beds and related facilities in the unit;

iv. houses all recipients for whom Title XIX payments are being claimed; and

v. is clearly identified.

h. Capital costs must not exceed the amount that a cost-conscious buyer would pay.

i. Authorization. Subchapter I, Part 100 of P. L. 98-21 provides a mandate for cost containment pursuant to Section 1122 of the Social Security Act. Utilizing the wording of the Provider's Reimbursement Manual, there is an expectation that the provider seeks to minimize costs and that its actual costs do not exceed what a cost—conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the

absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable.

ii. In an effort to contain capital costs involved in operating ICF/ MR facilities to reasonable levels the following procedure has been designed to establish the maximum amount that a cost conscious buyer would be expected to pay in capital costs.

(a). The Division of Policy, Planning and Evaluation shall, at the beginning of each fiscal year, obtain from the Division of Rate Administration, Office of Management and Finance, statistics on budgeted annual capital costs of newly approved facilities over the previous three year period grouped by urban/rural setting, facility type, facility size, and ownership arrangement.

(b). Reasonable Capital Cost will be computed by generating categories of facilities based on setting, facility type, facility size, and ownership arrangement; computing the mean budgeted capital cost for each category; and adding the value of one standard deviation.

(c). There are two adjustments which are made in the procedure described above for computing reasonable capital cost when warranted by circumstances.

(d). Whenever a category of facilities contains a Department of Housing and Urban Development sponsored facility, the capital cost of that facility will not be considered in computing the mean value for the category.

(e). On those infrequent occasions when an application is received for a facility in a category containing fewer than three values, reasonable capital costs cannot validly be based on the mean and standard deviation. In this circumstance allowable capital costs will be determined in one of two ways, depending on whether the facility and equipment are owned or leased.

(f). In the case of owned property and building, allowable capital costs shall be based on fair market value, including conversion costs and development costs, provided that the nature and size of the building and property are consistent with the nature of the programs to be provided. In the event that the fair market value is not known, it shall be established as the competitive market value. In the event that neither of these values can be determined, fair market value shall be estimated in consultation with an appropriate vendor other than one utilized by the applicant. These three values will be applied in the same sequence to establish the allowable cost of equipment.

(g). In the case of leased facilities and equipment in a category containing fewer than three values, reasonable cost shall be established as 16 percent of the fair market value plus an inflation factor (see definitions). When the lease is for land and/or buildings, an additional 11% of annual rent shall be added to cover vacancy time and property management and an amount equal to conversion costs amortized over the term of the lease shall be added. In the event that there is a lease for furnishings, equipment or chattel properly considered a capital expense item, the amount of the lease shall be averaged over its term to arrive at the amount to be budgeted as a capital cost.

iii. Section 1122 certification shall be for actual capital costs only up to the reasonable cost limit unless the provider can provide clear evidence that higher costs cannot be avoided.

iv. An applicant whose capital costs exceed the reasonable capital cost limit is not limited in the kinds and amounts of evidence which he may present to prove the higher costs cannot be avoided. However, the following types of evidence shall be considered clear evidence" when they support the applicant's claim.

(a). Documentation of special or unique program features that demand costly equipment, specially designed features of physical plant, expanded grounds, or other requirements that will drive capital costs up.

(b). Construction industry recognition that construction costs in the geographic location of the applicant facility are significantly higher than in other areas of the state, such as the *Locality Adjustments of the Dodge Construction Systems Costs*.

v. In carrying out the above procedure, the following definitions shall apply:

(a). *Appropriate Vendor*—is a vendor who sells property or equipment similar to that for which fair market value is being determined.

(b). *Capital Cost*—for the purpose of generating the annual mean, is that portion of the basic support component comprised of costs associated with buildings, land and equipment. More specifically it includes:

(i). in the case of proprietor owned facilities and equipment: depreciation, debt service, and property tax plus any amount of these cost elements associated with a central office that has been allocated to the facility's budget; and

(ii). in the case of leased facilities and equipment: lease amount plus any amount of capital cost elements associated with a central office that has been allocated to the facility's budget.

(c). *Facility Size*—is determined by the number of beds and consists of two categories, those with six beds or less and those with more than six beds.

(d). *Facility Type*—consists of two classifications, those that accommodate nonambulatory residents and those limited to ambulatory residents.

(e). *Inflation Factor*—applies in lease arrangements only and consists of a 5 percent annual increase in rental rate averaged over the lease term. Thus, for a three year lease it would amount to 10 percent/3 years 3.33 percent.

(f). *Ownership Arrangement*—consists of three categories, owned, leased and mixed. The mixed category consists of those facilities in which some of the property and

equipment is leased and some is owned, provided that neither owned nor leased amounts of annual capital costs shall be in an amount less than $100.

(g). *Urban/Rural*—an urban location is any location within one of Louisiana's Metropolitan Statistical Areas. Any other location shall be considered rural.

AUTHORITY NOTE: Promulgated in accordance with P. L. 93-641 as amended by P. L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11525. Ambulatory Surgery

A. Description

1. Ambulatory surgery is elective minor surgery for pre-examined and diagnosed low-risk patients. Ambulatory surgery is limited to excisional, incisional, or repair procedures which require local, regional, or general anesthesia followed by at least an hour of professional post operative observation, but do not require overnight inpatient care. It does not include procedures which can be safely and efficiently performed in a doctor's office or a clinic, or cases normally handled in the emergency room. It has been estimated that over 40 percent of all hospital operations could be performed on a same-day basis, saving the national health care delivery system between ten and fifteen billion dollars annually.

2. Some of the advantages of ambulatory surgery are reduced costs, more effective use of physicians' time, greater bed availability, and earlier return to work. Additionally, studies have shown that ambulatory surgery creates less psychological stress and less physical isolation for patients than inpatient hospital surgery. Because of the short stay, there is less exposure of the patient to hospital-acquired infections, and less need for pre-operative and post-operative medication.

3. For Section 1122 purposes, an ambulatory surgery facility is a facility, not a part of a hospital, which provides surgical treatment to patients not requiring hospitalization. The term does not include offices of private physicians or dentists, whether for individual or group practice. Ambulatory surgery facilities can be either hospital-based or free-standing. Hospital-based ambulatory surgery facilities are distinguished from same day surgery services provided in hospitals in that hospital-based ambulatory surgery facilities are used solely for ambulatory surgery and are licensed as hospital-based ambulatory surgery facilities.

B. Cost/Payment

1. Medicare and Medicaid provide payment for hospital-based ambulatory surgery, and for ambulatory surgery performed in free-standing facilities, if the services are medically necessary and the facility meets state and federal regulations. Blue Cross and most other hospitalization insurance programs reimburse for ambulatory surgery based on what is covered in the individual subscriber's contract. Generally, the procedure must be a medically necessary service which cannot be performed in a physician's office. Depending on the terms of coverage, hospitalization insurance programs can serve to promote or reduce the incidence of ambulatory surgery. Most health insurance programs, both public and private, recognize the potential savings offered by ambulatory surgery, and some policies offer financial incentives which promote ambulatory surgery. For example, Medicare does not pay for certain procedures unless they are performed on an outpatient basis, and some private insurance companies offer 100% coverage for ambulatory surgery.

2. One of the major advantages of ambulatory surgery over inpatient surgery is the cost savings. However, a proliferation of underutilized ambulatory surgery facilities is undersirable as an alternative to inpatient surgery. Optimal utilization of each ambulatory surgery facility should take into account the following factors:

a. number of operating rooms available for ambulatory surgery;

b. maximum number of surgical procedures to be performed per operating room per workday;

c. annual number of days available for ambulatory surgery;

d. average length of time per operation;

e. recovery room capacity.

3. There are two voluntary accreditation organizations for ambulatory surgery facilities, the Joint Commission on Accreditation of Hospitals (JCAH) and the Accreditation Association for Ambulatory Health Care (AAAHC).

C. Service Area. The service area for ambulatory surgery facilities is the health planning district in which the facility (or proposed facility) is located.

D. Resource Goals

1. Dedicated ambulatory surgery facilities should perform a minimum of 5 surgeries per operating room per workday (250 days per year). For new dedicated ambulatory surgery facilities, projections should be based on physician's estimates of procedures to be performed in the facility; for existing dedicated ambulatory surgery facilities proposing expansion, projections should be based on and documented by actual utilization data and reasonable estimates of future utilization. The applicant must demonstrate that the existing facility performs a minimum of five procedures per operating room per workday, and will maintain the minimum standard with the proposed additional operating rooms.

2. Ambulatory surgery facilities should be no more than 10 road miles from an acute care general hospital.

3. An applicant proposing to construct a new ambulatory surgery facility or proposing major renovations for the provision of ambulatory surgery must propose to build/renovate no fewer than two operating rooms.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finances, LR 13:246 (April 1987).

§11527. Preventive Health

A. Definition/Description

1. Traditional definitions of health prevention are divided into three levels of activity: those which prevent the occurrence of disease or illness, those which intervene after disease is detected but before it is symptomatic, and those which prevent the progression of symptomatic disease or illness. Because there is lack of agreement among professionals about a clear definition of health prevention, an accurate and complete inventory of preventive health programs cannot be compiled. Another reason for the difficulty in assessing the scope of health prevention activities is that health-related and prevention-related activities are frequently subsumed under other functions (e.g. defense, security, natural resources, environment). Programs and activities in areas traditionally regarded as preventive include, but are not limited to, the following:

a. health education/information/research (human sexualtiy, contraceptive use, excercise, stress, behavioral problems);

b. direct preventive health services (family planning, immunization);

c. nutrition;

d. environmental protection;

e. occupational health and safety;

f. transportation safety;

g. home safety codes and standards;

h. recreational safety;

i. consumer product quality and safety (food, drugs, cosmetics, appliances, alcohol, tobacco, firearms, motor vehicles);

j. fire prevention.

2. There is strong consensus among various professionals and agencies concerning the need for and value of preventive health measures, because it has been proven that prevention reduces morbidity and mortality, improves the quality of life, and is cost-effective.

B. Relationship to Health Promotion and Health Protection

1. Health, because of its pervasive and illusive nature, has been defined by the World Health Organization in terms of its outcome: a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity. This operational definition of wellness implies a balance of health promotion, health protection, and health prevention.

2. Of these three areas, health promotion is the most recent, and the least developed. Wellness and lifestyle programs directed toward health promotion require parallel development of risk, behavior, and intervention measures. Health promotion is an integral part of preventive health, and is addressed separately in this document. Health promotion was selected as one of the State Health Plan priority needs areas for 1982-87, in a statewide survey.

3. Health protection activities include regulation and enforcement, voluntary adherence to standards, infectious disease control, and surveillance and monitoring. These activities are dominant in the area of prevention, as they are intended to reduce exposure to a number of sources of hazards related to air, water, food, drugs, motor vehicles, and firearms; they cannot be isolated from health promotion and health prevention, and they often overlap.

4. Preventive health activities include an extensive array of procedures and services, provided to the individual by medical providers and other practitioners, which are designed to prevent disease or arrest its development. Examples of services are immunizations, screening tests, contraception, health and patient education, and counseling. For preventive strategies to be effective, activities must be targeted to and tailored to fir different settings (e.g. school, worksite, home, medical treatment setting, and community).

C. Scope

1. It is generally agreed that preventable health problems fall into three general areas of concern, for causes of morbidity and/or mortality: environment, lifestyle, and medical services.

2. Environmental factors are related to the influences and surroundings of home, work, and recreation. These settings or sources of external hazards increase the risk of health problems. Examples of the influences are food, water, transportation, pollution, consumer safety, occupational hazards, and communicable disease.

3. Lifestyle is the most difficult category in which to achieve results. Lifestyle is relative to an individual's personal behavior patterns, such as use of drugs, alcohol, and tobacco, nutrition, and physical fitness.

4. The area of medical services includes factors which influence health by preventing or treating disease or disability. Examples of preventive services (which can appear in a variety of settings) are immunization, genetic counseling, rehabilitation, dental services, early detection and treatment of chronic diseases, emergency services, family planning, prenatal and perinatal care.

D. Responsibility

1. The concept of health prevention concerns and interests everyone, but has no focus of responsibility. Ideally, prevention should become the prevailing element in medical care, with health maintenance, rather than cure, as the primary aim. Personal health care has been, and still is, essentially a complaint-response system, which is insufficient for complete health care. To change the emphasis from treatment of illness to promotion of wellness, a reorientation of medical practice and medical education is necessary.

2. Clarifying the requirements of a preventive lifestyle is the responsibility of various professions concerned with physical and mental health. However, preparing and convincing people to behave in healthful and safe ways is largely an educational responsibility. Through education, the largest possible number of individuals can conceivably learn to protect their own health. Preventive education of the general public and of the health professions is most effective when may agencies, institutions, businesses, and industries participate, although the schools have the overrall responsibility. Schools and pre-schools provide an effective setting for screening, diagnosis, counseling, basic health and nutrition education, dental health, accident prevention, mental health, and risk identification.

3. Participation of those being served is a key factor in preventive health; individuals must accept primary responsibility for their own health, instead of depending on physicians and other practitioners in the health care system. The ultimate responsibility for restoring, maintaining, and protecting optimal function lies with the individual. The intent of prevention is to return control for healthful and safe living to the individual.

E. Resource Goals

1. The goal of any prevention strategy is reduced disease and improved health. It is not feasible to quantify goals for prevention, or to mention every possible goal, due to the vast inter-disciplinary and interagency nature of preventive health. The following resource goals, although general, are intended to serve as initiatives in addressing the high priority problems in the state, and to contribute to enhanced physical and emotional well-being. The figures provided represent the most recent information available.

a. A population more aware of an actively seeking improved nutritional status and physical well-being through proper diet and exercise.

i. It is estimated that 1/3 of pre-school children in Louisiana do not receive recommended daily amounts of essential vitamins.

b. A population more aware of family planning principles, taking responsibility for preventing unwanted pregnancy, planning family size and spacing births, and considering age and health of parent:

i. Improved access to high quality fertility and contraceptive services, improved outreach and educational programs;

(a). in 1980, there were 234.3 illegitimate births per 1,000 live births in Louisiana;

(b). over 1/5 of the births in Louisiana each year are to girls aged 19 or younger.

c. Reduced incidence of morbidity and mortality associated with pregnancy and the neonatal and perinatal period, through increased awareness and availability of services:

i. in Louisiana, the percentage of low birthweight infants was 8.67 percent in 1979;

ii. Louisiana's infant mortality rate was 18.5 percent higher than the national average in 1979.

d. Reduced incidence of alcohol and drug abuse, and cigarette smoking, through increased awareness of the population of the harmful effects leading to morbidity and mortality:

i. it is estimated that there are 84,000 alcoholics in Louisiana;

ii. there were 27.8 deaths per 100,000 population in Louisiana with drug/alcohol related causes in 1979.

e. Reduced incidence of communicable disease:

i. increased immunization levels, through exposure in educational and informational services;

(a). 6 percent of all school age children in Louisiana are not current with their immunizations;

ii. control of sexually transmitted disease, through educational and information services, and early screening and diagnosis;

(a). Louisiana accounts for 2 percent of the cases of gonerrhea reported in the United States; 30 percent of the cases in Louisiana in 1977 were attributed to persons 0-19 years old; Louisiana has the second highest syphilis rate in the United States;

f. reduced incidence of chronic disease, with control through early screening, detection, and evaluation, and successful intervention when possible;

(a). reduced incidence and increased control of diabetes, respiratory disease, cardiovascular and hypertensive disease, due to changes in lifestyle and avoidance of known risk factors, and proper use of medical treatment;

(i). heart disease is the leading cause of death in Louisiana;

g. increased public and professional awareness of factors conducive to cancer and respiratory disease, and heightened efforts to remove or modify harmful environmental factors or modify personal habits;

i. Louisiana's age-adjusted death rate for cancer was 10 percent higher than the national rate in 1975;

h. A population increasingly aware of practical methods to avoid safety hazards and accidents in the home, workplace, and on the highway;

i. Louisiana ranks fourth in the nation in deaths caused by motor vehicle accidents;

i. A population increasingly aware of the need to preserve, protect, and improve the quality of the environment.

j. Increased public awareness of early symptoms of mental health and behavioral problems and knowledge of health system resources for early treatment.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R. S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11529. Comprehensive Physical Rehabilitation Facilities (Inpatient)

A. Definition. In general, rehabilitation is the process of restoring disabled persons to the fullest degree of physical, mental, social, vocational, and economic usefulness of which they are capable. Within this context, Comprehensive Physical Rehabilitation Facilities, (CPRF's) are medical facilities which emphasize physical restoration activities for patients with physiologically based disease and disabilities. These facilities are either freestanding or a component of a general hospital. They provide a comprehensive, integrated rehabilitation program of medical, psychological, social, and vocational services, using a multi-disciplinary approach, centered on the patient.

B. Scope of Services

1. Services provided by CPRF's vary in nature and intensity according to the degree of disability and the general condition of the patient. The combination of services provided is designed to meet the individual patient's needs. CPRF's provide or arrange for such services as medical services, rehabilitation, nursing services, occupational therapy, physical therapy, speech therapy, audiology, social services, psychological services, vocational services, prosthetic and orthotic services. The services may be provided directly by staff members or through consultation or affiliation agreements.

2. Comprehensive physical rehabilitation facilities may be highly specialized, and treat only selected conditions or age groups, or treat all or various types of disabilities. Many CPRF's also provide outpatient and/ or follow up care for patients they have rehabilitated. Some of the conditions treated within CPRF's are hemiplegia, paraplegia, quadriplegia, cerebral palsy, multiple sclerosis, amputations, arthritis, cervical/lower back pain syndrom, emphysema, stroke, and hip fracture. The conditions vary greatly, in that some primarily affect certain age groups, some result from accidents, some result from acute diseases, and some are chronic.

C. Coordination of Services

1. The team approach provides comprehensive care within the CPRF by involving different rehabilitation professionals in evaluating and treating the patient. Some experts believe that a physician, preferably a physiatrist, should manage the team, while others believe that a program coordinator may be a physician or another team member. The second option allows team members to serve in different roles on different patients' team. Decisions should be made by each CPRF, based on staffing and affiliation arrangements, staff size, and types and volume of patients.

D. Cost

1. Payment sources for services in comprehensive physical rehabilitation facility are Medicare, Medicaid, Blue Cross and private insurers, selfpaying patients, and charitable organizations. Although the cost of rehabilitation is high, studies have shown that CPRF services, when delivered to appropriate candidates, are cost effective. For example, stroke victims, who would otherwise have been placed in nursing homes, where rehabilitated (in 1977) for an average of $7,000 per patient; the cost of the institutional care would have been from $18,000 to $36,000 per patient per year. In these and many other cases, the cost of intensive short term rehabilitation care is less than the expense of long term maintenance care.

E. Setting/Accessibility

1. Questions have been raised regarding the most appropriate setting for CPRF's. Although there are proponents for both free-standing and hospital-based CPRF's, the appropriateness varies with the availability of specialized personnel, the location of the CPRF's and other health care facilities, and the patient's condition. It is generally agreed that all CPRF's should have working relationships with other segments of the health care system because rehabilitation should begin as soon as possible in the course of an illness. Free-standing CPRF's are usually affiliated with acute care institutions.

2. Availability and planning for CPRF services on a regional basis would serve to reduce costs and to promote the most effective rehabilitation, since utilization of rehabilitation services depends heavily on the spatial and temporal accessibility to the target population. Therefore, the bed need for rehabilitation hospitals or rehabilitation units in general hospitals is determined on a health planning district basis.

F. Service Area

1. The service area for all comprehensive physical rehabilitation beds is the health planning district in which the facility or proposed facility is located.

G. Resource Goals

1. The rehabilitation bed supply should be less than .325 beds per 1,000 population.

a. The methodology for establishing the bed to population ratio for rehabilitation beds is the methodology is based on the Orange County (California) Health Systems Plan published in 1981. The methodology utilizes an incidence-prevalence projection of the numbers of Louisiana citizens who would have one or more of the disabling conditions most commonly treated in a rehabilitation hospital. The formula also includes a percentage estimate of the patients who would actually seek treatment in a rehabilitation hospital.

b. In determining the bed to population ratio for the proposed or existing facility, Division of Policy, Planning and Evaluation will use population projections for the anticipated opening date (year) of the facility, which in no case shall exceed five years subsequent to the year in which the application is declared complete.

c. In determining bed supply, beds which are counted are (1) licensed but not Section 1122 approved beds which are in use or could be put into use within 24 hours*, (2) 1122 approved and licensed beds which are in use or could be put into use within 24 hours*, and (3) 1122 approved beds which are not yet licensed.

2. Occupancy Rate

a. Free-standing Comprehensive Physical Rehabilitation Hospitals

i. A comprehensive physical rehabilitation hospital shall maintain annual occupancy rates relative to the number of beds in the facility:

0— 49-50%
50— 99-60%
100-199-70%
200 + —75%

ii. In determining occupancy rates, beds used in the calculations include: (a.) licensed but not Section 1122 approved beds which are in use or could be put into use within 24 hours, and (b.) 1122 approved and licensed beds which are in use or could be put into use within 24 hours.

iii. *Beds that can be brought into service within 24 hours shall be construed to mean the appropriate number of beds in rooms originally constructed and equipped as hospital rooms that either (1) have not been converted to other uses, or (2) retain all essential nonmobable equipment and connections necessary for patient care in accordance with licensing standards. Nonmovable equipment shall include equipment which can be removed only through reconstruction or renovation.

iv. For any additional comprehensive rehabilitation beds to be approved:

(a). The bed to population ratio shall not exceed .325 per 1000 population and

(b). Either optimal occupancy must be reached by all freestanding comprehensive physical rehabilitation; hospitals in all bed size categories or a 75 percent occupancy of all rehabilitation hospitals in the health planning district must be attained.

H. Rehabilitation Unit of a General Hospital

1. A rehabilitation unit of general hospital shall maintain annual occupancy rates relative to the number of beds in the facility:

0— 49-50%
50— 99-60%
100-199-70%
200 + —75%

2. In determining occupancy rates, beds used in the calculations include:

i. licensed but not Section 1122 approved beds which are in use or could be put into use within 24 hours; and

ii. 1122 approved and licensed beds which are in use or could be put into use within 24 hours.

3. *Beds that can be brought into service within 24 hours shall be construed to mean the appropriate number of beds in rooms originally constructed and equipped as hospital rooms that either (1) have not been converted to other uses, or (2) retain all essential nonmovable equipment and connections necessary for patient care in accordance with licensing standards. Nonmovable equipment shall include equipment which can be removed only through reconstruction or renovation.

4. For any additional comprehensive rehabilitation beds of a general hospital to be approved:

a. the bed to population ration shall not exceed .325 per 1000 population; and

b. either optimal occupancy must be reached by all rehabilitation units of general hospitals in all bed size categories or a 75 percent occupancy of all rehabilitation units of all general hospital in the health planning district must be attained;

c. Adjustment. An existing rehabilitation hospital or rehabilitation unit of a general hospital which has operated at a level of 10 percent or more above its optimal occupancy, as determined by bed size category, for a period of 12 consecutive months will be allowed to add a number of beds that would bring its occupancy down to the optimal down to the optimal occupancy level for its bed size. The occupancy rate for the 12 consecutive months shall be determined by Division of Policy, Planning and Evaluation from the four most recent quarters of data due to have been reported by the hospital to the Division of Licensing and Certification;

d. a proposal to provide rehabilitation services as described herein shall indicate that the facility will meet licensing requirements and Medicare certification criteria as a hospital;

e. the proposal shall indicate that the hospital or rehabilitation unit of a general hospital will meet the following criteria:

i. At least 75 percent of the inpatient population will require intensive rehabilitative services for treatment of one or more of the following conditions:

(a). stroke;

(b). spinal cord injury;

(c). congenital deformity;

(d). amputation;

(e). major multiple trauma;

(f). fracture of femur (hip fracture);

(g). brain injury;

(h). Polyarthritis, including rheumatoid arthritis;

(i). Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease; and

(j) burns.

ii. A preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program or assessment.

iii. The facility will furnish through the use of qualified personnel, close medical supervision, rehabilitation nursing, physical therapy, speech therapy, occupational therapy, orthotic and prosthetic services, and social services or psychological services.

iv. The facility shall employ a full time director of rehabilitation who is a doctor of Medicine or Osteopathy, is licensed under state law to practice medicine or surgery, and has had, after completing a 1-year hospital internship, at least 1 year of training in the medical management of patients requiring rehabilitation services, or is board-certified in physiatry, neurology, neurosurgery, orthopedic surgery or rheumatology.

v. The facility shall have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.

vi. The facility shall use a coordinated multidisciplinary team approach to the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences to determine the appropriateness of treatment will be held at least every 2 weeks.

5. A rehabilitation unit of a general hospital must present a proposal indicating it will meet the following criteria:

a. written admission criteria must apply uniformly to both Medicare and non-Medicare patients;

b. the unit must have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily retrievable. The unit's policies must provide that necessary clinical information will be transferred to the unit when a patient of the hospital is admitted to the unit;

c. the hospital's utilization review plan must include separate standards for the type of care offered by the unit;

d. the beds assigned to the unit must be physically separate from (i.e. not commingled with) beds not included in the unit;

e. the unit and the hospital in which it is located must be services by the same fiscal intermediary;

f. the unit must be treated as a separate cost center for cost finding and apportionment purposes;

g. the accounting system of the hospital in which the unit is located must provide for the proper allocation of costs and maintain statistical data that are adequate to support the basis of allocation;

h. the cost report for the hospital must include the costs of the unit, must cover a single fiscal period and must reflect a single method of cost apportionment.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P. L. 96-79, and R. S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance LR 13:246 (April 1987).

§11531. Home Health Services

A. Definition/Description

1. Home health care is that component of comprehensive health care in which health services are provided to individuals and families in their places of residence for purpose of restoring health or maximizing the level of independence, while minimizing the effects of disability and illness, including terminal illness. Services appropriate to the needs of the individual patient and family are planned, coordinated, and made available by public or private providers organized for the delivery of home health care through the use of employed staff, contractual arrangements, or a combination of the two patterns.

2. Health services provided include, but are not limited to, the following:

a. skilled nursing respiratory therapy

b. home health aide occupational therapy

c. speech therapy and audiology medical social work

d. physical therapy medical supplies

e. nutrition durable medical equipment

3. The home health agency providing medical services maintains a plan for home health services for each patient in conformance with the patient's plan of treatment as prescribed by his/her physician. Such agencies provide care to patients with a wide range of diagnoses and at all levels of dependence, including those completely bed-ridden and those needing to be fed. Persons or groups in need of home health services include elderly persons whose activities are limited by physical and/or mental deterioration; persons who recuperating from a wide range of acute medical problems such as injuries, infections, diseases, and complications of pregnancy.

B. Advantages

1. Home health care provides an increased range of options for the provider, the community and the individual. Services are focused on the individual in need of care, rather than on groups, allowing for economy in the use of

professional and other staff. The largest expenditure in home health care is for personal care and supportive services.

2. Studies have shown that patients generally respond more rapidly and fully to care in the home. At a lower cost than a hospitalization, the home health patient generally has an improved outcome in terms of early discharge from care; is less often institutionalized; and has increased contentment, improved mental functioning and increased social activity.

C. Alternatives to Institutionalization

1. A health care system should provide an array of services which provide care without institutionalization, and which match an individual's needs to the appropriate service available. Some of the possible alternatives to institutionalization are adult day care centers, subsidized housing complexes with health services, homemakers, and home health services. There is convincing evidence that such services may not only postpone but often prevent more costly institutionalization.

2. Care at home, through a home health agency, is the most desirable alternative and should be considered first. It should be noted, however, that home care is not a viable alternative to institutionalization for all patients. The environment at home may be inappropriate, the family may be unable to handle the responsibility, or the patient may not have a family. Some patients require the sheltered support of an institution. In the natural order of things, however, institutionalization should be an alternative to home health care.

D. Act 347 of the 1984 Regular Session of the Legislature. Act 347 amends and reenacts R.S. 40:2009.34 relative to home health care agencies, to require the Secretary of the Department of Health and Human Resources to promulgate rules to require approval by the agency responsible for the implementation of Section 1122 of the Social Security Act as a condition for licensure. Such approval will be required for the first licensing of all home health agencies not in existence as of April 20, 1985.

E. Utilization.

1. The benefits of home health care over institutional care have been documented in preceding paragraphs; however, underutilization of home health agencies can lead to lower quality of care and a proliferation of underutilized agencies is undersirable as an alternative to institutionalization. Optimal utilization of each home health agency should take into account the following factors:

a. the number of direct service staff available to provide home health services;

b. the number of home health visits/services which can be delivered by each direct service staff member per day;

c. the number of days available for the provision of such services;

d. the average length of time used for each visit.

F. Area of Analysis. The area of analysis for home health agencies is defined as the health planning district in which the agency or proposed agency is located.

G. Resource Goals

1. Applicant shall project a caseload of 30 patients or more, and shall provide a list of practicing physicians with referral agreements with the proposed agency.

2. Home health services shall be available at least 8 hours a day 5 days a week and shall be available on an emergency basis 24 hours a day 7 days a week. Home health services shall be available to an individual in need within 1-3 days, contingent upon the patient's condition and the physician's recommendation.

3. A proposal to provide home health services shall indicate that the proposed agency will meet licensing requirements and Medicare certification criteria. Applicants seeking private payor only funds are exempt from meeting Medicare certification criteria.

H. The Department of Health and Human Resources, Division of Licensing and Certification, shall deny licensure to any home health agency which does not receive a favorable recommendation from the department's Division of Policy, Planning and Evaluation as a result of the applicant's failing to meet the criteria stated in the Resource Goals and the General Criteria for Need Certification Reviews.

I. Should the party seeking licensure desired to appeal, he must respond in writing to the Division of Licensing and Certification not more than 30 days after the date for notification of non-licensure in order to request a fair hearing or he forfeits his right of appeal. The hearing shall conform to rules set forth in the Louisiana Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11533. Magnetic Resonance Imaging

A. Definition/Description

1. Magnetic resonance imaging (MRI), also referred to as Nuclear magnetic resonance, is a diagnostic technique that employs magnetic and radio frequency fields to image body tissue and monitor body chemistry noninvasively. The basic principle of this modality involves the magnetizing of the hydrogen nuclei of the body which then become aligned, while spinning, in the direction of the magnetic field. A variable wobble is produced in the nuclei spin by a pulsating radio frequency current directed at a 90 degree angle to the magnetic field. The small voltage of a resulting electrical current is detected by a surface coil receiver and relayed to a computer for analysis.

2. Although different in principle there is some similarity between magnetic resonance imaging and computer assisted tomography (CT). These similarities are

associated with the purposes, uses, and output of the two modalities. Both are diagnostic modalities. Both are imaging devices capable of soft tissue scanning, although each demonstrates advantages specific to certain tissues, organs, and lesions. Finally, both produce cross-sectional images. Because of these similarities there is some overlap in capabilities of the two and the extent of this overlap appears to be increasing as magnetic resonance imaging becomes more refined. This has led to some speculation that MRI may supplant CT in the future.

3. However, there also exist some fundamental differences between the modalities. Among these differences are the facts that 1) MRI is not a radiation-based technology, 2) MRI has no moving parts, 3) parameters measured by MRI relate to tissue chemistry and 4) MRI is superior in lesion detection while CT provides greater anatomical information.

4. In applying planning strategies in the area of magnetic resonance imaging, there are several critical definitions which must be established. These are:

a. *MRI Procedure or Scan* is one discrete MRI study of one patient in one visit regardless of the number of tissues, organs or lesions examined in that one study.

b. *MRI Unit* is considered to be all of the essential equipment and facilities necessary to operate one MRI suite.

c. *Service Area* is defined as the health planning district in which the MRI is or will be located.

B. Use

1. MRI has been used in chemical analysis for some 30 years. Medical application has a much shorter history and the potential of the technique in this field has not been fully realized. An examination of its use, then, must distinguish between those applications which have been demonstrated to be efficacious and those which seem to have the potential to become efficacious. Addressing the first category, MRI, as an imaging device, has been demonstrated to be superior for scanning selected body parts such as the brain, brain stem, and spinal cord. MRI has the capability of providing better differentiation of gray and white matter than does CT scanning. Contributing to this capability is the fact that the Min image is unobstructed by bone. This property makes it particularly useful for head scans and, thus, for assessing neurological disease. This property also gives MRI an advantage over other imaging techniques in certain spinal cord and back injury cases including disc disease. A final property of MRI that bears mentioning in respect to its demonstrated clinical applications is its ability to image along the sagittal plane as well as the coronal and oblique planes. CT scanners do not enjoy this versatility, although their computer programs can reformat data to provide a sagittal view.

2. Moving to the category of potential uses of MRI, those receiving the greatest attention are related to the modality's capacity to analyze biochemical states. It is felt that, with additional research, it should become possible to distinguish between healthy and malignant tissues and to monitor chemical changes during therapy. Other potential applications include the detection of metastasis, measurement of blood flow rates from various organs, diagnosis of liver and kidney disease, determination of rejection of transplants and non-invasive heart studies.

C. Issues

1. Perhaps reflective of the relative recency of MRI's medical applications, there are a number of issues involved in its use. One of the more prominent categories of these issues consists of those related to safety and risks.

2. Because of the noninvasive quality of the modality, some feel that risks may be minimal. However, this quality is not an unmitigated asset, as it results in the technology falling outside the authority of such regulatory bodies as the Nuclear Energy Division of the Nuclear Regulatory Commission.

3. The Food and Drug Administration has the responsibility of determining whether an MRI device presents serious risks or a potential for serious risk to the health, safety or welfare of a subject. This agency has classified MRI as a Class III device, subject to the greatest degree of control. Formal premarket approval for each model is required prior to its being marketed in order to assure its safety and effectiveness. A number of safety issues escape this mechanism of protection, however. As examples, the magnetic field may interfere with cardiac pacemakers and produce movement of ferromagnetic aneurysm clips and heart valves which attempt to align with the magnetic field much as a compass needle does. It is also possible that the attraction of the magnetic field for metal objects such as hemostats, scissors, wrenches, and knives may be so strong that they may become dangerous projectiles as they move through the field. Additionally, the magnetic field may induce electrical currents within the body of the subject. Some risk may also be attributable to the radio-frequency field which, in the case of subjects with large ferrometal prostheses, may cause an elevation in temperature, and empirical evidence suggests that the testes and the lens of the eye may be particularly vulnerable to adverse effects.

4. Issues related to costs constitute another category. These issues include the large initial cost both of the device and the unit. Related issues, however, must include the extent to which such an investment in new technology should be condoned when there is existing technology that can provide many of the same functions; whether the technology should be considered a regional rather than a facility resource; and how the cost is to be reimbursed, especially prior to the time that the modality is declared safe and effective in the diagnosis and treatment of patients. Also related to cost, is the possibility that when MRI receives the approval of the Food and Drug Administration, the approval will probably be for specific clinical applications, thus raising the question of whether these limited procedures will generate enough volume to warrant the establishment of MRI units for clinical, nonresearch purposes in all types of hospitals.

D. Costs

1. The actual costs of MRI units are considerable and vary according to unique considerations. The most critical cost factor is the type of magnet purchased, with quoted costs ranging from $1 million to $1.7 million. Added to this are site preparation costs which may range from $300,000 to $1 million, again, depending partly on the type of magnet selected as well as the nature of the renovation or construction required. These several values suggest that the start-up costs for an MRI unit should not exceed $2.7 million. However, it is not uncommon for actual costs to exceed this amount. Operating costs can be expected to vary from $220,000 to $400,000 per year and the cost per procedure is projected to be around $500.

E. Resource Goals

1. The applicant shall document a projection of an annual utilization of at least 2,000 MRI procedures.

2. Demographics, patient referral patterns, patient accessibility and relationships with existing providers and facilities within the proposed primary service area are important determinants for MRI site selection.

a. A written plan specifically addressing MRI referrals must be presented with the application, in which it is established that the applicant is committed to accept appropriate referrals from other local providers and to provide feedback of patient information to the referring physician and facility.

b. The above documentation must establish that patients will be prioritized according to standards of need and appropriateness rather than source of referral.

3. Proposed MRI units must be located in facilities which have, either in-house or through formal referral arrangements, the resources necessary to treat most of the conditions diagnosed or confirmed by MRI. The following medical specialties must be available during normal working hours on-site, or by formal referral arrangements: neurology, neurosurgery, oncology and cardiology.

4. Applicants must demonstrate proposed staffing patterns appropriate to the nature of the unit. All units must be staffed by: a diagnostic radiologist familiar with a range of imaging techniques, who must have a background in MRI; a physicist knowledgable in the operational parameters of MRI systems; technicians trained in MRI procedures; and a medical statistician or data base manager. Units to be used for experimental research must also be staffed by specialists in the particular field of experimentation.

5. Applicants must demonstrate adequate safety precautions and these must include: documentation that the proposed model has been approved by the Food and Drug Administration as a class I, class II or class III device under 21 USC 360c-k; itemized safety precautions including screening of at-risk patients, metal detection, and emergency procedures; assurance that all safety recommendations of the manufacturer of the MRI unit will be complied with; a safety manual; and a plan for inservice training. Utilization must be subject to adequate peer review.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11535. Acquired Immunodeficiency Syndrome

A. Health Care for Persons with Acquired Immunodeficiency Syndrome

1. It is recognized that certain factors may limit accessibility of health care facility beds to persons who have been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or even persons who have tested positive for evidence of the virus (HIV) in the body. Many times persons must remain in a hospital for a significant number of days at $450-$800 per day because of the inaccessibility of nursing home care. Sixty percent of the cases documented to date are from Orleans Parish. For these reasons, a need exists for 100 beds which may be approved to care for these patients, not necessarily in the same facility. The Section 1122 approval process will consider the following priorities:

a. using existing beds in several health care facilities (acute or long term care) which can be converted to meet the standards for this care;

b. converting an entire existing facility to provide care for these patients; or

c. developing a new facility for this use.

2. Current estimates predict uninterrupted growth in the size of the AIDS population since no effective medical intervention exists. Each 12-14 months the total number of cases doubles. Since 1981, when these cases were first officially counted, there have been 419 diagnosed AIDS cases and 65 percent of 1988, an additional 400 or more new cases are expected to develop.

a. Of the new cases, some patients will experience fulminate disease resulting in early death, while others may remain relatively well or in need of episodic care with some periods of relative wellness. Others will survive hospitalization and will experience a partial recovery, but will need varying levels of nursing or personal care. It is estimated that 3540 percent for these new patients (140-160) will need institutional care at some time. With the addition of some of the AIDS patients still living from the cases occurring before FY 1988 (currently approximately 147), the significance of appropriate planning and providing for health care for these individuals is critical.

B. Applications for Proposals to Serve Patients with Acquired Immunodeficiency Syndrome

1. Section 1122 applications for health facility beds specifically for patients with Acquired Immunodeficiency Syndrome shall be submitted on the full review application form (nine copies) and shall be accepted by the Division of Policy, Planning and Evaluation on a schedule to be announced in the Potpourri Section of the Louisiana Register. All the policies and procedures contained in the Policies and Guidelines for the Section 1122 Program will

be applied to these applications. Neither the beds nor the ongoing utilization in this facility will be counted in determining the need for other nursing home facilities. The Section 1122 approval for these specialized beds is limited for the purpose of serving the AIDS population, except, if an existing facility converts beds for this purpose, the Section 1122 approval will be reinstated upon discontinuance of the need to serve this population.

2. The applications will be considered on a comparative basis and will be referred to a committee of knowledgeable professionals who will review the applications and provide written comments to the Division. The following will be members of the committee: The assistant secretary of the Office of family Security, the assistance secretary of the Office of Preventive and Public Health Services, and the assistant secretary of the Office of Charity Hospital at New Orleans, the administrator of the Division of Licensing and Certification. the chair of the Statewide health Coordinating Council, the ombudsman coordinator of the Governor's Office of Elderly Affairs and the director of the Bureau of Civil Rights of DHHR.

3. Division of policy, Planning and Evaluation shall forward copies of the applications to be review to the above noted committee members after such applications are declared complete. The transmittal will include the date of the public hearing and the decision due date. The Division shall also forward a summary of the public hearing comments to the committee members. Each committee member shall forward comments ad recommendations to the Division of Policy, Planning and Evaluation. These shall be received by the division at least five working days prior to the decision due date.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:438 (August 1987).

Chapter 117. Louisiana Medical Facilities Inventory

§11701. Explanation

A. The Louisiana Medical Facilities Inventory is not included as part of the 1985-1990 State Health Plan. The Louisiana health system is constantly changing. Including a static picture of this dynamic system as part of the State Health Plan is not helpful since most inventories are out of date within months of the publication of the plan.

B. Current facility inventories are available from the Division of Policy, Planning and Evaluation, 200 Lafayette Street, Suite 406, Baton Rouge, La. 70801 upon written request.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

Chapter 119. Health Care Manpower

§11901. Introduction

A. key component of any health care system is its manpower. Manpower planning is important because the status of health as well as the effectiveness of that system is heavily dependent upon both the quantity and quality of health professionals who provide health services. A shortage or maldistribution of health care professionals can lead to inaccessibility or inadequate health care for some of the system's consumers. A surplus of manpower supply in any one area can influence overutilization of health care services and result in a need for providers to increase their charges for services to compensate for shrinking patient caseloads. If the supply is adequate but it is not being used properly, then a problem of need is presented which is not reflective of actual need. Finally, an accurate picture of an area's health manpower status is essential for projecting future needs and identifying those areas where surpluses or shortages of health manpower will adversely affect an area's health status if left unchecked.

B. A discussion of health manpower includes four key dimensions:

1. Supply—This dimension deals with numbers. In short, "Is there enough manpower to serve the needs of the population?"

2. Distribution—This dimension deals with the location of the manpower supply. It attempts to answer the question, "Is the manpower located where it is most needed?"

3. Utilization—This dimension deals with the types of tasks that the manpower professionals perform and are trained to perform. It attempts to answer the question, "Are providers and consumers making the best use of the available manpower supply?"

4. Resource Renewal—This dimension deals with future need and supply. It attempts to answer the question, "How does the pattern of manpower supply meet the needs of the future population and health system configurations?"

C. For the purposes of this study, manpower supply will be addressed in four categories. The categories are physicians, dentists, nurses and allied health professionals. This division was chosen because available data is primarily limited to these classifications.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 amended by P. L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11903. Physicians

A. Introduction

1. In the late 1960's, a study was published by the Carnegie Institute which identified and forecast a large manpower shortage in the United States in the area of supply of physicians. Throughout the 1970's, a disproportionately

large number of students entered medical training schools. It is now thought by many experts that most of the forecast shortages have been prevented. The preliminary indications are that many previously identified shortages of physicians are being met in Louisiana and other forecast shortages allayed by a significant influx of physicians into the health care manpower supply. There are only a few exceptions to this generally healthy status of physician manpower in Louisiana.

B. Supply

1. The most recent data available indicates that Louisiana does not have any serious problems in terms of physician supply in making comparisons with the rest of the nation. According to figures released by the United States House of Representatives Sub-Committee on Health and Environment, the current national physician to population ratio is 165.3 per 100,000 general population. Similar figures for Louisiana indicate that its physician supply is 136.1 physicians per 100,000 general population. Louisiana compares favorably with other states in the region. The following table indicates the physician per 100,000 ratio for the United States and for those states in the southern region.

	Number of Physicians in Patient Care	Number of Physicians per 100,000
United States	218,497	165.3
Louisiana	5,436	136.1
Alabama	4,297	114.7
Kentucky	4,331	124
Mississippi	2,455	102.9
Tennessee	6,131	140.6
Arkansas	2,419	111.5
Oklahoma	3,489	121.9
Texas	18,406	139.0

2. A critical aspect of physician supply is the number of physicians available who practice in the various medical specialties and sub-specialties. The Louisiana Council on Physician Manpower has provided an analysis of physician manpower supply broken down according to the various specialties, with comparison to "ideal" practitioner to population ratios developed by the Graduate Medical Examiners National Advisory Committee (GMENAC). The ideal supply ratios developed by the GMENAC are based on health care utilization patterns in the U.S. population as a whole, and take into consideration the number of physicians who may be expected to participate in active patient care, attrition and expected additions to supply.

3. The analysis by the Louisiana Council on Physician Manpower is presented in Table 11.1. Physician specialty areas are separated into four basic categories: (a) those specialties in which Louisiana has achieved or surpassed the GMENAC standard; (b) those specialties in which Louisiana has not surpassed the GMENAC standard, but in which the state is likely to achieve and possibly surpass that standard with continuation of its present rate of manpower production; (c) those specialties in which Louisiana is short, but only in proportion to its overall shortage of physicians and in which production capacity (i.e., residency training positions) is sufficient to allay future shortage; and (d) those specialties in which the ratio of physicians in Louisiana is significantly higher than the ideal ratio and also significantly higher than the ratio for physicians in general. For this latter category, the Council recommends study and initiatives directed toward alleviating residency shortages, or problems with recruitment or problems within the specialty itself. There are a number of specialties not addressed in Table 11.1, primarily because of these specialty areas being so small as to make difficult the determination of "adequate supply". Clearly the specialties in category (d) warrant most attention. In this category are most of the primary care physicians (pediatrics, general practice, family practice, and general internal medicine) whose accessibility is a vital component of an effective health care system. Also in this category are psychiatry and anesthesiology, specialties whose distribution and availability are critical to local health system functioning.

Table 11.1
Louisiana, U.S. and GMENAC* Ratios of Physicians per 100,000 Population, by Specialty, 1979

Specialty	LA Ratio	US Ratio	GMENAC Recommended Ratio	No M.D.'s Needed in LA to Reach GMENAC Ratio
(a). General and C/R Surgery	11.2	11.4	9.7	-60
Neurosurgery	1.2	1.2	1.1	-4
Opthalmology	5.0	4.9	4.8	-8
(b). Ob-Gyn	9.6	9.2	9.9	+12
Urology	3.0	2.9	3.2	+8
Plastic Surgery	1.0	1.1	1.1	+4
(c). Otoloryngology	2.8	2.5	3.3	+20
Radiology	6.0	7.4	7.4	+56
Pathology	4.4	4.7	5.5	+44
Orthopedic Surgery	4.9	5.0	6.2	+52
IM Cardiology	2.5	3.8	3.2	+28
IM Allergy	0.6	0.7	0.8	+8
Ped. Allergy	0.3	0.2	0.4	+4

Table 11.1 Louisiana, U.S. and GMENAC* Ratios of Physicians per 100,000 Population, by Specialty, 1979				
Specialty	**LA Ratio**	**US Ratio**	**GMENAC Recommended Ratio**	**No M.D.'s Needed in LA to Reach GMENAC Ratio**
Thoracic Surgery	0.6	0.8	0.8	+8
IM Pulmonary Dis.	1.1	1.3	1.5	+16
Dermatology	2.0	2.1	2.9	+36
(d). General Pediatrics	7.7	9.1	12.4	+188
GP/Fam. Prac.	19.6	22.6	34.5	+596
Preventive Med.	1.6	2.3	3.0	+56
Neurology	1.2	1.8	2.3	+44
Gen. Int. Med.	14.7	21.1	28.9	+568
Ped. Cardiology	0.2	0.3	0.4	+8
IM Gastroenterology	1.0	1.5	2.0	+40
Anesthesiology	3.6	6.0	8.6	+200
Gen. Psychiatry	6.3	9.9	15.8	+380
Phys. Med. & Rehab.	0.3	0.7	1.3	+40
Child Psychiatry	0.7	1.3	3.7	+120

*Graduate Medical Examiners National Advisory Committee

4. A spokesperson for the Louisiana Council on Physician Manpower has indicated that the residency channels for many of the specialties in category (d) are operating at full or nearly full capacity, although psychiatry and the primary care specialties are not attracting sufficient residents. Psychiatry and primary care are specialty areas which have been identified nationally as having health care manpower shortage problems. Shortages exist in Louisiana as a whole in these specialty areas, but are depicted more meaningfully in an analysis of local distribution problems.

C. Distribution

1. In spite of the relatively adequate supply of physicians overall in Louisiana, there are areas of the state which suffer serious shortages. The National Health Planning Guidelines published in the Federal Register of November 17, 1980 indicate that an appropriate primary care physician to population ratio is 1/3500. The standard is reduced to 1/3000 if conditions of high need are established. The criteria to establish high need are (a) the area has more than 100 births per year per 1000 women aged 15-44; (b) the area has more than 20 infant deaths per 1000 live births; and (c) more than 20% of the population has an income below the poverty level. Almost every area of Louisiana meets the definition of high need because of high infant mortality and poverty levels. Therefore, the standard of 1/3000 can be used to evaluate the adequacy of primary care physicians in Louisiana.

2. Table 11.2 depicts those parishes and population areas in the state and health system areas where a manpower shortage has been designated for primary care physicians. One of the eleven parishes in the New Orleans/Bayou-River health system area is a designated shortage area, with five population pockets also identified as shortage areas. In Mid-Louisiana, eleven of the 24 parishes are designated shortage areas, with an additional four population areas also targeted. In North Louisiana, 13 of the 29 parishes are designated shortage areas, with four additional sites named as shortage areas. Thus it can be seen that 25 of the state's 64 parishes and eleven other sites do not have sufficient primary care physicians to provide health care services to the local population. The critical issue in primary care physician manpower at this time is distribution. A significant portion of the state's population does not have adequate accessibility to primary care physician services because of the maldistribution of available physicians.

Table 11.2 Primary Medical Care Designated Manpower Shortage Areas - 1980			
Area	**PC PHSY. FTE**	**POP. EST. (00s)**	**Priority Level***
New Orleans/Bayou-River			
Assumption Parish	5.0	205	2
Dulac	0.0	94	1
Desire/Florida (N.0.)	5.0	367	1
Teche	8.4	412	2
Lafitte	1.0	187	2
Northeastern St. Tammany	0.0	137	1
Mid-Louisiana			
Ascension Parish	1.0	40	3
Cameron Parish	1.0	42	3
East Feliciana Parish	1.0	74	1
Evangeline Parish	10.0	318	3
Iberville Parish	1.0	30	4
Jefferson Davis Parish	1.0	32	4
Livingston Parish	3.0	365	2
Pointe Coupee Parish	3.5	250	1
St. Helena Parish	2.0	93	3
West Baton Rouge Parish	2.0	202	1
West Feliciana Parish	2.0	113	3
St. Martin	0.0	N/A	2
Eden Park (B.R.)	2.0	230	1
Merryville	1.0	41	3
North Lake Charles	1.0	231	1
North Louisiana			
Bienville Parish	3.0	160	1
Bossier Parish	3.0	645	1

Table 11.2 Primary Medical Care Designated Manpower Shortage Areas - 1980			
Area	PC PHSY. FTE	POP. EST. (00s)	Priority Level*
Caldwell Parish	3.0	102	4
Catahoula Parish	3.0	114	3
DeSoto Parish	4.0	227	1
Grant Parish	2.0	136	1
Jackson Parish	5.0	168	4
Madison Parish	3.0	144	2
Tensas Parish	2.5	84	4
Vernon Parish	5.0	537	1
Webster Parish	1.0	401	2
West Carroll Parish	2.0	130	1
Winn Parish	5.1	164	4
Zwolle	0.0	66	1
West Union	1.0	59	2
Shreveport-Low-Income	0.0	86	1
E. A. Conway Hospital	0.0	N/A	4

* Priority levels are established by the federal Department of Health and Human Services.

3. The problem of bringing primary health care to rural area populations and other population groups who do not have access is one which has been given considerable attention at a national level. The recently de-funded National Health Service Corps placed 11 physicians in partially subsidized practices in several designated shortage areas in Louisiana since 1978. There are also three Rural Health Initiatives in operation in Louisiana, whose goal is to bring primary health care services to the rural population. RHI clinics operate in Tensas Parish, Madison Parish and Catahoula Parish.

4. Parishes with designated shortages of psychiatrists are: Lafourche and Terrebonne in the New Orleans/Bayou-River area; St. Mary in Mid-Louisiana; and in North Louisiana, Caldwell, East Carroll, Franklin, Madison, Morehouse, Ouachita, Richland, Tensas, and West Carroll parishes.

D. Utilization

1. Another problem area in physician manpower is in utilization. A large percentage of the state's physicians practice in areas which are not accessible to the general public. For example, although 80.4 percent of the state's physicians are involved in patient care, roughly half of that number are either involved in surgical specialties (22.3 percent) or in hospital-based practices (19.4 percent). Only 25.5 percent of the state's physicians are involved in General Practice or Medical Specialties. The table below provides a breakdown of how the state's physician supply is distributed among various practice settings.

Type of Practice	Number of Physicians	Percentage of Total
General Practice	731	11.4%
Medical Specialties	901	14.1%
Surgical Specialties	1426	22.3%
Other Specialties	828	13.0%
Hospital-Based	1239	19.4%
Other Activity	440	6.9%
Inactive	410	6.4%
Not Classified	392	6.1%
Total	6367	99.6%

3. The utilization of physicians is important in analyzing manpower need since an area may have significantly fewer physicians available to provide patient care than are counted as being active in the area. This is true particularly in an area such as New Orleans, where a large number of physicians are on staff at medical centers and teaching hospitals and devote only a minor amount of their time to the care of patients from the service area.

E. Resource Renewal

1. In terms of renewing the supply of physicians, Louisiana is slightly ahead of the rest of the nation. Between 1975 and 1979, Louisiana's physician supply grew at a rate of 18.5 percent. The rate for the nation in that time period was 12.8 percent. A spokesperson for the Louisiana Council on Physician Manpower has noted that increased enrollment at the Louisiana State Medical School in New Orleans and at the new school in Shreveport will begin to impact physician supply in about 1982. It takes approximately 7-9 years for the creation of new medical school placements to have an impact on the market supply of physicians. Because the full impact of these expansion programs is yet unknown, the next two to three years will be important ones for assessing any changes brought about by the new placements and for developing other initiatives as needed to address any problems with physician supply and distribution which persist.

F. Resource Goals

1. A supply of physicians actively practicing in the state which meet the suggested ideal practitioner to population ratio by specialty recommended by GMENAC. Improvements specifically are needed in the overall supply of physicians specializing in general pediatrics, general practice, family practice, preventive medicine, neurology, general internal medicine, pediatric cardiology, IM gastroenterology, anesthesiology, general psychiatry, physical medicine and child psychiatry.

2. Development of initiatives to improve the accessibility of primary care physician services in designated shortage areas.

3. Development of initiatives to improve the accessibility of psychiatrists in designated shortage areas.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11905. Dentists

A. Introduction

1. Dentists are an important primary health care provider. Like primary care physicians, it is essential that dentists be available and reasonably accessible to a population if regular preventive care is to be obtained and acute health problems minimized.

B. Availability/Supply

1. In evaluating dental manpower in Louisiana in terms of overall supply, there are significantly fewer dentists in the state as compared to the United States as a whole. Most recent statistics show Louisiana with 39.7 dentists per 100,000 population while the United States average is 54.2 per 100,000. This comparison does not reveal much about the actual sufficiency of the state's supply of dentists, however, since several studies have noted the oversupply of dentists as a problem in many areas of the country. Louisiana ranks on middle ground in dentist to population ratio in comparison to other states in the region, as depicted in Table 11.3.

Table 11.3
Active Dentists in the Population
1980

	Number of Dentists per 100,000 pop.	Number of Dentist per 5,000 pop.
United States	54.2	2.71
Louisiana	39.7	1.99
Mississippi	31.7	1.59
Alabama	35.2	1.76
Arkansas	33.3	1.67
Texas	42.4	2.12
Tennessee	47.6	2.38
Kentucky	42.3	2.12
Oklahoma	41.5	2.08

2. The National Guidelines for Health Planning suggest that an appropriate supply of dentists is one dentist to every 5,000 population except in areas of high need or where there is an insufficient capacity of existing dental care providers. As can be seen in Table 11.3, Louisiana as a whole has nearly two dentists to every 5,000 people.

3. Areas of "high need" are defined as those in which:

a. more than 20 percent of the area's population lives below poverty level; or

b. a majority of the area's population does not have a fluoridated water supply.

4. "Insufficient capacity of care" exists when:

a. there is an average of more than 5,000 visits per year to each active dentist in the area; or

b. there are waiting periods of more than six weeks for appointments for routine dental services with most dentists in the area; or

c. two-thirds or more of the area's dentists do not accept new patients.

5. The National Health Planning Guidelines suggest a supply ratio of one dentist to every 4,000 population when a condition of high need or insufficient capacity exists. This ratio of 1 to 4,000 would be applicable in many parts of Louisiana as only 28.9 percent of the state's population has fluoridated water and 41 of the state's 64 parishes have poverty levels exceeding 20 percent of the population.

6. In Louisiana, despite an adequate overall supply of dentists to serve the population, there are many areas where there are not enough dentists to provide adequate services for the population. Basically these areas are in rural low-income parts of the state where there are few active dentists. Eighteen of the twenty-nine parishes in the North Louisiana health system area are dental manpower shortage areas. Designated dental manpower shortage areas are depicted in Table 11.4. Other than West Baton Rouge Parish, all parishes with dental manpower shortages are in the North Louisiana area, with other designated shortage areas lying in urban poverty pockets.

Table 11.4
Dental Manpower Shortage Areas
1980

Service Area	FTE Dentist	Pop. (00s)	Pop. to Dentist Ratio	Pop. Below Poverty
New Orleans/Bayou-River				
New Orleans-Desire/Florida	4.0	321	8,035	46%
New Orleans-Irish Channel	0.0		200	43%
Mid-Louisiana				
West Baton Rouge Parish	3.0	202	6,733	35%
Baton Rouge-Eden Park	1.2	230	19,182	37%
North Louisiana				
Bienville Parish	2.0	172	8,613	38%
Caldwell Parish	.6	102	17,078	41%
Catahoula Parish	1.0	117	11,765	43%
Concordia Parish	5.0	222	4,447	39%
DeSoto Parish	4.0	237	5,926	44%
East Carroll Parish	2.0	116	5,827	60%
Franklin Parish	3.0	239	7,990	50%
Grant Parish	1.0	151	15,151	36%
Jackson Parish	3.0	168	5,631	29%
Lincoln Parish	8.0	371	4,649	32%
Madison Parish	1.0	149	14,980	54%
Morehouse Parish	7.0	336	4,813	40%
Natchitoches Parish	9.0	361	4,019	45%
Red River Parish	0.0	92	9,250	47%
Tensas Parish	1.0	84	8,400	54%
Union Parish	5.0	200	4,017	32%
Vernon Parish	2.3	537	23,347	19%
West Carroll Parish	1.0	128	12,835	43%

C. Accessibility/Distribution

1. The problem with supply of dentists in Louisiana is one of distribution, which is much the same problem as is seen with primary care physicians. Louisiana's manpower goals for dentists should then focus on making dental health care more accessible to residents of rural North Louisiana parishes, possibly through establishment of part-time clinics, mobile screening programs and other innovative ways in which dental services can be provided most cost effectively to poor, rural populations. Another goal for dental manpower

is in increased accessibility of dental services to residents of poor central city areas of Baton Rouge and New Orleans.

2. In alleviating problems with dental health care accessibility, attention should also be given to programs which provide low cost or subsidized services to low-income citizens. At present only children under the age of 21 are eligible for Medicaid-reimbursable general dental services. The only subsidized dental services available to adults are the Medicaid denture program (partial or complete dentures for appropriately-referred Medicaid eligibles) and treatment provided through the L. S. U. School of Dentistry in New Orleans.

3. The inability of people at poverty level incomes to pay for preventive and maintenance dental services is a factor which influences the distribution of dentists. Dentists will probably continue to find it difficult to maintain a profitable practice limited strictly to one setting in a poor rural area. It is for this reason that it is recognized that minimizing the problems of dental service inaccessibility will have to include the development of special methods of service delivery and will require commitment on the part of the state and/or federal government to support initiatives in this area.

D. Resource Renewal. Available data indicates that the growth of the number of dentists in Louisiana is fairly consistent with population, though not growing as fast as in the United States as a whole. Between 1975 and 1979, the number of active dentists in Louisiana increased 7.4 percent; in the United States the growth rate was 9.3 percent. Louisiana's population increased 15.3 percent during the decade between 1970-80, or an average of 6.1 percent for the four year period between 1975-79. It would appear then that the number of dentists entering active practice each year is sufficient to meet the needs of the state's population.

E. Resource Goals

1. Increased accessibility of dentists in all designated manpower shortage areas, particularly through the development of innovative and cost effective means of delivering services to residents of sparsely populated areas.

2. Increased accessibility of dental services through initiatives designed to reduce consumer costs, especially for low-income citizens.

F. Louisiana Dental Association—Manpower Planning Survey

1. In 1981, the Louisiana Dental Association commissioned the Division of Business and Economic Research, University of New Orleans to examine the workload and busyness of dentists by major types of practice (general practitioners and specialists) and geographical regions. The findings from the study were to be used to provide guidance to manpower planning for dentists in Louisiana during the decade of the 1980's.

2. The findings suggest that there is an excess of general practitioners and specialists relative to effective demand. Specialists tend to be less busy than general practitioners. As for general practitioners, there were geographical differences in workload measures, excess capacity and perception of busyness. Information gaps were found in the attempt to gather data from the files of the Louisiana Dental Association. It was recommended that a systematic means of gathering and maintaining profile data, workload data, etc., concerning Louisiana-based dentists be installed. In order to do a proper job of manpower planning, an improved data base is needed.

3. The conclusions from the survey have been summarized as follows:

a. General Practitioners

i. There is an excess of general practitioners relative to effective demand.

ii. General practitioners in Louisiana tend to have a lower workload and are less busy than dentists in the West South Central Region of the U.S. and the U.S. in general.

iii. Urban general practitioners are no more or no less busy than rural general practitioners.

iv. Younger and less-experienced general practitioners are less busy than experienced dentists, especially those in mid-career. This may be explained by one or more of the following reasons:

(a). an excessive supply of dentists;

(b). low consumer demand; or

(c). the problem of getting a practice started up and established.

v. There are geographical differences in workload measures, excess capacity, and perception of busyness within the state.

b. Specialists

i. There is an excess of specialists relative to effective demand.

ii. Specialists in Louisiana tend to have a lower workload and are less busy than dentists in the West South Central Region and the U.S. in general.

iii. There is no difference in the business of rural versus urban specialists.

iv. An examination of workload and capacity factors and perception of busyness show the findings to be mixed. In general, it seems that younger specialists may be somewhat busier than older, more experienced specialists. On the other hand, younger specialists felt they could handle a larger patient load.

v. Specialists tend to be less busy, in their perception, than general practitioners. Basically, specialists feel that they can handle more patients.

c. Other Comments

i. There is a need for an improved system of collecting profile and other data concerning Louisiana dentists. For example, in addition to profile data, information

such as that collected in the UNO study or the ADA survey could be collected every two years.

ii. The LDA should investigate the need for an effective education and promotion program directed toward consumers to raise effective demand.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P. L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11907. Registered Nurses

A. Introduction. In the mid 1970s both the federal Department of Health, Education and Welfare and the Louisiana Board of Regents reported that the state and the nation were well on their way to solving previously noted shortages in the area of nursing manpower. In light of this perception, federal funds were curtailed for nursing education and other initiatives were aborted. However, enrollment in nursing programs began to level off and as more job opportunities opened for women in other fields, many nurses left the profession for jobs that were either less strenuous or more rewarding, financially and otherwise. Due in great part to these trends, there is no longer an abundant supply of nurses and most areas and health care facilities in the state have difficulty filling all their nursing staff needs. This is true for both Registered Nurses (R.N.'s) and Licensed Practical Nurses (L.P.N.'s); however, the data reported in this analysis relates only to R.N.'s. The number of L.P.N.'s in the workforce is unknown at present since a nurse registry is maintained only for R.N.'s.

B. Supply

1. Louisiana lags behind the national average in the ratio of nurses to general population. The most recent data published by the U.S. House of Representatives and its Subcommittee on Health and the Environment indicate a national average of 520 nurses per 100,000 population. Similar figures for Louisiana indicate a rate of 367 nurses per 100,000. Relative to other states in the region, Louisiana's nursing supply is also below several comparable averages, as is reflected in the following table.

Active Registered Nurses	
Geographic Area	**per 100,000 general population**
United States	520.8
Louisiana	367.6
Alabama	350.2
Kentucky	402.6
Mississippi	394.8
Tennessee	363.0
Arkansas	325.7
Oklahoma	390.7
Texas	374.3

2. It can be seen that Louisiana is not unique in the southern region in having fewer nurses than is the average nationally. The Louisiana Board of Regents has reported that this disparity decreased greatly in Louisiana with the aid of federal funds for nursing education. In the years before funds were available (1958-1966), nursing enrollments in Louisiana grew not at all: 306 graduates in 1955 and 306 in 1965. After the enactment and implementation of the nurse training act of 1964, the number of graduates had risen to 435 in 1970. This number nearly tripled by 1978, as 1148 new graduates entered the nursing profession in Louisiana. Since then, there has been a significant decline. In 1981, there were 21,317 licensed R.N.'s in Louisiana.

C. Distribution

1. Because much of nursing work is done in health care institutions, geographical distribution is for the most part an inappropriate measure of judging the shortage or surplus of supply. The Louisiana State Board of Nursing has reported that more than 58.2 percent of the registered nurses within the state are employed in hospitals. Others are employed in nursing homes, by public and private health care agencies, and by physicians. A practitioner to population ratio analysis by small geographic area is limited in terms of its ability to identify areas of need. A more reliable indicator of supply need is whether primary employers of nurses are able to fill available positions.

D. Utilization

1. The following table depicts the relative distribution of nurses among various types of employment.

Registered Nurses in Louisiana by Field of Employment		
	Number	**Percent**
Hospital	9665	58.2%
Nursing Home	2161	13.2%
Nursing Education	580	3.4%
Private Duty	382	3.5%
Public Health	772	2.3%
School Nurse	333	4.6%
Occupational Health	242	1.4%
Office Nurse	1364	8.2%
Other	872	5.2%

2. Since nurses are an essential component of hospital care and hospitals such a large employer of nurses, the availability of nurses to meet the needs of hospital employment must be addressed. SHPDA staff spoke with a number of hospital administrators who state that due to high turnover rates and chronic shortages of nursing personnel, they are almost always forced to operate at less than full capacity. One administrator reported that at the time they had only 60 percent of the needed nursing staff complement. Other administrators noted that because of the shortages, they were forced to close down certain units of their hospitals.

3. Essentially it is the nature of the work which makes nurse retention in a hospital setting difficult. Shift work and holiday work make the field unattractive, especially to women who may have primary child care responsibilities at home. Another factor contributing to retention difficulties is the conditions of employment in hospital settings. In a survey conducted by the Mid-Louisiana Health Systems Agency, many nurses interviewed suggested that they were often perceived as "handmaidens" or "hired help" for

physicians. They felt that these were the perceptions of the doctors and hospital administrators. Furthermore, they felt that these perceptions were not only destructive to their professional status but also to their ability to perform their jobs. In this same survey, salaries were not mentioned as a problem by many of the nurses. It seems clear that there is a combined problem of too few students being attracted to nursing and too few hospital positions which offer satisfying work conditions to nurses.

4. Within other areas of nurse employment there are also problems with supply, though not as critical. Within nursing homes, the supply of R. N. personnel is not as inadequate. Part of the reason for this can be seen in the fact that nurses enjoy a greater degree of autonomy in decision-making and a higher professional status in nursing homes. The lack of a severe "shortage" in fields of employment outside hospitals lends credence to the thought that hospital employment conditions play a significant part in the nursing shortage.

5. State Health Planning Agency conducted a survey of major health care employers in March, 1982 requesting data on budgeted positions and vacancies among various allied health professions. Nurses were not included in the survey because of the availability of documentation concerning the number of R.N.'s in the Louisiana job market and the shortage of nursing personnel. Many responses from nursing home administrators contained comments added on the survey questionnaire concerning a shortage of licensed practical nurses (LPN's). Nursing home administrators in all areas of the state reported chronic shortage of LPN's.

E. Resource Renewal

1. Currently there are eighteen institutions within the state which provide nursing training. Six of these schools offer an associate's degree and graduated 319 nurses (or 32.8%) of the 1980 nursing class. Eight of these schools offer a baccalaureate degree and graduated 459 (or 47.2%) of the 1980 class. Four of the schools offer a diploma in nursing and graduated 194 (or 19.9%) of the 1980 class. (See Chapter XII for inventory of programs). Both enrollment and numbers of nursing graduates have been declining since the late 1970's, as is depicted in the following table.

Number of Graduating Nurses	**1975**	**1976**	**1977**	**1978**	**1979**	**1980**	**1981**
Associate Programs	279	366	371	339	350	319	308
Baccalaureate Programs	396	462	501	577	451	459	426
Diploma Programs	230	182	191	232	237	194	175
	566	1010	1063	1148	1038	972	909
Number of Nursing School Enrollments	**1975**	**1976**	**1977**	**1978**	**1979**	**1980**	**1981**
Associate Programs	961	1056	1082	979	936	959	1000
Baccalaureate Programs	3069	3197	3064	3003	2693	2728	2818
Diploma Programs	761	770	794	750	713	706	715
	4791	5023	4940	4732	4342	4393	4533

F. Summary and Conclusions

1. Given the declining number of nursing graduates compared to increasing population and increasing numbers of hospital and nursing home beds, the nurse shortage that the state is now experiencing can be expected to persist and worsen. Several solutions have been suggested to deal with this urgent problem of health care manpower.

2. Hospital administrators have suggested that either more schools for nursing or more funds for nursing education are needed. In light of declining numbers of enrollments and unfilled nursing classes, this solution may be an expensive and inefficient approach to the problem unless emphasis is on programs in geographic areas where nurse education has been relatively inaccessible. A spokesperson for the Louisiana State Nurses Association notes that the focus should shift to appropriate utilization and retention of nurses rather than to increased supply. The Board of Nursing does not find new schools of nursing to be an effective solution.

3. As a result of the Mid-Louisiana Health Systems Agency survey, four recommendations were developed which it was thought could improve hospital retention of nurses:

a. Improved communication between nurses, physicians and hospital administrators—It is felt that this would give nurses a needed voice in problem-solving and decision-making and help to enhance their professional status and professional self image.

b. Career Counseling—Potential nursing students and nurses considering returning to the field need a place to turn to for practical advice. Nurse burnout and job stress should be dealt with.

c. Continuing Education—Professional as well as personal growth should be a priority. Classes should be offered during work hours with in-service opportunities to work in specialty areas.

d. Incentives—It was felt by the respondents of this survey that more pay for more experience and shift differentials for night and weekend work would be of value in improving retention. Flexible work shifts and innovative scheduling were also mentioned, especially for working mothers. It was also recommended that day care facilities should be made available at the hospitals for pre-school children of employees.

G. Resource Goals

1. Nursing schools operating with full complement of students, that is at least 5,000 students enrolled annually.

2. At least 1,200 nursing graduates annually.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

§11909. Allied Health Professionals

A. The Health Manpower Training Act of 1972 defined allied health professions in the following manner: "Allied health professions are those with training and responsibilities for supporting and complementing or supplementing the professional functions of physicians, dentists and other health professionals in the delivery of health care to patients; or, assisting environmental engineers and other personnel in environmental health control and preventive medicine activities."

B. 1978 Board of Regents Study

1. A study released by the Louisiana Board of Regents in 1978 included the areas of Dental Hygiene, Occupational Therapy, Medical Records Administration, Health and Hospital Administration, Physical Therapy, Medical Technology, Cytotechnology, Dietetics, Radiologic Technology and Respiratory Care Technology within the allied health field. The Louisiana Office of Licensing and Regulation has also included Pharmacy and Social Work within this field for classification purposes.

2. In the Louisiana Board of Regents' 1978 study, Louisiana was reported to have no serious shortages in the area of allied health professionals. The study indicated that although some small rural hospitals and state hospitals did have problems in recruiting personnel, these were mainly due to conditions within the institutions (e.g. low pay, location, etc.) rather than a shortage of manpower supply. A spokesman for the Board of Regents provided a verbal update to this report in March, 1982, and suggested that the satisfactory rating in terms of allied health manpower supply in Louisiana may be reversing itself. Particularly in the areas of medical technology and physical therapy, the state appears now to be experiencing serious manpower shortages.

3. There is very little hard data available on which to base an analysis of allied health manpower resources. In 1978 the Louisiana Board of Regents recommended that the state maintain a registry of allied health personnel in order to build an adequate data base for manpower planning purposes. A spokesman for the Board of Regents reports that this has not yet been done. Any accurate assessment of allied health manpower in the state will be impossible until this data base is developed.

C. Resource Goals

1. Until statistical data becomes available, analysis or planning for the manpower supply in allied health cannot be accurate. The state may now be in the early stages of experiencing serious shortages of allied health professionals. It is recommended that the state begin registration of its allied health professionals so that a data base can be built and appropriate recruitment and training initiatives taken to maintain an adequate supply of allied health manpower. Available indicators of manpower supply need to be analyzed, however, so that preliminary projections can be made of need and supply of allied health professionals.

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P. L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

Chapter 121. Health Care Education Programs

§12101. Inventory of Health Care Education Programs

A. Introduction

1. A primary factor affecting the supply of health care manpower in a state is the availability of education programs which prepare candidates for licensure and/or employment in a health care profession. A large number of persons obtaining higher level educational training in a state will remain in the general locale where training was received. Individuals obtaining non-professional training ordinarily do not enter programs that are further than commuting distance from their homes. For these reasons, it is essential that the available supply of health care manpower be monitored closely, trends noted and responses duly initiated to assure an adequate production of trained health care professionals and paraprofessionals.

2. This Chapter contains a detailed inventory of Louisiana's health care education programs supplementing the manpower study contained in the preceding Chapter.

3. A national health priority, as mandated by Title XV of the Public Health Service Act (Public Law 96-79), states, "The Congress finds that the training and increased utilization of physician assistants, especially nurse clinicians, deserves priority consideration in the formulation of national health planning goals and in the development and operation of federal, state, and local health planning and resources development programs."

4. There is only a small number of physician assistants in the state partly because there is no education program in Louisiana for physician assistants. This health care field, as well as that of licensed nurse practitioners, has been one which has been opposed by some members of the medical community. There is concern among some that the quality of medical care is reduced when non-M.D.s perform any part of patient care. Since one way to provide medical care at a more reasonable cost is to allow a trained person other than a doctor to perform some patient care, more attention needs to be given to this issue.

5. Louisiana has 18 nursing programs preparing candidates to qualify for licensure as registered nurses—six at the associate level, four at the diploma level and eight at the baccalaureate level. Graduates of all 18 programs are equally eligible for RN licensure. Louisiana also has two master of nursing programs (MSN). One is offered by the Louisiana State University Medical School, New Orleans. The other is offered in Shreveport by Northwestern State University.

6. Allied Health Professions are those with training and responsibilities for supporting, complementing, or supplementing the professional functions of physicians, dentists, and other health professionals in the delivery of health care to patients; or assisting environmental engineers and other personnel in environmental health control and preventive medicine activities.

7. Numerous allied health profession training programs are hospital based and have specific academic affiliation with Louisiana colleges and/ or universities. Other programs are college and/or university-based, with academic requirements provided by the respective college or university and clinical placement at various health care centers.

8. The state of Louisiana operates a system of Vocational-Technical Schools which offers training in Health Occupations to meet the needs of the state and improve the quality of health service for its citizens. Existing programs in these schools offer health care occupational training for Dental Assistants, Dental Laboratory Technologists, Emergency Medical Technicians, Medical Assistants, Medical Laboratory Assistants, Nursing Assistants, Practical Nurses, Radiology Technologists, Respiratory Therapists, and Surgical Technicians. Many of these programs are also offered in 10 proprietary schools located in Alexandria, Baton Rouge, Lafayette, Monroe, New Orleans, and Shreveport.

9. Programs also exist within the secondary school systems. Across the state, there are about 20 schools that offer classes and/or training in health occupation, ranging from Nursing Assistant to Pre-Nursing.

10. The Governor's State Job Training Coordinating Council, through the Job Training Partnership Act (JTPA) has the explicit purpose of establishing training programs for the economically disadvantaged on a community level. These programs offer health care occupational training for Surgical Technicians, Licensed practical Nurses, Adult and Child Care Personnel, Dietary Aides, Nurse's Aide, Recreational Aides, Wards Clerks, Medical Technicians, Dental Assistants, Dental Laboratory Technicians, Pharmacy Clerks, Laboratory Technicians, Medical Record Clerks, Chiropractic Assistants, X-Ray Technicians and orderlies.

11. An inventory of health occupation education programs offered in the state is found on the following pages.

Louisiana Health Education Institutions
Physicians (M.D.)
LSU Medical Center—School of Medicine, New Orleans
LSU Medical Center—School of Medicine, Shreveport
Tulane University—School of Medicine, New Orleans
Dental (D.D.S.)
LSU Medical Center—School of Dentistry, New Orleans
Pharmacy
Northeast Louisiana University—School of Pharmacy, Monroe
Xavier University—School of Pharmacy New Orleans

Nursing Schools (R.N.)
Baccalaureate Degree
Dillard University New Orleans
LSU-New Orleans, New Orleans
McNeese State University, Lake Charles
Northeast Louisiana State University, Monroe
Northwestern State University, Natchitoches
Southeastern Louisiana University, Hammond
University of Southwestern Louisiana, Lafayette
Nicholls State University, Thibodaux
Associate Degree
LSU-Alexandria, Alexandria
LSU-Eunice, Eunice
LSU-New Orleans, New Orleans
Louisiana Tech University, Ruston
Nicholls State University, Thibodaux
Northwestern Shreveport
Diploma
Charity Hospital School of Nursing, New Orleans
Our Lady of the Lake Medical Center, Baton Rouge
Touro Infirmary School of Nursing, New Orleans
Baton Rouge General Hospital, Baton Rouge
Public Health Administration (M.S. And Ph.D.)
Tulane University, New Orleans

Louisiana Health Education Programs	
Allied Health Professional Programs	
Programs and Facility in Which Located	**City**
Occupational Therapy	
LSU Medical Center	New Orleans
Northeast Louisiana State University	Monroe
Physical Therapy	
LSU Medical Center	New Orleans
Radiologic Technology	
Alton Ochsner Medical Foundation	New Orleans
Baton Rouge General Hospital	Baton Rouge
Charity Hospital of New Orleans	New Orleans
Delgado Community College (Associate degree only)	New Orleans
Hotel Dieu Hospital	New Orleans
Lafayette Charity Hospital	Lafayette
Lallie Kemp Charity Hospital	Independence
Louisiana State Univ. Medical Center	Shreveport
McNeese State University	Lake Charles
Northwestern State University	Natchitoches
Northeast Louisiana State University	Monroe
St. Francis Cabrini Hospital	Alexandria
Speech Pathology and Audiology	
Grambling State University	Grambling
Louisiana Tech University	Ruston
Northeast Louisiana State University	Monroe
Northwestern State University	Natchitoches
University of Southwestern La.	Lafayette
LSU-Shreveport	Shreveport
LSU Medical Center	New Orleans
Southern University-Baton Rouge	Baton Rouge
Southern University-New Orleans	New Orleans
Tulane University	New Orlenas
Xavier University	New Orleans
Respiratory Care Technology	
Delgado Junior College (Certificate and Associate Degree)	New Orleans
Nicholls State University (Associate degree only)	Thibodaux
Southeastern Louisiana University (Associate degree only)	Hammond
L.S.U.-Eunice (Associate degree only)	Eunice
Programs and Facility in Which Located	City

Louisiana Health Education Programs	
Allied Health Professional Programs	
Programs and Facility in Which Located	**City**
Cytotechnology	
LSU Medical Center	New Orleans
L.S.U. - B.R.*	Baton Rouge
L.S.U. - Shreveport*	Shreveport
University of New Orleans*	New Orleans
Dental Hygiene	
Northeast Louisiana State University	Monroe
LSU Medical Center	New Orleans
Loyola University	New Orleans
Medical Records Administration	
Louisiana Tech University	Ruston
University of Southwestern Louisiana	Lafayette
Medical Laboratory Technology	
Louisiana Tech University	Ruston
McNeese State University	Lake Charles
Northwestern State University	Natchitoches
Northeast Louisiana State University	Monroe
Schumpert Hospital	Shreveport
Southeastern Louisiana University	Hammond
University of Southwestern Louisiana	Lafayette
L.S.U. in Baton Rouge*	Baton Rouge
L.S.U. in Shreveport*	Shreveport
L.S.U. Medical Center	New Orleans
University of New Orleans*	New Orleans
Southern University - Baton Rouge	Baton Rouge
Southern University - New Orleans	New Orleans
Xavier University	New Orleans
Louisiana College	Pineville
Loyola University	New Orleans
V.A. Hospital	Shreveport
Dietetics	
Louisiana Tech University	Ruston
Northheast Louisiana State University	Monroe
Southeastern Louisiana University	Hammond
University of Southwestern Louisiana	Lafayette
L.S.U. in Baton Rouge	Baton Rouge
Southern University-Baton Rouge	Baton Rouge
Grambling State University	Grambling

*Final year (of 4 years) must be finished at L.S.U. Medical Center in New Orleans.
Source: Louisiana Department of Education Office of Health Occupations Education

Louisiana Secondary Schools		
Health Care Occupation Programs		
School	**Location**	**Name of Program**
Alfred Lawless Sr. High	New Orleans, LA	Introduction to Health Science I Health Science II Health Science III
Belaire High School	Baton Rouge, LA	Health Occupations
Berwick Senior High	Berwick, LA	Health Occupations
Bunche Career Center	Metairie, La	Home Health Nursing
Caddo Career Center	Shreveport, LA	General Health Occupations
Career Development Center	Cottonport, LA	Introduction to Health Occupations Pre-Nursing
Eunice Vocational Center	Eunice, LA	Nurses Aide
G.W. Carver High School	New Orleans, LA	Introduction to Nursing Pre Nursing/Exploring Health Careers

Louisiana Secondary Schools		
Health Care Occupation Programs		
School	**Location**	**Name of Program**
Grant High School	Dry Prong, LA	Introduction to Health Occupations Medical Terminology Pre-Nursing
L.E. Rabouin High	New Orleans, LA	Health Science I Health Careers
Lafayette Parish Vo Center	Lafayette, LA	Health Occupations
Lincoln Career Center	Marrero, LA	Health Science I Health Science II Dental Assistant Nursing Assistant Ward Clerk
New Iberia Sr. High Career Campus	New Iberia, LA	Nursing Assistant 10th & 11th grade Nursing Assistant 12th grade
N.O. Center for Health Careers	New Orleans, LA	Health Occupations 10th and 11th Grade Health Occupations 12th Grade
0. Perry Walker Sr. High	New Orleans, LA	Introduction to Nursing Pre Nursing/Exploring Health Careers
Patterson Senior High	Patterson, LA	Health Occupations
Plaquemine Sr. High School	Plaquemine, LA	Nurse Aide
Terrebonne Vo-Tech High School	Houma, LA	Health Occupations
Washington Vocational Education Center	Washington, LA	Nurse Assistant
W.B.R. Vocational Skills Center	Port Allen, LA	Nursing Aide

Louisiana Proprietary Schools Health Care Occupation Programs		
American College	New Orleans, LA	Nursing Assistant
American College	Shreveport, LA	Nursing Assistant
Commerical College	Baton Rouge, LA	Medical Administrative Assistant
Delta College, Inc.	Baton Rouge, LA	Medical Secretary
Delta College, Inc.	Lafayette, LA	Medical Office Assistant
Delta College, Inc.	Monroe, LA	Nursing Assistant
Delta School of Commerce	Alexandria, LA	Nursing Assistant
La. School of Commerce	Shreveport, LA	Medical Assistant
Ruthledge College of Charlotte	New Orleans, LA	Nurse Assistant
Spencer College	Baton Rouge, LA	Medical Administrator

Universities	
School	**Name of Program**
University of Southwestern Louisiana Lafayette, LA	Medical Record Science Nursing Emergency Health Science

Universities	
School	**Name of Program**
	Associate Degree Microbiology Radiologic Technology Communicative Disorders Pre-Medical Technology Pre-Physical Therapy Pre-Optometry Pre-Medicine Pre-Dentistry
St. Bernard Parish Community College Chalmette, LA	Home Health Care Medical Office Receptionist
Louisiana Tech University Ruston, LA	Nursing Associate Degree General Dietetics Coordinated Undergraduate Program Speech-Language Pathology and Audiology Program Medical Record Technology Institution Management Master of Science in Home Economics Medical Technology Medical Record Administration Biomedical Engineering
Northeast Louisiana University Monroe, LA	Occupational Therapy Assisting Pre-Occupational Therapy Nursing Dental Hygiene Occupational Therapy Medical Technology Pharmacy Radiologic Technology
University Medical Center–USL Lafayette, LA	Medical Technology
Louisiana State University Baton Rouge, LA	Communication Disorders Veterinary Medical Science Master of Science Residency-M.S. Program Medicine Veterinary Medicine Internship
Louisiana State University–Eunice Eunice, LA	Respiratory Therapy Nursing
Delgado College New Orleans, LA	Radiologic Technology Master's Program Master's of Business Admin./Master's of Public Health Joint Degree Program Public Health Graduate Program
Northwestern State University Shreveport, LA	Nursing Bachelor of Science
Southeastern Louisiana University Hammond, LA	Dietetics Nursing
LSU medical Center - School of Nursing New Orleans, LA	Nursing Graduate Program Nursing Baccalaureate Program
Tulane University Hospital New Orleans, LA	Practical Nursing
LSU School of Dentistry New Orleans, LA	Dental Laboratory Technology Bachelor of Science Degree Dental Hygiene Bachelor of Science Degree Dental Hygiene Associate of Sciene Degree Dental Laboratory Technology

Universities	
School	**Name of Program**
	Associate of Science Degree
Tulane Medical Center New Orleans, LA	Health Systems Management
LSU Medical Center Shreveport, LA	Communication Disorders Occupational Therapy Physical Therapy Medical Technology Cardiopulmonary Science
LSU at Alexandria Alexandria, LA	Nursing
Nicholls State University Thibodaux, LA	Pre-Optometry Speech, Language, and Hearing Specialist Pre-Medicine Pre-Dentistry
McNeese State University Lake Charles, LA	Mortuary Science
Grambling State University Grambling, LA	Cytotechnology Cardiopulmonary Science Physical Therapy Medical Technology Rehabilitation Counseling Occupational Therapy
Xavier University of Louisiana New Orleans, LA	Medical Technology Pharmacy
Loyola University New Orleans, LA	Nursing Bachelor of Science Degree
Dillard University New Orleans, LA	Nursing

Hospitals	
School	**Name of Program**
Southern Baptist Hospital New Orleans, LA	Medical Technology
Schumpert Medical Center Shreveport, LA	Medical Technology Radiologic Technology
South Louisiana Medical Center Houma, LA	Medical Technology
St. Francis Medical Center Monroe, LA	Medical Technology
Rapides General Hospital Alexandria, LA	Radiologic Technology Medical Technology
Southern Baptist Hospital New Orleans, LA	Clinical Pastoral Education: Basic Clinical Pastoral Education: Advanced Clinical Pastoral Education: Supervisory
Baton Rouge General Medical Center Baton Rouge, LA	Respiratory Therapy Technician
Lafayette General Medical Center Lafayette, LA	Radiologic Technology
East Jefferson General Hospital Metairie, LA	Continuing Education Workshops for Nurses EMT Continuing Education Program
VA Medical Center New Orleans, LA	Medical Technology
Our Lady of Lourdes Regional Medical Ctr. Lafayette, LA	Medical Records Transcriptionist Training Surgical Technology
Our Lady of the Lake School of Nursing Baton Rouge, LA	Nursing
St. Patrick Hospital Lake Charles, LA	Medical Technology

Louisiana Health Occupations Education Postsecondary Health Care Occupation Programs		
Alexandria Vocational-Technical Institute	Alexandria, LA	Practical Nursing
Avoyelles Vocational-Technical School	Cottonport, LA	Practical Nursing
Bastrop Vocational-Technical School	Bastrop, LA	Practical Nursing
Baton Rouge Vocational-Technical Institute	Baton Rouge, LA	Practical Nursing
Concordia Vocational-Technical School	Ferriday, LA	Nursing Assistant
Delta-Ouachita Vocational- Technical Institute	West Monroe, LA	Practical Nursing
Elaine P. Nunez Vocational-	Chalmette, LA	EMT – Paramedic Practical Nursing
Evangeline Vocational-Technical School	St. Martinville, LA	Practical Nursing
Florida Parishes Vocational School	Greensburg, LA	Practical Nursing
Folkes Vocational-Technical School	Jackson, LA	Health Occupations Practical Nursing
Gulf Area Vocational-Technical School	Abbeville, LA	Practical Nursing
Hammond Area Vocational School	Hammond, LA	Practical Nursing
Huey P. Long Memorial Vocational Technical School	Winnfield, LA	Practical Nursing
J. M. Frazier Sr. Vocational Technical School	Baton Rouge, LA	Practical Nursing
Jefferson Davis Vocational Technical School	Jennings, LA	Practical Nursing
Jefferson Parish Vocational Technical School	Metairie, LA	Practical Nursing
Jefferson Parish Westbank Vocational-Technical School	Harvey, LA	Practical Nursing Respiratory Therapy
Lafayette Regional Vocational- Technical Institute	Lafayette, LA	Practical Nursing Medical Lab. Tech
Memorial Area Vocational School	New Roads, LA	Practical Nursing
Natchitoches-Central Area Vocational-Technical School	Natchitoches, LA	Practical Nursing
New Orleans Regonal Vocational- Technical Institute	New Orleans, LA	Practical Nursing
Northwest Louisiana Vocational School	Winnsboro, LA	Practical Nursing
Northwest Louisiana Vocational- Technical School	Minden, LA	Practical Nursing
Ruston Vocational-Technical School	Ruston, LA	Practical Nursing
Sabine Valley Vocational- Technical School	Many, LA	Practical Nursing
Shreveport-Bossier Vocational- Technical Institute	Shreveport, LA	Practical Nursing
Sidney M. Collier Vocational-Tec. School	New Orleans, LA	Practical Nursing
Slidell Vocational-Technical School	Slidell, LA	Practical Nursing
South Louisiana Vocational- Technical School	Houma, LA	Practical Nursing
Southwest Louisiana Vocational- Technical School	Crowley, LA	Practical Nursing
Sowela Technical Institute	Lake Charles, LA	Practical Nursing
Sullivan Vocational-Technical School	Bogulusa, LA	Practical Nursing
T. H. Harris Vocational Technical School	Opelousas, LA	Practical Nursing Nursing Asst.
Tallulah Vocational-Technical School	Tallulah, LA	Practical Nursing
Teche Area Vocational-Technical School	New Iberia, LA	Practical Nursing
Thibodaux Area Vocational- Technical School	Thibodaux, LA	Health Occupations
Ville Platte Vocational-Technical School	Ville Platte, LA	Health Occupations
West Louisiana Vocational- Technical School	Leesville, LA	Practical Nursing
Westside Vocational-Technical Technical School	Plaquemine, LA	Practical Nursing
Young Memorial Vocational- Technical School	Morgan City, LA	Practical Nursing
Vocational Curriculum Develop. and Research Center	Natchitoches, LA	Health Occupations

Secondary Schools, Postsecondary School and Proprietary Schools
Program Legend
A. Dental Assistant
B. Dental Laboratory Technology
C. Emergency Medical Technician (E.M.T.)
D. Medical Assistant
E. Medical Laboratory Assistant
F. Nursing Assistant
G. Practical Nursing
H. Radiology Technology (X-Ray)
I. Respiratory Therapy
J. Surgical Technician (Operating Room Technician)
K. Dietary Aide
L. Ward Clerk
M. Pharmacy Clerk
N. Medical Record Clerk
O. Orderly
P. Recreational Aide (Therapy)
Q. Home Health Nursing

AUTHORITY NOTE: Promulgated in accordance with P.L. 93-641 as amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance , LR 13:246 (April 1987).

Chapter 123. Glossary

§12301. Definitions of Words and Phrases Applicable to Health Planning

Accessibility—determination of the method and ease of an individual's (or group's) ability to obtain medical care.

Geographic, financial, social, ethnic and psychic considerations affect the problem of accessibility. It is also a function of availability.

Accreditation—the recognition given an agency or organization that it meets certain predetermined standards following a process of formal evaluation. This differs from *certification* (see definition) which is a similar process applied to individuals. *Accreditation* is usually given by a private organization created for that purpose (such as the Joint commission on Accreditation of Hospitals). *Accreditation* provides evidence to the public that certain standards are met in terms of physical plant, governing body, administration, staff background and organization of services; it is not a condition of lawful practice, which is covered by *licensure* (see definition).

Administrative Staff—the staff responsible for the management of an organization or institution.

Admissions—The number of persons formally accepted for overnight care by a hospital or other inpatient health care facility.

Allied Health Personnel—specially trained and in some localities, licensed, health workers other than physicians, dentists, podiatrists and nurses. The term has no constant or agreed upon detailed meaning; sometimes being used synonymously with paramedical personnel; sometimes meaning all health workers who perform tasks which must otherwise be performed by a physician; and sometimes referring to health workers who do not usually engage in independent practice.

Ambulatory Care—all types of health services provided on an outpatient basis in contrast to inpatient hospital care. Inpatients may be ambulatory, but ambulatory care refers to patients receiving care in a facility without the requirement for an overnight stay.

Amortization—the systematic payment of debt over a specific period of time, generally on an installment basis.

Ancillary Services—hospital or other patient health services other than professional services. They may include x-ray, drug, and laboratory services.

Annual Report—the report of a facility showing assets and liabilities, receipts and disbursements, and other information for a specified 12-month period (fiscal or calendar year).

Applicant—any individual, group, firm, association, corporation, government unit, or other entity requiring a review of need.

Application—the forms and supplements required from applicants by the primary review agency or the designated planning agency.

Assets—all available properties and claims that may be used to pay liabilities.

Availability—a measure (in terms of type volume and location) of the supply of health resources and services relative to the needs/demand of a given individual or community. It is the function of the distribution of appropriate resources, services and personnel and the willingness of the provider to serve the particular patient and need. Availability differs from accessibility, to which it is closely related, by its emphasis on the supply side, while accessibility focuses on the ease by which an available facility can be used.

Average Daily Census—the mean of the daily population of a facility on an inpatient basis in a given time period (usually a year). It is derived by dividing the total number of patient days for the period by the number of calendar days in that period.

Average Length of Stay—the arithmetic mean of days of stay of in-patients over a given period of time. (Also see *length of stay.*)

Back Up Staff—supporting staff to professional personnel involved in routine patient and non-patient related work.

Bed—beds are often used as a measure of capacity. The total number in a facility is usually related to the minimum square foot standards developed by the USPHS and used by State Health Departments. Hospital size is often denoted by bed capacity. Beds in the emergency, anesthesia and recovery rooms as well as beds for special diagnostic purposes are excluded from the measure of capacity. Licenses and certificates of need may be granted for specific number of types of beds. Facilities may have both licensed and unlicensed beds as well as active and unused beds.

Billable Costs—operational costs of services to patients which can be billed to third party payors or patients themselves.

Birth Rate—a fraction, whose numerator is the total number of births in a population in a given period and whose denominator is the total number of person-years lived by the population during that period. The latter is generally approximated by the size of the population at the midpoint of the period multiplied by the length of the period in years. The rate is usually stated per 1,000 persons.

Board—the governing body of a health care institution. In a governmental hospital, the powers of a board are generally vested in elected officials, who may or may not carry out customary board functions.

Board Certified—descriptive of a physician or other health professional who has passed an examination given by a medical specialty board and been certified by that board as a specialist in the subject in question. The examination cannot be taken until the professional meets requirements set by the specialty board for board eligibility.

Bond Issues—the offering for sale to the public of bonds; a written promise under seal to pay a sum of money at some definite future time. Used in the raising of funds for long-term capital needs.

Capital Expenditure—an expenditure:

1. made by or on behalf of a health care facility;

2. which generally accepted accounting principles is not properly chargeable as an expense of operation and

maintenance, or is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and which exceeds the expenditure minimum, substantially changes the bed capacity of the facility with respect to which the expenditure is made, or substantially changes the services of such facility. For purposes of Paragraph 2, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or any equipment with respect to which an expenditure described in Paragraph 2 is made shall be included in determining if such expenditure exceeds the expenditure minimum. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review under Section 422 shall be considered capital expenditures for purposes of Section 1122, and a transfer of equipment or facilities at fair market value would be subject to review under section 1122. For purposes of this paragraph, the term 'expenditure minimum' means $600,000.

Cash Flow—the revenues actually received and expenses actually paid by the facility. The difference represents the cash actually on hand or needed for repayment of expenses due.

Closure of Service—the elimination of a service in a health facility for reasons of cost effectiveness, duplication, or lack of need.

Community—used in several ways. May refer to a geographic entity whose boundaries depend on the frame of reference (the block, the neighborhood, the city, etc.); or to a group bound together by an association of interests (such as ethnic, religious or professional) of relevance to health facilities and planning bodies.

Community Participation—participation in a health facility or planning body by representatives or members of the defined *community*. (see definition) P. L. 93-641 and a number of other laws require community participation in the governing body. The guidelines for participation also define health service consumers and providers, and identify criteria for their inclusion.

Competing Proposal—proposals submitted to the reviewing agency by two or more facilities for providing similar services to the same population.

Competitive Bids—the practice of asking more than one contractor (generally three or more) to bid on a job that cannot be performed by the staff of a facility. The health facility provides the scope of work to be done and chooses between competing bids on the basis of price, time required, and judgment of the contractor's experience, staff and capability.

Consumer—the user of health care services or purchaser of health insurance; in terms of planning agencies, any person who does not provide health care services.

Consumer Charge—charge assessed against the patient (inpatient and outpatient) for services received. The charge may be less than, equal to, or more than the cost of services, depending on the patient's reimbursement method.

Continuity of Care—care provided so that all service elements affecting the health status of the patient, in a particular episode of care, and coordinated over a span of time. Coordination is achieved by the appropriate sharing of information between the levels of providers involved which may include a primary care physician, specialist(s), physician assistant(s), etc.

Cost Benefit Analysis—a method of analysis by which one can appraise the soundness of proposed activities by the calculation of the monetary values of the resources to be employed in the proposed activities (the cost) in comparison to the monetary value of the services to be produced (the benefit). If the anticipated returns compare favorable with the prospective ratios obtained from alternative uses to which resources might be put, the proposed activities may be regarded as sound.

Cost Containment—the attempt to slow down increases in cost or reduce the cost of health care by the introduction of more efficient methods of provider production, better organization of services, various economic incentives, or other mechanisms for regulating hospital costs. *Cost containment* has been among the objectives of public policy embodied in recent legislation including the Health Planning and Resources Development Act, PSRO, etc.

Cost Effectiveness—method of analysis in which costs are calculated and alternative methods are compared for achieving of results; the objective is both efficient use of funds and achievement of a specified result.

Criterion—a measureable characteristic of a health service (when used in the context of "Criteria and Standards").

Day Care Surgical Unit—within an institution, a unit related to a health care institution where minor surgery can be performed without the need of an overnight stay. It may be an integral part of a health facility or it may be free-standing.

Debt Retirement Fund—fund required by external sources to be used to meet debt service charges and the retirement of indebtedness on plant assets.

Demand—

1. in health economics it is the varying amount of a good or service sought at varying prices, given constant income and other factors;

2. in the operational sense, it is the sum of explicit requests, actual or projected, for a given medical care service. Demand may be generated by the patient when he initiates the medical care process, or by the doctor acting for the patient in the process of diagnosis and treatment. It differs from utilization, (the amount of services actually used) and need (the services required, though not necessarily requested, to maintain health status at some predetermined level).

Department—a functional or administrative division of a hospital, health program or government agency. In a hospital, it may be related to a medical specialty, i.e., pediatric, radiology, or surgery department.

Depreciation—the decline in value of capital assets with use over time. It assures an accounting life for the asset. The rate and amount of depreciation is calculated by a variety of methods whose purpose is the reviewing of historical cost, less salvage value, over the estimated lifetime of the asset.

Determination of Need—a determination, affirmative or negative in form, as to the need for one or more of the following: establishment of a new health facility at a designated location; replacement of an existing facility at its existing or at a new location; expansion, alteration, remodeling, renovation, or major repairs to an existing facility, or replacement of any part thereof, at its existing location; establishment by a hospital licensee of a new or relocated clinic at a different location from the hospital; any substantial change in the services of an existing facility at its existing or at a new location.

Diagnostic Services—services performed to aid in diagnosing or determining the nature of a disease. In the hospital setting, these services generally refer to the laboratory and x-ray procedures used as aids in diagnosis.

Difference Equations—a calculus approach to computing values (such as prevalence) at different periods.

Discharges—the number of patients released from a hospital (living or deceased) in a given period.

Economies of Scale—cost savings resulting from optimal use of resources in relation to production. For example, an increase in the number of physicians in a group up to a certain point may be accomplished without increasing administrative staff. *Economies of scale* occur as average cost decreases when one or any combination of factors of production are expanded proportionately.

Elective Admission—a scheduled hospital admission for which reasonable delays will not affect the outcome of the health problem unfavorably. The purpose of such admissions are to improve the patients' health, although they may not be lifesaving.

Emergency Care—care for patients with severe, life-threatening or potentially disabling conditions that require immediate intervention. Often provided in emergency wards which have been constructed for that purpose. Not all conditions seen in emergency wards, however, are of an emergent nature.

Emergency Medical Service System (EMSS)—an integrated system of appropriate health manpower, facilities, and equipment which provides all necessary emergency care in a defined geographic area. The development of such systems is federally assisted under the Emergency Medical Services Act of 1973, P.L. 93-54.

Evaluation—a systematic procedure for determining the degree of effectiveness and efficiency of a program in meeting stated goals and objectives.

Extended Care Service—services in a skilled nursing facility for a condition requiring a lesser level of skilled care than normally provided by a hospital. Such services are provided for a limited duration following a hospital stay.

Facility—a building, including physical plant, equipment and supplies, used in providing health services. Applicable to hospitals, nursing homes, and ambulatory care centers.

Fair Market Value—the price an item would cost in the open market.

Fee for Service—a procedure for charging patients or third-party payers for various services at rates which are determined individually or in accordance with a schedule of fees set by the provider.

Fee Schedule—

1. a provider's fee for service schedule; or

2. a payer's listing of acceptable fees, established allowances, or maximum payments for specified medical procedures.

Fertility Rate—the ratio of the number of births per year to the number of women of child-bearing age.

Financial Feasibility—the determination of a program's ability to, at least, balance operational income and expenses within a given time period. The time period often used is three years, but this varies depending on the specific needs of the institution.

Fixed Costs—costs that do not vary with level of output.

FTE—abbreviation for Full Time Equivalent applied to staffing patterns for positions staffed on a full-time basis or by one or more person on a less than full-time basis. The total hours in a given position expressed as a proportion of the total hours of one full-time person is the quantity of *FTE*.

Funding Depreciation—an accounting entity set up to account for depreciation.

Governing, Body—the policy making unit of a facility. (see definition for *board*).

Gross Revenues—the value, at the hospital's full established rates, of services rendered and goods sold to patients during a given time period.

Guideline—a method by which it is determined whether or not a standard has been met.

Handicapped (Physically)—possessing a physical disability which creates problems in moving about or performing usual physical skills.

Health—includes physical and mental health.

Health Care Facility—a building and/or facility used in the provision of health care, e.g., hospitals and nursing homes.

Health Educator—a person with special training and experience in developing educational programs relating to health for patients, their families, the hospital staff, and the community.

Health Maintenance Organization (HMO)—

1.a. a system for delivering a broad scope of services to members for a fixed or prenegotiated periodic fee. A public or private organization, organized under the laws of any state, which:

i. is a qualified health maintenance organization under section 1310(d); or

ii. provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out of area coverage;

b. is compensated (except for copayments) for the provision of the basic health care services to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health service actually provided; and provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

Health Planning Districts—for purposes of Section 1122 Review, there are nine Health Planning Districts which are the defined service areas for certain proposed or existing health care facilities (Refer to map of Health Planning Districts in Chapter 9).

Health Resources—health services, health professions personnel, and health facilities.

High Risk Population—a population group with special vulnerability toward certain diseases or conditions. For example, coal miners are a high risk population for black lung disease.

Home Health Care—health services rendered to an individual as needed in his home rather than in an institution. Such services are provided to aged, disabled, or convalescent individuals by such agencies as a visiting nurse association, a home health agency, hospital or other organized community group.

Hospital—an institution whose primary function is to provide surgical and non-surgical inpatient services, diagnostic and therapeutic, for a variety of medical conditions. Hospitals may provide outpatient services also.

HRA—health Resources Administration, an agency in the Department of Health, Education and Welfare. Responsible for the administration of P.L. 93-641 through its Bureau of Health Planning and Resources Development.

Informed Consent—agreement, usually in writing, obtained from a patient permitting the provider to carry out specific medical, surgical, or research procedures after the purpose, need and risks of the procedure have been fully explained, in non-technical terms.

Inpatient—a patient who has been admitted overnight to a hospital or other health facility for the purpose of receiving medical services.

Institutional Health Services—health services which:

1. are provided through private and public hospitals, rehabilitation facilities, nursing homes, and other health care facilities, as defined by regulation, and

2. entail annual operating costs of at least the 'expenditure minimum' ($75,000).

Intensive Care Unit (ICU)—a specialized unit within a hospital reserved for seriously ill patients needing constant observation and care.

JCAH—Joint Commission of Accreditation of Hospitals.

Lending Institution—institutions such as banks or insurance companies from whom funds are borrowed for short periods for operating needs, or for longer periods for capital needs.

Length of Stay—length of inpatient's stay in a hospital or other health facility, calculated by determining the total number of days in the facility for all discharges and deaths occurring during a period, divided by the number of discharges and deaths during the same period.

Levels of Care—refers to a concept of health care which attempts to organize hospital care on a functional basis which is related to geographic distribution of services. Care is generally defined in three levels:

1. Level I—Provision of services for patients with minor, uncomplicated medical and surgical needs which do not require the support of unusual laboratory or other services;

2. Level II—Provision of services for major health problems which may require the support of unusual laboratory facilities and subspecialist referrals;

3. Level III—Provision of services for complicated and uncomplicated problems. Includes patients with highly complex problems requiring specialized diagnostic procedures, treatment and rehabilitation services. Distinctions between levels of care are largely based on professional training and laboratory procedures, subspecialty referral services, and therapy teams.

Liability—a financial obligation or debt. An obligation shown in the balance sheet in terms of the cost needed to meet it.

License—Permission granted by public, competent authority to an individual or organization to engage in the delivery of health care. Usually granted on the basis of examination and/or education rather than on measures of performance.

Life Support Equipment—specialized equipment in a hospital used to sustain life (e.g., respirator).

Major Medical Equipment—means equipment which is used for the provision of medical and other health services

and which costs in excess of $150,000, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under Title XVIII of the Social Security Act to meet the requirements of Paragraphs (10) and (11) of section 1861(s) of such Act. In determining whether medical equipment has a value in excess of $150,000, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included.

Manpower Resources—the totality of people involved in the provision of health services.

Medicaid (Title XIX)—a federally aided, state operated and administered program which provides medical benefits for certain low income persons in need of health and medical care. The program is authorized by Title XIX of the Social Security Act.

Medical Staff—collectively, the physicians, dentists, and other professionals responsible for medical care in a health facility, typically a hospital.

Medicare (Title XVIII)—a nationwide health insurance program for people aged 65 and over, for persons eligible for social security disability payments for over two years, and for certain persons who need kidney transplantation or dialysis. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B). Blue Cross is the Part A carrier in Louisiana; Pan American Life Insurance Company is the Part B carrier.

Merger—the combination of one or more programs, services, or facilities, usually to create more efficient and effective service delivery.

Neonatal—pertaining to the first four weeks after birth.

Net Equity—the excess of assets over liabilities. An excess of liabilities over assets is known as a deficit in fund balance.

Newborn Nursery—section of the hospital reserved for the care of newborn infants.

Newborn Services—provision of care required by newborn infants.

New Construction—construction where none existed before, as opposed to renovation which involves alteration of existing facilities.

NICU (Neonatal Intensive Care Unit)—a specialized unit within a hospital reserved for seriously ill newborns needing constant observation and care.

Normile Method—a statistical method, based on mathematical probability, for determining the expected range of demand for beds.

Nurse—a person who is especially prepared in the scientific basis of nursing and who meets certain prescribed standards of education and clinical competence. The licensed practical nurse (LPN) is a graduate of a school of practical nursing whose qualifications have been examined by a state board of nursing and who has been legally authorized to practice under the supervision of a physician or registered nurse (RN). The RN is a graduate nurse who has been legally authorized to practice by a similar regulatory authority, and who is legally entitled to use the designation RN.

Nursing Assistant—an individual who performs nursing responsibilities under the supervision of the LPN or RN; does not require licensure.

Patients' Rights—the privilege or claim by patients for involvement in certain aspects of their health care process, including

communication, information and decision-making.

Peak Load—the heaviest demands on a health facility. Generally related to a time period which can be in terms of hours a day, days of a week, or a particular season.

Pediatric Unit—section of a hospital devoted to the care of children, with a usual age limit of 14 years.

Peer Review—generally the evaluation by practicing physicians or other professionals of the care given by other members of their professional category (peers). More recently, it has also referred to the activities of the Professional Standards Review Organizations (PSRO).

Penalty—a financial charge assessed for the non-performance of a contract or obligation.

Perinatal—pertaining to or occuring in the period shortly before and after birth. In medical statistics, generally considered to begin with completion of 28 weeks of gestation and variously defined as ending one to four weeks after birth.

Philanthropy—charitable contribution to a facility. Generally thought of in dollar terms, but may also be conceived in terms of time devoted to governing board or other voluntary activity.

Physician—a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by a State.

P. L. 93-641—the National Health Planning and Resources Development Act of 1974. The act requires the designation of a Health Systems Agency (HSA), a health planning and resources development agency, in each of the health service areas in the U.S., as well as a number of other agencies, councils, and organizations on the area, state and national levels.

P. L. 96-79—the amended National Health Planning and Resources Development Act of 1974.

Postpartum Unit—section of the hospital devoted to the care of mothers after delivery.

Prepayment—meanings include—synonymous with insurance—payment ahead of time to a provider for anticipated services; —payment to an organizational entity

(e.g., HMO, foundation for medical care, or prepaid group practice) which provides services as well as mediates the payment mechanism.

Principal—the face value of long-term debt. It is the amount borrowed or owed at a given time period exclusive of interest and other charges.

Proprietary Institution—an institution (hospital, nursing home, etc.) operated for the purpose of making a profit for its owners.

Provider—an individual or organization that provides health care services in exchange for reimbursement from a purchaser.

Provider of Health Care—an individual:

1. who is a direct provider of health care (including a physician, dentist, nurse, podiatrist, optometrist, physician assistant, or ancillary personnel employed under the supervision of a physician) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including hospitals, long-term care facilities, rehabilitation facilities, alcohol and drug abuse treatment facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by state law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration;

2. who holds a fiduciary position with, or has a fiduciary interest in, any entity described in clause ii or iv of Paragraph 3 other than an entity described in such clause which is also an entity described in section 501(c)(3) of the Internal Revenue Code of 1954 and which does not have as its primary purpose the delivery of health care, the conduct of research, the conduct of instruction for health professionals, or the production of drugs or articles described in Clause iii of Paragraph 3;

3. who receives (either directly or through the individual's spouse) more than one-fifth of this gross annual income from any one or combination of:

i. fees or other compensation for research into or instruction in the provision of health care,

ii. entities engaged in the provision of health care or in research or instruction in the provision of health care,

iii. producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care; or

iv. entities engaged in producing drugs or such other articles;

4. who is the member of the immediate family of an individual described in Paragraph 1, 2, 3; or 5 who is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits. Notwithstanding Paragraph 2, an individual shall not be considered a provider of health care solely because the individual is the member of the governing body of an entity described in clause ii or iv of Paragraph 3.

PSRO (Professional Standards Review Organization)—a physician-sponsored organization charged with comprehensive and on-going review of services provided under the Medicare, Medicaid, and the Maternal and Child Health Programs. The requirement for the establishment of PSRO's was added to the Social Security Amendments of 1972, P. L. 92-603.

Quality Assurance—a program designed to enhance the quality of medical care in a defined setting or program. Includes two major components:

1. a method for identifying deficiencies in care, generally by some form of peer review; and

2. an educational program through which the providers remedy such deficiencies which may be due to organizational, provider, or patient problems.

Quality of Care—medical care that is efficient, effective and efficacious. The term has been difficult to define with precision because of the methodological difficulties associated with the measurement of quality. Quality of care methodology has identified structure, process and outcome as the components of quality.

Quality Review—the methodology of review which may include: outcome and process studies, review of structure (often used in accreditation studies), and peer review. PSRO mandates utilization review (UR) and medical care evaluation (MCE) studies.

Queuing Theory—a statistical method, utilizing mathematical probability, for determining demand. Used to help control fluctuation of demand.

Rehabilitation Facility—an inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision.

Reimbursement—payment by third party payers such as Blue Cross, private insurance firms, or government (Medicare, Medicaid, etc.) to facilities which have contracted to pay for the care of covered patients.

Renovation—the alteration and rebuilding of existing facilities. (See *new construction*)

"1122" Review—a review by SHPDA and HSA's of health facility applications for capital expenditures to determine necessity. Authority for review is legislated by P. L. 94-603, the Social Security Act amendments of 1972.

Reliability—concerned with the consistency or dependability of the measurement. It is directly related to the kinds of data needed for use of the technique in question. Each variable that is added to a given formula has the potential for introducing a certain amount of error and hence the reliability of the technique. All models or formulas are affected by both validity and reliability. (In general, it is helpful to keep in mind that the validity of any given

methodology depends on how well the model's assumptions represent reality, or the actual environment in which it is used. In general, the resource and time available to the project as well as the required detail will affect the methodology selected.)

Salvage Value—the value of a capital asset at the end of a specified period. It is the current market price of an asset being considered for replacement.

Section 1122—an amendment to the Social Security Act by P. L. 92603. It provides that payments will not be made under Medicare, Medicaid or the Maternal and Child Health Act with respect to certain disapproved capital expenditures determined to be inconsistent with state or local health plans. P. L. 93-641 requires states participating in the *Section 1122* program to have the SHPDA serve as the Section 1122 agency for purposes of required review.

Service Expansion—enlarging the capability of a given service within a health facility.

Service Reduction—reducing the capability of a given service.

Shall—must. The presence of the term "shall" in a standard denotes that the state considers the standard as required for 1122 approval.

SHCC (also LSHCC) (Statewide Health Coordinating Council or Louisiana SHCC)—a council of providers and consumers (who shall be in the majority) appointed by the governor, required under P. L. 93-641 and 96-79. It is responsible for adopting the State Health Plan for review and coordination of the plans and budgets of the HSA's.

Should—ought to. The presence of the term *should* in a standard denotes that the state considers the standard as highly desirable or as a condition toward which the provider of services should strive in the future.

SHPDA (State Health Planning and Development Agency)—the agency established under P. L. 93-641 in each state. It is responsible for preparing an annual preliminary state health plan, and will also serve as designated review agency for *Section 1122* of the Social Security Act.

Social Worker—professionally trained person providing social services, either as a member of a health team, a social service section of a health facility, or on a consultant basis. Social services are provided to enable a patient, family members, or others to deal with problems of social functioning affecting the health or well-being of a patient.

Staffing Plan—a plan, showing how staff responsibilities and relations are organized internally.

Standard—(as a part of "Criteria and Standards") the value, quantitative or qualitative, assigned to a particular criterion.

Start-up Costs—the initial implementation costs incurred by a program before it begins to generate its own revenue.

State Health Plan—a long range plan prepared by the SHPDA and adopted by the SHCC for the state specifying the health goals considered appropriate by the agency and the state health officials and other experts.

Support Services—services required to back up the basic diagnostic and therapeutic skills of the physician. May include laboratory and other services required for patient care.

Surgery Beds—hospital beds reserved for patients requiring surgical procedures.

Surgery Suite—the section of a hospital in which surgical procedures are performed.

Third-Party Payor—the insurer or other agent who pays for some or all of the services provided to a patient. This may be an insurance company, Medicare, Medicaid, CHAMPUS or other coverage or entitlement.

Transfer Agreement—a written document entered into between two institutions (such as a hospital and nursing home) designed to facilitate transfer of patients from one institution to the other.

Underserved—an area in which the ratio of the health providers per thousand population is smaller than some normatively established figure.

Utilization—the extent to which a given group uses a specified service in a specified period of time. Usually expressed as the number of services used per year per 100 or per 1,000 persons eligible for the service, but rates may be expressed in other ratios.

Utilization Review (UR)—evaluation of the necessity, appropriateness and efficiency of the use of medical services, procedures, and facilities. In a hospital this may include review of appropriateness of admissions, services ordered and provided, length of stay, and discharge ctices. Medicare and Medicaid require as a condition of participation that hospitals have a utilization review committee in operation.

Validity—the ability of a technique to measure accurately the phenomenon which it purports to measure. (The critical question is whether or not a given technique adequately incorporates the variables which influence the number of beds needed)

Variable Costs—costs which generally increase or decrease as the size and composition of the enrollment fluctuates.

Working Capital—the sum of an institution's investment in short-term or current assets. Net working capital is the excess of total current assets over total current liabilities.

AUTHORITY NOTE: Promulgated in accordance with P. L. 93-641 amended by P.L. 96-79, and R.S. 36:256(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Management and Finance, LR 13:246 (April 1987).

Chapter 125. Facility Need Review

Subchapter A. General Provisions

§12501. Definitions

A. Definitions. When used in this Chapter the following terms and phrases shall have the following meanings unless the context requires otherwise.

Abeyance of Nursing Facility Beds─a situation in which a nursing facility, if it meets certain requirements, may have all (but not only a portion) of its approved beds disenrolled from the Medicaid Program without causing the approval for the beds to be revoked after 120 days.

Adult Day Health Care (ADHC)—provides services five or more hours a day (not to exceed five days per week) for medical, nursing, social, care management, and personal care needs to adults who are functionally impaired.

Adult Day Health Care Provider—any place owned or operated for profit or nonprofit by a person, society, agency, corporation, institution, or any other group, wherein two or more functionally impaired adults who are not related to the owner or operator of such agency are provided with adult day health care services.

Adult Residential Care Provider (ARCP)—a facility, agency, institution, society, corporation, partnership, company, entity, residence, person or persons, or any other group, which provides adult residential care services for compensation to two or more adults who are unrelated to the licensee or operator. Adult residential care includes, but is not limited to the following services: lodging, meals, medication administration, intermittent nursing services, and assistance with personal hygiene, assistance with transfers and ambulation, assistance with dressing, housekeeping and laundry. For the purposes of this FNR Rule, ARCP refers to an entity that is or will be licensed as an "ARCP level 4-adult residential care provider".

Applicant─the person who is developing the proposal for purposes of enrolling the facility, units and/or beds in the Medicaid Program. See the definition of *Person*.

Applicant Representative─the person specified by the applicant on the application form to whom written notifications are sent relative to the status of the application during the review process.

Approval─a determination by the department that an application meets the criteria of the Facility Need Review (FNR) Program for purposes of participating in the Medicaid Program or a determination by the department that an application meets the criteria of the FNR Program for purposes of being licensed by the department.

Approved─beds and/or facilities which are grandfathered in accordance with the grandfather provisions of this program and/or beds approved in accordance with the Facility Need Review Program.

Behavioral Health Services (*BHS*)—mental health services, substance abuse/addiction treatment services, or combination of such services, for adults, adolescents and children.

Behavioral Health Services Provider—a facility, agency, institution, person, society, corporation, partnership, unincorporated association, group, or other legal entity that provides behavioral health services or, presents itself to the public as a provider of behavioral health services.

CMS─Centers for Medicare and Medicaid Services.

Community Home─a type of community residential facility which has a capacity of eight or fewer beds.

Department─the Department of Health and Hospitals in the state of Louisiana.

Department of Health and Hospitals (DHH)─the agency responsible for administering the Medicaid Program in Louisiana.

Disapproval─a determination by the department that a proposal does not meet the criteria of the Facility Need Review Program and that the proposed facility, beds or units may not participate in the Medicaid Program.

Emergency Community Home Bed Pool─a pool consisting of approved beds which have been transferred from state developmental centers and which are made available for transfer to non state-operated community homes in order to address emergency situations on a case-by-case basis.

Enrollment in Medicaid─execution of a provider agreement with respect to reimbursement for services provided to Title XIX eligibles.

Facility Need Review (FNR)─a review conducted for nursing facility beds (including skilled beds, IC-I and IC-II beds), intermediate care facility for the developmentally disabled beds, and adult residential care units to determine whether there is a need for additional beds to enroll and participate in the Medicaid Program.

Group Home─a type of community residential facility which has a capacity of nine to 15 beds.

Health Standards Section─the section in the Bureau of Health Services Financing which is responsible for licensing health care facilities and agencies, certifying those facilities and agencies that are applying for participation in the Medicaid (Title XIX) and Medicare (Title XVIII) Programs, and conducting surveys and inspections.

Home and Community Based Service (HCBS) Providers—those agencies, institutions, societies, corporations, facilities, person or persons, or any other group intending to provide or providing respite care services, personal care attendant (PCA) services, supervised independent living (SIL) services, monitored in-home caregiving (MIHC) services, or any combination of services thereof, including respite providers, SIL providers, MIHC providers, and PCA providers.

Hospital Service District—a political subdivision of the state of Louisiana created or authorized pursuant to R.S. 46:1051 et seq.

Intermediate Care-Level I (*IC-I*)—a level of care within a nursing facility which provides basic nursing services under the direction of a physician to persons who require a lesser degree of care than skilled services, but who need care and services beyond the level of room and board. Services are provided under the supervision of a registered nurse seven days a week during the day tour of duty with licensed nurses 24 hours a day.

Intermediate Care-Level II (*IC-II*)─a level of care within a nursing facility which provides supervised personal care and health related services, under the direction of a physician, to persons who need nursing supervision in addition to help with personal care needs. Services are provided under the supervision of a registered nurse seven days a week during the day tour of duty with licensed nurses 24 hours a day.

Intermediate Care Facility for the Developmentally Disabled (*ICF-DD*)─a facility which provides developmentally disabled residents with professionally developed individual plans of care, supervision, and therapy in order to attain or maintain optimal functioning.

Legal Device─any legally binding instrument, such as a counter letter, made during the period a Notice of Abeyance is in effect, which would affect the transfer of disenrolled beds.

Notice of Abeyance─a written notice issued by the department to a nursing facility stating that the criteria for placing all of the facility's approved beds in abeyance have been met.

Medicaid Program─the medical assistance program administered in accordance with Title XIX of the Social Security Act.

Notification─is deemed to be given on the date on which a decision is mailed by the Facility Need Review Program or a hearing officer.

Nursing Facility─an institution which is primarily engaged in providing the following services to residents and has in effect a transfer agreement with one or more hospitals:

a. skilled nursing care and related services for residents who require medical or nursing care;

b. rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

c. on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities; said institutional facilities are those facilities which are not primarily for the care of mental diseases.

Pediatric Day Health Care (*PDHC*) *Providers*—a facility that may operate seven days a week, not to exceed 12 hours a day, to provide care for medically fragile children under the age of 21, including technology dependent children who require close supervision. Care and services to be provided by the pediatric day health care facility shall include, but not be limited to:

a. nursing care, including, but not limited to:

i. tracheotomy and suctioning care;

ii. medication management; and

iii. intravenous (IV) therapy;

b. respiratory care;

c. physical, speech, and occupational therapies;

d. assistance with activities of daily living;

e. transportation services; and

f. education and training.

Person─an individual or other legal entity.

Program─the Facility Need Review Program.

Review Period─the period of time in which the review is conducted.

Secretary─the secretary of the Department of Health and Hospitals.

Skilled Nursing Care─a level of care within a nursing facility which provides intensive, frequent, and comprehensive nursing care and/or rehabilitation services ordered by and under the direction of a physician. Services are provided under the supervision of a registered nurse seven days a week during the day tour of duty with licensed nurses 24 hours a day. Skilled beds are located in nursing facilities and in "distinct parts" of acute care hospitals.

a. Facility Need Review policies governing skilled beds in nursing facilities also apply to Title XIX skilled beds in hospitals. In order to be enrolled to participate in Title XIX, skilled beds in hospitals must be approved through Facility Need Review. Skilled care is also referred to as "extended care".

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), LR 28:2190 (October 2002), LR 30:1023 (May 2004), LR 32:845 (May 2006), LR 34:2611 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2437 (November 2009), LR 36:323 (February 2010), LR 38:1961 (August 2012), LR 41:135 (January 2015), LR 41:2636 (December 2015), LR 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:280 (February 2018).

§12503. General Information

A. The Department of Health and Hospitals will conduct a facility need review (FNR)to determine if there is a need for additional facilities, beds or units to enroll to participate in the Title XIX Program for the following facility types:

1. nursing facilities;

2. skilled nursing facilities; and

3. intermediate care facilities for persons with developmental disabilities.

B. 42 CFR Part 442.12(d) allows the Medicaid agency to refuse to execute a provider agreement if adequate documentation showing good cause for such refusal has been compiled (i.e., when sufficient beds are available to serve the Title XIX population). The Facility Need Review Program will review applications for additional beds, units and/or facilities to determine whether good cause exists to deny participation in the Title XIX Program to prospective providers of those services subject to the FNR process.

C. The department will also conduct an FNR for the following provider types to determine if there is a need to license additional units, providers or facilities:

1. adult residential care providers or facilities;

2. home and community-based service providers, as defined under this Chapter;

3. adult day health care providers;

4. hospice providers or inpatient hospice facilities;

5. pediatric day health care facilities; and

6. behavioral health services (BHS) providers that provide psychosocial rehabilitation (PSR) and/or community psychiatric support and treatment (CPST) services.

D. The department shall be responsible for reviewing proposals for facilities, beds, units and agencies submitted by health care providers seeking to be licensed or to participate in the Medicaid Program. The secretary or his designee shall issue a decision of approval or disapproval.

1. The duties of the department under this program include, but are not limited to:

a. determining the applicability of these provisions to all requests for approval to enroll facilities, beds, or units in the Medicaid Program or to license facilities, units, providers or agencies;

b. reviewing, determining and issuing approvals or disapprovals for proposals determined to be subject to these provisions;

c. adopting and promulgating such rules and regulations as may be necessary to implement the provisions of this program pursuant to the Administrative Procedure Act; and

d. defining the appropriate methodology for the collection of data necessary for the administration of the program.

E. No nursing facility, skilled nursing facility, or ICF-DD bed, nor provider units/beds shall be enrolled in the Title XIX Program unless the bed has been approved through the FNR Program. No adult residential care provider, home and community-based services provider or adult day health care provider may be licensed by the department unless the facility, unit or agency has been approved through the FNR Program.

F. Grandfather Provision. An approval shall be deemed to have been granted under this program without review for NFs, ICFs-DD and/or beds that meet one of the following descriptions:

1. all valid Section 1122 approved health care facilities/beds;

2. all valid approvals for health care facilities/beds issued under the Medicaid Capital Expenditure Review Program prior to the effective date of this program;

3. all valid approvals for health care facilities issued under the Facility Need Review Program; or

4. all nursing facility beds which were enrolled in Medicaid as of January 20, 1991.

G. Additional Grandfather Provision. An approval shall be deemed to have been granted under FNR without review for HCBS providers, ICFs/DD, ADHC providers, hospice providers, BHS providers, and pediatric day health care centers that meet one of the following conditions:

1. HCBS providers which were licensed by January 31, 2009 or had a completed initial licensing application submitted to the department by June 30, 2008;

2. existing licensed ICFs-DD that are converting to the Residential Options Waiver;

3. ADHC providers who were licensed as of December 31, 2009 or who had a completed initial licensing application submitted to the department by December 31, 2009, or who are enrolled or will enroll in the Louisiana Medicaid Program solely as a program for all-inclusive care for the elderly provider;

4. hospice providers that were licensed, or had a completed initial licensing application submitted to the department, by March 20, 2012; or

5. pediatric day health care providers that were licensed by the department before March 1, 2014, or an entity that meets all of the following requirements:

a. has a building site or plan review approval for a PDHC facility from the Office of State Fire Marshal by March 1, 2014;

b. has begun construction on the PDHC facility by April 30, 2014, as verified by a notarized affidavit from a licensed architect submitted to the department, or the entity had a fully executed and recorded lease for a facility for the specific use as a PDHC facility by April 30, 2014, as verified by a copy of a lease agreement submitted to the department;

c. submits a letter of intent to the department's Health Standards Section by April 30, 2014, informing the department of its intent to operate a PDHC facility; and

d. became licensed as a PDHC by the department no later than December 31, 2014;

6. behavioral health services providers that are licensed to provide PSR and/or CPST, or that have submitted a completed application for licensure as a BHS provider that includes PSR and/or CPST, prior to promulgation of this Rule; and

7. behavioral health services (BHS) providers that fall within the provisions of Act 33 of the 2017 Regular Session of the Louisiana Legislature, commonly referred to as accredited mental health rehabilitation providers, that submit a completed BHS provider licensing application by December 1, 2017 and become licensed by April 1, 2018.

H. Exemptions from the facility need review process shall be made for:

1. a nursing facility which needs to be replaced as a result of destruction by fire or a natural disaster, such as a hurricane; or

2. a nursing facility and/or facility building owned by a government agency which is replaced due to a potential health hazard.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2612 (December 2008), amended LR 35:2437 (November 2009), LR 36:323 (February 2010), LR 38:1593 (July 2012), LR 38:1961 (August 2012), LR 41:136 (January 2015), LR 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:281 (February 2018).

§12505. Application and Review Process

A. FNR applications shall be submitted to the Bureau of Health Services Financing, Health Standards Section, Facility Need Review Program. The application shall be submitted on the forms (on 8.5 inch by 11 inch paper) provided for that purpose, contain such information as the department may require and be accompanied by a nonrefundable fee of $200. An original and three copies of the application are required for submission.

1. Application forms may be requested in writing or by telephone from the FNR Program. The FNR Program will provide application forms, inventories, utilization data, and other materials relevant to the type of application.

2. The applicant representative specified on the application will be the only person to whom the FNR Program will send written notification in matters relative to the status of the application during the review process. If the applicant representative or his address changes at any time during the review process, the applicant shall notify the FNR Program in writing.

3. A prospective ARCP applicant shall submit the following documents as part of the application:

a. certification of the number and ratio of Medicaid approved nursing facility beds that will be converted to ARC units;

b. a letter of intent that includes the location of the proposed ARC site and the proposed date of opening;

d. certification that the applicant will provide services as defined in the statute; and

e. certification which includes the following:

i. that the applicant has reviewed the licensing regulations and will comply with the licensing regulation; and

ii. acknowledgement that failure to meet the time-frames established in this Chapter will result in automatic expiration of the FNR approval for the ARCP units.

B. The review period will be no more than 60 days, except as noted in the case of issuance of a request for proposals (RFP). The review period begins on the first day after the date of receipt of the application, or, in the case of issuance of an RFP, on the first day after the period specified in the RFP.

1. A longer review period will be permitted only when initiated by the Facility Need Review Program. A maximum of 30 days will be allowed for an extension, except as otherwise noted for the issuance of a RFP.

2. An applicant may not request an extension of the review period, but may withdraw an application (in writing) at any time prior to the notification of the decision by the FNR Program.

a. The application fee is non-refundable.

3. The FNR Program shall review the application within the specified time limits and provide written notification of the decision to the applicant representative.

a. Notification of disapproval shall be sent by certified mail to the applicant representative, with reasons for disapproval specified.

b. If notification is not sent by the sixtieth day, except as noted in the case of issuance of a RFP, the application is automatically denied.

4. If FNR approval is denied, the applicant may choose to:

a. pursue an administrative appeal pursuant to Subchapter G, §12541; or

b. within 30 days of receipt of the notice of denial of FNR approval, and prior to filing an administrative appeal, request a supplemental review of additional documentation to be submitted by the applicant;

i. the time period to submit the supplemental materials shall be no later than 30 days from the date the request is approved by the department and notice received by the applicant. If timely received, the supplemental documentation will be reviewed in conjunction with the original FNR application. The applicant will receive the results of such review in writing from the department;

ii. in the case of a failure to submit the supplemental materials in a timely manner or, upon a denial

of the supplemental application, the applicant may file an administrative appeal of the department's decision with the Division of Administrative Law (DAL). This request shall be submitted within 30 days of the date of receipt of notice of said failure or denial;

iii. failure to file timely for an administrative appeal shall exhaust the applicant's remedies with the department and the decision to deny FNR approval is final;

c. the administrative appeal shall be conducted by the DAL in accordance with the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:812 (August 1995), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2612 (December 2008), LR 35:2438 (November 2009), LR 36:323 (February 2010), LR 38:1593 (July 2012), LR 41:2636 (December 2015).

Subchapter B. Determination of Bed, Unit, Facility or Agency Need

§12507. Intermediate Care Facilities for the Developmentally Disabled

A. The service area for a proposed or existing facility is designated as the department's administrative region in which the facility or proposed facility is or will be located. The administrative regions and the parishes which comprise these regions are as follows:

1. Region I: Jefferson, Orleans, Plaquemines, and St. Bernard;

2. Region II: Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana;

3. Region III: Assumption, Lafourche, St. Charles, St. James, St. John, St. Mary, and Terrebonne;

4. Region IV: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion;

5. Region V: Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis;

6. Region VI: Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn;

7. Region VII: Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine and Webster;

8. Region VIII: Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, and West Carroll; and

9. Region IX: Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington.

B. The beds and population of the service area where the facility is located, or is proposed to be located, will be considered in determining the need for the facility or additional beds. The beds that are counted in determining the need for community and group homes are approved, licensed beds and approved, unlicensed beds as of the due date for a decision on an application.

C. Data sources utilized include information compiled by the FNR Program and the middle population projections recognized by the State Planning Office as official projections. The population projections utilized are those for the year in which the beds are to be enrolled in the Medicaid Program.

D. In accordance with the department's policy of least restrictive environment, there is currently no identified need for additional facilities with 16 or more beds. Therefore, applications for facilities of 16 or more beds shall not be accepted for review, and applications to increase existing facilities to 16 or more beds shall not be accepted for review.

E. At the present time, the recommended bed-to-population ratio for community and group homes has been achieved. However, special needs and circumstances may arise which the department may consider as indicators of need for additional beds such as occupancy rates, availability and accessibility of clients in need of placements, patient origin studies, and requests for special types of beds or services.

1. For service areas in which average annual occupancy for the four most recent quarters (as reported in the MR-2) is in excess of 93 percent, the department may review the census data, utilization trends, and other factors described in of this section to determine if additional beds are needed.

F. If the department determines that there is a need for beds in a parish with an average annual occupancy in excess of 93 percent, a Request for Proposals (RFP) will be issued. No applications will be accepted under these provisions unless the Department declares a need and issues a RFP. Applications will be accepted for expansion of existing facilities and/or for the development of new facilities.

1. The RFP will indicate the region in need of beds, the number of beds needed, the date by which the beds are to be available to the target population (enrolled in Medicaid), and the factors which the department considers relevant in determining the need for the additional beds.

2. The RFP will specify the MR-2 on which the determination of need is based.

3. The RFP will be issued through newspaper publication and will specify the dates during which the department will accept applications.

4. Applications will be accepted for a period to be specified in the RFP. Once submitted, an application cannot be changed and additional information will not be accepted.

G. The department will review the proposals and independently evaluate and assign points to each of the following 10 items on the application for the quality and adequacy of the response to meet the need of the project:

1. work plan for Medicaid certification;

2. availability of the site for the proposal;

3. relationship or cooperative agreements with other health care providers;

4. accessibility to other health care providers;

5. availability of funds; financial viability;

6. experience and availability of key personnel;

7. range of services, organization of services and program design;

8. methods to achieve community integration;

9. methods to enhance and assure quality of life; and

10. plan to ensure client rights, maximize client choice and family involvement.

H. A score of 0-20 will be given to the applicant's response to each item using the following guideline:

1. 0 = inadequate response;

2. 5 = marginal response;

3. 10 = satisfactory response;

4. 15 = above average response; and

5. 20 = outstanding response.

I. In the case of a tie for the highest score for a specific facility or additional beds, the department will be conduct a comparative review of the top scoring proposals which will include prior compliance history. The department will make a decision to approve one of the top scoring applications based on the comparative review of the proposals.

J. If no proposals are received which adequately respond to the need, the department may opt not to approve an application.

K. At the end of the 90-day review period, each applicant will be notified of the department's decision to approve or disapprove the application. However, the evaluation period may be extended for up to 60 days. Applicants will be given 30 days from the date of receipt of the notification by the department in which to file an appeal.

1. The issuance of the approval of the proposal with the highest number of points shall be suspended during the 30-day period for filing appeals and during the pendency of any administrative appeal. All administrative appeals shall be consolidated for purposes of the hearing.

L. Proposals approved under these provisions are bound to the description in the application with regard to type of beds and/or services proposed as well as to the location as defined in the RFP issued by the department.

1. Approval for Medicaid shall be revoked if these aspects of the proposal are altered.

2. Beds to meet a specific disability need approved through this exception must be used to meet the need identified.

M. Prior approval from the Office for Citizens with Developmental Disabilities is required before admission of all Medicaid recipients to facilities in beds approved to meet a specific disability need identified in a RFP issued by the department.

N. Exception for approved beds in downsizing large residential ICF-DD facilities (16 or more beds).

1. A facility with 16 or more beds which voluntarily downsizes its enrolled bed capacity in order to establish a group or community home will be exempt from the bed need criteria.

a. Beds in group and community homes which are approved under this exception are not included in the bed-to-population ratio or occupancy data for group and community homes approved under the FNR Program.

2. Any enrolled beds in the large facility will be disenrolled from the Title XIX Program upon enrollment of the same number of group or community home beds.

3. When the department intends to downsize the enrolled bed capacity of a state-owned facility with 16 or more beds in order to develop one or more group or community homes, and the approved beds will be owned by the state, a cooperative endeavor agreement (CEA) will be issued.

a. The CEA will be issued and beds shall be made available in accordance with the methods described in this Section;

4. For private facility beds downsized to privately owned group or community homes, these facilities should contact the regional Office for Citizens with Developmental Disabilities in the region where the proposed community or group home beds will be located. These proposals do not require facility need review approval.

O. Exception for Additional Beds for Certain ICFs-DD

1. Any ICF-DD which serves children or adults suffering from mental retardation, autism or behavioral problems and which had no less than 150 and no more than 180 approved beds as of August 15, 2003, shall, upon application to the department, be granted approval for up to 50 additional beds without being required to meet the standards set forth in this Section, §12505 or §12527.B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), LR 28:2190 (October 2002), LR 30:1023 (May 2004), LR 32:845 (May 2006), amended LR 34:2613 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2279 (October 2010).

§12508. Pediatric Day Health Care Providers

A. No PDHC provider shall be licensed to operate unless the FNR Program has granted an approval for the issuance of a PDHC provider license. Once the FNR Program approval is granted, a PDHC provider is eligible to be licensed by the department, subject to meeting all of the requirements for licensure.

B. For purposes of facility need review, the service area for a proposed PDHC shall be within a 30 mile radius of the proposed physical address where the provider will be licensed.

C. Determination of Need/Approval

1. The department will review the application to determine if there is a need for an additional PDHC provider in the geographic location and service area for which the application is submitted.

2. The department shall grant FNR approval only if the FNR application, the data contained in the application, and other evidence effectively establishes the probability of serious, adverse consequences to recipients' ability to access health care if the provider is not allowed to be licensed.

3. In reviewing the application, the department may consider, but is not limited to, evidence showing:

a. the number of other PDHC providers in the same geographic location, region, and service area servicing the same population; and

b. allegations involving issues of access to health care and services.

4. The burden is on the applicant to provide data and evidence to effectively establish the probability of serious, adverse consequences to recipients' ability to access health care if the provider is not allowed to be licensed. The department shall not grant any FNR approvals if the application fails to provide such data and evidence.

D. Applications for approvals of licensed providers submitted under these provisions are bound to the description in the application with regard to the type of services proposed as well as to the site and location as defined in the application. FNR approval of licensed providers shall expire if these aspects of the application are altered or changed.

E. FNR approvals for licensed providers are non-transferable and are limited to the location and the name of the original licensee.

1. A PDHC provider undergoing a change of location in the same licensed service area shall submit a written attestation of the change of location and the department shall re-issue the FNR approval with the name and new location. A PDHC provider undergoing a change of location outside of the licensed service area shall submit a new FNR application and appropriate fee and undergo the FNR approval process.

2. A PDHC provider undergoing a change of ownership shall submit a new application to the department's FNR Program. FNR approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, which must show the seller's or transferor's intent to relinquish the FNR approval.

3. FNR approval of a licensed provider shall automatically expire if the provider is moved or transferred to another party, entity or location without application to and approval by the FNR program.

F. The following time frames shall apply for complying with the requirements for obtaining approval of architectural plans and licensure.

1. PDHC facilities which are to be licensed in existing buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within one year from the date of the FNR approval.

2. PDHC facilities which are to be licensed in newly constructed buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

3. A one-time 90-day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant.

4. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the PDHC facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:136 (January 2015), amended LR 41:2636 (December 2015).

§12509. Emergency Community Home Bed Pool Exception

A. The emergency community home bed pool consists of all Medicaid enrolled beds which have been authorized to be transferred from state developmental centers to non state-operated community homes on or before June 30, 2002 in order to address emergency situations on a case-by-case basis.

B. Effective July 1, 2002, the secretary of the department may not authorize the transfer of any beds from the emergency community home bed pool to a non-state operated community home unless the bed had been authorized to be transferred to a non state operated community home on or before June 30, 2002 and was subsequently transferred from that facility back to the pool pursuant to the provisions of this Section.

C. Emergency situations which may be addressed through the use of the emergency community home bed pool shall include, but not be limited to situations in which it is

difficult or impossible to find a placement for an individual in an ICF-DD because of one of the following:

1. an inadequate number of available ICF-DD beds in the service area to serve the needs of the developmentally disabled population in general;

2. an inadequate number of available ICF-DD beds in the service area to serve the needs of the developmentally disabled population who also have physical or behavioral disabilities or difficulties; or

3. an inadequate number of available ICF-DD beds in the service area to provide for the transition of individuals from residing in large residential facilities to residing within the community.

D. Any agency or individual who becomes aware of an actual or potential emergency situation should contact the Office for Citizens with Developmental Disabilities (OCDD). OCDD shall submit its recommendations to the Facility Need Review Program for emergency placement. OCDD's recommendations shall include:

1. identification of the individual in need of emergency placement,

2. the individual's needs,

3. the service area in which transfer from the Emergency Community Home Bed Pool is requested, and

4. the names of one or more existing community homes that would be appropriate for the emergency placement.

E. To be eligible for transfer of one or more beds from the emergency community home bed pool, a community home must meet the following requirements, based on documentation provided by the Health Standards Section.

1. The facility must comply with the physical accessibility requirements of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 973; or if it does not comply with those requirements, it must have a written plan to be in compliance within 24 months.

2. The facility cannot have been on a termination track or have had any repeat deficiencies within the last 12 months.

3. The facility must meet all square footage requirements, *Life Safety Code* requirements and general construction requirements of 42 CFR Subpart I, Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded, as well as LAC 50:VII.Chapter 301 and LAC 48:I.Chapters 51, 63 and 79.

4. The facility must ensure the provision of sufficient staffing and behavior modification plans to meet the needs of current residents and prevent those residents from being adversely affected by the emergency admission.

F. The secretary shall authorize the transfer of the bed for use at the non state-operated community home. Upon the enrollment of the transferred bed at that community home, the bed shall be permanently transferred to that facility subject to the following conditions.

1. Once the bed is no longer needed to remedy the emergency situation, the facility shall continue to make it available for subsequent emergency placements. However, it may be used temporarily to serve other individuals until it is needed for a new emergency placement.

2. The facility shall make the bed available for a new emergency placement within 72 hours after receiving a request for such placement from the department as set forth herein. If the facility does not comply with such a request, the secretary may, at his discretion, transfer the bed from the facility back to the emergency community home bed pool.

G. Beds which have been placed in the emergency community home bed pool shall be exempt from the bed need criteria and the requirements for requests for proposals which are normally applicable to ICFs-DD.

H. For purposes of the emergency community home bed pool exception, the definition of a service area provided in §12507.A is applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), LR 34:2614 (December 2008).

§12511. Nursing Facilities

A. The service area for proposed or existing nursing facilities or beds is the parish in which the site is located.

1. Exception. Any parish that has any portion of the parish below Interstate 10 and which is intersected by the Mississippi river will be composed of two separate service areas as divided by the Mississippi River.

B. Nursing facility beds located in "distinct parts" of acute care general hospitals must be approved through FNR in order to be enrolled to participate in the Medicaid Program.

C. In reviewing the need for beds, all proposed beds shall be considered available as of the projected date of the project. The FNR Program does not recognize the concept of "phasing-in" beds, whereby an applicant provides two or more opening dates.

D. For reviews in which the bed to population ratio is a factor, the bed inventory which will be used is that which is current on the date on which the complete application is received.

1. The bed to population ratio will be recomputed during the review period when the report is incorrect due to an error by the department.

E. For reviews in which utilization is a factor, the occupancy report which will be used is that which is current on the date on which the complete application is received.

1. The occupancy rate will be recomputed during the review period when the report is incorrect due to an error by the department.

F. In determining occupancy rates of nursing facilities or beds:

1. beds for which occupancy shall be based shall include nursing facility beds (skilled, IC-I and IC- II) which are enrolled in Title XIX;

2. each licensed bed shall be considered as available for utilization for purposes of calculating occupancy; and

3. a bed shall be considered in use, regardless of physical occupancy, based on payment for nursing services available or provided to any individual or payer through formal or informal agreement.

G. The beds and population of the service area where the facility is located, or is proposed to be located, will be considered in determining need for the facility or beds.

1. The beds which are counted in determining need for nursing facilities or beds are approved, licensed beds and approved, unlicensed beds as of the due date for decision on an application.

H. Data sources to be used include information compiled by the FNR Program and the middle population projections recognized by the State Planning Office as official projections. Population projections to be used are those for the year in which the beds are to be enrolled in the Medicaid Program.

I. In order for additional beds or facilities to be added in a service area, the bed-to-population ratio for nursing facility beds shall not exceed 65 Medicaid approved beds per 1,000 elderly population in a service area, and the average annual occupancy for the four most recent quarters (as reported in the LTC-2) shall exceed 95 percent in the service area.

J. Exceptions for areas with high occupancy rates may be considered in the following situations.

1. A Medicaid enrolled nursing facility which maintains 98 percent average annual occupancy of its enrolled beds for the four most recent quarters (as reported in the LTC-2) may apply for approval of additional beds to be enrolled in the Medicaid Program.

a. In order for an application to be considered, all approved beds in the facility must be enrolled in Title XIX.

b. In order for a facility to reapply for additional beds, all approved beds must be enrolled in Title XIX for the four most recent quarters, as reported in the LTC-2.

c. The number of beds for which application may be made shall not exceed 10 beds.

d. In determining occupancy rates for purposes of this exception, only an adjustment of one additional day after the date of death, for the removal of personal belongings, shall be allowed if used for that purpose.

i. This adjustment shall not be allowed if nursing services available or provided to another individual are paid for through formal or informal agreement in the same bed for that time period.

e. In determining occupancy rates, more than one nursing facility bed enrolled in Title XIX shall not be considered occupied by the same resident, regardless of payment for nursing services available or provided.

f. For a Medicaid enrolled nursing facility with high occupancy to apply for additional bed approval, documentation of availability of health manpower for the proposed expansion shall be required.

g. For a Medicaid enrolled nursing facility with high occupancy to apply for additional bed approval, for the most recent 36 months preceding the date of application, compliance history and quality of care performance of the applicant facility must be void of any of the following sanctions:

i. appointment of a temporary manager;

ii. termination, non-renewal or cancellation, or initiation of termination or non-renewal of provider agreement; or

iii. license revocation or non-renewal.

2. When average annual occupancy for the four most recent quarters (as reported in the LTC-2) exceeds 95 percent in a parish, the department will determine whether additional beds are needed, and if indicated, may issue a Request for Proposals (RFP) to develop the needed beds.

a. Upon issuance of the utilization report, the department will identify the parishes with average annual occupancy in excess of 95 percent. The LTC-2 is issued by the department in the fourth month following the end of each calendar quarter.

b. In order to determine if additional beds are needed for each parish in which average annual occupancy is in excess of 95 percent, the department may review the census data, utilization trends, and other factors such as:

i. special needs in an area;

ii. information received from other health care providers and other knowledgeable sources in the area;

iii. waiting lists in existing facilities;

iv. requests from the community;

v. patient origin studies;

vi. appropriateness of placements in an area;

vii. remoteness of an area;

viii. occupancy rates in adjoining and/or adjacent parishes;

ix. availability of alternatives;

x. reasonableness of distance to facilities;

xi. distribution of beds within a service area or geographical area; and

xii. such other factors as the department may deem relevant.

c. The number of beds which can be added shall not exceed 15 percent of the existing approved beds in the parish, or 120 beds, whichever is less. The department will strive to assure that occupancy in existing facilities in the area will not decline below 85 percent as a result of the additional beds;

3. If the department determines that there is, in fact, a need for beds in a parish with average annual occupancy in excess of 95 percent, a RFP will be issued. No applications will be accepted under these provisions unless the department declares a need and issues a RFP. Applications will be accepted for expansions of existing facilities and/or for the development of new facilities.

a. The RFP will be issued through newspaper publication, and will specify the dates during which the department will accept applications. Also, nursing facilities in the service area and adjoining parishes will be notified of the issuance of the RFP.

b. The RFP will indicate the parish and/or area in need of beds, the number of beds needed, the date by which the beds are needed to be available to the target population (enrolled in Medicaid), and the factors which the department considers relevant in determining need for the additional beds. The RFP will specify the LTC-2 on which the determination of need is based.

c. Applications will be accepted for a 30-day period, to be specified in the RFP. Once submitted, an application cannot be changed and additional information will not be accepted.

d. The department will review the proposals and independently evaluate and assign points (out of a possible 120) to the applications as follows:

i. 0-20 points: Availability of beds to the Title XIX population.

NOTE: Work plan for Medicaid certification and availability of site for the proposal.

ii. 0-20 points: Appropriateness of location, or proposed location.

NOTE: Accessibility to target population, relationship or cooperative agreements with other health care providers, and distance to other health care providers.

iii. 0-20 points: Responsiveness to groups with special needs (e.g. AIDS patients, ventilator assisted patients; technology dependent patients);

iv. 0-20 points: Experience and availability of key personnel (e. g., director of nursing, administrator, medical director);

v. 0-20 points: Distribution of beds/facilities within the service area. Geographic distribution of existing beds and population density will be taken into account.

e. A score of 0-20 will be given to the applicant's response to each item using the following guideline:

i. 0 = inadequate response;

ii. 5 = marginal response;

iii. 10 = satisfactory response;

iv. 15 = above average response; and

v. 20 = outstanding response.

f. If there is a tie for highest score for a specific facility or beds, a comparative review of the top scoring proposals will be conducted. In the case of a tie, the department will make a decision to approve one of the top scoring applications based on comparative review of the proposals.

g. If no proposals are received which adequately respond to the need, the department may opt not to approve an application.

h. At the end of the 60-day review period, each applicant will be notified of the department's decision to approve or disapprove the application. However, the department may extend the evaluation period for up to 30 days. Applicants will be given 30 days from the date of receipt of the department’s notification by in which to file an appeal.

i. The issuance of the approval of the application with the highest number of points shall be suspended during the 30-day period for filing appeals and during the pendency of any administrative appeal. All administrative appeals shall be consolidated for purposes of the hearing.

4. Proposals submitted under these provisions are bound to the description in the application with regard to the type of beds and/or services proposed as well as to the site/location as defined in the request issued by the department.

a. Approval for Medicaid certification shall be revoked if these aspects of the proposal are altered.

NOTE: Pursuant to R.S. 40:2116(D)(2), the Department of Health and Hospitals shall not approve any additional nursing facilities or additional beds in nursing facilities through facility need review. This prohibition shall apply to additional licensed beds as well as Medicaid certified beds. This prohibition shall not apply to the replacement of existing facilities, provided that there is no increase in existing nursing home beds at the replacement facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), LR 34:2615 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:3264 (November 2011), LR 41:2637 (December 2015).

§12513. Alternate Use of Licensed Approved Title XIX Beds

A. In a service area in which average annual occupancy is lower than 93 percent, a nursing home may elect to temporarily convert a number of Title XIX beds to an alternate use (e.g., adult day care).

1. The beds may be converted for alternate use until such time as the average annual occupancy in the service area exceeds 93 percent (based on the LTC-2 report) and the facility is notified of the same.

2. The facility shall then either re-enroll the beds as nursing home beds within one year of receipt of notice from the department that the average annual occupancy in the service area exceeds 93 percent.

3. The approval for beds not re-enrolled by that time will be expired.

B. A facility is prohibited from adding beds when alternately using beds.

C. All approved beds must be enrolled as nursing home beds in Title XIX for the four most recent quarters, as reported in the department's occupancy report, in order for additional beds to be approved.

D. A total conversion of all beds is prohibited.

E. A nursing facility that has converted beds to alternate use may elect to remove the beds from alternate use and re-license and re-enroll the beds as nursing facility beds. The facility has 120 days from removal from alternate use to re-license and re-enroll the beds. Failure to re-license and re-enroll the beds within 120 days will result in the automatic expiration of FNR approval.

F. The nursing facility beds converted to alternate use shall be used solely for the purpose of providing health care services at a licensed and/or certified facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2617 (December 2008), amended LR 35:2438 (November 2009).

§12515. Additional Beds for Replacement Facility

A. A nursing facility that has had all approved beds enrolled for the four most recent quarters (as reported in the LTC-2) and is structurally older than 25 years, may apply for approval for additional beds to be enrolled in the Medicaid Program in a replacement facility.

B. The number of beds for which an application may be made shall not exceed 20 beds, with the following exception:

1. a facility may be approved for sufficient beds to bring the total approved beds in the replacement facility to 80.

C. A facility shall not be approved for beds that would exceed 130 total approved beds in the replacement facility.

D. Sufficient documentation must be submitted to demonstrate to the department's satisfaction that the facility is structurally older than 25 years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), LR 34:2617 (December 2008).

§12517. Adult Residential Care Provider

A. The FNR Program will determine the number of adult residential care provider (ARCP) units to be licensed by the department. No ARCP unit shall be licensed to operate unless the FNR Program has granted an approval for the licensed ARCP unit. Once the FNR Program approval is granted, the unit is then eligible to be licensed by the department, subject to meeting all the requirements for licensure.

1. An existing licensed nursing facility that converts Medicaid approved nursing facility beds to ARCP units shall be automatically granted FNR approval for the converted units. The nursing home must submit an application to the department requesting the approval. The application must detail the Medicaid approved nursing home beds being converted.

B. The service area for proposed or existing adult residential care units is the parish in which the units are to be located. Exceptions are the parishes of Ascension, Iberville, Plaquemines and St. John, each of which is composed of two separate service areas divided by the Mississippi River.

C. Determination of Need Methodology

1. Population Based Methodology. The FNR Program methodology projects the need for ARCP units to be 15 units per 1,000 persons who are 65 years old and older for each service area. The approved unit to population ratio for ARCP shall not exceed 15 units per 1000 persons who are 65 years old and older except as provided for in paragraph three.

2. The need for facilities will be projected five years forward using the most recent census data available from the Louisiana State Division of Administration.

3. Approval for additional units or facilities may be granted by the department if the service area's average annual occupancy for the four most recent quarters exceeds 98 percent. Approval for additional units in new or existing ARCP facilities shall be granted in increments not to exceed 20 units.

D. ARCP facilities that have approval for licensed units shall submit quarterly reports to the DHH Office of Aging and Adult Services (OAAS). The report shall contain the facility's patient/resident days and such other information as determined by OAAS.

E. Applications for approvals of licensed units submitted under these provisions are bound to the description in the application with regard to the type of units and/or services proposed as well as to the site/location as defined in the application. FNR approval of licensed units shall expire if these aspects of the application are altered.

F. FNR approvals for licensed units are non-transferable. Approvals for licensed units are limited to location and name of original licensee.

1. No portion of the units may be transferred to another party or moved to another location without the submission of a new application to and approval by the department's FNR Program. Approval of licensed units shall automatically expire if moved or transferred without application to and approval by the FNR Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2617 (December 2008).

§12519. Conversion of Medicaid Approved Nursing Facility Beds to Adult Residential Care Provider Units

A. Existing licensed nursing facilities that convert Medicaid approved beds to ARCP units will be automatically granted FNR approval of licensed ARCP units, upon submission of a completed application to the FNR Program.

B. Existing licensed nursing homes shall convert Medicaid approved beds to ARC units on a ratio of four Medicaid approved nursing facility beds for each approved ARCP unit if the existing nursing home facility structure is utilized.

1. Nursing facilities that build new ARC buildings shall surrender two Medicaid approved beds for each approved ARCP unit. The license for any such converted nursing facility bed is surrendered at the date of conversion.

C. Conversion of nursing facility beds to ARCP units is irrevocable and units so converted may not be returned to nursing facility service, except in the case of a gubernatorial or presidential declaration of emergency or natural disaster.

1. In the case of an emergency or natural disaster, the nursing home use shall be temporary, not to exceed six months.

D. Conversion Requirements

1. A nursing facility that utilizes the existing facility structure to convert Medicaid approved beds to ARCP units will have the square footage associated with those converted beds removed from its nursing facility fair rental value calculation.

2. If a nursing facility which constructs a new ARC building certifies that it will utilize the space associated with the converted beds for other nursing facility use, then nursing facility will not have the square footage associated with those converted beds removed from its nursing facility fair rental value calculation.

a. If a nursing home which constructs a new ARC building utilizes the converted space for any purposes other than nursing facility services associated with the remaining licensed beds in the facility, then the nursing facility will have the square footage associated with those converted beds removed from its nursing facility fair rental value calculation.

3. Beds forfeited for purposes of ARC units cannot simultaneously be utilized to convert semi-private rooms to private rooms or be used for any other separate benefits in the rate methodology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2618 (December 2008).

§12521. Architectural and Licensing Compliance

A. The following time frames shall apply for complying with the requirements for obtaining approval of architectural plans and licensure.

1. ARCP units which are converted from Medicaid approved beds in existing nursing facilities shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within one year from the date of the FNR approval.

2. ARCP units which are converted from Medicaid approved nursing facility beds in new facilities shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

3. ARCP units which are to be licensed in existing adult residential facilities shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within one year from the date of the FNR approval.

4. ARCP units which are to be licensed in new adult residential facilities shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

B. A one-time 90 day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant. Inappropriate zoning is not a basis for extension.

C. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the ARCP units.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2618 (December 2008).

§12523. Home and Community-Based Service Providers

A. No HCBS provider shall be licensed to operate unless the FNR Program has granted an approval for the issuance of an HCBS provider license. Once the FNR Program approval is granted, an HCBS provider is eligible to be licensed by the department, subject to meeting all of the requirements for licensure.

B. The service area for proposed or existing HCBS providers is the DHH region in which the provider is or will be licensed.

C. Determination of Need/Approval

1. The department will review the application to determine if there is a need for an additional HCBS provider in the geographic location for which the application is submitted.

2. The department shall grant FNR approval only if the FNR application, the data contained in the application, and other evidence effectively establishes the probability of serious, adverse consequences to recipients' ability to access health care if the provider is not allowed to be licensed.

3. In reviewing the application, the department may consider, but is not limited to, evidence showing:

a. the number of other HCBS providers in the same geographic location and region servicing the same population; and

b. allegations involving issues of access to health care and services.

4. The burden is on the applicant to provide data and evidence to effectively establish the probability of serious, adverse consequences to recipients' ability to access health care if the provider is not allowed to be licensed. The department shall not grant any FNR approvals if the application fails to provide such data and evidence.

D. Applications for approvals of licensed providers submitted under these provisions are bound to the description in the application with regard to the type of services proposed as well as to the site and location as defined in the application. FNR approval of licensed providers shall expire if these aspects of the application are altered or changed.

E. FNR approvals for licensed providers are non-transferrable and are limited to the location and the name of the original licensee.

1. An HCBS provider undergoing a change of location in the same licensed region shall submit a written attestation of the change of location and the department shall re-issue the FNR approval with the name and new location. An HCBS provider undergoing a change of location outside of the licensed region shall submit a new FNR application and fee and undergo the FNR approval process.

2. An HCBS provider undergoing a change of ownership shall submit a new application to the department's FNR Program. FNR approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, which must show the seller's or transferor's intent to relinquish the FNR approval.

3. FNR Approval of a licensed provider shall automatically expire if the provider is moved or transferred to another party, entity or location without application to and approval by the FNR program.

F. FNR-approved HCBS applicants shall become licensed no later than six months from the date of the FNR approval.

1. A one-time 90-day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant. Inappropriate zoning is not a basis for extension.

2. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the HCBS agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2438 (November 2009), amended LR 41:2637 (December 2015).

§12524. Behavioral Health Services Providers

A. Except as noted in Paragraph B below, no behavioral health services (BHS) providers or applicants seeking to provide psychosocial rehabilitation (PSR) and/or community psychiatric support and treatment (CPST) services shall be eligible to apply for licensure to provide PSR and/or CPST services unless the FNR Program has granted an approval for the issuance of a BHS provider license for such services. Once the FNR Program approval is granted, a BHS provider is eligible to apply for a BHS provider license to provide PSR and/or CPST services.

B. BHS providers who fall within the provisions of Act 33 of the 2017 Regular Session of the Louisiana Legislature, commonly referred to as accredited mental health rehabilitation providers, are required to submit a BHS provider licensing application by December 1, 2017 and become licensed by April 1, 2018.

1. Beginning December 2, 2017, such an "Act 33" BHS provider that failed to submit its completed licensing application by December 1, 2017, shall be subject to FNR and shall not be eligible to apply for licensure to provide PSR and/or CPST services unless the FNR Program has granted an approval for the issuance of a BHS provider license for such services. Once the FNR Program approval is granted, such a BHS provider is eligible to apply for a BHS provider license to provide PSR and/or CPST services.

2. Beginning April 2, 2018, such an "Act 33" BHS provider that submitted its completed licensing application by December 1, 2017, but failed to become licensed by April 1, 2018, shall be subject to FNR and shall not be eligible to apply for licensure to provide PSR and/or CPST services unless the FNR Program has granted an approval for the

issuance of a BHS provider license for such services. Once the FNR Program approval is granted, such a BHS provider is eligible to apply for a BHS provider license to provide PSR and/or CPST services.

C. The service area for proposed or existing BHS providers shall be the parish in which the provider is licensed and parishes directly adjacent to said parish.

D. Determination of Need/Approval

1. The department shall review the FNR application to determine if there is a need for an additional BHS provider to provide PSR and/or CPST services in the service area.

2. The department shall grant FNR approval only if the FNR application, the data contained in the application and other evidence effectively establishes the probability of serious, adverse consequences to recipients' ability to access behavioral health PSR and/or CPST services if the provider is not allowed to be licensed.

3. In reviewing the application, the department may consider, but is not limited to, evidence showing:

a. the number of other BHS providers providing PSR and/or CPST services in the same geographic location and service area servicing the same population;

b. the number of members that the BHS provider is able to provide PSR and/or CPST services to; and

c. allegations involving issues of access to behavioral health PSR and/or CPST services.

4. The burden is on the applicant to provide data and evidence to effectively establish the probability of serious, adverse consequences to recipients' ability to access behavioral health PSR and/or CPST services if the provider is not granted approval to be licensed. The department shall not grant any FNR approvals if the application fails to provide such data and evidence.

E. Applications for approvals of BHS providers of PSR and/or CPST services submitted under these provisions are bound to the description in the application with regard to the type of services proposed, as well as to the site and location as defined in the application. FNR approval of such providers shall expire if these aspects of the application are altered or changed.

F. Facility need review approvals for behavioral health PSR and/or CPST applicants are non-transferrable and are limited to the location and the name on the original licensee.

1. A BHS provider of PSR and/or CPST services undergoing a change of location in the same licensed region shall submit a written attestation of the change of location and the department shall re-issue the FNR approval with the name and new location. A BHS provider undergoing a change of location outside of the licensed region shall submit a new completed FNR application and required fee and undergo the FNR approval process.

2. A BHS provider of PSR and/or CPST services undergoing a change of ownership shall submit a new completed application and required fee to the department's FNR Program. FNR approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, which shall show the seller's or transferor's intent to relinquish the FNR approval.

3. Facility need review approval of a licensed BHS provider of PSR and/or CPST services shall automatically expire if the provider is moved or transferred to another party, entity or location without application to and approval by the FNR program.

4. Facility need review approved BHS providers of PSR and/or CPST shall become licensed no later than one year from the date of the FNR approval. Failure to meet any of the time frames in this section shall result in an automatic expiration of the FNR approval of the BHS provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 44:281 (February 2018).

§12525. Adult Day Health Care Providers

A. No ADHC provider shall be licensed to operate unless the FNR Program has granted an approval for the issuance of an ADHC provider license. Once the FNR Program approval is granted, an ADHC provider is eligible to be licensed by the department, subject to meeting all of the requirements for licensure.

B. For purposes of facility need review, the service area for a proposed ADHC provider shall be within a 30-mile radius of the proposed physical address where the provider will be licensed.

C. Determination of Need/Approval

1. The department will review the application to determine if there is a need for an additional ADHC provider in the geographic location for which the application is submitted.

2. The department shall grant FNR approval only if the FNR application, the data contained in the application, and other evidence effectively establishes the probability of serious, adverse consequences to recipients' ability to access adult day health care if the ADHC provider is not allowed to be licensed.

3. In reviewing the application, the department may consider, but is not limited to, evidence showing:

a. the number of other AHDC providers in the same geographic location and parish servicing the same population; and

b. allegations involving issues of access to health care and services.

4. The burden is on the applicant to provide data and evidence to effectively establish the probability of serious, adverse consequences to recipients' ability to access health care if the provider is not allowed to be licensed. The

department shall not grant any FNR approvals if the application fails to provide such data and evidence.

D. Applications for approvals of licensed providers submitted under these provisions are bound to the description in the application with regard to the type of services proposed as well as to the site and location as defined in the application. FNR approval of licensed ADHC providers shall expire if these aspects of the application are altered or changed.

E. FNR approvals for licensed ADHC providers are non-transferrable and are limited to the location and the name of the original licensee.

1. An ADHC provider undergoing a change of location in the same parish in which it is licensed shall submit a written attestation of the change of location and the department shall re-issue the FNR approval with the name and new location. An ADHC provider undergoing a change of location outside of the parish in which it is licensed shall submit a new FNR application and fee and undergo the FNR approval process.

2. An ADHC provider undergoing a change of ownership shall submit a new application to the department's FNR Program. FNR approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, which shall show the seller's or transferor's intent to relinquish the FNR approval.

3. FNR approval of a licensed ADHC provider shall automatically expire if the ADHC provider moves or relocates, if the ADHC provider sells, transfers, or conveys ownership of the ADHC provider to another party or entity, or if the ADHC provider sells, transfers or conveys the FNR approval to another party, entity, or location, unless the ADHC provider has submitted application to and received approval from the FNR Program.

F. The following time frames shall apply for complying with the requirements for obtaining approval of architectural plans and licensure.

1. ADHC facilities which are to be licensed in existing buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within one year from the date of the FNR approval.

2. ADHC facilities which are to be licensed in newly constructed buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

3. A one-time 90-day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant.

4. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the ADHC facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:323 (February 2010), amended LR 41:2637 (December 2015).

§12526. Hospice Providers

A. No hospice provider shall be licensed to operate unless the FNR Program has granted an approval for the issuance of a hospice provider license. Once the FNR Program approval is granted, a hospice provider is eligible to be licensed by the department, subject to meeting all of the requirements for licensure.

B. The service area for proposed or existing hospice providers is within a 50 mile radius of the proposed geographic location where the provider is or will be licensed.

C. Determination of Need/Approval

1. The department will review the application to determine if there is a need for an additional hospice provider within a 50 mile radius of the proposed geographic location for which the application is submitted.

2. The department shall grant FNR approval only if the FNR application, the data contained in the application and other evidence effectively establishes the probability of serious, adverse consequences to the recipients' ability to access hospice care if the provider is not allowed to be licensed.

3. In reviewing the application, the department may consider, but is not limited to, evidence showing:

a. the number of other hospice providers within a 50 mile radius of the proposed geographic location servicing the same population; and

b. allegations involving issues of access to hospice care and services.

4. The burden is on the applicant to provide data and evidence to effectively establish the probability of serious, adverse consequences to recipients' ability to access hospice care if the provider is not allowed to be licensed. The department shall not grant any FNR approvals if the application fails to provide such data and evidence.

D. Applications for approvals of licensed providers submitted under these provisions are bound to the description in the application with regard to the type of services proposed as well as to the site and location as defined in the application. FNR approval of licensed providers shall expire if these aspects of the application are altered or changed.

E. FNR approvals for licensed providers are non-transferrable and are limited to the location and the name of the original licensee.

1. A hospice provider undergoing a change of location within a 50 mile radius of the licensed geographic location shall submit a written attestation of the change of location and the department shall re-issue the FNR approval with the

name and new location. A hospice provider undergoing a change of location outside of the 50 mile radius of the licensed geographic location shall submit a new FNR application and fee and undergo the FNR approval process.

2. A hospice provider undergoing a change of ownership shall submit a new FNR application to the department's FNR Program. FNR approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, which must show the seller's or transferor's intent to relinquish the FNR approval.

3. FNR approval of a licensed provider shall automatically expire if the hospice agency is moved or transferred to another party, entity or location without an application being made to, and approval from, the FNR Program.

F. The following time frames shall apply for complying with the requirements for obtaining approval of architectural plans and/or licensure.

1. Outpatient hospice agencies shall be licensed within six months from the date of the FNR approval.

2. Inpatient hospice facilities which are to be licensed in existing buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within one year from the date of the FNR approval.

3. Inpatient hospice facilities which are to be licensed in newly constructed buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

4. A one-time 90-day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant.

5. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the hospice agency or facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1593 (July 2012), amended LR 41:2637 (December 2015).

Subchapter C. Revocation of Facility Need Review Approvals

§12527. General Provisions

A. Nursing Facilities

1. Beds which are added to an existing, licensed facility must be enrolled in the Title XIX Program within one year of the date of approval by the FNR Program.

2. New nursing facilities which are approved to be constructed must be enrolled in the Title XIX Program within 24 months of the date of the approval.

3. An extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant (e.g., acts of God). Inappropriate zoning is not a basis for extension.

B. Intermediate Care Facilities for the Developmentally Disabled

1. Group and community home beds must be enrolled in the Title XIX Program within nine months of the date of approval by the Facility Need Review Program.

2. A one-time 90-day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant (e.g., acts of God). Inappropriate zoning is not a basis for an extension.

3. If the beds are not enrolled in the Title XIX program within the time limits specified in this Section, the approval will automatically expire.

C. Approval of a group or community home bed shall be revoked when the Office for Citizens with Developmental Disabilities advises that the bed, which was approved for Title XIX reimbursement to meet a specific disability need identified in a RFP issued by the department, is not being used to meet that identified need based on the facility serving a Medicaid recipient in the bed without prior approval from the OCDD.

D. Except as provided in Subchapter E and Subchapter F of this Chapter, approval shall be revoked under the following circumstances:

1. a facility's license is revoked, not renewed, or denied, unless the facility obtains a license within 120 days from the date of such revocation, nonrenewal or denial.

2. a facility's provider agreement is terminated unless, within 120 days thereof, the facility enters into a new provider agreement.

E. Except as provided in Subchapter E and Subchapter F of this Chapter, beds may not be disenrolled except as provided under the alternate use policy and during the 120-day period to have beds relicensed or recertified. The approval for beds disenrolled will automatically expire except as otherwise indicated.

F. The facility need review approval for licensed nursing facilities or ICF/DDs located in an area(s) which have been affected by an executive order or proclamation of emergency or disaster due to Hurricanes Katrina and/or Rita, and which were operating at the time the executive order or proclamation was issued under R.S. 29:794, shall be revoked or terminated unless the nursing facility or ICF/DD re-licenses and re-enrolls its beds in the Medicaid Program within 120 days from January 1, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), LR 28:2190 (October 2002), LR 30:1023 (May 2004), LR 32:845 (May 2006), amended by the Department of

Health and Hospitals, Bureau of Health Services Financing, LR 34:2619 (December 2008), amended LR 35:2439 (November 2009).

Subchapter D. Relocation of Nursing Facility Beds

§12529. General Provisions

A. A nursing facility's approved beds (Medicaid facility need review approvals) cannot be relocated to a different service area, subject to the exceptions in Section 12529.C and Section 12529.D below.

B. Approved beds may be relocated in the same service area only under the following conditions.

1. Subject to the exceptions provided in Paragraphs 2 and 6, all of a nursing facility's approved beds must be relocated to a single new location.

a. The approval of any beds not relocated to that new location shall be revoked.

2. Notwithstanding the requirements of Subparagraph 1, a partial relocation of approved beds may be effected if the following conditions are met:

a. the approved beds are in a nursing facility owned by a hospital service district as of the date of adoption of this Rule and at the time of the partial relocation;

b. the partial relocation does not place the approved beds in a different service area;

c. the approved beds are relocated to the site of a currently operational hospital owned by the same or a different hospital service district.

i. If the new location is owned by a different hospital service district, the ownership of the approval of the relocated beds must be transferred to the hospital service district to which the beds are relocated; and

d. no more than 25 percent of the nursing facility's approved beds are relocated.

3. If, within five years after a partial relocation to a hospital site pursuant to Subparagraph 2, the hospital located at that site ceases operations, the relocated beds shall revert to the original facility from which they were relocated. This provision shall not apply to relocations which require a transfer of ownership of the approval of the relocated beds.

4. A hospital service district may relocate or transfer the ownership of the approval of approved beds pursuant to Subparagraph c only once.

5. Subparagraphs B.2, B.3 and B.4 are not intended to prohibit or restrict the relocation of all of the approved beds in a nursing facility by a hospital service district in accordance with Paragraph A and Subparagraph B.1.

6. The department may approve a one-time partial relocation/transfer of a nursing facility's approved beds (Medicaid bed approvals) to another operational nursing facility, provided that the following provisions are met.

a. The transferring nursing facility may relocate/transfer approved beds to another nursing facility pursuant to this subparagraph only once.

b. The transferring nursing facility may not relocate/transfer less than 10 approved beds to another nursing facility.

c. A transferring nursing facility may not relocate/transfer more than 25 percent of its approved beds to another nursing facility.

i. If the transferring nursing facility relocates /transfers more than 25 percent of its approved beds to another nursing facility, the approval of any beds not relocated to the receiving nursing facility shall be immediately revoked.

d. The approved beds relocated/transferred become approved beds of the receiving nursing facility, and the transferring nursing facility relinquishes all rights in those approved beds, but may retain licensure.

e. The relocation of approved beds is subject to the receiving facility having licensed-only capacity in order to accommodate the relocation/transfer. Under no circumstances shall a receiving nursing facility license additional beds in order to accommodate the relocated, approved beds.

f. All relocated, approved beds are subject to state and federal bed change guidelines and procedures.

g. The provisions of this rule pertaining to the splitting of facility need review approvals shall sunset in 24 months from the date of the promulgation of the final Rule and shall have no effect henceforth.

C. In addition to Subsection B, approved beds may be relocated in the same service district or same parish under the following conditions.

1. The department may approve a one-time partial relocation/transfer of a nursing facility's Medicaid facility need review (FNR) approvals to another licensed, certified, operational nursing facility in the same parish, provided that all of the following provisions are met:

a. The transferring nursing facility shall send a written request to the department's licensing section at least 30 days before the proposed transfer, for the department's review and approval.

b. The transferring nursing facility may relocate/transfer Medicaid FNR approvals to another nursing facility pursuant to Section 12529.C only once.

c. The transferring nursing facility and the receiving nursing facility shall be related companies which are under "common ownership."

i. For purposes of this Subsection, "common ownership" is defined as the same persons or entities owning at least 80 percent of both companies.

ii. For purposes of this Subsection, ownership includes, but is not limited to, shares in a corporation,

membership in a limited liability company, or partnership interest in a partnership or limited liability partnership.

d. The transferring nursing facility may not relocate/transfer less than 10 Medicaid FNR approvals to another nursing facility.

e. A transferring nursing facility may not relocate/transfer more than 25 percent of its Medicaid FNR approvals to another facility.

f. The Medicaid FNR approvals relocated/transferred become Medicaid FNR approvals of the receiving nursing facility, and the transferring nursing facility relinquishes all rights in those Medicaid FNR approvals, but may retain licensure of the licensed nursing facility beds.

g. At the time of the relocation/transfer of the Medicaid FNR approvals, the receiving facility shall have more licensed nursing facility beds than it has Medicaid FNR approvals. The number of Medicaid FNR approvals transferred shall not exceed the number of licensed-only beds (licensed nursing facility beds not having Medicaid FNR approval) at the receiving nursing facility; the receiving nursing facility is prohibited from receiving more Medicaid FNR approvals than can be utilized for the receiving nursing facility's current licensed bed capacity. Under no circumstances shall a receiving facility license additional beds in order to accommodate the relocated Medicaid FNR approvals. After the relocation, the receiving nursing facility shall have the same number of licensed beds as prior to the relocation.

h. All relocated Medicaid FNR approvals are subject to state and federal bed change guidelines and procedures.

i. The provisions of Section 12529.C pertaining to the transfer of Medicaid FNR approvals shall sunset in 24 months from the date of the promulgation of the final Rule implementing Section 12529.C and shall have no effect henceforth.

D. In addition to Paragraphs B and C of this Section, Medicaid FNR approvals of an existing licensed and certified nursing facility that is awaiting the completion of a replacement nursing facility building, may be temporarily relocated to a licensed building that may be outside of the service area or parish of the existing FNR approved service area or parish under the following conditions.

1. The department may approve a one-time temporary relocation of a nursing facility's Medicaid FNR approvals to another licensed building that may be outside the existing FNR approved service area or parish, provided that all of the following provisions are met:

a. The relocating nursing facility shall send a written request to the department's Health Standards Section at least 30 days before the proposed temporary relocation outside the existing FNR approved service area or parish, for the department's review and approval. This request shall include all good cause grounds for the temporary relocation of the Medicaid FNR approvals. The department will determine if approval of the temporary relocation will be granted.

b. The nursing facility shall not temporarily relocate to a licensed building located in a service area or parish that is greater than 100 miles from the existing licensed service area or parish of the nursing facility.

c. The temporarily relocating nursing facility shall maintain the same number of licensed and Medicaid FNR approved beds as prior to the relocation.

d. All temporarily relocated Medicaid FNR approvals of the licensed and certified nursing facility are subject to compliance with all state and federal licensure/certification guidelines and procedures.

e. The temporary location shall be in compliance with all licensing and certification standards for nursing facilities, and receive a temporary nursing facility license issued by the department.

f. The temporary license shall expire 18 months from the date of issuance and the facility shall relocate to its new replacement nursing facility building during that period. One extension of the temporary license, not to exceed six months, may be granted by the department for good cause shown.

g. During the period of temporary licensure, the nursing facility shall not accept any new admissions to the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), LR 28:2190 (October 2002), LR 30:1023 (May 2004), LR 32:845 (May 2006), LR 34:2619 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1009 (May 2010), amended by the Department of Health, Bureau of Health Services Financing LR 46:953 (July 2020), LR 47:1306 (September 2021), LR 48:303 (February 2022).

Subchapter E. Nursing Facility Bed Abeyance

§12531. General Provisions

A. A nursing facility may have all of its approved beds disenrolled from the Medicaid Program and placed in abeyance if the department determines that the average annual occupancy in the service area where the facility is located is less than 85 percent. The department shall base this determination on the occupancy figures contained in the most recent LTC-2 report issued by the department prior to its receipt of a written request that the facility's beds be placed in abeyance in accordance with Paragraph B of this Section.

B. In order to request that a facility's beds be placed in abeyance, all persons or entities who are the holders of the approval, the nursing facility license, and the Medicaid

provider agreement must submit to the department a written request signed by each such person or entity. The written request shall:

1. specify the date (which must be no later than 120 days after the receipt of the request by the department) on which the intended closure of the facility will occur; and

2. designate an individual (referred to hereinafter as the "designated contact person") who shall serve as the contact between the party(ies) submitting the request and the department with respect to all matters involving the placing of the facility's beds in abeyance and their removal from abeyance.

a. The written request must include the mailing address and telephone number of that person.

b. If the designated contact person is changed, a written notice thereof, signed by each person or entity who submitted the original request, shall be given to the department.

C. If the department determines that the requirements set forth (Paragraphs A and B) have been met, it shall issue a written Notice of Abeyance and forward it to the designated contact person within 30 calendar days after its receipt of the request for abeyance, subject to the provisions of Paragraph L. If the department determines that these requirements have not been met or that the issuance of a Notice of Abeyance would conflict with Paragraph L, it shall issue a written denial and forward it to the designated contact person within 30 calendar days after its receipt of the request.

D. All of a facility's approved beds must be disenrolled from the Medicaid Program within 120 days after the designated contact person's receipt of a notice of abeyance. An extension not to exceed 90 days may be granted if extenuating circumstances warrant said extension, such as safe transfer of patients. Otherwise, the notice of abeyance will automatically expire at the end of the 120-day period.

E. All of a facility's approved beds may be disenrolled before the designated contact person's receipt of a notice of abeyance. However if he or she does not receive a notice of abeyance within 120 days after the beds are disenrolled, the provisions of §12527. D and E will be applicable.

F. With respect to the facility's beds which are not designated to be re-enrolled as Medicaid nursing facility beds, the approval shall automatically expire after 120 days from receipt of the notice of abeyance by the designated contact person; unless the beds are re-enrolled by that date, thus rescinding the notice of abeyance.

G. A notice of abeyance shall remain in effect until the facility's beds are taken out of abeyance and are re-enrolled in Medicaid.

H. A facility's beds shall remain in abeyance until the average annual occupancy in the facility's service area, as shown in the most recent LTC-2 report, has exceeded 93 percent.

I. If the department determines that the average annual occupancy in the facility's service area, as shown in the most recent LTC-2 report, has exceeded 93 percent, it shall give written notice thereof to the designated contact person.

1. The written notice shall specify the number of the facility's approved beds which must be taken out of abeyance and re-enrolled as Medicaid nursing facility beds.

2. That number shall be determined by the department based upon the following criteria.

a. A nursing facility with 120 or fewer enrolled beds at the time of the request may return all of its enrolled beds from abeyance.

b. A nursing facility with 121 to 160 enrolled beds at the time of the request may return up to 80 percent of its beds from abeyance, but in no case shall it be required to return fewer than 120 beds.

c. A nursing facility with 161 or more enrolled beds at the time of the request may return up to 75 percent of its beds from abeyance, but in no case shall it be required to return fewer than 128 beds, nor shall it be allowed to return more than 175 beds.

d. A nursing facility may choose to return fewer beds from abeyance than are allowed by this Subparagraph and if it does so, the balance of the beds shall be disenrolled.

J. Within one year after the receipt of the written notice described in Paragraph I (or, in the case of new construction for a replacement facility, within 24 months after the receipt of such notice), the beds specified by the department must be taken out of abeyance and re-enrolled as Medicaid nursing facility beds.

1. An extension of that time may be granted at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant (e.g., acts of God).

2. Inappropriate zoning is not a basis for extension.

3. If the facility's beds which are designated to be re-enrolled as Medicaid nursing facility beds are not re-enrolled within the specified time period, the approval for those beds will automatically expire at the end of that period.

K. If, after issuing the written notice provided in Paragraph I to the designated contact person, the department determines that the requirement set forth in Paragraph H is no longer met, the obligation to place the facility's beds back in service in accordance with Paragraph J shall not be affected or negated.

L. If two or more requests to place beds in abeyance are pending at the same time, and the issuance of notices of abeyance for all of the pending requests would conflict with this Paragraph, priority shall be assigned to the requests as follows.

1. If two or more facilities are located in the same service area, a request with respect to a facility having a lower average annual occupancy rate shall have priority over

a request with respect to a facility having a higher average annual occupancy rate, based on the most recent LTC-2 report issued by the department.

M. While a facility's beds are in abeyance, the ownership of the approval for those beds may not be transferred and shall not be subject to any legal device.

N. All of a facility's beds which are taken out of abeyance and re-enrolled in the Medicaid Program must remain located together in one facility, which shall be either the original facility in which they were located before being placed in abeyance or another facility located in the same service area as the original facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1023 (May 2004), amended LR 34:2620 (December 2008).

Subchapter F. Exception Criteria for Bed Approvals

§12533. Declared Disasters and Emergency Events

A. The facility need review bed approvals for a licensed and Medicaid certified nursing facility, ICF/DD, or for a licensed adult residential care provider (ARCP) located in an area or areas which have been affected by an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766 shall remain in effect and shall not be terminated, revoked or considered to have expired for a period not to exceed two years for a nursing facility or ARCP, and one year for an ICF/DD, following the date of such executive order or proclamation, provided that the following conditions are met:

1. the nursing facility, ICF/DD, or ARCP shall submit written notification to the Health Standards Section within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the nursing facility, ICF/DD, or ARCP has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

b. the nursing facility, ICF/DD, or ARCP intends to resume operation as a nursing facility, ICF/DD, or ARCP in the same service area;

i. if the ICF/DD was approved through an RFP, the ICF/DD must conform to the requirements of the RFP as defined by the department; and

c. includes an attestation that the emergency or disaster is the sole causal factor in the interruption of the provision of services;

NOTE: Pursuant to these provisions, an extension of the 60-day deadline may be granted at the discretion of the department.

2. A nursing facility, ICF/DD, or ARCP resumes operating as a nursing facility, ICF/DD, or ARCP in the same service area, within two years for a nursing facility or ARCP and within one year for an ICF/DD, of the executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766; and

3. the nursing facility, ICF/DD, or ARCP continues to submit the required documentation and information to the department.

B. The provisions of this Section shall not apply to:

1. a nursing facility, ICF/DD, or ARCP which has voluntarily surrendered its facility need review bed approval; or

2. a nursing facility, ICF/DD, or ARCP which fails to resume operations as a nursing facility, ICF/DD, ARCP in the same service area, within two years for a nursing facility or ARCP and within one year for an ICF/DD, of the executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766.

C. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the facility need review bed approvals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 21:812 (August 1995), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2621 (December 2008), amended LR 35:2439 (November 2009), LR 39:1469 (June 2013).

§12535. Other Emergency Events (Non-Declared)

A. This section applies to emergency situations for which an executive order or proclamation of emergency or disaster, pursuant to R.S. 29:724 or R.S. 29:766, has not been issued.

B. The facility need review bed approvals for a licensed and Medicaid certified nursing facility or ICF/DD, or for a licensed ARCP that is rendered unable to provide services to the public because of an emergency situation or disaster, including, but not limited to, fire, flood, tornado or other condition for which the provider is not primarily responsible, shall remain in effect and shall not be terminated, revoked or considered to have expired for a period not to exceed two years for a nursing facility or ARCP, and one year for an ICF/DD, following the date of such emergency situation or disaster, provided that the following conditions are met:

1. the nursing facility, ICF/DD, or ARCP shall submit written notification to the Health Standards Section within 30 days of the date of the emergency situation or disaster that:

a. the nursing facility, ICF/DD, or ARCP has experienced an interruption in the provisions of services as a result of conditions that are described in §12535.B;

b. the nursing facility, ICF/DD, or ARCP intends to resume operation as a nursing facility, ICF/DD, or ARCP in the same service area;

i. if the ICF/DD was approved through an RFP, the ICF/DD must conform to the requirements of the RFP as defined by the department; and

c. includes an attestation that the emergency situation or disaster is the sole causal factor in the interruption of the provision of services;

2. the nursing facility, ARCP, or ICF/DD resumes operating as a nursing facility or ICF/DD in the same service area, within two years for a nursing facility or ARCP, and within one year for an ICF/DD, of the disaster or catastrophic condition; and

3. the nursing facility, ARCP, or ICF/DD continues to submit the required documentation and information to the department.

E. The provisions of this Section shall not apply to:

1. a nursing facility, adult residential care facility, or ICF/DD which has voluntarily surrendered its facility need review bed approval; or

2. a nursing facility, ARCP, or ICF/DD which fails to resume operations as a nursing facility or ICF/DD in the same service area, within two years for a nursing facility or ARCP, and within one year for an ICF/DD, of the emergency condition or disaster .

F. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the facility need review bed approvals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:1470 (June 2013).

§12537. Temporary Inactivation Due to Major Alterations

A. A licensed nursing facility, ICF/ID or level IV ARCP which is undergoing major alterations to its physical plant may request a temporary inactivation of a certain number of the facility's facility need review (FNR) bed approvals provided that:

1. the nursing facility, ICF/ID or level IV ARCP submits a written request to the licensing agency of the department seeking temporary inactivation of a certain number of its FNR bed approvals. Such written request shall include the following:

a. a statement that the nursing facility, ICF/ID or level IV ARCP is undergoing major alterations to ensure or enhance the health, safety and welfare of the residents;

b. a statement that the major alterations to the nursing facility, ICF/ID or level IV ARCP will cause a certain number of beds to be de-licensed and decertified;

c. an attestation that the alterations are the sole causal factor in the request for temporary inactivation of the FNR bed approvals;

d. the anticipated start date of the temporary inactivation of the FNR bed approvals;

e. the anticipated end date of the temporary inactivation of the FNR bed approvals; and

f. the number of FNR bed approvals requested to be inactivated temporarily;

2. upon receiving a completed written request by a facility for temporary inactivation of a certain number of FNR bed approvals, the department shall review the request to determine whether the request satisfies the requirements of this Section. If the requirements of this Section are met, the department shall issue a notice of temporary inactivation of a certain number of the facility's FNR bed approvals;

3. upon completion of the major alterations, the facility shall submit to the department a completed written request to reinstate the FNR bed approvals that were inactivated due to the major alterations to the facility;

NOTE: The FNR bed approvals capacity, after major alterations are completed, shall not exceed the FNR bed approvals capacity of the nursing facility, ICF/ID or Level IV ARCP at the time of the request to temporarily inactivate a certain number of its FNR bed approvals prior to the major alterations.

4. the provisions of this Subsection shall not apply to a nursing facility, ICF/ID or Level IV ARCP which has voluntarily surrendered its license or has voluntarily dis-enrolled the facility's beds from Medicaid;

5. there shall be no effect upon the Medicaid reimbursement rate of a nursing facility or an ICF/ID that is undergoing major alterations pursuant to this rule during the period of the inactivation of the FNR approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:1299 (August 2016).

Subchapter G. Administrative Appeals

§12541. Appeal Procedures

A. Administrative appeal hearings shall be conducted pursuant to the Administrative Procedures Act.

B. An applicant may request an administrative hearing within 30 calendar days after receipt of the department's notice of denial of facility need review.

1. The request for an administrative hearing must be made in writing to the department's Bureau of Appeals.

2. The request must contain a statement setting forth the specific reason with which the applicant disagrees and the reasons for the disagreement.

3. Unless a timely and proper request is received by the Bureau of Appeals, the findings of the department shall be considered a final and binding administrative determination.

4. The request shall be considered timely if it is postmarked by the 30th calendar day after receipt of the department's notice of denial.

5. A fee of $500 must accompany a request for an appeal.

C. When an administrative hearing is scheduled, the Bureau of Appeals shall notify the applicant in writing.

1. The notice shall be mailed no later than 15 calendar days before the scheduled date of the administrative hearing and shall contain the:

a. date of the hearing;

b. time of the hearing; and

c. place of the hearing.

D. The administrative hearing shall be conducted by an administrative law judge from the Bureau of Appeals according to the following procedures.

1. An audio recording of the hearing shall be made.

2. A copy of the recording may be prepared and reproduced at the request of a party to the hearing, provided he bears the cost of the copy of the recording.

3. Testimony at the hearing shall be taken only under oath, affirmation or penalty of perjury.

4. Each party shall have the right to:

a. call and examine parties and witnesses;

b. introduce exhibits;

c. question opposing witnesses and parties on any matter relevant to the issue, even though the matter was not covered in the direct examination;

d. impeach any witness, regardless of which party first called him to testify; and

e. rebut the evidence against him/her.

5. Any relevant evidence shall be admitted if it is the sort of evidence upon which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make the admission of such evidence improper over objection in civil or criminal actions.

a. Documentary evidence may be received in the form of copies or excerpts.

b. Irrelevant, immaterial, or unduly repetitious evidence shall be excluded.

c. The rules of privilege recognized by law shall be given effect.

6. The administrative law judge may question any party or witness and may admit any relevant and material evidence.

7. A party has the burden of proving whatever facts he/she must establish to sustain his/her position.

8. An applicant who has been denied through the facility need review process shall present his case first and has the burden to show by a preponderance of the evidence that facility need review approval should have been granted by the department pursuant to the provisions of this rules.

9. After an applicant denied facility need review has presented his evidence, the department will then have the opportunity to present its case and to refute and rebut the testimony and evidence presented by the applicant.

E. Any party may appear, and be heard, at any appeals proceeding through an attorney or a designated representative. The representative shall have a written authorization to appear on behalf of the applicant.

1. A person appearing in a representative capacity shall file a written notice of appearance on behalf of a provider identifying:

a. his/her name;

b. address;

c. telephone number; and

d. the party being represented.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2440 (November 2009).

§12543. Preliminary Conferences

A. Although not specifically required, the Bureau of Appeals may schedule a preliminary conference. The purposes of the preliminary conference include, but are not limited to:

1. clarification, formulations and simplifications of issues;

2. resolution of controversial matters;

3. exchange of documents and information;

4. stipulations of fact to avoid unnecessary introduction of witnesses;

5. other matters which may aid disposition of the issues; and

6. scheduling a hearing date that is convenient to all parties.

B. When the Bureau of Appeals schedules a preliminary conference, all parties shall be notified in writing. The notice shall direct any parties and their attorneys to appear on a specific date and at a specific time and place.

C. When the preliminary conference resolves all or some of the matters in controversy, a summary of the findings agreed to at the conference shall be provided by the administrative law judge. When the preliminary conference does not resolve all of the matters in controversy, an administrative hearing shall be scheduled on those matters still in controversy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2441 (November 2009).

§12545. Responsibilities of the Administrative Law Judge

A. The administrative law judge shall have the power to:

1. administer oaths and affirmations;

2. regulate the course of the hearings;

3. set the time and place for continued hearings;

4. fix the time for filing briefs and other documents; and

5. direct the parties to appear and confer to consider simplification of the issues.

B. At the conclusion of the administrative hearing, the administrative law judge shall:

1. take the matter under advisement; and

2. prepare a written proposed decision which will contain:

a. findings of fact;

b. a determination of the issues presented;

c. a citation of applicable policy and regulations; and

d. an order.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2441 (November 2009).

§12547. Witnesses and Subpoenas

A. Each party shall arrange for the presence of their witnesses at the administrative hearing.

B. A subpoena to compel the attendance of a witness shall be issued by the administrative law judge upon written request by a party or on his own motion.

C. The party is required to notify the administrative law judge in writing at least 10 days in advance of the hearing of those witnesses whom he wishes to be subpoenaed.

D. No subpoena shall be issued until the party (other than the department) who wishes to subpoena a witness first deposits with the hearing officer a sum of money sufficient to pay all fees and expenses to which a witness in a civil case is entitled pursuant to R.S. 13:3661 and R.S. 13:3671.

E. The department may request issuance of subpoenas without depositing said sum of money. The witness fee may be waived if the person is an employee of the department.

F. An application for subpoena duces tecum for the production by a witness of books, papers, correspondence, memoranda or other records, or to permit inspection of such, shall be made in writing to the administrative law judge. The written application shall:

1. give the name and address of the person or entity upon whom the subpoena is to be served.

2. precisely describe the material that is desired to be produced;

3. state the materiality thereof to the issued involved in the proceedings; and

4. include a statement that, to the best of applicant's knowledge, the witness has such items in his possession or under his control.

G. Any party or witness may file a motion to quash, which shall be scheduled by the administrative law judge for a contradictory hearing.

H. When any person summoned under this Section neglects or refuses to obey such summons, or to produce books, papers, correspondence, memoranda or other records, or to give testimony as required, any party may apply to the judge of the district court for the district within which the person so summoned resides or is found, for an attachment against him as for a contempt pursuant to the Administrative Procedures Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2441 (November 2009).

§12549. Continuances or Further Hearings

A. The Bureau of Appeals shall conduct the hearing within 90 days of the docketing of the administrative appeal. One extension, not to exceed 90 days, may be granted by the Bureau of Appeals upon good cause shown.

1. If the hearing is not commenced within 180 days from the docketing of the appeal, the decision of the department will be considered upheld.

B. Where the administrative law judge, at his/her discretion, determines that additional evidence is necessary for the proper determination of the case, he/she may:

1. continue the hearing to a later date and order the party(s) to produce additional evidence; or

2. close the hearing and hold the record open in order to permit the introduction of additional documentary evidence.

3. any evidence submitted shall be made available to both parties and each party shall have the opportunity for rebuttal.

C. Written notice of the time and place of a continued or further hearing shall be given. When a continuance of further hearing is ordered during an administrative hearing, oral notice of the time and place of the continued hearing may be give to each party present.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2441 (November 2009).

§12551. Proposed and Final Decisions

A. The written proposed decision shall be provided to the secretary of the department or his designee. The secretary or his designee may:

1. adopt the proposed decision;

2. reject it based upon the record; or

3. remand the proposed decision to the administrative law judge to take additional evidence.

a. If the proposed decision is remanded, the administrative law judge shall submit a new proposed decision to the secretary or his designee.

B. The decision of the secretary shall be final and binding upon adoption, subject only to judicial review by the courts. A copy of the decision shall be mailed to the applicant at his last known address or to his authorized representative.

C. Judicial review of the decision of the hearing officer shall be in accordance with the provisions of R.S. 49:964.

D. Motions for Rehearing, Reopening or Reconsideration.

1. A decision or order shall be subject to a motion for rehearing, reopening, or reconsideration by the agency, within 10 days from the date of its entry. Such motion may be made to either the administrative law judge, the director of the Bureau of Appeals, the secretary or the undersecretary, and a copy shall be filed into the administrative record.

2. The grounds for such motion shall be either that:

a. The decision or order is clearly contrary to the law and the evidence;

b. The party has discovered since the hearing evidence important to the issues which he could not have with due diligence obtained before or during the hearing;

c. There is a showing that issues no previously considered ought to be examined in order to properly dispose of the matter; or

d. There is other good ground for further consideration of the issues and the evidence in the public interest

3. Such motion shall be ruled upon within 15 days from the date of filing such motion. If the motion for rehearing, reopening or reconsideration is granted, the ALJ shall take further action to rehear, reopen or reconsider the matter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2442 (November 2009).

§12553. Failure to Appear at Administrative Hearings

A. If an applicant fails to appear at an administrative hearing, a decision shall be issued by the Bureau of Appeals dismissing the appeal. A copy of the decision shall be mailed to each party or his representative at his last known address.

B. Any dismissal may be rescinded upon order of the Bureau of Appeals if the applicant:

1. makes written application within 10 calendar days after the mailing of the dismissal notice; and

2. provides evidence of good cause for his/her failure to appear at the hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2442 (November 2009).

Chapter 129. Opioid Treatment Program (OTP) Need and Application Reviews

Subchapter A. General Provisions

§12901. Definitions

A. Definitions. When used in this Chapter the following terms and phrases shall have the following meanings unless the context requires otherwise.

Applicant—the individual or legal entity who is applying to open an OTP.

Applicant Representative—the person specified by the applicant on the application form who is authorized to respond to Department of Health and Hospital questions regarding the OTP application review process and to whom written notifications are sent relative to the status of the application during the review process.

Applicant Review Period—the period of time in which the review is conducted.

Approval—a determination by the Department of Health and Hospitals (DHH) that an application meets the criteria of the OTP application review.

Approved—opioid treatment programs which are grandfathered in accordance with the grandfather provisions of this program and/or opioid treatment programs approved in accordance with the OTP application review.

Committee—The Opioid Treatment Program (OTP) application review committee.

Department—the Department of Health and Hospitals (DHH) in the state of Louisiana. The following is a list of pertinent sections.

DHH Administrative Regions—The administrative regions and the parishes which comprise these regions are as follows:

a. Region I: Orleans, Plaquemines, Jefferson, and St. Bernard;

b. Region II: Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana;

c. Region III: Assumption, Lafourche, St. Charles, St. James, St. John, St. Mary, and Terrebonne;

d. Region IV: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion;

e. Region V: Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis;

f. Region VI: Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn;

g. Region VII: Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, and Webster;

h. Region VIII: Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, and West Carroll; and

i. Region IX: Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington.

Health Standards Section (HSS)—Section of Bureau of Health Services Financing, DHH that surveys, licenses and serves as the regulatory body for health care facilities in the state, including opioid treatment programs.

Methadone Maintenance Program—see *Opioid Treatment Program.*

Notification—is deemed to be given on the date on which a decision is mailed by DHH by certified mail to the last known address of the applicant.

Office for Addictive Disorders (OAD) or its successor organization—DHH office and single state agency that is statutorily responsible for the treatment and prevention of addictive disorders.

Opioid Treatment Program (OTP)—a program engaged in medication-assisted opioid treatment of individuals with an opioid agonist treatment medication.

Opioid Treatment Program Application Review—a review of applications to select an OTP to be licensed once a need has been determined.

Opioid Treatment Program Need Review—a review to determine whether there is a need for new or additional OTPs in a certain geographic location.

Secretary—the Secretary of the DHH.

State Opioid Treatment Authority—the OAD authority within DHH designated to exercise the responsibility and authority within the state for governing the treatment of opiate addiction with an opioid drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:521 (March 2010).

§12903. General Information

A. No opioid treatment program may be licensed in the state of Louisiana after July 1, 2001 unless the department has determined, in its discretion, that there is a need for new or additional opioid treatment programs in a certain geographic location. The department will provide criteria and processes for determining whether such a need exists and procedures for selecting an opioid treatment program to be licensed once a need has been determined. An offsite location and/or a mobile site of an existing OTP clinic is considered a new OTP and, as such, must receive approval of the department OTP need and applications reviews.

1. The department shall conduct an OTP need review to determine if there is a need for new or additional opioid treatment programs in a certain geographic location.

2. Once the need has been determined, the department will issue a request for applications for new or additional OTPs.

3. The department shall conduct an OTP application review.

4. Once the application review approval is granted, the OTP is then eligible to apply for a license from the department.

B. The duties of the department under this opioid treatment program (OTP) need review and application review include, but are not limited to:

1. defining the appropriate methodology for the collection of data necessary for the administration of the OTP need review; and

2. developing the application review process.

C. Grandfather Provision. An approval shall be deemed to have been granted without OTP need or application review for OTPs that were licensed and approved in Section 7403 prior to July 1, 2001.

D. OTP application review approvals are non-transferable. Approvals for licensed OTPs are limited to the name of the original licensee and to the location unless exempted from the need and application reviews.

1. For all OTPs undergoing a change of ownership after July 1, 2010, including those OTPs who qualify for the Grandfather Provision, the buyer must submit a new application and obtain approval from the OTP application review committee prior to the change of ownership.

2. For all OTPs undergoing a change in location after July 1, 2010, including those OTPs who qualify for the Grandfather Provision, the owner must submit a new

application and obtain approval from the OTP application review committee prior to the change of location.

E. Exemptions from OTP Need Review and Application Review

1. Exemptions from OTP need review and application review shall be made for OTP clinics that meet the following criteria:

a. an OTP clinic is replaced due to destruction by fire or a natural disaster, such as a hurricane, and is closed no longer than eight months; or

b. an OTP clinic is replaced due to potential

health hazard in the clinic and is closed for no longer than 150 days.

2. One extension of no more than three months may be granted upon the documentation of good cause, provided the extension is requested no later than one month from the original deadline.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:522 (March 2010).

Subchapter B. Determination of Need

§12905. Opioid Treatment Program Need Review

A. The OTP need review includes criteria and processes to determine the need for new or additional OTPs in a certain geographic location within an identified DHH administrative region.

B. Determination of Need

1. The department will determine need through a review and evaluation of the following criteria:

a. estimated prevalence of opioid addiction in the population of the geographic area to be served; and

b. estimated number of persons in need of medication-assisted treatment for opioid addiction in the geographic area; and

c. estimated treatment demand for medication-assisted opioid addiction treatment in the geographic area to be served; and

d. existing access, utilization and availability of medication-assisted opioid addiction treatment in the geographic area to be served.

2. A determination of need will utilize data sources that include information compiled and recognized by the department and/or any of the following: Substance Abuse and Mental Health Services Administration (SAMHSA), the United States Census Bureau, the Drug Enforcement Administration (DEA) and the National Institute on Drug Abuse (NIDA).

C. The department may conduct additional need reviews only when special needs and circumstances arise which indicate the need for additional medication-assisted opioid addiction treatment services, such as increased utilization rates, reduced availability, and/or reduced accessibility of services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:523 (March 2010).

Subchapter C. Procedure for Selection of Opioid Treatment Program

§12907. Opioid Treatment Program Application Review

A. If the department determines that there is a need for services in a DHH region, the department will issue a request for applications (RFA) announcement statewide through the Louisiana Press Association. The RFA will specify the dates during which the department will accept applications.

B. No applications will be accepted under these provisions unless the department declares a need and issues an RFA.

C. Any applicant to open an OTP must adhere to all policies, rules and regulations set forth by the State of Louisiana and the Department of Health and Hospitals. Services shall be provided in accordance with standards set forth by SAMHSA, DHH Health Standards, the US Department of Justice/Drug Enforcement Administration (DEA), the Louisiana Board of Pharmacy and all applicable, SAMHSA-approved accrediting bodies.

D. Any applicant to open an OTP shall be free of any conviction for, or guilty plea, or plea of nolle contendere to a felony. If the applicant is an agency, the owners of that agency must be free of such felony convictions.

E. The OTP request for applications will indicate which department administrative region is in need of openings, or slots, for clients; the number of slots needed, the date by which the slots need to be available to the target population and the factors which the department considered relevant in determining the need for the treatment slots. The OTP request for applications will specify the type of information on which the determination of need was based.

F. OTP applications shall be submitted to the DHH Office for Addictive Disorders, State Opioid Treatment Authority.

1. Application forms shall be requested in writing or by telephone from the Office for Addictive Disorders, State Opioid Treatment Authority, who will provide application forms, criteria utilized to determine need and other materials relevant to the application process.

2. The applicant representative specified on the application will be the only person to whom the DHH Office for Addictive Disorders will send written notification in matters relative to the status of the application during the

review process. If the applicant representative or his address changes at any time during the review process, the applicant shall notify the DHH Office for Addictive Disorders, State Opioid Treatment Authority, in writing.

3. A prospective OTP applicant shall submit the following documents as part of the application:

a. a letter of intent to inform the department that the applicant requests an OTP application review and to include the following:

i. the name, address and telephone number of the applicant;

ii. the name of the applicant representative, an individual authorized to respond to department questions regarding the application and who also signs the letter of intent;

iii. the proposed location of the OTP; and

iv. a brief description of the proposed service, and the proposed date of implementation;

b. an original and three copies of the application. An application shall be submitted on forms provided for that purpose, contain such information as the department may require, and be accompanied by a nonrefundable fee of $600.

4. Applications will be accepted for a period to be specified in the request for application.

5. Once submitted, an application cannot be changed and additional information will not be accepted.

6. Submitted applications failing to meet these guidelines or without the required fee will not be processed and will be returned to the applicant.

G. The OTP committee shall be appointed by the Secretary of the Department of Health and Hospitals. DHH appointments to the OTP committee shall include the following members:

1. DHH OAD Medical Director or physician who has expertise in substance abuse treatment and, in particular, opioid treatment;

2. Executive Director of the DHH Office for Addictive Disorders program service region or district in which the proposed OTP would be located;

3. licensed addiction counselor approved by the Louisiana Addictive Disorder Regulatory Authority and DHH Office for Addictive Disorders;

4. member of the Louisiana Board of Pharmacy;

5. Louisiana State Opioid Treatment Authority;

6. current President of the State Opioid Treatment Authority Alliance or a State Opioid Treatment Authority from another state; and

7. DHH OAD Fiscal Director.

H. No committee member shall have a proprietary, financial, professional or other personal interest of any nature or kind in any OTP.

I. The applicant shall make a brief presentation of the proposed program before the committee and respond to questions raised by the committee.

J. The department sets the review period, which will be no more than 60 days, except as noted below. The review period begins on the first day after the date of receipt of the application.

1. A longer review period will be permitted only when initiated by the committee. A maximum of 30 days will be allowed for an extension.

2. An applicant may not request an extension of the review period, but may withdraw an application (in writing) at any time prior to the notification of the decision by the DHH Office for Addictive Disorders.

K. The committee will review the applications and independently evaluate and assign points in each of the following subject areas for the quality and adequacy of the applicant's responses:

1. financial viability and availability of funds;

2. licensure and/or accreditation:

a. work plan for accreditation and state licensure;

b. history of compliance with accreditation, licensure and/or certification bodies related to the provision of healthcare services;

3. range of services and program design;

4. community integration:

a. availability, accessibility and appropriateness of the location of the proposed OTP site; (for example: accessibility to public transportation and healthcare providers; location in relation to children's schools and playgrounds);

b. methods to achieve community integration through a community relations plan.

L. A score will be given to the applicants' responses on the application.

M. The approved highest scoring application will then be forwarded to the DHH Secretary for final approval.

N. Upon the secretary's final approval, the Office for Addictive Disorders State Opioid Treatment Authority will forward a notice of approval letter to the applicant representative.

O. Each applicant will be notified of the department's decision. Notification shall be sent by certified mail to the applicant representative.

P. Notification shall be sent to the applicant at his last known address. An applicant is responsible for notifying the department of any change of address.

Q. Applications approved under these provisions are bound to the description in the application with regard to opioid treatment as well as to the location. The OTP application review approval shall expire if these aspects of the application are altered, except as noted below.

1. If, due to no fault of the approved OTP applicant, the location fails, the applicant has 30 days from the application approval date to secure an alternate location and submit the location to the committee.

2. The committee will approve or deny the alternate location within 15 days of submittal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:523 (March 2010).

Subchapter D. Administrative Appeals

§12909. Appeal Procedures

A. Upon denial of the department to grant an OTP proposal review approval, only the applicant shall have the right to request an administrative appeal.

1. A written request for such an appeal must be submitted to the secretary within 30 days after the notification of the denial is received by the applicant.

2. The request shall contain a statement setting forth the specific reasons the applicant disagrees with the denial.

3. All administrative appeals shall be consolidated for purposes of the hearing.

B. Administrative Hearings

1. The hearings shall be conducted at the DHH Bureau of Appeals in accordance with the Administrative Procedures Act.

2. Any party may appear and be heard at any appeal proceeding through an attorney or designated representative. A person appearing in a representative capacity shall file a written notice of appearance on behalf of the provider identifying his/her name, address, telephone number and the party being represented.

3. The hearing shall be conducted within 60 days after receipt of the written request for the hearing. Either party may request an extension of the hearing date upon a showing of good cause provided that the hearing is rescheduled to a date no later than 120 days from receipt of notice of the department's decision.

4. The Bureau of Appeals may schedule a preliminary conference. If one is scheduled, the parties shall be notified in writing of the date, time and place of the conference.

5. The applicant and department will be notified in writing of the date, time and place of the administrative hearing no later than 15 calendar days prior to the hearing.

6. An applicant who has requested an administrative appeal shall present his case first and has the burden to show by a preponderance of the evidence that his application should have been approved by the department pursuant to the provisions of this rule. After the applicant has presented his evidence, the department will then have the opportunity to present its case and to refute and rebut the testimony and evidence presented by the applicant.

7. If an applicant fails to appear at the administrative hearing, a decision shall be issued by the Bureau of Appeals dismissing the appeal. The dismissal may be rescinded upon order of the Bureau of Appeals if the applicant makes written application within 10 calendar days following the mailing of the dismissal order and provides evidence of good cause for the failure to attend the hearing.

C. The issuance of the approval shall be suspended if an applicant files an appeal. The suspension is effective only during the administrative appeal process.

D. Within 20 days of the completion of the hearing, The Bureau of Appeals shall make a written decision. The written decision shall be final, binding and enforceable. A copy of the decision shall be mailed to the applicant at his last known address or to his authorized representative.

E. An applicant has the right to file for judicial review in accordance with the Administrative Procedures Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:524 (March 2010).

§12911. Licensing and Certification Compliance

A. The following time frames shall apply for complying with the requirements for obtaining DHH licensure as an opioid treatment program and for complying with all applicable federal, state, and local laws and regulations.

1. Opioid treatment programs shall achieve DHH licensure no later than one year from the date of the OTP application review approval.

2. OTPs shall be in compliance with all applicable OTP federal, state, and local laws and regulations no later than one year from the date of the OTP application review approval.

B. Failure to meet the timeframes in this section could result in an automatic expiration of the OTP application review approval of the OTP.

C. An OTP that intends to relinquish application review approval prior to the expiration of the timeframes in this Section, shall submit a letter of such intent to the DHH Office for Addictive Disorders State Opioid Treatment Authority.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:525 (March 2010).

Subchapter E. Rescission of OTP Need Review Application Approvals

§12913. General Provisions

A. Opioid treatment program application review approval shall be automatically rescinded upon rendering of a final decision under the following circumstances:

1. a clinic's license is revoked;
2. a clinic's license is not renewed;
3. a clinic's license is denied;
4. a clinic's license is voluntarily surrendered;
5. a cessation of the clinic's business;
6. a clinic's accreditation is revoked;
7. a clinic's accreditation is not renewed;
8. a clinic's accreditation is denied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:525 (March 2010).

Subpart 7. Human Immunodeficiency Virus/AIDS

Chapter 135. HIV/AIDS Testing

§13501. Definitions

A. An HIV-related test is a test which is performed solely for the purpose of identifying the presence of antibodies or antigens indicative of infection with Human Immunodeficiency Virus (HIV) including but not limited to: HIV antibody ELISA, Western blot and Immunoflourescent Assay (IFA) tests, HIV viral cultures, Polymerase chain reaction (PCR) test for detection of HIV and HIV antigen tests.

B. HIV test result is the original document, or copy thereof, transmitted to the medical record from the laboratory or other testing site the result of an HIV-related test. The term shall not include any other note, notation, diagnosis, report or other writing or document.

C. Contact is a sex-sharing or needle-sharing partner, a person who has had contact with blood or body fluids to which universal precautions apply through percutaneous inoculation or contact with an open wound, non-intact skin, or mucos membrane, or a person who has otherwise been exposed to an HIV infected person in such a way that infection may have occurred as defined by the Department of Health and Hospitals regulations based upon Center for Disease Control guidelines.

AUTHORITY NOTE: Promulgated in accordance with R.S.40:38.5

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR18:182 (February 1992).

§13503. Consent for Testing

A. Informational Provisions. Prior to the execution of informed consent, the health care provider requesting the performance of an HIV-related test shall provide to the subject of an HIV-related test, or, if the subject lacks capacity to consent, to a person authorized by law to consent to health care for the subject, an oral, videotaped, or written explanation of the nature of AIDS and HIV-related illness, as well as oral, videotaped, or written information about behavior known to pose risks for transmission and contraction of HIV infection. The consent form developed by the Department of Health and Hospitals, Office of Public Health, contains the minimal requirements for meeting these provisions as does the informational brochure developed for this purpose. If the information is given orally to the subject it should describe at a minimum:

1. the voluntary nature of the test;

2. measures for the prevention of exposure to, and transmission of HIV, including discussion of abstinence, monogamy, safer sex using condoms, cleaning needles, or other prevention measures needed by the patient as well as partner notification;

3. the accuracy and reliability of testing for HIV;

4. the significance of the results of such testing, including the potential for developing the Acquired Immunodeficiency Syndrome;

5. encouraging the individual, as appropriate, to undergo such testing;

6. the benefits of such testing, including the medical benefits of diagnosing HIV disease in the early stages and the medical benefits of receiving early intervention services during such stages;

7. the possibility that the subject may suffer discrimination if the results of the test are disclosed inappropriately.

B. Informed Consent

1. Except as otherwise provided herein, no person shall order the performance of an HIV-related test to be performed on a person at a licensed hospital without first receiving the written informed consent of the subject of the test if the individual has capacity to consent or, when the subject lacks capacity to consent, that of the person authorized by law to consent to health care for such individual except as provided herein or authorized or required by law or regulation. Louisiana law specifically authorizes minors to consent to care for sexually transmitted diseases without parental approval. The written form developed by the Department of Health and Hospitals, Office of Public Health, has been developed to fulfill the requirements of this provision. Adherence to these rules, regulations, and forms shall constitute a legal presumption that consent for testing was validly obtained. While other forms of written consent or verbal consent can be obtained there shall be no legal presumption that consent secured through such means will be deemed valid.

2. If an HIV-related test is to be performed on a person who is an outpatient, or tested at a licensed hospital laboratory by the delivery of blood sample for testing, the person ordering such tests shall first obtain the consent of the patient and specifically so state on the order or request form furnished to the hospital or hospital laboratory, and likewise indicate the patient's choice as to the anonymity (see Subsection D below); such statement and/or certification by the person ordering the test may be relied upon by the hospital or hospital laboratory without the necessity for a copy of such consent and/or election by the patient being furnished.

3. If the HIV-related test is to be performed on a person who is an inpatient in a licensed hospital, a written consent form, duly completed and by the patient, must be in the patient's chart prior to any steps in such HIV-related testing.

C. Verbal Informed Consent. If a person is ordering an HIV-related test on a client who is in a setting other than as an inpatient in a licensed hospital, he/she has the option of either first receiving the written informed consent of the subject (or authorized person as indicated above) as in Subsection A above, or receiving the verbal informed consent of a subject contemporaneously documented in writing in the medical record. Verbal informed consent should be immediately and contemporaneously documented in writing in the medical record of the person being tested. Minimal requirements of valid verbal consent include a discussion of the topics as contained in the written consent form as summarized by the following:

1. the voluntary nature of the test;

2. measures for the prevention of exposure to, and transmission of HIV, including discussions of abstinence, monogamy, safer sex using condoms, cleaning needles, or other prevention measures needed by the patient as well as partner notification;

3. the accuracy and reliability of testing for HIV;

4. the significance of the results of such testing, including the potential for developing the Acquired Immunodeficiency Syndrome;

5. encouraging the individual, as appropriate, to undergo such testing;

6. the benefits of such testing, including the medical benefits of diagnosing HIV disease in the early stages and the medical benefits of receiving early intervention services during such stages;

7. the possibility that the subject may suffer discrimination if the results of the test are disclosed inappropriately. Both the written consent form and the informational brochure developed by the Department of Health and Hospitals, Office of Public Health, contain (independently) the necessary written information which can be provided to the person being tested. The informational brochure contains some additional information which may be useful to the person being tested but is not required to be given to the person being tested.

D. Anonymous Testing. A patient requesting the performance of an HIV-related test shall be provided an opportunity to remain anonymous by the use of a coded system with no correlation or identification of the individual's identity to the specific test request or results. A health care provided that is not able to provide this service shall refer, at no extra charge to the individual seeking anonymity, to a site which does provide anonymous testing. These anonymous provisions do not apply to inpatients in hospitals. Providers can locate sites where this testing can be done anonymously through the Louisiana AIDS Hotline at 1-800-99AIDS9 or the local parish health unit.

E. HIV Testing Not Requiring Informed Consent. Informed consent is not necessary as follows:

1. by a health care provider/facility in procuring human body parts or blood for transplantation or transfusion;

2. for accredited research such that the identity of the subject remains anonymous and cannot be retrieved by the researcher;

3. on a deceased person to determine the cause of death or for epidemiologic purposes;

4. if, in the opinion of the health care provider requesting the test, the request for consent would be medically contraindicated;

5. a child taken into custody of the Department of Social Services where department officials have cause to believe the child is infected with HIV;

6. on a child when the child's attending physician or health care provider reasonably believes such test to be necessary in order to properly diagnose or treat the childs medical condition and document such reason in the child's medical record;

7. on any person arrested, indicted, or convicted for crimes of aggravated rape, forcible rape, simple rape, or incest when required by a court to undergo an HIV related test;

8. for test performed pursuant to R.S. 40:1299(D).

AUTHORITY NOTE: Promulgated in accordance with R.S.40:38.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 18:183 (February 1992).

§13505. Disclosure of HIV-Related Test Results

A. Provision for Refusal of Disclosure. Except as otherwise provided by law or regulation, no person who obtains, retains, or becomes the recipient of confidential HIV test results in the course of providing any health or social service or pursuant to a release of confidential HIV test results may disclose such information pursuant to a written authorization to release medical information when the authorization contains a refusal to release HIV test results. The form developed by the Department of Health and

Hospitals, Office of Public Health, for the authorization for the release of confidential information has been developed in accordance with the Administrative Procedures Act for the release of medical information allowing a person to refuse to disclose HIV test results.

B. Disclosure of HIV Test Results without the Subject's Consent. HIV test results may be released to the following entities without authorization from the subject (or the person authorized by law to consent to health care for the subject);

1. to any person to whom disclosure of medical information is authorized by law without the consent of the patient;

2. to al health care facility/provider or employee thereof which;

a. is permitted to access medical records;

b. is authorized to obtain HIV test results;

c. maintains or processes medical records for billing or reimbursement purposes.

3. to a health care facility/provider or employee thereof when knowledge of HIV test results is necessary to provide appropriate care or treatment and afford the provider an opportunity to protect themselves from transmission of the virus;

4. to a health care facility/provider or employee thereof in relation to use of body parts for medical education, research, therapy, or transplantation;

5. to a health care facility staff committee, accreditation or oversight review organization authorized to access medical records;

6. to a federal, state, parish, or local health officer when the disclosure is mandated by federal or state law;

7. to an agency or individual in connection with the foster care programs of the Department of Social Services or to an agency or individual in connection with the adoption of a child;

8. to any person to whom disclosure is ordered by a court of competent jurisdiction;

9. to an employee or agent of the Board of Parole of the Department of Public Safety and Corrections (or of its office of parole) to the extent the employee or agent is authorized to access records containing HIV test results;

10. to a medical director of a local correctional institution to the extent he/she is authorized to access records containing HIV test results;

11. to an employee or authorized agent of the Department of Social Services, Office of Rehabilitative Services;

12. to an insurer, insurance administrator, self-insured employer, self-insured trust, or other person or entity responsible for paying or determining payment for medical services to the extent necessary to secure payment for those services.

C. Disclosure of HIV Test Results by a State, Parish or Local Health Officer. A state, parish, or local health officer may disclose confidential HIV test results when disclosure is specifically authorized or required by state law, disclosure is made pursuant to a release of confidential HIV test results, disclosure is requested by a physician pursuant to Subsection E below, or disclosure is authorized by a court order.

D. Disclosure by Persons to whom HIV Test Results have been Disclosed. Except for the individual or a natural person who is authorized to consent to health care for the individual, no person to whom confidential HIV test results have been disclosed pursuant to this Part shall disclose the information to another person except as authorized by this Part.

E. Notification of Contacts. A physician may, but is not obligated to, notify a contact of an HIV infected person if:

1. the physician reasonably believes the disclosure is medically appropriate and there is a significant risk of infection to the contact;

2. the physician has counseled the infected patient, if alive, regarding the need to notify the contact, and the physician reasonably believes the patient will not inform the contact;

3. the physician has informed the patient, if alive, of his or her intent to make such a disclosure and has given the patient the opportunity to express a preference as to whether the disclosure should be made by the physician directly or to a public health officer for the purpose of disclosure. This preference shall be honored by the physician. When making the disclosure, the physician or the public health officer shall not disclose the identity of the patient to the contact. A physician shall have no obligation to identify or locate any contact.

F. Other Disclosures Authorized by Law. A physician may, upon the consent of the parent or guardian, disclose confidential HIV test results to a state, parish or local health officer for the purpose or reviewing the medical history of a child to determine fitness of the child to attend school. A physician may disclose confidential HIV test results pertaining to a patient to a person authorized by law to consent to health care for the patient when the physician reasonably believes the disclosure is medically necessary in order to provide timely care and treatment for the patient and, after appropriate counseling as to the need for such disclosure, the patient has not and will not inform the person authorized by law to consent for health care. The physician shall not make such disclosure if, in the judgment of the physician, the disclosure would not be in the best interest of the patient or of the individual authorized by law to consent for such care and treatment. Any decision or action by a physician pursuant to this Subsection, and the basis thereof shall be recorded in the patient's medical record. A physician may choose not to disclose the results of a confidential HIV test to a person upon whom such a test has been performed when in the medical opinion of the physician the disclosure of such results would be medically contraindicated.

G. Court Authorization for Disclosure of Confidential HIV Test Results

1. Only a court of competent jurisdiction shall issue and order for the disclosure of confidential HIV test results.

2. A court may grant an order for disclosure if:

a. there is a compelling need for adjudication;

b. there is clear and imminent danger to the individual;

c. there is clear and imminent danger to the public health;

d. the applicant is lawfully entitled to the disclosure.

3. The court order authorizing disclosure shall direct communications to be sealed and shall direct further proceedings to be conducted in camera so as to protect the subject's confidentiality.

4. Adequate notice shall be given to those from whom disclosure is requested to allow them to prepare a written or personal response unless there is a clear and imminent danger to an individual. A court must weigh the compelling need for disclosure against the privacy interest of the protected individual and against the public interest which may not be served by disclosure which deters future testing or treatment or which may lead to discrimination.

5. No subpoena for hospital or other medical records shall be construed as a court order for disclosure of HIV-related test results unless accompanied by a copy of a court order authorizing the issue of a subpoena for such test results, after compliance with this Subsection. No release by a hospital or other health care provider made pursuant to and in compliance with a subpoena which is valid on its face, shall be considered to be in violation of this Section.

6. An order shall limit disclosure to necessary information and limit disclosure to those persons whose need for the information is the basis for the order and specifically prohibit additional disclosure by such persons to other persons, regardless of whether they are parties to the action.

AUTHORITY NOTE: Promulgated in accordance with R.S.40:38.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 18:184 (February 1992).

§13507. Regulation of Practices of Insurers' and Practices of Other Entities' and Individuals' Interacting with Insurers Relating to HIV-Related Testing or HIV Test Results

A. With the exception of §13505.B.12, in the case of a person applying for or already insured under an insurance policy who will be or has been the subject of a test to determine infection for human immunodeficiency virus (HIV), all facets of insurers' practices in connection with HIV-related testing and HIV test results shall be governed exclusively by Title 22 of the Revised Statutes of 1950 and any regulations promulgated pursuant thereto by the commissioner of the Department of Insurance who shall have authority to promulgate such regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S.40:38.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 18:185 (February 1992).

§13509. Forms

A. The Department of Health and Hospitals, Office of Public Health has developed forms for obtaining informed consent for HIV testing, for release of medical information, and a brochure to provide information to a person being tested for HIV pursuant to Act 1054. These forms are not included in the final rules for this act so that they can be updated as information regarding HIV and AIDS expands. Copies of these forms are available from the HIV/AIDS Services Program, Office of Public Health, 325 Loyola Avenue, Room 618, New Orleans, LA 70112.

AUTHORITY NOTE: Promulgated in accordance with R.S.40:38.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 18:185 (February 1992).

Chapter 137. Home Based Care

§13701. Definitions

A. When used in this Subpart, unless expressly stated otherwise or unless the context of subject matter requires a different interpretation:

Department–the Louisiana Department of Health and Hospitals.

Home Based Care–medical, hospice, and support services provided in the client's home by a licensed Home Health Care or Hospice agency.

Poverty Guideline–the federal income official poverty line applicable to a family of the same size as the applicant's as published annually in the Federal Register.

Program–the home based care program for HIV infected persons.

Service Agency or Agency–the licensed home health or hospice agency which has a contract to provide services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:256 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Resources Management, LR 20:1010 (September 1994).

§13703. Covered Services

A. All services provided under this program are to be performed in the home for HIV infected clients at a physician's order.

Visits are limited to a maximum of once a day unless otherwise indicated.

B. Home Based Care

1. Skilled nursing including but not limited to:

a. medication preparation, administration, and monitoring;

b. care of peripheral and central access devices;

c. insertion, irrigation and maintenance of foley catheters;

d. complex wound care and dressing changes;

e. oxygen therapy and monitoring and other respiratory therapy;

f. venipuncture for laboratory studies;

g. client/significant other education:

i. medications and adverse effects;

ii. diet;

iii. self care;

iv. disease process;

v. treatments;

vi. custodial care;

vii. infection control procedures.

h. aerosolized pentamidine treatments (IM pentamidine is not covered by this program);

i. palliative care focusing on pain relief and symptom control.

2. Home health aides (maximum of five visits per week) to assist with activities of daily living.

3. Supplies, durable medical equipment rental.

4. Medications at a maximum of 30 percent above cost. IV therapy needed more than once a day up to three times a day can be covered for up to eight weeks. Daily IV therapy can continue for the duration of the home based care. Medications covered are those provided under the Level 1, 2, or 3 state formularies or a formulary approved by the department through the LHCA HIV Ambulatory Care Sites.

5. Physical therapy.

6. Social worker services (maximum of two visits a week).

7. Routine diagnostic tests.

8. Nutritional therapy following the Louisiana Medicaid Guidelines including supplements at a maximum of 30 percent above cost. (Physician order need not specify enteral via tube for this program).

Total parenteral nutrition is not covered by this program.

C. Hospice Care

1. Skilled nursing services. Palliative care including but not limited to:

a. medication preparation, administration, and monitoring;

b. care of peripheral and central access devices;

c. insertion, irrigation and maintenance of foley catheters;

d. complex wound care and dressing changes;

e. oxygen therapy and monitoring and other respiratory therapy;

f. venipuncture for laboratory studies related to palliative care;

g. client/significant other education:

i. medications;

ii. comfort measures;

iii. self-care;

iv. disease process;

v. treatments;

vi. custodial care;

vii. infection control procedures;

viii. end stage care planning (anticipated signs and symptoms of approaching death);

h. palliative care focusing on pain relief and symptom control;

i. support for client, family, and significant others.

2. Home health aides (maximum of five visits per week) to assist with activities of daily living.

3. Supplies, durable medical equipment rental.

4. Medications at a maximum of 30 percent above cost. IV therapy needed more than once a day up to three times a day can be covered for up to eight weeks. Daily IV therapy can continue for the duration of the hospice care.

Medications covered are those provided under Level 1, 2, or 3 State Formularies or a formulary approved by the department through the LHCA HIV Ambulatory Care Sites.

5. Social worker services (maximum of two visits per week).

6. Pastoral care.

7. Bereavement follow-up for significant others and family members.

8. Trained volunteers to provide support to the client and family through tasks such as shopping, sitting, running errands, preparing meals, and listening.

NOTE: 6, 7, and 8 are not reimbursable services.

D. Personal Care Attendant Services. Personal care attendants to provide services including light housework, grocery shopping, and cooking (maximum of five visits per week and 160 hours per client per twelve month period).

Clients may be eligible for an additional 320 hours if they meet one of the following criteria:

1. patients currently receiving care from a licensed hospice agency;

2. prognosis of less than one month as determined by the primary care physician;

3. nursing home or residential care facility placement is not feasible within 30 days.

NOTE: Each agency would be strictly controlled in the use of the extension. The referral must come from the client's primary care physician and must meet one of the guidelines above. Approvals would be granted on a case-by-case basis for up to four weeks at a time. Authority for approvals would rest with the HIV Program Office.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:256 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Resources Management, LR 20:1011 (September 1994).

§13705. Client Eligibility

A. Client must be HIV infected and require medical and/or nursing intervention.

B. Client desires home based care as determined and documented by the social worker/case manager, and client's primary care physician.

C. Service is not covered by any other third-party coverage. This program should be used when all other sources of payment for home based care have been exhausted. This program will supplement gaps in existing third-party coverage for services listed including covering beyond the amount and frequency covered by medicaid.

D. Client must have a household income less than 200 percent of the federal poverty guidelines updated annually and available resources less than $4,000 based on Medicaid guidelines.

E. Client must have a physician who will provide orders in writing or verbally to the agency prior to the initiation of care, act as that client's primary care physician, maintain a consistent plan, and communicate changes from the initial plan directly to the agency or the physician must be willing to transfer the client to the care of the agency physician. If verbal orders are given to the agency, written orders must follow within 48 hours.

F. Client is certified by the agency and the client's physician as not being in need of acute care.

G. Client's physician or physician's associates are available 24 hours a day by phone or beeper or agrees that the home based care agency may refer the client to an emergency room for problems.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:256 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Resources Management, LR 20:1011 (September 1994).

§13707. Agency Requirements

A. Agency is licensed home health care or hospice provider.

B. Agency will confirm client's eligibility for the program as stated above before the initiation of care. If an agency initiates care prior to eligibility confirmation, it will be financially responsible for care for clients who are found to be ineligible for home based care assistance.

C. The home care nurse must obtain a clinical status report and home care orders from the physician for the referred client prior to beginning care, will conduct a first visit with the client and will develop a written plan of care. Progress notes will be kept and the client will be recertified for home based care and the plan of care updated at least every 60 days. The home based care nurse will maintain ongoing communication with the physician and case manager in compliance with Medicaid and Medicare Guidelines.

D. Home care will begin within 24 hours of discharge from inpatient setting or referral from physician unless otherwise specified.

E. Nurse will be available for consultation on a 24 hour, seven day a week basis.

F. Agency will participate in the Ryan White Consortium for the region to which they provide care and have a representative present at a minimum of 50 percent of the monthly consortium meetings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:256 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Resources Management, LR 20:1012 (September 1994).

§13709. Application Guidelines

A. A client can be recommended for home based care services by the physician, nurse, social worker, or case manager involved with the client's care. Client's eligibility must be verified by the service agency and verification provided to the department. Written orders for home based care services must be provided by the client's physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:256 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Resources Management, LR 20:1012 (September 1994).

§13711. Termination

A. Eligibility for services under this program will be terminated if the client:

1. subsequently is determined to have a household income greater than 200 percent of the federal poverty line;

2. subsequently is determined to have assets of greater than $4,000;

3. is not stable enough to be cared for outside of the acute care setting as determined by the agency or the client's physician;

4. moves from Louisiana;

5. no longer has a stable home environment appropriate for the provision of home based care as determined by the agency or the case manager;

6. no longer desires home based care;

7. no longer medically requires home based care as determined by the agency or the physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:256 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Resources Management, LR 20:1012 (September 1994).

§13713. Reporting Requirements

A. Agencies will submit invoices for services provided as required. Agencies will provide individual client service utilization reports as required under the Ryan White Uniform Reporting System. All eligibility forms and the signed plan of treatment are to be submitted within 48 hours of a referral.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:256 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Resources Management, LR 20:1012 (September 1994).

§13715. Fair Hearing

A. Persons requesting and denied services under this program are entitled to request a conference and/or fair hearing to review the decision of the service agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:256 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Resources Management, LR 20:1012 (September 1994).

§13717. Payment for Services

A. Payment for home based care services delivered under this program will be made directly to the service agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:256 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Resources Management, LR 20:1012 (September 1994).

§13719. Confidentiality

The confidentiality of HIV and AIDS related information is required in accordance with R.S. 40:38.5. Each disclosure of confidential HIV-related information must be accompanied by the appropriate release.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:256 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Resources Management, LR 20:1012 (September 1994).

§13721. Forms

A. The Department of Health and Hospitals, Office of Management and Finance, HIV Program Office has developed example forms that can be used in this program. These include client eligibility checklist and release of medical information form. In addition, a client service utilization report. While the specific forms do not need to be used, the information contained on the forms must be collected and provided to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:256 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Resources Management, LR 20:1012 (September 1994).

Subpart 9. Primary Health Care Services

Chapter 159. Introduction

§15901. Definitions

A. Act 819 (the Act) defines *primary service area* of a rural hospital as the smaller of either a radius of 25 miles from the rural hospital main campus or the number of postal zip codes, commencing with the rural hospital's zip code, in which 75 percent of a rural hospital's patients reside, as determined by using data derived from the hospital's most recent 12 month Medicare cost reporting period. In determining the primary service area, each outpatient encounter and each inpatient stay shall be viewed as a separate patient, and the zip code attributable to the patient shall be the zip code of the patient at the time of the inpatient stay or outpatient encounter. The term *primary service area* does not include the cities of Alexandria, Baton Rouge, Bossier City, Covington, Hammond, Houma, Kenner, Lafayette, Lake Charles, Mandeville, Monroe, New Iberia, New Orleans, Opelousas, Ponchatoula, Ruston, Shreveport, Slidell, Thibodaux, or West Monroe.

B. *Rural hospital* shall be defined as provided for in R.S.40:1300.143, as such law existed on April 1, 2006.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1306-1310.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Primary Care and Rural Health, LR 34:89 (January 2008).

§15902. Determination of Primary Service Area

A. Geographic Determination. As of July 6 2007, Louisiana has 51 rural hospitals. The 25 miles radius of each rural hospital has been identified by geocoding the zip code of each rural hospital and the 25 miles radius surrounding each of these hospitals. A map depicting the 25 miles radius surrounding each rural hospital is located at www.dhh.la.gov. In accordance with the Act, the Bureau of Primary Care and Rural Health will update the list of

Louisiana's rural hospitals and their 25 mile radius annually and provide these updates on www.dhh.la.gov.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1306-1310.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Primary Care and Rural Health, LR 34:89 (January 2008).

§15903. Determining the Smaller of the Two Primary Service Area Definitions

A. The Department of Health and Hospitals proposes the following process to determine if the hospital's primary service area is the smaller of either the 25 miles radius of the rural hospital or the number of postal zip codes, commencing with the rural hospital's zip code, in which 75 percent of a rural hospital's zip code, in which 75 percent of a rural hospital's patients reside, as determined by using data derived from the hospital's most recent 12 month Medicare cost reporting period.

1. *Primary service area* will be defined as the 25 mile radius of the rural hospital unless a formal request is made in writing to the Department of Health and Hospital's Bureau of Primary Care and Rural Health for a determination on the smaller of the two primary service area definitions. The request must include the legal name and address of the entity requesting the determination, the name and address of the rural hospital impacted by the request and the type of healthcare facility that seeks to locate in the service area of the rural hospital. Requests for this primary service area determination will be sent to DHH-Bureau of Primary Care and Rural Health.

2. Within 30 days of receipt of the written request for a primary service area determination, the Bureau of Primary Care and Rural Health will request cost report data with service area zip codes from the rural hospital identified in the request. Cost report data will be required to be submitted to the Bureau of Primary Care and Rural Health within 30 days of the bureau's request.

3. Within 30 days of receipt of this cost report data, the Bureau of Primary Care and Rural Health will geocode and map the zip codes of the cost report data to assess the primary service area of the rural hospital. The results of this analysis will be provided to the party issuing the request for the primary service area determination and the rural hospital impacted by the request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1306-1310.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Primary Care and Rural Health, LR 34:89 (January 2008).

Subpart 11. Community and Family Support System

Chapter 161. Community and Family Support System—Flexible Family Fund

§16101. Introduction

A. The first and primary natural environment for all people is the family. Children, regardless of the severity of their disability, need families and enduring relationships with adults in a nurturing home environment. As with all children, children with developmental disabilities need families and family relationships to develop to their fullest potential. Services for persons with developmental disabilities should be responsive to the needs of the individual and the individual’s family, rather than fitting the person into existing programs. Flexible Family Fund assists families in keeping their child with a severe developmental disability at home.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary and the Department of Social Services, Office of the Secretary, LR 18:186 (February 1992), repromulgated LR 33:1135 (June 2007), amended by the Department of Health and Hospitals, Office of the Secretary and the Department of Children and Family Services, Office of the Secretary, LR 37:2584 (September 2011), amended the Department of Health, Office for Citizens with Developmental Disabilities, LR 45:558 (April 2019).

§16103. Definitions

Child—an individual under the age of 18.

Developmental Disability—defined in accordance with the Developmental Disability Law at R.S. 28:451.2(12).

Emotional Disturbance Severity Screening Instrument—a tool selected and used by the Local Governing Entity (LGE) providing behavioral health services for the purposes of determining if the individual meets severity criteria to receive the Flexible Family Fund for the exceptionality of emotional disturbance.

Exceptionality—all disabilities identified under Individuals with Disabilities Education Act (IDEA), including gifted and/or talented as defined in state law.

Family—the basic family unit consists of one or more adults and children related by blood, marriage or adoption, and who reside in the same household.

Flexible Family Fund (formerly Cash Subsidy Program)—a monetary stipend paid to families of eligible children to assist in keeping their child with a severe disability at home.

Independent Education Evaluation (IEE)—an evaluation conducted by a qualified examiner not employed by the local education agency (LEA) responsible for the education of the child as a substitute for the evaluation of the child obtained

by the LEA in the event a parent disagrees with the LEA's evaluation.

Individualized Education Program (IEP)—a written statement for a child with a disability that is developed, reviewed, and revised in accordance with 34 C.F.R. 300.324 through 34 C.F.R. 300.328.

Intellectual/Developmental Disabilities (IDD) Screening Checklist—a tool used by the Local Governing Entity (LGE)for applicants of Flexible Family Fund, who have a qualifying exceptionality, to determine if the child meets the definition of Developmental Disability in accordance with R.S. 28:451.2(12).

Intellectual/Developmental Disabilities Severity Screening Instrument—a tool used by the LGE for applicants for the Flexible Family Fund, who have a qualifying exceptionality and have met the criteria on the Intellectual / Developmental Disabilities (IDD) Screening Checklist, to screen the degree of limitation and impact of the child's developmental disability on the child's functioning.

Licensed Health Professional—a person credentialed to provide health services by a professional board established and approved by the state of Louisiana, including those boards which examine physicians, psychiatrists, psychologists, social workers, counselors, nurse practitioners, etc.

Local Education Agency (LEA)—a public board of education or other public authority legally constituted within Louisiana for administrative control and direction of or to perform a service function for public elementary or secondary schools in a city, parish, or other local public school district or other political subdivision. The term includes an education service agency and special schools and school districts as that term is used in R.S. 17:1945 and any other public institution or agency having administrative control and direction of a public elementary or secondary school.

Local Governing Entity (LGE)—a human services district or authority with local accountability and management of behavioral health, intellectual disability, and developmental disability services. There are 10 LGEs, each responsible for a geographic region within the state.

Office of Behavioral Health (OBH)—the office within the Department of Health charged with performing the functions of the state which oversee services and continuity of care for the prevention, detection, treatment, rehabilitation, and follow-up care of mental and emotional illness in Louisiana and performing functions related to mental health. It is also charged with performing the functions of the state relating to the care, training, treatment, and education of those suffering from substance-related or addictive disorders and the prevention of substance-related and addictive disorders and administering the substance-related and addictive disorders programs in the state.

Office for Citizens with Developmental Disabilities (OCDD)—the office within the Department of Health that is responsible for the programs and functions of the state relating to the care, training, treatment, and education of people diagnosed with intellectual and developmental disabilities.

Qualifying Exceptionality—exceptionalities which have been identified as meeting the criteria to be considered for the Flexible Family Fund. A qualifying exceptionality is one of the following:

1. autism;

2. deaf-blindness (deaf and blind);

3. intellectual disability—severe;

4. intellectual disability—moderate with a behavior intervention or individual healthcare plan;

5. intellectual disability—mild with a behavior intervention or individual healthcare plan;

6. multiple disabilities;

7. orthopedic impairment;

8. other health impaired;

9. traumatic brain injury;

10. developmentally delayed for children ages three through eight years;

11. emotional disturbance (for Flexible Family Fund administered by the local governing entity providing behavioral health services);

12. EarlySteps eligibility for children until the age of three may also be considered for Flexible Family Fund.

Responsible Caregiver—a child's natural or adoptive mother or father, legal, testamentary, or dative tutor, or the person who is legally responsible, but not financially compensated, to act as caregiver for the primary care and management of the child.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary and the Department of Social Services, Office of the Secretary, LR 18:186 (February 1992), amended LR 23:862 (July 1997), LR 28:1019 (May 2002), LR 33:1135 (June 2007), amended by the Department of Health and Hospitals, Office of the Secretary and the Department of Children and Family Services, Office of the Secretary, LR 37:2584 (September 2011), LR 40:1523 (August 2014), amended the Department of Health, Office for Citizens with Developmental Disabilities, LR 45:558 (April 2019).

§16105. Application Process

A. Applications for Flexible Family Fund will be accepted by email, fax, mail and in person in the office of the local governing entity (LGE) for the region in which the child resides. There is no closing date for accepting applications.

B. The responsible caregiver is responsible for completing the application and submitting all required documentation related to the application.

C. Applications will be maintained on the waiting list by date/time order of application, only in the region in which the child lives; no child may be placed on a waiting list or receive a flexible family fund from more than one region or agency.

D. For the developmental disabilities exceptionalities, a completed application must be submitted with appropriate documentation for a qualifying exceptionality. Appropriate documentation includes one of the following:

1. the most recent, current within a year individualized family services plan (IFSP) (for EarlySteps eligibility for infants and toddlers until age three);

2. the most recent report, current within a year, from the Louisiana Department of Education (LDOE) special school programs pupil appraisal services showing the child's condition meets LDOE Bulletin 1508 criteria for one of the qualifying exceptionalities;

3. the most recent, current within a year, signed by school staff and parent/guardian individualized education plan (IEP) listing the child's exceptionality as one of the qualifying exceptionalities;

4. a report, current within a year, from a licensed health professional which states that a child's condition conforms to standards established in the LDOE Bulletin 1508 for one of the qualifying exceptionalities;

5. a current, within a year independent education evaluation (IEE) which states that a child's condition conforms to standards established in the LDOE Bulletin 1508 for one of the qualifying exceptionalities;

6. a current, within a year approved home study plan with a current within three years LDOE special school programs pupil appraisal services report showing the child's condition meets LDOE Bulletin 1508 criteria for one of the qualifying exceptionalities; or

7. an annual individual plan, current within a year, signed by school staff and parent/guardian, listing the child's exceptionality, created by schools approved by the LDOE to provide educational services to children with one of the qualifying exceptionalities, e.g., The school choice program for certain students with exceptionalities; or

E. For the exceptionality of emotional disturbance, a completed application must be submitted with the appropriate documentation of an emotional disturbance. Appropriate documentation includes one of the following:

1. a current treatment plan from a licensed community behavioral health center or evidence of an interagency service coordination process;

2. the most recent report, current within a year, from the LDOE special school programs pupil appraisal service showing the child's condition meets LDOE Bulletin 1508 criteria for emotional disturbance;

3. the most recent, current within a year, signed by school staff and parent/guardian IEP listing the child's exceptionality as emotional disturbance or its equivalent;

4. a report, current within a year, from a licensed health professional which states that a child's condition conforms to standards established in the LDOE Bulletin 1508 for emotional disturbance or its equivalent;

5. a current, within a year IEE which states that a child's condition conforms to standards established in the LDOE Bulletin 1508 for emotional disturbance or its equivalent;

6. a current, within a year approved home study plan with a current within three years LDOE special school programs pupil appraisal services report showing the child's condition meets LDOE Bulletin 1508 criteria for emotional disturbance or its equivalent; or

7. for a student who has been evaluated by a LEA, determined to have an exceptionality of emotional disturbance, and is deemed eligible to participate in the school of choice program for certain students with exceptionalities, an IEP or a services plan for any service in accordance with 34 CFR 300.37 or a nonpublic school created plan resulting from a determination of the evaluation of the student by a LEA that the student requires services for emotional disturbance.

F. The responsible caregiver shall provide appropriate documentation of a qualifying exceptionality annually in order for the child to maintain eligibility for the Flexible Family Fund waiting list.

G. A new application can be submitted at any time a flexible family fund is terminated or denied for any reason other than exceeding the eligible age for participation in the Flexible Family Fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary and the Department of Social Services, Office of the Secretary, LR 18:186 (February 1992), amended LR 23:862 (July 1997), LR 28:1020 (May 2002), LR 33:1136 (June 2007), amended by the Department of Health and Hospitals, Office of the Secretary and the Department of Children and Family Services, Office of the Secretary, LR 37:2585 (September 2011), LR 40:1523 (August 2014), amended the Department of Health, Office for Citizens with Developmental Disabilities, LR 45:559 (April 2019).

§16107. Determining Children Eligible for the Flexible Family Fund

A. The local governing entity (LGE) shall be responsible for determination of eligibility of all applicants for the flexible family fund for which they have responsibility.

B. To be found eligible for the flexible family fund on the basis of a qualifying intellectual/developmental disability exceptionality, four criteria must be satisfied:

1. A complete, signed application must be submitted;

2. The qualifying documentation must be submitted;

3. The child must meet the established criteria on the intellectual/developmental disabilities (IDD) screening checklist; and

4. The child must meet the established level of severity as measured by the intellectual/developmental disabilities severity screening instrument that is specified in the LGE's policy manual.

C. To be found eligible for the flexible family fund on the basis of the qualifying exceptionality of emotional disturbance, the following criteria must be satisfied:

1. a complete, signed application must be submitted;

2. the qualifying documentation must be submitted; and

3. the child must meet the established level of severity, specific to the exceptionality of emotional disturbance as measured by the emotional disturbance severity screening instrument that is specified in the LGE's policy manual.

D. A redetermination for eligibility will occur annually.

E. If at any time during the initial determination of eligibility, the responsible caregiver requests a re-evaluation by the local education agency (LEA) or licensed health provider of the child's exceptionality, the eligibility determination process will be held open for the re-evaluation plus 10 working days. Upon a determination of eligibility, flexible family funds will begin in the month that the next opportunity becomes available.

F. If at any time during the annual determination of eligibility, the responsible caregiver requests a re-evaluation by the LEA or licensed health provider, the child will maintain his or her slot for flexible family funds, but the monthly stipend will be put on hold until the re-evaluation becomes available plus 10 working days. Upon a determination of eligibility, flexible family funds will resume in the month the determination is made. Upon determination of ineligibility, flexible family fund will be terminated according to §16111, Terminations.

G. Families with adopted children may also be eligible to participate in the flexible family fund. Families with adopted children who receive a specialized adoption subsidy are not eligible to participate in the flexible family fund; families who have more than one child who are eligible to participate in the Flexible family fund will be eligible for the flexible family fund amount for each qualifying child.

H. Children who receive a home and community-based services waiver are eligible to participate in the flexible family fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary and the Department of Social Services, Office of the Secretary, LR 18:186 (February 1992), amended LR 23:863 (July 1997), LR 28:1020 (May 2002), LR 33:1136 (June 2007), amended by the Department of Health and Hospitals, Office of the Secretary and the Department of Children and Family Services, Office of the Secretary, LR 37:2586 (September 2011), LR 40:1523 (August 2014), amended the Department of Health, Office for Citizens with Developmental Disabilities, LR 45:560 (April 2019).

§16109. Payment Guidelines

A. The amount of the flexible family fund shall be $258 monthly to families of eligible children with severe disabilities to assist them in keeping their child at home; families may be asked to complete a survey periodically indicating how the flexible family funds are used to assist in keeping their child at home.

B. The termination date for a child attaining age 18 years shall be the last day of the birthday month.

C. If for any reason a recipient receives excess flexible family funds, the agency may follow-up with recoupment of funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:821et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary and the Department of Social Services, Office of the Secretary, LR 18:187 (February 1992), amended LR 23:863 (July 1997), LR 28:1021 (May 2002), LR 33:1136 (June 2007), amended by the Department of Health and Hospitals, Office of the Secretary and the Department of Children and Family Services, Office of the Secretary, LR 37:2586 (September 2011), LR 40:1524 (August 2014), amended the Department of Health, Office for Citizens with Developmental Disabilities, LR 45:560 (April 2019).

§16111. Terminations

A. Reasons for termination may include the following:

1. the responsible caregiver establishes residency or domicile outside Louisiana;

2. family requests termination of the flexible family fund stipend;

3. child is placed into a subsidized living setting or resides in a school away from the home or in another state;

4. death of the child;

5. fraud;

6. termination or limitation of funding of the program;

7. failure to comply with the provisions of the individual agreement or the flexible family fund, including the requirement to maintain quarterly contact with the LGE administering the flexible family fund and the requirement to provide required documentation;

8. child's exceptionality or degree of severity no longer meets eligibility criteria; or

9. child attains age 18 years;

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary and the Department of Social Services, Office of the Secretary, LR 18:187 (February 1992), amended LR 23:863 (July 1997), LR 28:1021 (May 2002), LR 33:1137 (June 2007), amended by the Department of Health

and Hospitals, Office of the Secretary and the Department of Children and Family Services, Office of the Secretary, LR 37:2586 (September 2011), LR 40:1524 (August 2014), amended the Department of Health, Office for Citizens with Developmental Disabilities, LR 45:561 (April 2019).

§16113. Ongoing Monitoring

A. The responsible caregiver is responsible for maintaining contact with the LGE administering the flexible family fund at least every 90 days to verify that the child is in the home and the conditions of the individual agreement and flexible family fund are being met.

B. Such quarterly contact shall be accepted by mail, email, fax, face-to-face meetings and telephone provided the responsible caregiver attests that the conditions of eligibility continue to be in effect. Failure to report significant changes in the child's status as described in §16111 may result in disqualification of the child to participate in the flexible family fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary and the Department of Social Services, Office of the Secretary, LR 18:188 (February 1992), amended LR 23:864 (July 1997), LR 28:1021 (May 2002), LR 33:1137 (June 2007), amended by the Department of Health and Hospitals, Office of the Secretary and the Department of Children and Family Services, Office of the Secretary, LR 37:2587 (September 2011), LR 40:1524 (August 2014), amended the Department of Health, Office for Citizens with Developmental Disabilities, LR 45:561 (April 2019).

§16115. Appeals

A. All persons receiving an adverse eligibility determination shall have the right to request a fair hearing from the Division of Administrative Law. Upon being terminated from Flexible Family Fund, the family will receive written notification of closure. The closure letter will include information about their right of appeal and the process to make an appeal at the point of initial eligibility determination and at termination of a Flexible Family Fund for any reason other than exceeding the eligible age for participation in the program. Flexible Family Fund stipends will continue for the duration of any appeal proceeding, unless a recipient is terminated for exceeding the eligible age for participation in the program.

B. All persons receiving an adverse eligibility determination shall have 30 calendar days from the date on the letter notifying the person of the adverse eligibility decision to request an appeal.

C. The local governing entity (LGE) will prepare a summary of evidence upon being notified of an appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary and the Department of Social Services, Office of the Secretary, LR 18:188 (February 1992), amended LR 23:864 (July 1997), LR 28:1022 (May 2002), LR 33:1137 (June 2007), amended by the Department of Health and Hospitals, Office of the Secretary and the Department of Children and Family Services, Office of the Secretary, LR 37:2587 (September 2011), LR 40:1524 (August 2014), amended the Department of Health, Office for Citizens with Developmental Disabilities, LR 45:561 (April 2019), LR 45:1775 (December 2019).

Subpart 13. Protective Services Agency

Chapter 171. Division of Adult Protective Services

§17101. Statement of Policy

A. The Department of Health and Hospitals is committed to preserving and protecting the rights of individuals to be free from abuse, neglect, exploitation, or extortion.

B. In pursuit of this commitment and in accordance with the provisions of R.S. 14:403.2, and R.S. 15:1501-15:1511 the Department of Health and Hospitals names the Office of Aging and Adult Services, Division of Adult Protective Services (APS) as the Protective Services Agency in order to provide protection to persons ages 18-59 with mental, physical, or developmental disabilities that substantially impair the person's ability to provide adequately for his/her own protection.

C. The primary function of Adult Protective Services is to investigate and/or assess reports of abuse, neglect, exploitation, or extortion consistent with the criteria contained in R.S. 14.403.2 and R.S. 15:1501-15:1511 to determine if the situation and condition of the subject of the report warrant further action and, if so, to prepare and implement a plan aimed at remedying or improving the situation. Adult Protective Services staff will provide protective services to each individual in need of protection until that person's situation has stabilized, that person is no longer at risk from the situation described in the report, or that person, having demonstrated the capacity to do so, refuses assistance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R. S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:434 (April 1994), amended LR 27:312 (March 2001), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:759 (April 2010).

§17103. Goals and Objectives

A. The primary goal of the OAAS Division of Adult Protective Services is to prevent, remedy, halt, or hinder abuse, neglect, exploitation, or extortion of individuals in need of services as defined in this regulation and consistent with the provisions of R.S. 14:403.2 and R.S. 15:1501-15:1511. In order to achieve this goal, Adult Protective Services shall pursue the following objectives:

1. to establish a system of mandatory reporting, intake, classification, timely investigation and response to allegations of abuse, neglect, exploitation, and extortion;

2. to provide protective services to the individual while assuring the maximum possible degree of self-determination and dignity;

3. in concert with other community service and health service providers, to arrange and facilitate the process toward developing individual and family capacities to promote safe and caring environments for individuals in need of protection;

4. to secure referral or admission to appropriate alternative living arrangements if all efforts to maintain the individual in his/her own home fail;

5. to assist individuals in need of protection to maintain the highest quality of life with the least possible restriction on the exercise of personal and civil rights;

6. to educate the general public, as well as private and public service agencies, regarding the Protective Services Agency and the requirements of R.S. 14:403.2.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:435 (April 1994), amended LR 27:313 (March 2001), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:760 (April 2010).

§17105. Definitions

A. For the purposes of this Chapter, the following definitions shall apply.

Abandonment—the desertion or willful forsaking of an adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

Abuse—the infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical injury, on an adult by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value. In determining whether an injury is sufficient to endanger the health, self-determination, or emotional well-being of the adult, the following criteria shall be considered:

a. with respect to physical injury, the injury must be sufficient to ordinarily require professional medical intervention beyond first-aid, or, the behavior in question must be sufficient to create a potential injury of that severity;

b. with respect to mental injury, the injury must be sufficient to ordinarily require mental health services of a clinical nature, or, the behavior in question must be sufficient to create a potential injury of that severity;

c. with respect to isolation, acts of isolation used in a manner where the individual is alone in a room/area from which he/she cannot leave, constitute behavior which has the potential to result in mental injury or unwarranted restriction of the adult's self-determination;

d. with respect to use of restraints, inappropriate and unauthorized use of any chemical and/or mechanical restraints, or any type of restraint which prevents the free movement of either the arms or legs and which immobilizes the individual, shall represent potential physical or mental injury and possible violation of an individual's self-determination. Chemical and/or mechanical restraints ordered by a physician and used in accordance with medical guidelines shall not constitute abuse.

Adult—any individual 18 years of age or older and under the age of 60, or an emancipated minor who, due to a physical, mental, or developmental disability is unable to manage his own resources, carry out the activities of daily living, or protect himself from abuse, neglect or exploitation.

Adult Protective Services (APS)—that division within the Department of Health and Hospitals' Office of Aging and Adult Services determined by the department as the Protective Services Agency for any individual between the ages of 18 and 59 years of age in need of adult protective services , pursuant to the provisions of R.S. 14:403.2 and R.S. 15:1501–15:1511, to provide protection to adults with disabilities as defined herein.

Capacity to Consent—the ability to understand and appreciate the nature and consequences of making decisions concerning one's person, including but not limited to provisions for health or mental health care, food, shelter, clothing, safety, or financial affairs. This determination may be based on assessment, or investigative findings, observation or medical or mental health evaluations.

Caregiver—any person or persons, either temporarily or permanently responsible for the care of a physically or mentally disabled adult. Caregiver includes but is not limited to adult children, parents, relatives, neighbors, day-care personnel, adult foster home sponsors, providers of substitute family care, personnel of public and private institutions and facilities, adult congregate living facilities, and nursing homes which have voluntarily assumed the care of an adult as defined herein have assumed voluntary residence with an individual, or have assumed voluntary use or tutelage of an individual's assets, funds, or property, and specifically shall include city, parish, or state law enforcement agencies.

Emancipated Minor—a person under the age of 18 who administers his/her own affairs or who is relieved of the incapacities which normally attach to minority. Minors can be emancipated by notarial act, marriage, or judicial pronouncement.

Exploitation—the illegal or improper use or management of an adult's funds, assets, or property, or the use of an adult's power of attorney or guardianship for one's own profit or advantage.

Extortion—the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, abuse, neglect, or official authority.

Isolation—includes:

a. intentional acts committed for the purpose of preventing, and which do serve to prevent, an adult from having contact with family, friends, or concerned persons. This shall not be construed to affect a legal restraining order;

b. intentional acts committed to prevent an adult from receiving his mail or telephone calls;

c. intentional acts of physical or chemical restraint of an adult committed for the purpose of preventing contact with visitors, family, friends, or other concerned persons;

d. intentional acts which restrict, place, or confine an adult in a restricted area for the purposes of social deprivation or preventing contact with family, friends, visitors, or other concerned persons. However, medical isolation prescribed by a licensed physician caring for the adult shall not be included in this definition.

Neglect—the failure by the caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall, for that reason alone, be considered to be neglected or abused.

Protective Services—those activities developed to assist individuals in need of protection. Protective services include but are not limited to: receiving and screening information on allegations of abuse, neglect, exploitation or extortion; conducting investigations and/or assessments of those allegations to determine if the situation and condition of the alleged victim warrants corrective or other action, preparing a plan using available community resources aimed at remedying or reducing the risk from abuse, neglect, exploitation or extortion, providing case management, as needed, to assure stabilization of the situation, and arranging of or making referrals for needed services and/or legal assistance to initiate any necessary remedial action.

Regional Coordinating Council—a regionally constituted committee composed of representatives of both public and private agencies providing services, with the objectives of identifying resources, increasing needed supportive services, avoiding duplication of effort, and assuring maximum community coordination.

Self-Neglect—the failure, either by the adult's action or inaction, to provide the proper or necessary support or medical/surgical or other care necessary for his/her well-being. No individual who is provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall, for that reason alone, be considered to be self-neglected.

Sexual Abuse—abuse of an adult, when any of the following occur.

a. The adult is forced, or otherwise coerced by a person into sexual activity or contact.

b. The adult is involuntarily exposed to sexually explicit material, sexually explicit language, or sexual activity or contact.

c. The adult lacks the capacity to consent, and a person engages in sexual activity or contact with that adult.

AUTHORITY NOTE; Promulgated in accordance with R.S. 36:254,R.S. 14:403.2 and R.S. 15:1501-15:1511

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Protective Services, LR 20:435 (April 1994), amended LR 27:313 (March 2001), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:760 (April 2010), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, Division of Adult Protective Services, LR 37:904 (March 2011), LR 37:904 (March 2011).

§17107. Eligibility for Services

A. The protection of this Rule extends to any adult as defined by law, 18-59 years of age or emancipated minors, living in unlicensed community settings, either independently or with the help of others, who is alleged to be abused, neglected, exploited, or extorted.

B. There is no financial eligibility requirement for services provided by Adult Protective Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:436 (April 1994), amended LR 27:313 (March 2001), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:761 (April 2010).

§17109. Reporting

A.1. Any person having cause to believe that an individual's physical or mental health or welfare has been or may be further adversely affected by abuse, neglect, exploitation, or extortion shall report that knowledge or belief. These reports can be made to:

a. Adult Protective Services; and/or,

b. any local or state law enforcement agency.

2. Reports of abuse, neglect, exploitation and extortion shall be processed through the DHH Office of Aging and Adult Services, Division of Adult Protective Services' central intake system. Reports should be made/forwarded to: Adult Protective Services, P.O. Box 3518, Bin #11, Baton Rouge, LA 70821. The local telephone number is (225) 342-9057. The state-wide, toll-free telephone number is 1-800-898-4910.

B. Intake. Incident reports received by APS shall be screened to determine eligibility, and shall be assigned a priority status for investigation as described in §17121 of this Chapter. When reports are not accepted by APS, the reporter shall be advised why his/her report was rejected for investigation. Such reports will be referred to other social, medical, and law enforcement agencies, as deemed appropriate or required by law.

C. Priorities. In order to assure the timely delivery of protective services and to eliminate the potential danger of prolonging an abusive situation, a priority system for case response has been established. At the time a report of abuse is received in Adult Protective Services, the report will be prioritized and assigned for investigation. In making assignments, the following categories will be used.

1. Priority One

a. Priority One reports are those which allege the individual in need of protection is abused, neglected,

exploited, or extorted, and has suffered or is at imminent risk of suffering serious harm or serious physical injury which, if untreated, may result in permanent physical damage or death.

b. Examples of Priority One reports include but are not limited to head injuries, spinal injuries, severe cuts, broken limbs, severe burns, and/or internal injuries and sexual abuse where there is danger of repeated abuse, situations where medical treatment, medications or nutrition necessary to sustain the individual are not obtained or administered, as well as over-medication or unreasonable confinement.

c. Staff must respond to Priority One cases within 24 hours of receipt by Adult Protective Services. For purposes of this Section, "case response" means that the investigator must attempt a face-to-face visit with the individual in need of protection within this 24-hour period.

2. Priority Two

a. Priority Two reports allege the individual in need of protection is abused, neglected, exploited, or extorted, and as a result, is at risk of imminent serious physical injury, or harm.

b. Priority Two reports may include, but not be limited to, those situations in which there is failure to provide or obtain mental health and medical treatment which, if untreated, may cause serious harm to the individual. This includes self-abusive behavior and failure to treat physical ailments. It could also include inadequate attention to physical needs such as insufficient food, medicine, inadequate heat or excessive heat, unauthorized use, and/or exploitation of the victim's income or property.

c. Staff must respond to Priority Two cases within five working days of receipt by Adult Protective Services. For purposes of this Section, "case response" means that the investigator must attempt a face-to-face visit with the individual in need of protection within a five working day period, so long as the investigation of Priority One cases is not delayed.

3. Priority Three

a. Priority Three reports include all other allegations in which the individual in need of protection is alleged to be abused, neglected, exploited, or extorted which do not involve risk of imminent serious physical injury, or harm and pose no immediate threat of serious injury or harm.

b. Staff must respond to Priority Three cases within 10 working days of receipt by Adult Protective Services. For purpose of this Section, "case response" means that the investigator must attempt a face-to-face interview with the individual in need of protection within this 10 day working period, so long as the investigation of Priority One and Two cases are not delayed.

4. When APS is not staffed sufficiently to respond promptly to all reported cases, APS shall set priorities for case response and allocate staff resources to serve those adults with disabilities with the most immediate need for protection.

D. Reporting Requirements

1. Allegations of known or suspected abuse, neglect, exploitation, or extortion shall include:

a. the name and address of the alleged victim;

b. the name and address of the person providing care to the alleged victim, if available; and

c. the name of the person(s) suspected of abuse, neglect, extortion or exploitation, where different from item b above, if available; and

d. other pertinent information.

2. Allegations of abuse, neglect, exploitation or extortion made by the alleged victim shall not be considered to be any less credible than allegations made by others and shall be reported according to procedures established in this Chapter.

3. All allegations of physical or sexual abuse shall be reported to the chief law enforcement agency of the parish in which the incident is reported to have occurred. This report is to be made by the end of the business day subsequent to the day on which the report is received.

E. Failure to report, false reporting, or obstructing reports or investigations may be reported by APS to law enforcement or other regulatory agencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:436 (April 1994), amended LR 27:314 (March 2001), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:761 (April 2010).

§17111. Investigation and Service Planning

A. Investigation. Reports accepted by Adult Protective Services for investigation shall be prioritized according to §17109 of this Rule. The subsequent investigation and assessment shall determine if the situation and condition of the adult requires further action and shall include determining the nature, extent, and cause of the abuse, neglect, exploitation, extortion, identifying the person or persons responsible for abuse, neglect, exploitation, or extortion, if known; if possible, interviewing the individual and visiting the individual's home or the location where the incident occurred. The investigation or assessment shall also include consultation with others having knowledge of the facts of the case. An Adult Protection worker shall have access to any records or documents including client-identifying information and medical, psychological, criminal or financial records necessary to the performance of the agency's duties without cost and without unnecessary delay. APS may petition a court of competent jurisdiction for such documents if access to them is refused. A report of the investigation shall be prepared, which contains an assessment of the individual's present condition/status.

B. Service Plan. The Protective Service worker will be responsible for developing a service plan based upon the case determination. If, at the end of the investigation, it is determined that the individual has been abused, neglected, exploited, and/or extorted by other parties, and that the problem cannot be remedied by extrajudicial means, Adult Protective Services shall refer the matter to the local district attorney's office. Evidence must be presented, together with an account of the protective services given or available to the individual, and a recommendation as to what services, if ordered, would eliminate the abuse/neglect.

C. Right to Refuse Services. Protective services may not be provided in cases of self-neglect to any individual who does not consent to such services or who, having consented, withdraws such consent. Nothing herein shall prohibit Adult Protective Services, the district attorney, the coroner, or the judge from petitioning for interdiction pursuant to Civil Code, Articles 389 through 399 or petitioning for an order for protective custody or for judicial commitment pursuant to R.S. 28.50 et seq., seeking an order for emergency protective services pursuant to R.S. 15:1511, or prohibit the district attorney from seeking an order for involuntary protective services pursuant to R.S.15:1508(B)(5).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:436 (April 1994), amended LR 27:314 (March 2001), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:762 (April 2010).

§17113. Legal Interventions

A. The Adult Protective Services Agency may petition any court of competent jurisdiction for the following types of orders. Except in the case of emergency orders, the DHH Bureau of Legal Services shall be consulted for assistance in preparing petitions:

1. order to be granted access [R. S. 15:1507(C)];

2. order of protective services [R. S. 15:1507(F) and 15:508];

a. to provide mandatory counseling;

b. enjoin the accused to prevent continued abuse, neglect, exploitation or extortion;

c. require an medical or psychiatric/psychological of the client to determine least restrictive setting;

d. enjoin any party from interfering with the provision of protective services;

e. provide protective services, if the adult lacks capacity to consent and no other authorized person is available or willing.

3. Ex parte order for emergency protective services may be filed to prevent immediate harm, and may be requested orally or telephonically when there is not time to file in writing. Oral orders are to be followed with written petitions by close of business of the following day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:437 (April 1994), amended LR 27:314 (March 2001), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:763 (April 2010).

§17115. Confidentiality

A. Information contained in the case records of Adult Protective Services shall not be released without a written authorization from the involved individual or his/her legally authorized representative, except that the information may be released to law enforcement agencies pursuing enforcement of criminal statutes related to the abuse of the adult or the filing of false reports of abuse or neglect, or to social service agencies, licensed health care providers, and appropriate local or state agencies where indicated for the purpose of coordinating the provision of services or treatment necessary to reduce the risk to the adult from abuse, neglect, exploitation, or extortion and to state regulatory agencies for the purpose of enforcing federal or state laws and regulations relating to abuse, neglect, exploitation or extortion by persons compensated through state or federal funds.

1. Requests for copies of confidential information are to be forwarded to the APS Director, P.O. Box 3518, Bin #11, Baton Rouge, La 70821.

2. In instances where the adult is determined by Adult Protective Services as unable to give consent and there is no legally appointed guardian, records may be released in response to an order by a judge of a court of competent jurisdiction.

B. The identity of any person who in good faith makes a report of abuse, neglect, exploitation, or extortion shall be confidential and shall not be released without the written authorization of the person making the report, except that the information may be released to law enforcement agencies pursuing enforcement of criminal statutes related to the abuse of the adult or to the filing of false reports of abuse or neglect.

C. Prior to releasing any information, except information released to law enforcement agencies as provided herein, the adult protection agency shall edit the released information to protect the confidentiality of the reporter's identity and to protect any other individual whose safety or welfare may be endangered by disclosure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:437 (April 1994), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:763 (April 2010).

§17117. Immunity

A. Under the provision of R.S. 15:1504.B, no cause of action shall exist against:

1. any person who, in good faith, makes a report, cooperates in an investigation by an agency, or participates in judicial proceedings;

2. any DHH Protective Services staff who, in good faith, conducts an investigation or makes an investigative judgment or disposition;

3. the persons listed in Items 1 and 2 of this Section shall have immunity from civil or criminal liability that otherwise might be imposed or incurred.

B. This immunity shall not extend to:

1. any alleged principal, conspirator, or accessory to an offense involving the abuse or neglect of the individual;

2. any person who makes a report known to be false or with reckless disregard for the truth of the report;

3. any person charged with direct or constructive contempt of court, any act of perjury as defined in Subpart C of Part VII of the Louisiana Criminal Code or any offense affecting judicial functions and public records as defined in Subpart D of Part VII of the Louisiana Criminal Code.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511

HISTORICAL NOTE: Promulgated by the Department of health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:437 (April 1994), amended LR 27:314 (March 2001), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:763 (April 2010).

§17119. The Department of Health and Hospitals' Protective Services System

A. The department will deliver protective services to adults living in unlicensed community settings through the Office of Aging and Adult Services, Division of Adult Protective Services

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:437 (April 1994), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:763 (April 2010).

§17121. Responsibilities of Regional Coordinating Councils

A. The Office of Aging and Adult Services, Division of Adult Protective Services shall convene and participate in Regional Coordinating Councils in each region of the state to coordinate community services in support of individuals in need of protection.

B. These councils will have as their objective to achieve maximum community coordination by efforts to:

1. identify resources, both in common to the agencies represented and available from outside resources; and

2. increase availability of needed services by maximizing existing resources and decreasing duplication of effort;

3. assure maximum community coordination of effort in providing necessary services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:438 (April 1994), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:764 (April 2010).

§17123. Training

A. To encourage prompt reporting of suspected abuse, neglect, exploitation, or extortion, Adult Protective Services staff shall provide for and/or participate in activities to inform the general public and, in particular, targeted professionals and service providers about the Adult Protective Service Program.

B. The adult protection agency shall also be responsible for ongoing inservice training for its staff which assures adequate performance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511

HISTORICAL NOTE: Promulgated by the Department of health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:438 (April 1994), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:764 (April 2010).

§17125. Dissemination

A. A copy of this Rule shall be made available to anyone, including individuals in need of protection, upon request.

B. Copies of this Rule shall be disseminated to state and local agencies which serve populations of persons with mental, physical, or emotional disabilities (including but not limited to community services offices of the Office for Citizens with Developmental disabilities, Office of Mental Health, Office of Addictive Disorders, Office of Public Health and state and local law enforcement agencies, advocacy agencies, nursing homes, hospitals, private care agencies, and other related service agencies).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511

HISTORICAL NOTE: Promulgated by the Department of health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:438 (April 1994), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:764 (April 2010).

Subpart 15. Emergency Response Network

Chapter 181. General Provisions

§18101. Scope

A. These rules are adopted by the Louisiana Emergency Network (hereinafter LERN) Board (hereinafter board) to effectuate the provisions of R.S. 40:2841 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:649 (April 2008).

Chapter 183. Louisiana Emergency Response Network (LERN)

§18301. Board Officers of Louisiana Emergency Response Network (LERN) Board

A. The chairman and vice-chairman, and any other officers that the board shall deem necessary, shall be elected for a two-year term at the first meeting held following January 1 of each even numbered year.

B. In the case of a vacancy in the office of chairman, the vice-chairman shall serve the remainder of the vacated term, and in the case of a vacancy in the office of vice-chairman, the board shall elect a new vice-chairman who shall serve the remainder of the vacated term.

C. The chairman shall:

1. preside at all meetings of the board;

2. determine necessary subcommittees and working group and appoint members to each subcommittee and working groups;

3. direct activities of staff between board meetings;

4. provide direction on behalf of board between meetings to all regional commissions;

5. designate the date, time and place of board meetings;

6. enter into confidentiality agreements on behalf of the board regarding pertinent data to be submitted to board and board staff which contain individually identifiable health or proprietary information;

7. perform all other duties as may be assigned by the board.

D. Should the chairman become unable to perform the duties of chairman, the vice-chairman shall act in his stead.

E. A ground for removal of a board officer includes conviction of a felony.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:2844(H) and 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:650 (April 2008).

§18303. Quorum

A. Eight members of the board shall constitute a quorum for all purposes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2844(H) and 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:650 (April 2008).

§18305. Grounds for Removal of Board Members

A. Grounds for removal of board members include conviction of a felony.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2844(H) and 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:650 (April 2008).

Chapter 185. Regional Commissions; Membership; Officers; Meetings; Duties and Responsibilities

§18501. Regional Commission Membership

A. Selection of Regional Commission Membership by Louisiana Emergency Response Network (LERN) Board

1. The process for selecting the regional commission members is as follows:

a. the LERN Board Chairman shall request in writing the name of a nominee to serve on each regional commission from each of the legislatively identified state organizations;

b. in the event there is more than one organization, state association or entity, each entity shall be requested to name a nominee and, once constituted, the commission shall choose from among the nominees; and

c. if no state or local organization exists in a category, but multiple nominees are identified in that category, the selection of the representative to serve on the regional commission will be determined by that category's group of nominees.

2. Once documentation is received from each organization or group, the compiled list of nominees is submitted to the board for ratification. The board shall appoint those selected by the various organizations.

B. Voting members of the regional commission may be added through a process employing the following steps:

1. majority vote of a quorum of voting members of the commission;

2. formal written request to LERN Board to add specified voting member, with reasons for adding. Such addition must represent a group which would enhance the working of the regional commission;

3. majority vote by LERN Board members at a meeting. If such a vote fails, the regional commission may appear in person at the following LERN Board meeting, where the subject will be revisited;

4. once an additional voting member is approved for one region, in order for other regions to add a member representing the same group, only a letter detailing the requirements of Paragraphs 1 through 3 above will be necessary to add the particular member. Board approval will not require an additional vote.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2845(A)(3)(a) and 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:650 (April 2008).

§18503. Regional Commission Officers

A. Each regional commission shall select a chairman and vice chairman.

B. The chairman and vice-chairman, and any other officers that the commission shall deem necessary, shall be elected for a two-year term at the first meeting held following January 1 of each even numbered year.

C. In the case of a vacancy in the office of chairman, the vice-chairman shall serve as chairman for the remaining vacated term; and in the case of a vacancy in the office of vice-chairman, the regional commission shall elect a new vice-chairman who shall serve until the expiration of the vacated term.

D. The chairman shall:

1. preside at all meetings of the commission;

2. determine necessary ad hoc committees, appoint a commission member to chair each such committee, and provide for the commission as a whole to name the membership of the committee;

3. provide direction to the commission to implement the mandates of the LERN Board;

4. direct that a record of all meetings of the commission shall be kept and such records shall be retained as permanent records of the transactions of the commission; and

5. perform all other duties pertaining to the office of chairman of the commission or as may be assigned by the commission.

E. Should the chairman become unable to perform the duties of chairman, the vice-chairman shall act in his stead.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2845(A)(3)(a) and 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:650 (April 2008).

§18505. Regional Commission Meetings

A. Meetings of the commission shall be noticed, convened and held not less frequently than quarterly during each calendar year and otherwise at the call of the chairman or on the written petition for a meeting signed by not less than the number of members which would constitute a quorum of the commission. Meetings shall be held on such date and at such time and place as may be designated by the chairman.

B. One third of the currently serving members of the commission shall constitute a quorum for all purposes. All actions which the commission is empowered by law to take shall be effected by vote of not less than a majority of the members present at a meeting of the commission at which a quorum is present.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2845(A)(3)(a) and 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:651 (April 2008).

§18507. Regional Commission Duties and Responsibilities

A. Each regional commission shall:

1. develop a written system plan for submission to LERN Board, which plan shall:

a. identify all resources available in the region for emergency and disaster preparedness and response;

b. be based on standard guidelines for comprehensive system development;

c. include all parishes within the region unless a specific parish portion thereof has been aligned within an adjacent region;

d. give an opportunity to all health care entities and interested specialty centers opportunity to participate in the planning process; and

e. address the following components:

i. injury prevention;

ii. access to the system;

iii. communications;

iv. pre-hospital triage criteria;

v. diversion policies;

vi. bypass protocols;

vii. regional medical control;

viii. facility triage criteria;

ix. inter-hospital transfers;

x. planning for the designation of trauma facilities, including the identification of the lead facility(ies); and

xi. a performance improvement program that evaluates processes and outcomes from a system perspective;

2. upon approval of the board, implement the system plan to include:

a. education of all entities about the plan components;

b. on-going review of resource, process, and outcome data; and

c. if necessary, revision and re-approval of the plan or plan components by LERN Board;

3. annually complete a regional needs assessment and conduct education and training within the region to meet the needs identified in the annual needs assessment;

4. develop and implement a regional performance improvement (PI) program plan;

5. develop and implement a regional injury prevention program;

6. at least quarterly, submit evidence of on-going activity, including meeting notices and minutes, to LERN Board; and

7. Annually submit a report to LERN Board which describes progress toward system development and demonstrates on-going activity;

B. Regional commission may request technical assistance from the LERN Board at any time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2845(A)(3)(a) and 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:651 (April 2008).

Chapter 187. Requirements for Louisiana Stroke Center Recognition

§18701. Stroke Center Recognition

A. The Louisiana Emergency Response Network Board (LERN) and the Louisiana Department of Health recognize the following six levels of stroke facilities:

1. CSC: comprehensive stroke center (formerly designated as level 1);

2. TSC: thrombectomy capable stroke center;

3. PSC-E: primary stroke center with endovascular capability;

4. PSC: primary stroke center (formerly designated as level 2);

5. ASRH: acute stroke ready hospital (formerly designated as level 3); and

6. stroke bypass hospital (formerly designated as level 4).

B. Participation in Louisiana stroke center recognition is voluntary and no hospital shall be required to participate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 40:2590 (December 2014), amended by the Department of Health, Emergency Response Network LR 46:1088 (August 2020).

§18703. Stroke Center Criteria

A. Each facility participating in stroke center recognition shall meet the following criteria.

1. CSC: a comprehensive stroke center (CSC) will meet the requirements specified by the joint commission or other board approved accrediting/certification body approved by LERN for comprehensive stroke center certification. Attestation as a CSC is only allowed after verification by the joint commission or other LERN approved accrediting/certification body that the facility meets all requirements set forth in the CSC standards.

2. TSC: a thrombectomy capable stroke center (TSC) will meet the requirements specified by the joint commission or other board approved accrediting/certification body approved by LERN for thrombectomy capable stroke center certification. Attestation as a TSC is only allowed after verification by the joint commission or other LERN approved accrediting/certification body that the facility meets all requirements set forth in the TSC standards.

3. PSC-E: a primary stroke center (PSC-E) shall meet the requirements specified by the joint commission, healthcare facilities accreditation program (HFAP), or other LERN approved accrediting/certification body for Primary Stroke Center verification. Attestation as a PSC-E is only allowed after verification by the joint commission, HFAP, or other LERN approved accrediting/certification body that the facility meets all requirements set forth in the PSC standards. In addition to PSC requirements, a PSC-E must have physician(s) credentialed to perform mechanical thrombectomy and must update resource management portal of endovascular availability at all times. If a physician credentialed to perform endovascular capability is not available, the PSC-E must notify all EMS providers in the region when endovascular resources are not available. The PSC-E must collect and submit quarterly to LERN the same data the joint commission requires the Thrombectomy Stroke Capable centers to collect.

4. PSC: a primary stroke center (PSC) shall meet the requirements specified by the joint commission, healthcare facilities accreditation program (HFAP), or other LERN approved accrediting/certification body for primary stroke center verification. Attestation as a PSC is only allowed after verification by the joint commission, HFAP, or other LERN approved accrediting/certification body that the facility meets all requirements set forth in the PSC standards.

5. ASRH: an acute stroke ready hospital (ASRH) will provide timely access to stroke care but may not meet all criteria for a CSC, TSC, or a PSC or a PSC-E facility. An ASRH will provide acute stroke care in urban and rural areas where transportation and access are limited. An ASRH is intended to recognize models of care delivery that have shown utility, including “drip-and-ship” and telemedicine. An ASRH must meet requirements adopted by LERN and submit quarterly data as required by LERN. LERN approved requirements are based on national best practice guidelines.

6. Stroke bypass hospital: a stroke bypass hospital should not receive patients exhibiting signs or symptoms of stroke except for instances when the clinical situation requires stopping at the closest emergency department. A stroke bypass hospital must have:

a. transfer protocol in place for transfer to higher levels of care through written and agreed upon relationship with a CSC, TSC, PSC, PSC-E or ASRH stroke center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 40:2590 (December 2014), amended by the Department of Health, Emergency Response Network LR 46:1088 (August 2020).

§18705. Attestation for Stroke Center Recognition

A. A hospital seeking CSC, TSC, PSC-E, ASRH or stroke bypass recognition will submit an affidavit of the hospital CEO to LERN detailing compliance with the requirements designated herein.

1. A center or hospital seeking CSC recognition which submits a copy of that level of certification by a LERN-recognized organization, such as the joint commission or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition.

2. A center or hospital seeking TSC stroke center recognition which submits a copy of that level of certification by a LERN-recognized organization, such as the joint commission, HFAP, or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition.

3. A center or hospital seeking PSC-E stroke center recognition which submits a copy of PSC certification by a LERN-recognized organization, such as the joint commission, HFAP, or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition. In addition to a copy of the certification, the CEO must also attest to meeting the additional board approved requirements.

4. A center or hospital seeking PSC stroke center recognition which submits a copy of that level of certification by a LERN-recognized organization, such as the joint commission, HFAP, or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition.

5. Although a center or hospital seeking ASRH stroke center recognition is not required to obtain certification by an external certifying body, a hospital which submits a copy of ASRH certification by a LERN-recognized organization, such as the joint commission, HFAP or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition. Hospitals must all meet LERN ASRH requirements and approved data submission requirements.

6. Each center or hospital shall submit proof of continued compliance every two years by submission of an affidavit by its CEO.

B. A hospital or center which fails to meet the requirements as attested, or which no longer chooses to maintain state Stroke Facility level recognition, shall immediately notify LERN and local EMS.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 40:2590 (December 2014), amended by the Department of Health, Emergency Response Network LR 46:1089 (August 2020).

§18706. Stroke Center Data Submission Requirements

A. All stroke centers, whether CSC, TSC, PSC-E, PSC or ASRH are required to submit certain data to the board on a quarterly basis.

B. The requirements of and for data submission are posted on the LERN website, http://lern.la.gov/lern-stroke-system/stroke-data-collection.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 46:1089 (August 2020).

§18708. Failure to Submit Stroke Data to LERN

A. Acute stroke ready hospitals not submitting data for one quarter or not submitting the required action plan and/or mock code, if applicable, will result in automatic probation, which will generate a warning letter to the CEO. The letter will communicate LERN board expectation for data and (action plan and/or mock code, if applicable) submission for the missed quarter and the following quarter.

B. For an ASRH not submitting data to the board for two consecutive quarters, the hospital will automatically be demoted to a stroke bypass hospital.

C. Once an ASRH demotes to a stroke bypass hospital for non-adherence with submission requirement, the hospital CEO cannot re-attest until the hospital has submitted two consecutive quarters of data meeting standards.

D. If an ASRH fails to meet the performance metrics after two quarters of participation in data review, the board appointed stroke subcommittee will present the blinded data to the board for a vote on demotion to stroke bypass hospital versus continued remediation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 46:1089 (August 2020).

Chapter 189. Requirements for Louisiana STEMI Receiving/Referral Centers

§18901. STEMI Center Recognition

A. The Louisiana Emergency Response Network Board (LERN), and the Louisiana Department of Health and Hospitals recognize the following types of facilities for the treatment of ST elevated myocardial infarction (STEMI):

1. STEMI receiving center; and

2. STEMI referral center.

B. Participation in the Louisiana STEMI center recognition is voluntary and no hospital shall be required to participate.

C. A facility seeking STEMI receiving center recognition shall meet the STEMI receiving center requirements adopted by LERN. LERN approved requirements are based on national best practice guidelines.

D. A hospital with an emergency room not meeting criteria for a STEMI receiving center will automatically default to a STEMI referral center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:2591 (December 2014).

§18903. Attestation for STEMI Center Recognition

A. A hospital seeking STEMI Center recognition will submit an affidavit of the hospital CEO to LERN detailing compliance with LERN Approved STEMI Receiving center requirements.

1. Those hospitals which submit a copy of certification by a LERN-recognized organization such as The American Heart Association Mission:Lifeline, Society of Cardiovascular Patient Care or other LERN approved accrediting/certification body shall be assumed to meet the requirements for recognition.

2. Each center or hospital shall submit proof of continued compliance every two years by submission of an affidavit of its CEO.

B. A hospital or center which fails to meet the criteria for a STEMI receiving center or which no longer choose to maintain state STEMI receiving center recognition, shall immediately notify LERN and local EMS.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), 48:2845(A)(7) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:2591 (December 2014).

§18905. STEMI Center Listing

A. LERN will publish a list on its website of hospitals or centers attesting to STEMI center criteria for recognition as either a STEMI receiving center or STEMI referral center. This list shall be made available to the LERN regional commissions for facilitation of EMS transportation plans.

AUTHORITY NOTE: Promulgated in accordance with La. R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:2591 (December 2014).

§18907. Hospital Destination/STEMI System Transport:

A. These rules are not intended to prevent any hospital or medical facility from providing medical care to any patient but rather to serve as a guideline to facilitate the timely and appropriate delivery of STEMI patients to the most appropriate care site for the definitive treatment of STEMI.

B. Knowledge of STEMI capabilities and the use of a STEMI pre-hospital destination protocol will enable providers to make timely decisions, promote appropriate utilization of the STEMI care delivery system, and ultimately save lives.

AUTHORITY NOTE: Promulgated in accordance with La. R.S. 40:2846(A), 48:2845(A)(7) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:2591 (December 2014).

Chapter 191. Trauma Protocols

§19101. Entry Criteria and Region 4 LERN LCC Destination Protocol

A. On November 15, 2007, the Louisiana Emergency Response Network Board [R.S. 40:2842(1)] adopted and promulgated “LERN Entry Criteria” and "LERN Region 4 LCC Destination Protocol" for region 4 of the Louisiana Emergency Response Network (R.S. 40:2842(3)), which region includes the parishes of Acadia, Evangeline, Iberia, Lafayette, St. Martin, St. Landry, and Vermilion, as follows.

1. LERN Entry Criteria

LERN Entry Criteria		
☐ Unmanageable Airway ☐ Tension Pneumothorax ☐ Traumatic cardiac arrest ☐ Burn patient without patent airway ☐ Burn patient >40% BSA without IV	YES→	Call LCC
Neurologic Trauma		
☐ GCS <14 + one or more of the following: ☐ Penetrating head injury or depressed skull fracture ☐ Open head injury with or without CSF leak ☐ Deterioration of the GCS ☐ Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit)	YES→	Call LCC
Physiologic		
☐ SBP <90 (adults and > 9 y/o) <70 + 2 [age (yrs)] (age 1 to 8) <70 (age 1 to 12 months) <60 (term neonate) ☐ RR <10 or >29 (adults and > 9 y/o) <15 or >30 (age 1 to 8) <25 or >50 (<12 m/o)	YES→	Call LCC
Anatomic		
☐ All penetrating injuries to neck, torso and extremities proximal to elbow and knee ☐ Flail Chest ☐ 2 or more proximal long-bone fractures ☐ Crush, degloved or mangled extremity ☐ Amputation proximal to wrist and ankle ☐ Pelvic Fracture ☐ Hip fractures (hip tenderness, deformity, lateral deviation of foot) ☐ Major joint dislocations (hip, knee, ankle, elbow) ☐ Open Fractures ☐ Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture, etc.)	YES→	Call LCC

LERN Entry Criteria		
Mechanism		
Falls > 20 ft. (adults) > 10 ft. (child) or 2 to 3 times height High-risk auto crash Intrusion > 12 in. occupant site: >20 in. any site Ejection, partial or complete from automobile Death in same passenger compartment Auto vs. pedestrian/bicyclist thrown, run over or >5 MPH impact Motorcycle crash >20 MPH	YES→	Call LCC
Special		
Pregnancy >20 weeks Burns (will follow ABA guidelines)	YES→	Call LCC
Other		
Age ≥55 y/o or <8 y/o Anticoagulation and bleeding disorders End stage renal disease Transplant patients	YES→	Call LCC

2. LERN Region 4 LCC Destination Protocol

LERN Region 4 LCC Destination Protocol		
Unmanageable Airway Tension Pneumothorax Traumatic cardiac arrest Burn patient without patent airway Burn patient >40 percent BSA without IV	YES→	Closest ED
NO ↓		
Neurologic Trauma		
GCS <14 + one or more of the following: Penetrating head injury or depressed skull fracture Open head injury with or without CSF leak Deterioration of the GCS Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit)	YES→	LERN Level II
NO ↓		
Physiologic		
SBP <90 (adults and > 9 y/o) <70 + 2 [age (yrs)] (age 1 to 8) <70 (age 1 to 12 months) <60 (term neonate) RR <10 or >29 (adults and ≥ 9 y/o) <15 or >30 (age 1 to 8) <25 or >50 (<12 m/o)	YES→	LERN Level II or III
NO ↓		
Anatomic		
All penetrating injuries to neck, torso and extremities proximal to elbow and knee Flail Chest 2 or more proximal long-bone fractures Crush, degloved or mangled extremity Amputation proximal to wrist and ankle Pelvic Fracture Hip fractures (hip tenderness, deformity, lateral deviation of foot) Major joint dislocations (hip, knee, ankle, elbow) Open Fractures Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture, etc.)	YES→	LERN Level II or III
↓		
Mechanism		
Falls > 20 ft. (adults) > 10 ft. (child) or 2 to 3 times height High-risk auto crash Intrusion > 12 in. occupant site: >20 in. any site Ejection, partial or complete from automobile Death in same passenger compartment Auto vs. pedestrian/bicyclist thrown, run over or >5 MPH impact Motorcycle crash >20 MPH	YES→	LERN Level II or III
NO ↓		
Special		
Pregnancy >20 weeks Burns (will follow ABA guidelines)	YES→	LERN
NO ↓		
Other		
Age ≥ 55 y/o or <8 y/o Anticoagulation and bleeding disorders End stage renal disease Transplant patients	YES→	LERN Level II, III or IV

B. On June 26, 2008, the Louisiana Emergency Response Network Board passed a resolution allowing any region of the Louisiana Emergency Response Network which agreed to use the foregoing "LERN Entry Criteria" and "LERN Region 4 LCC Destination Protocol" to begin operating using the "LERN Entry Criteria" and "LERN Region 4 LCC Destination Protocol" set forth above.

C. This protocol was published at LR 35:1181-1183 (June 20, 2009).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:138 (January 2015).

§19103. Region 7 LERN Entry and Destination Protocols

A. On November 15, 2007, the Louisiana Emergency Response Network Board [R.S. 40:2842(1)] adopted and promulgated "Region 7 LERN Entry and Destination Protocol" for region 7 of the Louisiana Emergency Response Network [R.S. 40:2842(3)], which region includes the parishes of Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine and Webster, as follows.

1.a. Traumatic patients who meet the following criteria will be entered to LERN call center and should be transported directly to LSUHSC in Shreveport, Louisiana, if possible:

i. airway compromise (intubated, apneic, or obstructed airway);

ii. penetrating wound of head, neck, chest, abdomen, groin, or buttocks;

iii. blood pressure ≤ 100 or signs of shock;

iv. GCS 12 or less;

v. new onset neurological deficit associated with traumatic event;

vi. extremity wound with absent pulse or amputation proximal to foot or hand.

b. Trauma patients who meet the following criteria, and are located outside the city limits of Shreveport and Bossier City, should be taken to nearest hospital for immediate stabilization followed by continued rapid transport to LSUHSC Shreveport per the LERN hospital protocol:

i. unable to establish and maintain adequate airway/ventilation;

ii. hypotension unresponsive to crystalloids (no more than 2 L);

iii. patients who meet trauma center criteria but have a transport time > 60 minutes;

iv. traumatic arrest.

B. On May 8, 2008, the Louisiana Emergency Response Network Board (R.S. 40:2842(1)) amended and promulgated, as amended, "Region 7 LERN Entry and Destination Protocol" for region 7 of the Louisiana Emergency Response Network (R.S. 40:2842(3)), which region includes the parishes of Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine and Webster, which protocol was originally adopted and promulgated on November 15, 2007, so that the "Region 7 Louisiana Emergency Response Network Entry and Destination Protocol," as amended, effective May 8, 2008, is as follows.

1.a. Traumatic patients who meet the following criteria will be entered to LERN call center and should be transported directly to LSUHSC in Shreveport, if possible:

i. airway compromise (intubated, apneic, or obstructed airway);

ii. penetrating wound of head, neck, chest, abdomen, groin, or buttocks;

iii. blood pressure ≤ 100 or signs of shock;

iv. GCS 12 or less;

v. new onset neurological deficit associated with traumatic event;

vi. extremity wound with absent pulse or amputation proximal to foot or hand;

vii. burn patients as identified following ABA guidelines;

viii. *healthcare provider discretion*—patients evaluated by hospitals may be entered into LERN if the evaluating hospitals medical personnel determines the patient has a medical condition requiring immediate surgical evaluation and/or intervention and the transferring hospital does not have these services immediately available at that facility (*Healthcare provider discretion* does not include orthopedic injuries.).

b. Patients that have been entered into LERN but will require greater than 60 minute transport time from the field should stop at local area hospitals for stabilization. These patients should still be entered into LERN from the field but will require transport to local area hospitals for stabilization. LERN will facilitate the movement of these patients from the local hospital once stabilizing measures are completed.

i. The following are conditions requiring immediate stabilization by local area hospitals:

(a). unable to establish and maintain adequate airway/ventilation;

(b). hypotension unresponsive to crystalloids (no more than 2 L);

(c). patients who meet trauma center criteria but have a transport time > 60 minutes;

(d). traumatic arrest.

C. The following will be routed directly to the LSUHSC Burn Unit from local area hospitals or from the field:

1. partial-thickness and full thickness burns greater than 10 percent of the total body surface area (TBSA) in patients younger than 10 years of age or older than 50 years of age;

2. partial-thickness and full thickness burns greater than 20 percent of the total body surface area (TBSA) in other age groups;

3. partial-thickness and full thickness burns involving the face, eyes, ears, hands, feet, genitalia, perineum, or skin overlying major joints;

4. full-thickness burns greater than 5 percent TBSA in any age group;

5. electrical burns, including lightning injury;

6. chemical burns;

7. patients with inhalation injury;

8. burn injury in patients with pre-existing illnesses that could complicate management, prolong recovery, or adversely affect mortality risk;

9. any burn patient in whom concomitant trauma poses an increased risk of morbidity or mortality may be treated initially in a trauma center until stable before transfer to a burn center;

10. children with burns seen in hospitals without qualified personnel or equipment for their care;

11. burn injury in patients who will require special social and emotional or long-term rehabilitative support, including cases involving suspected child abuse or neglect.

D. These protocols were published at LR 35:1183-1184 (June 20, 2009).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:139 (January 2015).

§19105. Standard LERN Entry Criteria; Standard Destination Protocol

A. On June 18, 2009, the Louisiana Emergency Response Network Board (R.S. 40:2842(1)) adopted and promulgated "Standard LERN Entry Criteria" and "Standard Destination Protocol" for use in all regions, except region 7, of the Louisiana Emergency Response Network (R.S. 40:2842(3)), replacing the "LERN Entry Criteria" and "LERN Region 4 LCC Destination Protocol," adopted and promulgated November 15, 2007, as follows.

1. Standard LERN Entry Criteria—Pre-Hospital and Hospital Triage Protocol

Standard LERN Entry Criteria Pre-Hospital and Hospital Triage Protocol		
☐ Unmanageable Airway ☐ Tension Pneumothorax ☐ Traumatic cardiac arrest ☐ Burn patient without patent airway ☐ Burn patient >40 percent BSA without IV	YES→	Call LCC
Neurologic Trauma		
☐ GCS <14 + one or more of the following: ☐ Penetrating head injury or depressed skull fracture ☐ Open head injury with or without CSF leak ☐ Deterioration of the GCS ☐ Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit)	YES→	Call LCC
Physiologic		
☐ SBP <90 (adults and > 9 y/o) <70 + 2 [age (yrs)] (age 1 to 8) <70 (age 1 to 12 months) <60 (term neonate) ☐ RR <10 or >29 (adults and > 9 y/o) <15 or >30 (age 1 to 8) <25 or >50 (<12 m/o)	YES→	Call LCC
Anatomic		
☐ All penetrating injuries to neck, torso and extremities proximal to elbow and knee ☐ Flail Chest ☐ 2 or more proximal long-bone fractures ☐ Crush, degloved or mangled extremity ☐ Amputation proximal to wrist and ankle ☐ Pelvic Fracture ☐ Hip fractures (hip tenderness, deformity, lateral deviation of foot) ☐ Major joint dislocations (hip, knee, ankle, elbow) ☐ Open Fractures ☐ Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture, etc.)	YES→	Call LCC

Standard LERN Entry Criteria Pre-Hospital and Hospital Triage Protocol		
Mechanism		
☐ Falls > 20 ft. (adults) > 10 ft. (child) or 2 to 3 times height ☐ High-risk auto crash Intrusion > 12 in, occupant site: >18 in. any site • Ejection, partial or complete from automobile • Death in same passenger compartment ☐ Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact ☐ Motorcycle crash >20 MPH	YES→	Call LCC
Special		
☐ Pregnancy >20 weeks ☐ Burns (will follow ABA guidelines)	YES→	Call LCC
Other		
☐ Age ≥ 55 y/o or <8 y/o ☐ Anticoagulation and bleeding disorders ☐ End stage renal disease ☐ Transplant patients	YES→	Call LCC

2. Standard Destination Protocol

Standard Destination Protocol		
☐ Unmanageable Airway ☐ Tension Pneumothorax ☐ Traumatic cardiac arrest ☐ Burn patient without patent airway ☐ Burn patient >40 percent BSA without IV	YES→	Closest ED
NO ↓		
Neurologic Trauma		
☐ GCS <14 ☐ Penetrating head injury or depressed skull fracture ☐ Open head injury with or without CSF leak ☐ Deterioration of the GCS ☐ Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit)	YES→	LERN Level I or II
NO ↓		
Physiologic		
☐ SBP <90 (adults and >9 y/o) <70 + 2 [age (yrs)] (age 1 to 8) <70 (age 1 to 12 months) <60 (term neonate) ☐ RR <10 or >29 (adults and >9 y/o) <15 or >30 (age 1 to 8) <25 or >50 (<12 m/o)	YES→	LERN Level I, II or III
NO ↓		
Anatomic		

Standard Destination Protocol		
☐ All penetrating injuries to neck, torso and extremities proximal to elbow and knee ☐ Flail Chest ☐ 2 or more proximal long-bone fractures ☐ Crush, degloved or mangled extremity ☐ Amputation proximal to wrist and ankle ☐ Pelvic Fracture ☐ Hip fractures (hip tenderness, deformity, lateral deviation of foot) ☐ Major joint dislocations (hip, knee, ankle, elbow) ☐ Open Fractures ☐ Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture, etc.)	YES→	LERN Level I, II or III
NO ↓		
Mechanism		
☐ Falls >20 ft. (adults) >10 ft. (child) or 2 to 3 times height ☐ High-risk auto crash • Intrusion >12 in. occupant site: • >18 in. any site • Ejection, partial or complete from automobile • Death in same passenger compartment ☐ Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact ☐ Motorcycle crash >20 MPH	YES→	LERN Level II or III
NO ↓		
Special		
☐ Pregnancy >20 weeks ☐ Burns (will follow ABA guidelines)	YES→	LERN Level II or III
NO ↓		
Other		
☐ Age ≥ 55 y/o or <8 y/o ☐ Anticoagulation and bleeding disorders ☐ End stage renal disease ☐ Transplant patients	YES→	LERN Level II, III or IV

B. These protocols were published at LR 35:1409 (July 20, 2009).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:140 (January 2015).

§19107. Interregional Transfer Protocol

A. On June 18, 2009, the Louisiana Emergency Response Network Board [R.S. 40:2842(1)] adopted and promulgated "Interregional Transfer Protocol" for the Louisiana Emergency Response Network [R.S. 40:2842(3)], as follows.

1. The LERN interregional transfer protocol only applies to those regions and (hospitals/EMS) that are participating in the LERN network.

2. The interregional transfer protocol will be tested over a 90 day period. At the end of the 90 days all interregional transfers will be reviewed for compliance with protocols, quality, patient safety and standards of care. This information will be shared with commissions of the regions participating as well as the LERN board and the "design the system group". Decisions regarding the interregional transfer protocol will be made at the end of the 90 days trial period.

3. Interregional Transfer Protocol

a. All patients whose condition exceeds the regionally available resources provided by local area hospitals may be transferred from one region to another following LERN interregional transfer protocol. Destination to the definitive care hospital in the receiving region will follow the LERN standard protocol (all laws regarding EMTALA apply).

b. Only regions operating with the LERN standard protocol will be involved in the LERN interregional transfer protocol.

c. Patients being transferred via the LERN interregional transfer protocol must:

i. be assessed at a local area hospital for treatment and stabilized by a physician and meet the entry criteria as determined by LERN standard protocol;

ii. treating physician will call LERN to request a transfer to another hospital;

iii. LCC (LERN call center) will determine the closest and most appropriate facility available following LERN standard protocol;

iv. if there are no available resources in the region then the LCC will locate an appropriate facility outside the region, and an interregional transfer will be considered. (All LERN interregional transfers will be reviewed by LERN medical directors and data will be collected for QI/PI.)

d. Exceptions

i. EMS requesting LERN for patients located on or close to borders between two regions will and can be directed to either region based on the patient needs and available resources.

ii. Air-med at the scene that is able to mitigate the time of transfer of long distances will and can be directed to hospitals outside the region they originate from based on patients needs and available resources.

iii. LERN medical directors will be involved in the decision making (real time) in all patients that fall into the exception category.

B. On August 20, 2009, the Louisiana Emergency Response Network Board [R.S. 40:2842(1)] adopted and promulgated the amended "Interregional Transfer Protocol" for the Louisiana Emergency Response Network [R.S. 40:2842(3)], as follows.

1. The LERN interregional transfer protocol only applies to those regions, hospitals and pre-hospital providers that are participating in the LERN network.

2. The interregional transfer protocol will be tested over a 90 day period, at the end of which all interregional transfers will be reviewed for compliance with protocols, quality, patient safety and standards of care. This information will be shared with regional commissions, LERN Board, and LERN design the system work group. Decisions regarding the Interregional Transfer Protocol will be made at the end of the 90-day trial period.

3. Interregional Transfer Protocol

a. All patients whose conditions exceed the regionally available resources provided by local area hospitals may be transferred from one region to another following LERN interregional transfer protocol. Destination to the definitive care hospital in the receiving region will follow the LERN standard protocol. All laws regarding EMTALA apply.

b. Only regions operating with the LERN standard protocol will be involved in the LERN interregional transfer protocol.

c. Patients transferred via the LERN interregional transfer protocol must:

i. be assessed at a local area hospital for treatment, be stabilized by a physician, and meet the entry criteria as determined by LERN standard protocol; and

ii. have a treating physician call LERN to request a transfer to another hospital.

d. The LERN call center (LCC) will determine the closest and most appropriate facility available following LERN standard protocol.

e. If there are no available resources in the region, the LCC will locate an appropriate facility outside the region, and a interregional transfer will be considered.

f. All LERN interregional transfers will be reviewed by LERN medical directors and data will be collected for QI/PI.

g. Exceptions

i. Pre-hospital providers requesting LERN for patients located on or close to borders between regions will and can be directed to either region based on the patient needs and available resources.

ii. Air-med at the scene able to mitigate the time of transfer of long distances will and can be directed to hospitals outside the region they originate from, based on patient needs and available resources.

iii. LERN medical directors will be involved in the decision making for all patients in the exception category.

C. These protocols were published at LR 35:2109-2110 (September 20, 2009).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:141 (January 2015).

§19109. Standard LERN Entry and Destination Criteria

A. On October 21, 2010, the Louisiana Emergency Response Network Board [R.S. 40:2842(1)] revised, adopted and promulgated "Standard LERN Entry Criteria" and "Standard Destination Protocol" for use in all regions, except region 7, of the Louisiana Emergency Response Network [R.S. 40:2842(3)], replacing the "LERN Entry Criteria" and "LERN Region 4 LCC Destination Protocol," adopted and promulgated June 18, 2009, as follows.

1. Standard LERN Entry Criteria—Pre-Hospital and Hospital Triage Protocol

Standard LERN Entry Criteria		
Pre-Hospital and Hospital Triage Protocol		
☐ Unmanageable Airway ☐ Tension Pneumothorax ☐ Traumatic cardiac arrest ☐ Burn patient without patent airway ☐ Burn patient >40 percent BSA without IV	YES→	Call LCC
Neurologic Trauma		
☐ GCS <14 + one or more of the following: ☐ Penetrating head injury or depressed skull fracture ☐ Open head injury with or without CSF leak ☐ Deterioration of the GCS ☐ Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit)	YES→	Call LCC
Physiologic		
☐ SBP <90 (adults and > 9 y/o) <70 + 2 [age (yrs)] (age 1 to 8) <70 (age 1 to 12 months) <60 (term neonate) ☐ RR <10 or >29 (adults and ≥ 9 y/o) <15 or >30 (age 1 to 8) <25 or >50 (<12 m/o)	YES→	Call LCC
Anatomic		
☐ All penetrating injuries to neck, torso and extremities proximal to elbow and knee ☐ Flail Chest ☐ 2 or more proximal long-bone fractures ☐ Crush, degloved or mangled extremity ☐ Amputation proximal to wrist and ankle ☐ Pelvic Fracture ☐ Hip fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls ☐ Major joint dislocations (hip, knee, ankle, elbow) ☐ Open Fractures ☐ Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture, etc.)	YES→	Call LCC
Mechanism		
☐ Falls >20 ft. (adults) >10 ft. (child) or 2 to 3 times height ☐ High-risk auto crash Intrusion >12 in. occupant site: >18 in. any site • Ejection, partial or complete from automobile • Death in same passenger compartment ☐ Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact ☐ Motorcycle crash >20 MPH	YES→	Call LCC
Special		
☐ Pregnancy >20 weeks ☐ Burns (will follow ABA guidelines)	YES→	Call LCC

Standard LERN Entry Criteria		
Pre-Hospital and Hospital Triage Protocol		
Other		
☐ Age ≥ 55 y/o or <8 y/o ☐ Anticoagulation and bleeding disorders ☐ End stage renal disease ☐ Transplant patients	YES→	Call LCC

2. Standard Destination Protocol

Standard Destination Protocol		
☐ Unmanageable Airway ☐ Tension Pneumothorax ☐ Traumatic cardiac arrest ☐ Burn patient without patent airway ☐ Burn patient >40 percent BSA without IV	YES→	Closest ED
NO ↓		
Neurologic Trauma		
☐ GCS <14 ☐ Penetrating head injury or depressed skull fracture ☐ Open head injury with or without CSF leak ☐ Deterioration of the GCS ☐ Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit)	YES→	LERN Level I or II
NO ↓		
Physiologic		
☐ SBP <90 (adults and >9 y/o) <70 + 2 [age (yrs)] (age 1 to 8) <70 (age 1 to 12 months) <60 (term neonate) ☐ RR <10 or >29 (adults and ≥9 y/o) <15 or >30 (age 1 to 8) <25 or >50 (<12 m/o)	YES→	LERN Level I, II or III
NO ↓		
Anatomic		
☐ All penetrating injuries to neck, torso and extremities proximal to elbow and knee ☐ Flail Chest ☐ 2 or more proximal long-bone fractures ☐ Crush, degloved or mangled extremity ☐ Amputation proximal to wrist and ankle ☐ Pelvic Fracture ☐ Hip fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls ☐ Major joint dislocations (hip, knee, ankle, elbow) ☐ Open Fractures ☐ Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture, etc.)	YES→	LERN Level I, II or III
NO ↓		
Mechanism		
☐ Falls >20 ft. (adults) >10 ft. (child) or 2 to 3 times height ☐ High-risk auto crash • Intrusion >12 in. occupant site: • >18 in. any site • Ejection, partial or complete from automobile • Death in same passenger compartment ☐ Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact ☐ Motorcycle crash >20 MPH	YES→	LERN Level II or III
NO		

Standard Destination Protocol		
↓		
Special		
☐ Pregnancy >20 weeks ☐ Burns (will follow ABA guidelines)	YES→	LERN Level II or III
NO ↓		
Other		
☐ Age ≥ 55 y/o or <8 y/o ☐ Anticoagulation and bleeding disorders ☐ End stage renal disease ☐ Transplant patients	YES→	LERN Level II, III or IV

B. These protocols were published at LR 36:2743-2745 (November 20, 2010).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:142 (January 2015).

§19111. Interregional Transfer Protocol

A. On January 20, 2011, the Louisiana Emergency Response Network Board (R.S. 40:2842(1) and (3)) adopted and promulgated "LERN Hospital Interregional Transfer Guidelines" and "LERN Hospital Interregional Transfer Protocol", replacing "Interregional Transfer Protocol" adopted June 18, 2009, as follows.

1. LERN Hospital Interregional Transfer Guidelines

a. All patients whose conditions exceed the regionally available resources provided by local area hospitals may be transferred from one region to another following LERN interregional transfer protocol.

b. The LERN hospital interregional transfer protocol only applies to hospitals that are participating in the LERN network.

c. Regions or individual parishes that have MOU's (which include medical control and destination guidelines), between an ACS verified level 1 trauma center and a local parish medical society(ies) will be incorporated into the LCC standard operating procedure for the effected region(s).

2. LERN Hospital Interregional Transfer Protocol

a. Patients transferred via the LERN hospital interregional transfer protocol must:

i. meet LERN standard entry criteria that requires resources and/or capabilities not available in that region;

ii. be assessed and stabilized to the best of their ability at a local area hospital prior to transport to the closest appropriate hospital;

iii. the treating physician/nurse must contact LERN to request a transfer. The LERN communications center (LCC) will determine the closest and most appropriate facility available following the LERN standard destination protocol.

B. These guidelines and protocols were published at LR 37:751 (February 20, 2011).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:143 (January 2015).

§19113. LERN Entry Criteria: Trauma; LERN Destination Protocol: Trauma

A. On January 20, 2011, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN ENTRY CRITERIA: Trauma; Pre-Hospital and Hospital Triage Protocol" and "LERN DESTINATION PROTOCOL: Trauma" replacing the "Standard LERN Entry Trauma Criteria" and "Standard LERN Entry Trauma Criteria Destination Protocol" adopted and promulgated January 20, 2011, as follows.

1. LERN Entry Criteria: Trauma

a. Pre-Hospital and Hospital Triage Protocol

Call LERN Communications Center for:
• Unmanageable Airway • Tension Pneumothorax • Traumatic cardiac arrest • Burn Patient without patent airway • Burn patient >40 percent BSA without IV
Physiologic
• GCS <14 • SBP <90 (adults and > 9 y/o) <70 + 2 [age (yrs)] (age 1 to 8 y/o) <70 (age 1 to 12 months) <60 (term neonate) • RR <10 or >29 (adults & ≥ 9 y/o) <15 or >30 (age 1 to 8 y/o) <25 or >50 (<12 m/o)
Anatomic
• Open or depressed skull fractures • Open head injury with or without CSF leak • Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit) • All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee • Flail Chest • 2 or more proximal long-bone fractures • Crush, degloved or mangled extremity • Amputation proximal to wrist and ankle • Pelvic Fractures • Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls • Major joint dislocations (hip, knee, ankle, elbow) • Open Fractures • Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture)
Mechanism
• Falls >20 ft. adults >10 ft. (child) or 2 to 3 times height • Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact • Motorcycle crash >20 MPH • High-risk auto crash • Intrusion >12 in, occupant site >18 in. any site • Ejection, partial or complete from automobile • Death in same passenger compartment
Other
• Pregnancy >20 weeks • Burns (follow ABA guidelines) • Age ≥ 55 y/o or <8 y/o • Anticoagulation and bleeding disorders • End stage renal disease • Transplant patients
Multi/Mass Casualty Incident (MCI)

2. LERN Destination Protocol: Trauma

LERN Destination Protocol: Trauma		
• Unmanageable Airway • Tension Pneumothorax • Traumatic cardiac arrest • Burn patient without patent airway • Burn patient >40 percent BSA without IV	YES→	Closest ED
Physiologic		
• GCS < 14 • SBP <90 (adults and > 9 y/o) <70 + 2 [age (yrs)] (age 1 to 8) <70 (age 1 to 12 months) <60 (term neonate) • RR <10 or >29 (adults and > 9 y/o) <15 or >30 (age 1 to 8) <25 or >50 (< 12 m/o)	YES→	LERN Level I, II, or III
Anatomic		
• Open or depressed skull fractures • Open head injury with or without CSF leak • Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit) • All penetrating injuries to neck, torso and extremities proximal to elbow and knee • Flail Chest • 2 or more proximal long-bone fractures • Crush, degloved or mangled extremity • Amputation proximal to wrist and ankle • Pelvic Fracture • Hip fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls • Major joint dislocations (hip, knee, ankle, elbow) • Open Fractures • Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture	YES→	LERN Level I, II, or III
Mechanism		
Falls > 20 ft. (adults) > 10 ft. (child) or 2 to 3 times height High-risk auto crash Intrusion > 12 in. occupant site: >18 in. any site Ejection, partial or complete from automobile Death in same passenger compartment Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact Motorcycle crash >20 MPH	YES→	LERN Level II, or III
Other		
• Pregnancy > 20 weeks • Burns (follow ABA guidelines) • Age >55 y/o or <8 y/o • Anticoagulation and bleeding disorders • End stage renal disease • Transplant patients	YES→	LERN Level II, III, or IV
MULTI/MASS CASUALTY INCIDENT (MCI)	YES→	LERN Level I, II, III,

LERN Destination Protocol: Trauma		
		or IV

B. These protocols were published at LR 37:1466-1468 (April 20, 2011).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:143 (January 2015).

§19115. LERN Destination Protocol: TRAUMA

A. On April 26, 2012, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN Destination Protocol: Trauma" replacing the "LERN Destination Protocol: Trauma" adopted and promulgated April 21, 2011, as follows.

• Unmanageable Airway • Tension Pneumothorax • Traumatic cardiac arrest • Burn Patient without patent airway • Burn patient >40 percent BSA without IV	→	Closest ED
Physiologic		
• GCS <14 • SBP <90 (adults and > 9 y/o) <70 + 2 [age (yrs)] (age 1 to 8 y/o) <70 (age 1 to 12 months) <60 (term neonate) • RR <10 or >29 (adults and ≥ 9 y/o) <15 or >30 (age 1 to 8 y/o) <25 or >50 (<12 m/o)	→	Level I, II, or III*
Anatomic		
• Open or depressed skull fractures • Open head injury with or without CSF leak • Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit) • All penetrating injuries to head, neck, torso, & extremities proximal to elbow & knee • Flail Chest • 2 or more proximal long-bone fractures • Crush, degloved or mangled extremity • Amputation proximal to wrist & ankle • Pelvic Fractures • Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls • Major joint dislocations (hip, knee, ankle, elbow) • Open Fractures • Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture)	→	Level I, II, or III*
Mechanism		
• Falls >20 ft. adults >10 ft. (child) or 2 to 3 times height • High-risk auto crash • Intrusion > 12 in. occupant site > 18 in. any site • Ejection, partial or complete from automobile • Death in same passenger compartment • Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact • Motorcycle crash >20 MPH	→	Level I, II, or III*
Other		
• Pregnancy >20 weeks • Burns (follow ABA guidelines) • Age ≥ 55 y/o or <8 y/o • Anticoagulation and bleeding disorders -patients w/ head injuries are at high risk for rapid deterioration	→	Level II, or III*
MULTI/MASS CASUALTY INCIDENT (MCI)	→	Level I, II, or III*

*Refers to ACS Verified Level Trauma Center—Where trauma center not available, patient will be routed to facility with appropriate resource which may not need be the highest level facility.

B. This protocol was published at LR 38:1462-1463 (June 20, 2012).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:144 (January 2015).

§19117. LERN Destination Protocol: Trauma

A. On November 21, 2013, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN Destination Protocol: TRAUMA" replacing the "LERN Destination Protocol: Trauma" adopted and promulgated April 26, 2012, and repealing "LERN ENTRY CRITERIA, Trauma Pre-Hospital and Hospital Triage Protocol" adopted and promulgated April 21, 2011, as follows.

1. Call LERN Communication Center at (866) 320-8293 for patients meeting the following criteria.

• Unmanageable airway • Tension pneumothorax • Traumatic cardiac arrest • Burn patient without patent airway • Burn patient > 40 percent BSA without IV	→	Closest ED/Trauma Center
NO ↓		
Physiologic		
• GCS < 14 • SBP < 90 (adults and > 9 y/o) < 70 + 2 [age (yrs)] (age 1 to 8 y/o) < 70 (age 1 to 12 months) < 60 (term neonate) • RR < 10 or > 29 (adults & ≥ 9 y/o) < 15 or > 30 (age 1 to 8 y/o) < 25 or > 50 (< 12 m/o)	→	To Appropriate Trauma Center or Hospital as Determined by LERN Communication Center
NO ↓		

Anatomic		
• Open or depressed skull fractures • Open head injury with or without CSF leak • Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit) • All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee • Flail Chest • 2 or more proximal long-bone fractures • Crush, degloved or mangled extremity • Amputation proximal to wrist and ankle • Pelvic Fractures • Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls • Major joint dislocations (hip, knee, ankle, elbow) • Open Fractures • Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture)	→	To Appropriate Trauma Center or Hospital as Determined by LERN Communication Center
NO ↓		
Mechanism		
• Falls >20 ft. adults >10 ft. (child) or 2 to 3 times height • High-risk auto crash • Intrusion >12 in. occupant site >18 in. any site • Ejection, partial or complete from automobile • Death in same passenger compartment • Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact • Motorcycle crash >20 MPH	→	To Appropriate Trauma Center or Hospital as Determined by LERN Communication Center
NO ↓		
Other		
• Pregnancy >20 weeks • Burns (follow ABA guidelines) • Age ≥ 55 y/o or <8 y/o • Anticoagulation and bleeding disorders - patients w/ head injuries are at high risk for rapid deterioration	→	To Appropriate Trauma Center or Hospital as Determined by LERN Communication Center
MULTI/MASS CASUALTY INCIDENT (MCI)	→	To Appropriate Trauma Center or Hospital as Determined by LERN Communication Center

B. This protocol was published at LR 40:190-191 (January 20, 2014).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network, LR 41:145 (January 2015).

§19119. Destination Protocol: TRAUMA

A. On November 20, 2014, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "Destination Protocol: Trauma" to be effective January 1, 2015, and replacing the "LERN Destination Protocol: Trauma" adopted and promulgated November 21, 2013, as follows.

1. Call LERN communication center at (866) 320-8293 for patients meeting the following criteria.

• Unmanageable airway • Tension pneumothorax • Traumatic cardiac arrest • Burn patient without patent airway • Burn patient > 40 percent BSA without IV	Yes→	Closest ED/ Trauma Center
↓ No		
Measure vital signs and level of consciousness		
• GCS ≤13 • SBP <90mmHg • RR <10 or >29 breaths per minute, or need for ventilator Support (<20 in infant aged <1 year)	Yes→	Transport to Trauma Center/ Trauma Program These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program. ** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.*
↓ No		
Assess anatomy of injury		
• All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee • Chest wall instability or deformity (e.g. flail chest) • Two or more proximal long-bone fractures • Crushed, degloved, mangled, or pulseless extremity • Amputation proximal to wrist or ankle • Pelvic fractures • Open or depressed skull fracture • Paralysis • Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture)	Yes→	Transport to Trauma Center/ Trauma Program These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program. ** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.*
↓ No		
Assess mechanism of injury and evidence of high-energy impact		
• Falls - Adults: >20 feet (one story is equal to 10 feet) - Children: >10 feet or two or three times the height of the child • High-risk auto crash - Intrusion, including roof: > 12 inches occupant site;	Yes→	Transport to Trauma Center/Trauma Program which, depending upon the defined trauma system, need not be the highest level trauma center/program. If no Trauma Center/Trauma Program in the region, LCC may route to the

> 18 inches any site - Ejection (partial or complete) from automobile - Death in the same passenger compartment - Vehicle telemetry data consistent with a high risk of injury • Auto vs. pedestrian/bicyclist/ ATV thrown, run over, or with significant (>20 mph) impact • Motorcycle crash >20mph		most appropriate resourced hospital.
↓ No		
Assess special patient or system considerations		
• Older Adults - Risk of injury/death increases after age 55 years - SBP <110 may represent shock after age 65 - Low impact mechanisms (e.g. ground level falls) may result in severe injury • Children - Should be triaged preferentially to pediatric capable trauma centers • Anticoagulants and bleeding disorders - Patients with head injury are at high risk for rapid deterioration • Burns - With trauma mechanism: triage to trauma center • Pregnancy >20 weeks • Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls • Major joint dislocations (hip, knee, ankle, elbow) • Open Fractures • EMS provider judgment	Yes→	Transport to Trauma Center/Trauma Program which, depending upon the defined trauma system, need not be the highest level trauma center/program. If no Trauma Center/Trauma Program in the region, LCC may route to the most appropriate resourced hospital.
↓ No		
Multi/Mass Casualty Incident	No→	Transport according to protocol

2. When in doubt, transport to a trauma center.

B. This protocol was published at LR 40:2710 (December 20, 2014).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:950 (May 2015).

§19121. LERN Destination Protocol: TRAUMA

A. On December 10, 2015, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN Destination Protocol: TRAUMA", which replaces the "LERN Destination Protocol: TRAUMA" found in §19121 adopted and promulgated November 20, 2014, as follows.

1. Call LERN communication center at (866) 320-8293 for patients meeting the following criteria.

• Unmanageable airway • Tension pneumothorax • Traumatic cardiac arrest • Burn patient without patent airway • Burn patient > 40 percent BSA without IV	Yes→	**Closest ED/Trauma Center**
No ↓		
Measure vital signs and level of consciousness		
• GCS ≤13 • SBP <90mmHg • RR <10 or >29 breaths per minute, or need for ventilator Support (<20 in infant aged <1 year)	Yes→	**Transport to Trauma Center/ Trauma Program** These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program. ** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.*
No ↓		
Assess anatomy of injury		
• All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee • Chest wall instability or deformity (e.g. flail chest) • Two or more proximal long-bone fractures • Crushed, degloved, mangled, or pulseless extremity • Amputation proximal to wrist or ankle • Pelvic fractures • Open or depressed skull fracture • Paralysis • Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture)	Yes→	Transport to Trauma Center/ Trauma Program These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program. ** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.*
No ↓		
Assess mechanism of injury and evidence of high-energy impact		
• **Falls** - Adults: >20 feet (one story is equal to 10 feet) - Children: >10 feet or two or three times the height of the child • **High-risk auto crash** - Intrusion, including roof: > 12 inches occupant site; > 18 inches any site - Ejection (partial or complete) from automobile	Yes→	**Transport to Trauma Center/Trauma Program** which, depending upon the defined trauma system, need not be the highest level trauma center/program. If no Trauma Center/Trauma Program in the region, LCC may route to the most appropriate resourced hospital.

- Death in the same passenger compartment - Vehicle telemetry data consistent with a high risk of injury • **Auto vs. pedestrian/bicyclist/ATV thrown, run over, or with significant (>20 mph) impact** • **Motorcycle crash >20mph**		
No ↓		
Assess special patient or system considerations		
• **Older Adults** - Risk of injury/death increases after age 55 years - SBP <110 may represent shock after age 65 - Low impact mechanisms (e.g. ground level falls) may result in severe injury • **Children** - Should be triaged preferentially to pediatric capable trauma centers • **Anticoagulants and bleeding disorders** - Patients with head injury are at high risk for rapid deterioration • **Burns** - With trauma mechanism: triage to trauma center • **Pregnancy >20 weeks** • Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls • Major joint dislocations (hip, knee, ankle, elbow) • Open Fractures • EMS provider judgment	Yes→	**Transport to Trauma Center/Trauma Program** or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control.
No ↓		
Multi/Mass Casualty Incident	No→	Transport according to protocol

2. When in doubt, transport to a trauma center.

B. This protocol was published at LR 42:169 (January 2016).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

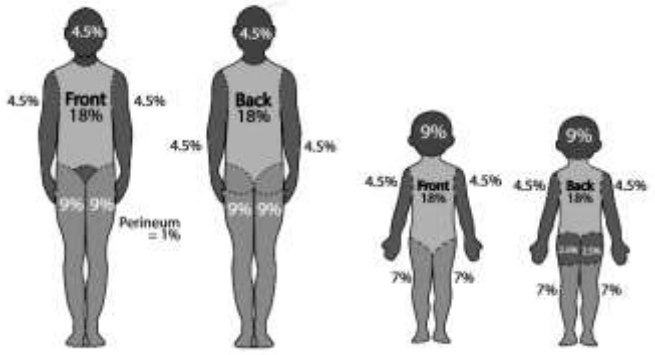
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 42:904 (June 2016).

Chapter 192. Burn Protocols

§19201. LERN Destination Protocol: BURN

A. Call LERN Communication Center at 1-866-320-8293 for patients meeting the following criteria.

Burn Patient with Trauma	Yes⟶	See LERN Trauma Destination Protocol
↓ No		
• Burn patient without patent airway • Patients with facial / airway burns or anticipated airway compromise • Burn patient with > 40 % BSA without IV or IO access	Yes⟶	Transport to Closest ED
↓ No		
2nd and 3rd degree burns involving: • > 10% BSA • Face, hands, feet, genitalia, perineum, or major joints • Circumferential Burns • Electrical burns, including lightning injury • Chemical burns Or • Inhalation injury • All Third Degree Burns	Yes→	Transport to Closest Burn Center ** If distance or patient condition impedes transport to burn center, consider transport to most appropriate resourced hospital.*
↓ No		
Transport per Local EMS Protocols		
• In the event of a burn disaster, each burn center should immediately contact LERN. LERN Call Center (LCC) will conduct a bed poll. • In the event of a burn disaster and excess beyond capacity, the next geographically closest burn center should be alerted immediately by LERN.		



AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 45:911 (July 2019).

Chapter 193. Stroke Protocols

§19301. LERN Destination Protocol: Stroke

A. On November 21, 2013, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN Destination Protocol: STROKE," as follows.

1. The following protocol applies to patients with suspected stroke.

Compromise Of: • Airway • Breathing • Circulation	→	Closest ED
NO ↓		
• All other patients with suspected stroke Patients with seizure with focal deficit, extended window (4-8 hrs from onset), and patients with unknown onset may benefit from evaluation at Level I or II hospital with on-site stroke expertise.	→	Transport to LERN Stroke Level I, II, or III
NO ↓		
Terminally Ill or Palliative Care Patient	→	Transport to LERN Stroke Level I, II, III, or IV
Guiding principles: • Time is the critical variable in acute stroke care. • Protocols that include pre-hospital notification while en route by EMS should be used for patients with suspected acute stroke to facilitate primary destination efficiency. • Treatment with intravenous tPA is the only FDA approved acute therapy for stroke. • EMS should identify the geographically closest facility capable of providing tPA treatment. • Transfer patient to the nearest hospital equipped to provide tPA treatment. • Secondary transfer to facilities equipped to provide tertiary care and interventional treatments should not prevent administration of tPA to appropriate patients.		

B. This protocol was published at LR 40:189-190 (January 20, 2014).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:146 (January 2015).

§19303. LERN Destination Protocol: Stroke

A. On April 21, 2017, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN Designation Protocol: Stroke", amending and replacing the previous "LERN Designation Protocol: Stroke" adopted on November 21, 2013 and set out in Section 19301, as follows.

LERN Destination Protocol: Stroke
LERN Call Center: (866) 320-8293

The following protocol applies to patients with suspected stroke:

Compromise Of:
- Airway
- Breathing
- Circulation

→ Closest ED for stabilization and then triage to closest appropriate hospital

NO

All other patients with suspected stroke, determine time last seen normal (LSN) and screen for large vessel occlusion (LVO)

LSN < 6 hours* AND screen for LVO is positive

Transport to LERN Stroke Level I, II, or III Center

If < 15 minutes of additional transport time to reach Level I or endovascular capable Level II Center, transfer to the Level I or endovascular capable Level II Center

LSN > 6 hours OR screen for LVO is negative

Transport to LERN Stroke Level I, II, or III Center

If > 15 minutes of additional transport time to reach Level I, II, or III Center than to reach stroke capable Off Site ED, it is acceptable to transport to a stroke capable Off Site ED

* The LSN < 6hrs should include patients without a definite time of LSN, but who could reasonably be assumed to be within 6 hrs of onset, including patients who wake-up with stroke symptoms.

Guiding Principles:
- Time is the critical variable in acute stroke care
- Protocols that include pre-hospital notification while en route by EMS should be used for patients with suspected acute stroke to facilitate initial destination efficiency.
- Treatment with intravenous tPA is the only FDA approved medication therapy for hyperacute stroke.
- EMS should identify the geographically closest hospital capable of providing tPA treatment.
- Transfer patient to the nearest hospital equipped to provide tPA treatment.
- Secondary transfer to facilities equipped to provide tertiary care and interventional treatments should not prevent administration of tPA to appropriate patients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 43:1758 (September 2017).

Chapter 195. STEMI Protocols

§19501. STEMI Triage Protocol for Pre-Hospital Providers

A. On November 21, 2013, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "STEMI Triage Protocol for Pre-Hospital Providers," as follows.

Acute coronary symptoms ≥ 15 minutes and < 12 hours AND 12 lead ECG criteria of 1 mm ST elevation in 2 or more contiguous leads OR LBBB NOT KNOWN to be present in the past EMS ECG interpreted or transmitted to hospital for MD consult for bypass and activation
↓

STEMI-Receiving Center with medical contact-to-device (PCI) ≤ 90 minutes (by ground or air)?	YES→	Transport to nearest STEMI-Receiving Center with pre-hospital notification/activation Goal medical contact to device (PCI) time of 90 minutes or less
NO ↓		
Transport to closest STEMI-Referral Hospital with Pre-hospital notification/activation Goal medical contact to fibrinolytic needle time of 30 minutes or less	→	Transport to nearest STEMI-Receiving Center for subsequent PCI

*O'Gara PT, Kushner FG, Ascheim DD, et all. 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infraction: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Journal of the American College of Cardiology. 2013;61(4):e78.

B. This protocol was published at LR 50:192 (January 20, 2014).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:146 (January 2015).

Chapter 197. Trauma Program Recognition

§19701. Generally

A. The goal of the Louisiana Emergency Response Network Board is to establish a trauma system that includes one verified trauma center in each region of the state. Trauma program recognition in excess of this goal will be determined utilizing a needs based assessment. The LERN communication center coordinates access to the trauma system by providing accurate and professional routing of patients experiencing time sensitive illness to the definitive care facility, which includes trauma programs recognized according to these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:1931 (November 2016).

§19703. Purpose

A. LERN recognizes the opportunity to reduce the morbidity and mortality of trauma patients in Louisiana in areas without an existing level I or level II trauma center or an existing level II or level III trauma program through this process which recognizes the achievement of specific benchmarks in hospitals actively pursuing levels II or III trauma center verification through the American College of Surgeons (ACS).

B. The purpose of this Chapter is to define the qualifications, procedure, and requirements for hospitals seeking trauma center verification by the ACS to be recognized by LERN as achieving the core components of a trauma program and thus qualified for recognition as a trauma program.

C. The criteria for trauma program recognition are drawn from *Resources for Optimal Care of Injured Patient 2014* published by the ACS.

D. Trauma program recognition is distinct and different from the trauma center certification by the state. To be certified as a trauma center, a hospital must satisfy the requirements of R.S. 40:2172 and 2173.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:1931 (November 2016).

§19705. Qualifications for LERN Trauma Program Recognition

A. The hospital must be located in a LERN region that does not have an existing ACS verified level I or level II trauma center.

B. A hospital providing care to trauma patients in a LERN region without an existing ACS verified level I or level II trauma center or without an existing level II or level III trauma program is eligible for trauma program recognition upon meeting the requirements of this rule.

C. If there is an existing LERN recognized level II or Level III trauma program in the LERN region, the hospital must complete the most current version of the ACS needs based assessment of trauma systems tool (ACS NBATS). If the number of trauma centers allocated by the tool is less than or equal to the number of existing trauma programs in the region, the hospital is not eligible for trauma program recognition.

D. A hospital must be in the process of working toward ACS verification to be eligible for trauma program recognition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:1932 (November 2016).

§19707. Procedure for Trauma Program Recognition

A. A hospital must complete the LERN approved form, "application for recognition of trauma program".

B. The hospital CEO must complete and sign the LERN approved trauma program checklist/attestation for the applicable trauma program level.

1. By this attestation, the hospital CEO ensures 24/7/365 availability of the resources listed.

2. The attestation must be validated by a site visit by LERN staff.

3. Upon CEO attestation and/or site visit, if it is determined by the LERN executive committee in conjunction with the LERN trauma medical director, that the required benchmarks are not in place the hospital will not be eligible for trauma program verification.

C. After satisfying the requirements of A. and B. above, the hospital will be recognized as a trauma program and such recognition will be added to the LERN resource management screen for the purpose of routing trauma patients.

D. To maintain trauma program recognition, the hospital must request an ACS verification or consultation site visit at the time of the attestation or within 30 days thereafter, with the consultation or survey to occur within 12 months of the attestation or as close to 12 months as the ACS schedule allows. Written documentation of the request and scheduling must be submitted to LERN.

1. If an ACS verification or consultation site visit is not requested within 30 days and does not occur within 12 months or as close to 12 months as the ACS schedule allows, the trauma program indicator on LERN resource management screen will be removed.

E. After a consultation visit for the desired trauma level, the hospital has 30 days to schedule the verification survey by the ACS to occur within 12 months of the consultation or as close to 12 months as the ACS schedule allows. Written documentation of the request and scheduling must be submitted to LERN.

1. If documentation of scheduling per required parameters is not submitted to LERN and the ACS verification survey is not scheduled to occur within 12 months of the consultation or as close to 12 months as the ACS schedule allows, the trauma program indicator will be removed on the LERN resource management screen.

2. If the hospital fails the ACS verification visit and a focused review visit, the hospital will lose trauma program status. The trauma program indicator will be removed on the LERN resource management screen.

F. After loss of trauma program status for failing the ACS verification visit and focused review visit, trauma program status may be regained provided the following conditions are met:

1. a LERN designee and either the LERN trauma medical director or a trauma surgeon must review the deficiencies and findings of the ACS at a site visit;

2. the hospital must develop a remediation plan and apply to the LERN board for approval of trauma program status;

3. the LERN board will review the LERN team assessment of deficiencies and the hospital's remediation plan;

4. the LERN board must vote to approve the trauma program status request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:1932 (November 2016), amended LR 44:63 (January 2018), LR 45:436 (March 2019), repromulgated LR 45:573 (April 2019).

Subpart 17. Personal Assistance Services

Chapter 201. State Personal Assistance Services Program

Editor's Note: This Chapter, formerly LAC 67:VII.Chapter 11, was moved to LAC 48.I.Chapter 201.

§20101. Mission
[Formerly LAC 67:VII.1101]

A. General Statement. The legislature of Louisiana recognizes the right of people with significant physical disabilities to lead independent and productive lives and further recognizes that persons with significant disabilities require personal assistance to meet tasks of daily living and, in many cases to avoid costly institutionalization. The creation of the State Personal Assistance Services Program, hereafter referred to as the SPAS Program, is to provide state personal assistance services to persons with significant disabilities in order to support and enhance their employability and/or to avoid inappropriate and unnecessary institutionalization. The mission of the SPAS Program is to provide for an orderly sequence of services to those persons who are determined eligible for the program.

B. Program Administration. The Department of Health and Hospitals, through Office of Aging and Adult Services (OAAS), is responsible for the administration of the SPAS Program.

C. Purpose of this Rule. This Rule sets forth the policies of OAAS in carrying out the agency's mission, specifically as this mission relates to the SPAS Program.

D. Exceptions. The secretary or secretary's designee shall have the sole responsibility for any exceptions to this policy manual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), repromulgated LR 19:1436 (November 1993), amended LR 33:1146 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:385 (February 2015).

§20103. Enabling Legislation
[Formerly LAC 67:VII.1103]

A. House Bill Number 1198, Act 939 of the 2010 Regular Session, LAC Title 48, Chapter 201, *Revised Statute* 46:2116.2.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991),

amended LR 19:1437 (November 1993), LR 33:1146 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:385 (February 2015).

§20105. Definitions
[Formerly LAC 67:VII.1105]

A. The following terms, when used in this manual, shall have the meaning, unless the context clearly indicates otherwise.

Self-Directed—the participant or legal/personal representative will direct, supervise, hire and discharge his/her personal attendant and be able to *self-direct* all goods/services needed.

Management Contractor/Fiscal Agent—contracted entity which may be responsible for day to day program activities including but not limited to eligibility requirements, etc.

Department—the Department of Health and Hospitals.

Individual with Significant Disabilities—an individual with loss of sensory or motor functions interfering with activities of daily living to the extent that the person requires assistance with non-medical personal care needs, domestic or cleaning needs, dressing and undressing, moving into and out of bed, transferring, ambulation, related services including but not limited to meal preparation, laundry, and grocery shopping, and/or other similar activities of daily living.

PA—personal assistance.

Secretary—the *secretary* of the Department of Health and Hospitals.

State Personal Assistance Services (SPAS) Program—services means goods and services which are required by a person with significant disabilities age 18 eighteen or older to increase a person's independence or substitute for a person's dependence on human assistance.

Intentional Program Violation—made a false or misleading statement, or misrepresented, concealed or withheld fact; or committed any act that constitutes a violation of the SPAS Program or SPAS policy and/or procedures.

AUTHORITY NOTE; Promulgated in accordance with 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1437 (November 1993), LR 33:1146 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:386 (February 2015).

§20107. General Requirements
[Formerly LAC 67:VII.1107]

A. Cost-Effective Service Provision. All services shall be provided in a cost-effective manner.

B. This program shall be considered as a source of last resort for personal assistance services after private and governmental sources have been expended.

C. Case File Documentation. All SPAS Program management contractors/fiscal agents must maintain a case file for each SPAS Program participant. The case file shall contain documentation to support the decision to provide, deny, or amend services. Documentation of the amounts and dates of each service provided to support all claims for reimbursement must also be included in the case file.

D. The department is under no obligation to perform any of the services described in R.S 46:2116 et seq., and can utilize other sources to provide these services. Additionally, funds appropriated for state plan personal assistance services may be used as match for available funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), repromulgated LR 19:1437 (November 1993), amended LR 33:1146 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:386 (February 2015).

§20109. Applicant and Participant Appeal Rights
[Formerly LAC 67:VII.1111]

A. Any individual whose request is denied for goods/services, denied eligibility or discharged from the program may appeal said decision in accordance with the provisions of R.S. 46:107. Such appeal shall be conducted in accordance with the Administrative Procedure Act and shall be subject to judicial review.

B. A participant's current services shall remain in place during the appeals process until a final administrative decision is reached. A decision is final when the Division of Administrative of Law renders a decision on the appeal.

AUTHORITY NOTE; Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1438 (November 1993), LR 33:1147 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:386 (February 2015).

§20111. Eligibility Decisions
[Formerly LAC 67:VII.1113]

A. An individual can be determined eligible for services as set forth in R.S. 46:2116.2 if that individual meets all of the following criteria:

1. is an individual with significant disabilities;

2. is age 18 or older;

3. needs goods and/or personal assistance services from this program to prevent or remove the individual from inappropriate placement in an institutional setting or enhance or maintain individual's employability;

4. provides verification of the disability from the treating physician;

5. is capable or has legal/personal representation capable of self-direction. Although the participant is capable

of self-directing they may chose a qualified provider agency for services; and

6. has unique economic and social needs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1439 (November 1993), LR 33:1147 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:386 (February 2015).

§20113. Economic Need
[Formerly LAC 67:VII.1115]

A. In determining an individual's financial need for services, the management contractor will use a system based upon the current federal poverty guidelines. The economic need status of each participant for the SPAS Program shall be considered in the initial determination of eligibility for services and at least annually thereafter. The participant must provide verification of income.

B. The total monthly income of the SPAS applicant and/or spouse shall be considered in determining the amount of available income in the determination of eligibility for services. Current income received on a regular basis must be considered regardless of its source.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 33:1148 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:386 (February 2015).

§20115. Plan for State Personal Assistance Services
[Formerly LAC 67:VII.1117]

A. Following a determination of eligibility for services, an appropriate individualized assessment will be completed to determine the scope of services. After a case-by-case assessment of needs, a service plan will be developed, implemented, and updated as appropriate. The service plan will be individualized and outcome oriented.

B. A state personal assistance services plan is to be developed between the participant and the management contractor to determine the specific goods/services needed. A SPAS plan shall be initiated annually or more often, if indicated. The SPAS plan and all updated plans shall be contained in the participant's case record.

C. The participant is to cooperate fully in the development of the SPAS plan, including all changes and amendments. The participant's signature is required for the personal assistance plan and any amendments.

D. Minimum content of the personal assistance plan:

1. identification of specific goods/services to be delivered;

2. the frequency of goods/services with flexibility;

3. the beginning date and service review dates.

E. Annual State Personal Assistance Services Plan Review. Every 12 months a review of the SPAS plan is mandatory and shall be reflected on the amended plan. A review can be done before 12 months, if indicated. In all cases, the participant shall be involved in any review and/or changes to his/her personal assistance plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1439 (November 1993), LR 33:1148 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:387 (February 2015).

§20117. Financial
[Formerly LAC 67:VII.1119]

A. Prior Authorization. A participant shall obtain prior authorization from contract manager for goods and/or services before they can begin. Failure to obtain prior authorization will result in a denial of goods or services. If an emergency situation exists where goods or services are needed to begin prior to the management contractor's receipt of written acceptance, management contractor may provide verbal authorization for services to begin. The management contractor must amend the SPAS plan before service can begin.

B. The participant of SPAS will invoice the management contractor bi-monthly in arrears for personal assistance services purchased and include copies of time sheets as verification of the services being provided. The invoice shall contain the following:

1. dates of services;

2. description of goods/ services provided along with the number of hours of personal assistance services per day and/or number of goods received;

3. rate of pay;

4. signature of direct service worker; and

5. signature of participant of the SPAS Program.

C. The participant of SPAS will submit receipts or invoices for the goods and/or other services purchased to the management contractor as verification of the goods and/or other services being provided.

D. All purchases must comply with state purchasing guidelines.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1439 (November 1993), LR 33:1148 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:387 (February 2015).

§20119. Management Contractor Responsibilities
[Formerly LAC 67:VII.1121]

A. The management contractor shall keep a waiting list of individuals wanting to apply for the SPAS Program.

B. The management contractor shall take a pre-application on participants who will be placed on the waiting list for services and shall use criteria developed by OAAS.

C. The management contractor shall maintain a case record on each participant and applicant. The case record must include, as a minimum, the pre-application form and, if applicable, a copy of the denial of eligibility letter, personal assistance plan and all amendments to this plan, documentation from medical and/or other appropriate sources, proof of income and any other additional material which is a necessary part of the application and/or reconsideration for the SPAS Program.

D. Upon admission into the program, the management contractor shall review and have the participant sign an agreement of understanding outlining the management contractor's responsibilities as well as the participant's. A copy should be left with the individual and a signed copy shall be maintained in the participant's case record.

E. The management contractor shall reassess all SPAS Program participants at least annually or more often if their needs change. If there is a change in circumstances, a revised personal assistance plan must be completed.

F. The management contractor shall make available all required OAAS training and certifications to all participants who self direct their personal assistance under this program. Documentation of training including dates, name of trainer and names of individuals trained should be included in the case record.

G. The management contractor shall maintain copies of the time sheets and/or invoices received. Time sheets and invoices shall document the date goods/services rendered, description of the goods/services, times services rendered, name and contact information of the provider. Payments for the time worked shall be paid within a reasonable period of time after the invoice is received by the management contractor.

H. The management contractor shall investigate information brought to the management contractor's attention which causes question of continued eligibility. This could include such items as falsification of time sheets, misuse of SPAS Program funds, and any other violation of the policy stated herein. This information shall be provided to the OAAS program manager for disposition. If the information provided is substantiated, this shall be reason for denial of services or loss of eligibility.

I. The management contractor shall provide the participant with a copy of the SPAS Program policy manual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1439 (November 1993), LR 33:1149 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:387 (February 2015).

§20121. Reasons for Closure and/or Termination [Formerly LAC 67:VII.1127]

A. The following may result in termination of services and/or closure:

1. the participant no longer meets eligibility criteria;

2. the participant intentionally falsified information;

3. the participant has shown consistent failure to cooperate with the service plan and management contractor;

4. the participant is unable to be contacted and/or whereabouts unknown for 90 days or more and no response after an attempted home visit and certified letter;

5. the participant made misrepresentations in the eligibility determination process;

6. the participant made misrepresentations to obtain goods and services;

7. any other reason which is contradictory to policy and procedures for the SPAS Program.

B. The management contractor should issue a "warning" to participants who commit a violation of policy. If the violation is not intentional, written notice of the violation and action to correct the violation is to be given to the participant. A copy of the warning notice to the participant is to be placed in the participants case record. The management contractor shall make a recommendation to the OAAS program manager to terminate a participant who continues to violate the policy and/or procedures of the SPAS Program after a warning has been issued. The decision to terminate will be based on the severity of the violation(s) and/or continued violation(s) and will be made by OAAS.

1. If the violation of policy by the participant was intentional, the management contractor shall immediately notify the OAAS program manager. In the case of an intentional violation of the policy by the participant, a warning does not need to be issued prior to termination from the program.

2. When a participant is terminated from this program the management contractor will send a termination letter to the participant that explains the reason(s) and right to an appeal;

C. Recoupment

1. In lieu of termination, the management contractor can demand that a participant refund the SPAS Program for all benefits received.

2. If the management contractor rules that the participant must repay the amount in question, the management contractor will determine the repayment schedule. Participant can remain eligible as long as recoupment is made and a willingness to comply with policies and procedures set forth in the SPAS Program are shown. The management contractor shall maintain close monitoring of the participant until such time the management contractor determines participant is complying with the policies and procedures.

3. Recoupment is required from fraudulently received benefits as well; however, the participant will not be eligible for further services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 21:1251 (November 1995), amended LR 33:1149 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:388 (February 2015).

Title 48
PUBLIC HEALTH—GENERAL
Part III. Mental Health Services

Chapter 1. General Provisions

§101. Purpose and Philosophy of Office of Mental Health (OMH)

A. The statutory functions of the Office of Mental Health (OMH) is the prevention, treatment, rehabilitation and follow-up care of mental and emotional illness in Louisiana. The treatment philosophy of OMH is based on the premise that each individual is unique and worthy of special attention. OMH services are available to all persons determined to be in need of service, regardless of age, sex, race, ethnic background and ability to pay. The comprehensive array of OMH services includes: crisis care; clinical outpatient services; community support services; inpatient services; pharmacy services; and prevention services/consultation and education.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:1-311.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Health, LR 13:246 (April 1987).

Chapter 3. Client Services

§301. Screening and Admission

A. The director of a mental health treatment facility or his/her representative shall screen or examine systematically in order to determine whether or not mental health services are indeed in the best interest of the applicants for services and, if they are needed, where they might best be obtained. All mental health treatment facilities shall have defined admission criteria. Each facility shall have established procedures for reviewing all applicants for services to determine whether they meet the facility's defined admission criteria. All persons who meet admission criteria are eligible for services and will be provided services in accordance with priorities established by the Office of Mental Health headquarters and individual facilities. If admission to a mental health treatment facility is indicated, appropriate recommendations will be made.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:50-64.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Health, LR 13:246 (April 1987).

§303. Hospital and Regional Overflow (Waiting List) Procedures

A. Hospitals will maintain their own waiting lists and will work with neighboring hospitals to place those for whom no bed is available at the initial facility.

B. A waiting list for inpatient treatment will be maintained by a designee of each regional director, and by the director of Orleans Inmate Treatment Service (OITS).

C. The person responsible for maintaining the regional or OITS waiting list will also assure that during the waiting period, the appropriate mental health clinic within the region maintains contact with the individual waiting or with those responsible for care of that individual during the waiting period and offers the most appropriate alternative treatment available through the center.

D. Center and hospital physicians will work cooperatively in assigning priority need to individuals who are waiting, based on the guidelines given below. Final decision regarding priority for admission shall rest with the hospital. Guidelines for assigning priority for admission are delineated as follows.

1. Priority for hospital admission should include consideration of the severity of clinical need, including the assessment of dangerousness to self and others; legal status; and availability and adequacy of supports for the patient as well as the availability and appropriateness of alternate forms of treatment.

2. Generally, top priority shall be given for admissions of persons who are medically assessed to be in current serious (life threatening) danger to self or others due to mental illness and who lack minimum supportive individuals and/or environment, and who also lack adequate access to outpatient and/or day treatment services due to any reason.

3. A high priority shall also be given to persons being held in jails and awaiting transfer to inpatient psychiatric services when medical assessment indicates that the state criteria for admission have been met by the individual.

E. The regional or 0ITS designee will notify hospitals immediately when an individual's circumstances or illness no longer require retention on the waiting list. Hospitals will notify the regional designee of all placements and bed offers declined, so that an accurate count of those waiting can be maintained.

F. On a monthly basis, the regional designee will prepare and submit to the Office of Mental Health (OMH) headquarters to the attention of the Information Service Division, the OMH Inpatient Waiting Census Report (See Appendix A). The report will be made for the calendar month and will be submitted no later than the third working day of the following month.

G. Hospital admission offices will retain all essential information over weekends, holidays, and evening hours,

and update the waiting list with each region in their service area at the first opportunity on the next regular work day.

H. Hospitals will maintain a waiting list of persons awaiting services from the areas administratively designated by the Office of Mental Health.

1. By mutual agreement, hospitals may transfer persons to the waiting list of another hospital. If a person is initially referred to a hospital outside the assigned service area, and the individual must be placed on the waiting list, the appropriate hospital (within the person's service area) shall be notified and shall carry the name on their waiting list unless otherwise agreed.

2. If a hospital agrees to carry a person who is located outside its service area on its waiting list, that hospital assumes responsibility for maintaining contacts and reports to the appropriate regional or OITS designee as spelled out above.

I. Procedures for admission and maintenance of waiting lists by Feliciana Forensic Facility and outpatient services are unchanged.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:258.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Health, LR 13:246 (April 1987).

§305. Policy, Rules, and Fee Scale for Outpatient Programs Operated by the Office of Mental Health

The Department of Health and Human Resources (DHHR), Office of Mental Health (OMH), has adopted uniform policies, rules, and fee scales for outpatient centers and clinics of the Office of Mental Health. Fees will be based on cost and adjusted according to the ability of the recipient to pay.

A. Fee Policy

1. All persons seen for services at an OMH center or clinic shall be assessed a fee for each chargeable service. Chargeable services are those defined as chargeable under Medicaid, regardless of the source of payment. These services are listed in Table 1. The unadjusted fee for each service shall be equivalent to the cost of service computed for reimbursement under Medicaid.

Table 1. Chargeable Services as Defined for Medicaid Reimbursement

Code	Service
00071	Psychosocial evaluation
00072	Psychiatric evaluation
00073	Psychological evaluation
00074	Physical evaluation
00075	Other evaluation assessment service
00076	Individual counseling/therapy
00077	Group counseling/therapy
00078	Family/group counseling/therapy
00079	Medication management
00080	Medication injection
00081	Occupational therapy
00082	Recreational therapy
00083	Music therapy
00084	Art therapy

2. All patients whose gross family income is above the minimum indicated on the fee adjustment schedule shall pay a fee for each service provided. Fees and adjustments to fees are to be established by the fee clerk at the time the patient is first admitted to the facility. It is the responsibility of the patient and/or his legally responsible family to justify any adjustment to the full fee authorized under this policy. The patient or family will be asked to present reasonable proof of income before any adjustment to the full fee will be made by the fee clerk. Appropriate center or clinic staff will assist the patient and family in verifying eligibility for a fee adjustment. There shall be adequate documentation of the information used in adjusting any fee. Such documentation shall be signed by the fee clerk who verifies the information and sets the adjusted fee. The full fee, and/ or the adjusted fee, shall be posted on the patient's ledger card and noted in the patient's permanent record.

3. Patients shall be charged a fee for each service, regardless of which service is provided, in the same manner in which Medicaid is charged. No fee shall be charged for failed or cancelled appointments.

4. All patients shall be asked to pay their fees at the time of service delivery. However, when patients do not pay at the time of the visit, they shall be billed on a regular basis, preferably monthly, but no less frequently than quarterly.

B. Fee Adjustment Schedule

1. The fee adjustment schedule is designed to provide for proportional payment for each service based on the family's ability to pay. Three variable figures are utilized in calculating the schedule:

a. state median income as promulgated annually by the Secretary of the United States Department of Health, Education and Welfare;

b. family size;

c. cost of service provided [for purposes of this scale the cost of service provided will be that figure currently agreed upon between OMH and the Office of Family Security (OFS) as the cost to be reimbursed under the Medicaid program].

2. The fee adjustment schedule will be calculated by OMH based on current state median income each time OMH and OFS adjust the figure for cost reimbursement under the Medicaid program.

3. Persons whose gross family income is less than one-half the current state median income adjusted for family size will not be responsible for payment of services. Persons whose gross family income is more than 150 percent of the current state median income adjusted for family size will be charged the full cost of services provided. Between these

two levels, fees will be adjusted in accordance with the following formula.

Gross Family Income as a Percent of Median Income Adjusted for Family Size	Fee as a Percent of Cost
50-55%	4% of cost
55-60%	8%
60-65%	12%
65%	16%
70%	20%
75%	25%
80%	30%
85%	35%
90%	40%
95%	45%
100%	50%
105%	55%
115%	60%
120%	65%
125%	70%
130%	75%
135%	80%
140%	85%
145%	90%
150%	100%

4. Adjustment of median income for family size shall be computed in accordance with the following formula.

Family Size	% of Median Income for a Family of Four
1	52%
2	68%
3	84%
4	100%
5	116%
6	132%
7, or more	148%

5. In computing each modification of the scale, the OMH will round actual fees to the nearest quarter dollar. Fee adjustment schedules will be computed annually by the central office based on current cost and distributed to the facilities.

C. Changes in Fees

1. The patient is to be informed that the fee clerk should be notified of any change which may later occur in income, employment, or family composition which might result in a change in the adjusted fee. The fee clerk shall also conduct a periodic check (no less frequently than annually) with each patient to determine any change in factors including cost changes which would cause change in the fee and adjusted fee. The staff member assigned to the case is also responsible for notifying the fee clerk of such changes as they occur. The fee clerk is authorized to adjust the fee appropriately in accordance with the fee adjustment schedule. The facility administrator is ultimately responsible for assuring that adjusted fees are current and correct.

2. No fees may be waived or reduced beyond the fee adjustment scale without the express approval of the facility administrator who must document the reason for change in the patient chart. When waiver or reduction is made, the administrator must sign and date such authorization in the case record and in addition must note and initial the adjusted fee on the ledger card.

3. Examples of acceptable justifications for waiving or reducing a fee include:

a. excessive expense due to other medical costs;

b. family hardship resulting in unusual and unexpected expenses; or

c. more than 20 chargeable services are required by the family unit during any month.

D. Medication

1. All Medicaid patients are to be provided their medication. Any patient whose adjusted fee is 15 percent or less of the full cost may also be considered eligible to receive medication from the center or clinic. The facility administrator may authorize provision of medication for other patients on presentation of evidence that cost of medication ordered by center physicians will present a serious hardship and exceed 3 percent of family's gross income. Documentation of such exceptions and their justification shall be made in the patient's chart and signed by the administrator. This should be reviewed in 90 days or whenever the amount of medication prescribed is reduced appreciably. It will be the responsibility of the physician and nurse reviewing medication orders to so notify the administrator.

E. Failure to Pay Fees

1. No person shall be denied service because of ability or inability to pay. However, when a patient becomes delinquent in his account, the delinquency shall be handled in accordance with DHHR policy on collections. Whenever possible, center or clinic staff shall make an effort to negotiate a plan of payment prior to referring the account to the Bureau of Central Collections. Any negotiated plan of payment shall be approved by the center or clinic administrator and OMH fiscal office.

F. Definitions

Dependent—as used herein, means all persons dependent on the household income as accepted by the Internal Revenue Service (IRS) for federal income tax purpose. In the case of a minor not claimed as a dependent for income tax purposes, the parents are still responsible for a contribution based on the fee schedule but may increase the dependent deductions by the client(s) in question.

Family—for purposes of establishing fees under the procedures, the basic family unit is defined as consisting of one or more adults and children, if any, related by blood, marriage or adoption, and residing in the same household. Where related adults, other than spouses, or unrelated adults reside together, each will be considered a separate family, unless they are included as part of the family unit for federal income tax reporting purposes. Children living with non-legally responsible relative, emancipated minors, and

children living under the care of unrelated persons will be considered a member of the family. Minors seen without the consent and knowledge of parents or legal guardians will be considered as separate family units and will be charged according to the minor's own income whether the source is allowance or earnings.

Gross Income—the monthly sum of income received from sources identified by the U. S. Census Bureau in computing the median income and defined in the *Code of Federal Regulations*, Volume 45, Section 228.66.

Responsible Persons—as used herein, the client's parents or guardians if the client is under the age of 18, unless someone else claims the client as a dependent for federal income tax purposes, in which case it is that person. If the client is over 18, he is responsible for his contribution based on his gross family income and allowed deductions, unless he is claimed as a dependent for income tax purposes, in which case the claimant becomes responsible for the fee toward the cost of care based on the claimant's family income.

G. General Regulations

1. Documentation of Income. This shall include federal and state income tax reports, Medicaid eligibility records, W-2 forms and employers' statements.

2. Failure to Provide Information. A person responsible for the payment of charges for services rendered who refuses to supply the information necessary for an accurate determination of the required rate of charges for services rendered shall be presumed to be able to pay the full cost of services rendered and shall be billed accordingly. Any person who is potentially eligible for medical assistance benefits from any federal or state program who refuses to apply for and follow through with application for said benefits shall be presumed to be able to pay the full cost of services rendered and shall be billed accordingly.

3. Insurance. An insurance company that the responsible party alleges has issued a policy or contract covering the charges for treatment and services rendered shall be billed the full cost of services rendered. Billings shall be made directly to the insured by the treating facility after securing execution of the forms necessary, including an assignment of benefits to the treatment facility, by the responsible person. The responsible party shall be billed in accordance with the applicable fee schedule up to the amount of charges not covered and paid by insurance. If the responsible person refuses to execute the forms necessary to assign the benefits under the policy alleged by him to cover the charges for treatment and services rendered and the forms necessary to file an insurance claim in accordance with the policy, that responsible party shall be presumed to be able to pay at the full cost of services rendered and shall be billed accordingly.

4. Collections. If the payment agreement is not kept, 15 days after the due date, a notice is to be mailed reminding the responsible party that payment was not received when due. If results have not been received within 15 days after the first notice was mailed, a second notice is to be sent. If results have not been received within 15 days after the second notice was mailed, a third notice is to be mailed advising the patient that his account will be referred to Central Collections for collection if payment is not received within 15 days. If payment has not been received 15 days after the third notice was mailed, the account is to be referred to Central Collections for collection. At the time account is referred to Central Collections, the following documents and information should be sent:

a. all demographic information accumulated (intake interview sheet);

b. copy of signed agreement;

c. copy of itemized bill;

d. copy of patient's ledger.

5. Only accounts in excess of $25 will be referred to Central Collections for handling. The admitting facility will make every effort to collect the $25 or less accounts. Only the director of a facility or his designee may charge off an account in the amount of $25 or less. If the account is in excess of $25, the request for charge off must be submitted through the Central Collections Section for approval by the Office of Management and Finance. Any request for adjustments in fees which deviate from the uniform fee schedule must be submitted to the undersecretary or his designee for review and decision. All collections received by agency, or institution after assignment of account to Central Collections will be deposited directly to the State Treasurer's Office through the regional bank and a list of all payments, giving patient name and amount paid, will be mailed to Central Collections on a weekly basis. Accounts will be referred to Central Collections when an insurance company refuses to pay a bill for any reason which is not clearly valid. Upon receipt of an account, Central Collections will send a series of collection letters and make telephone contacts with individuals regarding payments. If account is not brought current within 60 days or a satisfactory payment schedule arranged, the account will be assigned to an attorney for collection or charged off as a bad debt if total outstanding balance is less than $100.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:144.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Health, LR 13:246 (April 1987).

§307. Confidentiality

A. The Office of Mental Health, in order to protect, to the fullest extent possible, the privacy of individuals, while permitting the disclosure of medical information as is required to fulfill the administrative responsibilities of the Office of Mental Health and to assist the patient, strictly adheres to the rules of the Department of Health and Human Resources in this matter except in those instances when mental health treatment facilities are governed by federal regulations which provide stricter standards of confidentiality. In those instances, these rules shall be

deemed superseded by the federal regulations to the extent that they are in conflict with the federal regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 44:7.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Health, LR 13:247 (April 1987).

§309. Patient and Consumer Complaint Policy and Procedures

A. Policy Statement. It is the policy of the Office of Mental Health to promote and protect the rights of patients consistent with a concern for human dignity, respect, and quality care; to respond promptly and effectively to consumer concerns, inquiries, and complaints; and to promote and evaluate consumer satisfaction with services provided.

B. Definitions

Agency—Office of Mental Health.

Assistant Secretary—the Assistant Secretary of the Office of Mental Health.

Chief Executive Officer—the manager of an inpatient facility.

Complaint—verbal or written expression of concern or statement challenging patient care, behavior, action or inaction on the part of the facility staff and/or facility, an allegation of a rights violation, or an expression of dissatisfaction with services which requires further action. This may include dissatisfaction with departmental or agency policy.

Complainant—an individual who expresses dissatisfaction.

Consumer—patient; parent, friend, relative, or guardian of a patient; advocacy group; or other interested citizen and/or agency.

Facility—any inpatient or outpatient structure under the management or through contract with the Office of Mental Health.

Designee—an individual who has been designated the responsibility to resolve patient and consumer complaints by the chief executive officer or facility manager who reports directly to the chief executive officer or facility manager.

Facility Administrator—chief executive officer, facility manager, or executive administrator, as applicable.

Mental Health Advocate—an attorney from the Office of the Governor, Mental Health Advocacy Service, who is either housed or rotates to a facility.

Regional Office—the administrative unit that has the responsibility for managing the service delivery system with an assigned geographic area consistent with agency policies.

State Office—the executive office of the agency where the assistant secretary and his staff is located.

C. Process of Resolution

1. The employee who is initially made aware of a complaint should attempt a resolution and advise supervisor of action.

2. The facility administrator or his designee shall discuss the nature of the concern with the complainant. If it is determined that the complaint requires further formal action, a complaint form (see Appendix B) will be completed which describes the situation in detail. The form shall be signed by both the complainant and the facility administrator.

3. The facility administrator or his designee will take whatever action is appropriate: investigative; corrective; or educational.

4. The complainant will be requested to acknowledge in writing his/her satisfaction or dissatisfaction with the resolution.

5. If the complainant is satisfied, the record will be closed and filed at the facility for future reference. All records shall be confidential.

6. If a resolution is not reached at the facility level, a copy of all compiled information shall be forwarded to the regional manager who will address the problem by repeating Steps 2 through 5. (Inpatient facilities will proceed to Step 7.)

7. If, at this point, there is no resolution, all information shall be forwarded to the assistant secretary of the Office of Mental Health.

D. Reporting Mechanisms and Documentation. Reporting and documentation requires time and attention, but it is necessary to ensure accountability for promoting the rights of patients. Each facility is to establish documentation and reporting mechanisms which provide for:

1. Inquiry/Complaint Logging (see Appendix B). Every contact with a complainant or client which will require formal action shall be recorded on a log. Administrator/designee shall complete the date and name of the person contacted. A check mark is to be used to indicate if the contact represents a complaint or inquiry. The administrator/designee shall summarize in a few words the nature of the complaint or inquiry. If a complaint has been made, the administrator/designee records the complaint record number (CR#) after the complaint record form is completed.

2. Complaint Record Form (see Appendix C). A complaint record form shall be completed for all complaints requiring formal action. If a number of clients complain about the same condition or situation, only one form needs to be completed, but the number of clients affected shall be noted under "nature of the complaint." A number is assigned to the form, and these forms are filed by month.

3. Progress Report Form (See Appendix D). A progress report form shall be completed on every complaint

which represents a major risk to a patient or which remains unsolved after 30 days. Additional progress reports are to be completed every 30 days after the initial report until the final progress report which reflects resolution of the complaint. Progress reports should be attached to the appropriate complaint record and filed accordingly.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:171.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Health, LR 13:246 (April 1987).

§311. Restraint and Seclusion

It is the policy of the Office of Mental Health (OMH) that restraint and seclusion shall only be used to prevent a patient from injuring self or others, or to prevent serious disruption of the therapeutic environment. These may not be used as punishment, discipline or convenience to staff.

A. Process

1. Restraint or seclusion shall only be used when verbal intervention or less restrictive measures fail. Use of restraint or seclusion shall require documentation in the patient's record of the clinical justification for such use as well as the inadequacy of the less restrictive intervention techniques.

2. A written order from a physician is required for any use of restraint or seclusion.

3. In a non-emergency situation, the physician shall conduct a clinical assessment of the patient before writing the order for use of restraint or seclusion.

4. In an emergency, nursing personnel who have been trained in management of disturbed behavior may utilize restraint or seclusion. Nursing personnel shall then immediately notify the nursing supervisor who will observe and assess the patient. The nursing supervisor will then notify the physician and obtain an order. The physician will, as soon as possible, and, in no instance more than one hour after initiation, conduct a clinical assessment of the patient and give a written order.

5. Written orders for the use of restraint or seclusion shall be time limited and preferably not more than four hours in duration. In no instance shall it exceed 12 hours without a new order. If restraint or seclusion is utilized for longer than 24 hours, written approval of the head of the professional staff shall be required.

6. Staff who implement written orders for restraint or seclusion shall have documented training in the proper use of the procedure for which the order was written.

7. The registered nurse shall assign a responsible person for continuous monitoring and care of the patient. A patient in restraint or seclusion shall be evaluated every 15 minutes, especially in regard to regular meals, bathing, and use of the toilet, and appropriate documentation shall be entered in the patient's record. Blood pressure, pulse, and respiration shall be taken and recorded at least once per shift. If the responsible person is unable to obtain said vital signs, the reason(s) shall be documented.

8. Patients are to be taken out of restraint or seclusion as soon as it is determined that the reasons for this no longer exists, i.e., patient is in control and no longer dangerous to self or others or severely disruptive to the therapeutic environment.

9. PRN (as needed) orders shall not be used to authorize the use of restraint or seclusion. Locked door seclusion is not to be used with any Gary W. clients. All uses of restraint or seclusion (summarizing types used, duration, and reasons) shall be reported daily to the head of the professional staff who shall review and investigate any unusual or possibly unwarranted patterns of utilization. A copy of this report shall also be sent to the superintendent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:171.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Health, LR 13:246 (April 1987).

Chapter 9. Client Services

§901. Problem Gambler Telephone Information Service

A. The Office of Mental Health of the Department of Health and Hospitals shall provide a 24-hour, toll-free telephone information and referral service for persons with compulsive or problem gambling behavior. The Office of Mental Health shall make information available to the public regarding the program and services by providing signs to the Louisiana Lottery Corporation. The corporation shall require posting of these signs at lottery retail outlets, where gambling or gaming activities are conducted, at horse racing tracks and at charitable bingo parlors.

B. The format of the sign thus provided shall read:

If gambling is causing problems in your daily life, or, if you think you may have a problem controlling your gambling, you may need help. Call this 24-hour, toll-free number to find out about services available in your area.

1-800- -

Pursuant to R.S. 36:258(C)

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Assistant Secretary

Office of Mental Health

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:841 and R.S. 36:258(C).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Mental Health, LR 21:468 (May 1995).

Title 48
PUBLIC HEALTH—GENERAL
Part V. Preventive Health Services
Subpart 1. General Provisions

Chapter 1. General Provisions

§101. Refusal of Treatment for Minors

A. A minor (a person under 18 years of age) who has sought treatment on his or her own at an OPPHS clinic to refuse treatment and release OPPHS from responsibility when the minor desires to decline the recommended treatment and such treatment is not otherwise required by law. This is consistent with (1) the provisions of R.S. 40:1299.53(e) and 40:1299.56 allowing an adult or any pregnant female to refuse treatment for himself or herself; (2) R. S. 40:1095 allowing minors to consent to treatment on their own behalf, which permits, but does not require, a treating physician to inform the spouse, parent or tutor of the minor as to the treatment given or needed; and (3) the requirement for confidentiality of information about individuals receiving family planning services as contained in the Federal Register Vol. 45, No. 108, Rules and Regulations, 59.11.

B. Further, OPPHS will allow the use of a form in its public health facilities which documents the refusal of treatment and release of OPPHS from responsibility. The forms entitled "Refusal of Treatment and Release from Responsibility" will be used .

C. Nothing in this rule shall be construed to mean that a person of any age may refuse treatment for venereal disease, for which treatment is required by law, viz: Louisiana Revised Statutes 40:1064, or may refuse to comply with requirements concerning the control of diseases specified in the State Sanitary Code, Chapter II.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.53, R.S. 40:1299.56, R.S. 40:1095, FR Vol.45, No. 108, Rules and Regulations 59.11.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§103. Declaratory Orders and Rulings

A. The Office of Preventive and Public Health Services (OPPHS) shall entertain petitions for declaratory orders and rulings as to the applicability of any statutory provision, the enforcement of which is under the jurisdiction of this agency, or any rule or order of this agency, as required by R.S. 49:962.

B. The jurisdiction of OPPHS is defined by R.S. 36:258, R.S. 40:4, and R.S. 40:5.

C. Any person desiring a declaratory ruling or order of the kind set forth above shall forward his or her petition to the assistant secretary, Office of Preventive and Public Health Services, Box 60630, New Orleans, La. 70160.

D. The petition shall be legibly typed on white paper and shall be worded in a clear and concise manner. The petition shall set forth with specificity and particularity the factual situation giving rise to the inquiry and the statutes or rules of which interpretation is sought. The petition shall be signed by the petitioner or by an attorney at law acting on his or her behalf. The petition shall include the mailing address of the petitioner as well as that of his or her attorney, if any.

E. Upon receipt of a petition which is not in proper form, the assistant secretary shall promptly return the petition to the petitioner, who may resubmit it in proper form.

F. Upon receipt of a petition that is in proper form, the assistant secretary shall forward same to the OPPHS program administrator most closely connected with the subject matter of the request. The administrator shall prepare and sign a declaratory ruling or order and submit same to the assistant secretary. The assistant secretary shall promptly approve or disapprove the declaratory ruling or order. If approved, he or she shall immediately forward it to the secretary and state health officer for his, her or their approval and signing as provided in R.S. 40:2. If disapproved, it shall be returned to the program administrator for reconsideration.

G. When approved by the secretary and state health officer, the declaratory ruling or order shall be returned to the assistant secretary who shall cause it to be sent to the petitioner by certified mail, return receipt requested, and by regular mail. In no event shall more than 90 days elapse between the time a petition in proper form is received by the assistant secretary and the time the declaratory ruling or order is mailed to the petitioner.

H. If the petitioner is dissatisfied with the declaratory ruling or order, he or she may petition for reconsideration. A reconsideration may be granted if, in the assistant secretary's opinion, there is good cause. If the petitioner is still dissatisfied following reconsideration or following a denial of reconsideration, he or she may seek judicial review as provided in R.S. 49:962-964.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:258, R.S. 40:2-5, and R.S. 49:962-964.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subpart 3. Dental Services

Chapter 5. General Provisions

§501. Definitions

A. Family. A family is a group of two or more persons related by birth, marriage, or adoption who reside together; all such related persons are considered as members of one family, (If a household includes more than one family and/or more than one unrelated individual, the guidelines are applied separately to each family and or unrelated individual and not to the household as a whole.)

B. Family Unit of Size One. In conjunction with the income guidelines, a family unit of size one is an unrelated individual (as defined by the Census Bureau) i.e., a person 15 years old or over (other than an inmate of an institution) who is not living with any relatives. An unrelated individual may be the sole occupant of a housing unit (or in group quarters such as a roominghouse) in which one or more persons also reside who are not related to the individual) in question by birth, marriage, or adoption. (Examples of unrelated individuals residing with others include a lodger, a foster child, a ward, or an employee.)

C. Income

1. Refers to total annual cash receipts before taxes from all sources. (Income data for a part of a year may be annualized in order to determine eligibility.) Income includes money wages and salaries before any deductions, but does not include food or rent in lieu of wages. Income also includes net receipts from nonfarm or farm self-employment (receipts from a person's own business or farm after deductions for business or farm expenses.) Income includes regular payments from social security, railroad retirement, unemployment compensation, workers' compensation, strike benefits from union funds, veterans' benefits, public assistance (including Aid to Families with Dependent Children, Supplemental Security Income, and General Assistance money payments), training stipends, alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, and regular insurance or annuity payments; and income from dividends, interest, rent, royalties, or periodic receipts from estates or trusts.

2. For eligibility purposes, income does not include the following money receipts: capital gains; assets drawn down as withdrawals from a bank, the sale of property, a house, or a car; tax refunds, gifts, lump-sum inheritances, one-time insurance payments, or compensation for injury. Also included are noncash benefits, such as the employer-paid or union- paid portion of health insurance or other employee fringe benefits, food or rent received in lieu of wages, the value of rent from owner-occupied nonfarm or farm housing, and such federal programs as Medicaid, food stamps, or public housing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§503. Income Guidelines for Dental Program Eligibility

A. The annual family income listed in the right hand column is the maximum allowable for the family size number listed in the opposite left hand column.

Family Size	Annual Family Income
1	$ 6,825
2	9,165
3	11,505
4	13,065
5	16.185
6	18,525
7	20,865
8	23,205

B. For family units of more than eight members add $1,800 to annual income for each additional member.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public and Public Health Services, LR 13:246 (April 1987).

Chapter 7. Dental Clinics

§701. Primary Dental Care Clinics II

A. Name and Location

1. Caddo Parish Health Unit Dental Clinic, 2327 David Raines Road, Shreveport, Louisiana 71107.

2. Dental Trailer No. 1, State Planning District No. 5, which includes the following parishes: Allen, Beauregard, Calcasieu, Cameron and Jefferson Davis. The dental trailer is rotated to the various parish health units within the district.

3. Dental Trailer No. 2 State Planning District No. 3, which includes the following parishes: Assumption, Lafourche, St. Charles, St. James and Terrebonne. The dental trailer is rotated to the various health units within the district.

4. Jefferson Parish Health Unit Dental Clinic (east-bank), 111 North Causeway Boulevard, Metairie, Louisiana 70001.

5. Jefferson Parish Dental Clinic (west-bank), 1901 Eighth Street, Harvey, Louisiana 70058.

6. Rapides Parish Dental Clinic, 1200 Texas Avenue, Alexandria, Louisiana.

B. Objectives, Scope of Services and Fees Charged

1. The objectives of this program are to effectively coordinate and administer dental care offered to children of low income families, to improve the quality and increase the quantity of the services and to raise the dental awareness in the community.

2. Treatment, corrections and other activities offered include:

a. complete examination and diagnosis, including radiographs;

b. elimination of pain and infection;

c. preventive services including prophylaxis, topical fluoride treatment and oral hygiene instruction;

d. restoration of carious or fractured teeth and treatment of injuries to soft tissues;

e. elimination of disease of bone and soft tissues;

f. maintenance or recovery of space when this service will have an effect on occlusion;

g. treatment of injuries; and

h. emergency treatment.

3. No charges will be made for dental care at the clinics, except to the extent that payments will be made by a third party (including a government agency) which is authorized or under legal obligation to pay such charges.

C. Eligibility

1. Any family residing in Louisiana which is eligible and which requests dental services for its children may receive services at any of the clinic sites. (see appendix for income guidelines). Children who are presently enrolled in the state's Handicapped Children's Program or the state's EPSDT Program are also eligible. Parents or guardians must present evidence demonstrating the child's eligibility in these programs.

2. Persons 18 years of age or under are eligible.

3. All age-eligible patients, regardless of income, will be afforded screening and emergency services from the clinics.

4. Services will be made available without the imposition of any duration-of-residence requirement.

5. Other siblings in a family with a handicapped child are eligible if the family qualifies under the income guidelines.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§703. Special Dental Clinic: Handicapped Children's Dental Clinic

200 Henry Clay Avenue
New Orleans, LA70118

A. Objectives, Scope of Activities and Charges

1. The objectives of this program are to effectively coordinate and administer dental care offered to children in the state's Handicapped Children's Program and to improve the quality and increase the quantity of the services.

2. Comprehensive dental care is provided.

3. Oral surgery, hospitalization and operating room services are provided by the Handicapped Children's Program.

4. No charges will be made for dental care at the Handicapped Children's Dental Clinic except to the extent that payments will be made by a third party (including a government agency) which is authorized or under legal obligation to pay such charges.

B. Eligibility

1. Children registered in the state's Handicapped Children's Program are eligible.

2. Persons must be 20 years of age or under to be eligible.

3. Persons with a handicapping condition are eligible to receive diagnostic and emergency dental services.

4. A waiver of guidelines may be granted by the chief, Dental Health Section, to handicapped children of low income families (see appendix) who are not otherwise eligible for the Handicapped Children's Program because they suffer from a handicapping condition which is not treated by the program.

5. Other siblings in a family with a child on the Handicapped Children's Program are not eligible for this clinic.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subpart 5. Fluoridation

Chapter 11. General Provisions

§1101. Definitions

A. Words not defined in this Subpart shall have their common usage and meaning as stated in the *Merriam-Webster's Collegiate Dictionary-Tenth Edition* and other similarly accepted reference texts.

B. Unless otherwise specifically provided herein, the following words and terms are defined as follows.

Caries—tooth decay, also commonly known as cavities.

Community Water Fluoridation—the adjustment of fluoride deficient water in community water supplies to the optimal fluoride level/range for a specified geographic area.

Community Water Supply—a public water system which serves at least 15 service connections used by year-round residents or regularly serves at least 25 year-round residents.

Fluoride Deficient Water—any water supply system which provides potable water having a natural fluoride content below the optimal fluoride level/range for a specified geographic area.

Fluoride Source Material—the approved fluoride-containing product which is to be used to adjust the potable water supply to the optimal fluoride level/range.

Ground Water—subsurface water occupying the saturation zone from which wells and springs are fed. In a strict sense the term applies only to water below the water table.

Monitoring—the analysis and recording of the fluoride ion content of water in a community water supply on a regular basis.

Optimal Fluoride Level Range—that level of fluoride which has been deemed to be most beneficial to health as set forth by the Centers for Disease Control and Prevention (CDC) for community water supplies. For community water supplies in the state of Louisiana, the optimal fluoride level is 0.8 mg/L; however, the acceptable range is from 0.7 to 1.2 mg/L.

Permit—a written document issued by the state health officer through the Office of Public Health which authorizes construction and operation of a new potable water supply or a modification of any existing supply.

Person—any natural person, individual, partnership, corporation, association, governmental subdivision, receiver, tutor, curator, executor, administrator, fiduciary, or representative of another person, or public or private organization of any character.

Potable Water—water having bacteriological, physical, radiological, and chemical qualities that make it safe and suitable for human drinking, cooking and washing uses.

Potable Water Supply—a source of potable water, and the appurtenances that make it available for use.

Public Water Supply—public water system.

Public Water System—a system for the provision to the public of water for potable water purposes through pipes or other constructed conveyances, if such system has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year. Such term includes:

a. any collection, treatment, storage, and distribution facilities under the control of the operator of such system and used primarily in connection with such system; and

b. any collection or pretreatment storage facilities not under such control which are used primarily in connection with such system.

Sample Points—locations in a community water supply's distribution system where water samples are taken for fluoride analysis. These sample points of finished water shall be taken at the consumer's taps throughout the distribution system where the water will be representative of the whole community water system.

Service Connection—the pipe from the water main and/or water meter, potable water supply system or other source of potable water supply to the building or structure served.

Source Water—any water well, spring, cistern, infiltration gallery, stream, reservoir, pond, or lake from which, by any means, water is taken either temporarily or continuously for potable use.

Sub-Optimal Fluoride Level—any adjusted fluoride level that is below the optimal fluoride level/range for a specific geographic area.

Surface Water—derived from water sources on the surface of the earth such as streams, ponds, lakes, or reservoirs.

Surveillance—the necessary steps to assure that the fluoride content in water over a period of time is in compliance with the optimal fluoride level/range in a community water supply for a specific geographic area.

Water Supplier—a person who owns or operates a water supply system including, but not limited to, a person who owns or operates a public water system.

Water Supply System—the system of pipes or other constructed conveyances, structures and facilities through which water is obtained, treated to make it potable (if necessary) and then distributed (with or without charge) for human drinking, cooking, washing or other use.

Water Well (Well)—an artificial excavation that derives water from the interstices of the rocks or soil which it penetrates.

AUTHORITY NOTE: Promulgated in accordance with P.L. 97-35, Section 901; 45 CFR Parts 16, 74, and 96; 42 USC 2476; and R.S. 40:5.11(G).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 36:68 (January 2010).

Chapter 13. Statewide Fluoridation Program

§1303. Background and Purpose

A. The fluoridation of community water supplies is the most effective mechanism for preventing dental caries. It is the only means whereby people of all ages in an area can be reached from birth and at a low cost. This has added significance for the many people who are dentally indigent.

B. The benefits of community fluoridation in maintaining dental health are substantial.

1. Persons drinking water which contains fluoride within the optimal fluoride level/range have teeth which are more caries resistant.

2. The caries rate among children drinking water which contains fluoride within the optimal fluoride level/range can be as much as two-thirds less than among children drinking fluoride deficient water.

3. By the time that children reach their teens, about six times as many residing in communities which have their community water supply meet the optimal fluoride level/range are completely free of caries as their counterparts in fluoride deficient areas.

4. When the optimal fluoride level/range in a community water system is maintained, extractions of permanent teeth caused by premature loss of primary teeth can be prevented. In addition, crooked and overlapping permanent teeth caused by premature loss of primary teeth can be prevented.

5. Adults consuming water which contains fluoride within the optimal fluoride level/range throughout life can expect fewer tooth extractions due to caries and are less likely to become edentulous (lose all their natural teeth) in later years.

C. Community fluoridation of drinking water produces economies in children's dental care in terms of both cost and treatment time. The cost benefit ratio has been estimated to be 1:38. Children receiving the benefits of fluoridation in their drinking water require fewer dental treatment services and the treatment that is required is less complex and, therefore, less costly and less time consuming to provide. The costs of children's dental care in fluoridated areas can be less than one-half the cost in fluoride deficient areas.

AUTHORITY NOTE: Promulgated in accordance with 45 CFR Parts 16, 76 and 96; P.L. 97-35, Section 901; 42 USC 2476, and R.S. 40:5.11(G).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 36:70 (January 2010).

§1305. Requirements for Fluoridation of a Public Water System

A. LAC 51:XII.105 of the Louisiana State Sanitary Code requires approval by the state health officer or his/her duly authorized representative for certain types of changes made in the treatment of water offered the public. The addition of the fluoride ion to water is covered by that regulation.

B. For any public water system desiring to fluoridate its water, a formal request shall be made to the state health officer for approval to install the necessary fluoridation equipment.

C. In accord with R.S. 40:5.11(B), each community water supply having at least 5,000 service connections and natural fluoride levels that are outside the optimal fluoride level/range as defined in §1101.B of this Subpart shall acquire, install, operate, and maintain a fluoridation system in order to maintain the optimal fluoride level/range in the water being produced and distributed.

NOTE: Exemptions. Any community water supply to which Subsection C of this Section applies shall be exempt from the requirements of Subsection C of this Section when either of the following is applicable.

1. The Department of Health and Hospitals (DHH) is unable to identify a source of sufficient funds available to the community water supply to cover the capital costs, any associated costs to cover the installation, and the funds necessary to cover the cost of purchasing sufficient fluoride source material required to properly fluoridate the system for a period of six months from the date of initial installation and operation; or,

2. A community water supply has never used fluoridation to adjust fluoride levels in its water and its finished water contains fluoride in amounts outside of the optimal fluoride level/range as defined in §1101.B of this Subpart, and a local election on such exemption has been called and held in accordance with R.S. 40:5.11(B), and a majority of the registered voters who cast a vote in said election approve such exemption.

D. Any community water system with less that 5,000 service connections that submits a formal request per Subsection B of this Section must enclose with that request a copy of the ordinance or resolution directing the fluoridation of the water system duly passed by the appropriate governing body.

AUTHORITY NOTE: Promulgated in accordance with 45 CFR, Parts 16, 74, and 96; P.L. 97-35; 42 USC 2476; and R.S. 40:5.11(G).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987) , amended by the Department of Health and Hospitals, Office of Public Health, LR 36:70 (January 2010).

§1307. System Requirements

A. Detailed plans and specifications for which a fluoridation permit is requested shall be submitted in duplicate, to the Department of Health and Hospitals – Office of Public Health's (DHH-OPH) District engineer and the DHH-OPH's fluoridation engineer by the responsible person of the water supply system. Such plans and specifications shall be submitted prior to construction.

B. The following provides minimum requirements as well as additional information to assist in the application for a fluoridation permit and in the preparation of plans and specifications. The review and approval of plans and specifications submitted for the issuance of a permit, shall be made in accordance with the "Recommended Standards for Water Works, 2003 Edition" (aka the "Ten State Standards") plus any additional requirements as set forth in this Subpart. Additional fluoride-related documents which may be used by a community water system as guidance/information purposes may be found in the CDC's Morbidity and Mortality Weekly Report (MMWR) titled "Engineering and Administrative Recommendations for Water Fluoridation, 1995", as amended, and in the American Water Works Association (AWWA) "Water Fluoridation Principles and Practices M4, Fifth Edition", as amended.

1. Three general types of fluoride compounds are approved for fluoridation of water supplies; namely, sodium fluoride, sodium fluorosilicate and fluorosilicic acid. Each

has certain advantages and disadvantages, and the type chosen will depend on the characteristics of the water to be treated and the capacity of the supply.

2. The fluoride source material to be used must conform to NSF International/American National Standards Institute (NSF/ANSI) Standard 60-2009 and the applicable AWWA specification, as follows:

a. for sodium fluoride, AWWA Standard B701-99;

b. for sodium fluorosilicate, AWWA Standard B702-99; or

c. for fluorosilicic acid, AWWA Standard B703-00.

3. The fluoridation system shall only operate when a flow of water is detected. If the water supply system serves less than two hundred service connections, a secondary flow-based control device shall be provided as back-up protection.

4. A means of measuring the total amount of water treated daily and the amount of chemical injected within the same time period must be provided. These measurements must be accurate to within 5.0 percent.

5. Fluorosilicic acid shall be stored in the original containers or containers provided for the specific purpose, apart from the other chemicals used in the water treatment process. Bulk storage tanks shall be in secondary containment per LAC 33:IX.Chapter 9.

6. When bulk storage of fluorosilicic acid is provided, a day tank shall be provided. The day tank shall hold no more than a 30 hour supply, as calculated at maximum feed rate. The day tank should be scale mounted, preferably under shelter. If scales are not used, level indication can be used for the calculation of the amount of chemical used provided it is accurate within five percent. Filling of day tanks shall not be automated.

7. A diaphragm-type anti-siphon device shall be installed in the fluoride feed line when a metering pump is used and shall be located at the fluoride injection point. A second diaphragm-type anti-siphon device should be installed immediately downstream of the metering pump's discharge head. These anti-siphon devices shall have a diaphragm that is spring-loaded in the closed position.

8. The following safety equipment shall be required for operators handling the following fluoride compounds:

a. fluorosilicic acid: gauntlet neoprene gloves, a minimum of 12 inches long with cuffs; full face shield and splash-proof safety goggles; and a heavy-duty, acid-proof neoprene apron;

b. sodium fluoride or sodium fluorosilicate: the same safety equipment required under Subparagraph 8.a. of this Subsection for fluorosilicic acid with the exception that the full face shield shall be replaced by a National Institute for Occupational Safety and Health/Mine Safety and Health Administration (NIOSH/MSHA) approved, N-series respirator;

c. for dry chemical systems, an eye wash station should be available and easily accessible; and

d. for acid systems, an eye wash station shall be available along with a safety shower and both shall be easily accessible and connected to an approved potable water supply.

AUTHORITY NOTE: Promulgated in accordance with 45 CFR, Parts 16, 74 and 96; P.L. 97-35, Section 901; 42 USC 2476; and R.S. 40:5.11(G).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 36:70 (January 2010).

§1309. Monitoring and Compliance—Optimum Fluoride Levels

A. If a water supply system has a single fluoridation system which treats all the water distributed to system consumers, the supplier shall collect a daily water sample for fluoride analysis either in the distribution system or at the entry point. If a water supply system does not fluoridate all its water and/or has more than one fluoridation system, the supplier shall collect a minimum of one water sample daily in the distribution system and shall rotate the sample site daily in order to obtain representative results of the level of fluoride in the water provided throughout the distribution system. If the water supply system is such that a single daily sample taken in different locations cannot provide a representative level, then multiple samples may be required. The number, location, and frequency of samples shall be in accordance with a monitoring plan developed by the water supply system and approved by the DHH-OPH.

1. If more than 20 percent of the daily fluoride samples collected in a month by a water supply system fall outside the optimal fluoride level/range, the system shall be out of compliance with the optimal fluoride level/range.

2. At least once a month, any water supplier with an operating fluoridation system shall divide one sample and have one portion analyzed for fluoride in a "DHH-OPH Approved Chemical Laboratory/ Drinking Water" lab (normally, on-site of the water treatment plant—see LAC 51:XII.Chapter 15) and the other portion analyzed for fluoride in a "DHH-OPH Certified Laboratory for Drinking Water Analyses—Chemistry". (A list of such "DHH-OPH Certified Laboratory for Drinking Water Analyses—Chemistry" may be found on the DHH-OPH website at the following url address: "http://www.dhh.louisiana. gov/offices/?ID=204".)

3. Any water supply system with an operating fluoridation system shall sample the raw source water(s) annually and analyze for fluoride.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5.11(G).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 36:71 (January 2010).

§1311. Recordkeeping and Reporting

A. By the tenth day of each month following the month being reported, each water supplier fluoridating its potable water supply shall send operational reports to the DHH-OPH's District Engineer and the DHH-OPH fluoridation engineer which shall include the following:

1. The fluoride source material used and the calculated fluoride dose in mg/L based on the latest annual raw source water(s) fluoride level.

2. Information on any interruptions in the fluoridation treatment which may have occurred during the month including the duration of the interruptions, an explanation of the cause(s), and what corrective actions were taken to insure that fluoridation treatment was resumed in a timely manner;

3. The results of the daily monitoring for fluoride in the water distribution system reported in terms of daily result, ranges, and the number of samples collected; and,

4. The results of monthly split sample(s) analyzed per §1309.A.2 of this Chapter.

B. If a fluoride overfeed exceeding 10.0 mg/L occurs, the water supply system shall notify the DHH-OPH by the end of the business day of the occurrence or, if the overfeed occurs on a weekend, state holiday, or other times of state office closure, the water supply system shall notify the DHH-OPH via e-mail communication to: safe.water@la.gov.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5.11(G).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 36:71 (January 2010).

§1313. Funds Allocation

A. DHH-OPH shall prioritize water supply systems with 5,000 or more service connections that are not fluoridating to optimum fluoride levels for the receipt of funds as they become available. Priority will be based on cost effectiveness as well the level of funds available. The priority list will be periodically reviewed.

B. DHH-OPH shall also consider requests for funds from water supply systems with less than 5,000 service connections. Fund allocation will be based on cost effectiveness.

C. Within 90 days of written notification from DHH-OPH to the community water system of the availability of funds, the community water system shall submit an estimate of the cost to acquire and install the needed fluoridation equipment as well as an estimate of the cost of fluoride source material required to fluoridate the system for a period of six months from the date of initial installation and operation.

D. Upon acceptance of the submitted cost estimate by DHH-OPH, a written agreement between the State of Louisiana's DHH-OPH and the governing body of the community water system shall be executed for the commissioning, construction, and the first six months of fluoride source materials for the required fluoridation system. Transfer of funds shall be through reimbursement to the water supply system for paid invoices as they are submitted to the DHH-OPH.

E. All design, procurement, and construction shall be completed in a timely manner consistent with the reimbursement of funds by the DHH-OPH. Upon completion of construction and the receipt of the initial six months supply of fluoride source material, as well as the completion of appropriate operator training and certification, the water supply system shall promptly initiate water fluoridation and shall maintain the optimum fluoride level/range throughout its distribution system.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5.11(G).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 36:71 (January 2010).

§1315. Requirement for Continued Operation

A. Any public water system with over 5,000 service connections that has initiated fluoridation prior to, on, or after July 6, 2008 shall not discontinue fluoridation without the approval of a majority of the registered voters who cast a vote in a local election called and held in accordance with R.S. 40:5.11(B).

B. Any public water system with fewer than 5,000 service connections that has initiated fluoridation as directed by ordinance or resolution of the appropriate governing body shall not discontinue fluoridation without the approval of that governing body.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5.11(G).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 36:72 (January 2010).

Subpart 7. Maternal and Child Health Services

Chapter 17. Child Health Services

§1701. General Administration

A. Administration

1. Child health services are administered in accordance with the statutory requirements of the Social Security Act of 1935—Title V, Sections 501-516; P.L. 97-35, Title V, 42 U.S.C. 703, and R.S. 46:971-972.

2. Child Health Services in Louisiana are closely coordinated with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program administered by the Office of Family Security, Special Supplemental Food Program for Women, Infants, and Children (WIC), Handicapped Children's Services (HCS), Family Planning, and Dental Services programs administered by OPPHS. These services are also coordinated with other related federally and state-funded programs such as Developmental

Disabilities and Head Start to ensure non-duplication of effort and coordination, delivery of and access to these services. Child health services are intended to provide the best possible preventive health care in cooperation with other providers and to avoid duplication of services provided to the same patients by the private sector.

B. Eligibility. Any child from birth to age 21 residing in Louisiana is eligible for child health services.

C. Purpose. The goals of the Child Health Program are:

1. to promote and maintain the health of the children of Louisiana;

2. to reduce or participate in efforts to reduce health related mortality and morbidity of children in Louisiana; and

3. to provide direct and consultative preventive health care and referral services for infants, children, adolescents, and young adults.

D. Scope of Services

1. OPPHS child health services are provided in each parish statewide (except Plaquemines and Orleans parishes). OPPHS provides partial funding of child health services in Orleans parish through contractual agreement with the City of New Orleans, Department of Health. Services may vary according to the staff, equipment, facility and other resources available in each health unit.

2. The services are directed toward, but not limited to, children from low income families and those who may not have access to other sources of preventive health care such as private physicians or community health clinics. The primary focus of these preventive services is the newborn, infant and preschool age child. Age appropriate services are also provided to older children, adolescents and young adults. The services are primarily nursing services provided with appropriate medical backup and consultation.

E. Requests for Services. A parent or guardian may request preventive child health services for his child by contacting any OPPHS parish health unit. Requests for child health services may be made in person, by telephone, or by mail. Referral for such services are also received through various sources, including but not limited to, state supported hospitals, private physicians, the Office of Family Security, the Office of Human Development, and other state agencies.

AUTHORITY NOTE: Promulgated in accordance with Social Security Act of 1935- Title V, Section 501-516; P.L.97-35, Title V; 42 U.S.C. 703; R.S. 46:971-972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§1703. Description for Services

A. Child health clinics are scheduled in the parish health units on a regular basis utilizing an appointment system. Three follow-up contacts by telephone, mail and/or home visit are generally made on missed appointments. After three unsuccessful attempted contacts, the medical record on the patient is closed unless a serious medical problem exists which necessitates additional follow-up efforts by OPPHS.

B. Preventive health care for the well preschool age child generally follows a periodic schedule of the ideal minimum of services adopted from the Standards of Child Health Care, 3rd Edition, American Academy of Pediatrics, 1977. Services for the preschool age child are usually scheduled at ages 1 month, 2-3, 4-5, 6-7, 8-12, 13-15, 16-19, 23-25, 27-36 months, and 5-6 years. This schedule is also consistent with a continuing interagency contractual agreement with the Office of Family Security for services provided to EPSDT-eligible children and the WIC federal and state requirements.

2. Child health services for the preschool age child generally consist of a comprehensive assessment of the child's health status including:

a. medical history on the child and family;

b. unclothed physical inspection including listening to the chest;

c. height, weight determination, and head circumference measurement at specified age;

d. monitoring of physical and psycho-social development for physical handicaps and developmental delays;

e. dental screening;

f. screening for vision, hearing, speech, and language problems;

g. immunizations;

h. anticipatory guidance for parents and children;

i. nutritional counseling and health education;

j. screening and follow-up for anemia, lead poisoning and hypertension;

k. newborn screening for metabolic disorders including Phenylketonuria (PKU) and congenital hypothyroidism; and

1. screening for sickle cell disease on black children.

3. The same services are provided to all newborns, infants, and preschool age children with the exception of referrals for dental treatment which are primarily available to EPSDT-eligible children after their third birthday.

C. Services for EPSDT-eligible children five years or older are provided according to a continuing contractual agreement with the Office of Family Security for services to EPSDT-eligible children. These services are also provided to non EPSDT-eligible children. Services for children five years or older generally include:

a. physical, mental, and developmental history on the child;

b. unclothed physical inspection including listening to the chest;

c. height and weight determination;

d. laboratory tests and follow-up on anemia and sickle cell disease on black children (if not already screened);

e. laboratory tests for follow-up on sugar, blood or albumin in the urine;

f. laboratory tests (screening through age six only) and follow-up on lead poisoning when indicated;

g. anticipatory guidance and counseling of parents and school age children; and

h. nutritional status assessment and counseling.

2. General screening and preventive health services for this age group are provided every three years after age five. Rescreening and follow-up services are scheduled depending on risk factors, individual health needs and age at which the child entered into the program.

a. Child health services are primarily provided in nursing clinics. Children are periodically examined by a physician in medical clinics depending on need and the availability of physician services. The child health clinics are staffed by health care professionals including nurses, physicians, social workers, and nutritionists. Paraprofessional health care staff (aides, technicians) also provide services under professional supervision. All child health services described herein are subject to funding and clinic staffing limitations.

b. Home visits are made on a limited basis by nurses or medical social workers. These visits are made for necessary follow-up according to agency protocol and professional judgment.

3. OPPHS also provides health education to pregnant women and parents in Louisiana through its "Pierre the Pelican" pamphlets. A series of "Pierre" pamphlets covering the prenatal period and the period from birth through age six years is distributed to pregnant women upon request and all first time parents in Louisiana. Other parents may receive this pamphlet series by writing to "Pierre the Pelican", Maternal and Child Health, Office of Preventive and Public Health Services, Box 60630, New Orleans, Louisiana 70160.

AUTHORITY NOTE: Promulgated in accordance with Social Security Act of 1935, Title V, Sections 501-516; P.L. 97-35, Title V, 42 U.S.C. 703; R.S. 46:971-972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§1705. Referrals to Other Programs

A. Eligible children are routinely referred to the WIC Program. The WIC services are provided at the parish health units. Children whose screening results indicate potential handicaps or genetic disorders are referred to the regularly scheduled regional Handicapped Children's Services (HCS) clinics and regional genetics clinics for diagnosis, treatment, and other appropriate services. Children with vision, or hearing, speech or language problems are referred to the Eye Anomalies or Communicative Disorders Program for diagnostic work-ups. Referrals are made to OPPHS medical social services staff, state supported hospitals, and other health and social service providers for diagnosis, follow-up and/or treatment services. These referrals are made in accordance with OPPHS protocol, guidelines and/or professional judgment.

B. Suspected child abuse and/or neglect is reported promptly to Children's Protective Services by professional staff in child health clinics. These referrals are made in accordance with R.S. 14:403 and OPPHS protocol. Medical information is released to other providers in accordance with DHHR regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 14:403. HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§1707. Collection of Fees

A. Patients are not charged for services, except that reimbursement is received from Office of Family Security (OFS) for EPSDT eligible patients. This reimbursement rate is governed by a continuing interagency contractual agreement between OPPHS and OFS for EPSDT-eligible children according to the fee schedule below.

Description of Services	Fee Charged to Medicaid
Periodic screening by a physician	72.81
Initial screening by a nurse	72.81
Periodic screening by a nurse	72.81
Initial screening by a physician	72.81
Diagnosis and treatment by physician at same visit with nurse screening	33.71
Lead poison screening	33.71
Diagnosis and treatment by physician	33.71
Treatment	33.71
Special evaluation	33.71
Nurse counseling	33.71
Counseling by nutritionist	33.71
Social worker counseling	33.71

AUTHORITY NOTE: Promulgated in accordance with Social Security Act of 1935, Title V, Sections 501-516; P.L. 97-35, Title V, 42 U.S.C. 703; R.S. 46:971-972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 19. Maternity Services

§1901. General Administration

A. Administration

1. Maternity Services are administered in accordance with the Social Security Act of 1935—Title V, Sections 501-516; P. L. 97-35, Title V, 42 U. S. C. 703, and R. S. 46:971-972.

2. The state's Maternity Services Program is coordinated with the Medicaid Program of the Office of Family Security, Special Supplemental Food Program for Women, Infants, and Children (WIC), the Family Planning Program, and other related federal and state programs.

Maternity services offered in OPPHS clinics are closely coordinated with prenatal, delivery and post-partal services provided by state supported and private hospitals and private physicians to ensure nonduplication of effort. OPPHS maternity services are intended to provide a minimum standard of prenatal care to pregnant women in Louisiana in cooperation with other public and private providers.

B. Eligibility. Any woman of childbearing age residing in Louisiana is eligible for maternity services provided the woman by her own affirmation is not currently receiving these prenatal services elsewhere.

C. Purpose. The goals of the Maternity Program are:

1. To provide and/or support a minimum standard of prenatal care to all the pregnant women in Louisiana;

2. To participate in efforts to reduce neonatal and maternal mortality and morbidity in Louisiana;

3. To prevent or facilitate the prevention of health problems associated with indigent women in the childbearing years and promote their health and the health of their newborns;

4. To provide direct and consultative prenatal services to pregnant women identified as low risk maternity patients;

5. To maintain and enhance linkages and close coordination with state-supported hospitals and other agencies in order to provide the maximum quality of care possible; and

6. To provide postpartal nutritional services to eligible mothers.

D. Scope of Services

1. Services are targeted to low risk pregnant women from Louisiana's indigent population who are not receiving prenatal care elsewhere. Low risk pregnant women are those women identified not at risk of a significant obstetric complication or a serious medical illness coexistent with pregnancy. Prenatal care is provided by OPPHS in parishes where these services are not provided by state supported hospitals. The services offered by OPPHS are dependent on the level of financial support of the program.

2. These services may vary according to the staff equipment, facility and other resources available in each health unit. The services are primarily nursing services with appropriate medical support and consultation.

E. Requests for Services

1. Maternity services may be requested by contacting the OPPHS parish health unit. Requests for these services may be made in person, by telephone, or by mail. Referrals for such services are also received through various sources including but not limited to state supported hospitals, private physicians, the Office of Family Security and other state agencies. When the patient contacts the parish health unit for services, she will be briefly interviewed to determine the services being requested.

2. The patient is also asked whether she is currently receiving services elsewhere before an appointment is scheduled at the health unit. If prenatal care is not provided by OPPHS in the parish health unit, the patient is referred to the state supported hospital of the region for maternity services.

AUTHORITY NOTE: Promulgated in accordance with Social Security Act of 1935, Title V, Sections 501-516; P.L. 97-35, Title V, 42 U.S.C. 703, and R.S. 46:971972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§1903. Description of Services

A. Maternity services consist of prenatal services as well as postpartal WIC nutritional services to eligible women. The WIC Program is governed by departmental regulations appearing elsewhere. Maternity clinics are scheduled in the parish health units on a regular basis utilizing an appointment system. The maternity services offered by OPPHS generally follow the recommendations of the American College of Obstetricians and Gynecologists as described in the sixth edition of Standards for Obstetric-Gynecologic Services 1985. Continuous risk assessments are made, utilizing referrals to state supported hospitals for more specialized care of high risk pregnant women. Maternity patients are referred to the regional high risk facility, because of the obvious risk that they represent for a poor pregnancy outcome under the following conditions:

1. taking antihypertensive medications;

2. Rh-isoimmunized;

3. use of hard drugs (cocaine, heroin, and methadone);

4. forty years of age or older;

5. last baby weighed between one and four pounds at birth;

6. diabetes mellitus present;

7. sickle cell disease present;

8. current multiple pregnancy; and 9. previous caesarian section.

B. Patients referred to the high risk maternity clinic are contacted by telephone by parish health unit staff to insure that they have kept that clinic appointment.

C. The following services may be provided during the initial OPPHS maternity clinic visit:

1. laboratory tests including VDRL, Rubella titer, hemoglobin electrophoresis on black patients, hemoglobin/hematocrit, Rh factor, antibody screening, Pap smear, culture for gonorrhea, urine dipstick for sugar and protein, and pregnancy test (if indicated);

2. tetanus immunizations and tuberculin skin testing;

3. assessment for prenatal vitamins and iron;

4. patient's health history obtained by the nurse;

5. abdominal assessment by the nurse;

6. assessment of other symptomatology or problems by history and observation by the nurse;

7. nutritional assessment including review of diet intake with patient, nutrition counseling and referral to nutritionist if indicated;

8. social assessment including the patient's attitude toward pregnancy, family needs and referral to a medical social worker if appropriate;

9. counseling about the choice of choosing breast feeding or bottle feeding;

10. provision of other prenatal counseling, such as the recognition of the onset of labor, hospital and delivery procedures; and

11. continuing risk assessment for referral to the high-risk facility.

D. The patient is referred to the clinician in the parish health unit or to the regional state supported hospital prenatal clinic (if a physician is not available) for the initial complete physical examination in the health unit. The initial examination by the physician includes a complete physical examination with Pap smear and culture for gonococcus.

E. Patients following a normal prenatal course are scheduled to be seen by the public health nurse in maternity clinics every four weeks up to 28 weeks gestational age, every two weeks from 28 to 36 weeks, and every week thereafter. Other patients with problems that do not require referral to the high risk maternity clinic are seen according to the nurse's or physician's professional judgment.

F. Services generally provided to patients during return visits to the Maternity Clinic in the health unit include:

1. laboratory work consisting of VDRL, culture for gonorrhea, and repeat hemoglobin or hematocrit if indicated;

2. antibody screening referral to the regional state supported hospital where the patient plans to delivery (if the patient is Rh negative);

3. blood pressure determined;

4. height and weight plotted;

5. urine dipstick for glucose and protein and proper follow-up for a positive test;

6. nursing interview to obtain and evaluate interval history of symptomatology and for problems;

7. completed abdominal, leg and edema assessment;

8. counseling by the nurse regarding evaluation of the laboratory work and blood pressure, urine and weight findings, and referral as appropriate;

9. nutritional and social assessment by the nurse and referral to the nutritionist or medical social services if indicated; and

10. appropriate counseling by the nurse according to gestational age.

G. The patient is referred to the clinician in the parish health unit for a 32-36 weeks abdominal-pelvic physical examination. Patients having problems requiring medical attention are also referred to the clinician. Referrals are made to the state supported hospital if there is no physician present in the health unit.

H. Follow-up contacts by telephone, mail, or home visit are initiated by the parish health unit staff on missed maternity clinic appointments to offer the patient another appointment. The patient's record is generally closed if three consecutive appointments are failed by the patient or the parish health unit is unsuccessful in contacting the patient after three attempts.

I. Maternity services are primarily provided in nursing clinics. The maternity clinics are staffed by health care professionals including nurses, physicians, social workers, and nutritionists. Paraprofessional health care staff (aides and technicians) also provide services under professional supervision.

J. Home visits are made on a limited basis by nurses or medical social workers. These visits provide necessary follow-up according to agency protocol and professional judgment. Home visits are made by the nurse when:

1. patients consistently fail to keep appointments;

2. patients are in need of additional professional support services and counseling;

3. patients receive no prenatal care; and

4. patients are exhibiting prenatal indicators of child abuse or neglect.

AUTHORITY NOTE: Promulgated in accordance with the Social Security Act of 1935, Title V, Sections 501-516; P.L. 97-35, Title V, 42 U.S.C. 703; R.S. 971-972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§1905. Referrals to Other Programs

A. Eligible prenatal and postpartal patients are routinely referred to the WIC Program. WIC services are generally provided at the parish health units. Maternity patients are referred to the state supported hospital in the region for delivery services, specialized prenatal care for high risk pregnancies and other maternity services according to agency protocol and interagency agreements with the regional state supported hospitals. Referrals are also made to OPPHS medical social services staff, family planning staff and other health care and social services providers for follow-up and other services.

B. Medical information is released to other providers in accordance with DHHR regulations on disclosure of medical information.

AUTHORITY NOTE: Promulgated in accordance with the Social Security Act of 1935, Title V., Sections 501-516; P.L. 97-35, Title V; 42 U.S.C. 703; R.S. 46:971972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§1907. Collection of Fees

A. There are no patient fees for maternity care services provided at the health units except for women under 21 years of age who are eligible for Title XIX (Medicaid) in the EPSDT Program. Charges to EPSDT for services rendered to eligible women will be based on the fee schedule listed above under child health services.

AUTHORITY NOTE: Promulgated in accordance with the Social Security Act of 1935, Title V, Sections 501-516; P.L. 97-35, Title V.; 42 U.S.C. 703; R.S. 46:971972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 21. Communicative Disorders

§2101. General Administration

A. Administration

1. Communicative disorders services are administered in accordance with R.S.40:5, 17:2111, 46:261-263, and 46:971-972.

2. These services include speech, language, and hearing screening and follow-up testing necessary for presumptive diagnosis and appropriate referral for rehabilitation. Services provided are planned to ensure coordination with other associated federal, state, and local programs such as EPSDT, Handicapped Children's Services, Developmental Disabilities, Department of Education, Head Start, and local community service centers for the purpose of:

a. eliminating duplication of services resulting in cost effective operations;

b. maintain effective communications between disciplines working in respective agencies and programs for the benefit of clients served; and

c. ensure easy access to services provided across agencies and programs and expedite referrals for timely and comprehensive follow-up care.

B. Eligibility. Any child from birth to 21 years of age residing in Louisiana is eligible to receive program services.

C. Program Service Priorities and Target Populations

1. Priority services are directed toward the following populations:

a. infants, preschoolers, and kindergarteners for purposes of prevention and early detection;

b. children in geographic areas of the state where communicative disorders services are inaccessible or virtually nonexistent;

c. children from low income families who have limited access to private sector services.

d. other school age children in grades 1, 3, 7, and 11 in accordance with 1975 national testing guidelines recommended by the American Speech-Language-Hearing Association.

2. Program service priorities and target populations may be modified to conform with the degree of approved funding.

D. Purposes

1. Prevention, early detection, diagnosis, and timely referral for follow-up care of children in Louisiana with medically and/or educationally significant speech, language, and hearing problems which may impede normal growth and development.

2. To enhance public awareness of early warning signs of speech, language, and hearing problems which may be developing in children.

3. To facilitate referrals for preventive services so that early detection, diagnosis, and referral for rehabilitation will be made.

E. Access to Screening Services. Avenues of access to communicative disorders services are as follows:

1. appearing at health unit in person and requesting services;

2. direct referral from physician or nurse conducting other parish health unit child health clinics;

3. written referral and any associated medical information from a physician in the private sector;

4. Written referral and associated supportive audiological test results from local community based private and nonprofit service centers;

5. referral from school personnel with documented screening results attached; and

6. referral with appropriate documented screening results by program personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5; 17:2111; 46:261-263 and 46:971-972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§2103. Description of Services

A. Screening Services

1. Screening may be performed by trained volunteers, school nurses, health unit personnel, and/or OPPHS personnel depending upon the availability of staff. Communicative Disorders Program personnel provide training in screening activities in accordance with nationally

accepted professional standards for audiological screening. Screening equipment provided by the program conform to 1969 American National Standards Institute of calibration. Infant screening is primarily performed through identification of high risk factors, medical history, behavioral observations, and assessment of developmental milestones.

2. The parent or guardian is notified by mail as to the child's failure to pass screening. They are urged either in person or by letter to seek follow-up testing depending upon the availability of the parent or guardian at the time of screening. A child who does not receive follow-up testing from private sector providers may be referred to a OPPHS communicative disorders clinic in the parish health unit. Follow-up testing is provided by masters-level professional audiologists and/or speech pathologists. These professionals are certified by the American Speech-Language-Hearing Association and licensed by the state of Louisiana.

B. Communicative Disorders Clinic Services

1. Follow-up communicative disorders clinics are provided in parish health units throughout the state except Plaquemines parish. Clinics are scheduled according to numbers of children needing follow-up services. Clinic services include speech, language, and hearing assessment (including middle ear function) utilizing nationally accepted test procedures. These tests are performed in accordance with standards for accreditation set by the American Speech-Language-Hearing Association and state licensing standards. The clinic responsibilities of audiologists and speech pathologists include interpreting test results to parents or guardians. These results support the presumptive diagnosis. Preventative and rehabilitative counseling is provided consistent with recommendations for referral and treatment. Staff functions in the communicative disorders clinic are:

a. counseling for parents;

b. obtaining family history pertinent to comprehensive health care needs;

c. assessing financial means of the family; and

d. assisting the family in making arrangements for follow-up care to the private sector or to the handicapped children's services.

2. Medical information is released to other providers in accordance with DHHR regulations. Repeat clinic invitations for missed clinic appointments are provided at a parent's request.

C. Voice Clinic Services

1. Voice clinics are conducted in parish health units depending upon availability of physician services. Clinic services may include:

a. voice orientations and workshops with school speech clinicians and health unit personnel:

b. a medical examination and diagnosis by a board certified or board eligible otolaryngologist;

c. therapeutic recommendations and counseling services are jointly provided by a clinic physician and the OPPHS speech pathologist;

d. the clinic nurse obtains pertinent family history and counseling; and

e. the nurse make a provisional assessment of family finances which is necessary for appropriate referral.

2. Dependent upon medical findings appropriate referrals are made to private sector providers, to state supported hospitals for follow-up medical care, and/or certified speech therapists in the Department of Education for voice management and therapy. Procedures for obtaining access to voice clinic are identical to those provided for parish communicative disorders clinic.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§2105. Fee Collections

A. There are no fees collected for Communicative Disorders Program services with the exception of Head Start. Reimbursement to OPPHS is provided by Head Start for each child screened at Head Start centers in accordance with interagency agreements with Head Start centers throughout the state. A reasonable fee per child is collected under this agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 22. Identification of Hearing Impairment in Infants

§2201. Definitions

Advisory Council—the 14-member council created pursuant to R.S. 46:2265.

Audiologist—an individual licensed to practice audiology by the Louisiana Board of Examiners for Speech Pathology and Audiology.

Auditory Brainstem Response (ABR)—the synchronous electrical response elicited from the auditory nervous system within 20 msec after stimulation and its measurement as used for the detection of hearing loss.

Department—the Department of Health and Hospitals.

Discharge—release from the premises of a medical care facility.

Evoked Otoacoustics Emissions (EOAE)—acoustic echoes, evoked in response to acoustic stimuli, produced by the inner ear and measured by a microphone in the ear canal for the detection of hearing loss.

Hearing Screening—using procedures approved by the office to identify infants in need of diagnostic audiological assessment.

Infants at Risk—those infants who are at risk for hearing loss because they have one or more risk factors as indicated in R.S. 46:2263.

Office—the Office of Public Health within the department.

Other Birthing Site—any site of birth other than a hospital.

Other Risk Factors—any other condition(s) in addition to the factors cited in R.S. 46:2263 added by the office upon recommendation of the advisory council.

Other Screening Device—a device preapproved in writing by the office, comparable to or better than auditory brainstem response testing.

Program—the Hearing, Speech and Vision Program within the office.

Risk Registry—will be the data base kept by the office of all infants identified as high risk for hearing loss.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2261-2267.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 19:1430 (November 1993), amended LR 28:837 (April 2002).

§2203. Program for Identification of Hearing Loss in Infants

A. The program will include the following.

1. The office will require a newborn hearing screening report to be used by the hospitals to report hearing screening results and risk status on all newborns to the risk registry. This form will include written material regarding hearing loss and a toll-free hotline phone number (V/TDD).

2. The office will maintain a risk registry to include information reported on the newborn hearing screening report.

3. The office will notify parents of infants at risk of available follow-up services.

4. The risk registry will include periodic notification to parents of recommended procedures for infants and children at risk for progressive hearing loss.

5. The risk registry will include information on infants diagnosed with hearing loss.

6. The office will provide for a toll-free hotline service for parents and professionals to utilize to obtain information about the program and related services. This hotline will be accessible by voice or TDD.

B. Implementation

1. All birthing sites in Louisiana must be in compliance with this act by April 1, 2002.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2261-2267.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 19:1431 (November 1993), amended LR 28:838 (April 2002).

§2205. Procedures for Hospitals

A. Hospitals shall complete the newborn screening report on all live births.

B. Hospitals shall conduct hearing screening on all newborn infants before discharge.

C. Hospitals shall record the results of the hearing screening on the newborn hearing screening report.

D. Hospitals shall disseminate copies of the newborn hearing screening report to the parent, the office (within 14 calendar days of discharge), and the infant's primary health care provider.

E. If an infant is born in one hospital and transferred to one or more hospital(s), the last hospital to which the infant is transferred before being discharged into the care of a parent, or guardian for purposes other than transport, must complete the newborn infant hearing report and perform the hearing screening.

F. If an infant is to be placed for adoption and is to be transferred to another hospital for adoption, the hospital at which the infant is born is to complete the newborn hearing screening report and perform the hearing screening (unless §2205.E above applies). The parent copy of the newborn hearing screening report shall be sent to the guardian.

G. Referrals for infants failing the hospital screening process must be made within seven days of discharge to the infant's primary health care provider and a licensed audiologist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2261-2267.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 19:1431 (November 1993), amended LR 28:838 (April 2002).

§2207. Procedures for Other (Alternative) Birthing Sites

A. When the infant is born outside the hospital, the person filling out the birth certificate shall complete the newborn hearing screening report.

B. Hearing screening shall be performed at the alternative birthing site before discharge. The results of the screening shall be recorded on the newborn hearing screening report.

C. The person completing the newborn hearing screening report shall disseminate the copies to the parent, primary health care provider, and the office (within 14 calendar days).

D. Referrals for infants failing the alternative birthing site screening process must be made within seven days of discharge to the infant's primary health care provider and a licensed audiologist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2261-2267.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 19:1431 (November 1993), amended LR 28:838 (April 2002).

§2209. Hearing Screening Procedures

A. Personnel. Hearing screening will only be performed by:

1. board eligible or board certified physicians with special training in auditory brainstem response testing and/or otoacoustic emissions and in infant hearing testing. Evidence of training must be submitted to the office;

2. audiologists licensed by the Louisiana Board of Examiners for Speech Pathology and Audiology with special training in auditory brainstem response testing and/or otoacoustic emissions testing and in infant hearing testing. Evidence of training must be submitted to the office;

3. persons trained and supervised by personnel meeting requirements for §2209.A.1 or 2 above.

a. A board-certified or board-eligible physician or licensed audiologist who is supervising another individual performing hearing screening must at least be accessible by telephone while the screenings are being performed, review a percentage of the screening documentation and copies of the newborn hearing screening report and perform periodic direct observation of each individual at least once per month as they perform hearing screenings. After an individual supervised by an audiologist or physician has performed hearing screening under the above supervision for one year, direct observation every three months is required.

Note: To minimize liability it is recommended that the standard for special training be by an accredited medical or educational institution and include sufficient practicum for proficiency. Any deviation from this recommended standard may increase liability.

B. Test Procedures. The following test procedures are the only acceptable methods for use in infant hearing screening:

1. Auditory Brainstem Response (ABR) either automated or non-automated;

2. Evoked Otoacoustic Emission (EOAE);

3. test levels, failure criteria and all other test parameters are set by protocols established by the office, upon recommendations of the State Advisory Council.

C. Test Environment. The facility providing the hearing screening tests shall make all efforts possible to insure testing is conducted in a quiet environment.

D. Calibration of Equipment. Hearing screening equipment shall be calibrated annually and documentation maintained at the screening site.

E. Exemptions. Any requests for exemptions from hospitals or other birthing sites unable to perform hearing screening on all at-risk patients before discharge must be made in writing to the office. Exemptions will be considered on a site-by-site basis considering birth population, financial status, availability of services and other factors. Birthing sites requesting exemptions will be required to have an alternative testing site available for referral of at risk infants needing hearing screening within seven calendar days of discharge.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2261-2267.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 19:1431 (November 1993), amended LR 28:838 (April 2002).

§2210. Referral and Follow-Up

A. Referrals for infants failing screening must be made to the infants primary care physician and a licensed audiologist within seven days of discharge by the birthing center.

B. Appropriate protocols and standards for diagnostic evaluations to determine hearing loss shall be established by the office, upon recommendations of the State Advisory Council.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2261-2267.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:838 (April 2002).

§2211. Confidentiality of Information

A. All information on the newborn hearing screening report is considered confidential and cannot be released by the office, the hospital or the primary health care facility without the parent or guardian's written informed consent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2261-2267.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 19:1432 (November 1993).

§2213. Risk Registry and Tracking

A. The office will maintain a risk registry to include information on all live births and infants identified as at risk for hearing loss.

B. The office will track at risk infants who fail or do not receive hearing screening prior to hospital discharge. Assistance will be provided for service referrals when necessary.

C. The office will track and notify parents of infants and children at risk for progressive hearing loss of appropriate procedures for follow-up testing and monitoring of their child's hearing until age five.

D. The office will develop a system for reporting diagnosis of hearing loss by primary health care providers, audiologists and parents for children up to age 5.

E. The office will disseminate statistical reports regarding the number of infants tested and the number with diagnosed hearing loss to the Louisiana Commission for the Deaf, the Louisiana School for the Deaf, the Department of Education and other interested parties on an annual basis.

F. Infants and children with diagnosed hearing loss shall be referred to appropriate agencies for rehabilitation and education services with parental/caregiver consent. For infants and toddlers up to age three with diagnosed hearing loss, referral to Childnet shall be made for early intervention services.

G. Non-Compliance and Penalties

1. The State Advisory Council shall recommend to the office methods of monitoring hospitals, physicians and audiologists for compliance with all sections of this statute.

2. The State Advisory Council shall report any hospital, physician or audiologist found to be non-compliant to the appropriate licensing, regulatory or other appropriate agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2261-2267.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 19:1432 (November 1993), amended LR 28:838 (April 2002).

Chapter 23. Eye Anomalies Services

§2301. General Administration

A. Administration. The Eye Anomalies Program is administered in accordance with R.S. 40:5, R.S. 17:2111, R.S. 46:261-263 and R.S. 46:971-972.

B. Eligibility Criteria. Individuals birth to 21 years of age who reside in Louisiana are eligible for services provided by the Eye Anomalies Program.

C. Requests for Services. The program receives referrals from parents or guardians, public, parochial, and private school systems, day care centers, Head Start programs, interagency programs within OPPHS, private sector pediatricians, the Office of Family Security, the Department of Education, various state institutions, neonatal facilities in hospitals, and other state and private programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5, R.S. 17:211, R.S. 46:261-263 and R.S. 46:971-972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (Apri11987).

§2303. Program Procedures

A. Training workshops are conducted each year by the regional Eye Anomalies Program consultants in each parish throughout the state. Training is provided to school nurses, public health nurses, teachers, parents, volunteers, and others. These individuals are trained to conduct the basic initial screening procedures with school age children in public, parochial, and private schools.

B. Initial screening is performed by certified Eye Anomalies Program technicians on infants, preschoolers, kindergarten children, mentally retarded children, hearing impaired children, and children referred from the Department of Education, since more complex clinical skills and/or equipment are required for these individuals.

C. The eye anomalies staff employs more definitive test procedures to screen school age children in public, parochial, and private schools when these children are referred. If the results of this rescreening are positive, this indicates the need for an ophthalmic examination. These children are then referred into medical diagnostic clinics. Individuals initially tested by Eye Anomalies Program staff are referred directly into medical diagnostic clinics without rescreening procedures.

D. Medical diagnostic screening clinics are scheduled as needed at parish health units throughout the state. All individuals failing the initial or rescreening procedures conducted by Eye Anomalies Program staff are invited into a clinic where they are examined by an ophthalmologist. These ophthalmic examinations assist in determining whether a particular ocular problem requires medical or non medical treatment. Counseling services are provided focusing on communicating the child's needs to parents, to educators, and to health personnel. The Ophthalmic Advisory Committee (see Section 2307) assists in the recruitment of ophthalmologists for these clinics.

E. School nurses are asked to follow-up on public school children who fail to attend clinics. OPPHS Eye Anomalies Program staff and public health nurses conduct a follow-up of preschool, parochial, and private school children who do not attend clinics in order to determine if they have sought private care services.

F. Post clinic conferences attended by the parents or guardians and a public health nurse or Eye Anomalies Program staff member are utilized to initiate needed follow-up for those attending the medical diagnostic clinic. Follow-up services are also provided by other agencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5; R.S. 17:2111; R. S. 46:261-263 and R. S. 46:971-972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services. LR 13:246 (April 1987).

§2305. Referrals from the Program

A. After clients have been examined by an ophthalmologist in a medical diagnostic clinic and found in need of treatment services, a determination is made whether medical or non medical treatment is necessary. Referrals may be made to handicapped children's services, state supported hospitals, other state agencies, including but not limited to Division of Blind Services, Department of Special Education, and to provide sector ophthalmologists or optometrists of the parent's choice. Medical information is released to other providers in accordance with DHHR regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5; R.S. 17:2111; R.S. 46:261-263 and R.S. 46:971-972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§2307. Ophthalmic Advisory Committee to DHHR

A. The Ophthalmic Advisory Committee of DHHR shall be composed

1. of no more than 18 members made up of ophthalmologists and optometrists appointed to the committee by the state health officer. The state health officer and the director of Eye Anomalies Program shall serve as

2. ex-officio members of the committee. The director of OPPHS Eye Anomalies shall act as secretary of the committee and as liaison between the committee and the various offices of DHHR and other state agencies. The chairman of the committee shall be appointed by the state health officer.

B. Members shall serve for as long as they wish to remain actively involved with the committee. When ophthalmologist vacancies occur, the state health officer shall appoint a replacement from a list of five names of ophthalmologists submitted by the Louisiana Ophthalmology Association. When optometrist vacancies occur, the state health officer shall appoint a replacement from a list of five names submitted by the Louisiana State Association of Optometrists.

C. The DHHR Ophthalmic Advisory Committee shall meet periodically with permission of the state health officer. The committee advises DHHR and its various offices and programs on matters relating to departmental eye health programs and services either currently in operation or under consideration. In addition, individual members and subcommittees shall meet as requested by DHHR to fulfill duties for which the committee was established.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5; R.S. 17:2111, R.S. 46:261-263 and R.S. 46:971-972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§2309. Fee Collections

A. There are no fees collected for the Eye Anomalies Program services except under written agreements with Head Start centers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5; R.S. 17:2111, R.S. 46:261-263 and R.S. 46:971-972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 25. Sudden Infant Death Syndrome (SIDS)

§2501. General Administration

A. Administration

1. This program exists primarily to monitor compliance with R.S.33:1561, R.S. 33:1561.3, and R.S. 40:56 which mandate the following:

a. coroners must clearly state cause of death as "Sudden Infant Death Syndrome" where the findings so warrant and within 48 hours of such findings notify the director of the local parish health unit of this provisional diagnosis;

b. the director of the parish health unit or his agent, after consultation with the infant's physician, shall, within 48 hours contact the person or persons who had custody and control of the infant and explain the nature and cause of SIDS to the extent current knowledge permits; and

c. to ensure that the provisional cause of death as SIDS is verified, autopsies shall be performed whenever the cause of death of an infant is unexpected and without explanation.

2. The coordination of the SIDS Program is under the direction of OPPHS Medical Social Services.

B. Eligibility. Parents of children who are identified as victims of SIDS deaths in Louisiana are eligible for these services.

C. Purpose. The goals of the SIDS program are:

1. to provide early clarification of the cause of death so as to alleviate parental/familial guilt and thereby diminish as much as possible the usual long term trauma resulting from SIDS;

2. to provide educational materials to parents and the community at large regarding SIDS, with special focus on training persons who are most likely to have contact with persons experiencing SIDS; e.g., emergency medical units, bereavement groups, etc;

3. to make appropriate referrals of SIDS families to prevent family breakdown and/or psychological imbalance of any severe/long term nature—often associated with the experience of SIDS; and

4. to provide counseling, whenever possible, especially in those geographical areas where other resources are not available.

In addition to the above, statistics are complied in a central register to monitor the profile of SIDS families in Louisiana and to establish a base of data available for research relative to this population.

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:1561, R.S. 33:1561.3 and R. S. 40:56.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 246 (April 1987).

§2503. Program Services

A. The following procedures have been established to accomplish these goals.

1. Within 48 hours of notification by the Coroner's Office (or any concerned individual) that a SIDS death has occurred, the health unit; i.e., public health nurse, contacts the family to arrange a home visit; when notification is by any individual other than the coroner or his/her representative, confirmation of diagnosis is made by the public health nurse from the coroner's office.

2. Within 10 days a visit is made by the public health nurse. Information as described on the "Initial Case Report" form is obtained while clarifying to the parent's the current

knowledge about SIDS. Written materials in this regard are also supplied to the parents. Referrals are made as need is detected;

3. This completed report is sent to medical social services in OPPHS central registry on SIDS cases.

4. A copy of this report is sent to the regional medical social worker who visits the family four weeks later to provide professional assessment of the psychosocial status of the family, and counseling and/or referral that is needed. Subsequent visits may be arranged.

5. A written report of this activity is completed and sent to OPPHS central office for files.

6. Death certificates are matched with these reports; autopsy reports

or death certificates are requested whenever they have not been previously received.

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:1561, R.S. 33:1561.3 and R. S. 40:56.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subpart 9. Home Health Services

Chapter 27. Eligibility

§2701. Criteria

A. Any resident of Louisiana, (exclusive of Orleans and Plaquemines parishes), who is essentially homebound, 21 years of age or older and in need of skilled nursing services ordered by a physician, may receive home care services. Services shall only be provided to clients who do not have third party coverage (i.e., Medicare, Medicaid or private insurance), and who meet financial eligibility guidelines established by the Office of Preventive and Public Health Services.

B. Homebound. Clients shall be considered essentially homebound if they are unable to leave their home, or place of residence, without the aid of supportive devices such as crutches, canes, walkers or wheelchairs, the use of special transportation, the assistance of another person, or if they have a condition which is such that leaving their home is medically contraindicated.

C. 21 Years of Age. Clients must be 21 years of age or older in order to receive home care services.

D. Need of Skilled Nursing Services. Clients must be in need of skilled nursing services in order to receive home care services. These services shall be provided by a registered professional nurse (public health nurse) or a licensed practical nurse under the direct supervision of a registered nurse. All services shall be provided in accordance with the written orders of a physician licensed to practice in the state of Louisiana. Under normal circumstances, clients will be limited to two skilled nursing visits per week. Exceptions to this limit shall only be allowed for medical emergencies, or if the client's physician deems additional visits are medically necessary.

E. Third Party Coverage. Home care services shall only be provided to clients who do not have third party coverage. Such coverage includes Medicare (Part A or Part B), Medicaid, (Title XIX Medical Assistance administered by the Office of Family Security), or private insurance (Blue Cross/Blue Shield or other commercial third party insurance coverage). Clients who are eligible for Medicare coverage (Part A or Part B) who have been denied coverage for home health services by the Medicare fiscal intermediary, shall be considered eligible for home care services. Clients who are eligible for home health services under Medicaid, but who have exhausted their 50 visit limitation, shall be considered eligible for home care services.

F. Financial Eligibility Guidelines. Home care services shall be provided only to clients whose family income does not exceed the following financial eligibility guidelines.

Family Size	Monthly Income
1	
2	$1,877
3	$2,212
4	$2,450
5	$2,509
6	$2,571
7	$2,574

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.3140:2009.41, Title XVIII and XIX of the 1965 Admendments to the Social Security Act as amended by P.L. 90:248, 92-603, 93-233, 96-499 and 97-248.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 29. Services

§2901. Types of Services

A. Services Other than Nursing Services. Medical social worker and nutritional counseling services will be provided to clients when ordered by the attending physician.

B. Medical Supplies. Routine medical supplies used by OPPHS staff in the treatment of clients will be provided free of charge.

C. Durable Medical Equipment. Items of equipment such as hospital beds, wheelchairs, walkers, commode chairs, and other equipment which can withstand repeated use and is primarily and customarily used in the home to serve a medical purpose, are not provided to clients.

D. Transportation for Medical Care. Transportation for medical care is not provided to clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.3140:2009.41, Titles XVIII and XIX of the Social Security Act as amended by P.L. 90:248, 92-603, 93-233, 96-499 and 97-248.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§2903. Providers of Services

A. All services will be provided free of charge to clients by nursing and ancillary staff of the local parish health units, and the regional offices of the Office of Preventive and Public Health Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.3140:2009.41, Title XVIII and XIX of the Social Security Act as amended by P.L. 90:248, 92-603, 93-233, 96-499, and 97-248.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Services, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§2905. Service Delivery

A. Service Area. Statewide, except for Orleans and Plaquemines parishes.

B. Places of Service. All services will be provided in the client's home or place of residence (other than a nursing home).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.3140:2009.41.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§2907. Request for Services

A. Clients or members of client's family, client's physician, or any health care facility, may request home care services by contacting the local parish health unit in their area.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.3140:2009.41.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (Apri11987).

Subpart 11. High Blood Pressure Control Services

Chapter 31. General Provisions

§3101. Authority

A. In 1984, the legislature passed Act 701 enacting R. S. 40:2481-2483 to provide a statewide High Blood Pressure Control Program (LHBPCP), under the auspices of the Office of Preventive and Public Health Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2481-2483.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§3103. Goals and Services

A.1.The goal of the LHBPCP is to reduce morbidity and mortality associated with hypertension and its complications (heart disease and stroke) through a comprehensive preventive system. Services are targeted to the high risk population 14 years of age and older. The program provides services in six areas:

a. client education;

b. screening/rescreening;

c. counseling;

d. follow-up;

e. monitoring; and

f. direct referral to physician and hospital for diagnosis and treatment.

2. Additionally, the program provides support services to the medical community in identifying hypertensives and, once diagnosed, assists it in controlling blood pressure by facilitating patient compliance. The program may assist the patient in maintaining the medical regimen provided by his/her physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2481-2483.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subpart 13. Family Planning

Chapter 35. General Administration

§3501. Eligibility Requirements

A. Any person needing and requesting the services provided by the program is eligible. These include women capable of childbearing and those persons seeking infertility services. The male population is eligible for available family planning services.

All persons are eligible to the extent of the program's financial support. Priority shall be given to members of low income families.

AUTHORITY NOTE: Promulgated in accordance with 42 USC 300, 42 CFR, Subpart A, Part 59.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§3503. Principles of Operation

A. The aim of Louisiana's Department of Health and Human Resources, Office of Preventive and Public Health Services, Family Planning Program is to operate and administer an effective community program in family planning. This program shall provide family planning information and services which promote the dignity and integrity of the family, shall foster an environment which enhances the ability of the family to develop the potential of each child, and shall improve community health.

1. Services of the program are available to individuals and families seeking voluntary fertility and contraceptive services.

2. No coercion or compulsion shall be employed to induce persons to use family planning services.

3. Use of the family planning services shall not be a prerequisite to the receipt of the benefits of or participation

in any other activity funded by parish, state or federal tax revenue.

4. Services shall be made available in such a manner as to protect the dignity of the individual.

5. Family planning records shall be classified as confidential medical information.

6. Advice and assistance shall be available to each participant on a variety of family planning methods and techniques sufficient to ensure freedom of choice.

7. Services shall be made available without the impositions of any duration-of-residence or referral requirements.

8. Abortions shall not be provided as a method of family planning.

9. The program shall provide an opportunity for participation by persons broadly representative of all significant elements of the population to be served, and by others in the community knowledgableabout such needs, in the development, implementation, and evaluation of the projects and for the approval of educational and informational materials.

10. Medical services provided related to family planning shall include physician's consultation, examination, prescription, and continuing supervision; laboratory examination; contraceptive supplies; and necessary referrals to other medical facilities when medically indicated.

11. The Family Planning Program also provides social services related to family planning. These services include: counseling, referral to and from other social and medical services agencies, and such ancillary services as are necessary to facilitate clinic attendance.

12. Instruction in the effective usage of contraceptive devices and practices shall be provided.

13. A broad range of medically approved methods of family planning including natural family planning methods shall be available.

14. Diagnostic and referral services for infertility shall be available.

15. Referral arrangements with other providers of health care services, with local health and welfare departments, hospitals, and voluntary agencies, and health services projects support by other federal programs shall be available.

16. Informational and educational programs designed to achieve community understanding of the objectives of the program, to inform the community of the availability of services, and to promote continuing participation in the project by persons to whom family planning services may be beneficial shall be provided.

AUTHORITY NOTE: Promulgated in accordance with 42 USC 300; 42 CFR, Subpart A, Part 59.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 37. Fees

§3701. Fee Policy

A. All persons seen for family planning services at an Office of Preventive and Public Health Services health unit or at a site providing family planning services by contract with Office of Preventive and Public Health Services shall be assessed a fee for each chargeable service. Chargeable services are those defined as chargeable under The Louisiana Medicaid Program regardless of the source of payment. Fees will be based on cost and adjusted according to the ability of the recipient to pay.

B. All patients whose gross family income is above 100 percent poverty as determined by the U.S. Community Services Administration as indicated on the fee adjustment schedule shall pay a fee for each service provided. Fees and adjustment to fees are to be established by the fee clerk at the time the patient is registered for service.

C. Patients shall be charged a fee for each service, regardless of which service is provided, in the same manner in which Medicaid is charged. No fee shall be charged for failed or cancelled appointments.

D. Minors seen without the consent and knowledge of parents or legal guardians will be considered as separate family units and will be charged according to the minor's own income whether the source is allowance or earnings.

E. All patients shall be asked to pay their fees at the time of service delivery. However, when patients do not pay at the time of the visit, they shall be handed a "1st Notice of Payment Due". At the end of 60 days, a "2nd Notice of Payment Due" shall be sent out.

AUTHORITY NOTE: Promulgated in accordance with 42 USC 300; 42 CFR Subpart A, Part 59.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§3703. Fee Adjustment Schedule

A.1.The fee adjustment schedule is designed to provide for proportional payment of each service based on the family's ability to pay. Three variable figures are utilized in calculating the schedule:

a. United State Community Services Administration Poverty Guidelines as found in 45 CFR 1060.2;

b. family size; and

c. cost of service provided.

2. The client shall provide a statement of gross family size.

B. Persons whose income adjusted for family size is at or below 100 percent poverty as is defined by the United State Community Services Administration poverty guidelines shall not be responsible for payment of services. Persons whose

gross family income is set at or above 250 percent poverty as is defined by the United States Community Services Administration poverty guidelines shall be charged the full cost of services provided. Between these two levels, fees shall be adjusted in accordance with the formula used in the schedule of charges included in the following revised Fee Adjustment Schedule.

Fee Adjustment Schedule					
% Poverty Income Family Size	**I 100% or Less No Charge**	**II 101%-115% 10% of Cost**	**III 116%-103% 20% of Cost**	**IV 131%-145% 30% of Cost**	**V 146%-160% 40% of Cost**
1	6620	6686	7679	8672	9665
2	8880	8969	10301	11633	12965
3	11140	11251	12922	14593	16264
4	13400	13534	15544	17554	19564
5	15660	15817	18166	20515	22864
6	17920	18099	20787	23475	26163
7	20180	20382	23409	26436	29463
8	22440	22664	26030	29396	32762
9	24700	24947	28652	35357	36032
10	26960	27230	31274	35318	39362
11	29220	29512	33895	38278	42661
12	31480	31795	36517	41239	45961
13	33740	34077	39138	44199	19260
14	36000	36360	41760	47160	52560
15	38260	38643	44382	50121	55860
16	40520	40925	47003	53081	59159
17	42780	43208	49625	56042	62459
VI 161%-175% 50% of Cost	**VII 176%-190% 60% of Cost**	**VIII 191%-205% 70% of Cost**	**IX 205%-220% 80% of Cost**	**X 221%-235% 90% of Cost**	**XI 236%-250% 100% of Cost**
10658	11651	12644	13637	14630	15623
14297	15629	16961	18293	19625	20957
21574	23584	25594	27604	29614	31624
25213	27562	29911	32260	34609	36958
28851	31539	34227	36915	39603	42291
32490	35517	38544	41571	44598	47625
36128	39494	42860	46226	49592	52958
39767	43472	47177	50882	54587	58292
43406	47450	51494	55538	59582	63626
47044	51427	55810	60193	64576	68959
50683	55405	60127	64849	69571	74293
54321	59382	64443	69504	74565	79626
57960	63360	68760	74160	79560	84960
61599	67338	73077	78816	84555	90294
65237	71315	77393	83471	89549	95627
68876	75293	8170	88127	94544	100961

AUTHORITY NOTE: Promulgated in accordance with 42 USC 300; 42 CFR Subpart A, Part 59.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended LR 14:534 (August 1988), LR 15:471 (June 1989), LR 16:546 (April 1990, LR 17:888 (September 1991).

§3705. Changes in Fees

A. The patient shall be informed that the fee clerk shall be notified of any change which may later occur in income, employment, or family composition which might result in a change in the adjustment fee, and the patient shall so notify the fee clerk. The fee clerk shall also conduct a periodic check (no less frequently than semi-annually) with each patient to determine any change in factors including cost changes, which would cause a change in the fee or adjusted fee. The fee clerk shall adjust the fee appropriately in accordance with the fee adjustment schedule.

B. No fee may be waived or reduced beyond the fee adjustment scale without the express approval of the facility administrator who shall document the reason for change in the patient's chart. When waiver or reduction is made, the administrator shall sign and date such authorization in the case record and in addition shall note and initial the adjusted fee on the ledger card.

C. Examples of acceptable justifications for waiving or reducing a fee include:

1. excessive expense due to other medical cost;

2. family hardships resulting in unusual and unexpected expenses.

AUTHORITY NOTE: Promulgated in accordance with 42 USC 300, 42 CFR Subpart A, Part 59.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§3707. Failure to Pay Fees

A. No person shall be denied service because of inability to pay as determined by the foregoing criteria.

AUTHORITY NOTE: Promulgated in accordance with 42 USC 300, 42 CFR Subpart A, Part 59.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§3709. Failure to Provide Information

A. Any person who is potentially eligible for medical assistance benefits from any federal or state program who refuses to apply for and follow through with application for said benefits shall be presumed to be able to pay the maximum cost of services rendered and shall be billed accordingly.

AUTHORITY NOTE: Promulgated in accordance with 42 USC 300, 42 CFR Subpart A, Part 59.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§3711. Insurance

A. An insurance company that the responsible party alleges has issued a policy or contract covering the charges for treatment and services rendered shall be billed the full cost of services rendered. Billings shall be made directly to the insurer by the heath unit after securing execution of the forms necessary, including an assignment of benefits to the health unit by the responsible person. The responsible party shall be billed in accordance with the applicable fee schedule up to the amount of charges not covered and paid by insurance. If the responsible person refuses to execute the forms necessary to assign the benefits under the policy

alleged by her to cover the charges for services rendered and the forms necessary to file an insurance claim in accordance with the policy, that responsible party shall be billed according to the charges outlined in the class assigned her based on her income and family size as provided in Table I.

AUTHORITY NOTE: Promulgated in accordance with 42 USC 300, 42 CFR Subpart A, Part 59.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§3713. Collection Procedure

A. At the end of the clinic visit, outstanding receivable accounts shall be handed a "1st Notice of Payment Due". At the end of 60 days, a "2nd Notice of Payment Due" shall be sent out.

B. No services other than contraceptive method related emergency services shall be provided a client who has not paid on an outstanding account between clinic visit unless the client pays on the account prior to receiving services on the day that services are sought.

AUTHORITY NOTE: Promulgated in accordance with 42 USC 300, 42 CFR Subpart A, Part 59.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subpart 15. Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

Chapter 41. General Provisions

§4101. Purpose and Scope

A. The purpose of LAC 48:V.Subpart 15 is to adopt applicable and corresponding state regulations enacted under the authority of the federal Secretary of Agriculture in order to implement the federal Special Supplemental Nutrition Program for Women, Infants and Children (WIC program) within the state of Louisiana. Section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), as amended, states in part that “Congress finds that substantial numbers of pregnant, postpartum, and breastfeeding women, infants, and young children from families with inadequate income are at special risk with respect to their physical and mental health by reason of inadequate nutrition or health care, or both. It is, therefore, the purpose of the program to provide supplemental foods and nutrition education, including breastfeeding promotion and support, through any eligible local agency that applies for participation in the program. The program shall serve as an adjunct to good health care, during critical times of growth and development, to prevent the occurrence of health problems, including drug abuse, and improve the health status of these persons." The program shall be supplementary to the Supplemental Nutrition Assistance Program (SNAP); any program under which foods are distributed to needy families in lieu of SNAP benefits; and, receipt of food or meals from soup kitchens, or shelters, or other forms of emergency food assistance.

B. The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), also hereinafter known as “program” or “the program”, provides supplemental foods and nutrition education, including breastfeeding promotion and support, for women, infants and children. It is federally funded through the U.S. Department of Agriculture via cash grants to state agencies which administer the program. The Louisiana Department of Health, Office of Public Health, Center for Community and Preventive Health, Bureau of Nutrition Services, shall be responsible for the administration of the program in Louisiana. Extensive regulations have been published by the Food and Nutrition Service (FNS) of the U.S. Department of Agriculture in 7 CFR Part 246. Federal regulations stipulate participation requirements, length of certifications, certification processes and standards, participant responsibilities and participant grievance rights. If there is a conflict with any portion of LAC 48:V.Subpart 15 and 7 CFR Part 246, the provisions of 7 CFR Part 246 shall supersede the provisions of LAC 48:V.Subpart 15.

C. The annual Louisiana WIC program state plan, including a comprehensive policy and procedure manual, is available for review by any interested party at both of the Bureau of Nutrition Services offices in Louisiana, as follows: Room 828, 628 North Forth Street, Baton Rouge, LA 70802 and Suite 1906, 1450 Poydras Street, New Orleans, LA 70112.

D. As described in 7 CFR Part 246, the agency is to provide supplemental foods and nutrition education, including breastfeeding promotion and support, to categorically eligible participants who are income eligible and found to be at nutritional risk. The program shall serve as an adjunct to good health care during critical times of growth and development, in order to prevent the occurrence of health problems, including drug and other harmful substance abuse, and to improve the health status of these persons. The WIC state agency is responsible for providing services to as many eligible participants as funding allows.

AUTHORITY NOTE: Promulgated in accordance with 7 CFR Part 246, P. L. 95-627, and 41 USC 1786. Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health, Office of Public Health, LR 43:330 (February 2017).

§4103. Definitions

A. The following words and terms are defined for the purposes of this Subpart and for all contracts, guidelines, instructions, forms and other documents related hereto.

Above-50-Percent (*A50*) *Vendors*—vendors that derive more than 50 percent of their annual food sales revenue from WIC food instruments, and new vendor applicants expected to meet this criterion under guidelines approved by FNS. A50 vendors are subject to payment limitations that ensure that the prices of A50 vendors do not result in higher total food costs if program participants transact their food

instruments at A50 vendors rather than at non-A50 ("regular") vendors.

Administrative Review—a procedure by which a vendor may appeal an adverse action by the state agency.

Applicants—pregnant women, breastfeeding women, postpartum women, infants, and children who are applying to receive WIC benefits, and the breastfed infants of applicant breastfeeding women. Applicants include individuals who are currently participating in the program but are re-applying because their certification period is about to expire.

Authorized Supplemental Foods/WIC-Approved Foods—those supplemental foods authorized by the state agency for issuance to participants.

Authorized WIC Vendor (Vendor)—a retail grocery store that has submitted a complete WIC vendor application and any required supporting documentation, passed a pre-authorization on-site review, completed a training program, signed a formal vendor agreement binding the vendor to follow all WIC rules and policies upon authorization, and received a signed authorization letter from the Louisiana WIC program. Only authorized WIC vendors may transact WIC food instruments (FIs)/cash-value vouchers (CVVs).

Breastfeeding—the practice of feeding a mother's breast milk to her infant(s) on an average frequency of at least once a day.

Breastfeeding Women—women up to 1 year postpartum who are breastfeeding their infants.

CMP—civil money penalty.

CSFP—the Commodity Supplemental Food Program administered by the U.S. Department of Agriculture, authorized by section 4 of the Agriculture and Consumer Protection Act of 1973 [7 U.S.C. 1431(a)], as amended, and governed by 7 CFR Part 247.

Cash-Value Voucher (*CVV*)—a fixed-dollar amount check, voucher, electronic benefit transfer (EBT) card or other document which is used by a participant to obtain authorized fruits and vegetables.

Categorical Eligibility—persons who meet the definitions of pregnant women, breastfeeding women, postpartum women, infants or children.

Certification—the implementation of criteria and procedures to assess and document each applicant's eligibility for the program.

Change of Location—the move of a WIC vendor from one physical address to another address.

Change of Ownership—a change that results when all of the assets of the store are sold or transferred to a new owner or business entity. This includes adding a new partner(s).

Children—persons who have had their first birthday but have not yet attained their fifth birthday.

Clinic—a facility where applicants are certified.

Competent Professional Authority—an individual on the staff of the local agency authorized to determine nutritional risk and prescribe supplemental foods. The following persons are the only persons the state agency may authorize to serve as a competent professional authority: physicians, nutritionists (bachelor's or master's degree in nutritional sciences, community nutrition, clinical nutrition, dietetics, public health nutrition or home economics with emphasis in nutrition), dieticians, registered nurses, physician's assistants (certified by the National Committee on Certification of Physician's Assistants or certified by the state medical certifying authority), or state or local medically trained health officials. This definition also applies to an individual who is not on the staff of the local agency but who is qualified to provide data upon which nutritional risk determinations are made by a competent professional authority on the staff of the local agency.

Competitive Price Criteria (CPC)—price level at or below which WIC-approved foods shall be priced in order for a vendor applicant to be considered for authorization. The state agency determines CPC for each WIC-approved food item based on shelf prices for vendors within each peer group of regular vendors. CPC varies by vendor peer group. All vendors are subject to the CPC at all times in order to ensure that vendors do not raise prices, subsequent to selection, to a level that would make such vendors ineligible for authorization.

Confidentiality—in the context of the WIC program, not using or disclosing any confidential applicant, participant or vendor information gathered as a result of participation in the WIC program. Confidential applicant and participant information is any information about an applicant or participant, whether it is obtained from the applicant or participant, another source, or generated as a result of WIC application, certification, or participation, that individually identifies an applicant or participant and/or family member(s). Applicant or participant information is confidential, regardless of the original source. Vendors are required to keep confidential the customer's eligibility for and receipt of WIC benefits. Confidential vendor information is any information about a vendor (whether it is obtained from the vendor or another source) that individually identifies the vendor, except for vendor's name, address, telephone number, web site/e-mail address, store type, and authorization status.

Corrective Action Plan (CAP)—any plan developed by the state agency, or by a vendor and approved by the state agency, to correct deficiencies identified by the state agency in a vendor's compliance with WIC rules, regulations, policies, and/or procedures. Vendors shall implement CAPs when required by the state agency. CAPs may include, but are not limited to, requirements to provide store personnel or stock rotation training and/or to correct inappropriate WIC FI/CVV processing procedures used by the vendor.

Days—calendar days.

Disqualification—the act of ending the program participation of a participant, or authorized state or local

agency, whether as a punitive sanction or for administrative reasons and the act of ending program participation of an authorized WIC vendor for violations of the vendor agreement and/or federal or state rules, regulations or policy governing the WIC program.

Documentation—the presentation of written documents which substantiate oral, written, or electronic statements made by an applicant or participant or a person applying on behalf of an applicant or a vendor.

Drug—

a. beverage containing alcohol;

b. controlled substance (having the meaning given it in section 102 of the Controlled Substances Act of 1970 (21 U.S.C. 802(6)), as amended; or

c. controlled substance analogue (having the meaning given it in section 102 of the Controlled Substances Act of 1970 [21 U.S.C. 802(32)], as amended.

Dual Participation—simultaneous participation in the program in more than one WIC clinic, or participation in the program and in the CSFP during the same period of time.

Electronic Signature—an electronic sound, symbol, or process, attached to or associated with an application or other record and executed and or adopted by a person with the intent to sign the record.

FNS—the Food and Nutrition Service of the U.S. Department of Agriculture.

Family—a group of related or nonrelated individuals who are living together as one economic unit, except that residents of a homeless facility or an institution shall not all be considered as members of a single family.

Food Costs—the costs of supplemental foods, determined in accordance with 7 CFR §246.14(b).

Food Delivery System—the method used by state and local agencies to provide supplemental foods to participants.

Food Instrument (*FI*)—a voucher, check, electronic benefits transfer (EBT) card, coupon or other document that is used by a participant to obtain WIC-approved foods.

Food Package—WIC eligible food items listed on WIC food instruments in designated quantities.

Food Sales—sales of all SNAP eligible foods intended for home preparation and consumption, including meat, fish, and poultry; bread and cereal products; dairy products; and fruits and vegetables. Food items such as condiments and spices, coffee, tea, cocoa, and carbonated and noncarbonated drinks may be included in food sales when offered for sale along with foods in the categories identified above. Food sales do not include sales of any items that cannot be purchased with SNAP benefits, such as hot foods or food that will be eaten in the store.

Fraud and Abuse—conduct that violates WIC program rules, regulations, policies, and/or procedures, including, but not limited to, those violations leading to disqualification, as identified in the sanction schedule.

Full-Line Grocery Store—a retail food store/market (as defined under LAC 51:XXIII.101.A.) that stocks, and has on hand at all times, at least:

a. 5 varieties of cereal with 5 or more units of each variety;

b. 3 varieties of bread or tortillas with 5 or more units of each variety;

c. 4 varieties of fresh fruits with at least 5 units of each variety;

d. 4 varieties of fresh vegetables with at least 5 units of each variety; and

e. 4 varieties of fresh or frozen meat, poultry or fish with at least 5 units of each variety;

f. 2 varieties of rice with 6 or more units of each variety.

Health Services—ongoing, routine pediatric and obstetric care (such as infant and child care and prenatal and postpartum examinations) or referral for treatment.

Homeless Facility—the following types of facilities which provide meal service:

a. a supervised publicly or privately operated shelter (including a welfare hotel or congregate shelter) designed to provide temporary living accommodations;

b. a facility that provides a temporary residence for individuals intended to be institutionalized; or

c. a public or private place not designed for, or normally used as, a regular sleeping accommodation for human beings.

Homeless Individual—a woman, infant or child:

a. who lacks a fixed and regular nighttime residence; or

b. whose primary nighttime residence is:

i. a supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designated to provide temporary living accommodation;

ii. an institution that provides a temporary residence for individuals intended to be institutionalized;

iii. a temporary accommodation of not more than 365 days in the residence of another individual; or

iv. a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Incentive Items/Incentives—any goods or services provided as inducements to shop in a grocery store or recruit customers.

Infant Formula—a food that meets the definition of an infant formula in section 201of the Federal Food, Drug, and Cosmetic Act of 1938 (21 U.S.C. 321(z)), as amended, and that meets the requirements for an infant formula under section 412 of the Federal Food, Drug, and Cosmetic Act of 1938 (21 U.S.C. 350a), as amended, and the regulations at 21 CFR parts 106 and 107.

Infants—persons under 1 year of age.

Institution—any residential accommodation which provides meal service, except private residences and homeless facilities.

Judicial Review—the procedure by which a vendor may appeal a decision rendered at an administrative review, or a participant may appeal a decision rendered at a fair hearing.

Local Agency—a public or private, nonprofit or human service agency which provides health services, either directly or through contract, in accordance with 7 CFR §246.5.

Maximum Allowable Reimbursement Level (MARL)—the highest reimbursement amount for each FI for each peer group that the state agency may pay. The state agency determines a MARL for every WIC FI. Any FI that is submitted with a price higher than MARL shall be reduced through the automated clearing house (ACH) process.

Migrant Farmworker—an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode.

Non-A50 Vendors—see *regular vendors* (*non*-A50).

Nonprofit Agency—a private agency which is exempt from federal income tax under the *Internal Revenue Code* of 1954, (title 26 of the U.S.C.), as amended.

Nutrition Education—individual and group sessions and the provision of materials that are designed to improve health status and achieve positive change in dietary and physical activity habits, and that emphasize the relationship between nutrition, physical activity, and health, all in keeping with the personal and cultural preferences of the individual.

Nutritional Risk—

a. detrimental abnormal nutritional conditions detectable by biochemical or anthropometric measurements;

b. other documented nutritionally related medical conditions;

c. dietary deficiencies that impair or endanger health;

d. conditions that directly affect the nutritional health of a person, including alcoholism or drug abuse; or

e. conditions that predispose persons to inadequate nutritional patterns or nutritionally related medical conditions, including, but not limited to, homelessness and migrancy.

Other Harmful Substances—other substances such as tobacco, prescription drugs and over-the-counter medications that can be harmful to the health of the WIC population, especially the pregnant woman and her fetus.

Participant Access—the ability of a WIC participant to adequately access WIC-approved foods through the state agency's selection and authorization of an appropriate number and distribution of vendors consistent with ensuring effective state agency management, oversight, and review of its authorized vendors. The state agency has established participant access criteria in accordance with WIC regulations at 7 CFR part 246.

Participant Violation—any intentional or unintentional action of a participant, caregiver or a proxy that violates federal or state statutes, regulations, policies or procedures governing the program.

Participants—pregnant women, breastfeeding women, postpartum women, infants and children up to their fifth birthday who are currently enrolled in the WIC program and are receiving supplemental foods under the program, and the breastfed infants of participant breastfeeding women.

Participation—the sum of the number of:

a. persons who received supplemental foods or food instruments during the reporting period;

b. infants who did not receive supplemental foods or food instruments but whose breastfeeding mother received supplemental foods or food instruments during the report period; and

c. breastfeeding women who did not receive supplemental foods or food instruments but whose infant received supplemental foods or food instruments during the report period.

Peer Group—a group of vendors that is based on common characteristics or criteria that affect food prices. Vendors are grouped for management and cost containment purposes including, but not limited to, establishing and applying appropriate competitive price criteria (CPC) and MARLs to vendors.

Postpartum Women—usually, women up to six months after termination of pregnancy; however, this term shall also be apply to breastfeeding women up one year after termination of pregnancy.

Pregnant Women—women determined to have one or more embryos or fetuses *in utero*.

Price Adjustment—an adjustment made by the state agency, in accordance with the vendor agreement, to the purchase price on a food instrument after it has been submitted by a vendor for redemption. Price adjustments are made to ensure that the payment to the vendor for the food instrument complies with the state agency's price limitations.

Program—WIC (unless the context in which this word is used in this Subpart clearly indicates otherwise).

Proxy—any person designated by a woman participant, or by a parent or caretaker of an infant or child participant, to obtain and transact FIs and CVVs and/ or to obtain WIC-approved foods on behalf of a participant. The proxy shall be designated consistent with the state agency's procedures established pursuant to 7 CFR §246.12(r)(1). Parents or caretakers applying on behalf of child and infant participants are not proxies.

Regular Vendors (*Non-A50*)—vendors that do not meet the above-50-percent (A50) vendor's criterion, as defined elsewhere in this Subsection.

Reimbursement—the payment received by vendors after completing the routine process of depositing an FI or CVV into the banking system and the payment that may be received through the procedure an authorized vendor may use to request payment from the state agency when an FI or CVV has been refused by the bank or state agency. The state agency only reimburses vendors up to the applicable maximum allowable reimbursement level (MARL) for valid FIs and CVVs.

Sanctions—actions taken by the state agency when an authorized vendor fails to comply with WIC program rules, regulations, policies and/or procedures. Actions include, but are not limited to, CAPs, training requirements, termination of agreements, disqualifications or civil money penalties (CMPs), and fines.

Secretary—the secretary of the United States Department of Agriculture.

Sign or *Signature*—a handwritten signature on paper or an electronic signature. If the state agency chooses to use electronic signatures, the state agency shall ensure the reliability and integrity of the technology used and the security and confidentiality of electronic signatures collected in accordance with sound management practices, and applicable Federal law and policy, and the confidentiality provisions at 7 CFR §246.26.

State—the state of Louisiana.

State Agency—the state of Louisiana, Louisiana Department of Health, Office of Public Health, Center for Community and Preventive Health.

State Plan—a plan of program operation and administration that describes the manner in which the state agency intends to implement and operate all aspects of program administration within its jurisdiction in accordance with 7 CFR §246.4.

Supplemental Foods—those foods containing nutrients determined by nutritional research to be lacking in the diets of pregnant, breastfeeding and postpartum women, infants, and children, and foods that promote the health of the population served by the WIC program as indicated by relevant nutrition science, public health concerns, and cultural eating patterns, as prescribed by the secretary in 7 CFR §246.10.

Supplemental Nutrition Assistance Program (*SNAP*)—the program authorized by the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.), in which eligible households receive benefits that can be used to purchase food items from authorized retail stores and farmers' markets (formerly known as the Food Stamp Program).

Termination—the ending of a vendor agreement by the state agency for administrative reasons.

USDA—the United States Department of Agriculture.

Vendor—a sole proprietorship, partnership, cooperative association, corporation, or other business entity operating one or more stores authorized by the state agency to provide authorized supplemental foods to participants under a retail food delivery system. Each store operated by a business entity constitutes a separate vendor and shall be authorized separately from other stores operated by the business entity. Each store shall have a single, fixed location, except when the authorization of mobile stores is necessary to meet the special needs described in the state agency's state plan in accordance with 7 CFR §246.4(a)(14)(xiv).

Vendor Agreement—a document that is a legally binding agreement between an authorized vendor and the WIC program.

Vendor Authorization—the process by which the state agency assesses, selects, and enters into agreements with stores that apply or subsequently reapply to be authorized as vendors.

Vendor Limiting Criteria—criteria established by the state agency to determine the maximum number and distribution of vendors it authorizes pursuant to 7 CFR §246.12(g)(2).

Vendor Number—a distinctive five digit number assigned to each authorized vendor.

Vendor Overcharge—any intentional or unintentional charge for supplemental foods to the state agency for more than is permitted under the vendor agreement. It is not a vendor overcharge when a vendor submits a food instrument for redemption in accordance with the vendor agreement and the state agency makes a price adjustment to the food instrument.

Vendor Portal—a web-based application maintained by the state agency that serves as the primary point of contact for all Louisiana vendors and contains the WIC vendor price reporting system.

Vendor Selection Criteria—the criteria established by the state agency to select individual vendors for authorization consistent with the requirements in 7 CFR §246.12(g)(3) and (g)(4) and found in §4503 of this Subpart.

Vendor Violation—any intentional or unintentional action of a vendor's current owners, officers, managers, agents, or employees (with or without the knowledge of management) that violates the vendor agreement or federal or state statutes, regulations, policies, or procedures governing the program.

WIC—WIC program.

WIC-Approved Foods (*Authorized Supplemental Foods*)—those supplemental foods authorized by the state agency for issuance to participants.

WIC Program—the Special Supplemental Nutrition Program for Women, Infants and Children authorized by section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), as amended.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR12:869 (December 1988), amended by the Department of Health, Office of Public Health, LR 43:331 (February 2017).

Chapter 43. Participant Eligibility

§4301. Integration with Health Services

A. To lend administrative efficiency and participant convenience to the certification process, whenever possible, program intake procedures shall be combined with intake procedures for other health programs or services administered by the state and local agencies. Such merging may include verification procedures, certification interviews, and income computations. Local agencies shall maintain and make available for distribution to all pregnant, postpartum, and breastfeeding women, and to parents or caretakers of infants and children, any of whom are applying for and participating in the program, a list of local counseling and treatment resources for drug and other harmful substance abuse.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health, Office of Public Health, LR 43:334 (February 2017).

§4303. Eligibility Criteria

A. To be certified as eligible for the WIC program, applicants shall:

1. reside within the jurisdiction of the state, however, length of residency is not an eligibility requirement;

2. meet the income requirement as described in Subsection B of this Section; and

3. meet nutritional risk criteria as described in Subparagraph d (priority IV) of Paragraph 3 of Subsection C of this Section and in the state plan.

B. Income Criteria and Income Eligibility Determination

1. Income criteria for the program is established at 185 percent of poverty level (U.S. Department of Health and Human Services) as issued annually by the Louisiana Department of Health, Office of Public Health, Bureau of Nutrition Services. This shall have an effective date of no later than July 1 annually.

2. The state agency shall ensure that WIC clinics and local agencies determine income through the use of a clear and simple application form provided or approved by the state agency. Routine verification of income and/or a random selection to verify participant income is at the discretion of the state agency. Documentation of an applicant's participation in other agency-administered programs which routinely verify income, such as Medicaid, Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) may be accepted provided those programs have income guidelines at or below the WIC program guidelines.

C. Nutritional Risk. A competent professional authority shall determine if a participant is at nutritional risk through a medical and/or nutritional assessment. This determination may be based on referral data by an applicant or participant’s medical provider.

1. Determination of Nutritional Risk. At a minimum, height or length and weight of the participant shall be measured, and a hematological test for anemia such as a hemoglobin, hematocrit or free erythrocyte protoporphyrin test shall be performed. However, such tests are not required for infants under 9 months of age.

2. Appropriate nutritional risk codes, as specified in the state plan and as summarized in Paragraph 3 of this Subsection, shall be documented at each certification/recertification visit.

3. Nutritional Risk Priority System. The state agency shall, in the event that statewide participation has reached the maximum level, fill vacancies according to the federally mandated priority system. In the event a priority level must be partially closed, subpriorities are described in the state plan as approved by USDA. Priority levels are identified as follows.

a. Priority I consists of pregnant women, breastfeeding women and infants at nutritional risk as demonstrated by hematological or anthropometric measurements, or other documented nutritionally related medical conditions which demonstrate the need for supplemental foods.

b. Priority II consists of (except those infants who qualify for Priority I) infant up to 6 months of age born of women who participated in the program during pregnancy, and infants up to 6 months of age born of women who were not program participants during pregnancy but whose medical records document that they were at nutritional risk during pregnancy due to nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions which demonstrated the person's need for supplemental foods.

c. Priority III consists of children at nutritional risk as demonstrated by hematological or anthropometric measurements or other documented medical conditions which demonstrate the child's need for supplemental foods.

d. Priority IV consists of pregnant women, breastfeeding women, and infants at nutritional risk because of an inadequate dietary pattern.

e. Priority V consists of children at nutritional risk because of an inadequate dietary pattern.

f. Priority VI consists of postpartum women at nutritional risk.

g. Priority VII consists of individuals certified for WIC solely due to homelessness or migrancy and, at state agency option, previously certified participants who might regress in nutritional status without continued provision of supplemental foods.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 12:869 (December 1988), amended by the Department of Health, Office of Public Health, LR 43:335 (February 2017).

§4305. Timeframes for Processing Applicants

A. When the WIC clinic or local agency is not serving its maximum caseload, the local agency shall accept applications, make eligibility determinations, notify the applicants of the decisions made and, if the applicants are to be enrolled, issue food, cash-value vouchers or food instruments. All of these actions shall be accomplished within the timeframes set forth below.

1. The processing timeframes shall begin when the individual visits the local agency during clinic office hours to make an oral or written request for benefits.

2. Special nutritional risk applicants shall be notified of their eligibility or ineligibility within 10 days of the date of the first request for program benefits; except that state agencies may provide an extension of the notification period to a maximum of 15 days for those local agencies which make written request, including a justification of the need for an extension. The state agency shall establish criteria for identifying categories of persons at special nutritional risk who require expedited services. At a minimum, however, these categories shall include pregnant women eligible as priority I participants, and migrant farm workers and their family members who soon plan to leave the jurisdiction of the local agency.

3. All other applicants shall be notified of their eligibility or ineligibility within 20 days of the first date of the request for program benefits.

4. Each WIC clinic or local agency using a retail purchase system shall issue a food instrument(s) and if applicable a cash-value voucher(s) to the participant at the same time as notification of certification. Such food instrument(s) and cash-value voucher(s) shall provide benefits for the current month or the remaining portion thereof and shall be redeemable immediately upon receipt by the participant. Local agencies may mail the initial food instrument(s) and, if applicable, cash-value voucher(s) with the notification of certification to those participants who meet the criteria for the receipt of food instruments through the mail, as provided in 7 CFR §246.12(r)(4).

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health, Office of Public Health, LR 43:335 (February 2017).

§4307. Certification Periods

A. Program benefits shall be based upon certifications established in accordance with the following timeframes.

1. Pregnant women shall be certified for the duration of their pregnancy and for up to six weeks postpartum.

2. Postpartum women shall be certified for up to six months postpartum.

3. Breastfeeding women shall be certified at intervals of approximately six months and ending with the breastfed infant's first birthday.

4. Infants shall be certified up until their first birthday.

5. Children shall be certified at intervals of approximately six months and ending with the end of the month in which a child reaches its fifth birthday.

B. Upon request, participants shall receive verification of certification when transferring to another WIC program out of state.

C. If the nutritional risk determination is based on data taken before the time of entrance into the program, the certification period for breastfeeding women and children shall be based upon the date when the data was first taken.

D. Participants receiving program benefits may be disqualified during a certification period for the following reasons.

1. Participant violation including, but not limited to, intentionally making false or misleading statements or intentionally misrepresenting, concealing, or withholding facts to obtain benefits; exchanging CVVs, FIs, or WIC-approved foods for cash, credit, non-food items, or unauthorized food items, including WIC-approved foods in excess of those listed on the participant’s FI; threatening to harm or physically harming vendor staff; or making a written, electronic, or verbal offer to sell WIC benefits, including WIC-approved foods, FIs, CVVs, and/or EBT cards, or allowing someone else to do so.

2. If the state agency experiences funding shortages, it may be necessary to discontinue program benefits to a number of certified and participating participants. The state agency shall not enroll new participants during the period when currently participating participants, those who have received benefits during a current certification, are denied remaining benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health, Office of Public Health, LR 43:336 (February 2017).

§4309. Participant Rights and Responsibilities/ Notification/Fair Hearing

A. Participant Rights and Responsibilities. All applicants shall read or have read to them the programs' rights and responsibilities statement, including the restriction of dual participation in the program or between the program and CSFP. After reviewing the statement, all applicants shall sign attesting to have reviewed the statement.

B. Notification of Ineligibility. Participants found ineligible during a certification period shall be advised in writing of the ineligibility, the reasons for the ineligibility and of the right to a fair hearing.

C. Notification of Disqualification. Participants who are about to be disqualified from program participation during a certification period shall be advised in writing not less than 15 days before the effective date of disqualification, of the reasons for the disqualification and the right to a fair hearing.

D. Fair Hearing Procedures for Participants. The state agency provides a hearing procedure through which any individual may appeal, within 60 days of the date of notification by the state agency, an action which results in the denial of participation or the disqualification from the program.

1. The hearing process is governed by the procedures set forth in the Administrative Procedure Act, R.S. 49:950 et seq., and as mandated by federal regulations, 7 CFR part 246.

2. The state agency shall not summarily deny or dismiss an appeal unless:

a. the request is withdrawn in writing by the appellant or legal representative of the appellant;

b. the appellant or legal representative fails, without good cause, to appear at the scheduled hearing; or

c. the appellant has been denied participation by a previous decision following a hearing and does not allege in the request for appeal that circumstances relevant to program eligibility have changed in such a way as to justify a new hearing.

3. The state agency shall continue program benefits for a participant whose participation has been terminated during a certification period if a request for an appeal is received within the 15 days advance notification of disqualification. Benefits shall continue until the hearing officer reaches a decision or the certification period expires, whichever occurs first. Applicants who are denied benefits at initial certification or because of the expiration of their certification may appeal the denial, but shall not receive benefits while pending the hearing and decision of the hearing officer.

4. A participant or representative may appeal the fair hearing decision through judicial review as provided for in the Louisiana Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health, Office of Public Health, LR 43:336 (February 2017).

Chapter 45. Vendor Selection, Participation and Sanctions

§4501. Reserved.

§4503. Vendor Selection Criteria

A. As outlined in the *Federal Register*, 7 CFR part 246, the state agency has the responsibility to maximize the use of available funds by providing supplemental foods to participants at the most reasonable prices and to have an agreement with enough vendors to ensure adequate participant access. The state agency reserves the right to implement limiting criteria on vendors statewide by peer group in order to meet this responsibility. If the state agency elects to implement such limiting criteria, the criteria shall be made available to all vendors and applied equally to all vendors within peer groups.

B. Vendor Selection Criteria. In order to be eligible to participate in the Louisiana WIC program, the applicant vendor and/or authorized vendors shall:

1. submit a complete and notarized application, including any required supporting documentation, to the WIC state agency within applicable timeframes set by the WIC state agency;

2. be currently authorized and participating in the USDA Supplemental Nutrition Assistance Program (SNAP) and cannot have received a SNAP civil money penalty (CMP) for which the disqualification period, if it had been imposed, would not yet have expired;

3. have a grocery class permit to operate issued under the Bureau of Sanitarian Services of the Office of Public Health for the current state fiscal year;

4. maintain the establishment in a clean, orderly and safe condition, with no current sanctions for violations of the Louisiana state *Sanitary Code* (LAC 51), the *International Plumbing Code* as amended by the Louisiana State Uniform Construction Code Council (LAC 17:I.111), or local health code ordinances;

5. be open a minimum of 6 days, and at least 48 hours, per week;

6. have prices that are competitive with other vendors in the vendor's state agency designated peer group, as determined by the state agency's competitive price criteria (CPC). Applying vendors, whose prices are higher than the CPC applicable to their peer groups, shall be informed and given one opportunity to lower their prices to meet the CPC;

7. display prices for WIC-approved foods on the foods or on the shelves/display area in immediate proximity to the foods;

8. stock and maintain sufficient quantities and varieties of all WIC-approved foods in accordance with Louisiana WIC's minimum stock requirements, which can be found in the minimum stock requirements section of the vendor guide;

9. purchase infant formula only from vendors included on Louisiana WIC's list of infant formula manufacturers registered with the Food and Drug Administration (FDA) that provide infant formula, and licensed infant formula wholesalers, distributors ,and retailers. This list can be found at http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2328;

10. not have been denied WIC authorization or had a prior WIC authorization terminated by the state agency within the past year for any reason other than the expiration of the vendor agreement, store closing, or store relocation;

11. ensure that the vendor, vendor applicant or any of the vendor's or vendor applicant's current owners, officers, or managers shall not have been formerly employed by any vendor that was disqualified from any USDA food program within the prior six years;

12. ensure that the vendor, vendor applicant or any of the vendor's or vendor applicant's current owners, officers, or managers shall not have been convicted of any felony within the prior six years;

13. ensure that the vendor, vendor applicant or any of the vendor's or vendor applicant's current owners, officers, or managers shall not have been convicted of any federal, state or local tax violations within the prior six years;

14. ensure that the vendor, vendor applicant or any of the vendor's or vendor applicant's current owners, officers, or managers shall not have a civil judgment entered against them within the prior six years for any activity indicating a lack of business integrity (including but not limited to fraud, antitrust violations, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, and obstruction of justice);

15. be in good standing with no unpaid or overdue balances owed to the Louisiana WIC program;

16. not have had any WIC vendor agreement terminated due to false or inaccurate information provided to the WIC program within the past six years;

17. have access to a computer, with internet access, and shall have an e-mail account that can be used to send messages to and receive messages from the Louisiana WIC program, and shall be able to download and upload electronic documents sent/received via email or posted/requested on the vendor portal or any other online application used by the WIC program;

18. utilize a cash register system that performs split tender transactions and produces itemized receipts showing date of purchase, items purchased, price of items purchased, and the total sale amount, at a minimum;

19. redeem or expect to redeem at least 50 WIC FIs per month;

20. agree to be placed in a vendor peer group with other above-50-perecent vendors when deriving or expecting to derive more than 50 percent of their annual food sales revenue from WIC FI transactions. Vendors within this peer group shall maintain WIC-approved food prices at a level such that the average payments per FI for above-50-percent vendors does not exceed average payments per FI to regular vendors;

21. agree to neither provide nor advertise nor indicate an intent to provide customers with any incentive items, when deriving or expecting to derive more than 50 percent of their annual food sales revenue from WIC FI transactions. The state agency shall make a determination on what constitutes a violation of the intent of the previous sentence; however, incentive items definitively prohibited include, but are not necessary limited to:

a. services which result in a conflict of interest or the appearance of such conflict for the above-50-percent vendor, such as assistance with applying for WIC benefits;

b. lottery tickets at no charge or below face value;

c. cash gifts in any amount for any reason;

d. anything made available in a public area as a complimentary gift which may be consumed or taken without charge;

e. food, merchandise or services of any value provided to the customer;

f. food, merchandise sold to customers below cost, or services purchased by customers below fair market value;

g. any kind of incentive item which incurs a liability for the WIC program; and

h. any kind of incentive item which violates any federal, state, or local law or regulations;

22. not derive or expect to derive more than 50 percent of annual food sales revenue from WIC FI transactions; and

23. be a full-line grocery store, as defined by the state agency. The Louisiana WIC definition of a *full-line grocery store* can be found in §4103 of this Subpart.

C. After authorization, all WIC vendors shall continue to meet the criteria of this Section, and any changes thereto, at all times. A WIC vendor found to be out of compliance with the WIC regulations, vendor agreement, or WIC vendor selection criteria, at any time during the authorization period is subject to termination of the WIC authorization and vendor agreement and possible disqualification. Disqualification from WIC may result in disqualification from the Supplemental Nutrition Assistance Program

(SNAP) and such SNAP disqualification is not subject to administrative or judicial review under the SNAP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive Health Services, LR 13:246 (April 1987),, amended by the Department of Health, Office of Public Health, LR 43:337 (February 2017).

§4505. Agreement

A. The authorized vendor shall sign and agree to the conditions enumerated and/or referenced in the WIC vendor application and vendor agreement.

B. The authorized vendor shall accept state agency adjustments to WIC FI and CVV claims for reimbursement. The state agency may make adjustments to ensure that payments to the authorized vendor do not exceed the maximum allowable reimbursement level for the vendor's assigned peer group.

C. No request for reimbursement submitted by the vendor shall be paid by the state agency unless the claim is in accordance with the terms of the vendor agreement.

D. Unauthorized vendors that accept FIs or CVVs may be held liable for repayment of any funds received.

E. Terms of Agreement. An agreement shall be for a period not exceeding three years. The agreement is null and void if ownership changes. Neither party has an obligation to renew the agreement. Fifteen days written notice shall be given prior to the expiration of an agreement. Expiration of an agreement is not subject to appeal.

F. Termination of Agreement. The agreement may be terminated by 15-days written notice to the other party or by the mutual agreement to terminate of both parties. The 15-days written notice does not apply when the state agency terminates the agreement or disqualifies a vendor as a result of violation(s) of the terms of the agreement.

1. The state agency shall terminate an authorized vendor agreement for failure of the vendor to meet the selection criteria found in §4503.B of this Subpart

2. The state agency shall immediately terminate the agreement if it determines that the vendor has provided false information in connection with its application for authorization. Violations of the WIC program regulations shall result in termination of the agreement, disqualification, and/or possible referral for criminal prosecution.

G. A vendor may be subject to announced and unannounced monitoring visits and inventory audits by authorized personnel to determine compliance with the vendor agreement and/or federal or state rules, regulations or policy governing the WIC program.

H. WIC vendors agree to provide any records requested by authorized parties pursuant to their vendor agreement by established due dates.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health, Office of Public Health, LR 43:338 (February 2017).

§4507. Reimbursement of Altered or Bank Rejected Food Instruments or Cash-Value Vouchers

A. If a vendor has a FI or CVV that has been rejected or has had the payment amount adjusted by the Louisiana WIC contracted bank and the vendor feels that the rejection or adjustment was made in error, the vendor may request reimbursement from the state agency.

B. The vendor shall submit to the state agency, in a format specified by the state agency, any bank rejected FIs or CVVs within 60 days from the last day of the valid period. Any FIs or CVVs submitted thereafter shall not be considered.

C. In determining whether or not to reimburse vendors for FI(s) or CVV(s) rejected by the bank due to errors on the vendors' part, the state agency may consider the following criteria in making its determination:

1. the prior record of the same repeated errors;

2. the vendor's reported food costs versus the amount requested for reimbursement; and

3. the level of documented inventory on hand.

D. Vendors shall be notified of adverse reimbursement decisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (Apri1 1987), amended by the Department of Health, Office of Public Health, LR 43:338 (February 2017).

§4509. Vendor Sanctions for Violations

A. Federal Mandatory Vendor Sanctions

1. The state agency shall permanently disqualify a vendor convicted of trafficking in food instruments (FIs) or cash value vouchers (CVVs) or selling firearms, ammunition, explosives, or controlled substances (as defined in section 102 of the Controlled Substances Act of 1970 (21 U.S.C. 802), as amended) in exchange for FIs or CVVs.

2. The state agency shall disqualify a vendor for six years for:

a. one incidence of buying or selling a WIC FI or CVV for cash (trafficking); or

b. one incidence of selling firearms, ammunition, explosives, or controlled substances as defined in 21 U.S.C. 802, as amended, in exchange for a WIC FI or CVV.

3. The state agency shall disqualify a vendor for three years for:

a. one incidence of the sale of alcohol, alcoholic beverages, or tobacco products in exchange for a WIC FI or CVV;

b. a pattern of claiming reimbursement for the sale of an amount of a specific supplemental food item that exceeds the store's documented inventory of that supplemental food item for a specific period of time;

c. a pattern of vendor overcharges;

d. a pattern of receiving, transacting and/or redeeming FIs or CVVs outside of authorized channels, including the use of an unauthorized vendor and/or an unauthorized person;

e. a pattern of charging for supplemental foods not received by the participant; or

f. a pattern of providing credit or non-food items (not including alcohol, alcoholic beverages, tobacco products, cash, firearms, ammunition, explosives, or controlled substances as defined in 21 U.S.C. 802, as amended) in exchange for FIs or CVVs.

4. The state agency shall disqualify a vendor for one year for if:

a. a pattern of providing unauthorized food items in exchange for FIs or CVVs, including charging for supplemental foods provided in excess of those listed on the FI; or

b. a pattern of an above-50-percent vendor providing prohibited incentive items to participants as set forth in federal regulations at 7 CFR 246.12(g)(3)(iv).

B. Second Federal Mandatory Vendor Sanction. When a vendor that has previously been assessed a sanction for any of the federal mandatory vendor sanctions and then receives a second sanction for any of the federal mandatory vendor sanctions, the state agency shall double the second sanction. The total amount assessed in civil money penalties (CMPs) for a second sanction may not exceed the maximum limits allowed under federal regulations.

C. Third or Subsequent Federal Mandatory Vendor Sanction. When a vendor who previously has been assessed two or more sanctions for any of the federal mandatory vendor sanctions and then receives another sanction for any of the federal mandatory vendor sanctions, the state agency shall double the third sanction and all subsequent sanctions. The state agency may not impose a civil money penalty (CMP) in lieu of disqualification for third or subsequent sanctions for federal mandatory vendor sanctions.

D. State Agency Vendor Sanctions. The state agency identifies violations contained in Paragraphs 1 through 7 and 9 of this Subsection as actions subject to a corrective action plan for an initial violation. Corrective action plans shall be implemented in full by vendors when required by the state agency and can include, but are not limited to, store employee training, stock rotation training, and/or training on WIC FI/CVV processing procedures. If the vendor fails to implement a corrective action plan for failure to adhere to selection criteria, the state agency shall terminate the vendor agreement. The state agency may disqualify a vendor from participation in WIC for one year for a pattern of any of the following state agency violations:

1. providing cash for returned WIC-approved foods purchased with WIC FIs/CVVs;

2. failing to comply with FI and CVV processing and redemption procedures;

3. stocking or selling WIC-approved foods that are expired or otherwise not fresh, as determined by the state agency;

4. failing to participate in and complete training, as scheduled and required by the state agency;

5. failing to maintain or provide the state agency with required information by the due date identified by the state agency;

6. failing to notify the state agency of instances in which a participant or proxy has failed to comply with WIC program requirements;

7. failing to provide to WIC participants or proxies the same courtesies as offered to other customers;

8. failing to implement a corrective action plan imposed by the state agency; or

9. failing to adhere to any other requirements of the vendor agreement or vendor guide except those for which a longer disqualification period is required as specifically identified within Subsection A-A.2.f of this Section.

E. Civil Money Penalty. Except where prohibited by federal regulation or in those cases of permanent vendor disqualification pursuant to the application of Subsection A of this Section, if the state agency determines in its sole discretion that disqualification of the authorized vendor would result in inadequate participant access, the state agency shall impose a civil money penalty (CMP) in lieu of disqualification. Such CMP shall be calculated in accordance with federal regulations. If a vendor does not pay the CMP, only partially pays the CMP, or fails to make timely payment of the CMP in lieu of disqualification, the state agency shall disqualify the vendor for the length of the disqualification corresponding to the violation for which the CMP was assessed.

F. Recoupment of Excess Payment. The state agency shall recoup excess payments made to the authorized vendor resulting from the vendor's violation of the vendor agreement.

G. SNAP Disqualification. The state agency shall disqualify from the WIC program a vendor who is disqualified from SNAP. The disqualification shall be for the same length of time as SNAP disqualification, may begin at a later date than SNAP disqualification, and is not subject to administrative or judicial review under the WIC program.

H. SNAP CMP. The state agency shall disqualify a vendor who receives a CMP for hardship by SNAP. The

length of such disqualification shall correspond to the period for which the vendor would otherwise have been disqualified in SNAP.

I. Mandatory Sanction by another WIC State Agency. The state agency shall disqualify a vendor that has been disqualified or assessed a CMP in lieu of disqualification by another WIC state agency for a federal mandatory vendor sanction under the provisions of Subsection A.1-A.4.b of this Section. The length of the disqualification shall be for the same length of time as the disqualification by the other WIC state agency or, in the case of a CMP in lieu of disqualification assessed by the other WIC state agency, for the same length of time for which the vendor would otherwise have been disqualified. The disqualification may begin at a later date than the sanction imposed by the other WIC state agency.

J. Voluntary Withdrawal not Accepted. Voluntary withdrawal of a vendor and non-renewal of the vendor agreement as alternatives to WIC disqualifications shall not be accepted, and the disqualification shall be entered on the record.

K. Comprehensive Inclusion of Violations of Vendor Document Requirements (including the WIC vendor guide and the WIC vendor agreement which is not covered elsewhere in this Section). Vendor sanctions for violations of vendor document requirements (including the WIC vendor guide and the WIC vendor agreement not covered elsewhere in this Section) may result in termination or disqualification, following provision to the vendor of reasonable notice and opportunity to correct, where permitted by WIC regulations. Violations may give rise to the state agency's assessment of vendor claims, fines, and penalties. Termination of the vendor agreement does not relieve the vendor of the obligation to pay such assessments.

L. State Agency Actions. The state agency shall determine the action to be taken whenever vendor fraud, abuse, or administrative violations are discovered. If the state agency determines that the vendor has violated WIC rules or regulations, the vendor may be required to develop and submit a corrective action plan, the vendor agreement may be terminated and/or the vendor may be disqualified from participation in the WIC program for a period of time no more than the maximum period of time allowed under federal regulations at 7 CFR part 246. To obtain reauthorization, vendors who are disqualified or whose vendor agreement has been terminated shall reapply and meet all current requirements for authorization.

M. Vendor Notification. The state agency shall notify a vendor in writing when an investigation reveals an initial incidence of a violation for which a pattern of incidences must be established in order to impose a sanction, before another such incidence is documented, unless the state agency determines, in its discretion, on a case-by-case basis, that notifying the vendor would compromise an investigation. Notification shall not be provided for a pattern of claiming reimbursement for the sale of an amount of a specific supplemental food item that exceeds documented inventory.

N. Effect on Other Stores under Same Ownership. If an individual, partnership, corporation, limited liability company, or other business structure is convicted of a criminal offense involving WIC, SNAP, or any other program funded and administered by the Food and Nutrition Service of the U.S. Department of Agriculture, all grocery stores wholly or partially owned or managed by the convicted individual, partnership, corporation, limited liability company, other business structure, or by a partner of a convicted partnership or an officer, of a convicted corporation or a convicted limited liability company, shall be terminated from vendor authorization and shall be ineligible for future vendor authorization for the maximum period of time allowed by federal law and regulations. This termination and period of ineligibility shall occur whether or not the grocery store was the location at which the crime occurred, and regardless of whether or not a penalty was imposed upon the convicted party by the court of competent jurisdiction.

O. Legal Remedies Not Precluded by Sanction. The state agency sanctions for vendor violations or program abuse shall not be construed as excluding or replacing any criminal or civil sanctions or other remedies that may be applicable under any federal or state statute or local ordinance. A vendor who commits fraud or abuse of the program is liable to prosecution under applicable federal, state or local laws. Those vendors who have willfully misapplied, stolen or fraudulently obtained program funds shall be subject to a fine of not more than $25,000 or imprisonment for not more than 5 years or both, if the value of the funds is $100 or more. If the value of the funds is less than $100, such vendors shall be subject to a fine of not more than $1,000 or imprisonment for not more than 1 year, or both.

P. Prosecution Referral. The state agency shall, where appropriate, refer vendors who abuse the program to federal, state and/or local authorities for prosecution.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health, Office of Public Health, LR 43:338 (February 2017).

§4511. Administrative Review of State Agency Adverse Actions

A. Adverse actions taken by the Louisiana WIC program that affect vendors or vendor applicants may be subject to administrative review, if appealed.

B. The Louisiana WIC program shall provide written notification of the adverse action, the procedures to follow to request an administrative review, and the cause(s) for and the effective date of the action. If the vendor is disqualified due in whole or in part to violations of §4509.A of this Subpart, such notification shall include the following statement: "This disqualification from WIC may result in

disqualification as a retailer in SNAP. Such disqualification is not subject to administrative or judicial review under SNAP." If the WIC authorized vendor or applicant vendor wishes to appeal the decision, the vendor or applicant vendor shall submit a request for appeal stating the reason for the appeal. The request shall be submitted in writing and mailed to the Louisiana WIC program within 15 calendar days after the receipt of the state agency's written notification of the adverse action. Within the notice of adverse action, the Louisiana WIC program shall include an appropriate return mailing address, along with a staff member's contact name, so that an aggrieved party may properly submit a request for appeal.

C. The adverse action shall be imposed on the effective date noted in the written notification and shall remain in place during the administrative review unless the Louisiana WIC program determines, at its sole discretion, that the adverse action would result in inadequate participant access to supplemental foods.

D. Adverse actions subject to administrative review include the following:

1. denial of authorization based on the application of the vendor selection criteria for minimum variety and quantity of approved foods;

2. denial of authorization based on a determination that the vendor is attempting to circumvent a sanction;

3. termination of an agreement for cause;

4. disqualification, except as a result of a disqualification from SNAP;

5. imposition of a fine or a civil money penalty in lieu of disqualification;

6. denial of authorization based on the vendor selection criteria for business integrity;

7. denial of authorization based on the selection criteria for a current SNAP disqualification or civil money penalty for hardship;

8. denial of authorization based on the application of the vendor selection criteria for competitive price;

9. the application of the state agency's vendor peer group criteria and the criteria used to identify vendors that are above-50-percent vendors or comparable to above-50-percent vendors;

10. denial of authorization based on a state agency-established vendor selection criterion if the basis of the denial is a WIC vendor sanction or a SNAP withdrawal of authorization or disqualification;

11. denial of authorization based on the state agency's limiting criteria, if any;

12. denial of authorization because a vendor submitted its application outside the time frames during which applications are being accepted and processed, as established by the state agency;

13. termination of an agreement because of a change in ownership or location or cessation of operations;

14. a civil money penalty imposed in lieu of disqualification based on a SNAP disqualification; and

15. denial of an application based on a determination of whether an applicant vendor is currently authorized by SNAP.

E. A WIC authorized vendor or vendor applicant who files a proper appeal request for those actions subject to administrative review shall be provided:

1. adequate advance notice of the time and place of the administrative review to provide all parties involved sufficient time to prepare for the review and at least one opportunity to reschedule the administrative review date upon specific request;

2. the opportunity to examine, prior to the review, the evidence upon which the Louisiana WIC program's action is based;

3. the opportunity to be represented by counsel;

4. the opportunity to cross-examine adverse witnesses (when necessary to protect the identity of witnesses, they may be cross-examined behind a protective screen or other device);

5. the opportunity to present its case;

6. an impartial decision-maker, whose determination is based solely on whether the Louisiana WIC program has correctly applied federal and state statutes, regulations, policies, and procedures governing the program, according to the evidence presented at the review; and

7. written notification of the review decision, including the basis for the decision, within 90 days from the date of receipt of a vendor's request for an administrative review; however, this timeframe is only an administrative goal for the Louisiana WIC program and, should a decision of the appeal review not be made within the specified time frame, such delay shall not provide a basis to overturn the adverse action.

F. Actions not subject to administrative review include:

1. the validity or appropriateness of the Louisiana vendor limiting criteria, if any;

2. the validity or appropriateness of Louisiana's vendor selection criteria for the minimum variety and quantity of supplemental foods, business integrity, current SNAP disqualification, or civil money penalty for hardship;

3. the validity or appropriateness of the Louisiana selection criteria for a competitive price including, but not limited to, vendor peer group criteria and the criteria used to identify vendors that are above-50-percent vendors or comparable to above-50-percent vendors;

4. the validity or appropriateness of the state agency's participant access criteria and the state agency's participant access determinations;

5. the state agency's determination to include or exclude an infant formula manufacturer, wholesaler, distributor, or retailer from the list of businesses from which an authorized vendor may purchase infant formula pursuant to selection criteria;

6. the validity or appropriateness of the state agency's prohibition of incentive items and the state agency's denial of an above-50-percent vendor's request to provide an incentive item to customers;

7. the state agency's determination whether to notify a vendor in writing when an investigation reveals an initial violation for which a pattern of violations must be established in order to impose a sanction;

8. the state agency's determination whether a vendor had an effective policy and program in effect to prevent trafficking and that the ownership of the vendor was not aware of, did not approve of, and was not involved in the conduct of the violation;

9. denial of authorization if the state agency's vendor authorization is subject to the procurement procedures applicable to the state agency;

10. the expiration of a vendor's agreement;

11. disputes regarding food instrument or cash-value voucher payments and vendor claims (other than the opportunity to justify or correct a vendor overcharge or other error); and

12. disqualification of a vendor as a result of disqualification from SNAP.

G. A vendor that is permitted to continue program operations while its appeal is in process does not relieve such vendor from the responsibility of continued compliance with the terms of any written agreement with the Louisiana WIC program. Administrative review decisions of the Division of Administrative Law are the final action of the Louisiana WIC program. If the review decision upholds the adverse action against the vendor, the vendor may be able to pursue judicial review of the decision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health, Office of Public Health, LR 43:340 (February 2017).

§4513. Availability of Documents

A. The vendor application, the vendor agreement, and the WIC vendor guide shall be provided for review to any interested party by submission of an e-mail request to LAWICVendor@la.gov.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health, Office of Public Health, LR 43:342 (February 2017).

Subpart 17. Children's Special Health Services (CSHS)

Chapter 49. General Provisions

§4901. Purpose and Services

A. Purpose. Children's Special Health Services (CSHS) provides for the care of children in Louisiana with certain special health care needs (birth to 21 years).

B. Services Provided

1. Service Level I. CSHS provides general services for all children in Louisiana with special health care needs. Services are directed through information gathering, setting of service standards, program planning, public education, referral and family empowerment.

2. Service Level II. The program offers child specific medical care coordination for those families needing this service as determined by CSHS regional staff.

3. Service Level III. The Program offers child specific wraparound services which may include assessment,

intervention, and follow-up nursing, social and nutrition services. Other support services may include care coordination, parent-to-parent support, transition planning, and other allied health services.

4. Service Level IV. For those families who are financially and medically eligible (as defined in Chapter 51), the Program offers direct medical diagnostic and treatment services in addition to the services provided in Levels I, II and III. These direct medical services are available for children with certain chronic physical illnesses or serious disabilities which can be treated through an outpatient clinic approach.

a. These direct medical diagnostic and treatment services may include the provision of /or payment for hospitalizations, medications, (re)habilitative appliances and devices, medical equipment and allied health services as ordered by physicians on contract to CSHS.

b. Families receiving services from the Program are required to contribute financially through any form of medical insurance, (i.e., private, managed care plans, Medicaid or Medicare). Families may be required to make direct payment for services to vendors. A determination of ability to financially contribute is made by designated CSHS regional staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, R.S. 40:1299.111-120, and Title XIX, Public Health Service Act, Section 1905.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987). Amended by the Department of Health and Hospitals, Office of Public Health, LR 15:10, amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§4903. Referrals

A. Referrals to the Program

1. Families may be referred to the program by physicians, public health nurses, audiologists, private and public hospitals, other health care agencies and other Office of Public Health (OPH) Programs.

2. The usual point of entry into the program is through the OPH health unit in the child's parish of residence.

3. The public health nurse at the OPH health unit shall obtain needed information to complete the CSHS Application, provide the family an explanation about the program and send the application to the appropriate CSHS Regional Office for review and disposition.

4. Emergency medical referrals may be made directly to the CSHS Regional Office by telephone contact from physicians, nurses and hospital social workers. Examples of such referrals are a new-born infant with spina bifida, a child with a heart condition or hydrocephalus needing immediate medical attention or surgery.

B. Referrals Outside of the State. When a family is moving from Louisiana to another state and the child needs continuing care, efforts shall be made by the CSHS Regional Staff to direct them to an appropriate agency in the other state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, R.S. 40:1299.111-120, and Title XIX, Public Health Service Act, Section 1905.

HISTORICAL NOTE: Promulgated by the Department of health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987). Amended by the Department of Health and Hospitals, Office of Public Health, LR 15:10, amended by the Department of Health and Hospitals , Office of Public Health, LR 22:362 (May 1996).

§4905. Definitions

A. For the purpose of this Subpart the following definitions shall apply:

1. Child—a child is an individual from birth until twenty-first (21st) birthday.

2. Applicant—an applicant is the child for whom services are requested.

3. Family—a family is a group of people related by blood, marriage and/or legal adoption living together as one economic unit and supported by the reported income.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, R.S. 40:1299.111-120, and Title XIX, Public Health Service Act, Section 1905.

HISTORICAL NOTE: Promulgated by the Department of health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).Amended by the Department of Health and Hospitals, Office of Public Health, LR 15:10, amended by the Department of Health and Hospitals , Office of Public Health, LR 22:362 (May 1996).

Chapter 51. Eligibility for Service Level IV

§5101. Eligibility Criteria

A. Eligibility shall be based on two factors, medical eligibility and financial eligibility. This determination shall be made by the designated statewide CSHS Regional Staff . To be eligible to receive direct medical services, the applicant:

1. must reside in the State of Louisiana;

2. must not have reached his/her 21st birthday;

3. must have a condition for which the Program provides treatment services and must be reasonably expected to benefit from the services;

4. must be a member of a family who meets the financial eligibility criteria to receive services. Financial eligibility is based upon three (3) criteria; family size, income(s) and resource(s). All three criteria must be met in order for an applicant to be financially eligible.

a. Family Size. Family size shall be defined as the number of persons living together and related to the applicant by blood, marriage and/or legal adoption and supported by reported income. Foster parents are not to be counted as family members. If a child is in a foster placement and is in the custody of the Department of Health and Hospitals, or Department of Social Services, he shall be considered a family of one.

i. In situations of divorce, blended families, etc., the legal custody decree shall be considered as the rule in determining family size and income.

ii. A parent or step-parent required by a legal custody decree to pay child support to a child/children residing outside the family home is allowed to subtract the amount of the annual child support payment from the applicant's family gross income.

iii. Unusual family situations will be forwarded in writing to the CSHS Administrative Unit for consideration.

b. Family Income. Family income shall be defined as the total annual cash receipts from all sources before taxes. (Income data for a part of a year may be annualized in order to determine eligibility -for example, multiply by four the amount of income received during the most recent three months). Income includes money, wages, and salaries before any deductions, but does not include food or rent received in lieu of wages. Income also includes regular payments from Social Security, Railroad Retirement, unemployment compensation, strike benefits from union funds, veterans benefits, public assistance (including Aid to Families with Dependent Children and Supplement Security Income), alimony, child support, and military family allotments or other regular support from an absent family member or someone not living with the family, private pension, government employee pensions, cash gifts, regular insurance

or annuity payments, and income from dividends, interest, rent, royalties, or periodic receipts from estates or trusts.

i. Excluded from family income are non-cash benefits, such as employer or union paid health insurance or other fringe benefits, food or rent received in lieu of wages, the value of food produced and consumed on farms, and state entitlement programs such as Family Subsidy,(Cash Subsidy, Family Support).

ii. Accumulated family medical payment for bills not paid by insurance for the previous 12 months will be deducted from the annual income before eligibility is determined. The annual medical insurance premium paid by the family will also be subtracted from the gross income.

iii. All income must be verified by check stubs, previous year federal income tax form, statement from employer, and/or, upon request, other appropriate documents.

c. Family Resource. Family resources shall be defined as assets or possessions which a family can apply (directly or by sale or conversion) to meet needs. Resources for consideration in determining resource eligibility are as follows:

i. bank accounts (checking and savings; joint and individual);

ii. promissory notes;

iii. time deposits;

iv. mortgages held by applicant and/or family(only those from which income is derived);

v. mutual fund shares;

vi. municipal, corporate and government bonds/stocks;

vii. excess property (other than primary home);

viii. undivided estate (if the disposing of property is not within the control of the family, then it will not be considered);

ix. trust;

x. mineral rights;

xi. power-driven conveyances (not used in business, farming or other income producing activity. If the vehicle is not used for necessary transportation, it is considered personal property countable at equity value. Examples are motor homes, trailers, campers and boats.) The family is allowed two vehicles per family unit;

xii. lump sum settlements (structured or lump), awards or winnings;

xiii. crops in storage;

xiv. IRA and Keogh Plans (when another retirement option is also available). Resources include assets held individually or in joint names to which the family has unrestricted access.

d. Resource exclusions are as follows:

i. burial insurance and/or funds set aside for burial

ii. term life insurance;

iii. home and contiguous property;

iv. vehicle(s) used for necessary transportation;

v. Resources to which a person rather than the family holds the usufruct, i.e. designated trust.

e. The maximum allowable resource limits for CSHS are as follows:

i. $4,000 for individual;

ii. $5,000 for two;

iii. $6,000 for three;

iv. add $1,000 for each additional family member.

B. Medical Category Number. Medical category number is defined as the value of 1,5, or 10 used in the determination of financial eligibility to reflect the relative costliness of the medical condition of the child. A Medical Category Number is assigned only after the child is determined to have a condition which can be treated by CSHS. This number enables children who have conditions with the highest medical costs to be considered the highest priority for treatment. The CSHS medical category numbers are defined in Table I.

C. CSHS Regional Staff will determine the total gross income (resource and family income) of the applicant's family by completing a Family Income and Resource Worksheet with responses and documentation supplied by the applicant, parent(s) and/or guardian(s). The completed worksheet will be reviewed for correctness of documentation and signed as indicated.

D.1.The CSHS Family Income and Resource Worksheet Form is included as Exhibit I. A formula is used to calculate the Eligibility Determination Value. The three components of the formula are:

a. Family Income

b. Family Size

c. Medical Category Number

2. The formula is as follows:

Family Income

-Family size

+ Medical Category Number

Eligibility Determination Value

Establish Baseline Number as follows:

Family income in thousands--less:

a. child support payments;

b. annual medical insurance premium;

c. out of pocket medical payments for previous 12 months

Example: If the family income is $15,000, use 15 as baseline number.

If the family income is $15,500, use 16. ($500 or more, use the next higher number)

Subtract: Family Size

Example: Family of six with income of $15,500 whose child has Cystic Fibrosis with no countable resources.

Add: Medical Category Number (See Table I) Calculation Example:

Baseline Number 16

Less Family Size -6

Medical Category Number +1

Eligibility Determination Value 11

d. Any family that has an Eligibility Determination Value of less than 25 and meets the resource eligibility criteria will be financially eligible for CSHS. Applicants possessing a valid Medicaid card are automatically financially eligible for CSHS.

e. Insurance Coverage. CSHS will seek financial reimbursement for services rendered to families with medical insurance. A family failing to sign an Assignment of Insurance Benefits form (Exhibit II) and/or failing to complete application for other funding sources and Medicaid will be denied services or discharged from the program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, R.S. 40:1299. 111-120, and Title XIX, Public Health Service Act, §1905.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 15:10 (October 1989, amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5103. Appeal Process for Denied Applications

A. The Eligibility Determination Value shall be calculated at the time of initial application to the Program and annually thereafter, or, when a major expenditure is anticipated, or, whenever staff becomes aware of major changes in any portion of the formula. These changes may include salary raises, unemployment, additions or deletions of family members from the home, or any changes in the medical category. If such a redetermination of eligibility occurs prior to a major expenditure (i.e. hospitalization, purchase of an appliance or home IV therapy lasting longer than 10 days, etc.) and the family is determined to be no longer eligible for services, the expenditure may be covered prior to discharge from the Program.

B. The CSHS Regional Staff shall document extenuating circumstances that may arise and refer them to the CSHS Program Manager for special consideration. The CSHS Program Manager may convene the Administrative Unit made up of CSHS Program Specialist, medical, nursing, social service, nutrition and parent consultants for a team decision which then becomes the Program Manager's final decision.

C. When an application is denied, for whatever reason, the denial must be written, dated and hand delivered or sent by certified mail to the applicant's parents or legal representative. The letter of denial shall include information on the family's right to have the denial referred for an Administrative Review. The family must request an Administrative Review in writing within 15 days of the date of certified mailing or hand-delivery of the notice of denial. The written request will be forwarded by CSHS Regional Staff to the CSHS Program Manager for reconsideration.

D. After the Administrative Review, the CSHS Program Manager's decision shall be forwarded to the applicant's parents/or legal representative through the CSHS Regional Office. If the applicant's parent/legal representative disagrees with the decision, a fair hearing may be requested within 30 days from the date of mailing or hand-delivery of the Administrative Review denial.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, R.S. 40:1299. 111-120, and Title XIX, Public Health Service Act, §1905.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13: 246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 15: (October 1989), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5105. Redetermination

A. Eligibility redetermination shall be calculated annually or when a major expenditure is anticipated or whenever staff becomes aware of major changes in any portion of the formula. These changes may include salary raises, unemployment, additions or deletions of family members from the home, or any changes in the medical category. If such a redetermination of eligibility occurs prior to a major expenditure (i.e., hospitalization, purchase of an appliance or home IV therapy lasting longer than 10 days, etc.) and the family is determined to be no longer eligible for services, the expenditure may be covered prior to discharge from the Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, 40:1299.111-120; Title XIX,Public Health Service Act, Section 1905.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5107. Notification of Eligibility Status

A. All families will be notified in writing of their eligibility status as soon as all documentation (financial and medical) has been received, reviewed and determination of eligibility has been made by the CSHS Regional Staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, 40:1299.111-120; Title XIX,Public Health Service Act, Section 1905.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5109. Ineligibility

A. When an application is determined ineligible for CSHS Service Level IV, the CSHS Regional Staff may:

1. assist in finding and contacting another resource;

2. provide verbal and/or written referral to another care provider (public or private);

3. provide supportive services until the child is known to be receiving needed care; and

4. provide supportive and/or referral services for other family members, if needed.

B. Families have the right to reapply if their situation changes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, 40:1299.111-120; Title XIX,Public Health Service Act, Section 1905.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5113. Medical Diagnosis, Care and Treatment Consent

A. Consent for Medical Diagnosis, Care and Treatment form must be signed by the patient, parent(s), or guardian(s) prior to the provision of any diagnostic or treatment services by CSHS.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, R.S. 40:1299.111-120, and Title XIX, Public Health Service Act, Section 1905.

HISTORICAL NOTE: Promulgated by the Department of health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5115. Case Closure

A. Cases are closed by CSHS only after it has been clearly established that at least one of the following reasons exist. The following are closure codes and corresponding reasons.

Code	Reasons
01	Financial ineligibility/unable to establish eligibility
02	Definite diagnosis not established within one (1) year
03	Further treatment not indicated
04	Family no longer interested
05	No CSHS treatment available
06	No treatment indicated
07	Over age
08	Under care of another agency
09	Under private care
10	Refusal to sign necessary required documents (i.e., subrogation, insurance, etc.) and/or make application to other funding sources (i.e., SSI, Medical Needy, Medicaid, etc.)
11	Moved from the State of Louisiana
12	Death
13	Other
The "Other" category is used only after thorough assessment and intervention. Examples of situations falling in the "Other" category are: a. Excessive (3) missed appointments b. Non-compliance with treatment plan to the extent that the patient's progress is impeded (CSHS Central Office disposition is required prior to closure.)	

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, R.S. 40:1299.111-120, and Title XIX, Public Health Service Act, Section 1905.

HISTORICAL NOTE: Promulgated by the Department of health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5117. Lawsuits Filed on Behalf of Patients without Medicaid Coverage

A. When the patient, parent(s) or guardian(s) file a law suit to recover financial compensation for injuries sustained by the patient, the intervention and subrogation agreement form must be signed and notarized. This completed form (Exhibit III) must be returned to the CSHS Regional Office in the region of residence of the patient. Failure to execute and submit the Intervention and Subrogation form within 30 days of the date of mailing or hand-delivery of the form will cause the patient to be discharged from the Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, R.S. 40:1299. 111-120, and Title XIX, Public Health service Act, §1905.

HISTORICAL NOTE: Promulgated by the Department of Health and Human resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 15: (October 1989).1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

Chapter 53. Assignment to Subspeciality Clinics

§5301. Subspeciality Clinics

A. General Information. CSHS clinics are medical subspecialty treatment clinics. They are established on the basis of need, availability of subspecialist physicians, and fiscal resources. They are not screening clinics. Neither are they set up to provide acute or emergency care. A multidisciplinary team staffs each clinic. This team may be composed of a physician, nurse, social service staff, nutritionist, and others as appropriate to the clinic, i.e., orthotist, etc. Services are usually provided in the child's region of residence. However, on occasion, a child must travel to another region for clinics and services not available near home.

B. Subspecialty Clinics

1. Arthritis. Pediatric rheumatology services are provided for children with chronic arthritic diseases, i.e., diseases causing chronic synovitis which may be associated with a number of underlying diseases or causes. Services are limited for treatment for joint involvement.

2. Audiology. Diagnostic services are provided to evaluate hearing loss and for habilitation of impairment through provision of hearing aids and/or follow-up services.

3. Cardiology. Medical and surgical services are provided for children with congenital and acquired chronic diseases, conduction disorders and valve defects.

4. Cleft Lip And Palate. Children with cleft lip and/or palate defects, are provided surgical and habilitative services in team clinics. In addition to plastic surgery and/or oral surgery, other services may include orthodontia, dental and speech therapy services.

5. Cystic Fibrosis. Children diagnosed with cystic fibrosis are treated by the staff of Cystic Fibrosis Centers at Tulane Medical Center in New Orleans and LSU Medical Center in Shreveport. No other pulmonary conditions are covered.

6. Nephrology. Medical treatment is provided for metabolic disorders affecting the kidneys and recurrent or chronic renal infections. Care is not provided for children with end stage renal disease or needing dialysis or transplant.

7. Neurology. Medical services are provided for children with refractory or progressive seizure disorders, degenerative neurologic conditions, neuromuscular and acquired neurologic disorders.

8. Neurosurgery. Services are provided for children in the rehabilitation phase of treatment for head and spinal cord injuries and for children with congenital malformation of the nervous system requiring neurosurgical treatment. Children with myelodysplasia are seen in this clinic if no separate CSHS Spinal Cord clinic is available.

9. Ophthalmology. Medical and surgical services are provided for patients with congenital or acquired eye disease requiring specialized treatment i.e., strabismus, cataracts, glaucoma, or structural anomalies. Care is not provided for children with minor refractive errors only.

10. Orthopedic. Children with congenital or acquired defects: amputee deformities or chronic diseases affecting the musculoskeletal, cerebral palsy system and/or spinal cord are cared for by orthopedic specialists and in some CSHS regions there are specialized orthopedic clinics e.g. Scoliosis scoliosis, cerebral palsy, hand and amputee clinics.

11. Otology. Medical and surgical services are provided for children with significant hearing loss of any etiology. Congenital and acquired otological disorders requiring long term subspecialty care are treated. Care is not provided for acute problems, disorders of the nose, sinuses, throat, larynx and upper respiratory tract.

12. Reconstructive Surgery—Surgical and rehabilitative services are provided for the removal or correction of burn scars and/or contractures and of keloids, hemangiomas or similar conditions or deformities which limit function. Cosmetic surgery is not provided.

13. Spinal Cord. Multidisciplinary clinics in some CSHS regions serve children with myelodysplasia and other congenital or acquired spinal cord problems.

14. Urology. Surgical services are provided for the correction of congenital anomalies and acquired defects or obstructions of the urinary tract. Medical treatment is provided for chronic urinary tract infections. Care is not provided for acute infections, renal stones and genital disorders.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, R.S. 40:1299.111-120, and Title XIX, Public Health service Act, §1905.

HISTORICAL NOTE: Promulgated by the Department of Health and Human resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 15: (October 1989).1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

Chapter 55. Congenital Anomalies and Spinal Cord Dysfunctions

§5501. Physician Services

A. Medical Staff Categories

1. Attending Physicians. CSHS attending physicians (also known as staff or contract physicians) are those physicians with whom CSHS has a signed contract for direct medical services. The CSHS attending physician provides the medical component of the multidisciplinary team care provided to CSHS patients. These medical services are primarily provided in CSHS clinics but may also involve provision of care in hospitals, clinics, private offices or other out-patient settings. The attending physician is the CSHS physician of record and is authorized to order medically necessary procedures such as lab, x-ray, rehabilitative therapy, hospitalization, medications, equipment and supplies as well as make referrals and requests for services from other agencies.

a. CSHS attending physicians receive no direct reimbursement from the Program for services to CSHS patients. Instead a limited number of honorariums are granted as they become available. Travel expenses for attending physicians are reimbursed as per Louisiana Division of Administration Policy and Procedure. CSHS attending physicians must also be willing to serve, if requested, on CSHS Regional Office Advisory Boards and/or Quality Assurance Committees.

2. Consulting Physicians. CSHS consulting physicians must meet the same qualifications of licensure, Board Certification and experience as attending physicians but are limited to providing consultation to CSHS attending physicians. The attending physician remains in charge of the case for CSHS purposes. Consulting physicians must agree to abide by CSHS policies and procedures and accept CSHS consultation fees. It is the responsibility of the CSHS attending physician to inform the consultant of these fees and to request preauthorization by CSHS for the consult.

B. Conditions of Employment

1. Clinician Profile Form/Employment Eligibility Verification. To apply to be a CSHS attending physician, a Clinician Profile Form and an Employment Eligibility Verification Form must be submitted to the CSHS Central Office through the Regional CSHS Office where services are to be provided. If a physician is not yet Board Certified, a copy of the residency certificate must also be submitted. After verification, a contract is initiated by the CSHS Central Office.

2. Contractual Agreement. CSHS attending physicians provide medical services to CSHS patients under a contractual agreement between the Office of Public Health (OPH) and the physician or the medical institution with which the physician is affiliated. The contract must name the individual physician providing medical services to CSHS patients in order to be covered by the State for medical malpractice liability. By signing the contract, the physician agrees to abide by OPH and CSHS policies and procedures.

3. Qualifications. All CSHS physicians both attending and consulting must hold a current unrestricted Louisiana medical license, Board of Medical Specialties Certification or Eligibility, and have experience in the examination and medical care of children (and/or young adults) in that specialty. They must have hospital privileges at hospitals with CSHS contracts. CSHS physicians are responsible to notify the CSHS Central Office of any change in licensure or board certification status, disciplinary actions or changes in hospital privileges.

4. Family Centered/Team Philosophy. All CSHS attending physicians must be willing to develop a working relationship with families, other CSHS physicians and allied health care personnel to provide patient care in a family centered, culturally competent, community based and coordinated fashion.

C. Physician Assignment to CSHS Clinics. CSHS attending physician assignments to CSHS Clinics are made only after the physician's application information is verified and a contract between the physician and the Office of Public Health has been signed and approved by the Division of Administration. Assigning a new physician to an existing clinic is done on the basis of documented need for continuation or expansion of that specific clinic. There also should be assurance that adequate CSHS staffing , clinic space and schedule time are available. Qualified physicians practicing in the CSHS Region are given priority in clinic assignments in keeping with the philosophy of the Program to support community based services whenever possible.

D. Physician Attendance. CSHS attending physicians are expected to assure adequate coverage of all scheduled CSHS clinics. Coverage must be by physicians having a contract with OPH for CSHS services.

E. Medical Resident Participation. Medical residents may participate in CSHS clinics only under the direction of CSHS attending physicians. Residents must dictate CSHS notes in the name of the attending physician and may not sign orders, prescriptions, etc. The number of residents participating in CSHS clinics may be limited at the discretion of the CSHS nursing supervisor.

F. Physician Billing. CSHS physicians must not bill the patient or family for CSHS services. Arrangements to bill Medicaid or any other funding source for services rendered at CSHS clinics are made only by CSHS. Medicaid or insurance may be billed directly by CSHS attending physicians for in-patient hospital care, office visits or other services provided when medically necessary and occurring between regularly scheduled CSHS clinic visits. It is the physician's responsibility to do the billing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services. LR 13:246 (April 1987).1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5503. Hospital Services

A. CSHS contracts individually with hospitals statewide to provide hospital in-patient care as ordered by the CSHS attending physicians. Hospitalizations are authorized only for facilities with contracts with CSHS.

B. Prior authorization is required before a child may be hospitalized. This authorization is issued from the CSHS Regional Office in the child's region of residence. Authorization is issued for an estimated number of days and is not to exceed 15 days without approval from the CSHS Central Office. Requests for extensions of hospitalization authorization are reviewed for disposition by the CSHS Central Office.

C. In-patient hospital expenses shall be paid by the Program only when services provided are directly related to the condition(s) being treated by CSHS.

D. Children shall be hospitalized only with parental agreement and consent. Admission and consent forms used are those of the designated hospital and shall be signed by the parent (or legal representative) who must appear at that facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services. LR 13:246 (April 1987).1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5505. Emergency Hospitalization

A. When an emergency admission occurs, it is the responsibility of the family to contact the CSHS Regional Office immediately. This can be done by:

1. contacting the CSHS Regional Office directly;
2. asking the physician to call;
3. asking the hospital admissions clerk to call; or

4. asking the assistance of their public health nurse in the parish of residence.

B. If the admission occurs at a time when the CSHS Regional Office is closed, the family must contact the CSHS Regional Office on the first work day after the patient was admitted. If contact is not made, CSHS may not assume responsibility for the admission.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5507. Hospitalization of CSHS Patients Covered by Private Medical Insurance

A. At the time of hospital admission, the family must identify the child as being a CSHS patient and have proof of insurance, such as an I.D. card, insurance policy, or letter from an employer. Prior to the admission date, a CSHS Authorization form shall be sent by the CSHS Regional Office to the hospital with the notation:

"CSHS TO BE BILLED ONLY AFTER BASIC AND MAJOR MEDICAL BENEFITS HAVE BEEN APPLIED."

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, L.R.13.246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5509. Hospitalization of CSHS Patients Covered by Medicaid

A. CSHS does not supplement Medicaid nor issue Authorization forms for hospitalizations for patients with Medicaid coverage. CSHS Regional Office Staff may assist families in utilizing Medicaid benefits and may directly contact Medicaid on behalf of the patient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, L.R.13.246 (April 1987).1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5511. Requests for Out of State Hospitalization

A. CSHS does not pay for services provided outside of Louisiana except for cases of extraordinary need. Requests for out of state services must be approved by the CSHS Administrative Unit and will be considered only under the following circumstances:

1. the service is not available in Louisiana, and

2. the patient's condition is such that it can not be treated adequately by any other means available in Louisiana; and

3. the patient's condition is of such a serious nature that treatment is justified; and

4. the service is requested by a CSHS attending physician; and

5. No other funding source is available for the requested service.

B. The request must be made in writing, initiated by a CSHS attending physician and supported by a second CSHS attending physician. Circumstances 1-3 must be verified in writing by both physicians. CSHS Regional Office Staff of the patient's region of residence must forward this documentation to the CSHS Central Office along with copies of the following:

1. evidence of CSHS eligibility

2. evidence that there is no other funding source available

3. medical records

4. written documentation of the arrangements made for the requested service with the out-of-state hospital, physician(s),

laboratory(ies), and any other vendors who will be submitting bills to CSHS, and

5. transportation and related expenses.

B. A decision will be made on a case by case basis by the CSHS Administrative Unit depending on availability of funds. The CSHS Regional Office of the patient's region of residence will be notified in writing of the disposition of the request. CSHS will reimburse all vendors at the Medicaid rate of the State in which the service is provided. It is the responsibility of the CSHS Regional Staff to obtain this rate and acceptance by the out-of-state providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, L.R.13.246 (April 1987).1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5513. Out-Patient Services

A. Out-patient services for CSHS patients may be authorized when :

1. the service is ordered by a CSHS attending physician,

2. the need for the out-patient services is directly related to the condition(s) being treated by CSHS,

3. the patient's progress in treatment would be impeded or halted without the service,

4. the patient can benefit from the services recommended, and

5. the vendor is a Medicaid provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, L.R.13.246 (April 1987).1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5515. Medical Equipment

A. CSHS may provide orthotics, prosthetics, wheelchairs and other medical equipment which will aid the patient in rehabilitation. This medical equipment may be provided by the Program when:

1. it is prescribed by the CSHS attending physician and medical justification is provided;

2. the patient's progress in treatment would be impeded without it;

3. the patient can benefit from the use of the equipment;

4. the need for the equipment is directly related to the condition(s) being treated by CSHS;

5. the cost is justifiable in relation to the medical need and no other less costly equipment will suffice; and

6. the vendor is a Medicaid provider.

B. Medical equipment vendors and their employees who wish to provide services to CSHS should apply to the CSHS Central Office. Proper certification by the American Board of Certification for Orthotics and Prosthetics, Inc., of Washington, D.C. is required.

C. Vendors providing services to CSHS must not charge patients and their families any fees. Vendors must agree to abide by the policies of CSHS. Representatives from participating vendors shall attend appropriate clinics. CSHS reserves the right to limit the number of vendor representatives present during any clinic due to space limitation, or any other concerns.

D. Families may be required to make direct payment for services to vendors. A determination of ability to financially contribute is made by designated CSHS Regional Staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services. LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5517. Dental/Orthodontic Services

A. Dental Services are provided for patients with cleft lip and palate or an isolated cleft palate through CSHS. Other patients may receive dental services only with prior approval of the CSHS Program Manager.

B. Orthodontic services are provided on a limited basis to those patients having cleft lip and palate or an isolated cleft palate. Patients with other conditions which may impair function must be approved by the CSHS Program Manager.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5519. Transportation Services

A. Transportation of patients to and from CSHS clinics and treatment facilities is the responsibility of the family. In unusual or emergency situations, CSHS may assist and/or pay for transportation with the approval of the CSHS Program Manager

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987)1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

Chapter 57. Congenital Anomalies and Spinal Cord Dysfunctions

§5701. Central Registry

A. The purpose of this rule is to insure prompt referral to the state health officer of all persons residing in Louisiana born with congenital anomalies or spinal cord dysfunctions. These referrals are made in order that all such persons may obtain referrals to appropriate rehabilitative services rendered by existing state agencies, departments, and other organizations and individuals.

B. In the course of its operations each licensed public or private hospital or each licensed physician in the course of his private medical practice shall report to the state health officer any case of the following congenital anomalies:

1. Spina Bifida

2. Hydrocephalus

3. Cleft palate/cleft lip

4. Club foot

5. Severe anomalies of the heart and circulatory system

6. Debilitating deformity

7. Absence of limbs

8. Neurofibromatosis

9. Spinal cord dysfunctions

C. These reports are to be sent to: Central Registry of Congenital Anomalies and Spinal Cord Dysfunctions, Box 60630-Room 607, New Orleans, LA 70160.

D. The report required shall not be filed unless written permission has first been obtained from the person for whom a report is prepared or in the case of a minor, from a parent or guardian of the person for whom a report is prepared, except in those instances of acquired spinal injury, in which

instances reporting to the Central Registry is mandatory. The report form entitled "Central Registry of Congenital Anomalies and Spinal Cord Dysfunctions" (see Form A) shall be used for all reports.

E. All information received is kept confidential.

F. Persons admitted to the Central Registry will receive the following services:

1. Information regarding the availability of community services and programs including parent support groups.

2. Information regarding printed materials available through established agencies.

3. Information regarding advances in medical progress and research.

4. Notification of new laws as they become known, affecting the handicapped.

5. Information about federal benefits and programs.

G. A person's name will be removed from the Central Registry upon oral or written request. A person's name will also be removed if information is received that the client has moved from Louisiana or expired.

H. Inquiries. All inquiries should be directed to: Central Registry of Congenital Anomalies and Spinal Cord Dysfunctions, Box 60630-Room 607, New Orleans, Louisiana 70160.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Services, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 59. Supplemental Security Income/Disabled Children's Program

§5901. Referral and Services

A. All referrals shall be made from the Federal Supplemental Security Income through the Louisiana Data Exchange to the Children' Special Health Services (CSHS) Central Office on a quarterly basis. The information is then subdivided into regional packets for distribution to the appropriate Children's Special Health Services (CSHS) Offices.

B. Services are available in the following targeted areas: New Orleans CSHS Regional Office, Baton Rouge CSHS Regional Offices, Teche CSHS Regional Office, Lake Charles CSHS Regional Office, Alexandria CSHS Regional Office, Shreveport CSHS Regional Office, Monroe CSHS Regional Office, Greensburg CSHS Regional Office.

C. First priority is given to referred children whose disability enables them to be eligible for the Children's Special Health Services Program.

D. Second priority is given to children under seven years of age whose family may need assistance in understanding the disability and making the best use of case management.

E. All children are referred on to the child search coordinators to assure prompt planning for their acceptance into the education system.

F. Children with conditions not treated in the Children's Special Health Services Program Shall be referred to other state or private agencies when appropriate depending on the needs of the child as revealed by the multi disciplinary team's assessment.

G.1. Services provided consist of:

a. team evaluation;

b. family counseling;

c. case management;

d. Children's Special Health services as appropriate; and

e. Special Services (Limited)

2. Services needed by a child which cannot be met thru any other resources, which may include medical, social, educational, developmental, or rehabilitation services may be provided on a case by case basis where medically necessary or appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Services, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

§5903. Reference Material

A. Table I CSHS Medical Category

CSHS Medical Category	Treatment Phase	Number 1 = High Cost - Active treatment/Medically Fragile/Surgery 5 = Moderate Cost-Routine treatment/ Medically stable 10 = Least Cost-Follow-up/Observation
1. Arthritis	Active treatment/Medically fragile/surgery Active treatment/Medically stable Inactive - Remission	1 5 10

CSHS Medical Category	Treatment Phase	Number 1 = High Cost - Active treatment/Medically Fragile/Surgery 5 = Moderate Cost-Routine treatment/ Medically stable 10 = Least Cost-Follow-up/Observation
2. Audiology	Diagnosis Testing Audiology Appliances and Molds Follow-up	5 5 10
3. Cardiology	Surgery/Hospitalization Diagnostic Tests(inpatient) Active treatment/Medically stable Observation (includes routine clinic test)	1 1 5 10
4. Cleft Palate And/Or Lip	Surgery/Hospitalization Orthodontic Treatment Routine treatment/Medically stable Follow-up/Observation (No surgery or orthodontia anticipated)	1 1 5 10
5. Cystic Fibrosis	Treatment	1
6. Nephrology	Active treatment/Medically fragile Routine treatment/medically stable Inactive -Remission	1 5 10
7. Neurology	Hospitalization/Active treatment/Medically fragile Routine treatment/Medically stable Inactive - Remission	1 5 10
8. Neurosurgery	Surgery/Hospitalization Active treatment/Medically fragile Routine treatment /Medically stable Follow-up (No surgery or therapy anticipated)	1 1 5 10
9. Ophthalmology	Surgery/Hospitalization Active treatment Follow-up (No medication or treatment anticipated)	1 5 10
10. Orthopedic Amputee Cerebral Palsy Hand Scoliosis Spinal Cord	Surgery/Hospitalization Active treatment/Wheelchair/Bracing Active treatment (No bracing) Follow-up (No surgery or treatment anticipated)	1 1 5 10
11. Otology	Surgery/Hospitalization Active treatment Follow-up (No surgery or treatment anticipated)	1 5 10
12. Reconstructive Surgery (Other Than Cleft Lip And Palate)	Surgery/Hospitalization Active treatment/Therapy Follow-up (No surgery or therapy anticipated)	1 5 10
16. Urology	Surgery/Hospitalization Active treatment /Medically fragile Active treatment /Medically stable Follow-up (No surgery or hospitalization anticipated)	1 1 5 10
If a child has multiple conditions in mixed levels of activity, the lowest value shall be chosen. If two or more children in a family are applying for services, each child will be considered separately for medical eligibility.		

B. Exhibit I

PATIENT'S NAME:_____ PID Number _____

DOB:_____

CHILDREN'S SPECIAL HEALTH SERVICES

FAMILY INCOME AND RESOURCE WORKSHEET

Please fill out this form. You are responsible for its accuracy. A social services worker or Eligibility Determination Examiner will review the form with you and determine your eligibility for CSHS. CSHS requires eligibility to be determined when your child is a new patient, on an annual basis and when a major expenditure is anticipated.

FAMILY INCOME

Person(s) Employed	Yes	No	Total Monthly Gross Income	For CSHS Staff Use Only
Father	_____	_____	$_____	_____
Mother	_____	_____	$_____	_____
Other	_____	_____	$_____	_____

Sources of Other Income:

A.F.D.C.____ _____ _____ _____

S.S.I. ____ _____ _____ _____

Refugee Cash Assistance

____ _____ _____ _____

Social Security

____ _____ _____ _____

Veterans Benefits

____ _____ _____ _____

Pension or Retirement

____ _____ _____ _____

Unemployment Benefits

____ _____ _____ _____

Workman's Compensation

____ _____ _____ _____

Child Support ____ _____ _____ _____

Military Family Allotment

____ _____ _____ _____

Alimony ____ _____ _____ _____

Interest and Dividends from _____

Savings, Stocks, Bonds, etc.

____ _____ _____ _____

TOTAL FAMILY INCOME $_____ $_____

Less Deductions:

Child support payments for children

Living outside of your home $_____ $_____

Yearly medical insurance premiums _____ _____

Medical payments other than insurance

reimbursement for 12 months _____ _____

TOTAL DEDUCTIONS $_____ $ _____

----------FOR CSHS STAFF USE----------

Total Family Income $_____

Less Total Deductions(-)_____

Adjusted Family Income $_____

Less Size of Family (-)_____

Plus Medical Category Number (+)_____

ELIGIBILITY DETERMINATION VALUE _____

Income Eligible Yes _____ NO_____

FAMILY RESOURCE

FOR CSHS

Savings Accounts Yes No Value or Equity STAFF USE ONLY

Individual ____ _____ $_____ _____

Joint ____ _____ _____ _____

Both ____ _____ _____ _____

_____

Promissory Note ____ _____ _____ _____

_____

Time Deposit_____

(i.e., certificate of deposit)

____ _____ _____ ____ _____

Family-held Mortgage ____ _____ _____ _____

Mutual Fund Shares ____ _____ _____ _____

Municipal, Corporate and/or _____

Government Bonds/stocks ____ _____ _____ _____

Property (other than home) ____ ____ _____ _____

Share in Estate(undivided estate) _____

(when in control of family) ____ _____ _____ _____

Trust (have access to trust) ____ _____ _____ _____

Mineral Rights ____ _____ _____ _____

Vehicles (other than 2 family cars) ___ ____ _____ _____

(Description include boats, campers, motor homes, motorcycles, 4 wheelers)

Settlements (structured or lump sum) or winnings

____ _____ _____ _____

Crops in Storage ____ _____ _____ _____

IRA (when other retirement benefits are available)

____ _____ _____ _____

Keogh (same as above) ____ _____ _____ _____

----------FOR CSHS STAFF USE ONLY----------

Total Family Resources $ _____

Less Resource Allowance (-)

Total Adjusted Resource $_____

Resource Eligible Yes _____ No_____

The information I have given is true and correct to the best of my knowledge. I understand that verification of income and/or resources may be requested.

I understand that my application will be reviewed for eligibility purposes and that I have the right to appeal if my child is denied acceptance or if I feel my civil rights have been violated.

If verification of family income and resources are requested, the requested items must be returned within fifteen (15) days of this date to the CSHS Regional Office or the case will be closed and services terminated.

I agree to notify the CSHS Regional Office of any lawsuit filed on behalf of the applicant pertaining to his disability and for which the CSHS is providing medical services. Failure to sign necessary documents (i.e., SSI, Medical Needy, Medicaid, etc,) will cause the patient to be discharged from CSHS.

_____

Parent/Applicant or Appropriate Representative Date Relationship

_____

Witness Date

_____

CSHS Eligible _____ CSHS Ineligible _____ Pending _____

_____ ___

Reviewed by Title Date

C. EXHIBIT II

ASSIGNMENT OF INSURANCE BENEFITS

NAME OF INSURANCE COMPANY:

ADDRESS OF INSURANCE COMPANY:

NAME OF INSURED:

ADDRESS OF INSURED:

POLICY Number:

I/We,_____,
am/are the parent(s) and/or guardian(s) of

_____, who has been enrolled in CHILDREN'S SPECIAL HEALTH SERVICES of the Office of Public Health of the Department of Health and Hospitals.

I/We hereby authorize and direct CHILDREN'S SPECIAL HEALTH SERVICES to prepare and submit claims for the

medical or hospital expense incurred by _____ to the captioned insurance company.

I/We hereby authorize and direct the said insurance company to honor and recognized this instrument wherein I/we assign, transfer, set over and deliver to the said CHILDREN'S SPECIAL HEALTH SERVICES of the Office of Public Health of the Department of Health and Hospitals, as assignee herein, all money, checks, drafts or payments now due and payable to me/us, and to become due and payable to me/us, for the medical care and treatment of

_____, under the terms and conditions of the above numbered insurance policy. The insurance company is further directed to forward all such payment directly to CHILDREN'S SPECIAL HEALTH SERVICES at the address indicated on the papers submitting the claim(s).

In witness whereof I/we have executed this assignment at _____, the _____day of_____, _____.

WITNESSED BY:

_____ _____

Signature of insured

_____ _____

NOTE: Two witnesses are required who are age 21 or older.

D. EXHIBIT III

INTERVENTION AND SUBROGATION AGREEMENT

STATE OF LOUISIANA PARISH OF _____

BEFORE ME,

a Notary Public, duly commissioned and qualified, in and for the Parish of_____,

State of Louisiana, on this _____day of _____, ____ in the presence of the witnesses hereinafter named and undersigned, personally came and appeared:

WHO DECLARED that they are the parents or guardians of _____, who has received and/or is now under medical treatment and care provided by Children's Special Health Services of the Office of Public Health of the Department of Health and Hospitals, as the result of accidental injuries sustained by the said child on or about _____.

AND THE SAID APPEARERS FURTHER DECLARED that they hereby assign transfer, set over and deliver unto Children's Special Health Services of the Office of Public Health of the Department of Health and Hospitals, its successors and assigns, to its proper use and benefit forever, any and all sum or sums now due or owing said assignors, and all claims, demands and cause or causes of action of whatever kind and nature which said assignors had or now have or may have against _____, arising out of or as a result of the accidental injuries sustained by the said child on or about_____.

This assignment, however, is EXPRESSLY LIMITED to the value of the said medical treatment and care provided, furnished or obtained by Children's Special Health Services of the Office of Public Health of the Department of Health and Hospitals on behalf of the said child as the result of accidental injuries sustained by the said child on or about_____.

Nothing herein shall prevent the said appearers from presenting claims or claims, if any they had or have or may have against _____ for damages in an amount in excess of the assigned value of medical treatment and care described and referred to hereinabove; however, the said appearers do hereby further agree, consent and promise to duly notify Children's Special Health Services of the Office of Public Health of the Department of Health and Hospitals of any legal steps, if any, they may have taken or are now taking or may take against the said _____, as a result of the accidental injuries sustained by the said child as described and referred to hereinabove.

APPEARERS FURTHER hereby authorize and direct and empower said Children's Special Health Services of the Office of Public Health of the Department of Health and Hospitals to intervene in any legal cause of action of proceeding that appearers may have taken or are now taking or

may take against _____ as a result of the accidental injuries sustained by the said child as described and referred to hereinabove, such intervention-power EXPRESSLY LIMITED to the value of the said medical care and treatment.

THUS DONE AND PASSED AS AN AUTHENTIC ACT BEFORE ME,_____, a Notary Public, duly commissioned and qualified in and for the Parish of _____,

State of Louisiana in the presence of the undersigned witnesses and sworn to by the said appearers _____and_____this_____day of _____, _____.

APPEARERS:

_____

_____

WITNESSES: (address)_____

___ _____(address)_____

_____

NOTARY PUBLIC

and (affix seal)

_____(address)_____

(address)_____ _____

_____

DHH/Secretary

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.2, and R.S. 40:1299.111-120.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Services, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 22:362 (May 1996).

Subpart 18. Disability Prevention Program

Chapter 60. Severe Head Injuries

§6001. Mandatory Reporting Requirement

A. The purpose of this rule is to provide for the mandatory reporting of severe head injuries to the central registry for such injuries, located within the Disability Prevention Program of the Office of Public Health. The central registry will provide for the analysis and dissemination of collected date in an effort to develop appropriated prevention, care and support strategies for persons with severe head injuries.

B. Each licensed hospital or licensed physician in the course of his or her medical practice is required to report any case of severe head injury to the Office of Public Health.

C. The criteria for required reporting of a case of "severe head injury" are as follows:

1. acute, traumatic injury to the central nervous system within the portion of the skull enclosing the brain, excluding brain damage due to birth trauma, or to asphyxia or intoxications in the absence of trauma; and

2. at least one of the following clinical results:

a. death in the emergency room or during hospitalization;

b. coma for a duration of at least six hours during the first week after injury (not including unconsciousness due to anesthesia);

c. moderate disability (independent, but restricted in work and/or social activity) or more severe disability at hospital discharge or three months post-injury, whichever comes first;

d. surgical opening of the cranium.

D. The report form entitled "Confidential Report of Severe Traumatic Head injury" shall be used for all reports. Reports can be obtained from and are to be sent to: Disability Prevention Program, 325 Loyola Avenue, Room 307, New Orleans, LA 70112.

E. Confidentiality will be strictly maintained.

AUTHORITY NOTE: Promulgated in accordance with Act 215 of the 1990 Regular legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Disability Prevention Program, LR17:199 (February 1991).

Chapter 63. Newborn Heel Stick Screening

§6301. Eligibility

A. Any child born in or residing in the state of Louisiana shall be eligible for neonatal screening.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§6303. Purpose, Scope, and Laboratory Testing Methodology

A. R.S. 40:1081.1 and 1081.2 requires physicians to test Louisiana newborns for the disorders listed below along with the abbreviations used by the American College of Medical Genetics (ACMG).

1. Disorders of amino acid metabolism:

a. phenylketonuria (PKU);

b. maple syrup urine disease (MSUD);

c. homocystinuria (HCY

d. citrullinemia, type I (CIT);

e. argininosuccinate acidemia (ASA); and

f. tyrosinemia, type I (TYR I).

2. Disorders of fatty acid metabolism:

a. medium-chain acyl-CoA dehydrogenase deficiency (MCAD);

b. trifunctional protein deficiency (TFP);

c. very long-chain acyl-CoA dehydrogenase deficiency (VLCAD);

d. carnitine uptake defect (CUD); and

e. long chain-3-hydroxyacyl-CoA dehydrogenase deficiency (LCHAD).

3. Disorders of organic acid metabolism:

a. isovaleric acidemia (IVA);

b. methylmalonic acidemia (methylmalonyl-CoA mutase, MUT),(cobalamin disorders, CBL A, B);

c. glutaric acidemia type 1 (GA1);

d. propionic acidemia (PROP);

e. 3-hydroxy-3-methylglutaryl–CoA lyase deficiency (HMG);

f. multiple carboxylase deficiency (MCD) including, but not limited to, holocarboxylase synthetase deficiency;

g. beta-ketothiolase deficiency (BKT); and

h. 3-methylcrotonyl CoA carboxylase deficiency (3-MCC).

4. Other metabolic disorders:

a. biotinidase deficiency (BIOT); and

b. classic galactosemia (GALT).

5. Endocrine disorders:

a. congenital hypothyroidism (CH); and

b. congenital adrenal hyperplasia (CAH).

6. Hemoglobinopathies (sickle cell diseases):

a. hemoglobin S,S disease (sickle cell anemia) (Hb SS);

b. hemoglobin S,C disease (Hb SC);

c. hemoglobin S, beta-thalassemia disease (Hb S/βTH); and

d. other sickling diseases.

7. Pulmonary disorders:

a. cystic fibrosis (CF).

8. Immune Disorders:

a. severe combined immunodeficiency (SCID).

9. Neuromuscular disorders:

a. spinal muscular atrophy (SMA).

10. Lysosomal storage disorders:

a. mucopolysaccharidosis type 1 (MPS 1);

b. glycogen storage disease type II (Pompe).

B. Methodology

1. Filter Paper Specimen Form (Lab10), used in blood specimen collection for neonatal screening, can be obtained from the Genetic Diseases Program by calling 504-568-8254. There are two different types of Lab-10 forms which are color-coded.

a. For patients covered by Medicaid or Managed Care Plans, blue border Lab-10 forms are used. There is no charge to private providers for these blue border forms. The patient's Medicaid number (or mother's number, if the patient has not been issued one) shall be indicated on the form.

b. For private and non-Medicaid patients, red border Lab-10 forms are used. These red border Lab-10 forms are $30 each. The name of the insurance company and policy number shall be included on the form.

2. Private providers should order a mix of red and blue Lab-10 forms from the Genetic Diseases Program to match the Medicaid/non-Medicaid composition of newborns to be screened at their facility. The Lab-10 forms shall be completely filled out.

3. For non-Medicaid patients with a financial status of greater than 100 percent of the poverty guidelines as established by the Louisiana Department of Health (LDH) and who attend a parish health unit for just the newborn screening service, the parent or guardian shall be charged $30 upon registering at the parish health unit.

4. To ensure that specimens for testing are received within 24 to 48 hours or 1 to 2 days after collection, a state run courier will pick up specimens from each birthing facility and transport the specimens to the Office of Public Health (OPH) Laboratory. Specimens collected by other laboratories approved by OPH to perform newborn screening pursuant to the requirements of this Chapter, shall provide mailing envelopes to submitting hospitals which guarantee a delivery time no longer than ~~3~~2 days from mailing. The use of the United States Postal Service and all other companies and courier services providing the required level of service stated herein are acceptable.

C. Policy for Pre-Discharge, Repeat Screening and Education to Parents on Repeat Screening

1. Pre-Discharge Screening. All hospitals that have maternity units shall institute and maintain a policy of screening all newborns before discharge regardless of their length of stay in the hospital. The initial screening specimen should be collected between 24 and 48 hours after birth.

a. If the newborn is admitted or readmitted to the hospital within the first 28 days of life, the admitting facility shall collect and submit the newborn screening specimen unless proof of a previous normal newborn screening specimen result is available.

b. If the newborn transferred from one facility to another, the transferring facility shall collect the newborn screening specimen and notify the next facility that the newborn screening specimen has been collected. The facility transporting a sick newborn should have the initial newborn screen documented in the newborn's medical record. The receiving facility should determine if the newborn screen was done. If not, the newborn shall have an initial newborn screen collected upon admission.

2. Repeat Screening for Specimens Collected before 24 Hours. There is a greater risk of false negative results for specimens collected from babies younger than 24 hours of age. Therefore, full-term, healthy newborns screened prior to 24 hours of age must be rescreened at the first medical visit, preferably between 2-5 days of life. Repeat screening should be arranged by the primary pediatrician; however, it may be done by any primary healthcare provider or clinical facility qualified to perform newborn screening specimen collection.

3. For preterm, low birth weight, and sick infants admitted to the neonatal intensive care unit (NICU), an initial specimen should be collected upon admission, a second specimen shall be collected at 48-72 hours after admission and a final specimen shall be collected at 28 days or upon discharge, whichever comes first.

4. Policy for Result Reporting and Repeat Screening Post Transfusion. Whenever possible, a specimen should be collected prior to transfusion. Repeat testing is recommended 3 days after transfusion and 90 days after last transfusion. If the specimen was not collected before transfusion, the laboratory reporting the results to the submitter shall indicate that transfusion may alter all newborn screening results and include the above times for repeat screening.

NOTE: Please contact the Louisiana Genetic Diseases program for guidance on any other testing concerns.

5. Education to Parents on Repeat Screening. To ensure that newborns who need rescreening actually receive the repeat test, hospitals with maternity units must establish a system for disseminating information to parents about the importance of rescreening. This includes infants with an initial unsatisfactory specimen, infants with an initial collection performed at less than 24 hours of age, and infants admitted to the NICU

D. Notification of Screening Results

1. The Genetic Diseases Program follow-up staff shall notify the appropriate medical provider of the positive screening result by telephone. Otherwise, submitters should receive test results from the State Public Health Laboratory within 5 days after collection. Test results are available to submitters 24 hours a day, 365 days a year through the web-based Secure Remote Viewer (SRV) which is accessed via computer. Information on signing up for and using the SRV can be obtained by calling the Genetic Diseases Program Office at (504) 568-8254. If test results are not available, medical providers may fax in their requests to the following numbers: (225) 219-4905 (Public Health Biochemistry Laboratory) or (504) 568-8253 (Genetics Office). In order to retrieve test results from the SRV, the provider must have the infant's date of birth plus one of the following: mother's first name, mother's last name, baby's first name or baby's last name. Test results can also be found by the infant's medical record number or by the Lab 10 form number.

E. Unsatisfactory Specimens. The accuracy of a test depends on proper collection of the blood spot. Specimens of unsatisfactory quality for testing shall be indicated on the test result slip. If the laboratory determines the specimen to be unsatisfactory, the submitter shall collect and submit a second sample as soon as possible. If the newborn has been discharged, the submitter shall contact the newborn's primary care provider or parent or guardian to collect a second sample. Training on collecting adequate specimens is available on the Newborn Screening website at ldh.la.gov/newborn.

F. Medical/Nutritional Management

1. In order for a patient with PKU or other rare inborn errors of metabolism to receive the special formulas for the treatment of these disorders from the state's Genetic Diseases Program and/or Special Supplemental Nutrition Program for Infants, Women, and Children (WIC), the following guidelines shall be met:

a. The patient shall be a resident of the State of Louisiana.

b. The patient shall receive clinical and dietary management services through a metabolic center to include a medical evaluation at least once annually by a physician who is board certified in biochemical genetics or a medical geneticist physician with written documentation of a medical evaluation and continuing consultation with a physician board certified in biochemical genetics. A licensed registered dietitian must also be on staff and be readily available for both acute and chronic dietary needs of the patient. Children less than 1 year of age shall be seen by the dietitian and medical geneticist at least twice a year. Children greater than 1 year of age shall be seen at least once per year by the dietitian and medical geneticist.

c. The patient shall provide necessary blood specimens for laboratory testing as requested by the treating physician meeting the above requirements. Laboratory test result values for phenylalanine and tyrosine shall be submitted to the Genetics Program Office by the treating medical center within 15 working days after data reduction and interpretation.

d. The patient shall include dietary records with the submission of each blood specimen.

e. All insurance forms relative to charges for special formula shall be signed and submitted by the parent or appropriate family member.

f. The parent or guardian shall inform the Genetics Program Office immediately of any changes in insurance coverage.

g. If a patient fails to comply with these requirements, he/she shall not be able to receive metabolic

formula, medications and medical services through the Office of Public Health.

G. Acceptable Newborn Screening Testing Methodologies and Procedures for Medical Providers Not Using the State Laboratory. Laboratories performing or intending to perform the state mandated newborn screening battery on specimens collected on Louisiana newborns shall meet the conditions specified below pursuant to R.S. 40:1081.2.

1. The testing battery shall include testing for the disorders listed in Subsection A above.

2. The laboratory shall perform the newborn screening testing battery on at least 50,000 specimens a year unless the said laboratory has been routinely performing the full screening battery since January 1, 1995.

3. A laboratory shall perform the complete battery at one site. Using two laboratories for completion of the total battery is unacceptable as this increases the risk of error and delay in reporting.

4. When using dried blood spots, only specimen forms using filter paper approved by the Centers for Disease Control and Prevention (CDC) are acceptable.

5. Only the following testing methodologies listed in Table 6303.G.5 are acceptable without prior written approval from the Genetic Diseases Program.

Table 6303.G.5	
Disease	**Testing Methodology**
Disorders of Amino Acid Metabolism Disorders of Fatty Acid Metabolism Disorders of Organic Acid Metabolism (Specific disorders include those as listed under Subsection A)	Tandem Mass Spectrometry (MS/MS)
Biotinidase Deficiency	Time-Resolved Immunofluorescence assay Qualitative or Quantitative Enzymatic Colorimetric or Fluorometric
Galactosemia	Galt enzyme assay Total Galactose
Hemoglobinopathies (Sickle Cell Diseases)	Cellulose acetate/citrate agar Capillary isoelectric focusing (CIEF) Gel isoelectric focusing (IEF) High Pressure Liquid Chromatography (HPLC) DNA Mutational Analysis Sickle Dex – is NOT Acceptable Controls must include: F, A, S, C, D, E If controls for hemoglobins D and E are not included in the first tier testing methodology, then the second tier testing must be able to identify the presence of these hemoglobins. Result Reporting: by phenotype Positive/negative is NOT acceptable
Congenital Hypothyroidism	Radioimmunoassay (RIA), Fluorescent Immunoassay (FIA) time resolved fluoroimmunoassay, Enzyme Immunoassay (EIA) methods for T4 and/or Thyroid Stimulating Hormone (TSH) which have been calibrated for neonates
Congenital Adrenal Hyperplasia	17 hydroxyprogesterone (17OHP), time resolved fluoroimmunoassay
Cystic Fibrosis	Primary: Immunoreactive Trypsinogen; Time-Resolved fluoroimmunoassay Second Tier: Deoxyribonucleic Acid (DNA) mutation analysis Qualitative Sweat Conductivity Test is NOT acceptable as a primary screening methodology. Confirmatory Test Methodologies: Quantitative Pilocarpine Iontophoresis Sweat Chloride Test Qualitative Sweat Conductivity Test is NOT recommended.
Severe Combined Immunodeficiencies (SCID) Spinal Muscular Atrophy (SMA)	Real Time Quantitative Polymerase Chain Reaction (RTQPCR)
Mucopolysaccharidosis type I (MPS I) Glycogen storage disease type II (Pompe)	Digital microfluidics

a. Alternative Methodologies not listed in Table 6303.G.5. New Food and Drug Administration (FDA)-approved methodologies may be used if first found to be acceptable by the Genetics Diseases Program. Approval shall be requested from the Genetic Diseases Program in writing 60 days before the intended date of implementation by mailing the request to:

LDH OPH Genetic Diseases Program
P.O. Box 60630
New Orleans, Louisiana 70160-0630

b. Approval Process. Requests for approvals of methodologies not listed in Table 6303.G.5 shall be based on documentation of FDA-approved methodologies or on documentation of OPH Laboratory-developed test methodologies, as well as an in-house OPH Laboratory validation study of the applicable methodology proposed for use.

6. The laboratory shall comply with the regulations for proficiency testing as mandated in the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88 §493.1707). When using dried blood spots, the laboratory must participate in a proficiency testing program. The laboratory must report all proficiency testing results to the Genetic Diseases Program Office within one month of receiving the report from the proficiency testing provider.

7. The laboratory shall be able to provide test result data to physicians and nurses on their specific patients by telephone and by FAX or by use of the internet, 24 hours a day 365 days a year.

8. Mandatory Reporting of Positive Test Results Indicating Disease

a. To ensure appropriate and timely follow-up, positive results shall be reported, along with patient demographic information as specified below to the Genetic Diseases Program Office by fax at (504) 568-8253. Receipt of faxed results shall be verified by calling the Genetics Office at (504) 568-8254.

b. Described below are specific time deadlines after data reduction and interpretation for reporting positive results indicating probable disease to the Genetics Diseases Program Office. Laboratories shall make arrangements with the Genetics Diseases Program Office for reporting after hours, weekends and holidays for positive test results from tandem mass spectrometry and the assays for galactosemia, and congenital adrenal hyperplasia. Notification of presumptive positive results for biotinidase deficiency, sickle cell disease, congenital hypothyroidism and cystic fibrosis shall be made at the beginning of the next business day:

i. metabolic disorders identified by tandem mass spectrometry and for galactosemia—report results within 2 hours;

ii. biotinidase deficiency—report results within 24 hours;

iii. sickle cell disease—report results of FS, FSC, FSA from initial specimens within 24 hours;

iv. congenital hypothyroidism—report within 24 hours;

v. congenital adrenal hyperplasia—report within 2 hours; and

vi. cystic fibrosis—report within 24 hours.

c. The specified information to be reported:

i. child's name;

ii. parent or guardian's name;

iii. child's street address;

iv. child's date of birth;

v. child's sex;

vi. child's race;

vii. parent's telephone number;

viii. collection date;

ix. test results;

x. primary care physician;

xi. age at collection (< or > 48 hours old);

xii. birth weight;

xiii. full term or premature or gestational age; and

xiv. transfusion given?

Yes ____ No ____

If yes, date of last transfusion (if available): _____

xv. Feeding type: human milk, formula (type), both (formula type)

9. Provision of Follow-up Services. To ensure that reporting time deadlines specified under Subparagraph b of Paragraph 8 of this Subsection are met for every positive test result indicating probable disease, a follow-up system must be in operation. The protocol for a follow-up system may rely on the submitting hospital for the follow-up action which must include the following.

a. Locate the infant and ensure diagnostic and medical care:

i. telephone call to medical provider within 24 hours of positive lab result;

ii. if there is no medical provider available, a telephone call should be made to parent/guardian;

iii. if the parent/guardian does not have a telephone, then notify them by certified and regular mail;

iv. if there is no response to mail within five days, a home visit should be made; and,

v. report to the Genetic Diseases Program Office all patients with suspect results who are unable to be located.

b. Results of repeat testing should be obtained.

i. If results are normal, the case can be closed.

ii. If results are abnormal, the case must be reported to the Genetic Diseases Program Office.

10. Reporting requirements of private laboratories to the Genetic Diseases Program Office for public health surveillance and quality assurance purposes.

a. The laboratory shall submit quarterly statistical reports to the Genetic Diseases Program Office that indicate the number of specimens screened by method, the number of specimens unsatisfactory for testing, the number normal and positive, and for screening of hemoglobinopathies, the number by phenotype [see the Genetics Diseases Program Office's address near the end of the Diseases/Testing Methodology table (which may be found under Paragraph 5 of this Subsection)].

b. The laboratory shall electronically report newborn screening results on all Louisiana newborns screened to the Genetic Diseases Program Office on a monthly basis. The file format and data layout shall be determined by the Genetic Diseases Program. Essential patient data is the following and is required to be reported unless "optional" is indicated:

i child's name;

ii. child's last name;

iii. mother's first name;

iv. mother's last name;

v. mother's maiden name (optional);

vi. child's street address;

vii. child's city;

viii. child's state;

ix. child's zip code;

x. child's parish (optional);

xi. child's date of birth (format: mm/dd/yyyy);

xii. child's sex;

xiii. child's race (format: (W)hite, (B)lack, Native American, Asian, other, Hispanic);

xiv. mother's Social Security number (format: 999-99-9999); and

xv. child's test results.

11. The laboratory shall register by letter with the OPH's Genetic Diseases Program each year. This letter shall contain the following and shall be received in the Genetic Diseases Program Office by February 1 each year:

a. assurance of compliance with the requirements described in Subsection G. - G.9. of this Subsection;

b. the type of testing methodologies used;

c. the number of specimens projected to be tested or actually tested annually;

d. the type of specimen(s) used, i.e., filter paper or whole blood; and

e. reporting format for positive/abnormal test results.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1018.1 and 1081.2

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 17:378 (April 1991), LR 18:1131 (October 1992), LR 20:1386 (December 1994), LR 23:301 (March 1997), LR 27:545 (April 2001), LR 29:1490 (August 2003), LR 32:248 (February 2006), LR 34:442 (March 2008), amended by the Department of Health, Office of Public Health, LR 44:1908 (October 2018), LR 48:501 (March 2022).

Chapter 65. Regional Genetics Clinics

§6501. Eligibility

A. All Louisiana residents are eligible to attend a regional genetics clinic for genetic evaluation and counseling. These services are directed to the index patient and his/her family. The index patient is the person who brings the family to the attention of the geneticist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§6503. Purpose and Scope of Services

A. Regional genetics clinics have been established to provide genetics services to all areas of the state in settings accessible to the population.

B. Services provided at the genetics clinics include: genetic evaluation of the index patient and/or family and counseling regarding the impact of the disease on the individual and the family, the prognosis, the risk of recurrence, and the management of the disorder. Counseling services shall be provided in all state planning regions.

C. Anyone desiring to attend a genetics clinic may make an appointment by contacting his/her parish health unit. Residents of Orleans and Plaquemines parishes may call the central office at (504) 568-5075.

AUTHORITY NOTE: Promulgated in accordance with R.S.40:1299.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 67. Insurance Collection

§6701. General

A. Insurance carriers shall be charged by the program for special formulas required for children with PKU and Maple Syrup Urine Disease (MSUD) which are dispensed by OPPHS and for clinic visits at regional genetics clinics.

B. Cost for special formula is determined by actual charges made to OPPHS by the formula manufacturers plus a 25 percent fee for dispensing, shipping and delivery by OPPHS. As an example, the prices for the distribution of the three types of formulas, as of January 1, 1985, are listed below.

Type of Formula	Quantity	Cost
Phenyl-Free	1 Case (6 cans)	$280.13
Lofenalac	1 Case (6 cans)	$208.35
MSUD	1 Case (6 cans)	$221.78

C. The cost for a clinic visit depends on the type of service rendered by the attending medical geneticist. The medical geneticist shall base his cost on the type of service level in accordance with the definitions found in the Physician's Current Procedural Terminology Fourth Edition 1985 published by the American Medical Association and copyrighted 1984.

D. The prices associated with these levels of service are derived from average prices identified through a nationwide survey conducted by the Genetic Services Committee of the American Society of Human Genetics and found in their report of 1983, Report on Costs and Payment for Genetic Services. The FY'86 DHHR annual economic indicator index for medical care is included in the prices which appear below:

1. First Clinic Visit For Genetic Evaluation and Counseling—Fee Charged:

Limited	$49
Intermediate	$69
Comprehensive	$102
Complex	$128

2. Clinic Visit After Initial For Genetic Evaluation and Counseling—Fee Charged:

Limited	$27
Intermediate	$38
Extended	$62
Comprehensive	$69
Complex	$113

3. Genetic Counseling Only By A Medical Geneticist, Initial Or After Initial visit—Fee Charged:

Standard	$61
Long	$90

E. Fees charged may vary, subject to changes in the indicators mentioned above.

F. A clinic visit is defined as a medical genetic evaluation and counseling session conducted by the medical geneticist with the index patient and his/her family members.

G. A charge for one service rendered to the index patient would be made to the third party payor. In cases where extended families are provided genetic counseling and two index patients are identified by the geneticist, one service charge will be made for each index patient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 69. Genetic Diseases Program Advisory Committee

§6901. Composition and Meetings

A. The Genetic Diseases Program Advisory Committee is hereby created pursuant to federal recommendations and it shall be composed of members who are knowledgeable of medical genetic disorders. On the recommendations of the Genetics Program staff and with the approval of the maternal and child health medical director, members shall be appointed by the assistant secretary of OPPHS. There shall be representation from all medical schools within the state. The disciplines of genetics, pediatrics, obstetrics, and hematology shall be represented. Representation from OPPHS shall include but not be limited to nutrition, laboratory, social work, handicapped children's services, maternal and child health and the physicians connected with these programs. There shall be two consumer representatives.

B. The committee shall meet as often as necessary to conduct its business in a timely fashion, but meetings shall be held at least once a year.

C. The meeting site shall be determined by the committee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§6903. Duties

A. The committee shall:

1. Assist OPPHS in developing standards for the implementation of R.S. 40:1299 et seq. and in developing any new legislation affecting genetic services.

2. Consult with and assist OPPHS in setting policy and the scope of services.

3. Participate with OPPHS in developing and maintaining educational programs among health professionals and the lay public on the services offered by the Genetic Diseases Program and on genetic disorders.

4. Consult with OPPHS regarding the promulgation of rules and regulations necessary in the conduct of the Genetic Diseases Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 70. Lead Poisoning Prevention Program

§7001. Relationship of Local and State Poisoning Prevention Programs

A. The local lead prevention program shall collaborate with the state Lead Prevention Program at the Office of Public Health and adhere to current Centers for Disease Control and Prevention guidelines.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:950 et seq., and under the authority of R.S. 40:5; 40:1299.21; 40:1299:22, and 40:1299:23.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 26:85, (January 2000); amended LR 27:52 (January 2001).

§7003. Definitions

A Case of Lead Poisoning (in children between the ages of six months to 72 months of age)—

1. a venous blood-lead level greater than or equal to 15 μg/dl (micrograms per deciliter);

2. acute symptomatic illness consisting of lead colic with or without lead encephalopathy; or

3. chronic symptomatic illness consisting of the signs and symptomatic illness consisting of the signs and symptoms of chronic plumbism, including, but not limited to anemia, nephropathy, neuropathy, loss of developmental

skills, recurrent lead colic and/or recurrent lead encephalopathy.

Previously Reported—any case of lead poisoning which has been diagnosed by a medical provider, and reported to the Office of Public Health as specified in §7005.

Lead Contamination—shall be considered a health hazard to children or other persons, if said lead contamination exists in or about a dwelling, dwelling unit, household, or other premises which in the judgement of the State Health Officer, children or other persons visit with such frequency or duration as to create significant risk of lead poisoning. Lead contamination shall include:

1. paint or similar coating material, putty, plaster or other composition material, on an exposed surface or chewable surface, which contains ≥0.5 percent lead by weight as determined by laboratory analysis or ≥1.0 milligram per square centimeter of surface area as measured by x-ray fluorescence or equivalent method;

2. drinking water, dust, or soil which contains a level of lead which, in the judgement of the State Health Officer, is sufficient to be a source of lead poisoning to children or other persons;

3. any object or material which, in the judgement of the State Health Officer, can be a source of lead ingestion or inhalation.

Clinical Laboratory—a facility for the biological, microbiological, serological, chemical, immuneohematological, hematological, biophysical, cytological, pathological, or other examination of substances derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or in the assessment or impairment of the health of human being.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:950 et seq., and under the authority of R.S. 40:5; 40:1299.21; 40:1299:22, and 40:1299:23.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 26:85, (January 2000); amended LR 27:52 (January 2001).

§7005. Mandatory Blood Lead Screening of Children in High Risk Geographical Areas

A. Based on surveillance data gathered by the State Childhood Lead Poisoning Prevention Program and review by the state health officer and representatives from medical schools in the state, all parishes are identified as high risk for lead poisoning.

B. Medical providers providing routine primary care services to children ages 6 months to 72 months residing or spending more than 10 hours per week in these parishes must have such children screened in accordance to practices consistent with current Center for Disease Control and Prevention guidelines, which include the following specifications:

1. administration of a risk assessment questionnaire at every well baby visit;

2. use a blood lead test to screen all children at ages 12 months and at 24 months or at any time from ages 36 months to 72 months, if they have not been previously screened;

3. blood lead levels ≥15µg/dl obtained from finger stick samples will be confirmed using a venous blood sample.

C. Identified high-risk areas will be assessed annually and any additions or deletions will be provided through amendment of LAC 48:V.7005.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:950 et seq., and under the authority of R.S. 40:5, 40:1299.21, 40:1299.22, 40:1299.23, and 40:1299.25.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 26:85 (January 2000), amended LR 27:52 (January 2001), LR 31:1588 (July 2005), LR 34:2173 (October 2008).

§7007. Mandatory Case Reporting by Health Care Providers

A. Medical providers must report a lead case, which is indicated by a blood lead test result of >15µg/dl (micrograms per deciliter), to the Childhood Lead Poisoning Prevention Program, Office of Public Health within 24 working hours to ensure appropriate and timely follow-up. All health care providers shall assure that all the following information is submitted to the testing laboratory with all ordered blood lead samples for analysis and/or submitted with all lead case reports to the Lead Poisoning Prevention Program:

1. child's name;

2. parent's or the guardian's name;

3. child's street and mailing address, including the city state, parish, and zip code;

4. child's date of birth;

5. child's sex;

6. child's race;

7. child's national origin;

8. child's Social Security number;

9. phone number where child’s parent(s) or guardian can be reached;

10. Medicaid number if child is an enrolled recipient;

11. type of sample (venous or capillary);

12. sample collection date

13. type of test: first, annual, or repeat test;

14. blood lead level results documented in micrograms per deciliter (µg/dl).

B. Lead cases, along with the specified information shall be reported within 24 business hours by fax to the Lead Poisoning Prevention Program, Office of Public Health at 504-219-4452 and the original lead case reporting form shall

be mailed within five business days to the Louisiana Lead Poisoning Prevention Program Office at 3101 W. Napoleon Ave, Metairie, LA 70001.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:950 et seq., and under the authority of R.S. 40:5, 40:1299.21, 40:1299.22, 40:1299.23, and 40:1299.25.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 26:85 (January 2000), amended LR 27:52 (January 2001), LR 31:1588 (July 2005), LR 34:2174 (October 2008).

§7009. Reporting Requirements of Blood Lead Levels by Laboratories and by Health Care Providers Performing Office-Based Blood Lead Analyses for Public Health Surveillance

A. Health care providers who conduct blood lead level screenings using a CLIA-waived blood lead analysis device to determine blood lead levels and clinical laboratories responsible for conducting analysis to determine blood lead levels for health care providers and/or for referring laboratories, shall also report all results to the Louisiana Lead Poisoning Prevention Program by electronic transmission in a format consistent with the CDC guidelines for uniform reporting of blood lead results to state and local health departments as available at http://lcweb2.loc.gov/lasw/usa/1710299992p1106-310.pdf.

B. The following information is required and essential for appropriate monitoring, screening and treatment of lead poisoning.

1. All results of blood lead testing for children under 72 months of age must be reported regardless of the test results

2. All laboratories responsible for directly conducting blood lead level analyses and laboratories responsible for referring the analysis to another laboratories must collect all the information specified in items under §7007.A.1-14.from the health care provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:950 et seq., and under the authority of R.S. 40:5, 40:1299.21, 40:1299.22, 40:1299.23, and 40:1299.25.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 26:85 (January 2000), amended LR 27:53 (January 2001), LR 31:1588 (July 2005), LR 34:2174 (October 2008).

Chapter 71. Hemophilia Program

§7101. Eligibility

A To be eligible for the program a client has to reside in Louisiana and have medically diagnosed hemophilia, as defined in R.S. 40:1299.5. For a patient to receive factor and other medical supplies and services through the program he must:

1. receive a medical evaluation at least once annually at the Louisiana Comprehensive Hemophilia Care center;

2. submit infusion records upon sending in prescriptions to the program office;

3. sign and submit all insurance forms relative to charges for factor and other supplies;

4. inform the Program office immediately of any changes in insurance coverage.

B. If a patient fails to comply with these requirement, he/she will not be able to receive factor and other medical supplies and services through the program.

AUTHORITY NOTE: Promulgated in accordance with R. S. 40:1299.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended LR 15:545 (July 1989).

§7103. Collections

A. Insurance carriers, Medicare and Medicaid are charged by the program for the blood products (e.g., factor, monoclate, stimate and autoplex) and medical supplies (syringes and needles). Costs are determined by charges made to the program for the blood products and medical supplies, plus an administrative fee for dispensing, shipping and delivery by the state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended LR 15:545 (July 1989).

§7105. Hemophilia Advisory Committee

A. The Hemophilia Advisory Committee shall be composed of not more than 17 members made up of such citizens who are knowledgeable of and/ or have an interest in hemophilia and related bleeding disorders. The membership shall reflect a geographic crosssection of the state of Louisiana.

B. Vacancies on the committee shall be filled by the secretary, Department of Health and Human Resources, under the provisions of R.S. 36:254B (2), from nominees submitted by the assistant secretary, Office of Preventive and Public Health Services.

C. The committee chairman shall be appointed by the secretary of the Department of Health and Human Resources in accordance with the provisions of R . S. 36:254 B(2).

D. The committee shall advise the Office of Preventive and Public Health Services in the implementation of R.S. 40:1299.5.

E. The committee shall adopt necessary rules to govern its operations and procedures including provisions for removal of inactive members.

F. The committee shall meet as often as necessary to conduct its business in a timely fashion but meetings shall be held at least quarterly.

G. The meeting site shall be determined by the committee.

H. Travel expenses of the committee to the committee meetings shall be provided in the budget of the Louisiana State Hemophilia Program. Expenses for such travel shall be kept to a minimum.

I. The committee shall:

1. Advise in 'developing standards for the implementation of R. S. 40:1299.5.

2. Advise in establishing criteria for eligibility for participation in the State of Louisiana's Hemophilia Program.

3. Advise the Office of Preventive and Public Health Services in the preparation of an annual budget for the operation of the State of Louisiana's Hemophilia Program.

4. Advise and participate in instituting and maintaining educational programs amoug physicians, dentists, hospitals, public health units and departments, schools, and the public concerning hemophilia, including dissemination of information and the conducting of educational programs, concerning the methods of care and treatment of persons suffering from hemophilia and other bleeding disorders.

5. Advise and participate in monitering the use of blood and blood products by those Louisiana citizens who are participants in the Louisiana Hemophilia Program.

6. Advise and participate in monitoring the Office of Preventive and Public Health Services in the operation of the Louisiana Hemophilia Comprehensive Care Center.

7. Advise the Department of Health and Human Resources and its Office of Preventive and Public Health Services regarding the promulgation of rules and regulations necessary to effectuate the Louisiana Hemophilia Program.

J. A liaison between the committee and the Office of Preventive and Public Health Services shall serve as an ex-officio member of the committee without voting privileges.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, and R.S. 40:1299.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subpart 21. Water and Wastewater Operator Certification

Chapter 73. Certification

§7301. Definitions

A. Unless otherwise specifically provided herein, the following words and terms used in this Chapter are defined for the purposes thereof as follows.

Committee of Certification—as defined in statue R.S. 40:1142.

Community Sewerage System—any sewerage system which serves multiple connections and consists of a collection and/or pumping/transport system and treatment facility.

Department—the Louisiana Department of Health and Hospitals, Office of Public Health.

Person—an individual, a public or private corporation, an association, a partnership, a public body created by or pursuant to state law, the state of Louisiana, an agency or political subdivision of the state, a federally recognized Indian tribe, the United States government, a political subdivision of the United States government, and any officer, employee, or agent of one of those entities.

Operator—the individual, as determined by the Committee of Certification, in attendance on site of a water supply system or sewerage system and whose performance, judgment, and direction affects either the safety, sanitary quality, or quantity of water or sewage treated or delivered.

Public Water System—a system for the provision to the public of water for potable purposes through pipes or other constructed conveyances, if such system has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:502 (March 2002), repromulgated LR 28:839 (April 2002).

§7303. Certification Requirements

A. The basic requirements for certification are set forth in R.S. 40:1141-1151.

B. The Operator of any public water system or any community sewerage system shall hold current and valid professional certification(s) of the required category(s) at or above the level required for the total system and individual facility. Additionally, an operator shall demonstrate that, when not actually on site at the facility, he is capable of responding to that location within one hour of being notified that his presence is needed.

C. Systems operating multiple shifts are required to have a minimum of one certified operator present on each shift. Exact numbers of certified operators required may be determined by the committee of certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:502 (March 2002), repromulgated LR 28:839 (April 2002).

§7305. Categories of Certification

A. Certifications are offered in each of the following areas (categories), of qualification:

1. water production;

2. water distribution;

3. water treatment;

4. wastewater collection;

5. wastewater treatment.

B. Water production certifications are required on all facilities. For those systems which use groundwater as a source of raw water and which do not alter the physical, chemical or bacteriological quality of the water other than simple disinfection, operators will not be required to hold certificates for treatment in addition to production.

C. Water distribution certifications are required on all portions of the water supply system in which water is conveyed from the water treatment plant or other supply point to the premises of the consumer.

D. Water treatment certifications are required for all operators of facilities which use surface water as a source of raw water, as well as those groundwater systems that involve complex treatment and/or which in some way alters the physical, chemical or bacteriological quality of the water. Water Treatment certification shall not be required for groundwater systems for which the only type of treatment employed is simple disinfection, and where the well(s) has been determined to be not under the direct influence of surface water.

E. Wastewater treatment certifications are required on all facilities which provide for the treatment of wastewater and the reduction and/or handling of sludge removed from such wastewater.

F. Wastewater collection certifications are required on all components of a sewerage system except for the sewage treatment plant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:503 (March 2002), repromulgated LR 28:839 (April 2002).

§7307. Levels (Classes) of Certification for Types of Facilities

A. Required levels of certification for an operator, based on facility classification, are as follows:

Population Served	Facility Classification
<1,000	Class 1
1,001-5,000	Class 2
5,001-25,000	Class 3
Over 25,000	Class 4

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:840 (March 2002).

§7309. Operator Qualifications—General (Education/Experience)

A. Whereas R.S. 40:1141-1151 specifies minimum operator qualifications in years, these values have been converted to "points" for ease of integration with continuing education credits and substitutions between education and experience. Operator qualifications for the various levels of certification shall be determined by minimum point values as follows.

Certification Level	Required Points
Op-In-Training	0
Class 1	1
Class 2	2
Class 3	5
Class 4	8

NOTE: A minimum educational requirement of a High School Diploma (or G.E.D.) is applied to ALL levels of certification. Required point values for education and experience are in addition to this minimum level of education. Point value required for Classes 1 and 2 may be from experience alone although 25 percent of this value may be acquired from education credit. No more than 75 percent of the total required points for Classes 3 or 4 may be obtained from education or experience alone.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:504 (March 2002), repromulgated LR 28:840 (April 2002).

§7311. Operator Qualifications—Substitutions/ Assignment of Point Values

A. Point values for education, continuing education, and experience are assigned as follows.

1. Education

a. Each year of formal college education (minimum of 30 semester hours) = 1 point

b. Each year of formal graduate level education = 1.5 points

c. Each semester hour (credit) for college-level courses = 0.033 point

d. Each 40-hour qualified, approved training course = 0.10 point

e. Each 8 hours of qualifying, approved continuing education = 0.02 point

f. Each 1 hour of qualifying, approved continuing education = 0.0025 point

2. Experience

a. Each year of qualifying operator experience = 1 point

b. Each year of qualifying related experience = 0.5 point

c. Each year of qualifying supervisory experience = 1.5 points

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:504 (March 2002), repromulgated LR 28:840 (April 2002).

§7313. Professional Certification

A. All persons seeking professional certification must be employed or seeking employment by a water or wastewater utility.

B. Certificates must be displayed by the holder in a prominent place in the classified facility. Additionally, at such time as a certified operator is issued a certified operator identification card, the operator shall carry his identification card on their person while on duty in the classified facility. Failure to do so may be considered grounds for revocation of the certificate in accordance with R.S. 40:1145(D).

C. Certificates shall be valid only so long as the holder uses reasonable care, judgment, and knowledge in the performance of his/her duties. No certificate will be valid if obtained or renewed through fraud, deceit, or the submission of inaccurate qualification data.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:504 (March 2002), repromulgated LR 28:840 (April 2002).

§7315. Limited Certificates

A. Only those limited certificates issued prior to the effective date of these Rules, in compliance with R.S. 40:1141-1152 remain valid, and shall remain valid only for the system in which the operator was previously employed and for the conditions of operations and duties involved on the original effective date of this Rule.

B. Limited certificates shall be renewable upon application provided the requirements for renewal without reexamination for certificates of even grade are satisfied.

C. Persons granted limited certificates and renewals of limited certificates shall pay the same fees as are fixed for mandatory certificates of like grade.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:504 (March 2002), repromulgated LR 28:840 (April 2002).

§7317. Operator-in-Training

A. Operator-in-Training certificates may be granted to newly hired personnel, who have not previously been certified, or who have not held any type of certification for in excess of two years, and who do not presently qualify for a professional or provisional certificate. Such individuals may make application for the appropriate category (water, wastewater) of operator-in-training certificate. The certification officer will then begin maintaining records of all approved education, training and experience credits accumulated by the operator-in-training. An operator-in-training certificate shall be valid for a period of 24 months from the date of issue, and may be renewed in the same manner as provisional or professional certificates. Operators-in-training may not be designated as the operator of the system/facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:504 (March 2002), repromulgated LR 28:840 (April 2002).

§7319. Provisional Certificate

A. A provisional certificate may be issued to any applicant who successfully passes an examination. Provisional certificates shall not qualify an individual to serve as the operator of a facility.

B. A provisional certificate may be converted to a professional certificate if the certificate holder meets all qualifications and assumes the duties of an active operator of a water or wastewater system.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:504 (March 2002), repromulgated LR 28:841 (April 2002).

§7321. Examinations—General

A. All operators wishing to become certified by the State of Louisiana, must pass an examination demonstrating they have the necessary knowledge, skills, judgement, and abilities as specified by the committee of certification. All exam questions will be validated by the committee of certification or their appointees.

B. Exams shall be conducted in the English language.

C. The committee of certification has established open examination periods for water and/or wastewater operators to be examined. They are as follows.

1. One annual open exam shall be conducted at the conclusion of the annual Louisiana Conference on Water Supply, Sewerage and Industrial Waste "Short Course," meeting which is held in various locations around the state.

2. One open exam shall be conducted at the conclusion of the Louisiana Rural Water Association Annual Conference.

3. Other open examinations may be scheduled at other locations as determined by the committee of certification based on their determination of need subject to provisions of §7305 of these Rules.

4. Application for examinations to be given following scheduled training courses, seminars, workshops, etc., (as listed in §7329 and §7331 of these Rules) will be considered on a case-by-case basis by the committee of certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:505 (March 2002), repromulgated LR 28:841 (April 2002).

§7323. Examinations—Individual Operator Requirements

A. Individual operators must make written application to the committee of certification to take each examination or

series of examinations. The application forms will be made available to the examinee prior to the exam period with ample time given to allow completion prior to the actual exam period. The operator (examinee) carries the responsibility for the accuracy of the information contained in the application.

B. Applicants for certification examinations must pay the prescribed exam fee at the conclusion of testing (see §7333 of these Rules).

C. All examinations shall be administered in the English language. Requests for examinations to be administered orally may be considered by the administrator, upon written request by an applicant, submitted at least 30 days in advance, with verifiable proof from a physician that the applicant has a medical condition temporarily preventing him from taking the examination in the conventional manner.

D. Exams shall be taken and passed in sequence from the Class 1 to the Class 4 in each category.

E. Applicants may not apply to take and may not take examinations for certification higher than one level above that for which they are currently qualified.

F. If an applicant takes an examination and fails to attain a passing grade (70 percent or higher), he must wait a minimum of 90 days before he can take another exam in the same category and level. After three failed attempts at the same examination, an applicant will be required to attend a 40-hour training course before retesting will be allowed.

G. All examinations will be graded by department personnel and retained for two years. The examinee will be notified of the results. Examinations will not be returned to the examinee, but may, upon written request, be reviewed in the Operator Certification Program Office in Baton Rouge within 30 days following receipt of the notification of results.

H. Individuals caught cheating during the operator certification examinations or found to have prejudiced these exams or applications in any way shall be entitled to an administrative hearing before the committee of certification. If the committee finds that valid grounds exist, it shall revoke the subject's current certificate, it may refuse to certify the applicant and it may reject future applications. As provided in the Administrative Procedure Act, an aggrieved party may seek judicial review of the committee of certification's action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:505 (March 2002), repromulgated LR 28:841 (April 2002).

§7325. Application for Certification

A. All applications for certificates shall be addressed to: Administrator, Operator Certification Program, Louisiana Department of Health and Hospitals, Office of Public Health, 6867 Bluebonnet Boulevard, Baton Rouge, LA 70810. Applications for certificates must be accompanied by the prescribed fees.

B. All initial applications for any category of either new certificates or renewal certificates received subsequent to the effective date of this Rule, shall be accompanied by a "Certification Law and Rules Examination" to be completed by the applicant as part of the application process.

C. Applicants who pass the required examinations, and meet the minimum education and experience requirements, and are actively employed by a water or wastewater system, will be notified that they may apply for the earned professional operator certification.

D. Applicants who pass an examination but do not meet the education and experience requirements will be notified of what education and/or experience and/or training is required to qualify. Such applicants, upon payment of the prescribed fee, will be issued a provisional certification in the classification(s) for which they have passed the examination(s). At whatever time the applicant qualifies, an application with the necessary fee must be submitted or re-examination may be required.

E. Individuals who have combined work experience in both water and wastewater may make written application to the certification committee for credit toward certification in either or both of the two categories. The work experience will be listed in a detailed resumé application which details the overlapping areas of work responsibility. This application will be certified by the immediate supervisor of the individual requesting certification. The committee of certification will rule on each individual application as presented. These applications will be reviewed twice a year by a screening subcommittee composed of members of the operator certification committee.

F. One individual may be designated as the operator over (several) more than one water or wastewater system or district provided that he can demonstrate that he is actively involved on a day-to-day basis in the operation of each of the systems, and is able to respond to the systems locations within one hour of notification that his presence is required.

G. Experience must be in actual water system or sewage system operation or its approved equivalent and must be in the field applying to the respective certificates. Experience as foreman or supervisor in most capacities in water and sewerage systems may be considered acceptable. Experience in purely clerical capacity, such as accounting, bookkeeping cannot be considered as acceptable experience. Experience in narrow technical capacities, such as laboratory technicians or meter readers may be considered for partial credit by the committee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:505 (March 2002), repromulgated LR 28:841 (April 2002).

§7327. Renewal and Recertification

A. Renewal Requirements. In order to qualify for renewal of certificates held in any and all classes, all operators of water and sewerage works shall enumerate, certify and provide evidence that he/she has attended a minimal number of contact hours of approved operator training for each certificate held during the previous two-year certification period. A minimum of 16 contact hours is required for renewal of any certifications held in water categories or 8 hours per certificate whichever is the greater. Likewise, a minimum of 16 contact hours is required for renewal of any certifications held in wastewater categories. Failure to attend the required training or failure to furnish the required information shall constitute grounds for refusal to renew the certificate. Approved training is defined as the completion of any of the training courses listed in §7329. It is strongly recommended that course outlines (or lesson plans) for other proposed in-service training be submitted for approval prior to the proposed date of training.

B. Recertification. Operators for whom certification has been expired in excess of two years are not eligible to renew their license(s), and shall be required to reapply for certification under the provisions of this Rule. In such cases, applicants shall be re-examined and shall demonstrate compliance with appropriate education and experience requirements before any certificates will be issued. In those instances where an operator's license has previously been revoked by the committee, the committee shall recommend any additional requirements for recertification that are deemed appropriate, and rule on the operator's eligibility to reapply for a license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:506 (March 2002), repromulgated LR 28:842 (April 2002).

§7329. Training—General

A. Training Courses Available. To be approved for training credit by the Administrator of the Operator Certification Program, the training courses identified in Paragraph B of this Section must meet the following general requirements.

1. The administrator must have on file a copy of the course outline of the training course, seminar, workshop, etc. to make his approval decision.

2. Information must include dates, place held, sponsoring organization, speakers/instructors and time (length of subject), and target audience (category and levels of certification addressed).

3. No blanket approvals (from year to year) will be given or implied and a separate approval must be given by the Operator Certification Program each time training is given. On doubtful courses, the administrator will bring the matter to the committee of certification for disposition. (An aggrieved applicant may apply for an administrative hearing to be conducted by a panel of the committee of certification.)

4. Operators shall be responsible to assure the sponsoring organization submitting his certified transcript of training credits earned to the administrator.

B. Training courses, short courses, technical sessions, seminars, workshops, etc., recognized by both the committee of certification and department include, but are not limited to the following:

1. annual short course of the Louisiana Conference on Water Supply, Sewerage and Industrial Wastes;

2. regional conferences of one or more days sponsored and/or co-sponsored by the Louisiana Conference on Water Supply, Sewerage and Industrial Wastes;

3. American Water Works Association Annual Conferences, technical sessions, seminars and workshops;

4. National Association of Water Companies Annual Conferences seminars and workshops;

5. Southwest Section, American Water Works Association Annual Conference, technical sessions, seminars and workshops;

6. college or university and vocational-technical sponsored water and/or wastewater courses, as approved by the certification committee;

7. Water Environment Federation Annual Conference, regional meetings, technical sessions, seminars and workshops;

8. Louisiana Water Environment Association regional meetings, technical sessions, seminars and workshops;

9. Louisiana Rural Water Association annual training and technical conference, regional meetings, technical sessions, seminars and workshops;

10. Louisiana Environmental Training Center, at University of Louisiana at Lafayette, training courses, technical sessions, seminars and workshops;

11. regional meetings, technical sessions, seminars, workshops and/or training programs, sponsored and/or co-sponsored by the Department of Health and Hospitals, or the Department of Environmental Quality;

12. water and/or wastewater operator training courses approved for certification examinations by the committee of certification;

13. short schools, technical courses, seminars, workshops and training programs sponsored by other states.

C. A water and/or wastewater organization or utility not listed above may apply to the committee of certification for recognition and approval to conduct a training course.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:506 (March 2002), repromulgated LR 28:842 (April 2002).

§7331. Examinations in Conjunction with Training Courses

A. Applicants for approved training courses may request that certification exams be conducted following the completion of the course. In order to obtain approval from the committee of certification, the applicant (sponsoring individual or organization) must comply with the following requirements and rules.

B. The applications must be submitted to: Administrator, Operator Certification Program, Louisiana Department of Health and Hospitals, Office of Public Health, 6867 Bluebonnet Boulevard, Baton Rouge, LA 70810.

C. Applications must be submitted 30 days prior to the beginning of the course.

D. No exam shall be conducted without prior written approval.

E. Blanket approval for training courses and exams will not be given by the committee of certification, i.e., each training course and each exam period must be approved according to these Rules.

F. No exam shall be approved to follow a training course consisting of less than 32 hours. An exception to this Rule may be granted to the Louisiana Conference on Water Supply, Sewerage and Industrial Waste as this organization and its sub-organizations comprise the official training arm of the committee of certification.

G. Approval will be given to conduct exams only for the classes and categories covered by the training course, i.e., for training in Class I, II, III or IV in production, treatment or distribution, or wastewater collection or treatment.

H. The classes and categories for which the course is designed must be stated in the application.

I. The applicant must submit a detailed course outline to include:

1. the goal of the training course;

2. which operators in water and/or wastewater would benefit from taking the course;

3. each subject to be covered;

4. a formal lesson plan for each subject area to be covered;

5. the number of hours covered in each subject;

6. what references will be supplied in the course;

7. what references and materials the student should bring to the course.

J. The applicant must submit the names of all instructors, and their qualifications, including their education and work experience credentials and their certification levels. Instructors shall possess, at a minimum, a "provisional" certification in the subject area covered; or, shall have completed a qualified instructor training course or equivalent; or, be specifically accepted by the committee based upon their credentials.

K. Only those examinations prepared under the auspices of the administrator and the committee of certification will be recognized for certification.

L. All examinations will be conducted and monitored by members of the staff of the department and/or members of the committee of certification. No exams will be conducted without the presence of a sufficient number of monitors approved by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:507 (March 2002), repromulgated LR 28:843 (April 2002).

§7333. Examination Fees

A. All fees for examinations shall be paid to the committee of certification.

B. Examination Fees shall be established as authorized by the Legislature, but in no case shall be less than $5 per exam.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:507 (March 2002), repromulgated LR 28:843 (April 2002).

§7335. Certification Fees

A. Certificate fees, in addition to the examination fee, shall be:

1. collected for issuance, renewal and/or reciprocation of all classes of certificates. The amount of the certificate fee shall be as established by the legislature, but in no case shall be less than $10 for certification in the first category in water and/or sewerage and an additional $5 for each added category;

2. communities, municipalities, utilities and/or corporations may elect to utilize a flat fee system regarding their employees' certification. For a fee of $50 per year for either field of water or sewerage or $100 per year for both, all eligible operators may be certified, either initially or renewed. In addition to the flat fee, there will be a $5 per certificate charge for each certificate issued. In the instance of the flat fee, the individual operators at each facility will be the responsibility of the principal of the organization and shall be submitted with each renewal (flat fee) payment;

3. duplicate certificates will be issued for a fee of not less than $5 per certificate.

4. water and wastewater operator certificates will be renewed on a two-year basis, with the fees remaining at the same annual rates as are currently in effect but collected every two years.

5. fees are to be paid in the form of a check or money order payable to the Committee of Certification, 6867 Bluebonnet Boulevard, Baton Rouge, LA 70810. Failure to

attend the required training or failure to furnish the required information shall constitute grounds for refusal to renew the certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:507 (March 2002), repromulgated LR 28:843 (April 2002).

§7337. Reciprocity

A. Reciprocity shall be granted at the discretion of the committee of certification, without examination, to holders of comparable certificates issued by other states, territories, or possessions of the United States. The applicant for a certificate under the reciprocity clause must submit his application on an official application blank, obtainable from the administrator. The application must be accompanied by the appropriate fee. The applicant must submit a copy of his certificate or other proof, satisfactory to the committee of certification that he holds a certificate issued by a governmental agency of another state, territory or possession of the United States. Such certificates must have been received after passage of an examination at least equivalent to that given by the Louisiana committee of certification for the level of competency for which application is made.

B. The burden of proof to submit sufficient information for the committee of certification's consideration shall be upon the applicant. If, after receiving such an application, the committee of certification is satisfied that the applicant qualifies for a certificate, it may, at its discretion award him a certificate in the appropriate grade. A reciprocal certificate will not ordinarily be issued unless the applicant is employed, or has accepted employment, in a Louisiana water or wastewater facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:507 (March 2002), repromulgated LR 28:844 (April 2002).

§7339. Notification

A. Failure to receive any notices previously mentioned does not relieve the certificate holder or applicant from complying with the rules of the committee of certification. The burden is upon the certificate holder or applicant to provide the committee of certification with a current mailing address.

B. Any request for applications, training course approvals, reciprocity, etc., and/or questions on operator certification should be addressed to: Administrator, Operator Certification Program, DHH-OPH, 6867 Bluebonnet Boulevard, Baton Rouge, LA 70810.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:507 (March 2002), repromulgated LR 28:844 (April 2002).

Chapter 75. Sewerage Program

§7501. Purpose

A. The Sewerage Program of the Department of Health and Human Resources (DHHR) is administered by the Office of Preventive and Public Health Services (OPPHS). Program related activities are authorized, delineated and/or mandated by R.S. Title 40 and other related statutes, the Louisiana State Sanitary Code, and Memorandums of Understanding. The purpose of the Sewerage Program is to regulate sewage treatment, sanitary sewerage disposal and other water and wastewater matters in order to safeguard the general public health.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1148, and R. S. 2321-2323.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§7503. Administration

A. Services rendered by OPPHS in response to Sewerage Program responsibilities are public health-oriented in nature. Program services are offered upon request and are governed by program priorities. Program regulations, as are detailed in Chapter 1, 13, and 16 of the Louisiana State Sanitary Code, generally constitute the basis for the majority of the activities attributable to the Sewerage Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1148, and R.S. 40:2321-2323.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§7505. Services

A. Among these activities are responsibilities for plans review, permitting, approvals, facilities and premises inspections, surveillance, sample collections, laboratory and field testing, complaint investigations, code compliance assurance and related enforcement. OPPHS may respond to requests from other state and federal agencies, such as the U.S. Army Corps of Engineers and the Louisiana Department of Natural Resources, for comments and/or letters of objection or no objection pertaining to proposed developments or activities which require the approval of such agencies prior to their initiation. Comments or letters of objection or no objection shall be based upon the substantive criteria contained in the *Sanitary Code* and in any other applicable DHHR regulations. Pursuant to R. S. 48:385 and other state or federal statutory requirements, DHHR may respond to petitions or other opportunities for review or consideration in matters requiring consent or denial of consent, as appropriate. Such considerations shall be based upon the substantive criteria contained in the *Sanitary Code* and other applicable DHHR regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1148, and R.S. 40:2321-2323.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§7507. Charges

A. Sewerage Program services are free of charge. While verbal requests for services may be honored, written requests may be required. Requests shall be conveyed to the chief sanitarian of the parish health unit having jurisdiction over the parish in which the service is to be rendered. Final disposition with respect to service request shall be made by the DHHR secretary or designee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1148, and R.S. 40:2321-2323.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subpart 25. Drinking Water

Chapter 77. Drinking Water Program

Subchapter A. General Provisions

§7701. Purpose and Scope

A. Acting under the authority derived from RS. 40:4, 40:5, and 40:11411151 in addition to an assumption of primacy for the Federal Safe Drinking Water Act granted in 1977 by the U.S. Environmental Protection Agency; the Office of Preventive and Public Health Services (OPPHS) conducts a program for the regulation of public water supplies in order to protect the public against disease transmitted through water supplied for drinking, cooking and washing purposes. OPPHS staff provides technical assistance and guidance to managers of water systems which must function in compliance with federal program requirements and to persons with individual private water supplies. OPPHS regulations pertaining to the certification of public water supply operators pursuant to R.S.40:1141-1151 are published separately.

B. Procedures used to enforce OPPHS regulations embodied in Chapter 12 of the Louisiana State Sanitary Code are described in Chapter 1 of that code. Chapter 12 of the State Sanitary Code, entitled "Water Supplies" includes requirements pertaining to permits to construct and operate public water supplies, approval of plans for new supplies or modifications to existing supplies, the operation of supplies, water quality monitoring, standards of water quality; record keeping; reporting requirements; and public notification requirements.

C. Drinking Water Program activities include: plans review; both routine and investigative monitoring/inspection of water quality for bacteriological, chemical and radiological contaminants; technical and emergency advisory assistance to public water supplies. Although public water supplies are not charged for these services, these activities are limited by budgetary restraints, staff workload, and similar factors affecting the prioritization of program activities.

D. Public water supplies seeking information about the foregoing activities or persons wishing additional information or desiring to make a complaint may contact their parish health unit or regional office of OPPHS.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4, R.S. 40:5, R.S. 40:1141-1151, and 41 CFR 142(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§7703. Services

A. Services available upon request to the owners of individual private water supplies include technical advice, inspection of construction, water sampling (bacteriological), and evaluation of wells/springs/cisterns. These services are provided free of charge when program resources are available. In addition, sampling and analysis in the OPPHS laboratories for chemical or radiological contamination is available when in the determination of the OPPHS district engineer, a need exists. Such need may be evidenced by a physician's request or by the proximity of the water supply to a pollution source. Sampling and analysis in the OPPHS laboratories for biological contamination (including the coliform test) is available on request except when, in the judgement of the parish health unit's chief sanitarian repeat sampling would be redundant. Request for services by owners of individual private water supplies should be made to the local parish health unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40;4, R.S. 40:5, R.S. 40:1141-1151, and 41 CFR 142(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§7705. Other Regulatory Programs

A. Several other regulatory programs have an impact on drinking water, including pollution control programs of the Louisiana Department of Environmental Quality, the Office of Conservation in the Louisiana Department of Natural Resources, and the Office of Public Works in the Louisiana Department of Transportation and Development.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4, R.S. 40:5, R.S. 40:1141-1151, and 41 CFR 142(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subchapter B. Public Water System Capacity Development

§7707. Introduction

A. The Department of Health and Hospitals, Office of Public Health (OPH) is the state agency within Louisiana granted primary enforcement responsibility from the United States Environmental Protection Agency (USEPA) to ensure that public water systems (PWSs) within the state are in dompliance with state drinking water regulations which are as stringent or more stringent thatn federal drinking warer regulations adopted inaccordance with the Safe Water Act (SDWA) (42 U.S.C. 300f et seq.). The SDWA Amendments of 1996 authorized the state to develop and implement a capacity development strategy for new public water systems,

public water systems applying for Drinking Water State Revolving Fund (SRF) monies, and existing public water systems to assess and ensure that such systems acquire and maintain technical, managerial, and financial capacity to facilitate compliance with and further the health protection objectives of the SDWA.

B. In accordance with the Louisiana Constitution and authorizing legislation, regulations governing Public Water System Capacity Development are promulgated by OPH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4(A)(8) and 5.8 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Division of Environmental Health Services, LR 24:1767 (September 1998).

§7711. Definitions

A. The following terms used in these regulations shall have the following meanings

Business Plan—includes, but not limited to, an explanation of the assets of the system, the service area's basic needs, how these needs are to be addressed, and how the system is goin to operate and sustain itself over time.

Committee of Certification—the committee created by R.S. 40:1141 through 1151, responsible for certification of public water system operators.

Community Water System—a public water system that serves year-round residents within a residential setting.

Department—the Office of Public Health (OPH) of the Department of Health and Hospitals (DHH).

Financial Capacity—relates to, but not limited to, ownership accountability, staffing and organization, and effective external linkages.

Managerial Capacity—relates to, but not limited to, ownership accountability, staffing and organization, and effective external linkages.

Non-Transient Non-Community Water System—a public water system that is not a community system and regularly serves at least 25 of the same persons (non-residents) over six months per year.

Operator—the individual(s), as determined by the state, who is in attendance, onsite at a public water system and whose performance, judgment and direction affects either the safety, sanitary quality or quantity of water treated or delivered.

Public Water System—a system for the provision to the public of water for potable purposes, through pipes or other constructed conveyances, if the system has at least 15 service connections or regularly serves an average of at least 25 individuals daily for at least 60 days out of the year. The term includes:

a. any collection, treatment, storage, and distribution facilities under the control of the operator of the system and used primarily in connection with the system; and

b. any collection or pre-treatment storage facilities not under such control which are used primarily in connection with the system.

State—the state of Louisiana or any agency or instrumentality thereof.

State Health Officer—the assistant secretary of the Department of health and Hospitals and/or his authorized representative.

Technical Capacity—related to, but not limited to, source water adequacy, infrastructure adequacy, and technical knowledge and implementation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1767 (September 1998), amended LR 27:1521 (September 2001), repromulgated LR 27:1691 (October 2001).

§7713. New Systems

A. Business Plan. All community and non-transient non-community public water systems wanting to commence operation after January 1, 1999 shall be required to submit a business plan to the department to aid in the department's determination of technical, managerial and financial capacity. Required information for the business plan shall be provided by the department. The Office of Public Health (OPH) will exempt from the requirement for submission of the business plan all new public water systems funded by either the United States Department of Agriculture's (USDA) Rural Utilities Service (RUS) and/or the Division of Administration's (DOA) Louisiana Community Development Block Grant (LCDBG) program, provided those public water systems are certified by RUS and/or LCDBG as meeting the respective agency's minimum capacity requirements. OPH staff will continue to review plans and specifications for all new public water systems.

B. Operator Requirement. All such prospective public water systems meeting the population requirement to require a certified operator must have an operator who holds a certificate in the appropriate classes) of certification for the population serviced by the system. The system must have an operator on duty at all times, or the operator must be available to respond and be on-site within an hour of notification. Any such prospective public water system not meeting the population requirements at the time of request to commence operation must have an operator who has had at least 16 hours of operator training which meets the guidelines of the State Committee of Certification, and must have at least 16 hours of continuing training yearly. The system must provide such an operator on duty at all times, or the operator must be available to respond and be on-site within an hour of notification. Such requirements for systems not meeting the population requirement for systems not meeting the population requirements for a certified operator shall remain in effect until such time as the United States Environmental (USEPA) requires that all public water systems have certified operators or the state requires same,

whichever occurs first. At such time, the then current requirement would be applied.

C. Management Training. As a part of meeting the managerial capacity requirements, all appropriate personnel, e.g., board members, council members, mayors, owners, etc., of new public water systems wanting to commence operation after January 1, 1999, shall attend the next scheduled training session provided by the state, its contractors or other state recognized trainers. Such arrangements shall be made upon making application to the department for approval to commence operation.

D. Financial Audit. A financial audit will be conducted on the system as one means of determining financial capacity of the public water system.

E. Approval for Operation. After January 1, 1999, written approval to commence operation, i.e., issuance of the permit to construct and operate, for such new public water systems will be given by the department only after the department is satisfied that technical, managerial, and financial capacity requirements are being met, in addition to all other applicable regulations. The Office of Public Health (OPH) will issue the permit to construct and operate a new public water system funded by the RUS and/or the LCDBG program, provided those public water systems are certified by RUS and/or LCDBG as meeting the respective funding agency's minimum capacity requirements and the plans and specifications are reviewed and approved by OPH staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1768 (September 1998), amended LR 27:1521 (September 2001), repromulgated LR 27:1692 (October 2001).

§7717. Existing Systems

A. Business Plan. All existing public water systems shall be required to submit a shortened and simplified business plan to the department to aid in the department's determination of technical, managerial, and financial capacity. Required information for the business plan will be provided by the department. The department and the concerned parties will revise the content of the business plan, as necessary, to adapt it to the needs of existing system capacity requirements. A grant or a loan from either RUS and/or LCDBG programs will not trigger the requirement for submission of the business plan. Prioritization for the required capacity assessment of existing systems, including submission of the business plan, will be based on whether the existing water system has been issued an administrative order , and/or is on the significant non-compliers list and/or has had primary Maximum Contaminant Level (MCL) violations during the past three years. However, the Office of Public Health (OPH) will exempt from the requirement for submission of the business plan all existing public water systems actively seeking funding by the RUS programs, provided those public water systems are certified by RUS as meeting their minimum capacity requirements. Such plan must be submitted to the department within six months after the initial visit by the designated party of the state who is providing assistance to the public water system in preparation of the business plan.

B. Operator Requirements. All such public water systems meeting the population requirements to require a certified operator must have an operator who holds a certificate in the appropriate classes(es) of certification for the population served by the system. The system must have an operator on duty at all times, or the operator must be available to respond and be on-site within an hour of notification. Any such public water system not meeting the population requirements at the time of submission of the business plan must have an operator who has had at least 16 hours of operator training which meets the guidelines of the State Committee of Certification, and must have at least 16 hours of continuing training yearly. The system must provide such an operator on duty at all times, or the operator must be available to respond and be on-site within an hour of notification. Such requirement of systems not meeting the population requirements for a certified operator shall remain in effect until such time as the United States Environmental Protection Agency (USEPA) requires that all public water systems have certified operators or the state requires same, whichever occurs first. At such time, the then current requirement would be applied.

C. Management Training. As a part of meeting the managerial capacity requirements, all appropriate staff of existing public water systems shall attend a training session provided by the state, its contractors or other state recognized trainers for board members, council members/mayors/owners, etc. Management training for all board members/council members/mayors/owners of existing public water systems will be based on whether their water system has been issued an administrative order, and/or is on the significant non-complier's list and/or has had primary MCL violations during the past three years. The department will continue to encourage attendance on a voluntary basis at management training sessions by board members/council members/mayors/owner' of other public water systems. Training sessions shall be provided periodically and appropriate parties as noted above will have the opportunity to attend one of the scheduled sessions within six months after the system has been notified that is it being evaluated for technical, managerial, and financial capacity.

D. Financial Audit. A financial audit will be conducted on the system as one means of determining financial capacity of the public water system.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1768 (September 1998), amended LR 27:1521 (September 2001), repromulgated LR 27:1692 (October 2001).

§7719. Miscellaneous

A. Evaluations. Evaluations to determine technical, managerial, and financial capacity will be conducted in accordance with a developed strategy prepared by the department in partnership with concerned parties and for which approval has been given by USEPA.

B. Coordination. Implementation of the strategy will be coordinated between the Department staff and contracting parties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1769 (September 1998), amended LR 27:1522 (September 2001), repromulgated LR 27:1693 (October 2001).

Chapter 78. Drinking Water Revolving Loan Fund

§7801. Introduction

A. The Department of Health and Hospitals, Office of Public Health (OPH) is the state agency within Louisiana granted primary enforcement responsibility from the United States Environmental Protection Agency (EPA) to ensure that Public Water Systems (PWSs) within the state are in compliance with state drinking water regulations which equal or exceed federal drinking water regulations adopted in accordance with the Safe Drinking Water Act (SDWA) (42 U.S.C. 300f et seq.). The SDWA Amendments of 1996 authorized a state revolving loan fund program to assist water systems in financing the costs of infrastructure improvements to facilitate compliance with and further the health protection objectives of the SDWA.

B. In accordance with the Louisiana Constitution and authorizing legislation, the Department of Environmental Quality (DEQ) is assisting OPH in the financial administration of the Drinking Water Revolving Loan Fund (the fund). Regulations governing the revolving loan fund program are promulgated by both OPH and DEQ.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Division of Environmental Health Services, LR 24:692 (April 1998).

§7803. Authority

A. Act 480 of the 1997 Regular Session of the Louisiana Legislature amended and reenacted R.S. 30:2011(A)(3) and (D)(23), 2073(8), 2074(A)(4), 2078(A), and (B)(1), the introductory paragraph of (B)(2), (B)(2)(a) and (I), (B)(3), and (C), 2079(A), 2080, 2081, 2083, 2087 and 2088, and enacted R.S. 30:2074(B)(8) and Chapter 32 of Title 40 of the Louisiana Revised Statutes of 1950, comprising R.S. 40:2821-2826, relative to state funds; creates the fund; provides for administration of the fund program by OPH, including the authority to establish assistance priorities and perform oversight and other related activities; authorizes the secretary of DEQ to administer the financial and environmental review aspects of the fund; requires that certain monies received be deposited into the fund; authorizes imposition of administrative fees; provides for rulemaking authority; provides for an exemption to certain public bond trust restrictions; and provides for related matters.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Division of Environmental Health Services, LR 24:692 (April 1998).

§7805. Definitions

A. The following terms used in these regulations shall have the following meanings:

Applicant—any person who submits an application for financial assistance in accordance with LAC 48:V.Chapter 78.

Community Water System—a public water system that serves year-round residents within a residential setting.

Construction—preliminary planning, engineering, architectural, legal, fiscal, and economic investigations and/or studies, surveys, designs, plans, working drawings, specifications, erection, building, acquisition, alteration, remodeling, improvement, or extension of the project.

Department—the Office of Public Health (OPH) of the Louisiana Department of Health and Hospitals (DHH).

Disadvantaged Community—a community:

a. whose application for a construction loan is primarily to resolve a health and compliance problem;

b. that will serve a population of less than 3,300 on a retail connection basis; and

c. where the median household income is 65 percent or more below the state average. Larger communities may receive this designation if taking over another public water system which would be determined to be disadvantaged under these criteria or by providing drinking water service to existing unserved areas with health problems.

Drinking Water Facilities—facilities which are for the purpose of protecting, producing, collecting, transporting, and treating source water, and for storing, distributing, or holding drinking water.

Environmental Review—an assessment by the DEQ of the environmental impact of a proposed project and assurances that the project will comply with all environmental laws and executive orders applicable to the project area.

Financial Assistance—loans, credit enhancement devices, guarantees, pledges, interest rate swap agreements, linked deposit agreements, and other financial subsidies authorized by law.

Fund—the Drinking Water Revolving Loan Fund established by the department in accordance with the Safe Drinking Water Act (SDWA) Amendments of 1996 and Act 480 of the 1997 Regular Session of the Louisiana Legislature.

Governmental Agency—the state, its political subdivisions, or any agency thereof, Indian tribes, and combinations of governmental entities, which have authority

to own, construct, or operate a public water system and other related activities.

Letter of Intent—a written notification of the intent of the applicant to participate in the fund program. The notification must include a request for financial assistance, the estimated amount of financial assistance, an estimated construction schedule; and must document the authority of the applicant to make the request.

Loan or Loans—a disbursement of money from the fund made by the department to a person in accordance with a loan and pledge agreement.

Loan and Pledge Agreement—a contractual arrangement by and between a person and the state acting by and through DEQ, providing for a loan or loans to such person for the purpose of paying the eligible cost of a project or projects.

Noncommunity Water System—a public water system that serves persons in a nonresidential setting.

Nonprofit Noncommunity Water System—a noncommunity water system that is owned by an entity organized under Louisiana law which qualifies as a tax exempt organization under the provisions of section 501(c)(3) of the Internal Revenue Code.

Person—any individual, partnership, firm, corporation, company, cooperative, association, society, trust, or any other business unit or entity, including the state, its political subdivisions, or any agency thereof, Indian tribes, and combinations of governmental entities.

Privately Owned System—a public water system that is not owned by a governmental agency.

Project—improvements or activities that are to be undertaken by a public water system which:

a. are of a type that will facilitate compliance with state drinking water regulations which are no less stringent than any federal drinking water regulations adopted pursuant to the SDWA; or

b. further the health protection objectives of the SDWA.

Public Water System—a system intended to provide potable water to the public, which system has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days per year. The term includes:

a. any collection, treatment, storage, and distribution facilities under the control of the operator of the system and used primarily in connection with the system; and

b. any collection or pretreatment storage facilities not under such control which are used primarily in connection with the system.

Publicly Owned System—a public water system that is owned by a governmental agency.

Secretary—the secretary of the Department of Health and Hospitals.

State—the State of Louisiana or any agency or instrumentality thereof.

System Improvement Plan—the document containing the necessary plans, specifications, and studies relating to the construction of a complete project of drinking water facilities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Division of Environmental Health Services, LR 24:693 (April 1998).

§7807. Pre-Application and Eligibility for Participation

A. Pre-Application. To be considered for financial assistance, a completed pre-application must be submitted to the department by the applicant, using the form(s) provided by the department.

B. Letter of Intent. An applicant shall include a letter of intent to the department as part of the pre-application package.

C. Eligible Projects. Financial assistance may be provided only for the construction of drinking water facilities as described in a system improvement plan approved by the department. The department may consider only applications for projects by community water systems, both publicly and privately owned, and nonprofit noncommunity water systems.

D. Project Priority Rating. All eligible projects for which a pre-application is submitted will be assigned a priority rating annually by the department based upon the priority criteria described in the Intended Use Plan submitted to the EPA each year as part of the federal capitalization grant application.

E. Allowable/Eligible Costs

1. Allowable cost determinations, based on applicable federal law and guidance, will be made by the department on a project-by-project basis.

2. Pre-Application Conference. Applicants whose pre-application project falls in the fundable portion of the annual priority list, and who have demonstrated a commitment to proceed with the application process, shall be invited to an application conference with the department and the DEQ in order to insure the applicant is acquainted with program requirements and to assist the applicant in preparing an application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Division of Environmental Health Services, LR 24:693 (April 1998).

§7809. Application Requirements and Loan Conditions

A. Limitation on Applications. An application shall only be funded after authorization from both the department and

the DEQ. Completed application packages shall be provided to both the department and the DEQ simultaneously.

B. Application Package. The contents of the application package must contain all applicable information required by the department including, but not limited to, the following:

1. System Improvement Plan. The applicant will submit a System Improvement Plan (SIP) consisting of those necessary plans, specifications and studies that directly relate to construction of drinking water facilities. The SIP must contain enough information to allow the department to perform an engineering review of the proposed project to determine compliance with the State Sanitary Code, and to allow for the appropriate environmental review as required by the DEQ.

2. Financial Information. The applicant is required to submit sufficient information to demonstrate its legal, institutional, managerial, and financial capability to ensure the construction, operation, and maintenance of the drinking water facilities and repayment of the loan, interest, and administrative fees.

3. Site Certificate. he applicant must submit a certificate executed by an attorney certifying that the applicanthas acquired all property sites, easements, rights-of-way, or specific use permits necessary for construction, operation, and maintenance of the project described in the approved SIP.

4. Engineering Review. The department will perform a technical review of the SIP to insure that the proposed improvements are necessary and eligible for program funding, and that the completed project will result in compliance with the SDWA and any applicable state drinking water regulations. This review shall include the review of bidding documents to verify that the proposed contractor has complied with all applicable federal cross-cutting authorities and has or will have all required bonds and insurance certificates.

C. Loan Conditions. Loans for projects will be made only to eligible applicants who comply with the conditions and requirements established by the DEQ.

D. Loan Period. Standard loans shall be made by the DEQ for a period of time not to exceed 20 years from the completion date of the project. Loans to disadvantaged communities may be extended to a period of 30 years. Interim construction financing shall not exceed two years without written approval from the department and from DEQ.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Division of Environmental Health Services, LR 24:694 (April 1998).

§7811. Miscellaneous

A. Coordination. Coordination of project review and approval for funding shall be conducted in accord with the Memorandum of Understanding (MOU) to be executed by the department and the DEQ.

B. Inspection During Construction. By making application for financial assistance to the department, applicants consent and agree to allow the department and/or the DEQ the right of reasonable access and opportunity for inspection as follows.

1. From the time a completed application for financial assistance is received by the department, throughout all stages of construction, and at any other time while financial assistance from the department to the applicant is outstanding, the department shall have the right to inspect any and all projects, and any and all incidental works, areas, facilities and premises otherwise pertaining to the project for which application is made.

2. The department and the DEQ shall further have the same right of inspection to examine any and all books, accounts, records, contracts, or other instruments, documents, or information in the possession of the applicant or its contractors, agents, employees, or representatives which relate in any respect to the receipt, deposit, or expenditure of project-related financial assistance funds.

C. Project Changes/Modifications

1. The applicant shall receive approval from the department and the DEQ prior to effecting any changes which:

a. alter the project performance standards;

b. alter the type or degree of water treatment provided by the project;

c. substantially delay or accelerate the project schedule;

d. substantially alter the design plans and/or specifications; or the location, size, or capacity; or quality of any major part of the project.

2. Minor changes in the project which are consistent with the scope and objectives of the project and the requested financial assistance do not require the approval of the department prior to implementation of the change. However, the amount of the financial assistance may be increased only by means of a formal amendment to the assistance agreement which must first be approved by both the department and the DEQ.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Division of Environmental Health Services, LR 24:694 (April 1998).

Subpart 27. Plans Review

Chapter 79. General Provisions

§7901. Plans Reviewed by the Parish Sanitarian

A. The builder/owner/developer responsible for the following entities shall submit plans and specifications to the

parish health unit for review and approval. The review and approval of plans and specifications are the responsibility of the parish sanitarian. This responsibility does not preclude district or regional engineer assistance if requested by the parish sanitarian. Plans and specifications must be submitted to the parish health unit for the following entities:

1. Food service establishments, including but not limited to: restaurants, bars, groceries, school cafeterias departments of institutions and mobile food processors or vendors.

2. Water supplies of less than 3,000 gallons per day. 3. Sewerage facilities which handle less than 3,000 gallons per day.

B. Plans listed in Section 7903 submitted to a parish health unit shall be forwarded to OPPHS District Engineering Services staff for review and approval.

C. Parish sanitarians, after approving plans, shall notify the builder/ owner/developer in writing that the plans are approved and will be maintained for three years in the parish health unit. These plans will be used by the parish sanitarian to determine if facilities are built in accordance with approved specifications.

D. Parish sanitarians, after disapproving plans, shall notify the builder/ owner/developer in writing of defects which resulted in the disapproval. The builder/owner/developer may correct the cited defects and submit the revised plans for review.

E. The parish sanitarian may store relevant sections of the plan. Other sections may be returned to the builder/owner/developer. The parish sanitarian shall, at the end of three years, offer in writing to return the plans to the builder/owner/developer. If the builder/owner/developer does not claim them within 30 calendar days, the plans will be destroyed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4, and R.S. 40:5.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§7903. Plans Reviewed by the District Engineer

A. There shall be four OPPHS district areas. District 1 consists of State Planning Regions I and III. District 2 consists of State Planning Regions II and IV. District 3 consists of State Planning Regions IV and V, and District 4 consists of State Planning Regions VI and III.

B. The following plans shall be submitted by the builder/owner/developer to the district engineers (or to parish health unit who in turn will forward them to the district engineer) for review.

1. State projects

2. Jails

3. Schools

4. Institutions

5. Hospitals

6. Nursing homes

7. Public swimming pools

8. Public water facilities greater than 3,000 per day

9. Public sewerage facilities greater than 3,000 per day

C. District engineers, after approving the plans, shall notify the builder/ owner/developer in writing that the plans are approved and forwarded to the parish health unit for keeping.

D. District engineers, after disapproving the plans, shall notify the builder/ owner/developer in writing of failings or defects. The builder/ owner/ developer may correct the cited deficiencies and resubmit the revised plans for review.

E. A major defect is a defect that is an imminent health hazard. A minor defect is a defect that is a potential health hazard but not an imminent health hazard. A letter explaining the defect will be sent if the defect is minor. If the defect is major, part of the reviewed plans will have to be redrawn.

F. All parties involved—the builder/owner/developer, the regional engineer, and the parish sanitarian—will notify in writing all other parties of suggested plans changes.

AUTHORITY NOTE: Promulgated in accordance with R.S 40:4, and R.S. 40:5.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subpart 28. Drinking Water Laboratories

Chapter 80. Certification of Laboratories Performing Drinking Water Analyses

Subchapter A. General Provisions

§8001. Scope and Authority

A. This Chapter, adopted pursuant to R.S. 36:254(B)(7), the federal Safe Drinking Water Act (42 USC 300f et seq.) and its implementing regulations (40 CFR Parts 141 and 143), and the State Sanitary Code (LAC 51) constitutes the Department of Health, Office of Public Health (hereinafter referred to as "department") regulations governing the certification of laboratories performing drinking water analyses required to be performed by regulations or orders issued pursuant to those acts and regulations. The authority of the department to grant, maintain or revoke a laboratory's State Certification shall not be delegated to an outside person or body. Portions of the certification process may be contracted out by the department but the authority to grant, maintain, suspend or revoke certification remains with the department. This Chapter establishes the procedures for obtaining and maintaining certification, and the criteria and

procedures laboratories shall follow in analyzing drinking water samples.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3215 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1090 (August 2020).

§8003. Construction

A. These rules shall be liberally construed to permit the department to discharge its statutory functions, and to effectuate the purposes of the laboratory certification program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3216 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1090 (August 2020).

§8005. Purpose of the Regulations

A. This Chapter is promulgated for the following purposes:

1. to establish a certification program for laboratories performing analyses of drinking water samples;

2. to establish the administrative procedures to be followed by laboratories seeking certification and by laboratories maintaining certification;

3. to establish the categories and parameters for which laboratories may be certified;

4. to require that the certification status of a laboratory be contingent upon that laboratory's continued compliance with the standards set forth herein; and

5. to establish the enforcement procedures the department shall follow to ensure that all certified laboratories or laboratories seeking certification are in compliance with this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3216 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1091 (August 2020).

§8007. Certification Program Requirements

A. The laboratory certification program is voluntary and open to any laboratory to apply for certification. However, any laboratory wishing to analyze drinking water samples for compliance with regulations adopted or orders issued pursuant to the Safe Drinking Water Act, or R.S. 36:254(B)(7), R.S. 36:254(B)(8), R.S.40:4(A)(8), R.S.40:5(6), R.S.40:5.9, or Part XII of the department's Sanitary Code (LAC 51) shall follow the procedures set forth herein in order to obtain and maintain certification.

B. Certified laboratories and laboratories seeking certification shall analyze all drinking water samples in accordance with the procedures and methods required by this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3216 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1091 (August 2020).

§8009. Incorporation by Reference

A. The department hereby adopts and incorporates into these regulations:

1. the "National Primary Drinking Water Regulations," 40 CFR 141, July 1, 2019 edition;

2. the "National Secondary Drinking Water Regulations," 40 CFR 143, July 1, 2019 edition; and

3. the Manual for the Certification of Laboratories Analyzing Drinking Water, Criteria and Procedures Quality Assurance Fifth Edition (EPA 815-R-05-04) January 2005 including Supplement 1(EPA 815-F-08-006), June 2008, both published by the United States Environmental Protection Agency (USEPA or EPA).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3216 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1091 (August 2020).

§8011. Program Information

A. Unless otherwise specified, any questions concerning the requirements of this program as detailed in this Chapter should be directed to:

Laboratory Certification Program
Department of Health
Office of Public Health
1209 Leesville Avenue Baton Rouge, LA 70802
225-219-5200
www.ldh.la.gov/lab

1. All requests for information and performance testing data shall be submitted to the entity above.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3216 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1091 (August 2020).

Subchapter B. Program Procedures and Requirements

§8015. Scope

A. This Subchapter establishes the following:

1. requirements of certification;

2. categories for which certification is available;

3. procedures for becoming a certified drinking water laboratory;

4. procedures for a certified drinking water laboratory to renew or modify its certification;

5. procedures for cancellation, suspension, and revocation of certification; and,

6. fees for certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3216 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1091 (August 2020).

§8017. Requirements of Certification

A. All water sample analyses performed for the purpose of determining compliance with the chemical, physical, or radiological requirements of the State's primary and secondary drinking water regulations, or when required by order issued by the department pursuant to the authority of the federal Safe Drinking Water Act, or any other regulations adopted pursuant to those acts, shall be performed in laboratories certified for this purpose pursuant to this Chapter. Analyses performed in laboratories not so certified shall not be accepted by the department as being in compliance with the requirements, regulations or orders of the federal Safe Drinking Water Act.

B. To be clear, the requirements of LAC 48:V.8009.A.1 and 8009.A.2 shall apply to all laboratories regardless of the number of categories specified in §8019 for which the laboratory is seeking certification. The requirements of Paragraphs 8019.A.1, 8019.A.2 and 8019.A.3 shall apply dependent upon the particular category or categories for which the laboratory is seeking certification.

C. Primary certification shall only be granted to laboratories located in the state of Louisiana. The department shall, in accord with the provisions of this Section, grant reciprocity to a laboratory located outside of the state of Louisiana if the laboratory requesting certification also meets each of the following requirements:

1. the laboratory is accredited by a The NELAC Institute (TNI), the National Environmental Laboratory Accreditation Program (NELAP) recognized primary accreditation body;

2. the laboratory submits an acceptable application for certification to the State; and

3. the laboratory pays all applicable fees;

D. The department shall consider only the current certification of accreditation issued by the TNI NELAP recognized primary accreditation body and shall grant reciprocal certification for the fields of testing, methods and analytes for which the laboratory holds primary TNI NELAP accreditation. The department will issue a Louisiana certificate within 30 calendar days of receipt of the laboratory's application if all the above reciprocity requirements are met by the laboratory. The department, does not require any additional proficiency testing, quality assurance, or on-site assessment requirements for fields of testing for which the laboratory holds primary TNI NELAP accreditation.

E. Only laboratories certified pursuant to these regulations may be called a state certified drinking water laboratory and no laboratory may adopt any name or make any oral or written statement intended or likely to mislead the public with the respect to its certification status.

F. Once a laboratory is certified, the period of certification shall extend to the end of the calendar year in which certification is received. For laboratories seeking to renew certification, the period of certification shall be one year beginning on January 1 and shall be considered to be ongoing if the appropriate fees are timely received by the department.

G. If there is a difference in the drinking water regulations of the USEPA and the regulations of the department, a laboratory must follow the more stringent requirement(s).

H. Applications shall be processed in the chronological order in which they have been received.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3217 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1091 (August 2020).

§8019. Categories for Certification

A. A laboratory may apply for certification in any one or more of the following certification categories and shall be certified in those fields of certification within the category for which it demonstrates acceptable performance on proficiency samples and meets all other requirements of this Chapter. The laboratory certificate shall specify the categories and the fields of certification within each category for which the laboratory is certified and shall be conspicuously displayed in the laboratory in a location visible to the public. In addition, the current laboratory certificate specifying the certification categories, the fields of certification, and the expiration date of the certificate shall be posted on its publicly accessible website. The certificate must be removed and returned to the department if the laboratory's certification has been revoked. In addition, the laboratory shall post such revocation or suspension of the laboratory's certification on its publicly accessible website. The certificate does not have to be returned if it simply expired (reached the expiration date). The following are the certification categories available.

1. Inorganic Chemistry. The inorganic chemistry category comprises chemical and/or physical tests or analyses required to determine compliance with the federal Safe Drinking Water Act regulations (40 CFR 141 and 40 CFR 143) and Part XII of the Louisiana Sanitary Code (LAC 51), except those analyses for which gas or liquid chromatography methods are specifically required. Tests or analyses for the inorganic chemistry category shall be conducted in accordance with the methods and procedures specified in 40 CFR 141 and 40 CFR 143 for compliance

with the federal Safe Drinking Water Act and Part XII of the Louisiana Sanitary Code (LAC 51).

2. Organic Chemistry. The organic chemistry category comprises chemical tests or analyses required to determine compliance with the federal Safe Drinking Water Act regulations (40 CFR 141 and 40 CFR 143) and Part XII of the Louisiana Sanitary Code (LAC 51) for which the gas or liquid chromatography methods are applicable or required. Tests or analyses for the organic chemistry category shall be conducted in accordance with the methods and procedures specified in 40 CFR 141 and 40 CFR 143 for compliance with the federal Safe Drinking Water Act and Part XII of the Louisiana Sanitary Code (LAC 51).

3. Radiological Testing. The radiological testing category comprises those tests or analyses for radioactivity required to determine compliance with the federal Safe Drinking Water Act regulations (40 CFR 141 and 40 CFR 143) and Part XII of the Louisiana Sanitary Code (LAC 51). Tests or analyses for the radiological category shall be conducted in accordance with the methods and procedures specified in 40 CFR 141 and 40 CFR 143 for compliance with the federal Safe Drinking Water Act and Part XII of the Louisiana Sanitary Code (LAC 51).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3218 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1092 (August 2020).

§8021. Application Procedures for Laboratories Located in Louisiana

A. The owner or director of a laboratory who wishes an in-state laboratory to be certified in any or all of the certification categories and fields of certification/parameters thereof, described in the federal Safe Drinking Water Act regulations or §8019 of this Chapter, shall apply for certification to the department in writing on forms provided by the department. Laboratories applying for certification may be fixed-base or mobile. The department shall determine what constitutes an individual fixed-base laboratory when noncontiguous laboratory facilities operate under the same ownership, technical directorship, and quality system as the parent laboratory. A separate certification is not required for a mobile laboratory that is owned by a certified fixed-base laboratory, operates under the same quality system as the fixed-based laboratory, performs a subset of the analyses for which the fixed-base laboratory is certified, and analyzes samples exclusively from within the state. Separate certification is required for a mobile laboratory that is owned by a fixed-base laboratory but operates under a different quality system or performs analyses for which the parent fixed-base laboratory is not certified.

B. If the applicant fails to submit all the information requested or fails to submit the appropriate fees, the department shall reject the application without prejudice and the applicant notified. The application fee is nonrefundable.

C. If the applicant submits a complete, signed application, the appropriate fee, proficiency data (if required), quality manual (if required), and the information submitted meets the minimum requirements of this Chapter for the category or categories for which certification is requested, the application shall be accepted. Acceptance of the application does not authorize the laboratory to perform water analyses regulated by this Chapter. The applicant shall be notified of the acceptance and shall be subject to an evaluation including but not limited to the following:

1. personnel;
2. proficiency testing;
3. on-site assessment; and
4. quality assurance/quality control procedures.

D. Neither certified nor interim certified status will be granted to any laboratory which has not met the performance criteria specified in any federal Safe Drinking Water Act regulations or, for those chemicals or other analyses wherein performance criteria may not be specified under the federal Safe Drinking Water regulations, by the performance criteria specified under a written policy of the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3218 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1092 (August 2020).

§8023. Application Procedures for Laboratories Not Located in Louisiana

A. Laboratories located outside of Louisiana, possessing TNI NELAP accreditation from an approved NELAP accreditation body, and desiring to perform water analyses in any or all of the categories described in §8019 for public water systems (PWSs) and for other potable water supplies located in Louisiana, or as required by the federal Safe Drinking Water Act regulations or Part XII of the Louisiana Sanitary Code (LAC 51), shall apply for reciprocal certification in accordance with the procedures set forth in §8017 and §8021 and shall submit the standard fee amount(s) specified under §8027 for the category or categories being applied for.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3218 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1093 (August 2020).

§8025. Renewal of Certification

A. Applications for renewals of certification will be accepted by the department from October 15 through December 1 of each year and shall be submitted at least 30 calendar days prior to the expiration date of the current certificate on forms provided by the department. The appropriate application fee must accompany the application in accordance with §8027.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3219 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1093 (August 2020).

§8027. Fees

A. Owners of laboratories applying for certification or renewal of certification shall submit the appropriate fee obtained from the annual fee schedule below along with the required application materials. Fees are nonrefundable.

Annual Laboratory Certification Fee Schedule	
Chemistry Category/Categories	**Fee**
Inorganic	$750
Organic	$800
Both Inorganic and Organic	$1000
Radiological Testing	$800

B. The annual fees shall not be prorated and shall apply in full to any portion of the calendar year which remains prior to the annual renewal date.

C. This Section is also applicable to laboratories approved for interim certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7) [the same fee schedule amounts initially adopted in LR 15:968 (November 20, 1989) under this statute's authority].

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3219 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1093 (August 2020).

§8029. Required Laboratory Personnel Policies

A. Every certified laboratory and laboratories seeking certification shall have sufficient properly qualified personnel commensurate with the workload and types of tests or analyses required to be performed for the parameters for which the laboratory is certified, or is seeking certification, pursuant to the requirements of this Chapter; and Chapters IV and VI of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

1. General requirements for technical staff. The management of a certified laboratory or laboratory seeking certification shall ensure the competency of all technical staff employed by the laboratory.

a. An environmental laboratory certified under this Chapter or seeking certification under this Chapter shall have sufficient personnel with the necessary education, training, technical knowledge, and experience for their assigned functions.

b. Each technical staff member of the environmental laboratory certified under this Chapter or seeking certification under this Chapter shall be responsible for complying with all quality assurance/quality control requirements that pertain to their organization/technical function.

c. Each technical staff member must have a combination of experience and education to adequately demonstrate a specific knowledge of their particular function, and a general knowledge of laboratory operations, analytical procedures, quality assurance/quality control, and records management.

d. The department will consider that the accountability for negligence, the falsification of data, records or instrument parameters will rest upon the analyst, the laboratory management and parent company.

B. Current employee records shall be maintained, which shall include a résumé documenting each employee's training, experience, duties, and date or dates of relevant employment.

1. Evidence must be on file that demonstrates all employees are aware of and are using the latest edition of the laboratory's in-house quality documentation.

2. Training courses or workshops on specific equipment, analytical techniques or laboratory procedures that relate to employee's job responsibilities shall all be documented.

3. Analyst training shall be considered up-to-date when documentation in the files indicate acceptable performance of a blind sample (singly blind to the analyst) at least once per year and a certification that technical personnel have read, understood, and agreed to perform the most recent version of the method, the approved method (if applicable) or standard operating procedure.

C. Data Integrity Training. Data integrity training shall be provided as a formal part of new employee orientation and shall also be provided on an annual basis for all current employees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3219 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1093 (August 2020).

§8031. Proficiency Testing

A. At the time each laboratory applies for certification, it shall notify the department which field(s) of testing it chooses to become certified for and shall participate in the appropriate proficiency test (PT) studies. Except when determined by the department that an appropriate PT is not readily available, all certified laboratories or laboratories seeking certification shall participate in an approved proficiency testing program covering all tests, analytes and analytical methods as made available within the category and categories in which the laboratory is certified or seeks certification. The laboratory shall purchase PT studies for the parameters for which certification is requested. A laboratory seeking state of Louisiana drinking water laboratory certification only shall participate in proficiency studies at the frequency that meet the requirements of federal Safe Drinking Water Act regulations (40 CFR 141 and 40 CFR 143).

B. All PT records shall be retained for a minimum of 10 years and available for assessment by the department.

C. To be certified initially and to maintain certification the laboratory shall participate in one PT study, where available, per year for each PT field of testing for which it seeks or wants to maintain certification. For a laboratory seeking to obtain certification, the most recent three rounds attempted shall have occurred within 18 months of the laboratory's application date for certification with the analysis date of the most recent PT sample having been no more than six months prior to the application date for certification. The department will complete the assessment of the final evaluation report for PT studies within 60 days of receipt of each study report. The department shall suspend the certification of a laboratory for a field of proficiency testing pursuant to the conditions specified in Chapter III of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3220 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1093 (August 2020).

§8033. On-Site Assessment

A. The department will perform an initial on-site assessment of an environmental laboratory seeking certification, except as provided in §8017, prior to granting certification, and reassessments at intervals of three years and at such other times as the department deems necessary to determine continued compliance to this rule. All assessments performed by the department shall be pursuant to the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

B. The department may conduct announced or unannounced on-site assessments of an environmental laboratory to ensure compliance with this Chapter or orders issued by the department at any time.

C. The laboratory shall ensure that records including its quality manual, analytical methods, standard operating procedures, quality assurance/quality control data, proficiency testing data, and all records needed to verify compliance to the federal Safe Drinking Water Act (42 USC 300f et seq.) and its implementing regulations (40 CFR Parts 141 and 143); the Louisiana State Sanitary Code (LAC 51) and this rule are available for review during the on-site assessment. The laboratory shall allow the department's authorized personnel to examine records, observe laboratory procedures, facilities, equipment and to interview staff during the on-site assessment.

D. The department will provide the laboratory with a written assessment report documenting any findings found by the department, observations documenting competence and conformity, within 30 calendar days of the last day of the assessment.

E. The laboratory shall submit a corrective action plan to the department within 30 calendar days from receipt of the on-site assessment report from the department where the department has found deficiencies. The corrective action plan shall document the corrective action taken by the laboratory to correct each deficiency.

F. In addition to on-site assessments, the department shall perform other surveillance activities to monitor certified laboratories' continued compliance to the provisions of this Chapter throughout the period of certification. Annually, the department shall review among other things, proficiency testing, internal audits, corrective action reports and any other certification-related laboratory records the department deems appropriate to establish continued compliance to the provisions of this Chapter.

G. Nothing in this Section shall be construed as requiring the department to reassess a laboratory prior to taking a regulatory or administrative action affecting the status of the laboratory's certification. Nothing in this Section shall be construed as limiting in anyway the department's ability to revoke or otherwise limit a laboratory's certification upon the identification of such deficiencies as to warrant such action.

H. Copies of all assessment reports, checklists, and laboratory responses shall be retained by the department for a period of at least 10 years, or longer if required by specific State or Federal regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3220 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1094 (August 2020).

§8035. Issuance and Display of Certificate and Use of Certification

A. The department will issue a certificate to each laboratory meeting the requirements of this Chapter indicating that the laboratory is certified by the department. The numbered certificate will be signed by a laboratory director, or assistant laboratory director, of the department's Laboratory Services Section and the designated laboratory certification staff personnel and will be considered an official document. It will be transmitted as a sealed and dated (effective date and expiration date) document and contain the certification logo. Addenda or attachments to the certificate shall be considered official documents. Information on the addenda or attachments shall include the matrix, fields of certification, methods, analyte/analyte group and technologies.

1. The certified laboratory shall display their most recent certificate in a prominent place in the laboratory, visible to the public. The certificate shall include the certification status of the laboratory and a list all fields of testing for which the laboratory is certified.

B. A certified laboratory must not use its certificate, certification status and/or certification logo to imply, either orally or in any literature, endorsement of the laboratory by the state of Louisiana or the department. A certified laboratory must not make any inaccurate statements concerning their fields of certification and certification status.

C. A certified laboratory's certification number or other identifier shall be included when the certification body's name is used on general literature such as catalogs, advertising, business solicitations, proposals, quotations, laboratory analytical reports or other material.

D. The laboratory must distinguish between proposed testing for which the laboratory is certified and the proposed testing for which the laboratory is not certified.

E. The laboratory must return to the department any revoked certification certificate(s) and must discontinue use of all catalogs, advertising, business solicitations, proposals, quotations, laboratory analytical results or other materials that contain reference to their past certification status and/or display their past certification logo.

F. The department shall take suitable actions including, but not limited to, legal action when incorrect references to the certification body's certification, misleading use of the laboratory's certification status and/or unauthorized use of the certification logo is found in catalogs, advertisements, business solicitations, proposals, quotations, laboratory analytical reports or other materials. All reports of questionable laboratory practices must be reported to the department's laboratory director, or assistant laboratory director, and to the department's laboratory certification program manager. The department's laboratory certification program manager shall investigate the merits of the report and forward the findings to the department's laboratory director, or assistant laboratory director. If it is determined that a formal investigation is needed, the department's laboratory director, or assistant laboratory director, shall contact the Bureau of Legal Services within the Department of Health (LDH) for guidance and assistance in the investigation. If the investigation determines that action is merited, the laboratory shall be issued a revocation order via certified mail revoking the laboratory's certification. All legal actions taken by the department shall proceed in accordance with the Louisiana Administrative Procedure Act (R.S. 49:950 et seq.) and under the direction of LDH's Bureau of Legal Services. No laboratory's certification shall be revoked without the right to due process. The laboratory has a right to an administrative hearing thereon, if requested in writing within 20 days of receipt of the revocation order. Said hearing shall be held before an Administrative Law Judge and in accordance with the Louisiana Administrative Procedure Act (R.S. 49:950 et seq.) All documents related to the investigation(s), including the final disposition, shall be retained by the department for 10 years from the date of such final disposition.

G. Certification may be transferred when the legal status or ownership of a certified laboratory changes without affecting its staff, equipment, and organization. The department may conduct an on-site assessment to verify the effects, if any, of such changes on laboratory performance.

H. The following conditions apply to the change in ownership and/or the change in location of a laboratory, as well as to a change in top management, key personnel, resources, or premises that is, or previously was, certified by the department under a previous owner and/or at a previous location.

1. In the event there are any changes in the name, location, ownership, top management, key personnel, main polices, resources or premises of a certified laboratory to which the provisions of this Chapter apply, written notice thereof shall be made within 30 days to the entity below:

Laboratory Certification Program
Laboratory Services
Department of Health,
Office of Public Health
1209 Leesville Avenue
Baton Rouge, LA 70802

2. The department shall evaluate the significance of any change that might alter or impair the laboratory's capability and quality, and indicate to the affected laboratory the results of the evaluation in writing. The department shall retain records to indicate that such an evaluation was conducted.

3. A change in ownership and/or location will not necessarily require recertification or reapplication in any or all of the categories in which the laboratory is currently certified.

4. A change in ownership and/or location may require an on-site assessment with the elements of the assessment being determined by the assessor.

5. Any change in ownership shall assure historical traceability of the laboratory certification number(s).

6. For a change in ownership, the following additional conditions shall be in effect.

a. The previous owner (transferor) shall agree in writing, before the transfer of ownership takes place, to be accountable and liable for any analyses, data and reports generated up to the time of legal transfer of ownership.

b. The buyer (transferee) must agree in writing to be accountable and liable for any analyses, data and reports generated after the legal transfer of ownership occurs.

c. All records and analyses performed pertaining to certification shall be kept for a minimum of 10 years and are subject to review and inspection by the department during this period without prior notification to the laboratory. This stipulation is applicable regardless of change in ownership, accountability or liability.

d. If ownership is transferred, the transferee shall not be responsible for payment of fees to the department during the remainder of the calendar year, provided that the previous owner has fully paid the required fees to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3221 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1094 (August 2020).

§8037. Management System Establishment

NOTE: The August 2020 amendment of this Section references the Fifth Edition, EAP 815-R-05-004, January 2005, *Manual for Certification of Laboratories Analyzing Drinking Water.*

A. The laboratory shall establish and maintain a management system pursuant to and meeting the required elements contained in Chapter III of the US EPA *Manual for the Certification of Laboratories Analyzing Drinking Water.*

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3222 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1095 (August 2020).

§8039. Denial, Suspension, Revocation and Voluntary Withdrawal of Certification

A. Denial of Certification. Denial means to refuse to certify in part or in total a laboratory applying for initial certification or resubmission of initial application.

1. Reasons to deny an initial application may include:

a. failure to submit a completed application;

b. failure of laboratory staff to meet the personnel qualifications as required by the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water. These qualifications include, but are not limited to, education, training and experience requirements;

c. failure to successfully analyze and report PT samples as required in the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water;

d. failure to attest that analyses are performed by methodologies as required in 40 CFR Parts 141 and 143 for the analysis of drinking water parameters;

e. failure to implement a quality system as defined in the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water;

f. failure to respond to a deficiency report from the on-site assessment with a corrective action report within 30 calendar days after receipt of the assessment report;

g. failure to implement the corrective actions detailed in the corrective action report within the specified time frame as required by the department;

h. failure to pay required fees;

i. failure to pass required on-site assessment(s) as specified in §8033 of this Chapter;

j. misrepresentation of any material fact pertinent to receiving or maintaining certification; or

k. denial of entry during normal business hours for an on-site assessment as mentioned under §8033.B of this Chapter.

2. A laboratory shall have two opportunities to correct the areas of deficiencies which results in a denial of certification.

3. If the laboratory is not successful in correcting the deficiencies as required by §8033 of this Chapter, the laboratory must wait 6 months before again reapplying for certification.

4. Upon reapplication, the laboratory shall be responsible for all or part of the fees incurred as part of the initial application for certification.

5. No laboratory's certification will be denied without the right to due process. The laboratory has a right to an administrative hearing thereon, if requested in writing within 20 days of receipt of the denial letter. Said administrative hearing shall be held before an Administrative Law Judge and in accordance with the Louisiana Administrative Procedure Act (R.S. 49:950 et seq.).

B. Suspension of Certification. Suspension means the temporary removal of a laboratory's certification for a defined period of time which shall not exceed 6 months. The purpose of suspension is to allow a laboratory time to correct deficiencies or areas of non-compliance with this Chapter.

1. A laboratory's certification may be suspended in part or in total. The laboratory shall retain those areas of certification where it continues to meet the requirements of this Chapter.

2. Reasons for suspension may include:

a. the department finds during the on-site assessment that the public interest, safety or welfare requires emergency action;

b. failure to successfully complete PT studies and maintain a history of at least two successful PT studies for each affected certified field of testing out of the most recent three PT studies;

c. failure to notify the certification body of any changes in key certification criteria, as set forth in §8029 of this Chapter;

d. failure to maintain a quality system as defined in §8037 of this Chapter; or

e. failure of the laboratory to employ staff who meet the personnel qualifications including, but not limited to, education, training and experience as required by this Chapter.

3. A laboratory under suspension will not have to reapply for certification if the cause/causes for suspension are corrected within 6 months. The laboratory's suspended certification status will change to certified when the laboratory complies with this Chapter.

4. A suspended laboratory:

a. cannot continue to analyze samples for the affected fields of testing for which it holds certification; and

b. shall remain suspended (without appeal rights) due to unacceptable proficiency testing sample results.

5. If the laboratory is unable to correct the reason for the suspension, the laboratory's certification shall be revoked

in total or in part within 6 months after the effective date of the suspension.

6. No laboratory's certification will be suspended without the right to due process. The laboratory has a right to an administrative hearing thereon, if requested in writing within 20 days of receipt of the suspension order. Said administrative hearing shall be held before an Administrative Law Judge and in accordance with the Louisiana Administrative Procedure Act (R.S.49:950 et seq.)

C. Revocation of Certification. Revocation means partial or total withdrawal of a laboratory's certification by the department.

1. The department's Laboratory Services Section shall revoke a laboratory's certification, in part or in total, for failure to correct the deficiencies after certification had been suspended. The laboratory shall retain those areas of certification where it continues to meet the requirements of this Chapter.

2. Reasons for revocation, in part or in total, include a laboratory's:

a. failure to submit an acceptable corrective action report in response to a deficiency report and failure to implement corrective action(s) related to any deficiencies found during a laboratory assessment(the laboratory may submit two corrective actions plans within the time limits specified by the department); or

b. failure to correctly analyze a parameter(s) in three consecutive PT studies. Should this occur, the laboratory's certification shall be revoked for each affected certified field of testing(s), method(s) and analyte(s).

3. Reasons for total revocation include a laboratory's:

a. failure to respond with a corrective action report within the required 30 calendar days;

b. failure to participate in the PT program as required by §8031 of this Chapter;

c. submittal of PT sample results generated by another laboratory as its own;

d. misrepresentation of any material fact pertinent to receiving or maintaining certification;

e. denial of entry during normal business hours for an on-site assessment as required by §8033 of this Chapter;

f. conviction of charges for the falsification of any report of or relating to a laboratory analysis; or

g. failure to remit the certification fees within the time limit as established by the department may be grounds for immediate revocation.

4. After correcting the reason/cause for revocation, the laboratory may reapply for certification no sooner than six months from the official date of revocation.

5. No laboratory's certification will be revoked without the right to due process. The laboratory has a right to an administrative hearing thereon, if requested in writing within 20 days of receipt of the revocation order. Said administrative hearing shall be held before an Administrative Law Judge and in accordance with the Louisiana Administrative Procedure Act (R.S. 49:950 et seq.).

D. Voluntary Withdrawal of Certification. If an environmental laboratory wishes to withdraw from the laboratory certification program, it must submit written notification to the department no later than 30 calendar days before the end of the certification year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3222 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1095 (August 2020).

§8041. Interim Accreditation

A. If a laboratory completes all of the requirements for certification except that of an on-site assessment because the department is unable to schedule the assessment in a timely manner, the department may issue an interim certification. Interim certification is not available for first time certification of a laboratory or after revocation of certification. Interim certification will allow a laboratory to perform analyses and report results with the same status as a fully certified laboratory until the on-site assessment requirements have been completed. Interim certification status may not exceed 12 months. The interim certification status is a matter of public record and will be noted on the certificate of the laboratory.

B. Revocation of Interim Certification. Revocation of interim certification may be initiated for due cause in accord with the requirements of §8039 of this Chapter.

C. The department may approve a laboratory application to add an analyte or method to its scope of certification by performing a data review without an on-site assessment. An addition to the scope of certification via a data review of PT performance (if available), quality control performance, and written standard operating procedure is at the discretion of the department. An addition of a new technology or test method requiring specific equipment may require an on-site assessment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3223 (December 2012), amended by the Louisiana Department of Health, Office of Public Health, LR 46:1096 (August 2020).

§8043. Ethics, Standards of Professional Conduct and Conflict of Interest

A. Professional standards apply to every employee of the department including laboratory assessors, whether a government employee or an employee of a third party organization conducting assessments under an agreement with the department or other certification body.

1. Department employees, including assessors that knowingly engage in unprofessional activity, may be liable

for punitive actions as initiated by the department. Standards for professional conduct outlined herein are based upon 5 CFR 2635, January 1, 2019 edition, (Standards of Ethical Conduct for Employees of the Executive Branch) and will be followed in all laboratory certification related matters. Additionally, conformance with the Louisiana Code of Governmental Ethics, R.S. 42:1101 et seq., is required.

2. All employees including assessors representing the department shall:

a. have no interest at play other than that of the department during the entire certification process;

b. act impartially and not give preferential treatment to any organization or individual;

c. provide equal treatment to all persons and organizations regardless of race, color, religion, sex, national origin, age and/or disability;

d. not use their position for private gain;

e. not solicit or accept any gift or other item of monetary value from any laboratory, laboratory representative or any other affected individual or organization doing business with, or affected by, the actions of the assessor's employer or the department;

f. not hold financial interests that conflict with the conscientious performance of their duties;

g. not engage in financial transactions using information gained through their positions as assessors to further any private interest;

h. not engage in employment activities (seeking or negotiating for employment) or attempt to arrange contractual agreements with a laboratory that would conflict with their duties and responsibilities as an assessor;

i. not knowingly make unauthorized commitments or promises of any kind purporting to bind the department; and

j. attempt to avoid any actions that could create even the appearance that they are violating any of the standards of professional conduct outlined in this Section.

3. It is the individual's responsibility to report to the department any personal issues or activities that constitute a conflict of interest before an assessment occurs. It is up to the department to determine if the reported issues and activities regarding a specific assessor constitute, or may be construed as, a conflict of interest. The department's laboratory director, or assistant laboratory director, shall contact the Bureau of Legal Services within the Department of Health (LDH) for guidance and assistance in deciding a conflict of interest case and the course of action the department should take.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3223 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1096 (August 2020).

Subchapter C. Criteria and Procedures for Chemical Testing and Analysis

§8045. Scope

A. This Subchapter establishes the department's requirements which a certified laboratory or laboratory seeking certification shall continually meet and follow when performing chemical analyses.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3224 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1097 (August 2020).

§8047. Laboratory Facilities and Safety

A. All certified laboratories or laboratories seeking certification pursuant to this Subchapter shall have laboratory facilities and safety procedures that meet the requirements in Chapter IV of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

B. The analysis of compliance samples shall be conducted in a laboratory where the security and integrity of the samples and the data can be maintained.

C. The laboratory facilities must be clean, have adequate temperature and humidity control, have adequate lighting at the bench top and must meet applicable Occupational Safety and Health Administration (OSHA) standards.

D. The laboratory must have provisions for the proper storage and disposal of chemical wastes. The appropriate type of exhaust hood is required, where applicable.

E. There must be sufficient bench space for processing samples. Workbench space should be convenient to sink, water, gas, vacuum and electrical sources free from surges.

F. Instruments must be properly electrically grounded.

G. For safety reasons, facilities for inorganic and organic analyses shall be in separate rooms. Organic analysis and sample extraction should also be separated to prevent cross contamination.

H. The analytical and sample storage areas must be isolated from all potential sources of contamination.

I. There should be sufficient storage space for chemicals, glassware and portable equipment, sufficient floor and bench space for stationary equipment and areas for cleaning materials.

J. Volatile or corrosive chemicals and flammable solvents shall be stored in accordance with the federal Occupational Safety and Health Act and its attendant regulations.

K. Adequate fire precautions shall be taken including, but not limited to, having readily available a fire extinguisher rated for the types of fires that may reasonably be foreseen given the types of testing and analyses

performed by and the types of materials handled by the laboratory.

L. Appropriate occupational safety and health laws and regulations shall be posted and observed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3224 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1097 (August 2020).

§8049. Specifications for Laboratory Equipment and Instrumentation

A. Laboratories which have received certification or are seeking certification to perform any of the required chemical analyses, shall have on the premises and under the control of the technical manager, all of the equipment and instruments necessary to analyze each parameter in which the laboratory is certified, or is seeking certification. All instruments shall be properly maintained and calibrated and such equipment and instruments including records shall meet the requirements in Chapter IV of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3224 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1097 (August 2020).

§8051. Measurement Traceability

A. Laboratories which have received certification or are seeking certification to perform any of the required chemical analyses, shall meet the measurement traceability requirements specified in Chapter IV of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3224 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1097 (August 2020).

§8053. Sample Collection, Handling and Preservation

A. Laboratories which have received certification or are seeking certification to perform any of the required chemical analyses, shall have procedures for sample collection, handling and preservation techniques that meet the requirements in Chapter IV of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

B. Samples requiring preservation shall be preserved at the time of collection. A laboratory that has interim approval or certification shall accept only samples which are properly labeled, and for which there is reasonable assurance that they have been collected, preserved, processed, stored and transported in such a manner as to identity and stability of the sample with respect to the requested tests or analyses. If the identity/stability of the sample has not been assured, the laboratory report shall clearly state that the result may be invalid due to an unsatisfactory sample.

C. All samples requiring thermal preservation shall be considered acceptable if the arrival temperature of a representative sample container is within the method's specified range. Additional acceptance criteria are specified in the approved reference method(s) specified in 40 CFR Parts 141 and 143 for the analysis of drinking water parameters and in the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water. The laboratory must measure and record the temperature of the sample when it arrives when temperature preservation is required by the method.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3225 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1097 (August 2020).

§8055. Methodology and Method Validation

A. Laboratories which have received certification or are seeking certification to perform any of the required chemical analyses, shall use the test procedures specified in 40 CFR Parts 141 and 143 for the analysis of drinking water parameters. Additionally, the laboratories shall comply with the requirements in Chapter IV of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

B. The laboratory shall list, in its quality manual, and have on-hand the standard operating procedures (SOPs) for each analytical method used. This listing should include the name of the method and a complete reference as to the source.

C. Applicable SOPs shall be available in the laboratory at the analyst's work station.

D. The laboratory shall validate reference methods via the procedures specified in Chapter IV of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

E. Prior to the acceptance and institution of any method, a satisfactory initial Demonstration of Capability (DOC) shall be performed by the laboratory pursuant to the requirements in the approved reference method(s) specified in 40 CFR Parts 141 and 143 for the analysis of drinking water parameters. Documentation shall be maintained by the laboratory for the initial and any ongoing DOC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3225 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1097 (August 2020).

§8057. Quality Assurance for Environmental Testing

A. Laboratories which have received certification or are seeking certification to perform any of the required chemical analyses, shall have established quality control procedures

pursuant to Chapter IV of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

B. The laboratory shall implement the essential quality control procedures in Chapter IV of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

C. The laboratory shall perform all quality control procedures at the frequency required in the approved reference method(s) specified in 40 CFR Parts 141 and 143 in the analysis of drinking water parameters. In addition, the laboratory shall meet the acceptance criteria specified in the applicable, approved reference method(s) specified in 40 CFR Parts 141 and 143 in the analysis of drinking water parameters.

D. Control charts, generated from the laboratory's control sample (however named), shall be maintained by the laboratory. Until sufficient data are available from the laboratory, usually a minimum of 20 to 30 test results on a specific analysis, the laboratory shall use the control limits (if specified) in the method. When sufficient data becomes available, the laboratory shall develop control charts from the mean percent recovery ($\bar{X}$) and the standard deviation (S) of the percent recovery for the Quality Control (QC) checks specified in the above Subsections of this Section (also, see Chapter VI of the *Handbook for Analytical QC in Water and Wastewater Laboratories*, EPA-600/4-79-019 or *Standard Methods for the Examination of Water and Wastewater*, 20th edition, Part 1020B, or similar laboratory analytical QC reference texts for further information). These data are used to establish upper and lower control limits as follows:

1. upper control limit= $\bar{X}$ + 3S
(upper warning limit, use + 2S instead of + 3S);

2. lower control limit = $\bar{X}$ - 3S
(lower warning limit, use - 2S instead of - 3S).

E. After each five to ten new recovery measurements, new control limits should be calculated using the most recent 20-30 data points. These calculated control limits shall not exceed those established in the method. If any of these calculated control limits are tighter than the control limits specified within the method, the laboratory shall use the tighter criteria.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3225 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1098 (August 2020).

§8059. Records and Data Reporting

A. Laboratories which have received certification or are seeking certification to perform any of the required chemical analyses, shall meet the requirements for reporting results pursuant to Chapter IV of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

B. Compliance monitoring data shall be made legally defensible by keeping thorough and accurate records. The quality manual and/or SOPs shall describe the policies and procedures used by the facility for record retention and storage. If samples are expected to become part of a legal action, chain of custody procedures shall be used.

C. Maintenance of Records. Public water systems are required to maintain records of chemical analyses of compliance samples for 10 years (40 CFR 141.33) and lead and copper for 12 years (40 CFR 141.91). The laboratory should maintain easily accessible records for 10 years. The client water system should be notified before disposing of records so they may request copies if needed. This includes all raw data, calculations, and quality control data. These data files may be either hard copy, microfiche or electronic. Electronic data shall always be backed up by protected tape or disk or hard copy. If the laboratory changes its computer hardware or software, it should make provisions for transferring old data to the new system so that it remains retrievable within the time frames specified above.

D. Sampling Records. Data should be recorded in ink with any changes lined through such that the original entry is visible. Changes shall be initialed and dated. The following information should be readily available in a summary or other record(s):

1. date of sampling, location [including name of utility and PWS identification (ID) number (#) if the water system is a PWS], sampling site within the water system, time of sampling, name, organization and phone number of the sampler, and analyses required;

2. identification of the sample as to whether it is a routine distribution system sample, check sample, raw or finished water sample, repeat or confirmation sample or other special purpose sample;

3. date of receipt of the sample by the laboratory;

4. sample volume/weight, container type, preservation and holding time and condition on receipt;

5. pH (from plant records) and disinfectant residual at time of sampling (from on-site analysis by sampler at the time of sampling);

6. disinfectant residual by laboratory immediately prior to analysis; and

7. transportation and delivery of the sample (person/carrier, conditions).

E. Analytical Records. Data shall be recorded in ink with any changes lined through such that original entry is visible. Changes shall be initialed and dated. The following information shall be readily available:

1. laboratory and persons responsible for performing the analysis;

2. analytical techniques/methods used;

3. date and time of analysis;

4. results of sample and quality control analyses; and

5. calibration and standards information.

F. Personnel Records. Résumés and training records shall be maintained for all personnel.

1. Documentation of the initial demonstration of capability for analysts/technicians shall be kept on file as well as the results of proficiency testing.

G. Reconstruction of Data. Adequate information shall be available to allow the assessor to reconstruct the final results for compliance samples and performance evaluation samples.

H. Computer programs. Computer programs shall be verified initially and periodically by manual calculations and the calculations shall be available for inspection. Access to computer programs and electronic data shall be limited to appropriate personnel.

I. The original or true duplicate of the results of the test or analysis shall be sent promptly to the person who requested such tests or analysis. In addition, the results of compliance monitoring samples are to be sent to the Engineering Services Section of the department.

1. The results data shall be signed by the technical manager or a designee whose designation is in writing and whose name has been submitted to the department. Data and results submitted to the department shall be submitted electronically, maintained, and stored in writing in the format specified by the Engineering Services Section of the department. When any sample result exceeds the maximum contaminant level (MCL), secondary MCL, or may cause a treatment technique requirement violation for any regulated contaminant listed in the federal Safe Drinking Water Act (42 USC 300f et seq.) and its implementing regulations (40 CFR Parts 141 and 143), a certified laboratory shall report the result to the supplier of water and the Engineering Services Section of the department as soon as possible but no later than the end of the next business day after the result was determined.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3226 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1098 (August 2020).

§8061. General Laboratory Practices

A. Chemicals/Reagents. Chemicals and reagents used must meet the specifications in the referenced method. If not specified therein, then analytical reagent (AR) grade or American Chemical Society (ACS) grade chemicals or better shall be used for analyses in certified laboratories.

B. Reagent Water. The laboratory shall have a source of reagent water having a resistance value of at least 0.5 megohms-cm (conductivity less than 2.0 micromhos/cm) at 25ºC. High quality water meeting such specifications may be purchased from commercial suppliers. Quality of reagent water is best maintained by sealing it from the atmosphere. Quality checks to meet specifications above shall be made and documented at planned intervals based on use. This planned interval should not exceed daily. Individual analytical methods may specify additional requirements for the reagent water to be used. Reagent water for organic analysis must be free from interferences for the analytes being measured. It may be necessary to treat water with activated carbon to eliminate all interferences. If individual methods specify additional requirements for the reagent water to be used, these must be followed.

C. Glassware Preparation. Specific requirements in the methods for the cleaning of glassware must be followed. If no specifications are listed, then glassware should be washed in a warm detergent solution and thoroughly rinsed first with tap water and then with reagent water. This cleaning procedure is sufficient for general analytical needs. It is advantageous to maintain separate sets of suitably prepared glassware for the nitrate, mercury, and lead analyses due to the potential for contamination from the laboratory environment. For a summary of glassware cleaning procedures, refer to Chapter IV of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

D. Distilled and deionized water shall have at a minimum, resistivity values between 0.5 to 2.0 megohms-cm (2.0 to 0.5 micromhos/cm.) at 25º C. Preferably, distilled and deionized water should have resistivity values greater than 1.0 megohms-cm (less than 1.0 micromhos/cm) at 25ºC. When purchasing distilled or deionized water, laboratories should request a list of quality specifications for the water purchased. Containers of distilled or deionized water should be capped when not in use and should be capped immediately after each use.

E. All solutions shall be properly labeled with identification of the compound, concentration, solvent, date, and analyst who prepared the solution.

F. All chemicals, solutions, and standards, shall be dated upon receipt by the laboratory; and the date opened by the laboratory shall also be noted.

G. Compositing of samples for inorganic and organic analyses must be done in the laboratory. Samples shall only be composited if the laboratory detection limit is adequate for the number of samples being composited (up to a maximum of five) and the holding times will not be exceeded.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3226 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1098 (August 2020).

§8063. Management Systems General Requirements

A. Laboratories which have received certification or are seeking certification to perform any of the required chemical analyses shall establish, implement and maintain a management system. The laboratory's management system policies related to quality, including a quality policy statement, shall be defined in a quality assurance plan (however named). The quality assurance plan shall include all the requirements in the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water. The

quality assurance plan shall be made available to all laboratory personnel.

B. Laboratories which have received certification or are seeking certification to perform any of the required chemical analyses shall establish and maintain a documented data integrity system. There are four elements within a data integrity system. These are:

1. data integrity training;

2. signed data integrity documentation for all laboratory employees;

3. in-depth, periodic monitoring of data integrity; and

4. data integrity procedure documentation.

C. The procedures of the data integrity system required under Subsection B of this Section shall be signed by top management.

D. Laboratories which have received certification or are seeking certification to perform any of the required chemical analyses, shall maintain SOPs that accurately reflect all phases of current laboratory activities, such as assessing data integrity, corrective actions, handling customer complaints and all analytical methods. All quality control data and records required by this Section shall be retained by the laboratory for a minimum of 10 years and shall be made available for inspection by the department. Such retained data shall include, but shall not be limited to, the results of and raw data generated by PT analyses.

E. Control of Nonconforming Environmental Testing Work. Laboratories which have received certification or are seeking certification to perform any of the required chemical analyses shall meet the requirements for the control of nonconforming environmental testing pursuant to the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

F. Laboratory Improvement, Corrective Action and Preventive Action. Laboratories which have received certification or are seeking certification to perform any of the required chemical analyses shall meet the requirements for improving the laboratory, and implementing corrective and preventive actions pursuant to the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

G. Internal Audits. Laboratories which have received certification or are seeking certification to perform any of the required chemical analyses shall meet the requirements for establishing and conducting internal audits of laboratory activities pursuant to the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3227 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1098 (August 2020).

Subchapter D. Criteria and Procedures for Radiological/ Radiochemical Testing and Analysis

§8065. General [Formerly §8064]

A. This Subchapter, in conjunction with other requirements contained in other portions of this Chapter, establishes the department's requirements to which a certified laboratory or laboratory seeking certification shall continually meet and follow when performing radiological/radiochemical analyses.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3228 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1099 (August 2020).

§8067. Laboratory Facilities and Safety [Formerly §8065]

A. All certified laboratories or laboratories seeking certification pursuant to this Subchapter shall have laboratory facilities and safety procedures that meet the requirements in Chapter VI of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

B. The analysis of compliance samples shall be conducted in a laboratory where the security and integrity of the samples and the data can be maintained.

C. The laboratory facilities must be clean, have adequate temperature and humidity control, have adequate lighting at the bench top and must meet applicable Occupational Safety and Health Administration (OSHA) standards.

D. The laboratory must have provisions for the proper storage and disposal of chemical and radiological wastes. The appropriate type of exhaust hood is required where applicable.

E. There must be sufficient bench space for processing samples. Workbench space should be convenient to sink, water, gas, vacuum and electrical sources free from surges.

F. Instruments must be properly electrically grounded.

G. Counting instruments must be located in a room other than one in which samples and standards are being prepared or where other types of chemical analyses are performed.

H. The analytical and sample storage areas must be isolated from all potential sources of contamination.

I. There should be sufficient storage space for chemicals, glassware and portable equipment, sufficient floor and bench space for stationary equipment and areas for cleaning materials.

J. Volatile or corrosive chemicals and flammable solvents shall be stored in accordance with the federal Occupational Safety and Health Act (OSH Act) and attendant OSHA regulations.

K. Adequate fire precautions shall be taken including, but not limited to, having readily available a fire extinguisher rated for the types of fires that may reasonably be foreseen given the types of testing and analyses performed by and the types of materials handled by the laboratory.

L. Appropriate occupational safety and health laws and regulations shall be posted and observed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3228 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1099 (August 2020).

§8069. Specifications for Laboratory Equipment and Instrumentation [Formerly §8067]

A. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses, shall have on the premises and under the control of the technical manager, all of the equipment and instruments necessary to analyze each parameter in which the laboratory is certified, or is seeking certification. All instruments shall be properly maintained and calibrated and such equipment and instruments including records shall meet the requirements in Chapter VI of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3228 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1099 (August 2020).

§8071. Measurement Traceability [Formerly §8069]

A. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses shall meet the measurement traceability requirements specified in Chapter VI of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3228 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1100 (August 2020).

§8073. Sample Collection, Handling and Preservation [Formerly §8071]

A. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses shall have procedures for sample collection, handling and preservation techniques that meet the requirements in Chapter VI of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

B. Samples requiring preservation shall be preserved at the time of collection. A laboratory that has interim approval or certification shall accept only samples which are properly labeled, and for which there is reasonable assurance that they have been collected, preserved, processed, stored and transported in such a manner as to identity and stability of the sample with respect to the requested tests or analyses. If the identity/stability of the sample has not been assured, the laboratory report shall clearly state that the result may be invalid due to an unsatisfactory sample.

C. All samples requiring thermal preservation shall be considered acceptable if the arrival temperature of a representative sample container is within the method's specified range. Additional acceptance criteria are specified in the approved reference method(s) specified in 40 CFR Parts 141 and 143 for the analysis of drinking water parameters and in the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water. The laboratory must measure and record the temperature of the sample when it arrives when temperature preservation is required by the method.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3229 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1100 (August 2020).

§8075. Methodology and Method Validation [Formerly §8073]

A. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses shall use the test procedures specified in 40 CFR Parts 141 and 143 for the analysis of drinking water parameters. Additionally, the laboratories shall comply with the requirements in Chapter VI of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

B. The laboratory shall list, in its quality manual, and have on hand the SOPs for each analytical method used. This listing should include the name of the method and a complete reference as to the source.

C. Applicable SOPs shall be available in the laboratory at the analyst's work station.

D. The laboratory shall validate reference methods via the procedures specified in Chapter VI of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

E. Prior to the acceptance and institution of any method, a satisfactory initial DOC shall be performed by the laboratory pursuant to the requirements in the approved reference method(s) specified in 40 CFR Parts 141 and 143 for the analysis of drinking water parameters and in Chapter VI of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water. Documentation shall be maintained by the laboratory for the initial and any ongoing DOC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3229 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1100 (August 2020).

§8077. Quality Assurance for Radiochemical Testing [Formerly §8075]

A. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses, shall have established quality control procedures pursuant to Chapter VI of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

B. The laboratory shall implement the essential quality controls procedures in Chapter VI of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

C. The laboratory shall perform all quality control procedures at the frequency required in the approved reference method(s) specified in 40 CFR Parts 141 and 143 for the analysis of drinking water parameters. In addition, the laboratory shall meet the acceptance criteria specified in the applicable, approved reference method(s) specified in 40 CFR Parts 141 and 143 for the analysis of drinking water parameters.

D. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses, shall maintain control charts for each instrument and method used by the laboratory for compliance monitoring sample measurements. Instrument initial calibrations and all efficiency and instrument background checks shall be maintained in a permanent record. Control charts shall be maintained as specified in Chapter VI of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water. Until sufficient data are available from the laboratory, usually a minimum of 20 to 30 test results on a specific analysis, the laboratory shall use the control limits (if specified) in the method. When sufficient data becomes available, the laboratory shall develop control charts from the mean percent recovery ($\bar{X}$) and the standard deviation (S) of the percent recovery for the Quality Control (QC) checks specified in the above Subsections of this Section (also, see Chapter VI of the Handbook for Analytical QC in Water and Wastewater Laboratories, EPA-600/4-79-019 or Standard Methods for the Examination of Water and Wastewater, 20th Edition, Part 1020B, or similar laboratory analytical QC reference texts for further information). These data are used to establish upper and lower control limits as follows:

1. upper control limit = $\bar{X}$ + 3S (upper warning limit, use + 2S instead of + 3S);

2. lower control limit = $\bar{X}$ - 3S (lower warning limit, use - 2S instead of - 3S).

E. After every 20 new recovery measurements, new control limits should be calculated using the most recent 20-30 data points. These calculated control limits shall not exceed those established in the method. If any of these calculated control limits are tighter than the control limits specified within the method, the laboratory shall use the tighter criteria.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3229 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1100 (August 2020).

§8079. Records and Data Reporting [Formerly §8077]

A. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses, shall meet the requirements for reporting results pursuant to Chapter VI of the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

B. Compliance monitoring data shall be made legally defensible by keeping thorough and accurate records. The quality manual and/or SOPs shall describe the policies and procedures used by the facility for record retention and storage. If samples are expected to become part of a legal action, chain of custody procedures shall be used.

C. Maintenance of Records. PWSs are required to maintain records of radiological/radiochemical analyses of compliance samples for 10 years (40 CFR 141.33). The laboratory should maintain easily accessible records for 10 years. The client water system should be notified before disposing of records so they may request copies if needed. This includes all raw data, calculations, and quality control data. These data files may be either hard copy, microfiche or electronic. Electronic data shall always be backed up by protected tape or disk or hard copy. If the laboratory changes its computer hardware or software, it should make provisions for transferring old data to the new system so that it remains retrievable within the time frames specified above.

D. Sampling Records. Data should be recorded in ink with any changes lined through such that the original entry is visible. Changes shall be initialed and dated. The following information should be readily available in a summary or other record(s):

1. date of sampling, location (including name of utility and PWS ID #, if the water system is a PWS), sampling site within the water system, time of sampling, name, organization and phone number of the sampler, and analyses required;

2. identification of the sample as to whether it is a routine distribution system sample, check sample, raw or finished water sample, repeat or confirmation sample or other special purpose sample;

3. date of receipt of the sample by the laboratory;

4. sample volume/weight, container type, preservation and holding time and condition on receipt;

5. pH (from plant records) and disinfectant residual at time of sampling (from on-site analysis by sampler at the time of sampling);

6. disinfectant residual by laboratory immediately prior to analysis; and

7. transportation and delivery of the sample (person/carrier, conditions).

E. Analytical Records. Data shall be recorded in ink with any changes lined through such that the original entry is visible. Changes shall be initialed and dated. The following information shall be readily available:

1. laboratory and persons responsible for performing the analysis;

2. analytical techniques/methods used;

3. date and time of analysis;

4. results of sample and quality control analyses; and

5. calibration and standards information.

F. Personnel Records. Résumés and training records shall be maintained for all personnel. Documentation of the initial demonstration of capability for analysts/technicians shall be kept on file as well as the results of proficiency testing.

G. Reconstruction of Data. Adequate information shall be available to allow the assessor to reconstruct the final results for compliance samples and performance evaluation samples.

H. Computer programs. Computer programs shall be verified initially and periodically by manual calculations and the calculations shall be available for inspection. Access to computer programs and electronic data shall be limited to appropriate personnel.

I. The original or true duplicate of the results of the test or analysis shall be sent promptly to the person who requested such tests or analysis. In addition, the results of compliance monitoring samples are to be sent to the Engineering Services Section of the department.

1. The results data shall be signed by the technical manager or a designee whose designation is in writing and whose name has been submitted to the department. Data and results submitted to the department shall be submitted electronically, maintained, and stored in writing in the format specified by the Engineering Services Section of the department. When any sample result exceeds the maximum contaminant level (MCL), secondary MCL, or may cause a treatment technique requirement violation for any regulated contaminant listed in the federal Safe Drinking Water Act (42 USC 300f et seq.) and its implementing regulations (40 CFR Parts 141 and 143), a certified laboratory shall report the result to the supplier of water and the Engineering Services Section of the department as soon as possible but no later than the end of the next business day after the result was determined.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3230 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1101 (August 2020).

§8081. General Laboratory Practices [Formerly §8079]

A. Chemicals/Reagents. Chemicals and reagents used must meet the specifications in the referenced method. If not specified therein, then analytical reagent (AR) grade or American Chemical Society (ACS) grade chemicals or better shall be used for analyses in certified laboratories.

B. Reagent Water. The laboratory shall have a source of reagent water meeting the requirements of being an American Society of Testing Materials (ASTM) Type 1, 2, or 3 reagent water, having a minimum resistivity of 10 megohms-cm (conductivity less than 0.1 microhoms/cm) at 25ºC. It shall be monitored daily by measuring the reagent water's conductivity or resistivity and documented. Radioactive components have been known to break through reagent water manufacturing units before an increase in resistivity is noted. To monitor the background radioactivity of the reagent water, it is to be screened for radioactivity each time the treatment unit is serviced, and periodically thereafter depending on the volume of reagent water use at the laboratory between servicing units.

C. Glassware Preparation. Specific requirements in the methods for the cleaning of glassware must be followed. The purpose of these requirements are to minimize the possibility that glassware can contaminate samples, and should include acid rinsing. Acid rinsing not only mobilizes any metals remaining adhering to their surfaces, but also hydrates the outer silica layer on the glassware which inhibits contamination with radioactive materials. If there are no specifications for cleaning glassware in the method, then the glassware should first be washed in detergent solution, then thoroughly rinsed in tap water followed by a second rinse in a dilute acid solution, and finally rinsed with reagent water and dried.

D. Distilled and deionized water shall have at a minimum, resistivity values between 0.5 to 2.0 megohms-cm (2.0 to 0.5 micromhos/cm.) at 25º C. Preferably, distilled and deionized water should have resistivity values greater than 1.0 megohms-cm (less than 1.0 micromhos/cm) at 25ºC. When purchasing distilled or deionized water, laboratories should request a list of quality specifications for the water purchased. Containers of distilled or deionized water should be capped when not in use and should be capped immediately after each use.

E. All solutions shall be properly labeled with identification of the compound, concentration, solvent, date, and analyst who prepared the solution.

F. All chemicals, solutions, and standards, shall be dated upon receipt by the laboratory; and the date opened by the laboratory shall also be noted.

G. Compositing of Samples. If deemed acceptable by the department, samples may be composited by the utility or the laboratory, provided that all the sample aliquots are properly preserved at the time of collection. Since the required compliance protocol monitoring measurements is "total activity" (i.e., the composited sample is required to represent the maximum potential exposure from drinking water), samples shall not to be filtered before preservation. Samples must be drawn on a quarterly basis and where compositing is not done by the laboratory, there shall be documentation submitted with the composited sample detailing on what particular day(s) each aliquot was obtained, its volume, and when it was preserved. A sample of the preservative itself shall accompany the composited sample to the laboratory to determine the contribution of radioactivity, if any, from the addition of the preservative to the sample. Analysis of the composited sample shall be completed within 1 year after the first sample is collected or within normal holding times if the compositing period is less than 90 days. Wherever possible, the laboratory should be responsible for managing the compositing of samples.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:3231 (December 2012), amended by the Department of Health, Office of Public Health, LR 46:1102 (August 2020).

§8083. Management System General Requirements [Formerly §8081]

A. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses shall establish, implement and maintain a management system. The laboratory's management system policies related to quality, including a quality policy statement, shall be defined in a quality assurance plan (however named). The quality assurance plan shall include all the requirements in the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water. The quality assurance plan shall be made available to all laboratory personnel.

B. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses shall establish and maintain a documented data integrity system. There are four elements within a data integrity system. These are:

1. data integrity training;

2. signed data integrity documentation for all laboratory employees;

3. in-depth, periodic monitoring of data integrity; and

4. data integrity procedure documentation.

C. The procedures of the data integrity system required under Subsection B of this Section shall be signed by top management.

D. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses shall maintain SOPs that accurately reflect all phases of current laboratory activities, such as assessing data integrity, corrective actions, handling customer complaints and all analytical methods. All quality control data and records required by this Section shall be retained by the laboratory for a minimum of 10 years and shall be made available for inspection by the department. Such retained data shall include, but shall not be limited to, the results of and raw data generated by proficiency test analyses.

E. Control of Nonconforming Environmental Testing Work. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses shall meet the requirements for the control of nonconforming environmental testing pursuant to the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

F. Laboratory Improvement, Corrective Action and Preventive Action. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses shall meet the requirements for improving the laboratory, and implementing corrective and preventive actions pursuant to the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

G. Internal Audits. Laboratories which have received certification or are seeking certification to perform any of the required radiological/radiochemical analyses shall meet the requirements for establishing and conducting internal audits of laboratory activities pursuant to the USEPA Manual for the Certification of Laboratories Analyzing Drinking Water.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254(B)(7).

HISTORICAL NOTE: Promulgated by the Department of Health, Office of Public Health, LR 46:1102 (August 2020).

Subpart 29. Immunization Services

Chapter 81. Vaccine Preventiable Disease Program

§8101. Purpose

A. The purpose of this program is to prevent the occurrence and transmission of disease through immunization, surveillance, epidemiology, surveys, and mass immunizations in outbreak and low protection locations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§8103. Eligibility

A. Immunization delivery services are available to each individual in Louisiana. A $5 fee will be collected in parish health units for each childhood vaccination visit by a patient

whose other pediatric services are provided outside the Department of Health and Hospitals system. No One will be denied services due to inability to pay .All persons in the state may be considered to be at risk of infection although the target population are individuals susceptible to the following vaccine preventable diseases: Diphtheria, Tetanus, Pertussis, Poliomyelitis, Rubeola, Rubella, Mumps, and Haemophilus influenzaeb..

AUTHORITY NOTE: Promulgated in accordance with R.S 40:5.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended LR 15:1084 (December 1989).

§8105. Consent Forms

A. When an individual seeks immunization services, an immunization record is completed. The patient, parent or guardian, as appropriate, is required to execute an informed consent form. Each time the patient returns to the health unit for an additional immunization the patient, parent or guardian, as appropriate, is required to execute an informed consent form. The signed portion of the consent form is retained and filed by the health unit; the remainder of the informed consent form is returned to the patient for reference. A public health nurse shall review the consent form with the patient, parent or guardian, as appropriate, to discuss the illness, the risks, contraindications, and side effects of the vaccine and to answer any questions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 83. Cancer and Lung Trust Fund Board

§8301. Purpose

A. The purpose of the Louisiana Cancer and Lung Trust Fund Board is to annually receive monies appropriated by the legislature and other sources to be used solely for research on cancer and cardio-pulmonary diseases and clinical investigations and training in the fields of cancer and cardio-pulmonary diseases. The board is to direct the disbursement of these monies to those persons/institutions whose proposed grant applications have been reviewed and approved by peer review committees and reaffirmed by a majority vote of the board. The board is also responsible for other activities as provided under R. S. 40:1299.80 through 1299.90 including developing policies for the operation of a Louisiana State Tumor Registry and establishing rules and regulations for accumulation and distribution of data collected.

AUTHORITY NOTE: Promulgated in accordance with R. S. 40:1299.80 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services.

§8303. Board Membership

A. Membership of the board is determined by R.S. 40:1299.88(D) and consists of members appointed and reappointed by the governor, to serve at his pleasure, upon recommendation of each institution and organization represented: (1) a representative from Tulane University School of Medicine, (2) a representative from the Louisiana State University School of Medicine, New Orleans, (3) a representative from the Louisiana State University School of Medicine, Shreveport, (4) a representative from the Alton Ochsner Medical Foundation, (5) a representative of the American Cancer Society, Louisiana Division, (6) a representative of the Leukemia Society of America, Inc., Louisiana Chapter, (7) a representative of the Mary Byrd Perkins Cancer, Radiation and Research Foundation, Inc., (8) a representative of the Flint Goodridge Hospital, (9) a representative of the Louisiana State Medical Society, (10) a representative of the American Lung Association of Louisiana, and (11) a representation of the Acadiana Medical Research Foundation.

B. A member will serve on the board for an unlimited term, subject to R.S. 40:1299:88(D).

C. A member of the board may send a substitute to a board meeting, but that substitute is not entitled to a vote, nor entitled to any authorized reimbursement of expenses to which the member is entitled under R. S. 40:1299.88(E)3. A substitute member shall not be counted towards a quorum.

D. If any member of the board misses three consecutive meetings the member's sponsoring institution or organization will be requested to recommend a replacement for that member to the governor. The only exception to this Section will be for circumstances uncontrolled by the absentee member explained in writing and accepted by a majority vote of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.88.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended LR 14:534 (August 1988).

§8305. Board Officers

A. There shall be a chairman, vice-chairman, secretary, and treasurer of the board, with duties provided under R.S. 1299.88(E). Any member may hold two of these positions.

B. Officers shall serve two-year terms, beginning on the first day of October. No officer shall hold the same office more than two consecutive terms.

C. At the first meeting after January 1, the chairman shall appoint a two-person Nominating Committee for the purpose of soliciting candidates for office. The Nominating Committee shall submit either a single or double slate of recommendations to the chairman at the regular meeting immediately prior to October 1. Election of officers will be by voice vote at that meeting and the new officers will begin their terms on October 1.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.88.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended LR 14:534 (August 1988).

§8307. Board Meetings

A. The board will meet at least three times per calendar year, with notices being mailed 30 days prior to the meeting. Emergency meetings may be held upon 24 hours actual notice and business may be transacted, provided that not less than a majority of the full board concurs in the proposed action.

B. Six members shall constitute a quorum for the transaction of business; however, no board action shall be taken by a vote of less than a majority of the full board. The chairman shall vote only when it would affect the outcome.

C. The board shall meet at a convenient place selected by the chairman.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.88.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§8309. Committees

A. Peer Review Committees shall be appointed by a vote of the board as provided under R.S. 40:1299.88(D)1. Reimbursement for expenses, including travel expenses, incurred in the discharge of their duties will be provided to members of the Peer Review Committees. The board may elect to provide honorariums to members of these committees within the budget and statutory provisions of the Trust Fund Act and the state. Board members or Advisory Committee members are not entitled to honorariums should they serve on Peer Review Committees.

B. The board may establish advisory committees as provided under R.S. 40:1299:88(E)8.

C. The chairman may appoint ad hoc committees as determined by the needs of the board. Members of these committees, if not regular members of the board, are not entitled to any reimbursements for expenses.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.88.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§8311. Disbursement of Grant Funds

A. All applications for funding will undergo evaluation and priority rating by a Peer Review Committee. The applications shall be submitted by the Peer Review Committee to the board, who will elect to award funds to the applications. Decisions of the board are final.

B. Grant applications will be handled in the following manner: Advertisement of monies available and where to obtain grant applications shall be made in the Louisiana Register and directly to all appropriate institutions, organizations, and individuals. Grant applications will be forwarded to the appropriate peer review committees.

C. The board shall review the peer review committees' recommendations and notify all applicants of the funding decisions. The chairman of the board shall be responsible for notifying all grant applicants via mail of the decisions of the board within 10 days of the board meeting.

AUTHORITY NOTE: Promulgated in accordance with R. S. 40:1299.80 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§8313. Rules of Operation and Revisions

A. The operation of the board and all committees will be guided by Robert's Rules of Order, Revised, 1979 Edition, in all instances not covered by these procedures.

B. Any revisions to R.S. 40:1299.80 through 1299.90, the Louisiana Cancer and Lung Trust Fund statutes, by the legislature will automatically affect these procedures. Subsequent additions and amendments are to be proposed by a member of the board in writing, and approved by a three-fourths vote of the full board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.80 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subpart 31. Louisiana Tumor Registry

Chapter 85. Statewide Tumor Registry Program

§8501. Purpose

A. R.S. 40:1105.1 et seq., established a "statewide registry program for reporting cancer cases for the purpose of gathering statistical data to aid in the assessment of cancer incidence, survival rates, possible causes of specific cancers, and other related aspects of cancer in Louisiana." In order to provide cancer registry data for interventions to reduce exposure to cancer risks, increase early detection, and improve cancer care and health-related quality of life, the registry will obtain data via new technology from medical/health records, linkages with external files, and directly from cancer patients. The LTR will use its infrastructure and data to assist in the statewide cancer care coordination program. In carrying out this mandate, the Louisiana Tumor Registry collaborates with the National Cancer Institute, the Centers for Disease Control and Prevention, national and international cancer surveillance programs, health care providers and facilities, public health agencies, and research institutions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1105.3(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the

Louisiana State University Medical Center, Office of the Chancellor, LR 24:1298 (July 1998), amended by the LSU Health Sciences Center, Health Care Services Division, Tumor Registry, LR 30:2836 (December 2004), amended by LSU System, Louisiana State University Health Sciences Center, Louisiana Tumor Registry, LR 35:2786 (December 2009), LR 39:3304 (December 2013), LR 44:71 (January 2018).

§8502. Background

A. In December 1971, President Richard Nixon signed the National Cancer Act (P.L. 92-218). As a result of this act, the Surveillance, Epidemiology and End Results (SEER) Program, a national cancer surveillance program within the National Cancer Institute, was established. Data on cancer incidence and survival were collected in selected states and regions, beginning with cases diagnosed on January 1, 1973. The importance of cancer registration was subsequently reinforced by the passage of federal legislation in 1992 (Public Law 102-515) establishing the National Program of Cancer Registries within the CDC. Louisiana participates in both cancer surveillance programs.

B. Acts No. 1197 of the 1995 Louisiana Legislative Session clarified the cancer-reporting responsibilities of health care professionals and institutions, provided for intervention in cases of noncompliance, reinforced the confidentiality requirements to protect participants from civil liability, authorized the exchange of cancer incidence data with other states, and provided for related matters.

C. Acts No. 1138 §2 of the 1995 Session transferred the Louisiana Tumor Registry program and the Louisiana Cancer and Lung Trust Fund Board to the Board of Supervisors of the Louisiana State University Agricultural and Mechanical College, to be administered by the Louisiana State University Health Sciences Center at New Orleans.

D. Acts No. 197 of the 2001 Regular Legislative Session replaced "Secretary of the Department of Health and Hospitals" and "Secretary" with "President of the Louisiana State University System, or his designee" or "President" and replaced "office of public health in the Department of Health and Hospitals" with "office of the President." It also mandated the reporting of follow-up information and confirmed the ability of the LTR to release data to qualified researchers and other state cancer registries.

E. Acts No. 225 of the 2003 Regular Legislative Session added benign and borderline tumors of the brain and central nervous system to the reportablity list and authorized the LTR to cooperate with other designated national and international cancer surveillance programs.

F. Acts No. 373 of the 2017 Regular Legislative Session requires LTR, within the confines of federal privacy laws, to provide diagnostic, treatment and follow-up information for a patient at the request of a physician or medical facility. It also requires LTR to continue to cooperate with Office of Public Health of the Department of Health (LOPH) in the implementation of a program of cancer investigation and intervention, if funding is available, and on evaluation of programs. It changes the smallest level of data released by the LTR to the census tract, if it does not violate suppression rules or federal privacy laws. If a data request is denied by LSUHSC-New Orleans' Institutional Review Board (IRB), the requestor must be given notice in writing of the reason. The LTR Research Committee is expanded to include more qualified members. The annual report is now required to be sent to more governmental entities and the governing body of each parish, as well as LTR creating a mechanism for individuals to be notified when it is published on its website.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1105.3(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Louisiana State University Medical Center, Office of the Chancellor, LR 24:1298 (July 1998), amended by the LSU Health Sciences Center, Health Care Services Division, Tumor Registry, LR 30:2836 (December 2004), amended by LSU System, Louisiana State University Health Sciences Center, Louisiana Tumor Registry, LR 35:2786 (December 2009), LR 39:3304 (December 2013), LR 44:71 (January 2018).

§8503. Definitions

Confidential Data—shall include any information that pertains to an individual cancer case, as ordinarily distinguished from group, aggregate, or tabular data. Statistical totals of "0" or "1" may be deemed confidential, case-specific data. Confidential, case-specific data include, but are not limited to, primary or potential personal identifiers. In addition, in research involving data contained in the National Center for Health Statistics database, statistical totals of 5 or less are also deemed confidential data and are suppressed unless prior written consent of all of the affected respondents has been obtained in accordance with 42 U.S.C. §242k(l); 5 U.S.C. §552(a); and http://www.cdc.gov/nchs/data/misc/staffmanual2004.pdf (p. 16).

Director—the *director* of the Louisiana Tumor Registry, who is appointed by the president of the Louisiana State University System.

Follow-Up Information—information that is used to document outcome and survival for all types of cancer. The information includes, but is not limited to, patient identifiers, treatment, recurrence or progression, vital status, and date of last contact. If the patient is deceased, date of death and causes of death are included.

Health Care Provider—every licensed health care facility and licensed health care provider, as defined in R.S. 40:1231.1(A)(10), in the state of Louisiana, as well as out-of-state facilities and providers that diagnose and/or treat Louisiana residents.

Louisiana Tumor Registry/LTR—the program in Louisiana State University System that administers a population-based statewide cancer registry.

Regional Tumor Registry—an organization that is contracted with the Louisiana Tumor Registry (LTR) to provide in its region such services as: screening all possible sources to identify reportable cases, abstracting required

information on all reportable cases, obtaining current follow-up information, editing data, performing quality assurance programs, training personnel from hospitals and other reporting facilities, and furnishing electronic records of acceptable quality to the LTR from all medical facilities and health care providers in the parishes assigned to that region.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1105.3(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Louisiana State University Medical Center, Office of the Chancellor, LR 24:1298 (July 1998), amended by the LSU Health Sciences Center, Health Care Services Division, Tumor Registry, LR 30:2836 (December 2004), amended by LSU System, Louisiana State University Health Sciences Center, Louisiana Tumor Registry, LR 35:2787 (December 2009), LR 39:3305 (December 2013), LR 44:71 (January 2018).

§8505. Responsibilities of Health Care Facilities and Providers

A. All hospitals, pathology laboratories, radiation centers, physicians, nursing homes, hospices, other licensed health care facilities and providers as defined in R.S. 40:1231.1(A)(10) as well as coroners' offices shall report all reportable cases (see §8507.A) to the LTR, a public health authority. In addition, they shall provide information for all cancer-related studies conducted by the cancer registry program. Health care facilities and providers shall report cases regardless of whether the patient is a resident of Louisiana or of where the patient was originally diagnosed and/or treated. As needed for surveillance or cancer studies, the LTR shall have remote electronic access, where available, or physical access to all medical records, aligning identifiers (name, Social Security number, and date of birth), and obtain related diagnostic material such as biospecimens of cancers. Physician offices diagnosing and treating cancer patients shall submit cancer case information electronically to the LTR if their electronic health record (EHR) has the capability.

B. The LTR is mandated to conduct cancer studies and may request additional information from medical/health records and self-reported surveys of cancer patients, and diagnostic material in order to carry out these studies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1105.3(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Louisiana State University Medical Center, Office of the Chancellor, LR 24:1298 (July 1998), amended by the LSU Health Sciences Center, Health Care Services Division, Tumor Registry, LR 30:2837 (December 2004), amended by LSU System, Louisiana State University Health Sciences Center, Louisiana Tumor Registry, LR 35:2787 (December 2009), LR 39:3305 (December 2013), LR 44:72 (January 2018).

§8507. Case Reporting

A. Reportable Cases. Any in situ or invasive neoplasm, as designated by the most recent edition of the *International Classification of Diseases for Oncology,* published by the World Health Organization, is considered a reportable diagnosis. In addition, benign and borderline tumors as well as other neoplasms mandated by the LTR or its funding agencies shall be considered reportable. The LTR may require the reporting of precursor lesions for special surveillance programs. Details are available at the LTR website.

B. Transmission and Format for Reporting

1. All reports are to be transmitted electronically.

2. Facilities without electronic medical records must submit hard copies.

3. The LTR will stipulate the format for reporting, the required codes, and the format for transmitting data by all hospitals, pathology laboratories, radiation centers, physicians, nursing homes, hospices, and other licensed health care facilities and providers.

4. Diagnosis-related material, such as cancer biospecimens and pathology slides, as well as biological materials such as saliva samples, shall be sent to the Louisiana Tumor Registry if requested.

C. Data Quality. Data must meet the quality standards defined by the LTR. Data submissions of unacceptable quality will be returned for correction and must be resubmitted as specified by the LTR. Adequate text must accompany all coded data items to ensure data quality.

D. Variables to be Reported

1. At a minimum, the reports from non-hospital reporting sources shall include the identifiers, demographic, diagnostic, treatment, and follow-up information required by U.S. Public Law 102-151. Hospital-based reporters must use the standard variables, including identifiers, and codes established by the North American Association of Central Cancer Registries. A complete list of data items is available on the LTR website. Additional variables may be requested as needed to carry out the full mandate of registry operations, including Louisiana-specific cancer studies and meeting the requirements of the LTR funding agencies.

E. Deadlines for Reporting

1. Hospitals must submit completed cancer abstracts within six months of diagnosis or first contact with the patient for that cancer.

2. Pathology laboratories, radiation centers, surgery centers, physicians, and other licensed health care facilities and providers, shall report cancer cases, as defined in §8507.A, within two months of diagnosis or of the facility's first contact with that patient for cancer.

3. Hospices and nursing homes shall identify cancer cases and provide copies of medical records (electronic or paper copies) as requested.

4. In addition, providers shall notify the LTR within one month if they diagnose or treat any cancer patient under age 20 years old.

F. Failure to Report. If a facility fails to meet the deadline for reporting in the format specified by the Louisiana Tumor Registry or if the data are of unacceptable quality, personnel from the LTR or its contractors may enter the facility to screen and abstract the information. In such situations, the facility shall reimburse the Louisiana Tumor Registry or its contractor $45 per case or the actual cost of screening, abstracting, coding, and editing, whichever is greater. Facilities refusing to cooperate within one month of the LTR's request for cancer reporting may be fined. Fines accrue daily after this one month of noncooperation at $100 per day, with a cap of $5000 total. Money from fines accrue to the LTR account, for LTR operations. The LTR may take legal action if necessary to enforce compliance with the law.

G. Quality Assurance

1. Staff members from the LTR central office, the regional registries, and national cancer surveillance programs designated by the LTR shall perform periodic quality assurance studies at all reporting facilities. These studies shall include:

a. rescreening medical and health records to ensure that all reportable cases have been identified;

b. reabstracting the records of patients to ensure that all data have been abstracted and coded correctly.

2. Reporting facilities shall assist LTR staff by compiling a list of cancer patients in the format required by the LTR and by obtaining the necessary medical and health records.

H. Follow-Up. Current follow-up, as defined in §8503, is required for all cancer cases. Health care facilities and providers will supply this information when requested.

I. External Linkages. LTR data may be linked with external databases in order to improve the accuracy and completeness of follow-up data or for research. All linkages shall be carried out in compliance with LTR confidentiality rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:11105.3(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Louisiana State University Medical Center, Office of the Chancellor, LR 24:1298 (July 1998), amended by the LSU Health Sciences Center, Health Care Services Division, Tumor Registry, LR 30:2837 (December 2004), amended by LSU System, Louisiana State University Health Sciences Center, Louisiana Tumor Registry, LR 35:2787 (December 2009), LR 39:3305 (December 2013), LR 44:72 (January 2018).

§8509. Confidentiality

A. R.S. 40:1105.6 and 1105.8 of Acts 1995, No. 1197, strengthen and enforce previous legislative provisions to ensure the confidentiality of patients, health care providers, and reporting facilities. These laws protect licensed health care providers and facilities that participate in the cancer registration program from liability. They also specify the confidentiality requirements of the Louisiana Tumor Registry.

B. Louisiana Tumor Registry policies and procedures comply with the standards of the Health Insurance and Portability and Accountability Act (HIPAA). The Office of Civil Rights has determined that releases of confidential data to state-mandated cancer registries do not require patient consent, since the registries serve as a public health authority.

C. LTR Responsibilities. The president or his or her designee shall take strict measures to ensure that all case-specific information is treated as confidential and privileged. All employees, consultants, and contractors of the Louisiana Tumor Registry and of its regional offices shall sign an "agreement to maintain confidentiality of data" each year, and these agreements shall be kept on file. Any employee who discloses confidential information through gross negligence or willful misconduct is subject to penalty under the law.

D. Protection of Reporting Sources. Health care providers and facilities that disclose cancer morbidity or mortality information to the Louisiana Tumor Registry or its employees in conformity with the law shall not be subject to actions for damages. Their licenses shall not be denied, suspended, or revoked for good-faith release of confidential information to the Louisiana Tumor Registry.

E. Protection of Case-Specific Data Obtained by Special Morbidity and Mortality Studies and Other Research Studies

1. R.S. 40:3.1(A) through (H) and R.S. 40:1105.8(F) state that all confidential data such as records of interviews, questionnaires, reports, statements, notes, and memoranda that are procured or prepared by employees or agents of the Office of Public Health shall be used solely for statistical, scientific and medical research purposes. This applies also to data procured by employees or agents of the Louisiana Tumor Registry or organizations, including public or private college universities acting in collaboration with the Louisiana Tumor Registry in special cancer studies.

2. No case-specific data shall be available for subpoena, nor shall they be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding, nor shall such records be deemed admissible as evidence in any civil, criminal, administrative, or other tribunal or court for any reason.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1105.3(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Louisiana State University Medical Center, Office of the Chancellor, LR 24:1298 (July 1998), amended by the LSU Health Sciences Center, Health Care Services Division, Tumor Registry, LR 30:2838 (December 2004), amended by LSU System, Louisiana State University Health Sciences Center, Louisiana Tumor Registry, LR 35:2789 (December 2009), LR 39:3306 (December 2013), LR 44:72 (January 2018)

§8511. Release of Information

A. Confidentiality of Published Data

1. Reports published or presented by the Louisiana Tumor Registry shall include aggregate, not case-specific, data.

2. Information that would potentially identify a patient or a health care provider or facility shall not be disclosed, except to treating, diagnosing, and follow-up facilities and providers or qualified investigators currently approved by both the LTR and the LSUHSC Institutional Review Board, in conformity of R.S. 40:1105.8.1

3. When collecting self-reported information from cancer patients, patient privacy will be protected by HIPAA-compliant procedures.

B. Diagnostic, Treatment, and Follow-Up Information. Diagnostic, treatment, and follow-up information about a patient shall be provided, if requested, to a physician or medical facility diagnosing or treating the case. Section 45 CFR 164.506 of the Health Information Portability and Accountability Act (HIPAA) allows such sharing of health information.

C. Collaboration with Federal and State Public Health Agencies and National and International Cancer Surveillance Programs

1. The LTR is authorized to collaborate with the National Cancer Institute, the Centers for Disease Control and Prevention, and other national and international cancer surveillance programs and organizations designated by the LTR, including but not limited to the North American Association of Central Cancer Registries and the International Agency for Research on Cancer, in providing cancer data and participating in cancer studies.

2. In addition, the LTR shall work closely with the LOPH in investigating cancer concerns, evaluating programs, and other cancer-related issues. This includes cooperating in the implementation of the program of cancer investigation and intervention provided for in R.S. 40:1105.8.1, if sufficient funding is available for this purpose. LOPH requests for case-specific data will require annual approval by the Institutional Review Board of the Louisiana State University Health Sciences Center-New Orleans (LSUHSC-New Orleans). In addition, the LOPH must comply with LTR confidentiality standards, and reports written for public release using registry data must be reviewed by the registry in advance.

3. The use of registry data by LOPH officials and Louisiana Cancer Prevention and Control Programs, who sign an annual agreement to maintain the confidentiality of registry data, shall be considered an in-house activity and shall be processed expeditiously.

D. Requests for Case-Specific LTR Incidence Data. Case-specific data may be released to qualified persons or organizations for the purposes of cancer prevention, control, and research. Such data do not include information collected for special studies or other research projects.

1. The LTR reserves the right to prioritize its responses to data requests.

2. Requests from researchers for case-specific LTR incidence data, including data linkages, must be submitted in writing and shall be reviewed and approved by the LTR Data Release Committee following the established policies of the Louisiana Tumor Registry. A detailed description of the policies and procedures for requesting Registry data can be obtained from the LTR website. These established policies include, but are not limited to, the following requirements:

a. approval from the LSUHSC-New Orleans Institutional Review Board and compliance with the LSUHSC-New Orleans HIPAA research policy as well as approval from the researcher's Institutional Review Board and compliance with that institution's HIPAA research policy;

b. signature of the LTR “agreement to maintain confidentiality of data” by all investigators who will have access to the data, agreeing to adhere to the LTR confidentiality provisions and prohibiting the disclosure of LTR data in any civil, criminal, administrative, or other proceeding;

c. provision of a copy of the complete protocol for the project;

d. completion of all requirements listed in the document on the LTR website;

e. notification of physician, if required, before contacting patients or their next-of-kin;

f. destruction or return of data once the research is completed.

3. LTR Research Committee. The research committee shall be coordinated by the director of the LTR or designee and may include, but not be limited to, the director of the LTR, and a qualified representative from each of the following entities: LSUHSC-New Orleans, OPH, and the Cancer and Lung Trust Fund Board. The committee will verify:

a. that the researchers are able to execute the proposal, in terms of both financial support and professional qualifications;

b. that the study has scientific and ethical merit;

c. that all appropriate confidentiality protections are in place; and

d. that appropriate consent will be obtained.

E. Requests for Aggregate Data

1. Data requested by the Office of Public Health for responding to concerns about threats to public health shall receive priority in determining the order of processing requests.

2. Subject to the provisions of the Public Records Act, R.S. 44:4.1 et seq., other requests for aggregate data shall be processed in the order of their receipt. The registry shall

respond to public requests in as timely a manner as resources permit, provided that these requests meet certain requirements in conformity with R.S. 40:3.1(A) and (F) and R.S. 40:1108.8(F) et seq.

3. Those requesting data may be asked to reimburse the LTR for actual costs for compiling and providing data. In no event shall the LTR be obligated to perform original work to create data not currently in existence.

4. According to R.S. 40:1105.8.1. The census tract is the smallest geographic area for which aggregate data may be released, if it does not violate both the suppression rule of the United States Cancer Statistics Program, and HIPAA. LTR may combine years of data to overcome these rules. IRB approval is required when requesting data for smaller geographic areas or areas that are restricted by the aforementioned rules and laws, except for mandated public health investigations. If a data request is denied by the IRB, the IRB shall provide written notice of the reason why to the requestor electronically or via mail.

F. Annual Report. A statistical report shall be prepared and made available on the LTR website. This report will also be submitted to the president of the LSU system, LSUHSC-New Orleans, LSUHSC-Shreveport, the Cancer and Lung Trust Fund Board, participating hospitals, the governor, the speaker of the House of Representatives, the president of the Senate, the Legislative Committees on Health and Welfare, and the governing body of each parish.

1. The LTR shall have a mechanism on its website which individuals may elect to receive notifications and the annual report in electronic form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1105.3(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Louisiana State University Medical Center, Office of the Chancellor, LR 24:1298 (July 1998), amended by the LSU Health Sciences Center, Health Care Services Division, Tumor Registry, LR 30:2839 (December 2004), amended by LSU System, Louisiana State University Health Sciences Center, Louisiana Tumor Registry, LR 35:2789 (December 2009), LR 39:3307 (December 2013), LR 44:73 (January 2018).

§8512. Patient-Reported Data

A. The LTR is authorized to contact cancer patients to obtain information on self-reported family history of cancer, health-related quality of life, and other related topics to support patient-centered cancer care. Participation of cancer patients is voluntary. The LTR shall use appropriate data collection means to minimize the burden on participants.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1105.3(7).

HISTORICAL NOTE: Promulgated by LSU System, Louisiana State University Health Sciences Center, Louisiana Tumor Registry, LR 44:74 (January 2018).

§8513. Interstate Exchange of Data

A. Because cancer patients may be diagnosed or treated in other states, the Louisiana Tumor Registry is authorized to sign agreements with other states to acquire cancer data concerning Louisiana residents and, in return, to provide those states with cancer data relating to their residents. Each signatory state shall agree in writing to follow standard procedures to safeguard patient confidentiality and ensure data security.

B. Before the release of any confidential information to other state cancer registries, an interstate data exchange agreement shall be executed by a representative of the other state registry who is authorized to legally obligate the registry and by a representative of the Louisiana State University System.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1105.3(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Louisiana State University Medical Center, Office of the Chancellor, LR 24:1298 (July 1998), amended by the LSU Health Sciences Center, Health Care Services Division, Tumor Registry, LR 30:2840 (December 2004), amended by Louisiana State University System, Louisiana State University Health Sciences Center, Louisiana Tumor Registry, LR 35:2790 (December 2009), LR 39:3308 (December 2013), LR 44:74 (January 2018).

§8514. Cancer Care Coordination

A. The LTR is authorized to work collaboratively with the Louisiana Department of Health and the Louisiana Cancer Prevention and Control Programs to provide information to cancer patients regarding access to clinical trials and other care services for the statewide cancer care coordination program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1105.3(7).

HISTORICAL NOTE: Promulgated by LSU System, Louisiana State University Health Sciences Center, Louisiana Tumor Registry, LR 44:74 (January 2018).

§8515. Contact Information for the Louisiana Tumor Registry

Louisiana Tumor Registry
2020 Gravier St., Third Floor
New Orleans, LA 70112
Phone: (504) 568-5757
Fax: (504) 568-5800
Website: http://sph.lsuhsc.edu/louisiana-tumor-registry/

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1105.3(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Louisiana State University Medical Center, Office of the Chancellor, LR 24:1298 (July 1998), amended by the LSU Health Sciences Center, Health Care Services Division, Tumor Registry, LR 30:2840 (December 2004), amended by LSU System, Louisiana State University Health Sciences Center, Louisiana Tumor Registry, LR 35:2790 (December 2009), LR 39:3308 (December 2013), LR 44:74 (January 2018).

Subpart 33. Venereal Disease Control Services

Chapter 87. Venereal Disease Control Program

§8701. Purpose

A. The Office of Preventive and Public Health Services (OPPHS) administers the Venereal Disease Control Program to protect the public against sexually-transmitted (i.e. venereal) diseases. The purpose of the program is to prevent death, disability and social loss by reducing and preventing the incidence of sexually-transmitted diseases through treatment of infected patients and the identification of potentially infectious patients and their medical evaluation.

AUTHORITY NOTE: Promulgated in accordance with R.S 40:1061-1068.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§8703. Eligibility

A. There are no eligibility requirements for the public to obtain these services. All persons in the state may be considered to be at risk of infection, although the target population is usually considered to be sexually active persons between the ages of 14 and 45. Minors may be examined and treated for venereal disease in Louisiana without the consent of parents or guardians. This mandate is contained in R.S. 40:1065.1 under minor's consent for treatment of venereal diseases.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1061-1068.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§8705. Reporting

A. The first step in the control of venereal disease is its rapid identification, followed by notification to the local health authority that a case of disease exists within the particular jurisdiction so that prevention or containment measures can be enacted. These program-related activities are authorized and/or mandated by R.S. 40:1061-1068 and Chapter II of the Louisiana Sanitary Code concerning the reporting of venereal disease. To summarize the codal provisions, it is the duty of every physician practicing medicine in the state of Louisiana to report to the state health officer, through the health unit of the parish or municipality wherein such physician practices, any case of reportable disease (including sexually transmitted diseases) which he is attending. The report shall be made promptly at the time the physician first visits, examines or prescribes for the patient, and such report shall state the name, age, sex, race, place where the patient is to be found, nature of the disease and date of onset. OPPHS does not follow-up private patients unless requested to by or with the permission of the private physicians. Venereal disease records are confidential and every effort shall be made to ensure the confidentiality even in the clinical setting. The authority of the confidential nature of sexually transmitted disease records is contained in R. S.44:3.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1061-1068.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§8707. Services

A. OPPHS conducts four basic activities pertaining to the control of venereal disease: (A) clinic services, which involve testing, diagnosis, and treatment of persons seen in the clinics; (B) epidemiology, which is the location and early treatment of sexual contacts of persons who have venereal disease; (C) screening, as a mechanism to discover infections in certain populations; and (D) education, primarily of patients, as to the nature of their disease. OPPHS administers these services through health units in all 64 parishes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1061-1068.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services. LR 13:246 (April 1987).

§8709. Sexually-Transmitted Disease Control Manual

A. OPPHS recommendations for treatment of venereal disease patients were published in the Sexually-Transmitted Disease Control Manual, as revised. This document was authorized by the Venereal Disease Control Section of DHHR/OPPHS. Copies of the manual can be obtained from the VD Control Section, Box 60630, New Orleans, La. 70160.

AUTHORITY NOTE: Promulgated in accordance with R.S. 1061-1068.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subpart 35. Adolescent Family Life Project

Chapter 89. Fees

§8901. Introduction

A. The Department of Health and Human Resources, Office of Preventive and Public Health Services has adopted policies and procedures used in the operation of the Northwest Louisiana Adolescent Family Life Project in accordance with the Administrative Procedure Act, R. S. 49:950, et. seq.. These policies and procedures specifically cover the charging of fees to service recipients as mandated by federal regulations as published in the Federal Register, Vol. 47, No. 40, Monday, March 1, 1982, page 8682.

B. In accordance with Title XX of the Public Health Service Act (42 U.S.C. 300z-2) administered through the United States Department of Health and Human Services, Office of Adolescent Pregnancy Programs, all individuals served by the Adolescent Family Life Project must be

charged a fee. Charges are to be made to persons according to a sliding fee schedule based on ability to pay, which is generally determined by income. No person shall be denied services because of inability to pay.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 300z et seq., and 42 CFR, Part 52.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§8903. Fee Policy

A. All persons receiving services from the Adolescent Family Life Project shall be assessed a fee for each chargeable service. Chargeable services include the Parent Family Life Education Sessions and the In-Depth Family Life Sessions. Fees will be based on cost and adjusted according to the ability of the recipient to pay.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 300z et seq., and 42 CFR, Part 52.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§8905. Fee Adjustment Schedule

A. All persons whose gross family income is above 150 percent of the level of poverty as determined by the U.S. Community Services Administration as indicated on the fee adjustment schedule, shall pay a fee for each chargeable service. The attached fee adjustment schedule (see Exhibit A), has been approved by the federal granting agency. Fees and adjustments to fees shall be explained by the Adolescent Family Life Project staff to the organization sponsoring the Parent Family Life Education Sessions, i.e. churches, and PTA's. The sponsoring organization shall be responsible for assessing the charges according to the participant's income. If indicated, the fees shall be collected by the sponsor and given to the project staff person at the time the session is conducted. Funds collected are handled in accordance with Division of Administration policy and procedures.

Service	**I No Charge**	**II 5% Charge**	**III 10% Charge**	**IV 20% Charge**	**V 30% Charge**	**VI 40% Charge**	**VII 50% Charge**	**VIII 60% Charge**	**IX 70% Charge**	**X 80% Charge**	**XI 90% Charge**	**XII 100% Charge**
Teen Living Series	----------contributions----------											
Individual Parenting Class	----------contributions----------											
Parent Family Life Education Series		$0.25	$0.50	$1.00	$1.50	$2.00	$2.50	$3.00	$3.50	$4.00	$4.50	$5.00
In-depth Family Life Sessions		$0.50	$1.00	$2.00	$3.00	$4.00	$5.00	$6.00	$7.00	$8.00	$9.00	$10.00
% Poverty Income Family Size	**I * No Charge**	**II 150% 5% of Cost**	**III 155% 10% of Cost**	**IV 160% 20% of Cost**	**V 165% 20% of Cost**	**VI 170% 40% of Cost**	**VII 175% 50% of Cost**	**VIII 180% 60% of Cost**	**IX 185% 70% of Cost**	**X 190% 80% of Cost**	**XI 195% 90% of Cost**	**XII 200% 100% of Cost**
1	$ 4,310	$ 6,465	$ 6,681	$ 6,896	$ 7,112	$ 7,327	$ 7,543	$ 7,758	$ 7,794	$ 8,189	$ 8,405	$ 8,620
2	5,690	8,535	8,820	9,104	9,389	9,673	9,958	10,242	10,527	10,811	11,096	11,380
3	7,070	10,605	10,959	11,312	11,666	12,019	12,373	12,726	13,080	13,433	13,787	14,140
4	8,450	12,675	13,098	13,520	13,943	14,365	14,788	15,210	15,633	16,055	16,478	16,900
5	9,830	14,745	15,237	15,728	16,220	16,711	17,203	17,694	18,186	18,677	19,169	19,660
6	11,210	16,815	17,376	17,936	18,497	19,057	19,618	20,178	20,739	21,299	21,860	22,420
7	12,590	18,885	19,515	20,144	20,774	21,403	22,033	22,662	23,292	23,921	24,551	25,180
8	13,970	20,955	21,654	22,352	23,051	23,749	24,448	25,146	25,845	26,543	27,242	27,940
9	15,350	23,025	23,793	24,560	25,328	26,095	26,863	27,630	28,398	29,165	29,933	30,700
10	16,730	25,045	25,932	26,768	27,605	28,441	29,278	30,114	30,951	31,787	32,624	33,460
11	18,110	27,165	28,071	28,976	29,882	30,787	31,693	32,598	33,504	34,409	35,315	36,220
12	19,490	29,235	30,210	31,184	32,159	33,133	34,108	35,082	36,057	37,031	38,006	38,980
13	20,870	31,305	32,349	33,392	34,436	35,479	36,523	37,566	38,610	39,653	40,697	41,740
14	22,250	33,375	34,488	35,600	36,713	37,825	38,938	40,050	41,163	42,275	43,388	44,500
15	23,630	35,445	36,627	37,808	38,990	40,171	41,353	42,534	43,716	44,897	46,079	47,260
16	25,010	37,515	38,766	40,016	41,267	42,517	43,768	45,018	46,269	47,519	48,770	50,020
17	26,390	39,585	40,905	42,224	43,544	44,863	46,183	47,502	48,822	50,141	51,461	52,780
Note: Income shown under each group is maximum income for that group.												

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 300 et seq., and 42 CFR, Part 52.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (Apri11987).

Subpart 37. Tuberculosis Control

Chapter 91. Tuberculosis Control

§9101. Purpose and Eligibility

A. The Tuberculosis Control Program provides evaluation, treatment, and followup for tuberculosis cases, suspected cases, and contacts to cases residing in the state of Louisiana. Persons infected with tuberculosis, without active disease, who are at increased risk of future disease due to age or medical condition, are eligible for evaluation, treatment and followup.

B. Clinical evaluation services shall be provided in each OPPHS region. Followup services, including patient education, sputum collection, patient monitoring for anti-tuberculosis drug side effects, anti-tuberculosis drug delivery, contact and suspect identification and referral for evaluation, shall be available through local public health units.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5, R.S. 40:28, and R.S. 40:29.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§9103. Reporting and Investigation

A. The reporting and investigation of tuberculosis cases and suspected cases, and investigation for the identification of cases, suspected cases and contacts is provided for in Chapter II, Sections 2:001-013 of the State Sanitary Code.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5, R.S. 40:28, and R. S. 40:29.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§9105. Quarantine

A. The quarantining of an infectious case to protect the public health is provided for in Chapter II, Sections 2:014-2:019 of the State Sanitary Code. Violations of quarantine are punishable under R.S. 40:6.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5, R.S. 40:48, and R.S. 40:29.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subpart 45. Vital Records

Chapter 111. Delayed and Altered Certificates

Subchapter A. Altered Certificates

§11101. Proofs Necessary

A. All documents submitted to accomplish alterations to vital records in the custody of the state registrar shall be certified, true copies of the original instrument. No alteration may be made to an original signature. All alterations shall be effected as set forth in Volume 9, Number 5, page 324 of the Louisiana Register, dated May 20, 1983.

1. Certificate of Live Birth

a. Last Name.

i. Obvious errors in spelling may be altered by a baptismal record or letter issued by the delivering hospital or midwife from their medical records.

ii. A complete change of surname can be made with an acknowledgment of paternity or act of legitimation for illegitimate births; the parents marriage application for legitimate births; a name change judgment will suffice in all instances.

b. First and Second Names

i. Between birth and 12 years of age, these names may be altered by an affidavit executed by the mother and father (if a father's name appears on the certificate) or the survivor of them or the parent having legal custody or a baptismal certificate or delivering hospital record.

ii. The names of persons over 12 years of age may be altered by a five year old record containing the registrant's facts of birth, e.g., school record, marriage application, baptismal certificate, application for a social security number or voter registration record.

c. Date of Birth. In instances where the request for alteration encompasses a period of less than one calendar year, a hospital statement or baptismal certificate (if baptism occurred during the first year) may be utilized to alter this item. Note that this is possible only where the new birth date is prior to the file date shown on the certificate.

d. Hour of Birth, This Birth, Order of Birth, Place of Birth, Date of Birth, Date of Signature, and the Section Entitled "Information for Medical and Health Use Only." Item appearing in or under these listed designations will require a statement signed by the hospital administration, attending physician or midwife.

e. Sex

i. In case of erroneous classification at birth, this item may be altered by hospital, attending physician or midwife records, an early school record or marriage application.

ii. Other requests for alteration relating to sex will be processed as set forth in R.S. 40:62-1.

f. Father and Mother of Child. Information pertaining to the mother and father listed on the certificate may be altered with the parent(s') birth certificate(s, marriage application or child's baptismal certificate.

g. Race. In the absence of definitive statutory or jurisprudential guidelines, a request for race alteration must be handled on a case by case basis with the applicant submitting documents pertaining to his/her ancestry to support the change. The state registrar of his representative will offer suggestions or assistance in an attempt to reach an amicable solution.

2. Delayed Certificate of Birth. All alterations to this document shall be predicated upon an order from a court of competent jurisdiction. If the alteration pertains to date of birth, the order shall be issued by civil district court of the parish of Orleans.

3. Certificate of Death. The coroner of the parish where death occurred can cause alteration of any item on a death certificate, when that request is communicated on his letterhead with his original signature. Otherwise, alterations may be effected upon presentation of proofs appearing herein below.

a. Last Name, Parents and Birthplace. Alterations to the last name shall be predicated upon the birth certificate of the deceased (if available), a baptismal certificate or the parents' marriage application.

b. First, Second Name, Date of Birth and Sex. These items may be altered by a five year old record containing the registrant's facts of birth, e.g. school record, marriage application, baptismal certificate, application for a social security number or voter registration record.

c. Date, Place and Hour of Death. Alterations of these sections sill require a written statement of the attending physician or coroner.

d. Surviving Spouse. Where a name of a spouse does not appear on the certificate, it may be added with the marriage application and affidavit executed by the surviving spouse that he/she has not remarried. In the event a request is made to the registry to displace the name of a spouse shown on the certificate, the registry may consider an order from a court of competent jurisdiction.

e. Usual Occupation Kind of Business or Industry and Usual Residence of Deceased. An affidavit executed by the informant will cause this section to be amended.

f. Cause of Death, Death Due to External Violence and Physician's Certification. Alterations to these sections can only occur after receipt of a written statement of the attending physician or coroner submitted ion his letterhead and containing his original signature.

g. Type of Disposition and Name and Location of Cemetery. Alteration to this section shall be supported bya statement signed by the section.

4. Certificate of Marriage

a. Only those marriage records on file in the vital records registry representing the purchase of a license in Orleans Parish are addressed in this section. Requests for alterations to other marriage records should be brought to the attention of the clerk of court in the parish of license purchase.

b. Information pertaining to the bride or groom extracted from the birth certificate presented upon application for license may be altered by an amended birth certificate or an order issued by a court of competent jurisdiction.

c. Data pertaining to usual residence can be altered with an affidavit executed by the affected marriage participant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:33 and R.S. 40:59.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§11103. Inactive Files

A. At the expiration of six months, all files which do not evidence activity during that period shall be closed and all documents submitted shall be returned to the customer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:33 and R.S. 40:59.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§11105. Procedure

A. All alterations of original birth, death, and marriage certificates maintained by the Vital Records Registry pursuant to R.S. 40:33 shall be accomplished by the interlinear method of drawing a line through the old information and entering the new information. The line shall not obscure the original information.

B. Thereafter the certificate shall be distinctly marked "altered" on its face and include the evidentiary basis for the alteration, the date of alteration and the initials of the state registrar or his designee making the alteration. Original information appearing on a document accepted for filing by the state registrar shall not be obliterated under any circumstances. See R.S. 40:59 and R.S. 40:60.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:32 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§11107. Following Name Change Judgments

A. Attention is called to R.S. 13:4751 through R.S. 13:4755, concerning "change of name." In addition to other requirements set forth therein, certain requisites must be met if the birth record on file on the vital records registry is to reflect the results of proceedings under the name change

statute. Complete identifying personal data on the petitioner is essential.

B. The data shall include:

1. petitioner's name at birth

2. birth date

3. birthplace

4. mother's maiden name

5. father's name.

C. The identifying data shall be included in a certified copy of the judgment presented to the registry, or if not in the judgment, in the petition, in which case a certified copy of both petition and judgment must be furnished.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:33, R.S. 40:59, and R.S. 13:4751-4755.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Subchapter B. Delayed Certificates

§11115. Delayed Birth Certificates

A. Delayed Birth Certificates—Six Months to 12 Years

1. In instances where there exists no birth certificate of record of a person born in Louisiana, who is six months to 12 years of age ion file with the Vital Records Registry, an applicant shall be furnished an application with instructions for filing a certificate of birth for a child ages six months to 12 years only.

2. The state registrar shall not furnish such applications unless he is satisfied that the applicant thereof is the person who has no birth certificate or record, or is a member of the immediate or surviving family of said person, or is named in a court proceeding as a member of the immediate or surviving family of said person. The credentials of an attorney at law authorized to practice in this state, together with a written declaration of the record in which he is interested, that he is a legal representative of one of the named parties at interest, shall constitute sufficient proof of a direct interest in the matter to warrant being furnished an application.

3. The certificate shall be completed by a hospital official, unless the child is delivered by someone other than a physician, in permanent black ink, or with a black typewriter ribbon, The original signature of the physician or attendant who delivered the child must appear on the face of the certificate, certifying that the physician or attendant attended the birth of that child and that the child was bon alive on the date and hour stated on the certificate. The affidavit in the lower portion of the certificate must be signed by a parent or legal guardian, in the presence of a notary public. Upon completion, the certificate shall be forwarded to the health unit or local registrar in the parish of birth, where upon it will be forwarded to the central office of the state registrar in New Orleans for official recordation.

B. Delayed Birth Certificate—12 Years and Older

1. In instances where there exists no birth certificate of record on file for a person born in Louisiana and that person is 12 years of age or older, the applicant shall be furnished an application with instructions for filing a delayed certificate of birth.

2. The state registrar shall not furnish such applications unless he is satisfied that the applicant thereof is the person who has no birth certificate of record, or is a member of the immediate or surviving family of said person, or is named in a court proceeding as a member of the immediate or surviving family of said person. The credentials of an attorney at law authorized to practice in the state, together with a written declaration of the record in which he is interested, that he is a legal representative of one of the named parties at interest, shall constitute sufficient proof of a direct interest in the matter to warrant being furnished an application.

3. The applicant is required to submit certain documentation as evidence to establish the facts of birth. The types of records generally acceptable in establishing the facts of birth are listed below. Original records are preferred for examination; certified or true copies are acceptable only if it is impossible to secure original records.

a. Records that may support date of birth, birthplace and names of parents:

i. baptismal, cradle roll, confirmation certificate—form issued by church. The form must have the signature of the priest or pastor and the seal of the church;

ii. Social Security record—photostatic copy of application;

iii. attending physician's office record—notarized abstract signed by physician or custodian, based on office record made at time of birth;

iv. newspaper clipping (noting of birth)—notarized abstract signed by publisher showing the name of the newspaper and the date of issue;

v. public welfare record—certified abstract of record.

b. Records That May Support Date of Birth or Age and Name of Parent or Parents

i. School enrolling record—records of enrollment in two different schools on dates at least five years apart will be acceptable as two different records. Records must be signed by the principal of the school or the superintendent of schools. Records are not acceptable if signed by a teacher.

ii. Application for marriage license—if the registrant Is married, obtain the document from the clerk of court of the parish or county in which the license was issued.

iii. Local health unit records—the local registrar, upon request, will make a search of health unit records and if a record is found, will abstract the data contained therein onto the lower section of the delayed certificate.

c. Records That May Support Date and Place of Birth

i. Application for voting registration—if the registrant has been a qualified voter for more than five years, obtain from the registrar of voters or other authorized official a statemen as to the facts of birth as given on the applicant's original registration record.

ii. Application for insurance—the registrant may obtain from the insurance company a statement as to the facts of birth contained on an original application for insurance. If the registrant has a photostatic copy of the insurance application in his possession, this Photostat may be submitted. Policies taken out with two different companies on dates at least five years apart will be acceptable as two different records. In every case it is necessary that the name and address of the company and the policy number be given. Forms are only acceptable when signed by a manager or other duly authorized representative of the company. Certifications by agents of companies are not recognized.

iii. Birth certificate of registrant's child—send the name of the child, date and place of birth, and the names of the child's parents (registrant and wife or husband) to the Office of Vital Records of the state in which the child was born. Request a photostatic certified copy.

d. Records That Support One or More Facts of Birth

i. Hospitalization, employment, fraternal and military services records—abstracts of hospitalization, employment and fraternal records may be obtained by writing said agencies. A military services record (discharge(may be submitted for perusal.

ii. Family bile records—acceptable as evidence only when the bible itself is presented to a local registrar.

iii. Record of federal or local census—if the registrant cannot secure and other records, he may apply to this office for a form to send to the U.S. Bureau of Census for a copy of records on file. Two federal census records of two different decades, together with an affidavit of personal knowledge will suffice.

4. When the state registrar has reasonable cause to question the validity, accuracy or authenticity of any evidence submitted, the state registrar shall so advise the applicant as provided by R.S. 40:60E as amended and reenacted by Act No. 776 of 1979.

5. The certificate shall be entitled "Delayed Certificate of Birth." All delayed certificates of birth are reviewed for correctness and acceptability by the Vital Records Registry. Acceptable certificates are numbered and filed accordingly. Unacceptable certificates are returned for further investigation and clarification. If there is no response from an applicant or the applicant is unable to submit the necessary documentation within a six month period the file shall be closed and the materials and documents returned.

6. In addition, any person born in Louisiana who is over 12 years of age and who has no birth record on file with the Vital Records Registry may establish a birth record as provided by R.S. 40:67 through R.S. 40:71 as amended and reenacted by Act No. 776 of 1979.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:32, R.S. 40:33, R.S. 40:59, R.S. 40:60, R.S. 40:67, and R.S. 40:71.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§11117. Delayed Death Certificates

A. In instances where there exists no death certificate of record, of a death or stillbirth occurring in the state, the coroner or medical examiner, the funeral director, or the hospital or institution wherein the death occurred shall complete a certificate of death based on their records. Said certificate shall be accompanied by a letter attesting to the facts contained therein.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:33, R.S. 40:59, and R.S. 40:60.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§11119. Delayed Marriage Certificates

A. Orleans Parish Only

1. Marriage certificates of persons married in Louisiana are filed with the clerk of court in the parish where the marriage license was purchased, except in Orleans Parish, where the marriage certificates are filed with the Vital Records Registry of the Office of Preventive and Public Health Services of the state of Louisiana.

2. The state registrar shall not furnish applications or instructions unless he is satisfied that the applicant is the person who has no marriage certificate or record, or is a member of the immediate or surviving family of said person, or is named in a court proceeding as a member of the immediate or surviving family of said person. The credentials of an attorney at law authorized to practice in this state, together with a written declaration of the record in which he is interested, that he is a legal representative of one of the named parties at interest, shall constitute proof of a direct interest in the matter to warrant being furnished applications or further instructions.

3. In instances where there exists no marriage certificate of record the applicant shall bed instructed to contact the officiant of the marriage ceremony.

a. If the officiant is in possession of the original certificate, the Vital Records Registry may accept the certificate for delayed filing.

b. If the officiant is in possession of a duplicate of the original marriage certificate and he/she attests in writing to the facts of the marriage as contained therein, the Vital Records Registry shall issue another marriage license requiring only the medical certification of the parties in compliance with R.S. 9:241.

B. For parishes other than Orleans, contact the clerk of court for information or assistance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:241, R.S. 40:33, and R.S. 40:59-60.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 113. Incomplete or Incorrect Original Certificates

§11301. Birth Certificates

A. No certified copy of an original birth record that has been submitted for "registration" in the Vital Records Registry as defined in R.S 40:32 (1) shall be issued unless and until the said original birth record contains the information required by R.S. 40:34 A(1)(a) through (q), and as required by duly promulgated regulations relative thereto, including the following provisions.

1. If an original birth records is incomplete, incorrect or irregular, the state registrar shall attempt to have the problem resolved through the assistance of the local registrar in parishes other than Orleans, and in the interim period no certified copies of the document will be issued.

2. The provisions of R.S. 40:34 A(1)(a) relative to the child's surname appear to conflict with similar provisions in R.S. 40:42 A. To resolve this apparent conflict, the provisions of R.S. 40:34 A(1)(h), which specifically address the "full name of the father" shall only mean the legal husband of the mother of the child at the time of either conception or birth. It shall also include the name of the husband of the mother of the child, who although divorced from her at the time of the birth, was not legally divorced from the mother of the child more than 300 days prior to the birth of the child. This interpretation conforms fully with Louisiana substantive law, La. Civil Code arts. 179, 184 and 185.

a. It likewise follows that the "legal husband of the mother of the child's" age, race, residence and birthplace shall be entered on the birth certificate pursuant to R.S. 40:34 A(1)(j), (k), (1) and (m); and also that his surname shall be entered as the child's surname pursuant to R. S. 40:34 A(1)(a).

3. In addition to the minimum required information set forth in R.S. 40:34 A(1)(a) through (q), the birth certificate form also requires the signature of a legal parent of the child, or the signature of some "other informant," certifying that the stated information is true and correct to the best of his or her knowledge. Should the document not be signed, no certified copy shall be issued as provided therein above.

AUTHORITY NOTE: Promulgated in accordance with La. Civil Code Arts. 179, 184, 185; R.S. 40:32, R.S. 40:33, R.S. 40:34, R.S. 40:38, and R.S.40:42.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 115. Acknowledgments

§11501. Acknowledgment of Paternity

A. Introduction

1. All documents submitted to accomplish changes on a birth certificate as a result of acknowledgement of paternity of judgments of filiation shall be either the original or certified true copies of the original instruments bearing an official seal. All documents submitted shall be retained by the state registrar.

2. Certificates of live birth, new or altered as a consequence of an act of acknowledgement of a filiation judgment shall be distinctly marked "acknowledgement" or "filiation judgment" in the confidential section and shall include the evidentiary basis for the action, the date of the action, and the full signature of the state registrar or his designee.

3. A birth certificate which bears a father's surname and data shall only be altered when there has been a successful disavowal of paternity by the father or heirs in accordance with Codal Articles 187 and 190 within the time specified by Codal article 189. When such a disavowal cannot be obtained, it is suggested that an adoption be considered.

B. Voluntary Acknowledgement of Paternity—Minors

1. In circumstances wherein the birth certificate of a child on file in the Vital Records Registry does not reflect the name of a father, the certificate may be altered by an authentic act of acknowledgement in compliance with the provisions of Louisiana Civil Code, Article 203.

2. The state registrar of vital records shall recognize formal and authentic acts of acknowledgement executed before the notary public, by the father and the mother jointly in the presence of two competent witnesses; when the mother is unable to appear before a notary public, the registrar shall recognize a formal and authentic act of acknowledgement executed by the father before a notary public and two competent witnesses which has been endorsed by the mother in the presence of two competent witnesses signifying that the mother concurs. An acknowledgment by the child's mother or father alone, while authorized pursuant to Article 203, shall have no effect on the birth record. In other words, the child's mother or father, acting alone, may not cause a father's name or data to be added onto a birth record.

3. The act of acknowledgement shall set forth the acknowledging father's address and full name, city and state of birth, age at the time of the child's birth, and the father's race. In the event that the above information relating to the child's father is not a part of the authentic act itself, that information may be otherwise provided in writing by the acknowledging parent(s) or an attorney acting on his or their behalf.

4. The surname of the child that the parents desire appear on the birth certificate shall be specifically included

in the acknowledgement of paternity. The surname may be either the maiden name of the mother, the surname of the biological father or a hyphenated combination of the two surnames in the order specified by the parents.

5. After a birth record has been filed and registered in the vital records registry and upon presentation of an act of acknowledgement and parental information, the state registrar or his designee shall prepare a new certificate of live birth for the child incorporating the specified birth facts. The biological father shall sign the new certificate. The date of the informant's signature shall be left blank on the certificate of live birth. The mother's signature shall be obtained if the father is not available. If neither are available, the state registrar is authorized to sign for the parents.

6. Except in instances of "in-hospital" acknowledgements, when the attendant's name is not legible on the original certificate of live birth, it shall be the responsibility of the parents to obtain a written, signed statement from the attendant attesting to his attendance at the birth. When such a signed statement cannot be obtained from the attendant, the statement may be obtained from the administrator of the medical institution where the birth occurred or his designee on the letterhead of that institution. The name of the attendant shall be typed on the certificate of live birth along with the date of the attendant's signature as it appeared on the original birth document.

7. No alterations of birth data other than the child's surname, and the data relative to the biological father may occur based on an act of acknowledgement.

8. The fee specified for an acknowledgement [see R.S. 40:40 (8)] shall be applicable for this transaction as shall the statutory issuance fee [see R.S. 40:40 (11)] for any copies of the revised certificate of live birth desired by the parents.

C. Obtaining a New Certificate of Live Birth on an Old Acknowledgment of Paternity for those Persons who have not Reached the Age of Majority

1. The mother or father of a child who was acknowledged prior to the effective date of this rule may formally request that a new certificate of live birth be issued. Provided that the acknowledgement documents on file are in proper order as specified in paragraph A.1 above and the information regarding the attendant is provided, a new certificate may be issued. Any deviation from the surname of the child as it appears on the certificate of live birth already on file shall be in accordance with the naming process outlined above and shall require and affidavit in which the mother and biological father concur in the revised surname.

2. The fee specified for a certificate of live birth correction [see R.S.40:40(10)] shall be applicable for this transaction as shall the statutory issuance fee [see R.S. 40:40(11)] for any copies of the revised certificate of live birth desired by the parents.

E. Acknowledgement of Paternity of Persons who have Reached the Age of Majority

1. If at the time of acknowledgement of paternity, or judgment of paternity or filiation the registrant shall have reached the age of majority, the state registrar shall require an affidavit(s) to be obtained from the district attorney(s) of the place (s) of residence and domicile of the said person for the past five years, wherein the district attorney(s) shall state objections, if any exist, to the name change aspects, prior to the preparation of the altered of new certificate of live birth. If there is an objection, the state registrar may not proceed with the alteration or new certificate until the distric attorneys' objections, if any, have been resolved.

AUTHORITY NOTE: Promulgated in accordance with La. Civil Code Art. 203; R. S.40:32, R.S. 40:33, R. S. 40:46, and R.S.40:59-60.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended LR 15:273 (April 1989).

§11503. Legitimation

A. Except as herein provided in these rules and regulations, a legitimation of an illegitimate child pursuant to Article 198 of the Louisiana Civil Code may result in the sealing of the registrant's original certificate of birth and the issuance of a new certificate of birth in the new name of the registrant wherein the registrant's surname shall be that of his father, only if the provisions of R.S. 40:46 have been met along with payment of the required fee(s) as set forth in R. S. 40:40.

1. As provided in R.S. 40:46A, a new certificate may be issued only if both parents had been free of any impediments and could have married each other at the time of the child's conception, in accordance with the laws of Louisiana in existence at the time of the child's conception.

2. In circumstances wherein both parents had been free to marry each other and who later do marry but without a formal act of legitimation, and due to the death of one or both parents only informal acknowledgment material is available, a court order will be required before a new certificate may be issued, since neither the state registrar nor the personnel under his supervision in the Vital Records Registry is empowered to adjudicate such a status determination when only informal means of acknowledgment are available.

3. In circumstances where the parents were not free to marry each other at the time of the subject child's conception, and where the parents have later married, if a new certificate is desired, an adoption procedure is recommended. In the alternative, a mandamus proceeding may be brought against the state registrar at the domicile of the Vital Records Registry in an effort to compel the issuance of a new certificate.

B. In circumstances involving an Act of Legitimation pursuant to Article 200 of the Louisiana Civil Code wherein the parents had no impediments to their marriage to each other and where neither parent had any legitimate descendants at the time of the conception and/or legitimation of the subject child by an Act of Legitimation (i.e., the said

parents do not later marry), and where the child's original certificate of birth has been registered in accordance with R.S. 40:34 (1) (a) in the surname the same as the mother's maiden surname, nd no name of the father appears on the certificate, the said original certificate birth may be altered in the manner and respects as follows:

1. If only the child's mother "legitimates" the child in accordance with Article 200 of the Louisiana Civil Code, the original certificate will be stamped altered with the date of the alteration, along with an inscription of the words "Act of Legitimation by Mother" together with its date on the face of the original certificate. In such case no further alteration may be made. The Vital Records Registry, however, will retain a certified copy of the "Act of Legitimation" in its archives.

2. In circumstances wherein the father along has executed an "Act of Legitimation," the word altered and the date of the same will be stamped and inscribed on the face of the original certificate, along with the words "Act of Legitimation by Father" and the date of same. The original certificate will be further amended by inserting the father's name, place of birth, in the standard spaces provided for this information on the original certificate. The child's surname will be "lined out" and the father's surname inscribed above it.

3. In circumstances where both parents jointly execute an "Act of Legitimation," the word altered will be stamped along with the date of the alteration, and the words "Act of Legitimation by Father and Mother" will be inscribed on the face of the original certificate. In addition, the father's name, etc., will be added and the child's surname changed to that of the father, in similar fashion as above described.

4. In each of the above mentioned circumstances pertaining to an "Act of Legitimation," the provisions of R.S. 9:391 applies, i.e., there must have been no legal impediments to the marriage of the father and mother in existence at the time of the conception of the child.

C. In circumstances where a subject child's original certificate of birth on its face reflects that the child has a legitimate status, i.e., in instances where the child's birth was registered in the surname of the legal husband of the child's mother at the time of conception, and where the legal husband's name appears on the said original certificate as legal father of the child, a court order will be required to determine the child's status before any alteration will be made. Since the child in such an instance appears to have a legitimate status, it follows that Article 198 of the Louisiana Civil Code does not apply, since it applies only to illegitimate children. Like-wise, Article 200 of the Louisiana Civil Code would not apply, since there was an impediment to the marriage between the alleged biological father and the child's mother at the time of the child's conception. Thus where the biological parents have later married each other, it is again recommended that the subject child be adopted, especially if a new certificate is desired.

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:391, R.S. 43:33, and La. Civ. Code, Art 198,200.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 117. Availability of Records

§11701. Free Services to Public Bodies

A. As used in R.S. 40:40(13) public bodies include the state of Louisiana, agencies of the state of Louisiana, the United States government, agencies of the United States government, the individual states of the United States, agencies of the individual states of the United States and law enforcement bodies.

B. To protect the integrity of vital records and ensure their proper use the state registrar of vital records may disclose information in accordance with the following:

1. Components of the Office of Preventive and Public Health Services of the Department of Health and Human Resources may have access to vital records information without charge. Vital records information shall be provided, without charge and without a signed release, to the state health officer or his designee, in accordance with the provisions of R. S. 40:5.

2. Other offices of the Department of Health and Human Resources may be provided certified copies of vital records without charge upon presentation of proof of custody or a release signed by the interested party as described in R.S. 40:41(C).

3. Federal, state and local bodies of government may be provided vital records information without charge, when requested in the conduct of their official duties for purposes of law enforcement and criminal investigation, as deemed appropriate by the state registrar of vital records.

4. Federal, state and local bodies, not specifically addressed in this rule, shall be required to submit the fee prescribed by R. S. 40:40 and a release form signed by the party at interest as described in R.S. 40:41(C).

5. Nothing in this rule shall be construed to permit disclosure of information contained in the "Confidential Information for Medical and Health Use Only" section of the certificate unless specifically authorized by the state registrar.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5, R.S. 40:32, R.S. 40:33, R.S. 40:40, and R.S. 40:41.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§11703. Loan of Birth Rosters

A. To protect the integrity of vital records and ensure their proper use, the state registrar of vital records shall disclose information in accordance with the provisions set forth as follows:

1. All birth rosters released to city and parish supervisors of child welfare and attendance shall remain the property of the Vital Records Registry.

2. The rosters shall be requested in writing by the supervisor charged with enforcing school attendance and that person shall be responsible for the roster while it is in his/her custody, the Vital Records Registry shall be notified when a change in the supervision occurs.

3. The rosters shall retain the seal of confidentiality while in the custody of supervisors and shall not be considered public records under R. S.44:1 et seq.

4. The rosters are not transferable, shall not be duplicated and shall

be utilized only for administrative purposes; they shall not be divulged or shared with any other person or city or parish entity, public or private.

5. Annual rosters will be available beginning May 1, 1986, reflecting calendar year 1985 with subsequent rosters becoming obtainable May 1 of each year thereafter.

6. Upon completion of enforcement procedures, the rosters shall be returned to the Vital Records Registry.

7. Recipients of the roster shall sign an agreement holding Department of Health and Human Resources, Office of Preventive and Public Health Services harmless for any breach in confidentiality set forth herein above.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:33, and R.S. 40:41.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§11705. Orleans Parish Marriage Records

A. Pursuant to R.S. 40:41C, persons seeking to obtain copies of Orleans parish marriage records, which are the only marriage records on file in the Vital Records Registry, are not required to demonstrate a tangible interest; however, space, personnel, and equipment limitations and the fragile conditions of many of these records make direct access to the document impractical. The questor shall provide the names of the bride and groom and date of the marriage, thereby enabling registry staff to retrieve and certify a copy. The fee set forth in R.S. 40:40 is applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:30, R.S. 40:41 (C), and R.S. 40:40.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§11707. Copies of Certified Records

A. Certified Records through the Mail. Certified copies of records in the custody of the state registrar may be purchased by writing to Vital Records Registry, Box 60630, New Orleans, LA 70160. Release of these records is possible when the requirements as set forth in R.S. 40:32 et seq. are met. When writing the requestor shall:

1. indicate his/her relationship to the person named in the document;

2. provide the necessary identifying information to enable vital records personnel to locate the document:

a. births—fee as mandated by the Louisiana Revised Statutes:

i. name of registrant;

ii. date;

iii. city or parish of birth;

iv. maiden name of mother;

v. name of father;

b. deaths—fee as mandated by the Louisiana Revised Statutes:

i. name of deceased;

ii date of death;

iii. city or parish of death;

c. marriage—fee as mandated by the Louisiana Revised Statutes:

NOTE: Only records pertaining to a license purchased in Orleans parish are available through the registry. In all parishes, except Orleans, certified copies of marriage certificates may be obtained from the clerk of court in the parish of license purchase.

i. name of bride;

ii. name of groom;

iii. date of marriage.

d. Payment must be made either by check or money order. The registry cannot accept responsibility for cash sent through the mails.

B. Certified Records at the Service Counter. Certified copies may be purchased by the requestor appearing in person at Room 103, 325 Loyola Avenue, New Orleans, LA, between the hours of 8:15 a.m. and 4 p.m. Monday through Fridays (excluding holidays). The requestor must complete a form supplying the pertinent information enumerated in Paragraph A.2, sign the application form, supply identification in accordance with posted identification requirements and pay the collectible fee as set forth in the Louisiana Revised Statutes. The requestor may purchase a certified copy of his/her birth certificate a the service counter by submitting a completed affidavit of identity, a confirmation of identity statement, and payment of the collectable fee as set forth in the Louisiana Revised Statutes. Payment must be made in cash, check, or money order.

1. Definitions. As used in this Section, the following terms shall have the meaning s ascribed to them in this Paragraph unless otherwise provided for or unless the context otherwise indicates:

a. Affidavit of Identity—a notarizes affidavit executed by the requestor of a certified copy of that person's birth certificate.

b. Confirmation of Identity Statement—a signed and dated written statement executed by an authorized individual of a qualifying organization on behalf of the requestor of a certified copy of the requestor's birth certificate.

c. Displaced Person—a person who is experiencing disruptive life circumstances, such as homelessness that may have caused the person to be without the documents or resources necessary to obtain identification.

d. Registrar—the state registrar of vital records.

e. Requestor—means the person requesting a certified copy f his or her birth certificate.

f. Qualifying Organization—any organization, association, corporation, coalition, confederation, company, business, alliance, establishment, enterprise, firm, club league, lodge, order, fellowship, fraternity, brotherhood, union, society, group, government entity, or other similar body that has met the requirements set forth in this rule for proper registration with the vital records registry.

2. Issuance of Birth Certificates. The registrar of vital records shall issue a certified copy of a birth certificate to a displaced person pursuant to this rule upon receiving an affidavit of identity fro the displace person accompanies by a confirmation of identity statement from a qualifying organization and upon payment of the required fees.

3. Affidavit of Identity

a. The affidavit shall be executed by the requestor before a notary public.

b. the affidavit shall include the following information insofar as known to the requestor:

i. the requestor's full legal name;

ii. the requestor's date of birth including the year, the month, and the day;

iii. the requestor's sex;

iv. the requestor's race;

v. the requestor's parish and/or city of birth, if known;

vii. the mother's maiden name, her parish, and/or city of birth, if known;

vii. the affidavit of identity should be in substantially the following form or in conformance herewith:

AFFIDAVIT OF IDENTITY

STATE OF LOUISIANA

PARISH OF_____

BEFORE ME, the undersigned notary, duly qualified, personally cam and appeared _____who, being by me first duly sworn, deposed and said that:

My full legal name is _____, I was born on the _____day of_____, 19_____, in _____ Parish/City. My mother's maiden name was _____ and she born in _____ Parish/City. The information contained within this affidavit is truthful and accurate to the best of my knowledge and belief.

_____

SIGNATURE OF AFFIANT

SWORN TO AND SUBSCRIBED BEFORE ME, this _____ day of _____, 19_____,

_____

NOTARY PUBLIC

d. The vital records registry will produce and maintain a supply of blank affidavit of identity forms. They will be made available upon request of requestors of certified copies of birth certificates and qualifying organizations free of charge.

e. Improperly executed defective, or suspect affidavits may be rejected by the registrar.

f. The affidavit of identity must be accompanied by a confirmation of identity statement from a qualifying organization.

4. Confirmation of Identity Statement

a. The confirmation of identity statement must be a written, data, and signed statement from a qualifying organization completed on behalf of a displaced person and must sufficiently identify the displaced person.

b. The confirmation of identity statement shall include the following information:

i. the name of the qualifying organization;

ii. the name of the agent of individual of the qualifying organization, or his designee, executing the confirmation of identity statement and the agent's capacity with the organization.

iii. the location of the qualifying organization and the mailing address, if different;

iv. the telephone number of the qualifying organization;

v. the name and sex of the requestor on whose behalf the confirmation of identity statement is being written;

vi. a statement attesting to the fact that the qualifying organization is properly registered with the Vital records Registry;

vii. a statement attesting to the fact that the qualifying organization has had a sufficient on-going relationship with the requestor to establish the reliability of the requestor's identity with the qualifying organization.

c. The confirmation of identity statement should be in substantially the following form or in conformance therewith:

CONFIRMATION OF IDENTITY STATEMENT

TO: Registrar of Vital Records

FROM: (Name of qualifying organization)

DATE: (Date of execution of statement)

I have been designated by _____ (QUALIFYING ORGANIZATION), _____(STREET ADDRESS), _____(CITY), Louisiana, _____(ZIP CODE), ____-_____ (TELEPHONE NUMBER), to execute this statement on behalf of _____ (REQUESTOR'S NAME).

MR./Mrs./Ms. _____ (REQUESTOR'S NAME), has had a sufficient on-going relationship with the _____(QUALIFYING ORGANIZATION) to establish identity.

(Additional relevant information may be included).

_____ (AGENTS'S SIGNATURE)

_____ (POSITION WITH QUALIFYING ORGANIZATION)

d. If the confirmation of identity statement is written on the qualifying organization's letterhead or stationery, the required information contained on the letterhead or stationery need not be duplicated within the text of the statement.

e. The individual executing the confirmation of identity statement must have a signature on file with the Vital Records Registry.

f. Improperly executed, defective, or suspect confirmation of identity statements may be rejected by the registrar.

g. A confirmation of identity statement executed in good faith by a qualifying organization shall not subject the qualifying organization to any sanction or liability.

5. Qualifying Organization—Criteria

a. To be recognized as a qualifying organization by the Vital Records Registry an organization must:

i. provide some type of service, assistance, aid, help, or support to displaced persons;

ii. submit a completed qualifying organization registration application to the office of vital records;

iii. be approved by the registrar of vital records.

6. Registration Requirements. An organization seeking qualification shall provide the Vital Records Registry with the following information.

a. Documents that prove its existence, such as articles of incorporation, articles of partnership, articles of association bylaws, federal or state income tax returns, tax exempt status, bank accounts, letterhead or stationery, or any other such documentation that the registrar deems acceptable.

b. The street address of the organization and its mailing address, if different

c. The telephone number of the organization.

d. The name and position of any designees authorized to execute confirmation of identity statements on behalf of the qualifying organization.

e. Signatures of the designees.

f. A concise statement of the goals or purposes of the organization and how they relate to the needs of displaced persons.

7. Registration Procedure

a. Upon receipt of a properly completed application the registrar shall have up to 20 days to approve or disapprove the application.

b. If incomplete, the application shall be returned with a list of deficiencies and notice that the organization may resubmit the application for further consideration.

c. An organization shall be notified in writing of the registrar's decision. If disapproved, the registrar shall state the reasons for disapproval.

d. The registrar, at his discretion, may reconsider a disapproved application upon the submission of additional information by the organization.

e. An organization may not submit more than one additional application within 180 days from the date of the disapproved application.

f. The Vital Records Registry shall produce and maintain a supply of qualifying organization application forms The forms shall be made available upon request free of charge to any organization seeking to become a qualifying organization.

g. The qualifying organization application shall be in substantially the following form or in conformance therewith:

APPLICATION FOR REGISTRATION AS A QUALIFYING ORGANIZATION

_____, 19_____

Org. Name

Org. Address

Mailing Address

If Different

Org. Phone #

Documentation of Existence

1.

(List Type & Attach Copies)
2.
3.

Name, Signature, and Position of Person(s) Authorized to Execute Confirmation of Identity Statements

NAME: POSITION:

SIGNATURE:

NAME: POSITION:

SIGNATURE:

NAME: POSITION:

SIGNATURE:

Concise Description of Org. Goals/Purposes:

Signature of Person Completing

Form for Qualifying Organization:

****

DO NOT WRITE BELOW THIS LINE

( ) Approved ( ) Disapproved

Date: , 19

Signature of

Registrar:

h. The Vital Records Registry shall maintain a registry of qualifying organizations whose applications for registration have been accepted pursuant to this rule

i. The qualifying organization shall keep its application current by submitting to the registrar any changes of information.

8. Penalties

a. Any improper action, misuse, fraud, misrepresentation, or deceit on the part of a qualified organization may result in the revocation of its registration. A revoked application shall be so noted and placed in the disapproved file.

b. Any suspected unlawful activity shall be reported to the appropriate police agency or district attorney's office for investigation and possible prosecution.

9. Payment of Fees

a. The Vital Records Registry shall accept the checks of qualified organizations for the payment of fees provided that the qualifying organization has supplied documentation of a checking account with an in-state bank.

b. A returned check may subject the qualifying organization to revocation of its check payment privileges, revocation of its registration as a qualifying organization, or both.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:33C.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended LR 15:473 (June 1989), LR 17:377 (April 1991).

§11709. Use of Vital Records in Research

A. Definitions

Department—Department of Health and Hospitals

Human Subject—A person to whom the record pertains or his next of kin as described in R.S. 40:41(C).

Limited Research—The investigator or researcher provides the name, date and place of birth/death for all requests and assures that no contact with the subjects or subjects' families will occur.

Panel—Refers to Vital Records Review Panel consisting of the state health officer, the state registrar of vital records and the tumor registry administrator as described in R.S. 40:41(D), along with a representative from Louisiana State University Medical School-New Orleans and a representative from Tulane University Medical School.

Research—A systematic epidemiological and/or public health investigation designed to develop or contribute to medical knowledge.

B. Panel

1. Panel Members. The state health officer, the state registrar, and the tumor registry administrator form the nucleus of the panel and shall be called "Class A" members. One representative each from Louisiana State University, New Orleans and Tulane Medical Schools will be appointed for two-year terms by medical schools and shall be called "Class B" members. The state health officer may also appoint resource persons, who are not necessarily employed by the department to attend panel meetings and review proposals. These resource persons shall be called "Class C" members.

2. Panel Quorum. A quorum shall require the presence of two Class A members and one additional member from either Class A or Class B. Only Class A and Class B members may vote. A majority of the voting members present must concur via roll call vote for the panel to take action on the approval or disapproval of any application.

C. Public Health Research

1. Panel Records. Adequate documentation of the panel activities shall be maintained including the following:

a. copies of all research proposals reviewed, including attachments;

b. minutes of all panel meetings shall be in sufficient detail to show attendance at meetings, actions taken by the panel, the vote on the actions including the number of members voting for, against or abstaining, the basis for requiring changes in or disapproving research, and a written summary of controversial issues and their resolution;

c. copies of all correspondence;

d. the records required by these rules shall be retained for at least three years after completion of the research.

2. Application. A request for the use of vital records for research shall be in writing and shall be addressed to the State Registrar of Vital Records. The data request must include:

a. a complete experimental protocol including public health objectives, rationale for the study, design detail and scientific basis for selection of subjects;

b. a summary of the protocol;

c. a copy of the informed consent form and an outline of the consent process which meets the consent requirements described in these rules, as provided in Paragraph C.4;

d. provisions to protect the confidentiality of the data and the privacy of the subjects and their families;

e. resumes of all investigations, listing educational degrees and societies, certifying boards and academic institutions which have recognized their competence by granting membership, diplomate, or title, previous work in the subject area and employment;

f. approval from an institutional review board for this study or approval from and educational department chairman where the applicant is employed by or associated with an institution which requires such approval;

g. affirmation that a report of the findings resulting from the sue of the records shall be provided to the state health officer;

h. a signed agreement to indemnify and hold the department and its employees harmless from any liability arising out of authorized or unauthorized access to the vital records.

3. Confidentiality. The researcher must establish reasonable administrative, technical and physical safeguards to prevent unauthorized use or disclosure of the records. Information that allows the individual to be indentified must be removed or destroyed at the earliest time which is consistent with the purpose of the project.

4. Informed Consent

a. The following elements of informed consent must be provided to each subject when the research design calls for personal contact or other follow-up:

i. a statement that the study involves research, an explanation of the purpose of the research, the expected duration of the subject's participation, and a description of the procedure to be followed;

ii. a statement describing the extent to which confidentiality of records identifying the subject will be maintained;

iii. a statement describing the extent to which confidentiality of records identifying the subject will be maintained;

iv. an explanation of whom to contact for answers to pertinent questions about the research and the rights of the subject;

v. a statement that participation is voluntary. Refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled. The subject may discontinue participation at any time without penalty.

b. An investigator shall seek the consent of the subject under circumstances that provide sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence.

c. The information that is given shall be in language understandable to the subject.

d. In obtaining informed consent, no exculpatory language through which the subject is made to waive or appear to waive any of the subject's legal rights, or releases or appears to release the investigator or the sponsor from liability for negligence shall be used.

e. A written document embodying the elements of informed consent as described above must be signed by each subject. The original shall be retained by the investigator's research.

5. Criteria for Approval of Research. The following shall be the criteria for the approval of research.

a. The study objective and design reflect that the proposal is in the best interest of the public health.

b. The selection of subjects is made on a scientific basis.

c. The investigators/researchers are deemed qualified based on their past research, employment and education.

d. Where appropriate, as provided in Subparagraph C.2.f, approval of an institutional review board has been obtained.

e. Provisions to protect the confidentiality of the data and the subjects comply with Paragraph C.4.

f. The informed consent process and forms, follow the guidelines required in these rules and will be appropriately documented as required.

6. Notification. The panel shall notify requestors in writing of the decision to approve or disapprove the proposed study or of modifications required to secure approval of the research activity. If the committee disapproves a request, it shall include in its written notification a statement of the reasons for tits decision and give the investigator/researcher and opportunity to request reconsideration in writing.

7. Requests for Reconsideration. Requests for reconsideration must be field within 30 days of the date appearing on the notification. The principal investigator/researcher may be invited to appear at the hearing. The decision of the committee after reconsideration is final.

8. Fees. Fess for copies of certificates will be the same as those set forth in R.S. 40:40. The cost per reel for computer tape with no accompanying certificates will be $100.

9. Exception to Approval Process. Requests for vital records information may be approved by the state health officer or a duly authorized representative without being presented to the panel if the request is for a limited research and the investigator/researcher provides the name, date, and place of birth/death for all requests. An affidavit stating that no family members will be contacted and that stringent confidentiality procedures will be followed to protect the data and the privacy of the subject must be submitted. A signed hold harmless agreement and a description of the research design must be submitted. A signed hold harmless agreement and a description of the research design must be submitted.

AUTHORITY NOTE: Promulgate in accordance with R.S. 40:33(C) and 40:41(D)(1).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Health Services, LR 10:465 (June 1984), amended in the repromulgation by the Department of Health and Human Resource, Office of Preventive and Health Services, LR 13:246 (April 1987), revised and repromulgated by the Department of Health and Hospitals, LR 15:475 (June 1989).

§11711. Issuance of Certified Copies of Vital Records, Clerks of District Court

A. Access to Vital Records Registry Database

1. The state registrar of vital records shall facilitate online computer access by the clerk of district court in each parish to birth and death databases via the data network operated by the office of the Secretary of State to the extent necessary to identify and electronically print certified copies of birth and death certificates. The registrar shall provide a system inquiry interface including print functionality for those birth and death records that can be printed electronically. Access shall be limited to those records that can be electronically issued to the extent necessary to serve authorized customers.

2. The state registrar shall assign vital records system access to clerks of district courts and designated members of their staffs upon receipt of written applications accompanied by properly executed confidentiality forms. The application for system access and confidentiality assurances shall be made on forms supplied by the state registrar. The birth and death database access given to clerks of district courts shall be expanded in logical increments as the missing data fields required to electronically generate certified copies of birth and death records are added, or the images are stored and indexed making them accessible and printable, except that current records (new births and death certificates) shall be made accessible to clerks of district courts for issuance purposes 90 days after the date of the vital event provided they are available in suitable electronic format in the vital records registry database.

B. Vital Records Issuance Services

1. Clerks of district courts may issue birth abstracts (commonly called birth cards) on all birth events more than 90 days old but less than 101 years old, except in those instances where the birth record filed with the vital records registry is a delayed birth certificate (a record filed more than 12 years after birth), the birth is not registered, the certificate filed with the state is irregular or incomplete, or the birth data is not available electronically. In the case of delayed certificates of birth, no birth abstracts will be issued.

2. Clerks of district courts may issue electronic certified copies of long-form birth certificates for those birth events that are more than 90 days old and are available in long-form format in the birth database except in those instances where the birth is not registered, the certificate filed with the state is irregular or incomplete, or the birth data is not available electronically. As additional records become available, the registrar shall enable electronic issuance functionality over the data network of the Secretary of State.

3. Clerks of district courts may issue electronic certified copies of death certificates for those death events that are more than 90 days old and less than 51 years old except in those instances where the death is not registered, the certificate filed with the state is irregular or incomplete, or the death data is not available electronically. As additional records become available, the registrar shall enable electronic issuance functionality over the data network available through the office of the Secretary of State.

4. Government agencies including law enforcement agencies and courts shall be referred to the office of the registrar of vital records for document issuance and vital event verification services, unless the government agency presents a formal release bearing the original signature of the registrant or a member of the registrant's immediate family and pays the statutory document search/issuance fee.

5. In accordance with R.S. 40:39.1 C, certified copies of birth and death records issued through the offices of clerks of district courts shall be accepted as an original record for all legal purposes.

C. Security/Confidentiality

1. Clerks of district courts shall not issue notarized copies of birth or death certificates, nor shall clerks issue certified copies from any source other than the online service provided by the state registrar of vital records.

2. All certified copies of birth and death certificates issued by clerks of district courts shall be issued on security paper provided by the state registrar of vital records.

3. Birth and death certificate issuance services provided by clerks of district courts shall comply with the

provisions of R.S. 40:41C.(1) and (2) as they relate to persons authorized to purchase certificates. Applications for certified copies shall be made on standard forms provided or approved by the state registrar of vital records.

4. Clerks of district courts shall only issue certified copies of birth and death certificates to individuals who are authorized by law to receive the documents and who produce proper identification. For the purposes of birth and death certificate issuance, proper identification shall be the same identification criteria used in document issuance offices operated by the state registrar of vital records.

5. Access to the online vital records registry birth and death inquiry systems shall be limited to those individuals assigned user access by the state registrar of vital records.

6. Inquiries against the vital records registry online birth and death systems shall be limited to official inquiries substantiated by a document application form signed by an authorized customer. The statutory fee shall be assessed for each inquiry. The fee is not subject to waiver or refund. No other inquires against the birth/death database are authorized or allowed. In those instances where the birth or death record is not indexed on the computer, the clerk shall so notify the customer and shall refer the inquiry to the state registrar of vital records for further investigation.

7. Access to vital records registry security document issuance paper shall be strictly controlled, and the paper shall be stored under lock when not in use. Any loss or theft of security document issuance paper shall be immediately reported to the state registrar.

D. Customer Service Documentation/Retention of Records/Audits

1. Document application forms submitted by customers shall be retained for not less than 3 years, and shall be made available to the registrar of vital records or his designee on request. A photocopy of the identification document(s) presented by the applicant shall be appended to the application form. Alternatively, the clerk may maintain a separate photographic file of the customer and the identification provided by the customer. The identification document must be legible in the photograph.

2. The clerk of court shall key the audit number of the document issuance paper (including voids) used in providing each customer service in the space provided on the research screen to enable the generation of an electronic audit/billing record.

3. The registrar of vital records or his designee shall periodically conduct a site visit and audit at each office where certified copies of birth/death certificates are issued to verify compliance with applicable laws and procedures.

E. Vital Records Issuance and Informational Supplies

1. The registrar of vital records shall supply security birth and death certificate issuance paper to clerks of district courts without charge.

2. The registrar of vital record shall supply document application forms and information sheets to clerks of district courts without charge.

3. Clerks of district courts shall order replacement supplies as necessary on forms provided by the state registrar.

F. Service Fees/Remittance to State Registrar

1. Clerks of district courts shall collect the fees specified in R.S. 40:39.1. As per R.S. 40:40(12), if there is no record on file, the fee shall be retained to cover the cost of the search.

2. The clerk shall remit to the state registrar the fees specified in R.S. 40:40 and the tax specified in R.S. 46:2403 for each certified copy of a vital record issued or searched.

3. On or before the second Friday of each month, the clerk shall submit a monthly report to the state registrar on forms provided by the registrar. The report shall summarize the number of birth and death record services provided during the prior month, the number of sheets of security paper voided, and the total amount of fees collected on behalf of the state registrar. All security document issuance paper voided during the prior calendar month shall be appended to the monthly report. As per R.S. 40:39.1B2, each clerk shall remit payment to the vital records registry on a monthly basis either directly or through the Office of the State Treasurer in a manner mutually agreeable to the clerk and the state registrar of vital records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:33 and 40:39.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Vital Records Registry, LR 26:1300 (June 2000).

Chapter 119. Vital Records Registrars

§11901. Local Registrars

A. Notice of Deaths Filed—Registrar of Voters

1. The first working day of each months the local registrar of vital records in which of the parishes of the state shall prepare on forms provided by the state registrar, in triplicate, by parish of residence of the decedents, separate lists of all the death certificates filed with the local registrar during the previous month.

2. Information included on the registrar of voters list shall be as a minimum the name of the decedent, date of death, address of the decedent and parish of residence. The list shall be mailed n the day competed to the local registrar of voters in the respective parishes of residence of the decedents.

B. Accurate and Complete Certificate of birth and Death. Local registrars of vital records shall not accept for filing or transmittal to the state registrar any certificate of live birth or death certificate until said certificate has been accurately and fully completed by the person preparing said certificate, whether it be a physician, funeral director or any other individual.

C. Local Registrars; Death Certificates; Certification; Fees

1. Local registrars, in accordance with law, may for ten days following the date of the acceptance of a certificate of death issue certified copies of the certificate over their signature and that of the state registrar. The certified copies shall be issued from the original certificate of a copy of the original in their possession. They shall collect the fee provided by law for each certified copy, shall maintain an accurate record of copies issued, to whom issued, and fees collected. Fees collected shall be promptly remitted in accordance with Office of Public Health policies and procedures. A summary of copies issued and fees collected shall be reported to the state registrar on forms provided by him.

2. Copies of said death certificates shall only be issued to those persons authorized by law to receive them. Copies of said certificates shall be requests in writing and the request form or letter shall bear the requestor's signature. The statutory fee shall be collected prior to the issuance of the certificates. If checks are tendered in payment of said fees, they shall bear the name, address, phone number and driver's license number or social security number of the person issuing the check; however, this provision shall be waived as to checks issue by funeral homes or directors.

3. Each working day, the local registrar shall promptly transmit to the state registrar by mail all copies of death certificates which have exceeded the 10-day holding period at the parish health unit and shall not thereafter retain or issue any copies or certified copies of said certificates. Thereafter, all copies of said death certificates shall remain in the possession of the state registrar, and he shall be the only person authorized to issue certified copies.

AUTHORITY NOTE: Promulgated in accordance with R. S. 40:32 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended LR 15:474 (June 1989).

§11903. State Registrar

A. Certified Copies of Death Certificates. The state registrar of vital records shall indicate on the original of each death certificate the date that said certificate is received in his office. The state registrar shall indicate by date stamp, the date requests for certified copies of death certificates are received in his office. The state registrar shall, within forty-eight hours, or two working days, process and mail certified copies of death certificates to fill requests received in his office.

AUTHORITY NOTE: Promulgated in accordance with R. S. 40:32 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 121. Birth Certification Cards

§12101. Birth Certification

A. The vital records registry of the Office of Preventive and Public Health Services of the Department of Health and Human Resources, upon receipt of written request for a certified copy of a birth certificate shall proceed to do so by preparing a birth certification card containing a true certification of name and birth facts as recorded on the registrant's original birth certificates, for a required fee to two dollars.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:33.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§12103. Preparation of Certificates

A. Section "This Child"

1. "Last Name" (Item 1A)
2. "First Name" (Item 1B)
3. "Second Name" (Item 1C)
4. "Date of Birth" (Item 2A)
5. "House of Birth" (Item 4)
6. "Sex" (Item 3)
7. "This Birth" (Item 4)
8. "If Twin or Triplet...." (Item 5)

B. Section "Place of Birth"

1. "Place of Birth" (Item 6A)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:33.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 123. Preparation of Certificates

§12301. Introduction

A. The certificate forms referenced in the following Sections of Chapter 123 are formally adopted. Only those forms prescribed and printed by the State Registrar shall be used for reporting births, deaths, marriages, divorces, stillbirths, abortions and for issuing burial transit permits. Forms shall be typewritten in black type or printed in permanent black ink.

B. If errors are made in preparation, a new document shall be prepared; erasures and the use of liquid paper shall not be permitted. Only those documents completed and executed properly shall be acceptable for registration and/or processing. Certificates deemed incomplete by the state registrar shall not be issued except for use in adoption

proceedings, upon subpoena or for use in criminal investigations or law enforcement activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:33, R.S. 40:49, and R.S. 40:54-56.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, LR 15:970 (November 1989).

§12303. Certificate of Live Birth Preparation (PHS 19)

A. Section—"This Child"

1. Last Name (Item 1A)

a. Enter the child's last, first, and middle names as required R.S. 40:34.

b. Enter the full name of the childe exactly as given by the parent(s).

c. Generation indicator's such as Jr. and II shall be entered immediately following the surname.

d. In the child is legitimate, the surname of the child shall be the surname of the husband of the mother if he was married to the mother of the child at the time of conception and the birth of the child or had not been legally divorced from the mother of the child for more than 300 days prior to the birth of the child, or , if both the mother and husband agree, the surname of the child may be the maiden name of the mother or a combination of the surname of the husband and the maiden name of the mother . Surnames which are combinations of the parents' names may be hyphenated or unhyphenated.

e. If the child is illegitimate, the surname of the child shall be that of the mother's maiden name, unless both the mother and biological father of the child consent to the use of the biological father's surname for the child, or, if both the mother and father agree, the surname of the biological father and the maiden name of the mother. In either case, the signature of the natural father shall be required on the original certificate of live birth in the space provided for the signature of the parent or other informant, and an authentic act of acknowledgement of paternity shall be executed by the father. The acknowledgement of paternity shall be executed after the birth of the child.

f. The original or certified copy of the authentic act of acknowledgement of paternity shall accompany the certificate of live birth to the local registrar. The act shall be executed by the father and shall be counter-signed by the mother in presence of two witnesses. The acknowledgement document shall include the name of the mother of the child, the date of birth of the child, the place of birth of the child, the full name of the child as agreed by the parents, the full name of the father of the child, the city and state of birth of the father of the child, and the date of birth of the father.

g. If the parents do not have a given name selected for the child, leave the item blank. Never enter "baby girl," or "infant boy." Certified copies of the birth certificate shall not be issued until the given name has been added to the certificate except as provide under §12301.

2. Date of Birth (Item 2A-Month, Day, and Year)

a. Enter the exact month, day, and year the child was born.

b. The names of the months may be entered in full or the following abbreviations may be used: Jan., Feb., Mar., Apr., Aug., Sept., Oct., Nov., and Dec. Always enter the complete spelling not to be used to indicate months in this date field.

c. consider a birth at midnight to have occurred at the end of the day rather than the beginning of the next day.

3. Hour of Birth (Item 2B)

a. Enter the hour of birth indicating a.m. or p.m. If the institution is on 24-hour or military time, the hour of birth may be so expressed. The a.m./p.m. indicator may be omitted for military time for 1300 hours and later. Any other omission of the indicator will result in the certificate being returned to the preparer for completion.

4. Sex (item 3)

a. Enter male or female. Do not abbreviate or use other symbols. In instances where sex is not readily determines, either sex of the child bases on the predominant indicator. If sex cannot be determined after verification with medical records, mother of the child, informants, or other sources, make no entry. Attach a note to the certificate stating the reason for omission.

b. Certified copies shall not be issued while Item 3 is blank except as provided under §12301.

5. Plurality (Item 4A – Specify Single, Twin, etc.). Enter the appropriate term.

6. Order (Item 4B – Specify Order). If not a single birth, enter "first born," "second," etc. If not applicable, enter "not applicable" or leave blank.

7. Birth Weight (Item 5). Enter the weight as shown in the hospital record, in either grams or pounds and ounces. Do not convert from one measure to the other. Specify the type of measure used (grams or pounds and ounces). Only the following standard abbreviations may be use: pounds = lbs., ounces=ozs., grams=gms.

B. Section "Place of Birth"

1. Place of Birth 9Item 6A—City, Town or Location). Enter the full name of the city, town, village, or location where the birth occurred. For births occurring on a moving conveyance, enter the city, town, village, or location where the child was first removed from the conveyance.

2. Parish of Birth (Item 6B)

a. Enter the name of the parish where the birth occurred. For births occurring on a moving conveyance, enter the parish where the child was first removed from the conveyance.

b. If the birth occurred on a moving conveyance in the United States and the child was first removed from the

conveyance in this state, complete a birth certificate showing eh place of birth as this state.

c. If the birth occurred on a moving conveyance in international waters, international airspace, or in a foreign country or its airspace, and the child was first removed from the conveyance in this state, complete a birth certificate in this state, but enter the actual place of birth insofar as can be determined.

3. Place of Birth (Item 6C—Specifiy). Enter the place where the birth occurred. A "birthing" center located in and operated by a hospital is considered part of the hospital and should be reported as occurring in the hospital. Freestanding birthing centers include those facilities that are operated independently from hospitals (autonomously). The "clinic/doctor's office" category includes other non-hospital out-patient facilities where births occasionally occur.

4. Name of Hospital or institution (Item 6D)

a. If the birth occurred in a hospital or institution, enter the full name of the facility where the birth occurred.

b. If the birth occurred at home, enter the full name of the facility to or on arrival at a facility where the birth occurred.

c. If the birth occurred at home, enter the house number and street name of the place where birth occurred.

d. If the birth occurred at some place other than those described above, enter the number and street name of the location.

e. If the birth occurred on a moving conveyance that was not en route to a facility, enter as the place of birth the address where the child was first removed from the conveyance.

5. Place of Birth Inside City Limits (Item 6E). Specify "yes" or "no."

C. Section—"Usual Residence of Mother." The mother's residence is the place where her household is located. This is not necessarily the same as her "home state," "voting residence," "mailing address," or "legal residence." The state, parish, city, and street address should be for the place where the mother actually lives. Never enter a temporary residence, such as one used during a visit, business trip, or vacation. Residence for a short time at the home of a relative, friend, or home for unwed mothers for the purpose of awaiting the birth of the child is considered temporary and should not be entered here. However, place of residence during a tour of military duty or during attendance at college is not considered temporary and should be entered on the certificate as the mother's place of residence. The address entered in 7A is the address used to query the mother if there is a need to contact her shortly after the birth.

1. Usual Residence of Mother (Item 7A). Enter the full name of the city, town, or location where the mother usually resides.

2. Parish (Item 7B). Enter the full name of the parish (county) of usually residence of the mother.

3. State (Item 7D). Enter the full name or standard abbreviation of the state in which the mother lives. This may direr from the state in her mailing address. If the mother is not U.S. resident, enter the name of the country and the name of the nearest unit of government that is the equivalent of a state.

4. Zip (Item 7D). Enter the Zip Code of the usual residence of the mother.

5. Street Address (Item 7E)

a. Enter the number and street name of the place where the mother lives. Although a post office box alone is not acceptable, a post office box may be entered in parentheses at the end of the street address.

b. If this location has no number and street name, enter the rural route number or a description of the place that will aid in identifying the precise location.

6. Is Residence in Inside City Limits (Item 7F). Enter "yes" or "no."

D. Section –"Father of Child"

1. Father's Last Name (Item 8A)

a. In general, if the child was:

i. born to a mother who was married at the time of birth, enter the name of her husband;

ii. conceived in wedlock, but born after a divorce was granted or after the husband died, type or print the name of the mother's deceased or divorced husband;

iii. conceived and born out of wedlock to a divorced, widowed, or never-married mother, make no entry regarding the father's name and omit items 8B, 8C, 8D, and 8E.

b. If the mother is unmarried and was not married at any time during the past 300 days, the child may be acknowledged at the time of birth by the biological father. If the acknowledgement is in proper from, the biological father's name may be entered in Item 1A on the birth certificate and items 8A, 8B, 8C, 8D, and 8E may be completed.

c. The surname of the father and the child are usually the same. When they are different, carefully review this information for compliance with state law and with the parent(s) to ensure that there is no mistake.

2. First Name (Item 8B). If the surname of the father was entered in 8A, enter the second name of the father. If the father does not have a second name, leave the space blank.

4. City and State of Birth (Item 8D)

a. If the surname of the father was entered in 8A, enter the city and state of birth.

b. If the father was born in the United States, enter the name of the state.

c. If the father was born in a foreign country or a U.S. territory, enter the name of the country or territory.

d. If the father was born in the United States, but he state is unknown, enter "U.S.—Unknown."

e. If the father was born in a foreign country, but the country in unknown, enter "Foreign—Unknown."

f. If no information is available regarding place of birth, enter "unknown." Do not leave this item blank.

5. Date of Birth (item 8E).

a. If the surname of the father was entered in 8A, enter the exact month, day, and year the father was born.

b. The following abbreviations may be used: Jan., Feb., Mar., Apr., Aug., Sept., Oct., Nov., and Dec. Enter the complete spelling for the months of May, June, and July.

E. Section—"Mother of Child"

1. Mother's Maiden Name (Item 9A). Type of print the last name of the mother as given at birth or adoption, not a name acquired by marriage.

2. First Name (Item 9B). Enter the first name of the mother.

3. Second Name (Item 9C). Enter the second name of the mother. If the mother has no second name, leave the item blank.

4. City and State of Birth (Item 9D)

a. Enter the city and state of birth.

b. If the mother was born in the United State, enter the name of the state.

c. If the mother was born in a foreign country of a U.S, territory, enter the name of the country or territory.

d. If the mother was born in the Unites State, but eh state is unknown, enter "U.S.–Unknown."

e. If the mother was born in a foreign country, but the country is unknown, enter "Foreign—Unknown."

f. If no information is available regarding place of birth, enter "Unknown." Do not leave this item blank.

5. Date of Birth (Item 9E)

a. Enter the exact month, day, and year that the mother was born.

b. The following abbreviations may be used: Jan., Feb., Mar., Apr., Aug., Sept., Oct., Nov., and Dec. Enter the complete spelling of May, June and July.

F. Section –"Informant's Certification"

1. Name of Informant (Item 10)

a. Obtain the signature of the informant. The signature shall be limited to the space provided. A person other than the mother or the father whose signature appears in this area shall check "other."

b. If the informant fails to sign, send a certified letter return receipt requested to the last known address of the mother requesting that she sign the certificate. If the mother fails to comply with the request within a reasonable period of time, transmit the unsigned certificate to the local registrar along with a copy of the letter and the "return receipt." The state registrar of vial records may, at his discretion, withhold issuance of certified copes of unsigned certificates.

c. If the mother is un married and an authentic act of acknowledgement has been executed by the father, the father shall sign the birth certificate as the informant in accordance with R.S. 40:34 (B)(1)(iv). Additionally, the mother shall initial item 10.

2. Date of Certification (Item 11). Enter in numeral form (e.g. 10/10/89 or 10-10-90 for October 10, 1989) the month day and year of the signature in Item 10.

3. Address of Informant (Item 12A). Enter the street address, rural route or otherwise indicate the residence of the person whose signature appears in the Item 10 above or the individual whose name has been entered as the informant. If the address is the same as the address information provided for the mother in items 7A-E, the entry in this item may be limited to the SIP code. If the information is an employee at the hospital or clinic where the delivery occurred, the address of that facility may be entered.

4. Relationship to Child (Item 12B). Enter the relationship of the person whose signature appears in Item 10 to the child whose name appears in Item 1A. If there is no relationship, enter "none."

G. Section –"Attendant"

1. Signature and Address of Attendant (item 13)

a. The person signing attests to the fact that he attended the birth and that the child was born alive at the place and time and on the date stated.

b. Obtain the signature of the physician or other person in attendance at the birth. Rubber stamps or other facsimile signatures are not permitted. The signature shall be in permanent, black ink and shall be confined to the space provided.

c. Signatures which overflow to adjoining blocks obscure other important information and interfere with any efforts to machine read birth data at a later date. Birth documents which contain such signatures may be returned to the hospital or other preparer to be properly prepared.

d. For births occurring in institutions, the administrator of the institution or his designee shall sign if the physician or other person in attendance is unable or unwilling to certify within 72 hours after the birth. In such instances the name of the physician or other person in attendance is unable or unwilling to certify within 72 hours after the birth. In such instances the name of the physician or other person who actually attended the delivery shall be typed or printed and the administrator or designee shall sign in black ink. For births occurring outside an institution, the midwife or other person managing the birth shall complete this item.

e. In all instances, check the appropriate box to identify the actual attendant's title. M.D.=doctor of medicine, D.O.=doctor of osteopathy, C.N.M.=certified nurse midwife. Lay midwives should be identified as "Other Midwife." If "Other (Specify)" is checked, type the title of the attendant on the line provided.

2. Date of Signature (Item 14). Enter the date in numeral form separated by slashes or dashes, or in alphabetic form.

H. Section—"Registrar's Certification." These items are to be completed only by the state registrar or his designee.

1. Date of Acceptance by Local Registrar (Item 15A.)

a. Enter the exact month, day, and year of acceptance.

b. The following abbreviations may be used: Jan., Feb., Mar., Apr., Aug., Sept., Oct., Nov., and (e.g. Dec. 1, 1989). Enter the complete names of the month for May, June, and July.

2. Signature of the Local Registrar (Item 15B.)

a. This item is signed by the local or state registrar when the certificate is filed.

b. The signature documents the fact that the certificate has been accepted by and filed with the registrar. If another person signs for the local registrar, that person shall write the registrar's name per his/her initials.

3. Date Filed by State Registrar (Item 15C.)

a. Enter date accepted in the Vital Records Registry.

b. The following abbreviations may be used: Jan., Feb., Mar., Apr., Aug., Sept., Oct., Nov., and (e.g. Dec. 1, 1989). Enter the complete names of the month for May, June, and July.

I. Section—"Social Security Number (Item 16)

1. Place a "x" in the "yes" or "no" block and sign. When this item is left blank, "no" will be assumed. Only a parents signature will be accepted in Item 16. When the "yes" block is checked and the item is properly signed, information may be released to the Social Security Administration to facilitate assigning a Social Security Number to the child.

2. Signatures which overflow to adjoining blocks obscure other important information and interfere with efforts to machine read birth date at a later date. Birth documents which contain such signatures may be returned to the hospital or other preparer to be properly prepared.

J. Section—"Origin, Race, and Education"

1. Hispanic Origin (Items 17A. and 17B.)

a. If the parents are not of Hispanic origin, indicate "no." If unknown, indicate "unknown." If a parent or both parents are Hispanic origin, specify.

b. "Hispanic" refers to those people whose origins are from Spain, Mexico, or the Spanish-speaking countries of Central or South America. Origin can be viewed as the ancestry, nationality, lineage, or country in which the person or his or her ancestors were born before their arrival in the United States.

c. There is no set rule as to how many generations are to be taken into account in determining Hispanic origin. A person may report Hispanic origin based on the country of origin of a parent, grandparent, or some far-removed ancestor. The response should reflect what the person considers himself or herself to be and is not based on percentages of ancestry. Although the prompts include the major Hispanic groups of Cuban, Mexican, and Puerto Rican, other Hispanic groups should also be identified in the space provided.

d. If a person indicates that he or she is a multiple Hispanic origin, enter the origins as reported (for example, Mexican-Puerto Rican).

e. If a person indicates that he or she is Mexican-American or Cuban-American, enter the Hispanic origin as stated.

f. This item is not a part of the Race item. A person of Hispanic origin may be of any race. Each question, Race and Hispanic origin, should be asked independently.

2. Race (Items 18A. and 18B.)

a. Enter the race of the mother and of the father as obtained from the parent(s) or other informant. This item shall be completed for the mother on all certificates but for the father only if a father's name appears in item 8A. The entry in this item shall reflect the response of the informant.

b. For Asians and Pacific Islanders, enter the national origin of the mother and father, such as Chinese, Japanese, Korean, Filipino, or Hawaiian.

c. If the informant indicates that the mother and/or father is of "mixed race," enter both races or ancestries.

3. Ages of Parents (Items 19A. and 19B.)

a. Enter the ages in years of the mother and the father at the date of birth of the child.

4. Education of Parents (Items 20A. 20B.)

a. Elementary/Secondary (0-12) - College (1-4 or 5+)

b. Enter the highest number of years of regular schooling completed by the mother and father in either the space for elementary/secondary school or the space for college. An entry should be made in only one of the spaces. The other space should be left blank. Report only those years of school that were completed. A person who enrolls in college but does not complete one full year should not be identified with any college education in this item.

K. Medical/Social History. Items 21 through 35 collect a medical/social history of the mother and the child. The information is collected for statistical analysis and public health planning. Upon acceptance of the Certificate of Live Birth, the medical/social history shall be key-punched and

the original medical history portion shall be severed from the remainder of the document and be destroyed.

1. Live Births Now Living (Item 21A.). Enter the number of children born live to the mother who were living at the time of the birth. Specify zero, "0", if none.

2. Live Births Now Dead (Item 21B.). Enter the number of children born live to this mother who were dead at the time of this birth. Specify zero, "0", if none.

3. Date of Last Live Birth (Item 21C.)

a. Enter the date (month and year) of birth of the last live-born child of the mother.

b. If this certificate is for the second birth of a twin set, enter the date of birth for the first baby of the set, if is was born alive. Similarly, for triplets or other multiple births, enter the date of birth of the set. If all previously born members of a multiple set were born dead, enter the date of the mother's last delivery that resulted in a live birth.

c. Enter "-," "Not applicable," or "None" if the mother has not had a previous live birth. Do not leave this item blank.

d. The following abbreviations may be used: Jan., Feb., Mar., Apr., Aug., Sept., Oct., Nov., and (e.g. Dec. 1, 1989). Enter the complete names of the month for May, June, and July.

4. Other Terminations (Items 21D. and 21E.)

a. Enter the number of fetuses that were delivered dead regardless of the length of gestation. Include each recognized loss of a product of conception, such as ectopic pregnancy, still-birth, and spontaneous or induced abortion.

b. Check "None" if this is the first pregnancy for this mother or if all previous pregnancies resulted in live-born infants.

c. Enter the date (month and year) of the last termination of pregnancy that was not a live birth regardless of the length of gestation.

d. If the mother has never had such a termination, enter "-," "Not applicable," or "None." Do not leave this item blank.

e. The following abbreviations may be used: Jan., Feb., Mar., Apr., Aug., Sept., Oct., Nov., and (e.g. Dec. 1, 1989). Enter the complete names of the month for May, June, and July.

f. If this certificate is for the second birth of a twin set and the first was born dead, enter the date of delivery of that fetus. Similarly, for other multiple births, if any previous member of the set was born dead, enter the date of delivery of that fetus. If all previously born members of a multiple set were born alive, enter the date of the mother's last delivery that resulted in a fetal death.

5. Mother Married? (Item 22). Enter "Yes" if the mother was married at the time of conception, at the time of birth, or at any time between conception and birth. Otherwise, enter "No." A woman is legally married even if she is separated. A person is no longer legally married when there is a signed divorce decree. If divorced or widowed, enter "no" in this space and the date of the divorce or death of the spouse in the left hand margin.

6. Date Last Normal Menses Began (Item 23). Enter the actual date that the last menses began. The following abbreviations may be used: Jan., Feb., Mar., Apr., Aug., Sept., Oct., Nov., and (e.g. Dec. 1, 1989). Enter the complete names of the month for May, June, and July.

7. Month of Pregnancy Prenatal Care Began (Item 24)

a. Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman.

b. The month of pregnancy in which prenatal care began is measured from the date the last normal menses began and not from the date of conception.

c. If prenatal care begins in the last month of pregnancy, enter "first" or "1." Similarly, enter "second" or "2" if prenatal care begins in the second month of pregnancy, etc. Enter "none" or "-" if the mother did not receive prenatal care. Never enter a named month. Such an entry is not responsive to the question.

8. Prenatal Visits-Total Number (Item 25). Enter the number of visits made for medical supervision of the pregnancy by a physician or other health care provider during the pregnancy. If no prenatal care was received, enter "None." If Item 24 is reported as "None," this item should also be completed as "None." Do not leave this item blank.

9. Clinical Estimate of Gestation (Item 26). Enter the length of gestation as estimated by the attendant. Do not compute this information from the date last normal menses began and date of birth. If the attendant has not done a clinical estimate of gestation, enter "None." Do not leave this item blank.

10. Apgar Score(Item 27A. and 27B.)

a. Enter the Apgar score (0 through 10) as assigned by the delivery room personnel one minute after birth in 27A.

b. Enter the Apgar score (0 through 10) as assigned by the delivery room personnel five minutes after birth in 27B.

11. Mother Transferred Prior to Delivery (Item 28A)

a. Specify "yes" or "no." If "yes," enter name of facility transferred from.

b. Indicate "no" if this is the first facility the mother was admitted to for delivery. Indicate "yes" if the mother was transferred from one facility to another facility before the child was delivered. If the mother was transferred more than once, enter the name of the last facility from which she was transferred.

12. Infant Transferred (Item 28B). Indicate "no" if the infant was not transferred to another facility. Indicate "yes"

if the infant was transferred from this facility to another facility after delivery. If the infant was transferred, enter the name of the facility the infant was transferred to. If the infant was transferred once, enter the name of the first facility to which the infant was transferred.

13. If delivery at Home-Intentional (Item 28C.). If delivery was at home, specify "yes" or "no." If delivery was not at home, specify "not applicable" or "NA."

14. Did Child Die at Facility (Item 29). Specify "yes" or "no."

15. Medical Risk Factors (Item 30A). Check each of the medical risk factors that the mother experienced during this pregnancy. If the mother experienced medical risk factor(s) not identified in the list for example, other infectious diseases, AIDS, or syphilis-check "Other" and enter the risk factor on the line provided. Medical risk factors should be identified from the hospital or physician record. If there were no medical risk factors, check "None." Do not leave this item blank.

16. Other Risk Factors (Item 30B.)

a. Complete each question/statement. Check "Yes" for tobacco use if the mother smoked tobacco at any time during the pregnancy. Check "No" if the mother did not smoke during the entire pregnancy. Also check "No" if a non-cigarette form of tobacco was used exclusively during the pregnancy. If "Yes" is checked, specify the average number of cigarettes the mother smoked per day during her pregnancy. If, on the average, she smoked less than one cigarette per day, enter "Less than one." If "No" is checked, do not make any entry on the line requesting the average number of cigarettes per day.

b. Check "Yes" for alcohol use if the mother consumed alcoholic beverages at any time during her pregnancy. Check "No" if the mother did not consume any alcoholic beverages during the entire pregnancy. If "Yes" is checked, specify the average number of drinks she consumed per week. One drink is equivalent to five ounces of wine, 12 ounces of beer, or one ounce of distilled liquor. If, on the average, she drank less than one drink per week, enter "Less than one." If "No" is checked, do not make any entry on the line requesting the average number of drinks per week.

c. Enter the amount of weight gained by the mother during the pregnancy in pounds. Do not enter the total weight of the mother. If no weight was gained, enter "None." If the mother lost weight during her pregnancy, enter the amount of weight lost (for example, "Lost 10 pounds). Do not leave this item blank.

d. Information for this item should be obtained from the mother's medical chart or the physician. If the medical chart is not available or does not include this information and the physician is unavailable, the informant should be asked to respond to these items.

17. Obstetrical Procedures (Item 31). Check each type of procedure that was used during this pregnancy. More than one procedure may be checked. If a procedure was used that is not identified in the list, check "Other" and specify the procedure on the line provided. If no procedures were used, check "None." Do not leave this item blank. This information should be obtained from the mother's medical chart or the physician.

18. Complications of Labor and/or Delivery (Item 32). Check each medical complication present during labor and/or delivery. If a complication was present that is not identified in the list, check "Other" and specify the complication on the line provided. If there were no complications, check "None." Do not leave this item blank. This information should be obtained from the mother's medical chart or the physician.

19. Method of Delivery (Item 33). Check the method of delivery of the child. If more than one method was used, check all methods that apply to this delivery. Do not leave this item blank. This information should be obtained from the mother's medical chart or the physician.

20. Abnormal Conditions of the Newborn (Item 34). Check each abnormal condition associated with the newborn infant. If more than one abnormal condition is present that is not identified in the list, check "Other" and specify the condition on the line provided. Do not leave this item blank. This information should be obtained from the mother's and infant's physicians or the medical records (obstetric and pediatric).

21. Congenital Anomalies of Child (Item 35). Check each anomaly of the child. Do not include birth injuries. The checklist of anomalies is grouped according to major body systems. If an anomaly is present that is not identified in the list, check "Other" and specify the anomaly on the line provided. Note that each group of system-related anomalies includes an "Other" category for anomalies related to that particular system. If there is a question as to whether the anomaly is related to a specific system, enter the description of the anomaly in "Other (Specify)" at the bottom of the list. If there are no congenital anomalies of the child, check "None." Do not leave this item blank. This information should be obtained from the mother's and infant's physicians or the medical records (obstetric and pediatric).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:33, R.S. 40:49, and R.S. 40:54-56.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, LR 15:971 (November 1989).

§12305. Requirements for Registration of Children Born Outside of Hospitals

A. In addition to requirements set forth in R. S. 40:45B, registration shall occur in the parish health unit with the person in attendance appearing in proper person.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:45 (B), and R.S. 36:258.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§12307. Certificate of Death Preparation

A. Section—Personal Data of Deceased

1. Last Name (Item 1A). Enter the surname of the deceased. Identifications, e.g., Jr. II, III, etc., shall appear immediately following and as a part of the surname. The surname of a married women may be either her maiden name or that of her husband.

2. First Name Enter the first name of the deceased.

3. Second Name Enter the second name of the deceased. If the name is not known or cannot be determined, enter "unknown".

4. Date of Death.

a. Enter the month, day and year using the following abbreviations: Jan., Feb., Mar., Apr., Aug., Sept., Oct., Nov., and Dec.

b. Enter the complete spelling for the months of May, June and July.

5. Hour of Death. Enter the hour of death indicating A.M. or P.M. If the institution operates on 24 hour or military time, the hour of death may be so expressed.

6. Sex Enter male or female.

7. Color or Race. Enter race as provided by informant, e.g., White, Black, American Indian (indicate tribe if known). For non-white groups other than black or American Indian, enter the national origin, e.g., Chinese, Japanese, Puerto Rican, etc. Generic designations of Oriental, Polynesian, European, etc., are not acceptable.

8. Marital Status Check the appropriate blank.

9. Surviving Spouse. If the decedent was legally married at death, enter the name (maiden name in the case of a widow) of the survivor. If the deceased was single at death, enter "none."

10. Date of Birth of Deceased. Enter the month, day and year per instructions for Item 2A. If the birthdays is not known, enter "unknown" in full. If the birth date represents an approximation, enter birth date as "Approx." then date, example—"Approx. Mar. 12, 1935."

11. Age of Deceased. Enter the age of the deceased in years, months and days. If the exact information is not known, enter an approximation of age. If the deceased was under 24 hours old, enter hours and minutes. Place dashes (-) in blocks that are not applicable.

12. Birthplace. Enter the city and state if full. If the deceased was born outside of the United States, enter the name of country in full.

13. Citizen of What Country. If the deceased was a citizen of the United States, enter "U.S.A." Enter the name of the country in full if deceased was not a citizen of the United States. If citizenship is not known, enter "unknown."

14. Usual Occupation. Notwithstanding the decedent's occupation at the time of death or that the deceased was retired, enter the type of occupation performed during the longest period of his/her working life. If the deceased had never been employed, enter "never employed." Enter "unknown" if the information is not available. If the deceased was under 14 years of age, a dash (-) should be entered.

15. Kind of Business or Industry. Enter as specifically as possible the kind of business or industry in which the deceased was employed. Do not enter the name of the company. Avoid unclear designations, e.g., "factory" or "mill." Instead enter "paint factory" or "saw mill."

16. Ever in U.S. Armed Forces? Check the appropriate block.

17. Social Security Number. Enter the Social Security Number; if it is not known, enter "unknown."

B. Section—Place of Death

1. City, Town, or Location of Death. Enter the full name of city, town or location where death occurred, regardless of size.

2. Parish of Death. Enter the name of parish in full.

3. Name of Hospital or Institution. If death occurred in a hospital or institution, enter the name of the facility. If death did not occur in a hospital or institution, enter the street address or otherwise enter location.

4. Death in Hospital. Complete this item only if death occurred in a hospital; check the appropriate block.

5. Is Place of Death Inside City Limits? Check "yes" or "no" as appropriate.

C. Section—Usual Residence of Deceased

1. City, Town or Location. Enter the city, town or location of usual residence.

2. Parish. Enter the name of the parish of usual residence.

3. State. Enter the name of the state in full.

4. Street Address. Enter the street address of the urban community or location, if rural.

5. If Residence Inside City Limits? Check "yes" or "no" as appropriate.

D. Section—Parents

1. Father's Name. The name of the father shall refer to the husband of the mother of the deceased, unless the biological father had formally acknowledged or legitimated the deceased prior to his/her death. Enter the last, first and second name of the father; if not known, enter "unknown."

2. Father's Place of Birth. If the father was born in the United States, enter the city and state. If born outside the United States, enter the name of that country in full. If the father's place of birth is not known, enter "unknown."

3. Mother's Maiden Name. Enter the last, first and second name of the mother. If the name is not known, enter "unknown."

4. Mother's Place of Birth. If the mother was born in the United Stated, enter the city and state. If born outside the United States, enter the name of that country in full.

E. Section—Informant's Certification

1. Signature and Address of Informant

a. The signature and address of the person providing information contained in Items 1A through 15B should appear in this space. If the informant is unable to write, his "X" and two witnesses are required. The informant shall limit his signature to the space provided.

b. In the event information is taken from institutional records, the entry shall read "Hospital (or name of institution) Records" and be signed by the custodian of those records.

c. Another person may sign the informant's name with permission as follows: John Doe/initials of the third party.

2. Date of Signature. Enter the date of signature in Item 16A.

F. Section—Cause of Death

This section is to be completed only by the attending physician or coroner certifying in H.2 (Item 21A)

1. Death was Caused By:

(A). Immediate Cause. Enter the disease or condition which cause death.

(B) and (C)Due to or as a consequence of:

i. Enter on these lines in appropriate sequence those causes, if any, in existence prior to death which may have given rise to the cause entered in (A).If (B) and (C) do not apply, enter "none" or leave blank. For each cause appearing on lines (A), (B) or (C) use as accurate terminology as is possible. Approximate internals between onset of the cause and death.

2. Other Significant Conditions

a. Enter any other conditions unrelated to those appearing in part I that contributed unfavorable to the fatal outcome.

b. Example: A complication of pregnancy might be reported in part I. But, if pregnancy was without complication and within 3 months of the date of death, it should be reported in Part II.

3. Autopsy. Check "yes" or "no" as appropriate.

4. If yes—Complete this item only if yes is checked in Item 18A.

G. Section—Death Due to External Violence

1. Complete this section only for deaths due to other than natural causes.

2. Describe How Injury Occurred. Enter the nature and description of the injury if injury appears in Part I or II of Item 17.

3. Time of Injury. Enter the time and date of injury, if applicable.

4. Injury Occurred. If applicable, indicate whether the injury occurred on or off the job.

5. Place of Injury. Specify where the injury occurred, if applicable.

6. If appropriate, enter the street address or location, city and state where the injury occurred.

H. Section—Physician's Certification

1. Certification (Attendance). Enter dates of medical attendance of the deceased.

2. Signature and Address of Physician.

a. The person legally responsible, physician or coroner, shall personally sign in this space in permanent black ink indicating professional status, i.e., M.D. or Coroner. The physician or coroner shall limit his signature to the space provided. Enter the address of the signatory.

NOTE: This section shall only be completed by the attending physician or coroner (including assistants) certifying death. No one else may sign for him and facsimiles or stamps shall not be acceptable.

b. If accident, suicide or homicide is checked, the signature shall be that of the coroner or his assistant in the parish where death due to external violence occurred.

3. Date. Enter date Item 21A was completed.

I. Section—Funeral Director: Certification. Immediately below the word "Certification" enter the funeral director's facility license number. This is in addition to the license number to appear in Item 23B. If a person other than a funeral director is managing the body of the deceased, enter "not applicable" in this space.

1. Enter the manner of disposal and the date thereof.

2. Name and Location. Enter the official name and address or location, including city or location and state of the cemetery or crematory where final disposition is to be made.

3. Signature and Address of Funeral Director. The person authorized to act in the name of the funeral director, or other person managing the body shall sign in black, permanent ink and include the business address.

4. License Number. Enter the Embalmer's license number. If the body is not embalmed, enter "not applicable."

J. Section—Burial Transit Permit Number

1. Burial Transit Permit Number

a. The number of the burial-transit permit issued is entered here by the person issuing the permit at the time of issuance.

b. Note that permits are to be issued only upon presentation of a properly completed death certificate. However, if a funeral director presents a death certificate completed to the limits of his ability and resources and for reasons beyond his control he is unable to present an entirely completed death certificate, a permit shall be issued. The permit is issued with the provision and understanding that the funeral director will present a completed document as soon as humanly possible. In the event that the funeral director abuses his privilege, the privilege is to be withdrawn.

2. Parish of Issue. Enter the parish name in full where the permit was issued.

3. Date of Issued. Enter the date the permit was issued.

4. Signature of Local Registrar. Enter the name of the Local Registrar of the parish where the certificate is filed. The signature shall be in permanent black ink.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:32 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§12309. Certificate of Marriage Preparation

A. The marriage license/certificate shall be prepared in duplicate for those issued in Orleans parish (PHS-5) and in triplicate for those issued in other parishes (PHS-5). At the point of license issue, the original and souvenir copy shall be provided to the bride and groom. Upon completion of the certificate, distribution instructions appearing on the lower right are to be followed. At least one of the applicants shall be a resident of the parish in which the license is purchased.

B. Section—Groom. This section as well as all information pertaining to the bride and groom shall be prepared on the basis of the applicants' birth certificate and/or statements.

1. Last Name of Groom. Enter the last name of the groom.

2. First Name. Enter the first name of the groom.

3. Second Name. Enter the second name of the groom.

4. Usual Residence. Enter the street address, rural route and city and state.

5. Is Residence Inside City Limits? Check the appropriate block.

6. Parish. Enter the parish of residence.

7. State. Enter the state of residence.

8. Race of Color. Enter the race or color as it appears on the applicant's birth certificate. In cases wherein race does not appear on the birth certificate or a waiver was presented as permitted by R. S. 9:242, the statement of the applicant shall be accepted.

9. Date of Birth. Enter the date of birth as it appears on the applicant's birth certificate or as it is provided by the applicant if a waiver pursuant to R. S. 9:242 is presented. Enter the applicant's age in years.

10. State of Birth. Enter the information as shown on the birth certificate. If birth occurred outside the United State, enter the name of the country.

11. Father-Name. The name of the father shall be the husband of the mother of the groom, otherwise, a father's name shall not be entered. If a father's name is to be entered, complete this item as it appears on the applicant's birth certificate or accept the statement of the applicant.

12. State of Birth. If a father's name is entered in Item 9, enter the state of birth, or if outside the United States, the name of the country of birth.

13. Mother-Maiden Name. Enter the maiden name of mother.

14. State of Birth. This section shall be completed per instructions outlined in the previous section.

C. Section—Bride. This section shall be completed per instructions outlined in the previous section.

D. Section—Place of Issue of Certificate

Parish. City or Town 3. Date of Issue Enter the month, day and year of issuance in numerals.

E. Section—Marriage Certification

1. Shall be completed by the officiate certifying that he/she officiated at the marriage ceremony of the bride and groom whose names appear on the license. The officiant shall ensure that all the essential signatures are affixed before the officiant signs in Item 34.

2. Signature of Witness. The signature of one of the witnesses shall appear in this item.

3. Signature of Groom. The signature of the groom shall appear in this item.

4. Signature of Witness The signature of one of the witnesses shall appear in this item.

5. Signature of Bride The signature of the bride shall appear in this item.

6. Signature of Witness This item shall be left blank; see Act 817, 1984 Regular Session.

7. Signature and Title of Officiant. Enter the signature of the person completing the certification in Item 28 and indicate his/her title.

8. Local Recording Officer's Signature. Enter the signature of the parish recording officer authorized to issue the license. Stamps or facsimilies are permissible.

9. Enter the title of the person whose signature appears in Item 35.

E. Section—Confidential Information Groom and Bride Enter the following information on the groom and bride:

1. Number of this marriage

2. If previously married—If the applicant was previously married, the applicant shall provide a certified copy of a judgment of divorce or a certified copy of a death certificate, whichever is applicable.

3. Date—If the applicant was previously married, enter the date the marriage was dissolved.

4. Education—Circle the highest grade completed.

5. If the bride had been married before, enter the full name of the previous husband.

F. Reverse Side of Form

1. Applicant's Affidavit

a. This section shall be completed by the licensing official and signed by the applicant and the licensing official or his designee. Officiant's Authorization.

b. This section shall be completed and signed by the licensing official or his designee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:32 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§12311. Burial Transit Permit

A. Burial transit permits shall be issued as required by R.S. 40:52, 40:53 and prepared as set forth in Chapter XXVI of the Sanitary Code, state of Louisiana.

B. The burial transit permit shall be issued only on forms provided by the State Registrar of Vital Records and shall consist of three sections: the first section shall be prepared by the State Registrar or his designee to whom the certificate of death is presented, and shall be prepared as follows.

1. Name of Deceased. Enter the name of the deceased as it appears on the certificate of death. In the event of a stillbirth (fetal death), enter "stillbirth of and the mother's name.

2. Sex. Enter the sex of the deceased as it appears on the certificate of death.

3. Color. Enter the racial identity of the deceased as it appears on the certificate of death.

4. Age. Enter the age of the deceased as it appears on the certificate of death.

5. Place of Death. Enter the city, town or location of death as it appears on the certificate of death.

6. Parish. Enter the parish of death as it appears on the certificate of death.

7. Ward-Omit

8. Date of Death. Enter the date of death as it appears on the certificate of death.

9. Issued To. Enter the name of the funeral director or person acting as such and the business address of that person.

10. Issued By. The signature of the local registrar, parish and date of issue are to be entered.

11. The second section of the permit shall be completed and signed by the funeral director or other person designated as custodian of the body, and shall contain a statement as to the method of embalming or preparation for final disposition and the date thereof.

12. The third section shall be filled out and signed by the section or person in charge of burial or other disposition, and shall contain a statement as to the method of final disposal, date and name and location of the cemetery or crematory and the lot number if burials is in a cemetery.

B. The burial transit permit shall be prepared in duplicate with the carbon retained by the local registrar. The sexton or person in charge of the final disposal of the body or remains shall return the original burial transit permit to the parish of burial within 10 days. The burial transit permits shall be retained by the local registrar for a period of not less than three years at the end of which time they shall be shipped to the vital records registry.

AUTHORITY NOTE: Promulgated in accordance with R. S. 40:32 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

§12317. Notice of Parental Rights Form

A. Procedure of Notice of Parental Rights

1. Prior to the final disposition of a miscarried child, but not more than 24 hours after the miscarriage occurs in a health facility, the facility shall notify the patient, or if the patient is incapacitated, the spouse of the patient, both orally and in writing, of both of the following:

a. the parent’s right to arrange for the final disposition of the child through the use of a parental rights form;

b. the availability of a chaplain or other counseling services concerning the death of the child, if such services are provided by the health facility.

B. Notice of Parental Rights Form

1. The notice of parental rights form shall contain, at a minimum, all of the following:

a. a definitive statement that reads as follows: “This notice of parental rights form is required to be provided to you pursuant to Louisiana law;”

b. a brief description of the provisions of R.S. 40:1191 along with concise instructions for the patient to follow regarding how to properly complete the form and return it to the health facility in the event the patient desires to arrange for the final disposition of the child;

c. a concise statement of the timelines that must be satisfied in order for the patient to arrange for the final disposition of the miscarried child;

d. a listing of state, regional, or national grief counseling organizations that may provide counseling services concerning the death of a child.

2. The form should be in substantially the following form or in conformance therewith.

Notice of Parental Rights

Louisiana law requires this form to be given to you to inform you of your right to arrange for the final disposition of fetal remains resulting from a miscarriage. Please read carefully.

You are only required to sign and return this form if you would like to make arrangements for the burial or cremation of the fetal remains. If you do not sign and return this form the health facility will be allowed to make final disposition of the remains according to state law.

By signing and returning this form, you are choosing to make arrangements for the final disposition of the remains and agree to the following:

1. I understand that Louisiana law requires me to return this completed and signed form to the location listed below within forty-eight (48) hours of the health facility providing me the form. Failure to return the form within forty-eight hours will allow the facility to make final disposition of the remains according to state law. Return the form to:

(Health Facility Contact Information Here)

2. I understand that the health facility will notify me or my designee that the fetal remains may be obtained from the facility within seventy-two (72) hours from the time the facility notifies me or my designee. Failure to obtain the remains within seventy-two (72) hours will allow the hospital to make final disposition of the remains according to state law. Please provide below your contact information and the contact information of your designee who will be taking possession of the remains.

Patient/Spouse/Legal Guardian Signature Date

3. I understand that choosing to arrange for the final disposition of the fetal remains is at my expense and it is my responsibility to ensure that the final disposition of the fetal remains is in accordance with Louisiana law.

I have read and understand the information presented to me on this form and my signature indicates my desire to arrange for the final disposition of the fetal remains.

You may inquire about the chaplain or other counseling services that may be offered by this facility. Other counseling options can be located on the Louisiana Department of Health website at http://new.dhh.louisiana.gov/index.cfm/page/2656.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1191.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Office of Public Health, LR 43:1393 (July 2017).

Chapter 125. Requirements for Orleans Parish Marriage Licenses

§12501. Requirement for Obtaining a License to Marry in New Orleans, Louisiana

A. An application for license may be made by either party, (both parties need not be present.). One of the applicants must be a resident of Orleans parish or the marriage ceremony must be performed in Orleans Parish in accordance with R.S. 9:222.

B. A 72-hour waiting period is required by R.S. 9:241 between time of issuance of license and the ceremony. Permission to waive waiting period may be granted by a judge of the First City Court and must be attached to the returned license.

C. As required by R.S. 9:225, certified copies of birth records shall be presented for both parties. (This requirement may be waived by a judge of the First City Court for those born outside Louisiana.) The certified copies of birth certificates shall be issued by the proper vital statistics registration authority of the cities, states, or countries of birth. The raised seals or stamps of the agencies or authorities issuing the certificates must be fixed thereto.

D. Marriage between a male and female under age 18 is prohibited by R.S. 9:211, unless as specified below. Applicants over the age of 16 but less than 18 will need the signed consent of both parents or an order from a judge of juvenile court. Females under age 16 will be issued a license only upon the written order of the juvenile court judge.

E. If either party has been divorced, a certified copy of the final decree of divorce shall be presented to the issuing officer. See C.C. Art 93.

F. A certified copy of a death certificate shall be presented when a widow or widower is applying for a license to marry. See C.C. Art. 93.

G. A marriage license expires and becomes invalid 30 days after date issued as set forth in R. S. 9:235. An expired marriage license may be reissued upon request of the original expired license by the Vital Records Office. See R.S. 9:236.

H. Prior to the issuance of a marriage license, the statutory fees set forth in the Louisiana Reviews Statutes shall be paid by the applicant(s). Such payment may be made by cash, check or money order.

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:203, R.S. 9:206, R.S. 9:208, R.S. 9:241, R.S. 9:242, R.S. 40:40, and La. Civ. Code. Art. 93 and 100.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, LR 15:474 (June 1989).

§12503. Requirements When No Record of Marriage on File

A. When it develops that a license was issued in Orleans parish and a record of the marriage is not on file in the registry, the procedure appearing below shall be followed in the order listed.

1. Should the officiant have the original record of marriage in his possession, the registry will record same.

2. Should the officiant have a duplicate original in his possession containing his certification and all required signatures, the registry will record same.

3. Should the original keepsake copy furnished to the bride and groom be available, that document along with an authentic act executed by the officiant and a complete

marriage record (PHS-5A) will support a recording of the marriage in the registry. In cases wherein only a photostat of the keepsake copy is available, at least one witness to the ceremony must execute an authentic act as well.

4. In the event items 1-3 cannot be applied and a duplicate license is available in registry files, that duplicate may be made available to the bride and groom. All requirements for purchase of a license shall be waived with the exception of the medical one.

B. The completed record shall be recorded and the date of the marriage shall be a date subsequent to the date the duplicate was released to the bride and groom.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:258.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 127. Requirements for Burial Transit Permits

§12701. Requirements for Purchase of Burial Transit Permits

A. When appearing in proper person, burial transit permits may be purchased at a cost of two dollars by licensed funeral directors and embalmers, as well as others authorized to do so by the state health officer acting as permitted by R. S. 40:5 when the conditions listed hereinunder are met:

1. The death certificate must be completed as set forth in R. S. 40:34. If the certificate is completed, a burial transit permit is issued.

2. In cases wherein the certificate preparer fails to present a duly completed and executed certificate for reasons beyond his control, a tentative permit may be issued with the understanding that the certificate will be completed as quickly as humanly possible.

3. If certified copies of the completed certificate are required at the point the permit is issued, the funeral director or embalmer must complete an application and pay fees as set forth in R. S. 40:40.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:5, R.S. 40:34, and R.S. 40:40.

HISTORICAL NOTE: Promulgated by the Department Of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987).

Chapter 129. AIDS Drug Reimbursement Program

§12901. Eligibility

A. State residents who are low income individuals who are not covered under the state Medicaid program or another third party payor, whose state Medicaid program of another third party payor, whose state Medicaid program does not provide this coverage, shall be targeted as recipients of state purchased Azidothymidine (AZT). Louisiana Department of Health and Hospitals has defined low-income for purposes of this program and to establish medical eligibility criteria for potential recipients of the drug. In order to develop these eligibility criteria, the state health officer established financial and medical criteria and to grant approval status to applicants. The review board has met and established the following criteria for use in determining potential recipients of AZT.

B. Criteria for Patient Eligibility for Azidothymidine (AZT)

1. The patient must have been diagnosed with AIDS or patient must be HIV positive and have a T4-cell count of 500 or less.

2. The patient must be willing to be followed as felt necessary by his/her physician. Poor patient compliance can be reason for discontinuing medication.

3. The patient's financial status is within the definition of 200 percent of the federal poverty level as follows:

1 person household	$1,047/month
2 person household	$1,404/month
3 person household	$1,761/month
4 person household	$2,116/month

4. The patient must have no other financial means for access to AZT.

C. Program Referral Procedures

1. All referrals or potential recipients shall be directed to the program review board by the patient's physician. The referring physician shall assure that the patient meets all of the above stated eligibility criteria.

2. The review board shall review all applications on a first come first serve basis using the above criteria to determine eligibility for approved participation in the program at no cost to patients.

AUTHORITY NOTE: Promulgated in accordance with Public Health Services Act, Section 319, P.L. 100-71.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventative and Public Health Services, LR 14:2 (January, 1988), repromulgated by the Department of Health and Hospitals, Office of Public Health, LR 16:692 (August 1990).

Subpart 49. Community Based and Rural Health Services

Chapter 133. Funding Eligibility

§13301. Rural Health Program (Formerly §15101)

A. Contingent upon available funding, the Health Resources Management Section may establish one or more application cycles in any state fiscal year. At the beginning of any application cycle, eligible entities will be notified that applications are being accepted for grant projects.

B. Criteria for Applicants

1. Applicants for primary care clinic grants, demonstration grants, state matching funds for federal grants, and physician salary subsidy must:

a. be from rural areas as defined by the Department of Health and Hospitals, must be in a federally designated rural health-professional shortage area or medically underserved area of highest need;

b. be a local governmental entity or a nonprofit (501)(c)(3) organization domiciled in Louisiana;

c. serve low-income and indigent persons; and

d. have a sliding scale for payment of services.

2. Applicants for emergency health services grants must:

a. be small rural hospitals, defined as public and private acute care hospitals licensed for 60 beds or less which have a service municipality with a population of 20,000 people or less;

b. be in a federally designated rural health-professional shortage area or medically underserved area of highest need; and

c. serve low-income and indigent persons.

C. The HRM Section will provide forms and/or guidelines for application to apply for program funds. The application shall be received by the deadline date and signed by the authorized representative and submitted to the HRM Section.

D. The HRM Section shall conduct a review of the application for eligibility, completeness and programmatic priority.

E. All applications and/or requests for funding will be referred to the Objective Review Committee for award recommendations. The committee will consider the project and may confer with outside parties as necessary to obtain information on the financial feasibility, and readiness to proceed and make written recommendations to the Health Resources Management Section.

F. Recommendations will be forwarded to the assistant secretary, OPH for approval. The assistant secretary will act on the application after a time period of proper consideration, but no later than 45 days after the application has been received by the assistant secretary.

G. The HRM Section will notify the applicant of the approval or disapproval of its application within 10 working days of the assistant secretary's action. Written notification of the approval will be accompanied by an agreement to be signed by an authorized representative of the applicant and returned by certified mail.

H. All communications regarding an eligible entity's application shall be directed to the HRM Section.

I. Grant Type Categories:

1. Emergency Health Services

a. Small rural hospitals, defined herein, can apply for grants up to $75,000 to strengthen their capability to provide high quality emergency health services to indigent and low income persons in rural areas.

b. A letter of intent must be submitted and shall reflect how the funds requested will be utilized.

2. Primary Care Clinic Grants

a. A request for an application kit to establish or enhance a primary care clinic in a rural area may be obtained from the Health Resources Management Section.

b. The proposal must include a needs assessment, a management plan, a detailed budget and budget justification, and other information as defined in the application kit.

c. The proposal including any appendices, may not exceed 50 typed, double-spaced, letter size pages.

d. Grant requests may not exceed $150,000.

3. Demonstration Grants

a. Applicants must be located in a rural medically underserved area and may apply for a grant to fund a project designed to innovatively, efficiently, and effectively develop and provide out-patient primary care services.

b. Demonstration projects can include, but are not limited to the establishment or acquisition of mobile health clinics, healthy communities projects, school-based clinic projects or others that will then secure other local or federal funding.

c. The grantee will be required to provide a 25 percent match (cash and/or in-kind) from the community or participating organization.

d. The proposal must include a needs assessment, a management plan, a detailed budget and budget justification, and other information as defined in the application kit.

e. Application kits can be obtained from the Health Resources Management Section.

4. Physician Salary Subsidy

a. Local health agencies or communities may apply for state matching funds for physician salary guarantees of $100,000 annually in salary and benefits to assist in recruiting and/or retain full time primary care physicians in the rural areas.

b. Primary care shall include pediatrics, OB/GYN, internal medicine, family practice, or general practice.

c. Subspeciality training is permitted provided the physician practices only primary care as specified.

d. A full time primary care physician is defined as a physician who practices out-patient preventive and primary care medicine at least 32 hours per week in not less than four days.

e. Local health agencies or communities are eligible for more than one award.

f. Only one award per physician is allowable under this program.

g. Eligible physicians must be newly hired or recently employed, as specified above, within the last five years.

h. State salary subsidies will not exceed $50,000, and the local community must demonstrate its ability to at least match the state amount.

i. The Health Resources Management Section will contract directly with the local health agencies or communities who, in turn, contract with the primary care physician in the rural area. As such, agencies/communities must submit with their request for assistance, a copy of a contract with a physician which shall address the $100,000 guarantee.

j. The Department of Health and Hospitals will make no payments under this incentive until the physician's actual received income and benefits are reconciled against his/her contract.

5. State Matching Funds for Federal Grants

a. Requests for one time funding only will be accepted for new projects to provide primary care out-patient services to indigent or low income persons as proposed in federal grant applications.

b. Eligible applicants must provide a copy of the federal announcement and completed federal application at the time of request for funding.

J. Eligibility. In order to be eligible to receive a grant through this program, in addition to meeting the criteria set forth in Subsection B, the following requirements must be met by an eligible entity:

1. An eligible entity shall be a community-based organization that may include hospitals, primary care clinics, or other local agencies that provides outpatient primary care in a rural area.

2. An eligible entity shall have a governing board whose membership is generally representative of the health care underserved area served.

3. An eligible entity which is a primary care clinic shall sustain or provide a minimum level of primary care services through the services of a physician or midlevel practitioner as provided for by Louisiana medical practice law.

a. Services may additionally include, but not be limited to, medical support, diagnostic and treatment services, pharmacy, laboratory, radiology, preventive health services, emergency medical services, mental health, patient follow-up, and/or dental and dental support services.

b. Such services shall be provided in coordination with primary medical care services.

4. An eligible entity shall have policies and procedures which assure that no person will be denied services because of inability to pay.

5. An eligible entity shall comply with all applicable federal, state, and local laws and regulations.

6. An eligible entity shall ensure the grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service:

a. under:

i. any state compensation program;

ii. an insurance policy; or

iii. any federal state health benefits programs; or

b. by an entity that provides health services on a prepaid basis.

7. Other requirements as determined by the department.

K. Review and Reporting Requirements

1. The successful applicant shall sign a Memorandum of Agreement for one-time funding only for the term of one year.

2. The grantee shall then submit programmatic and expenditure reports on a periodic basis as agreed upon in the MOA.

3. An audit report shall be submitted after the end of the contract period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2195, as amended by Act 363 of 1995.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 22:840 (September 1996).

§13303. Urban Community-Based Health Program

A. Contingent upon available funding, the Health Resources Management Section may establish one or more application cycles in any state fiscal year. At the beginning of any application cycle eligible entities will be notified that applications are being accepted for grant projects.

B. Applications will only be accepted from entities in a federally designated urban health-professional shortage area or medically underserved area, must:

1. be in an area of highest need;

2. serve low income and indigent persons;

3. have a sliding scale for payment; and

4. be a local governmental entity or a nonprofit (501)(c)(3) organization domiciled in Louisiana.

C. The HRM Section will provide forms and/or guidelines for application to apply for program funds. The application shall be received by the deadline date and signed by the authorized representative and submitted to the HRM Section.

D. The HRM Section shall conduct a review of the application for eligibility, completeness and programmatic priority.

E. All applications and/or requests for funding will be referred to the Objective Review Committee for award recommendations. The committee will consider the project and may confer with outside parties as necessary to obtain information on the financial feasibility, and readiness to proceed and make written recommendations to the Health Resources Management Section.

F. Recommendations will be forwarded to the assistant secretary, OPH for approval. The assistant secretary will act on the application after a time period of proper consideration, but no later than 45 days after the application has been received by the assistant secretary.

G. The HRM Section will notify the applicant of the approval or disapproval of its application within 10 working days of the assistant secretary's action. Written notification of the approval will be accompanied by an agreement to be signed by an authorized representative of the applicant and returned by certified mail.

H. All communications regarding an eligible entity's application shall be directed to the HRM Section.

I. Grant Type Categories

1. Primary Care Clinic Grants

a. A request for an application kit to establish or enhance a primary care clinic in an urban area may be obtained from the Health Resources Management Section.

b. The proposal must include a needs assessment, a management plan, a detailed budget and budget justification and other information as defined in the application kit.

c. The proposal, including any appendices, may not exceed 50 typed, double-spaced, letter size pages. Grant requests may not exceed $150,000.

2. Demonstration Grants

a. Applicants must be located in an urban health-professional shortage area or medically underserved area and may apply for a grant to fund a project designed to innovatively, efficiently, and effectively develop and provide outpatient primary care services.

b. Demonstration projects can include, but are not limited to the establishment or acquisition of mobile health clinics, healthy communities projects, school-based clinic projects or others that will then secure other local or federal funding.

c. The grantee will be required to provide a 25 percent match (cash and/or in-kind) from the community or participating organization.

d. Application kits can be obtained from the Health Resources Management Section.

3. Physician Salary Subsidy

a. Local health agencies or communities may apply for state matching funds for physician salary guarantees of $100,000 annually in salary and benefits to assist in recruiting and/or retaining full time primary care physicians in the inner-city urban areas.

b. Primary care shall include pediatrics, OB/GYN, internal medicine, family practice, or general practice.

c. Subspeciality training is permitted provided the physician practice only primary care as specified.

d. A full time primary care physician is defined as a physician who practices outpatient preventive and primary care medicine at least 32 hours per week in not less than four days.

e. Local health agencies or communities are eligible for more than one award.

f. Only one award per physician is allowable under this program.

g. Eligible physicians must be newly hired or recently employed, as specified above, within the last five years.

h. State salary subsidies will not exceed $50,000, and the local community must demonstrate its ability to at least match the state amount.

i. The Health Resources Management Section will contract directly with the local health agencies or communities, who in turn contract with the primary care physician in the urban area. As such, agencies/communities must submit with their request for assistance, a copy of a contract with a physician which shall address the $100,000 guarantee.

j. The Department of Health and Hospitals will make no payments under this incentive until the physician's actual received income and benefits are reconciled against his/her contract.

4. State Matching Funds for Federal Grants

a. Request for one time funding only will be accepted for new projects to provide primary care outpatient services to indigent or low income persons as proposed in federal grant applications.

b. Eligible applicants must provide federal announcement and completed federal application at the time of request for funding.

J. Eligibility. In order to be eligible to receive a grant through this program, the following requirements must be met by an eligible entity:

1. An eligible entity shall be a community-based nonprofit organization, hospital, primary care clinic, or organization that provides outpatient primary care in an urban health-professional shortage area.

2. An eligible entity shall have a governing board whose membership is generally representative of the health-care underserved area served.

3. An eligible entity which is a primary care clinic shall sustain or provide a minimum level of primary care services through the services of a physician or midlevel

practitioner as provided for by Louisiana medical practice law.

a. Services may additionally include, but not be limited to, medical support, diagnostic and treatment services, pharmacy, laboratory, radiology, preventive health services, emergency medical services, mental health, patient follow-up, and/or dental and dental support services.

b. Such services shall be provided in coordination with primary medical care services.

4. An eligible entity shall have policies and procedures which assure that no person will be denied services because of inability to pay.

5. An eligible entity shall comply with all applicable federal, state, and local laws and regulations.

6. An eligible entity shall ensure the requested funds will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service:

a. under:

i. any state compensation program;

ii. an insurance policy; or

iii. any federal state health benefits programs; or

b. by an entity that provides health services on a prepaid basis.

7. Other requirements as determined by the department.

K. Review and Reporting Requirements

1. The successful applicant shall sign a Memorandum of Agreement for one-time funding only for the term of one year.

2. The grantee shall then submit programmatic and expenditure reports on a periodic basis as agreed upon in the MOA.

3. An audit report shall be submitted after the end of the contract period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2195, as amended by Act 363 of 1995.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 22:842 (September 1996).

Chapter 137. Laboratory Services

§13701. Definitions

A. Unless the context otherwise requires, the words defined in §13701 shall have the following meanings in LAC 48:V.Chapter 137.

Billable Submitter—individual authorized to submit specimens for scientific analysis by the Division of Laboratories that does not fall into one of the categories listed under §13703.B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:29.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:942 (May 1998).

§13703. Applicability

A. Except as otherwise provided under this Title, these laboratory fees shall not be charged:

1. to the Office of Public Health of the Louisiana Department of Health (LDH) or for laboratory services for a patient at a clinic or health unit operated by the Office of Public Health or to any physician, nurse, dentist, veterinarian, sanitarian or other licensed health care provider who is treating a patient or providing services in an official capacity in relation to the treatment of a patient of the Office of Public Health of the Louisiana Department of Health, including the network of parish health units operated by the Office of Public Health;

2. in any instance when the state health officer declares an epidemic, for any test, procedure, function, or operation related to such epidemic;

3. if exemption from payment is otherwise provided by the State Sanitary Code; or

4. to any state hospital or institution when the secretary of the Louisiana Department of Health requires the Office of Public Health laboratory to act for such institution in case of emergency.

B. These fees shall be charged for all tests, procedures, functions, or any operations performed by each laboratory independently operated by the Office of Public Health of the Louisiana Department of Health as a state laboratory on human specimens, environmental samples, cultures, analytical and research procedures and related services which are submitted by any physician, hospital, clinic or health unit not operated by the Office of Public Health, nurse, veterinarian, sanitarian or any other licensed health care provider authorized to submit specimens for scientific analysis by the Division of Laboratories of the Office of Public, LDH. The charges or fees for these services will be assessed according to the following schedule.

Test Description	Fee
1. Ab identification, RBC each panel, each serum technique	$ 57
2. Ab screen, RBC each serum technique	$ 21
3. Adenovirus Ab	$ 18
4. Alpha Fetal protein (amniotic fluid)	$ 22
5. Alpha Fetal protein (Serum)	$ 22
6. Antibiotic Disc Test	$ 4
7. Blood-Hemogram, automated and manual differential WBC (CBC)	$ 8
8. Blood-RBC antigen other than ABO and Rh(D), each antigen	$ 5
9. Blood-Rh (D) antigen	$ 19
10. Blood-typing, ABO	$ 4
11. Bordetella parapertussis Ab	$ 19
12. Bordetella pertussis Antigen	$ 19
13. Bordetella pertussis Culture	$ 11
14. Borrelia Ab IgG (Relapsing fever)	$ 19

Test Description	Fee
15. Borrelia Ab IgM (Relapsing fever)	$ 19
16. Borrelia Ab Total (Relapsing fever)	$ 19
17. Brucella abortus Ab	$ 14
18. Chlamydia AB(LGV)	$ 18
19. Chlamydia testing by DNA gene probe, each probe used	$ 18
20. Clinical chemistries/21 + amylase	$ 15
21. Corynebacterium diptheriae culture (throat or nose)	$ 11
22. Coxiella Burnetti (Q fever) Phase 1-IgG and IgM	$ 18
23. Coxiella Burnetti (Q fever) Phase 2-IgG and IgM	$ 18
24. Cryptococcus Ab	$ 21
25. Culture Typing, Precipitin Method (grouping) per antiserum	$ 7
26. Culture Typing, Serologic method, agg grouping, per antiserum	$ 7
27. Culture Typing, Serologic Method, speciation	$ 5
28. Culture, Bact, screen, stool	$ 13
29. Culture, Bact, anaerobe, ID, any source without GLC	$ 11
30. Culture, Bact, ID, aerobe, any source	$ 11
31. Culture, Bact, screen (aerobic and anaerobic plates)	$ 15
32. Culture, Bact, screen, other source	$ 12
33. Culture, Bact, screen, throat or nose	$ 11
34. Culture, Bact, anaerobe, isolation, any source	$ 13
35. Culture, Bacti, ID anaerobe with GLC	$ 20
36. Culture, Bacti, ID any source, in addition to primary culture	$ 8
37. Culture, Bacti, ID presumptive, any souce, multiple organism	$ 12
38. Culture, Bacti, ID presumptive, any souce, single organism	$ 10
39. Culture, Bacti, ID screen, any souce, single Organism	$ 9
40. Culture, Bacti, ID, screen, multiple organisms	$ 12
41. Culture, Bacti, ID, urine	$ 9
42. Cytomegalovirus (CMV) Ab IgG	$ 20
43. Cytomegalovirus (CMV) Ab IgM	$ 20
44. Dengue Fever Ab	$ 18
45. Encephalitis testing in birds (per viral study)	$ 19
46. Encephalitis, Eastern Equine IgG	$ 19
47. Encephalitis, Eastern Equine IgM	$ 19
48. Encephalitis, La Crose (California) IgG	$ 19
49. Encephalitis, La Crose (California) IgM	$ 19
50. Encephalitis, Saint Louis IgG	$ 19
51. Encephalitis, Saint Louis IgM	$ 19
52. Encephalitis, Western Equine IgG	$ 19
53. Encephalitis, Western Equine IgM	$ 19
54. Enterovirus Ab (e.g. coxsackie, echo, polio)	$ 19
55. Ehrlichia Ab	$ 18
56. Estradiol Assay	$ 52
57. Fluorescent Ab screen, each Ab (Bordatella)	$ 18
58. Fluorescent Ab titer, each Ab	$ 17
59. Fluorescent Antibody (Direct) (Rabies DFA)	$ 18
60. Fluorescent Antibody (Indirect)	$ 34
61. Fluorescent Antibody-double stain	$ 8
62. Follicle Stimulating Hormone (FSH)	$ 35
63. Francisella tularensis Ab	$ 15
64. Glucose quantitative	$ 7
65. Hepatitis, Anti-A	$ 18
66. Hepatitis, Anti-C	$ 18
67. Hepatitis, Anti-HBc Total	$ 17
68. Hepatitis, Anti-HBe	$ 18
69. Hepatitis, Anti-HBs	$ 15

Test Description	Fee
70. Hepatitis, HBe Ag	$ 16
71. Hepatitis, HBs Ag	$ 15
72. Herpes I Group IgG	$ 19
73. Herpes II Group IgG	$ 19
74. Herpes II Group IgM	$ 19
75. Herpes simplex Type 1 and 2 Ab differential	$ 20
76. HIV- Dry Blood spot analysis	$ 6
77. HIV-1 EIA	$ 13
78. HIV-1 WB	$ 28
79. Human Arbovirus IgG	$ 18
80. Human Arbovirus IgM	$ 18
81. Human Chorionic Gonadotropic (hCG) Pregnancy Test-Quantitative	$ 21
82. Human Chorionic Gonadotropic (hCG) Pregnancy Test-Qualitative	$ 11
83. Human Rickettsia IgG	$ 10
84. Human Rickettsia IgM	$ 10
85. Influenza A Ab	$ 20
86. Influenza B Ab IgG	$ 20
87. Legionella Ab	$ 21
88. Leptospirosa Ab	$ 19
89. Leutinizing Hormone Assay	$ 36
90. Lipoproteins HDL cholesterol	$ 14
91. Lipoproteins triglycerides	$ 11
92. Lymes-(Borellia burgdorferi) IgG	$ 22
93. Lymes-(Borellia burgdorferi) IgM	$ 22
94. Meningoencephalytic Ab (adult)	$ 18
95. Meningoencephalytic Ab (childhood)	$ 18
96. Mumps Virus Ab	$ 19
97. Mycoplasma pneumonia Ab	$ 19
98. Neisseria gonorrhoeae testing by DNA gene probe	$ 18
99. Newborn Screening Panel	$ 30
100. Parainfluenza I Ab	$ 18
101. Parainfluenza II Ab	$ 18
102. Borellia III Ab	$ 18
103. Parasite large volume filtration	$ 47
104. Polio Virus Ab-Type I	$ 19
105. Polio Virus Ab-Type II	$ 19
106. Polio Virus Ab-Type III	$ 19
107. Prolactin Assay	$ 36
108. R. rickettsii Ab to antigen (Rocky Mountain Spotted Fever) IgG or IgM	$ 18
109. R. typhi Ab (Typhus fever) IgG or IgM	$ 18
110. Rabies Analysis	$ 73
111. Reovirus Ab	$ 18
112. Respiratory Syncytial Virus (RSV) Ab	$ 18
113. Rheumatoid factor-qualitative (latex)	$ 8
114. Rheumatoid factor-quantitative	$ 8
115. Rotavirus Ab	$ 19
116. Rubella (German measles) Ab, IgG	$ 20
117. Rubella (German measles) Ab, IgM	$ 20
118. Rubeola (Red measles) Ab, IgG	$ 18
119. Rubeola (Red measles) Ab, IgM	$ 18
120. Sensitivity study; antibiotics, disk method, per plate (212)	$ 10
121. Smear with interpretation	$ 6
122. Syphilis test VDRL qualitative (serum and CSF)	$ 6
123. Syphilis test VDRL-quantitative, MHA-TP (serum and CSF)	$ 6
124. T cells including cell ratio	$ 54
125. TB Panel (bilirubin, AST, uric acid, creatinine)	$ 11
126. TB Screen-AST	$ 7
127. TB, AFB, Antibiotic sensitivities; each drug (includes culture)	$ 8
128. TB-AFB smear	$ 8

Test Description	Fee
129. TB-Concentration and Isolation of Mycobacteria, each	$ 16
130. TB-DNA probe identification of AFB cultures	$ 18
131. TB-HPLC Ident of Mycobacterium	$ 26
132. Tissue Culture Studies	$ 163
133. TORCH Ab (CMV, Herpes, Rubella, Toxo)IgG	$ 82
134. TORCH Ab (CMV, Herpes, Rubella, Toxo)IgM	$ 82
135. Toxoplasma Ab, IgG	$ 18
136. Toxoplasma Ab, IgM	$ 21
137. Treponema pallidum Ab-Confirmatory test FTA-ABS	$ 19
138. Typhus in rats-antigen to antibody	$ 10
139. Varicella Zoster Ab, IgG	$ 18
140. Vibrio cholerae ID	$ 93
141. Vibrio vulnificus ID	$ 47
142. Viral Load studies for HIV	$ 121
143. Virus ID-Tissue Cult. Additional Studies, each isolate	$ 34
144. Virus ID-Tissue Cult. Inoculation and Observation	$ 37
145. Virus ID-Tissue Cult. Inoculation of Egg/Small animal, Observation and Dissection	$ 28
146. Yersinia pestis (plague) study in rats; includes slide prep, animal inoculation, plague demo	$ 154
147. Any Public Health Biochemistry procedure not expressly stated will be charged based on the cost per unit of time (Work Time Unit or WTU) as calculated by the fiscal department of the Office of Public Health	Not to Exceed $1.75 WTU
148. Any Public Health Microbiology procedure not expressly stated will be charged based on the cost per unit of time(Work Time Unit or WTU) as calculated by the fiscal department of the Office of Public Health	Not to exceed $1.75 WTU
149. Any Public Health Serology procedure not expressly stated will be charged based on the cost per unit of time (Work Time Unit or WTU) as calculated by the fiscal department of the Office of Public Health	Not to exceed $1.75 WTU
150. Any Public Health Virology procedure not expressly stated will be charged based on the cost per unit of time (Work Time Unit or WTU) as calculated by the fiscal department of the Office of Public Health	Not to exceed $1.75 WTU
151. Any Research Procedure not expressly stated will be charged based on the cost per unit of time (Work Time Unit or WTU) as calculated by the fiscal department of the Office of Public Health	Not to exceed $1.75 WTU
152. A-1 (FC MPN)	$ 20
153. Adipates/Phthalates	$ 160
154. Alfatoxins (HPLC)	$ 119
155. Alfatoxins (Screen)	$ 40
156. Alkalinity (Total)	$ 9
157. Aluminum	$ 16
158. Antibiotic disc assay	$ 16
159. Antibiotic sensitivity study/antibiotic	$ 6
160. Antimony	$ 33
161. Arsenic	$ 16
162. Barium	$ 16
163. Beryllium	$ 16
164. BOD-5 day (manual)	$ 160
165. BOD-Automated robotics testing	$ 26
166. Bottled and Vended waters-Colilert	$ 4
167. Bottled Water-Herbicides	$ 237
168. Bottled Water-Trihalomethanes (THM)	$ 33
169. Bottled Water-VOC (P/T)	$ 172
170. Butter analysis	$ 121
171. Butterfat, Babcock	$ 27
172. Butterfat, Roese-Gotlieb (Confirmation)	$ 92
173. Butterfats and Nonfat Solids	$ 32
174. C. jejeuni and C.	$ 33

Test Description	Fee
campylobacter-Environmental	
175. Cadmium	$ 16
176. Cadmium in foods	$ 3
177. Caffeine	$ 79
178. Calcium hardness	$ 8
179. Carbamates	$ 200
180. Caustics	$ 11
181. Cereal analysis-qualitative	$ 1
182. Cereal analysis-quantitative	$ 32
183. Charm I; App N antibiotic testing	$ 13
184. Charm II; App N antibiotic testing-Cloaxacillin	$ 13
185. Charm II; App N antibiotic testing-Other	$ 13
186. Charm II; App N antibiotic testing-Quantitative	$ 40
187. Charm II; App N antibiotic testing-Sequential	$ 13
188. Chemical Oxygen Demand (COD)	$ 80
189. Chloride percent-Hypochlorites and Chloramines (screen)	$ 7
190. Chloride percent; Hypochlorites and Chloramines (Confirmation)	$ 21
191. Chlorides	$ 7
192. Chromium	$ 17
193. Coffee (chicory)	$ 4
194. Coliform Determinations-Confirmed (includes MPN for coliform and fecal coliform)	$ 31
195. Coliform Determinations-E. coli (Verified)-each isolate	$ 13
196. Coliform Determinations-Fecal	$ 8
197. Coliform Determinations-Fecal by MPN (includes presumptive, completed and confirmed tests)	$ 45
198. Coliform Determinations-Fecal Coliforms (includes coliform and E.coli MPN)	$ 31
199. Colilert	$ 8
200. Color	$ 5
201. Color and preservatives in food	$ 80
202. Compliance analysis of nutritional content and labeling	$ 13
203. Conductivity	$ 7
204. Copper Flame AA	$ 9
205. Copper ICAP	$ 4
206. Corrosion Control (copper, lead, pH, Alkalinity, THRD)	$ 53
207. Cosmetics (organoleptics, net weight, filth and foreign material)	$ 13
208. Cryoscope (added water)	$ 8
209. Cyanide	$ 160
210. Dairy Waters-MTF	$ 19
211. Diquat	$ 200
212. Dissolved Oxygen (DO)	$ 8
213. Drained weight analysis	$ 7
214. Dry Skim Milk-Qualitative	$ 3
215. Dry Skim Milk-Quantitative	$ 119
216. Dual Column (confirmation)	$ 33
217. E. coli 015:H7	$ 27
218. E. coli MPN	$ 31
219. E. coli speciation	$ 20
220. Endothall	$ 253
221. Ethylene Dibromide (EDB)	$ 133
222. Etiological agent ID for consumer food, beverages	$ 100
223. Fecal Coliform MPN (includes presumptive, completed and confirmed tests)	$ 31
224. Filth and Foreign (filter)	$ 5
225. Filth and Foreign (Macro)	$ 5
226. Filth and Foreign (Micro)	$ 7
227. Filth and Foreign (trap/sv)	$ 389
228. Fluoride analysis	$ 20

Test Description	Fee
229. Fluorides	$ 11
230. Foreign Fat (RI)	$ 4
231. Formaldehyde testing (AIR)	$ 409
232. Fossomatic CC	$ 12
233. Fossomatic OSCC	$ 13
234. Free CO2	$ 12
235. Gamma screen	$ 26
236. GC/MS Confirmation	$ 479
237. General Chemistry (Borellia, Net weight, filth and foreign materials)	$ 16
238. Glycol/Recirculating Water (10-Tube MPN)	$ 13
239. Glycol/Recirculating Water (HPC)	$ 8
240. Glycophosphate	$ 160
241. Gross alpha and beta (Radon 222, Radium 226, Radium 228, Radon, Uranium)	$ 67
242. Heavy Metal (ICAP)	$ 100
243. Heavy Metals (Includes Hg)	$ 180
244. Herbicides	$ 240
245. Heterotrophic Plate Count (HPC)	$ 8
246. Inorganic Chemicals	$ 299
247. Iodine 131	$ 396
248. Iron	$ 17
249. Iron and alumina oxide	$ 33
250. Lead-Other analysis by furnace atomic absorption	$ 55
251. Lead analysis (wipes)	$ 20
252. Lead analysis in water/chemistry	$ 20
253. Lead analysis in waters schools, day care, water coolers, faucets/chemistry	$ 20
254. Lead analysis of paint	$ 40
255. Lead and copper analysis for private residence water	$ 23
256. Lead-Blood lead Screen by Graphite Furnace Atomic Absorption	$ 13
257. Listeria analysis-milk	$ 27
258. Listeria analysis-food	$ 100
259. Listeria culture-Environmental	$ 20
260. Loss on Ignition	$ 5
261. Manganese	$ 16
262. Mercury in foods	$ 79
263. Mercury in Water	$ 20
264. Metal (1 metal) ICAP	$ 16
265. Metals (13 metals)ICAP	$ 53
266. Metals (4 metals) ICAP	$ 24
267. Metals (ICAP) plus Mercury	$ 180
268. Metals in food-ICAP	$ 40
269. Microbiology culture for environmental organisms (Listeria, Campylobacter, Yersinia, Salmonella, Staphylococcus and E.coli)	$ 175
270. Milk Containers-paper and Plastic	$ 17
271. Net Weight and Contents	$ 7
272. Nickel	$ 16
273. Nitrate	$ 13
274. Nitrates and Nitrites	$ 13
275. Nitrites	$ 13
276. Nonfat Solids	$ 5
277. Nuisance Organisms	$ 20
278. Oil and Grease	$ 158
279. Organoleptic Exam	$ 3
280. Organoleptic Exam in foods	$ 13
281. Oyster meat analysis for Vibrio and Salmonella	$ 40
282. Oyster waters-analysis for Salmonella, Shigella, Vibrio, Staph	$ 33
283. Oyster waters; metals	$ 100
284. Oyster waters; organics	$ 40
285. Oyster waters; Pesticides	$ 233
286. Pesticide (Endrin, lindane, methoxychem.	$ 100

Test Description	Fee
toxophene)	
287. Pesticide battery 12 assays	$ 201
288. Pesticide residues-food	$ 273
289. Pesticide residues-grains	$ 273
290. Pesticide residues-vegetables	$ 233
291. Pesticide/PCBs in soil	$ 246
292. Pesticides/Herbicides and PCB	$ 100
293. Pesticides/metals-ICP	$ 313
294. Pesticides/PCBs	$ 233
295. Pesticides/PCBs (Food)	$ 233
296. Pesticides/PCBs (HECD)	$ 273
297. Pesticides/PCBs (NPD)	$ 273
298. Pesticides/PCBS (Serum)	$ 64
299. Pesticides/PCBS GC/MS	$ 475
300. Pesticides/PCBs in seafood	$ 233
301. Pesticides/PCBs in water (multi scan)	$ 233
302. Pesticides/water (Multi scan)	$ 231
303. pH	$ 5
304. Phenols	$ 319
305. Phosphatase by Fluorophos	$ 7
306. Phosphatase by Sharer	$ 11
307. Phosphatase by Sharer-Reactivation	$ 46
308. Phosphatase by Sharer-Interfering Substances	$ 11
309. Phosphatase by Sharer-Microbial	$ 34
310. Phosphates	$ 40
311. Polyaromatic Hydrocarbons (PAH)	$ 79
312. Potassium	$ 16
313. Priority Chemicals	$ 166
314. Radionuclides; Gamma	$ 53
315. Radium 226 and 228	$ 725
316. Radon 222	$ 79
317. Red Tide (Sample prep for mouse assay)	$ 67
318. Red Tide (Tissue Culture assay)	$ 133
319. Reducing Sugars	$ 133
320. Residual Chlorine (chloramines)	$ 20
321. Residue/insoluble materials (pipe scales)	$ 237
322. Salinity	$ 7
323. Salmonella analysis-food	$ 27
324. Salmonella and Vibrio analysis	$ 126
325. Salmonella culture	$ 20
326. Salmonella culture-chocolate	$ 47
327. Secondary Chemicals	$ 146
328. Sediment analysis	$ 240
329. Selenium	$ 33
330. Shellfish-Microbial Screen (Staph aureus, Salmonella, Shigella, Vibrio, Listeria)	$ 166
331. Silicates	$ 40
332. Silver	$ 16
333. Silvex 2-,4-D and 2,4 TP	$ 237
334. Sodium	$ 16
335. Sodium and Potassium	$ 11
336. Staphylococcus analysis-Environmental	$ 20
337. Staphylococcus aureus ID-Environmental	$ 13
338. Strontium 89 and 90	$ 396
339. Sulfates	$ 8
340. Sulfides	$ 47
341. Sulfite analysis-qualitative	$ 3
342. Sulfite analysis-quantitative	$ 48
343. Surfactants (MBAS)	$ 158
344. Synthetic Organic Chemicals (13 classes)	$ 1,131
345. Syrup-polarization	$ 106
346. Thallium	$ 33
347. Total Chlorine residual	$ 11
348. Total Dissolved Solids	$ 11
349. Total Hardness	$ 8
350. Total Solids	$ 11
351. Total Solids (lactometer)	$ 7

Test Description	Fee
352. Total Solids-Drying	$ 17
353. Total Suspended Solids	$ 27
354. Trihalomethanes (THM)-(Liquid/Liquid)	$ 33
355. Trihalomethanes (THM)-(purge and trap)	$ 79
356. Tritium (H3)	$ 79
357. Turbidity	$ 4
358. Unregulated Volatile Organics	$ 173
359. Uranium	$ 198
360. Urines for methylparathion	$ 8
361. Vibrio cholerae Identification and Typing	$ 150
362. Vibrio vulnificus Identification	$ 118
363. Vitamin A	$ 158
364. Vitamin A and D	$ 185
365. Vitamin D	$ 158
366. Volatile Organic Chemicals (VOCs) (Liquid/Liquid)	$ 33
367. Volatile Organic Chemicals (VOCs) (Purge and Trap)	$ 172
368. Yersinia culture-Environmental	$ 30
369. Zinc	$ 16
370. Zinc in foods	$ 3
371. Any Environmental Chemistry and Toxicology procedure not expressly stated will be charged based on the cost per unit of time (Work Time Unit or WTU) as calculated by the fiscal department of the Office of Public Health	Not to exceed $1.75 WTU
372. Any Environmental Microbiology procedure not expressly stated will be charged based on the cost per unit of time (Work Time Unit or WTU) as calculated by the fiscal department of the Office of Public Health	Not to exceed $1.75 WTU
373. Any Research Procedure not expressly stated will be charged based on the cost per unit of time (Work Time Unit or WTU) as calculated by the fiscal department of the Office of Public Health	Not to exceed $1.75 WTU

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:29.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Health Services and Environmental Quality, LR 3:245 (May 1977), amended by the Department of Health and Hospitals, Office of the Secretary, LR 15:477 (June 1989), amended by the Office of Public Health, LR 24:942 (May 1998), amended by the Department of Health, Office of Public Health, LR 44:1911 (October 2018).

§13705. Billing and Payment Procedures

A. The fees shall be billed to the submitter as follows.

1. A submitter who meets the definition of a billable submitter and wishes to contract with the Division of Laboratories (DOL) to provide one or more of the laboratory tests described in the fee schedule should contact the health laboratory director or the health laboratory assistant director at (504) 568-5373 or in writing at Box 60630, New Orleans, LA 70160.

2. A contract stating the tests and associated fees to be charged will be signed by both parties and an account number assigned. The submitter will be issued a Laboratory Submission Manual by the DOL and may begin submitting specimens and samples following approved DOL procedures and lab submittal forms. The submitter must place the account number on all lab forms when requesting analysis.

3. Billing will be done on a monthly basis. The Division of Laboratories will submit an invoice of fees for laboratory services by the fifteenth each month for each separate account. The invoice shall describe the analysis performed, the date of analysis, date of report, the fee per test and the total charge for current services rendered. Past due amounts will be added to the current charges and the extended total provided.

4. The customer will remit payment by check within 30 days of the billing date. Checks will be made out to the Office of Public Health and mailed to Box 60630, New Orleans, LA 70160. When the checks are received they will be credited to the appropriate account number by staff in the Division of Laboratories. A roster of checks by number and account will be generated. The checks and the accompanying check roster will be transferred to the Fiscal Office of DHH at 1001 Howard Avenue, New Orleans, LA 70112 for final processing within the state system.

5. If payment is not received within 30 days of the billing date, the DOL will issue a past due letter. The customer must respond in writing or by telephone if a discrepancy exists. Otherwise, payment by check to cover the overdue amount on the statement must be made within 30 days of the date of the past due letter.

6. If the customer does not respond or payment is not received within 30 days, the account will be turned over to the OPH Fiscal Services Department and future laboratory services will be discontinued until full payment is made.

7. If the customer does not respond to the collection agency and payment is not received within 90 days of the transfer of the account to the collection agency then the account will be turned over to the DHH Bureau of Legal Services for action.

8. The DOL will engage the services of a CPA (Certified Public Accountant) to oversee the ongoing collection of fees and to audit the system on an annual basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:29.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:948 (May 1998).

Subpart 53. State Center for Health Statistics

Chapter 151. State Health Care Data Clearinghouse

§15101. Purpose

A. Louisiana R.S. 40:1300.111 et seq. established a "state health care data clearinghouse" in the Office of Public Health with responsibility for the collection and dissemination of health care data. The legislative action was based upon a finding that as a consequence of rising health care costs, a shortage of health care professionals and health services in many areas of the state, and the concerns expressed by health care providers, consumers, third party payors, and others involved with planning for the provision of health care, there is a need to understand patterns and

trends in the availability, use, and charges for these services and the underlying patterns of disease which result in these services. The statute requires that state agencies and licensed health care providers shall provide the information necessary to carry out the purpose of this law. In accordance with the statute, the collection of hospital discharge data is to be accomplished in collaboration with representatives from hospitals, health care providers, payors, data users and other state agencies. It is the purpose of these regulations to provide directions for the required collection, submittal, management and dissemination of health data and to provide for the confidentiality of the data.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1933 (October 1998).

§15103. Definitions

A. For the purposes of these regulations, the following words and phrases, when used herein, shall be construed as listed below.

Act—the Act 622 of the 1997 Regular Legislative Session, R.S. 40: 1300.111 et seq.

Aggregate Data Set—an array of counts of patient level records, or of totals of patient level record quantities (example: Total Charges), classified by data categories (example: "year of discharge"). Aggregate data sets may be used to present health data usefully, yet in a manner which can minimize potential for identification of confidential information, since they can be assured to have any necessary minimum cell size. Aggregate data sets shall not include the following information:

a. facility identifiers;

b. patient or insured identifiers;

c. physician or other health care service provider identifiers;

d. payor identifiers;

e. employer identifiers.

Confidential Information—that information defined as confidential in this rule including, but not limited to:

a. employer identifiers, facility identifiers, patient or insured identifiers, payor identifiers, or physician or other service provider identifiers;

b. information identified by the identifiers;

c. combinations of data categories derived from part or all of the hospital discharge database information that would identify or tend to identify an employer, facility, patient or insured person, payor, or physician or other service provider; and

d. information identified by combinations of these data categories.

Data Base—a structured repository of data, consisting of one or more related structured data tables.

Data Category—one of the typically (though not necessarily) non-unique data values of a data element, or to equivalent labels for these values. For example, the data categories of the data element years may be three in number: "98," "99," and "00," and may be labeled "1998," "1999," and "2000," whereas the data categories of the data element patient birth date may have thousands of possible values, some of which are probably uniquely associated with exactly one person.

Data Element—a logical field of a data record or a column of a data table, and includes both the named data elements in this rule, and any other data elements obtained or created by analytic or synthetic methods. Examples: discharge year, age group, sex, or disease group.

Data Record—the row of a data table, or the set of related rows from related tables in a database.

Data Set—a structured subset of data from a database.

Department—the Louisiana Department of Health and Hospitals.

Employer Identifier—employer name, employer location/address excluding the first three digits of the ZIP code, or other information that identifies an employer.

Facility Identifier—provider name, provider telephone number, provider fax number, federal tax number or ein, federal tax sub ID, Medicare provider number, national provider identifier, mailing address excluding the first three digits of the ZIP code, or other information that identifies a facility.

Guide—the Hospital Discharge Data Submittal Guide included in §§15113-15129 of this rule.

Health Research—the study of patterns or trends in health or health care.

Hospital—any institution, place, building or agency, public or private, whether organized for profit or not-for-profit, which is subject to licensure as a hospital by the Louisiana Department of Health and Hospitals.

Hospital Discharge Information—all billing, medical, and personal information describing a patient, the services received, and charges billed, associated with a single inpatient hospital stay, including all elements of the Uniform Billing form, UB-92.

Hospital Discharge (Data) Record—the structured document, in paper or electronic form, of all the UB 92 data for a single hospital stay, or the data content of that document. This often will include more than one data record.

Hospital Stay or Inpatient Hospital Stay—the period, activities, events, and conditions associated with a patient, from the time of admission to a hospital, to the time of discharge from that hospital. Facilities licensed as hospitals and having different provider numbers are, for the purpose

of this definition, distinct hospitals having discrete hospital stays and hospital discharges.

Intermediary—a data processing agent of a hospital, who is contracted or employed by that hospital to relay their Hospital Discharge Records to OPH in compliance with these rules.

Office, also OPH—the Louisiana Office of Public Health;

Panel or Research Panel—the Hospital Discharge Data Research Panel as described in §15007 of this rule.

Patient or Insured Identifier—patient name, insured's name, patient address or insured's address (specifically including P.O. Box or street address, but not city, 5-digit ZIP Code, or state), patient control number, SSN, medical record number, health insurance claim identification number, or information that would identify or tend to identify an individual patient or insured person under whom the patient may be covered.

Patient Level Data—the non-aggregate, one logical record per discharge, form of data submitted by hospitals which includes part or all of the submitted data elements or recoded data derived from submitted data elements. This term refers to both the raw patient level data still in the form in which it is submitted, and the cleaned patient level data which may have had error checking or edits applied or which may have been separated into the specifically named patient or insured identifier data elements and the remaining data elements. Patient level data may include all or part of the hospital discharge data record.

Payor Identifier—the payor name, payor identification, insured group name, insurance group number, or other information that identifies a payor.

Physician and Other Service Provider Identifier—attending physician name, attending physician number, operating physician name, operating physician number, other physician name, other physician number, or other information that identifies a physician or other service provider.

Publish—to make any hospital discharge information available in paper or electronic form to person(s) who are not:

a. part of the research group authorized to use that information by the research panel as described in §15109; or

b. OPH staff authorized to use that information.

Release—a conditional distribution of hospital discharge information for purposes authorized by this rule.

Secure Information—that information which is not subject to release by OPH or the research panel, and will not be released for any purpose. Secure information includes patient and insured identifiers.

Submit—(with respect to a submission date, and data, reports, surveys, statements or documents required to be submitted to the Louisiana Office of Public Health) to deliver, or to cause to be delivered, to the Office of Public Health, in the form and format specified, by the close of business on the prescribed date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 2419340 (October 1998).

§15105. Confidentiality

A. Act 622 of 1997 provides for the strictest confidentiality of data and severe penalties for violation of the Act. After editing and compilation of data submitted under this rule, the Office of Public Health shall separate all secure information from the rest of the file. Redundant methods shall be employed to assure physical security, media security, transmission security, logical security, secure authorized access, and backup of all secure or confidential information. The collection, editing, compilation, storage, analysis and dissemination of reports or data shall be done in a manner that protects publication of information that identifies or tends to identify an individual patient.

B. Patient level data and the individual forms, computer tapes, or other forms of data collected by and furnished for the State Health Care Data Clearinghouse shall not be available for public inspection. In accordance with R.S. 40:1300.111D, any data that can be used to identify any individual patient shall not be subject to discovery in civil or criminal proceedings.

C. Data may be used as described in §§15107 and 15109 below.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1935 (October 1998).

§15107. Use of Hospital Discharge Records by OPH

A. Patient level data (raw or cleaned) may be released by OPH to the data provider that submitted that particular data.

B. The office may use patient level data in fulfilling its public health mission. The office will establish procedures for secure use of the data by OPH staff.

C. The office may release patient level data (excluding secure information) for use in health research, public education, administrative and health industry research in accordance with the provisions of §15109 of this rule (approval of the Hospital Discharge Data Research Panel). In consideration of the existing information industry in Louisiana, and to assure a measure of completeness and quality of this data during the initial years of the implementation, this data will not be released during the first 12 months following discharge. Starting with year 2000 discharges, the minimum delay observed will decrease by one month per year (a discharge 1/1/2000 may be released 12/1/2000), until 2010, when a minimum delay will no longer be observed.

D. Aggregate Information

1. The office may develop and publish aggregate data reports and aggregate data as resources permit that do not disclose confidential information as defined in §15103 of this rule. The aggregate data reports and aggregate data shall be public information and may be distributed electronically.

2. The office may also release aggregate data on request, as resources permit. Such data may be released when it does not disclose confidential information, as defined in §15103 of this rule. The data request should be made to the director of the Division of Health Information, DHH-OPH and must include:

a. rationale for the study or data use;

b. a summary of the research plan, including a definition of, and justification for the particular fields and records necessary for the research;

c. signed agreement for use of data affirming that data will be used only for the purpose stated in the request, and that no attempts will be made to combine data provided for this request with other data provided from a previous request or another source, or attempt to identify confidential information;

d. affirmation that a copy of any publication resulting from the use of the records shall be provided to the director of the Division of Health Information;

e. a signed agreement to indemnify and hold the state, DHH, and OPH, its employees, and the original providers of the patient level data harmless from any liability arising out of the authorized or unauthorized use of the data.

E. OPH Reports Containing Identifiers

1. The office may apply to the Hospital Discharge Data Research Panel (§15109 of this rule) for approval for publication of health care data reports with employer, facility, payor and/or physician and/or other healthcare provider identifiers. The application shall state the purpose of the report and a justification for releasing it with identifiers. If the panel approves the request, a copy of the report(s) shall be provided to all panel members at least one full working day prior to release for publication.

2. The criteria for approval by the panel shall include, but are not limited to:

a. the report content and design reflect that the proposal is in the best interest of the public health;

b. the report reflects the use of accepted methods of data analysis;

c. the investigators/researchers are deemed qualified based on their past research, employment and education;

d. provisions to protect the confidentiality of the patient identifiers comply with §15109.B.2.

3. Panel action on office proposals to publish employer, facility, payor, physician or other healthcare provider specific reports shall be in accordance with §15109.B of this rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1935 (October 1998).

§15109. Use of Hospital Discharge Records in Research

A. Any person may apply to the office to conduct research for health surveillance, public education, administrative, or health industry purposes using patient level data. Non-aggregate data (patient level data) shall be disclosed only when the Hospital Discharge Data Research Panel has deemed that it would be impractical to perform the research with aggregate data. Only the fields and records necessary for the proposed study will be released.

1. Panel. Pursuant to R.S. 40:1300.112.B(1) and D., the Hospital Discharge Data Research Panel is established. It shall operate in accordance with the following guidelines.

a. Membership. The panel shall be composed of at least 15 members with varying background and expertise, to promote complete and adequate review of research activities commonly conducted using hospital discharge data.

i. The panel membership shall reflect sufficient experience and expertise with hospital data and/or data analysis, sensitivity to cultural diversity and privacy issues, and the professional competence necessary to review research proposals in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice.

ii. The panel shall include the following representatives of the Office of Public Health:

(a). the state health officer or programmatic designee;

(b). the director of the Division of Health Information; and

(c). the State Registrar of Vital Records. The state health officer or his designee shall chair the panel.

iii. The state health officer shall appoint 12 additional panel members representing groups and organizations that have knowledge and expertise in fields related to research using health care data. Accordingly, the appointees will include a representative of health care consumers, a representative of payors, private hospital representation, and members of the following organizations:

(a). Louisiana Health Care Review Inc.;

(b). Louisiana Health Information Management Association;

(c). Louisiana Hospital Association;

(d). Louisiana State Medical Society;

(e). Louisiana State University;

(f). Metropolitan Hospital Council of New Orleans;

(g). Rural Hospital Coalition;

(h). Tulane University; and

(i). VHA Gulf States.

b. Panel Meetings. The state health officer or designee shall convene panel meetings. The panel will review research requests on a quarterly basis or as needed. Regular meeting dates shall be communicated to panel members in writing at least 21 calendar days prior to the meeting. If any emergency or ad-hoc meetings are required, meeting dates for these additional meetings shall be communicated to panel members, in writing, at least seven calendar days prior to the meeting.

c. Panel Quorum. A quorum shall require the presence of eight members. A majority of the members present must concur via a roll call vote for the panel to take action on the approval or disapproval of any research application.

d. Panel Records. Adequate documentation of the panel activities shall be maintained including the following:

i. copies of all research and special report proposals reviewed, including attachments;

ii. minutes of all panel meetings shall be in sufficient detail to show attendance at meetings, actions taken by the panel, the vote on the actions including the number of members voting for, against or abstaining, the basis for requiring changes in or disapproving research, and a written summary of controversial issues and their resolution;

iii. copies of all correspondence;

iv. the records required by these rules shall be retained for at least three years after completion of the research. These records shall be exempt from the Public Records Law.

2. Research Using Patient Level Records

a. Application. A request for use of hospital discharge information, excluding secure information, in research shall be in writing and shall be addressed to the state health officer. The data request must include:

i. a complete experimental protocol, including health objectives, rationale for the study, design detail and scientific basis for selection of subjects;

ii. a summary of the protocol, including a definition of, and justification for, the particular fields and records necessary for the research;

iii. copy of the informed consent form and an outline of the consent process, if required by the panel (for proposed follow-back research or contact with employers, payors, facilities, physicians or other healthcare providers);

iv. provisions to fully protect the confidentiality of the data and the privacy of patients and insured persons related to the patient;

v. affirmation that data files provided by OPH to the applicant will not be re-released to other researchers or anyone else not connected to the specific study for which the data is released;

vi. résumés of all investigators identifying their specific qualifications to do the research proposed, listing educational degrees and societies, certifying boards and academic institutions which have recognized their competence by granting membership, diploma, or title, previous work in the subject area and employment;

vii. approval from an institutional review board for this study or approval from an educational department chairman where the applicant is employed by or associated with an institution which requires such approval;

viii. affirmation that a report of the findings resulting from the use of the records shall be provided to the state health officer;

ix. a signed agreement to indemnify and hold the office, its employees, panel members, and the original providers of the patient level data harmless from any liability arising out of the authorized or unauthorized use of the data.

b. Use of employer, facility, payor, physician or other healthcare provider identifiers. Researchers requesting any of these identifiers must additionally affirm that none of these identifiers or combinations of elements that identify or tend to identify any of these parties will be published or otherwise disclosed without the specific approval of the panel. If any physicians or other healthcare providers will be identified in a proposed publication, the panel must receive a copy of the study or report prior to submission for publication. Following receipt of this copy, the panel will require a two-week waiting period prior to final approval for publication.

c. Confidentiality of Data Used for Research. The researcher shall establish reasonable administrative, technical and physical safeguards to prevent unauthorized use or disclosure of the records. At the end of the project all confidential information will be destroyed.

d. Criteria for Approval of Research. The criteria for the approval of research shall include, but are not limited to:

i. the study objective and design reflect that the proposal is in the best interest of the public health;

ii. the selection of subjects is made on a scientific basis;

iii. the investigators/researchers are deemed qualified based on their past research, employment and education or other appropriate credentials;

iv. where appropriate, approval of an institutional review board has been obtained;

v. provisions to protect the confidentiality of the data and subjects comply with §15109.B.2 of this rule;

vi. the informed consent process and forms follow the guidelines required in these rules and will be appropriately documented as required.

e. Panel Review and Notification. The panel will review research requests on at least a quarterly basis. Following review, the panel shall notify requesters, in writing, of the decision to approve or disapprove the proposed study or modifications required to secure approval of the research activity. If the panel disapproves a request, it shall include in its written notification a statement of the reasons for its decision and give the investigator/researcher an opportunity to request reconsideration, in writing.

f. Requests for Reconsideration. Requests for reconsideration must be filed within 30 days of the date appearing on the notification. The panel shall schedule a hearing of the appeal to be held within 90 days of the date of receipt of the appeal. The principal investigator/ researcher has the right to appear to defend the proposal at a reconsideration hearing. If on reconsideration the research proposal is denied, the requester shall have a right to appeal the panel's decision in accordance with the procedure outlined below.

g. Appeal of Data Use Denial. Any person who submits a research, educational or administrative use proposal to the panel that is denied shall have a right to petition for judicial review of the panel's final action in accordance with the Administrative Procedure Act (R.S. 49:950 et seq.). This remedy shall be the exclusive means of appealing the action of the panel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1936 (October 1998).

§15111. Incorporation by Reference

A. The following documents are incorporated by reference. They are available for public review at the State Center for Health Statistics, Office of Public Health.

1. International Classification of Diseases, Clinical Modifications 9. Copies are available from the World Health Organization, P.O. Box 5284, Church Street Station, New York, New York 10249.

2. International Classification of Diseases, Clinical Modifications 10 (due for publication, December 1998). Copies will be available from the World Health Organization, P.O. Box 5284, Church Street Station, New York, New York 10249.

3. Louisiana Uniform Billing Training Manual, UB-92, including final addenda of July 21, 1993. Copies are available from the Louisiana Hospital Association, P.O. Box 80720, Baton Rouge, LA 70898-0026.

4. Uniform Hospital Billing Form 1992 (UB92/HCFA-1450). Copies are available from the Office of Public Affairs, Health Care Financing Administration Humphrey Building, Room 428-H, 200 Independence Avenue S.W., Washington, D.C. 20201.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1937 (October 1998).

§15113. Hospital Discharge Data Submittal Guide—General

A. Data Reporting Source. All facilities operated and licensed as a hospital in the state of Louisiana by the Louisiana Department of Health and Hospitals will report discharge data to the Office of Public Health (OPH) for each patient admitted as an inpatient. A failure to report may result in action by the licensing authority.

B. Reporting Responsibilities

1. The single billing discharge data record must be submitted for the reporting period within which the discharge occurs. If a claim will not be submitted to a provider or carrier for collection (e.g., charitable service), a hospital discharge data record must still be submitted to OPH, with the normal and customary charges, as if the claim was being submitted.

2. Multiple Discharges. For a patient with multiple discharges, submit one discharge data record for each discharge.

3. Multiple Billing Claims. For a patient with multiple billing claims, the facility should submit all data related to a discharge in one of two ways:

a. consolidate the multiple billings into one discharge data record for submittal for the reporting period within which the discharge occurs; or

b. submit each interim billing claim for the reporting period in which the claim is generated.

4. A hospital may submit discharge data directly to OPH, or may designate an intermediary, such as a commercial data clearinghouse. Use of an intermediary does not relieve the hospital from its reporting responsibility. In order to facilitate communication and problem solving, each hospital should designate a contact person and a backup for the contact person. Provide the names, telephone numbers, and job titles of the persons assigned this responsibility to the Office of Public Health, Center for Health Statistics, on forms provided by OPH.

C. Confidentiality of Data. Act 622 provides for the strictest confidentiality of data and severe penalties for the violation of the Act. Any information collected from hospitals that identifies a patient or person under whom the patient is insured cannot be released. In addition, physician, facility, payor or employer identifiers cannot be released without Research Panel approval. The Office of Public Health needs patient-specific information to complete analyses. The office will take every prudent action to ensure the confidentiality and security of the data submitted. Procedures include, but are not limited to, physical security

and monitoring, separation of personal identifiers from the analytical file, access to the files by authorized personnel only, passwords and encryption. Not all measures taken are documented or mentioned in this guide to further protect the data. After receiving and editing the data, OPH will separate personal patient identifiers (i.e., name, street address or P.O. Box, and SSN or other patient number). The database edits system will assign a unique nonpersonal key in order to maintain patient level data (i.e., a patient with multiple discharges can be tracked within and among hospitals.)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1937 (October 1998).

§15115. Guide—Hospital Discharge Data Submittal Schedule

A. Each licensed Louisiana hospital which collects Hospital Discharge Information, as set forth in this rule, shall submit Hospital Discharge Records to the Office of Public Health in a manner that complies with the provisions of the guidelines here included for all hospital discharges occurring on or after January 1, 1998. While all hospitals are responsible for submitting their data to the Office of Public Health, some may contract with third-party intermediaries. All hospitals or their intermediaries will submit data to the Office of Public Health according to the reporting schedule listed below. See the section on use of intermediaries for further details.

1. Submittal Schedule. Discharge data records will be submitted to the Louisiana Office of Public Health as specified below.

a. Reporting Period. Hospitals (or their representatives) must generate and submit their data to OPH quarterly, excepting the first year (1998), in which data may be submitted semiannually. Monthly submittal via electronic transfer is also encouraged.

b. Data Source. The submittal file must be created from the current transaction file or an equivalently cumulatively updated claim file and the submittal must be received by OPH no later than the dates below. Earliest practical submission of complete data is requested.

NOTE: It is understood that data for a given claim may not be complete during the first three-month post-discharge.

2. Reporting Schedules by Year

Reporting Schedules by Year	
Person's Date of Discharge Is	**Data Must be Received By**
1998	
January 1 through June 30, 1998	December 31, 1998
July 1 through December 31, 1998	June 30, 1999
1999	
January 1 through March 31	September 15, 1999
April 1 through June 30	December 15, 1999
July 1 through September 30	March 15, 2000
October 1 through December 31	June 15, 2000
2000 and after	
January 1 through March 31	August 31 (same year)
April 1 through June 30	November 30 (same year)
July 1 through September 30	February 28 (following year)
October 1 through December 31	May 31 (following year)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1938 (October 1998).

§15117. Guide—Use of Data Processing Intermediaries

A. Third-party intermediaries may be utilized by hospitals for the delivery of data to the Office of Public Health. Intermediaries must be registered with OPH on registration forms provided by the Office. Additions and deletions to the intermediary's list of hospitals represented must be submitted at least 10 days prior to the submittal schedule reporting due date.

B. Hospitals shall notify the Office by January 1 of each year if they plan to submit the required data to the Office through a third-party intermediary that is registered with the Office. Hospitals selecting this option are responsible for ensuring that the submitted data conform to specifications contained in the Guide. These specifications include, but are not limited to, the format, timeliness, and quality criteria of completeness, validity and consistency outlined in the Guide. The third-party intermediary is responsible to the hospital for ensuring that the data are submitted to the Office in conformance with specifications contained in the Guide.

C. The following additional requirements and information apply to intermediaries delivering data to OPH:

1. Data may be delivered in any number of submittals (i.e., one per hospital, several hospitals combined, or all hospitals combined in one submittal), but the minimum unit of data submittal is all discharge records from one hospital per submittal time period.

2. Data may be submitted via any approved transfer media - declared at the time of registration.

3. Data may be submitted in any approved data format declared at the time of registration.

4. The intermediary must submit data for three or more hospitals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1938 (October 1998).

§15119. Guide—Extensions and Waivers

A. All hospitals will submit discharge data in a form consistent with the requirements unless an extension or waiver has been granted. Extensions may be granted when the hospital documents that unforeseen difficulties, such as technical problems, prevent compliance. Waivers may be

granted when the hospital documents the need for data format changes before it can begin collecting and submitting specific data elements. Waivers will also be granted upon request for difficulties that prevent compliance for the time period January 1 to June 30, 1998. Requests for extensions or waivers should be in writing and be directed to: Director, Division of Health Information, Louisiana Office of Public Health, 325 Loyola Avenue, Suite 503, New Orleans, LA 70112. Phone: (504) 568-7708 fax: (504) 568-6594.

1. Extension of Time for Data Submittal

a. Any hospital which determines it temporarily will be unable to comply with a data submittal date or with data submittal time lines established in a previously submitted plan of correction may apply to the Office for an extension. An application for extension should be submitted at least 15 working days prior to the data submission deadline. The application for extension shall reference the relevant section number(s) and the relevant text of the rule or the documents incorporated by reference under §15111. The application for extension shall include specific reasons why the provider cannot comply with the rule in the required time frame, a specific plan sufficient to correct the problem, and the proposed data submission date.

b. The office shall act upon an application for extension of time within 10 working days of receiving the written request. Failure of the office to act on the application shall be deemed as a grant of the extension.

c. A denial of the application for extension shall be appealable to the assistant secretary of the Office of Public Health. The appeal shall be filed within seven days of receipt of the denial letter. The assistant secretary shall act on the request within seven days of its receipt and his/her action shall be final.

2. Waivers of Data Requirements

a. Any hospital which determines it will be unable to comply with any of the provisions of this rule or with the provisions of a previously submitted plan of correction, for submission of particular data elements of the required format, quality or completeness for specific discharge periods, may apply to the office for a waiver. A data element-based waiver may be granted for the submission of specific data elements for specific durations and does not, in this case, relieve the hospital of the obligation to submit other required data elements in a timely manner. A general waiver may also be granted for compliance with the required data format. An Application for Waiver should be submitted at least 30 working days prior to the data submission deadline on a form provided by the office. In every case, the Application for Waiver shall reference the relevant section number(s) and the relevant text of the rule or the documents incorporated by reference under §15111. The Application for Waiver shall include specific reasons why the hospital cannot comply with the rule, a specific plan sufficient to correct the problem(s), and the earliest date(s) when the hospital will be compliant. Waivers will be granted upon determination of a satisfactory application during the first year, and as necessary thereafter.

b. The office shall act upon an Application for Waiver within 20 days of receiving the written request. Failure of the office to act on the application shall be deemed as a grant of the waiver.

c. A denial of the Application for Waiver shall be appealable to the assistant secretary of the Office of Public Health. The appeal shall be filed within seven days of receipt of the denial letter. The assistant secretary shall act on the request within seven days of its receipt and his/her action shall be final.

d. Failure of the hospital to submit an acceptable plan or to follow an accepted plan shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the assistant secretary of the Office of Public Health.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1939 (October 1998).

§15121. Guide—Data Errors and Certification

A. Hospitals will review the discharge data records prior to submittal for accuracy and completeness. Correction of invalid records and validation of aggregate tabulation are the responsibility of the hospital. All hospitals will certify the data submitted for each reporting period in the manner specified and will annually review summary reports before statistical analyses are published by the Center for Health Statistics, Louisiana Office of Public Health.

1. Error Correction

a. The hospital is responsible for submitting accurate and complete data in one of the specified formats. The state may identify errors for hospital review, comment, and correction when applicable. The records with errors will be identified in a simplified format providing record identification and an indication or explanation of the error. The error report will be sent by certified mail or e-mail to the attention of the individual designated to receive the correspondence at the hospital.

b. In the event 5 percent or more of the records per hospital in a submittal period are in error, the submittal for that hospital will be rejected. A record is in error when one or more Required Data Elements are missing or in error (excepting those elements for which a waiver has been granted). Notification of the rejection will accompany the error report and will be sent by certified mail to the attention of the individual designated to receive the correspondence at the hospital.

c. After the submittal has been corrected, the submittal is to be resubmitted, in its entirety and original format, within one month of receipt, to the Center for Health Statistics, Louisiana Office of Public Health. This correction cycle may repeat.

2. Certification and Review

a. Following receipt of a data submittal and completion of any needed error correction, the Center for Health Statistics will send the hospital-designated contact a Discharge Data Summary Report containing the total number of records received for the reporting period, by discharge disposition, and by payor class for each hospital.

b. The hospital-designated responsible contact will validate, in writing, the accuracy of the Discharge Data Summary Report and verify that the data sent were complete for that reporting period. Regardless of any waiver granted, the hospital will provide an estimate of the number of any unreported discharges for the reporting period. The signed validation will be returned to the Center for Health Statistics, Louisiana Office of Public Health within 10 working days.

3. Noncompliance

a. Upon written notification of noncompliance by the office, the chief executive officer shall have 10 working days following receipt of the written notification of noncompliance to provide the office with a written plan for correcting the deficiency. The plan of correction shall include specific reasons why the hospital cannot comply with the rule in the required time frame, a specific plan sufficient to correct the problem, and the proposed data submission date.

b. Failure of the hospital to submit an acceptable plan or to follow an accepted plan shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the assistant secretary of the Office of Public Health.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1939 (October 1998).

§15123. Guide—Data Submittal Specifications

A. Currently, data may be submitted by modem (the preferred method), PC diskette, CD-ROM, magnetic tape (reel), or electronic media to be determined by OPH. Additional media or modes of transfer will be announced by OPH as they become available. Data submittals not in compliance with transfer media or format specifications will be rejected unless approval is obtained prior to the scheduled due date from the Center for Health Statistics. Media labeling and data submittal specification updates will be posted on the OPH Web page.

1. Transfer. Data submittal standards shall encourage the use of electronic transfer of database files (structure to be provided by OPH) or structured ASCII files via telecommunications. Editing of data prior to submittal is encouraged and assistance from OPH will be provided.

2. Address for Data Submittal: Center for Health Statistics, Louisiana Office of Public Health, 325 Loyola Avenue, Suite 503, New Orleans, La 70112; or: LAHIDD@dhhmail.dhh.state.la.us.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1940 (October 1998).

§15125. Guide—Data Elements

A. Listed below are required and conditionally required data elements. Submission of any other data elements is optional; hospitals do not need to suppress or strip other elements appearing in their claims files. All elements submitted will be treated confidentially.

1. Required Data Elements. If a hospital is currently or temporarily unable to provide any of the data elements listed here, the hospital must apply for a waiver or extension, as detailed in §15119 of this rule.

Data Element	Form Locator	1300 Record Number	1450 Record Type	1450 Record Number
Patient Control Number· assigned by Provider	3	1	20	3
Type of Bill	4	2	40	4
Federal Tax ID (Facility EIN)· with Sub ID Number if applicable	5	3165	10	45
Statement Covers Period From	6	4	20	19
Statement Covers Period Thru	6	5	20	20
Patient Name	12	(none)	20	4-6
Patient Address	13	6(zip only)	20	12-16
Patient Date of Birth	14	7	20	8
Patient Sex	15	8	20	7
Admission Date	17	9	20	17
Type of Admission	19	11	20	10
Source of Admission	20	12	20	11
Patient Status at time of discharge	22	13	20	21
Medical/Health Record Number	23	14	20	25
Revenue Codes· Include all listed· Must be valid UB92 codes	42	Odd Number's 15-59	6050	4, 13, 14, 4, 11, 12, 13
Units of Service· Include all listed	46	Odd Number's 97-141	60	8, 13, 14
Total Charges· Include all listed	47	Even Number's 16-60	6050	97
Payor Classification· Include all listed· HCFA Payor ID number preferred	50	156, 157, 158	30	5
Principal Diagnosis Code	67	69	70	4
Other Diagnosis codes· Include	68-75	70-77	70	5-12
Admitting Diagnosis Code	76	78	70	25
External cause of injury code (E- Must contain data if possible	77	79	70	26
Principal Procedure Code and Date	80	80-81	70	13-14
Other Procedure Codes and Include all listed	81	82-91	70	15-24
Attending Physician ID· State	82	92	80	5
Operating Physician Number· State License Number· Required if present	83	93	80	6
Other Physician ID· State Required if present	84	94	80	7-8
Patient Social Security Number	60Only if	161	22	5a

Data Element	Form Locator	1300 Record Number	1450 Record Type	1450 Record Number
	insured			
Patient Race	none	155	22	7a
*Number of Claims	N/A	N/A	95	6
*Record Type	N/A	N/A	all	1
*Sequence Number	N/A	N/A	21-70, 72, 80-81	2

a. Elements marked with an asterisk are required for submittals of the electronic 1450 only; they are included because they are essential to the 1450.

b. The definitions of most data elements referred to in this rule can be found in the Louisiana UB-92 Users Manual referenced in §15109 of this rule. Hospitals using data sources other than uniform billing should evaluate their definitions for agreement with the definitions specified in this Guide and the Louisiana UB-92 Users Manual. The exceptions to referenced definitions are listed below.

i. Patient's Race—this alphanumeric one-character element contains race category information based on self-identification, which is to be obtained from the patient, a relative, or a friend. The hospital should not categorize the patient based on observation or personnel judgment. The patient may choose not to provide the information. If the patient chooses not to answer, the hospital should enter the code for unknown. If the hospital fails to request the information, the field should be space filled. Code as follows: 1 = Native American or Alaskan Native: A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition. 2 = Asian or Pacific Islander: A person having origins in any of the peoples of the Far East, South East Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa. 3 = African American/Black: A person having origins in any of the black racial groups of Africa. 4 = Caucasian/White: A person having origins in any of the Caucasian peoples of Europe, North Africa, or the Middle East. 5 = Other: Any possible options not covered in the above categories. 6 = Unknown: A person who chooses not to answer the question. Blank Space: The hospital made no effort to obtain the information.

ii. Patient Social Security Number—numeric, 10-character entry containing the Social Security Number of the patient receiving care. This field is to be right justified with zeroes to the left to complete the field. The format of SSN is 0123456789 without hyphens. If the patient is a newborn, use the mother's SSN. If a patient does not have a social security number fill with zeroes. The field is edited for a valid entry.

2. Additional Data Elements Required if Available. These elements are required if the facility systematically collects the data in the ordinary course of operations as part of the facility's standard operating procedures and that data is readily available for inclusion in the claim file.

Date Element	Form Locator	1300 Record Number	1450 Record Type	1450 Record Number
Provider Name	1	(none)	10	12
Provider Address· Must include zip code and city	1	(none)	10	13-16
Marital Status	16	(none)	20	9
Admission Hour	18	10	20	18
Discharge Hour	21	166	20	22
Provider Number	51	62,144,149	30	24
Insured's Name	58	(none)	30	12-14
Patient's Relationship to the Insured	59	63, 145, 150	30	18
(Insured's) Certificate/SSN/Health Insurance Claim/Identification Number	60	64, 146, 151	30	7
Insured Group Name	61	(none)	30	11
Insurance Group Number	62	65, 147, 152	30	10
Treatment Authorization Code	63	(none)	40	5-7
Employment Status Code	64	66	30	19
Employer Name or EIN	65	67	3121	94
Employer Location	66	68(zip only)	3121	10-135-8

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1940 (October 1998).

§15127. Guide—Record Formats

A. The accepted data record formats are the UB-92 1450 version 4.1 format and the UB-92 1300 flat file format. The definition specified for each data element is in general agreement with the definition in the UB-92 Users Manual. Hospitals using data sources other than uniform billing should evaluate definitions for agreement with the definitions specified in this Guide and the UB-92 Users Manual. See §§15125 and 15127.B.3 to identify possible differences between standard referenced formats and requirements under this rule.

1. UB-92 1450 Version 4.1 Record Specification. The UB-92 1450 claim record is made up of a series of 192-character physical records, as listed in the Louisiana UB-92 Training Manual. Record Types not specified in the required data elements list are requested but are not required for submittal.

2. UB-92 1300 Record Specification. The UB-92 1300 flat file contains one record per discharge, except in the case of multi-page claims. However, the standard 1300 format does not contain some fields that are found on the 1450 format. The 1300 record format is included in §15127.A.2.c below.

a. Use of Multi-Page Claims. All data except revenue code and charge fields should be duplicated on successive records. All available revenue and charge fields should be completely filled before using additional records. The last entry must be the Total Charge (001) Revenue Code and the Charge Amount must be the total of all previous entries. Any remaining revenue and charge fields must be blank or zero filled. No zero or space filled fields should precede the 001 entry.

b. Exceptions to 1300 Format. Inclusion of the 1300 format as an accepted data format required the addition of data elements not found in the version currently used in Louisiana. The following fields indicate the locations for the additional data elements.

Number	Field Name	Form Locator
10	Admission Hour	FL18
14	Medical Record Number	FL23
78	Admitting Diagnosis	FL76
93	Operating Physician Number	FL83
153	Infant Birth Weight	(none)
154	Infant APGAR Score	(none)
155	Patient Race	(none)

c. 1300 Discharge Record. The record layouts that follow will provide the following information.

i. Record Number—Sequentially assigned record number (This is not the Form Locator).

ii. Field Name—the name of the data element (field).

iii. Picture—this is the COBOL picture. Pic X is initialized to blanks and Pic 9 is initialized to zeroes. All money and date fields are Pic 9.

iv. Justification—indicates how the data field is justified (left or right).

v. Start Position—leftmost position in the record.

vi. End Position—rightmost position in the record.

vii. Form Locator—this is the number found on the UB-92 paper form associated with the given field.

Record Number	Field Name	Picture	Justif-ication	Start	End	Form Locator
1.	Patient Control Number	X(20)	L	1	20	FL03
2.	Type of Bill	9(3)	R	21	23	FL04
3.	Federal Tax Number (EIN)	X(10)	L	24	33	FL05
4.	Statement Covers Period: FROM MMDDYYYY	9(8)	R	34	41	FL06
5.	Statement Covers Period: TO MMDDYYYY	9(8)	R	42	49	FL06
6.	Patient Address Zip Code	X(9)	L	50	58	FL13
7.	Patient Date of Birth	9(8)	R	59	66	FL14
	MMDDYYYY					
8.	Patient Sex	X(1)	L	67	67	FL15
9.	Admission Date	9(8)	R	68	75	FL17
10.	Admission Hour	9(2)	R	76	77	FL18
11.	Type of Admission	X(1)	L	78	78	FL19
12.	Source of Admission	X(1)	L	79	79	FL20
13.	Patient Status	9(2)	R	80	81	FL22
14.	Medical Record Number	X(17)	L	82	98	FL23
15.	Revenue Code Line 1	9(4)	R	99	102	FL42
16.	Total Charges by Revenue 1	S9(8)V99	R	103	112	FL47
17.	Revenue Code Line 2	9(4)	R	113	116	FL42
18.	Total Charges by Revenue 2	S9(8)V99	R	117	126	FL47
19.	Revenue Code Line 3	9(4)	R	127	130	FL42
20.	Total Charges by Revenue 3	S9(8)V99	R	131	140	FL47
21.	Revenue Code Line 4	9(4)	R	141	144	FL42
22.	Total Charges by Revenue 4	S9(8)V99	R	145	154	FL47
23.	Revenue Code Line 5	9(4)	R	155	158	FL42
24.	Total Charges by Revenue 5	S9(8)V99	R	159	168	FL47
25.	Revenue Code Line 6	9(4)	R	169	172	FL42
26.	Total Charges by Revenue 6	S9(8)V99	R	173	182	FL47
27.	Revenue Code Line 7	9(4)	R	183	186	FL42
28.	Total Charges by Revenue 7	S9(8)V99	R	187	196	FL47
29.	Revenue Code Line 8	9(4)	R	197	200	FL42
30.	Total Charges by Revenue 8	S9(8)V99	R	201	210	FL47
31.	Revenue Code Line 9	9(4)	R	211	214	FL42
32.	Total Charges by Revenue 9	S9(8)V99	R	215	224	FL47
33.	Revenue Code Line 10	9(4)	R	225	228	FL42
34.	Total Charges by Revenue 10	S9(8)V99	R	229	238	FL47
35.	Revenue Code Line 11	9(4)	R	239	242	FL42
36.	Total Charges by Revenue 11	S9(8)V99	R	243	252	FL47
37.	Revenue Code Line 12	9(4)	R	253	256	FL42
38.	Total Charges by Revenue 12	S9(8)V99	R	257	266	FL47
39.	Revenue Code Line 13	9(4)	R	267	270	FL42
40.	Total Charges by Revenue 13	S9(8)V99	R	271	280	FL47
41.	Revenue Code Line 14	9(4)	R	281	284	FL42
42.	Total Charges by Revenue 14	S9(8)V99	R	285	294	FL47
43.	Revenue Code Line 15	9(4)	R	295	298	FL42

Record Number	Field Name	Picture	Justif-ication	Start	End	Form Locator
44.	Total Charges by Revenue 15	S9(8)V99	R	299	308	FL47
45.	45 Revenue Code Line 16	9(4)	R	309	312	FL42
46.	Total Charges by Revenue 16	S9(8)V99	R	313	322	FL47
47.	Revenue Code Line 17	9(4)	R	323	326	FL42
48.	Total Charges by Revenue 17	S9(8)V99	R	327	336	FL47
49.	Revenue Code Line 18	9(4)	R	337	340	FL42
50.	Total Charges by Revenue 18	S9(8)V99	R	341	350	FL47
51.	Revenue Code Line 19	9(4)	R	351	354	FL42
52.	Total Charges by Revenue 19	S9(8)V99	R	355	364	FL47
53.	Revenue Code Line 20	9(4)	R	365	368	FL42
54.	Total Charges by Revenue 20	S9(8)V99	R	369	378	FL47
55.	Revenue Code Line 21	9(4)	R	379	382	FL42
56.	Total Charges by Revenue 21	S9(8)V99	R	383	392	FL47
57.	Revenue Code Line 22	9(4)	R	393	396	FL42
58.	Total Charges by Revenue 22	S9(8)V99	R	397	406	FL47
59.	Revenue Code Line 23	9(4)	R	407	410	FL42
60.	Total Charges by Revenue 23	S9(8)V99	R	411	420	FL47
61.	Filler	X(25)		421	445	
62.	First Provider Number (Payor)	X(13)	L	446	458	FL51A
63.	Patient's Relationship to Insured	X(2)	L	459	460	FL59A
64.	Certificate/SocSec Number/Health Insurance Claim/ Identification Number	X(19)	L	461	479	FL60A
65.	Insurance Group Number	X(20)	L	480	499	FL62A
66.	Employment Status Code	X(1)	L	500	500	FL64
67.	Employer Name	X(24)	L	501	524	FL65
68.	Employer Zip Code	X(9)	L	525	533	FL66
(For Diagnosis and Procedure Codes (69-90)-omit decimal)						
69.	Principal Diagnosis Code	X(6)	L	534	539	FL67
70.	Other Diagnosis Code 1	X(6)	L	540	545	FL68
71.	Other Diagnosis Code 2	X(6)	L	546	551	FL69
72.	Other Diagnosis Code 3	X(6)	L	552	557	FL70
73.	Other Diagnosis Code 4	X(6)	L	558	563	FL71
74.	Other Diagnosis Code 5	X(6)	L	564	569	FL72
75.	Other Diagnosis Code 6	X(6)	L	570	575	FL73
76.	Other Diagnosis Code 7	X(6)	L	576	581	FL74

Record Number	Field Name	Picture	Justif-ication	Start	End	Form Locator
77.	Other Diagnosis Code 8	X(6)	L	582	587	FL75
78.	Admitting Diagnosis	X(6)	L	588	593	FL76
79.	External Cause of Injury (E-Code)	X(6)	L	594	599	FL77
80.	Principal Procedure Code	X(7)	L	600	606	FL80
81.	Principal Procedure Date MMDDYY	9(6)	R	607	612	FL80
82.	Other Procedure 1: Code	X(7)	L	613	619	FL81
83.	Other Procedure 1 : Date MMDDYY	9(6)	R	620	625	FL81
84.	Other Procedure 2 : Code	X(7)	L	626	632	FL81
85.	Other Procedure 2 : Date MMDDYYYY	9(6)	R	633	638	FL81
86.	Other Procedure 3 : Code	X(7)	L	639	645	FL81
87.	Other Procedure 3 : Date MMDDYY	9(6)	R	646	651	FL81
88.	Other Procedure 4 : Code	X(7)	L	652	658	FL81
89.	Other Procedure 4 : DateMMDDYY	9(6)	R	659	664	FL81
90.	Other Procedure 5 : Code	X(7)	L	665	671	FL81
91.	Other Procedure 5 : Date MMDDYY	9(6)	R	672	677	FL81
92.	Attending Physician Number	X(22)	L	678	699	FL82
93.	Other Physician Number	X(22)	L	700	721	FL83
94.	Other Physician Number	X(22)	L	722	743	FL84
95.	Filler	X(2)	L	744	745	
96.	Century Flag Patient's DOB0=Birth Year 19001=Birth Year<1900	9(1)	R	746	746	
(Dates of Service-even numbers from 97-142; MMDDYY)						
97.	Units of Service Line 1	9(7)	R	747	753	FL46
98.	Date of Service Line 1	9(6)	R	754	759	FL45
99.	Units of Service Line 2	9(7)	R	760	766	FL46
100.	Date of Service Line 2	9(6)	R	767	772	FL45
101.	Units of Service Line 3	9(7)	R	773	779	FL46
102.	Date of Service Line 3	9(6)	R	780	785	FL45
103.	Units of Service Line 4	9(7)	R	786	792	FL46
104.	Date of Service Line 4	9(6)	R	793	798	FL45
105.	Units of Service Line 5	9(7)	R	799	805	FL46
106.	Date of Service Line 5	9(6)	R	806	811	FL45
107.	Units of Service Line 6	9(7)	R	812	818	FL46
108.	Date of Service Line 6	9(6)	R	819	824	FL45
109.	Units of Service	9(7)	R	825	831	FL46

Record Number	Field Name	Picture	Justif-ication	Start	End	Form Locator
	Line 7					
110.	Date of Service Line 7	9(6)	R	832	837	FL45
111.	Units of Service Line 8	9(7)	R	838	844	FL46
112.	Date of Service Line 8	9(6)	R	845	850	FL45
113.	Units of Service Line 9	9(7)	R	851	857	FL46
114.	Date of Service Line 9	9(6)	R	858	863	FL45
115.	Units of Service Line 10	9(7)	R	864	870	FL46
116.	Date of Service Line 10	9(6)	R	871	876	FL45
117.	Units of Service Line 11	9(7)	R	877	883	FL46
118.	Date of Service Line 11	9(6)	R	884	889	FL45
119.	Units of Service Line 12	9(7)	R	890	896	FL46
120.	Date of Service Line 12	9(6)	R	897	902	FL45
121.	Units of Service Line 13	9(7)	R	903	909	FL46
122.	Date of Service Line 13	9(6)	R	910	915	FL45
123.	Units of Service Line 14	9(7)	R	916	922	FL46
124.	Date of Service Line 14	9(6)	R	923	928	FL45
125.	Units of Service Line 15	9(7)	R	929	935	FL46
126.	Date of Service Line 15	9(6)	R	936	941	FL45
127.	Units of Service Line 16	9(7)	R	942	948	FL46
128.	Date of Service Line 16	9(6)	R	949	954	FL45
129.	Units of Service Line 17	9(7)	R	955	961	FL46
130.	Date of Service Line 17	9(6)	R	962	967	FL45
131.	Units of Service Line 18	9(7)	R	968	974	FL46
132.	Date of Service Line 18	9(6)	R	975	980	FL45
133.	Units of Service Line 19	9(7)	R	981	987	FL46
134.	Date of Service Line 19	9(6)	R	988	993	FL45
135.	Units of Service Line 20	9(7)	R	994	1000	FL46
136.	Date of Service Line 20	9(6)	R	1001	1006	FL45
137.	Units of Service Line 21	9(7)	R	1007	1013	FL46
138.	Date of Service Line 21	9(6)	R	1014	1019	FL45
139.	Units of Service Line 22	9(7)	R	1020	1026	FL46
140.	Date of Service Line 22	9(6)	R	1027	1032	FL45
141.	Units of Service Line 23	9(7)	R	1033	1039	FL46
142.	Date of Service Line 23	9(6)	R	1040	1045	FL45
143.	Filler	X(25)	L	1046	1070	
144.	Second Provider umber (Payor)	X(13)	L	1071	1083	FL51B
145.	Patient's Relationship to Insured	X(2)	L	1084	1085	FL59B
146.	Certificate/SocSec Number/ Health Insurance Claim/ Identification Number	X(19)	L	1086	1104	FL60B
147.	Insurance Group Number	X(20)	L	1105	1124	FL62B
148.	Filler	X(25)	L	1125	1149	
149.	Third Provider Number (Payor)	X(13)	L	1150	1162	FL51C
150.	Patient's Relationship to Insured	X(2)	L	1163	1164	FL59C
151.	Certificate/SocSec Number/ Health Insurance Claim/ Identification	X(19)	L	1165	1183	FL60C
152.	Insurance Group Number	X(20)	L	1184	1203	FL62C
153.	Infant Birth Weight (in grams)	9(4)	R	1204	1207	
154.	Infant APGAR Score	9(4)	R	1208	1211	
155.	Patient Race	9(1)	R	1212	1212	
156.	Primary Payor Code	X(2)	L	1213	1214	FL50A
157.	Second Payor Code	X(2)	L	1215	1216	FL50B
158.	Third Payor Code	X(2)	L	1217	1218	FL50C
159.	Medicaid Provider Number	X(12)	L	1219	1230	FL51
160.	Medicare Provider Number	X(12)	L	1231	1242	FL51
161.	Patient Social Security Number	X(9)	L	1243	1251	FL60
162.	Primary Payor Carrier ID Code	X(4)	L	1252	1255	
163.	Second Payor Carrier ID Code	X(4)	L	1256	1259	
164.	Third Payor Carrier ID Code	X(4)	L	1260	1263	
165.	Federal Tax Sub ID.	X(4)	L	1264	1267	
166.	Filler	X(2)	L	1268	1269	
167.	Filler	X(31)	L	1270	1300	

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1300.112(D).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 24:1941 (October 1998).

Subpart 55. Birth Defects Surveillance System

Chapter 161. General Provisions

§16101. Definitions

Advisory Board—the nine-member advisory board of the program.

Birth Defect—an abnormality of structure, function or metabolism that develops during prenatal, perinatal or early postnatal life that is diagnosed before a child reaches 3 years of age.

Case Finding—the process used to identify potential birth defects cases for inclusion into the central registry or central database of the Louisiana Birth Defects Monitoring Network.

CSHS—the Children's Special Health Services Program within the Office of Public Health.

Confidential Information—information collected through the Louisiana Birth Defects Monitoring Network that is private and protected under state and federal laws.

Director—the program director for the Louisiana Birth Defects Monitoring Network.

Department—the Department of Health and Hospitals.

LBDMN—the Louisiana Birth Defects Monitoring Network, which the office will establish to collect information about children with birth defects. The LBDMN is established to carry out the directives of the Louisiana Birth Defects Surveillance System, which was created under Louisiana Revised Statutes 40.31.41-31.48.

Office—the Office of Public Health within the Department of Health and Hospitals.

Registry—the centralized database where data collected through the LBDMN is housed.

Reporting Source—any physician, nurse or allied health professional, hospital, laboratory, and any other facility or agent directly or indirectly responsible for providing medical services to an individual affected by a birth defect.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.31.48.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 30:1019 (May 2004).

Chapter 163. Program Procedures

§16301. Procedures for Identification and Referral of Children with Birth Defects

A. The program will include the following.

1. Reporting sources required to report pursuant to the rule shall allow personnel from the department or its contractors to abstract information from the mother's and infant's files on their demographic characteristics, family history of birth defects, and outcomes of that and other pregnancies by that mother, according to the case definition used in LBDMN.

2. The chief operating officer, administrator, manager, director, and/or person in charge of each reporting source shall appoint one staff member as a contact person for the LBDMN surveillance activities. That staff member should be responsible for coordinating scheduled visits by LBDMN staff to review logs, discharge indices, and other case-finding sources, and will be responsible for arranging medical records review visits and record management.

3. LBDMN staff and the contact individual at the reporting source shall establish a schedule of case-finding and record review visits. This schedule shall take into account the capabilities of each individual reporting source in responding to data/information requests, as well as the need for timely case-finding and reporting for the LBDMN.

4. Potential cases are obtained/abstracted through review of medical records, logs, indices, appointment rosters, and other records.

5. The original medical records and other materials provided by the reporting source shall not be removed from that facility. Copies and other data should be made in compliance with existing federal and state laws and regulations.

6. The office will require information from a reporting source to be collected on a birth defects reporting form. This may be an electronic or paper form, as determined by LBDMN procedures.

7. The office will maintain a centralized database to include information reported on the birth defects reporting form.

8. The office will notify parents of infants and children identified of available early intervention services in their community.

B. Implementation

1. All reporting sources must comply with Act 194 of 2001 and these rules by July 1, 2004.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.31.48.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 30:1019 (May 2004).

§16303. Reporting Requirements

A. The office shall determine the health care facilities and providers which shall be required to report all birth defects, the types of conditions or defects that shall be reported, the type of information that shall be contained in the confidential report and the method for making the report.

B. To ensure an accurate source of data necessary to investigate the incidence, prevalence, and trends of birth defects, a reporting source shall make available to the program staff, office staff, or authorized agent medical records or other information upon request that relates to the occurrence of a birth defect.

C. The department secretary may require, in lieu of active case finding, reporting sources identifying and diagnosing birth defects to report the birth defects to the program within 30 days of diagnosis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.31.48.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 30:1020 (May 2004).

§16305. Confidentiality

A. Except as specifically authorized by this Chapter, information furnished to a LBDMN employee or to an authorized agent of the office that relates to cases or suspected cases of a birth defect is confidential and may be used only for the purposes outlined in this Chapter.

B. Information relating to individual cases or individual suspected cases of birth defects is not public information and shall not be released or made public except as provided by this Chapter.

C. The LBDMN may release information:

1. for summary reporting purposes, if released without personal identifiers;

2. to medical personnel, appropriate state agencies, health authorities, regional directors, and public officers of parishes and municipalities as necessary to comply with this Chapter and board rules relating to the identification, monitoring, and referral of children with birth defects;

3. to appropriate federal agencies, as authorized by law and provided that the information contains no personal identifiers.

D. No reporting source shall be held civilly or criminally liable for conveying confidential information, except in a case of gross negligence or willful misconduct.

E. A board member, the secretary of the department, an employee of the LBDMN or office, or an authorized agent may not be examined in a civil, criminal, special, or other proceeding as to the existence or contents of pertinent records of or reports or information about a child identified or monitored for a birth defect without the consent of the child's parents, managing conservator, guardian, or legally authorized representative.

F. All employees or authorized agents of the LBDMN or office given access to medical or registry records shall agree, in writing, to maintain confidentiality of information about children with birth defects and to protect the privacy of individuals and families who become part of the LBDMN registry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.31.48.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 30:1020 (May 2004).

§16307. Access to Information from the Central Registry

A. The LBDMN or other authorized persons may conduct investigations of cases or suspected cases in the LBDMN registry.

B. Access to the central registry information is limited to LBDMN personnel. Other persons with a valid scientific research interest may be granted access to the information upon approval by program director, the board, and the Department's Institutional Review Board. These persons must satisfy any requirements stipulated by the board, and must receive Institutional Review Board permission to obtain the data.

C. All persons granted access to confidential information and data shall agree, in writing, to maintain confidentiality, and shall be subject to civil penalties and/or internal proceedings and penalties if confidentiality is violated. Penalties may include denial of future access to confidential information.

D. The department and LBDMN shall maintain a listing of each person who is given access to confidential information in the LBDMN registry. The listing is public information and shall be made available to the public during the office's normal hours of operation. The listing shall include:

1. the name of the person authorizing access;

2. the name, title, and organizational affiliation of each person who is granted access;

3. the dates of access;

4. the specific information requested;

5. the specific purpose for which the information was used;

6. results of independent research.

E. Progress reports and reports of findings generated from approved studies shall be submitted to the LBDMN staff and board annually or at the conclusion of the project, if the duration is shorter than 12 months.

F. All persons granted access to LBDMN information and data shall certify the destruction of data at the conclusion of the project.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.31.48.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 30:1020 (May 2004).

§16309. Program Operation

A. The office shall monitor reporting sources for compliance with all sections of this statute.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.31.48.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 30:1021 (May 2004).

Title 48
HEALTH AND HOSPITALS—GENERAL
Part VII. Alcohol and Drug Abuse Services

Chapter 1. Program Authorization

§101. Statutory Authority

A. State Statutes. The Office of Prevention and Recovery from Alcohol and Drug Abuse (OPRADA) was created by Act 899 of the 1984 Regular Legislative Session.

B. Federal Statutes OPRADA is the designated single state agency and single state authority for management of National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism grants and contracts for alcohol and drug abuse prevention treatment and rehabilitation services within the State of Louisiana. These funding sources comprise the Alcohol and Drug Abuse and Alcoholism grants and contracts for alcohol and drug abuse prevention, treatment and rehabilitation services within the State of Louisiana. These funding sources comprise the Alcohol and Drug Abuse Mental Health Services (ADAMHS) block grant. An annual application shall be promulgated which describes how the ADAMHS block grant shall be expended.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:258(J).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (April 1987).

§103. Definitions

A. Commission means the Louisiana Commission on Alcohol and Drug Abuse.

B. Methadone means a synthetic narcotic analgesic used in treatment of narcotic addiction, including detoxification and maintenance programs.

C. OPRADA means the Office of Prevention and Recovery from Alcohol and Drug Abuse.

D. Substance Abuse means the maladaptive or inappropriate use of mood altering chemicals in a manner that results in a state of psychological and/or physical dependence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:258(J).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (April 1987).

§105. Purpose

A. The Office of Prevention and Recovery from Alcohol and Drug Abuse is the designated operating agency for planning, administering, coordinating and providing a comprehensive statewide program for alcohol and drug abuse prevention and treatment services. Excluded under this scope of responsibility are the substance abuse prevention programs of the Department of Education and the Highway Safety Act of 1966 administered by the Highway Safety Commission of the Department of Public Safety and Corrections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:258(J).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (April 1987).

§107. Admission Criteria

A. Any person with an assessed alcohol or other drug dependency problem as well as a family member or significant other who is the victim of an alcohol or other drug dependency related problem is eligible for services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:258(J).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (April 1987).

§109. Service Components

A. The range of treatment modalities for the chemically dependent person includes detoxification, inpatient treatment, long-term residential treatment, halfway house services and outpatient treatment. Prevention and early intervention programming are also major components of service provision.

B. Services are provided directly by OPRADA operated facilities and through contractual agreements with other public or private not for profit organizations.

AUTHORITY NOTE: Promulgated in accordance with R. S. 36:258(J).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (April 1987).

§111. Appeal Procedure for Providers

A. Any service provider who is adversely affected by the action of OPRADA in denying or revoking Alcohol and Drug Abuse and Mental Health Service Block Grant funds may file an appeal of the action to the Secretary of DHHR through the DHHR Appeals Section within 30 calendar days of receipt of the notice. The appeal or request for a hearing shall be in writing and specify in detail the reasons for submission of the appeal and how the service provider has been adversely affected by the action of the office.

B. In the event of an appeal, the hearing shall be conducted in accordance with the Louisiana Administrative Procedure Act R.S.49:950 et seq.

C. The decision will be provided in writing to the appealing party. The written decision shall constitute final administrative action on the appeal. If the contract was originally solicited in accordance with R.S.39:1503(A)(2), the Division of Administration, Office of Contractual Review regulations apply.

AUTHORITY NOTE: Promulgated in accordance with R. S.36:258(J).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (April 1987).

§113. Licensure Requirements

A. OPRADA operated and contracted programs shall be duly licensed in accordance with the licensure standards promulgated by Department of Health and Human Resources, Division of Licensing and Regulation for alcohol and drug abuse programs, as contained in Title 48, Part 1, Chapter 73. Licensure as a substance abuse facility or a hospital is a prerequisite for public or private substance abuse programs to receive state or federal funding through the Department of Health and Human Resources.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:258(J).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (March 1987).

§115. Fee Policy for Outpatient Programs

A. Fee Policy

1. All persons seen for services at an OPRADA center or clinic shall be assessed a fee for each chargeable service. Chargeable services are those defined as chargeable under the Medicaid Program, Title XIX of the Social Security Act, regardless of the source of payment. These services are listed in Table 1. The unadjusted fee for each service shall be equivalent to the cost of service computed for reimbursement under Medicaid.

Table 1
Chargeable Services as Defined for Medicaid Reimbursement Procedure

Code	Service
00140	Individual Counseling/Therapy
00141	Group Counseling/Therapy
00142	Family Counseling/Therapy
00143	Collateral Counseling
00144	Medical Treatment
00145	Medical Injection
00146	Occupational Therapy
00147	Recreational Therapy
00148	Music Therapy
00149	Art Therapy
00150	Screening and Intake
00151	Psychosocial Evaluation
00152	Psychiatric Evaluation
00153	Medical Evaluation
00154	Other Evaluation

2. All patients whose gross family income is above the minimum indicated on the fee adjustment schedule shall pay a fee for each service provided. Fees and adjustments to fees are to be established at the time the patient is first admitted to the facility. It is the responsibility of the patient and/or legally responsible family to justify any adjustment to the full fee. The patient or family will be asked to present reasonable proof of income before any adjustment to the full fee will be made. Appropriate center or clinic staff will assist the patient and family in verifying eligibility for a fee adjustment. There shall be adequate documentation of the information used in adjusting any fee. Fees may be adjusted during the patient's course of treatment based on changes in the economic status of the patient. The full fee, and/or the adjusted fee, shall be posted on the patient's ledger card and noted in the patient's permanent record.

3. Patients shall be charged a fee for each service, regardless of which service is provided, in the same manner in which Medicaid is charged. No fee shall be charged for failed or cancelled appointments.

4. All patients shall be asked to pay their fees at the time of service delivery. However, when patients do not pay at the time of the visit, they shall be billed on a regular basis, preferably monthly, but no less frequently than quarterly.

B. Fee Adjustment Schedule

1. The fee adjustment schedule is designed to provide for proportional payment for each service based on the family's ability to pay. Three variable figures are utilized in calculating the schedule: (1) state median income as promulgated annually the Secretary of the United States Department of Health and Human Services; (2) family size; and (3) cost of service provided as computed for Medicaid.

2. The fee adjustment schedule will be recalculated by OPRADA based on current state median income each time OPRADA and the Department of Health and Human Resources, Office of Family Security adjust the figure for cost reimbursement under the Medicaid program.

3. Persons whose gross family income is less than one-half the current state median income adjusted for family size will not be responsible for payment of services. Persons whose gross family income is more than one hundred fifty percent of the current state median income adjusted for family size will be charged the full cost of services provided. Between these two levels, fees will be adjusted in accordance with the following formula.

Gross Family Income as a Percent of Median Income Adjusted for Family Size	Fee as a Percent of Cost
50-55%	4% of cost
55-60%	8%
60-65%	12%
65	16%
70	20%
75	25%
80	30%
85	35%
90	40%
95	45%
100	50%
105	55%
115	60%

Gross Family Income as a Percent of Median Income Adjusted for Family Size	Fee as a Percent of Cost
120	65%
125	70%
130	75%
135	80%
140	85%
145	90%
150	100%

a. Adjustment of median income for family size shall be computed in accordance with the following formula.

Family Size	% of Median Income for a Family of Four
1	52%
2	68%
3	84%
4	100%
5	116%
6	132%
7 or more	148%

4. In computing each modification of the scale, the OPRADA will round actual fees to the nearest quarter dollar. Fee adjustment schedules will be computed annually based on current cost and distributed to the facilities.

C. Changes in Fees

1. The patient is to be informed that the fee clerk should be notified of any change which may later occur in income, employment, or family composition which might result in a change in the adjusted fee. The fee clerk shall also conduct a periodic check with each patient to determine any change in factors including cost changes, which would caused change in the fee and adjusted fee.

2. No fee may be waived or reduced beyond the fee adjustment scale without the express approval of the facility administrator who must document the reason for change in the patient chart. When waiver or reduction is made, the administrator must sign and date such authorization in the case record and in addition must note and initial the adjusted fee on the ledger card.

3. Examples of acceptable justifications for waiving or reducing a fee include:

a. excessive expense due to other medical costs;

b. family hardship resulting in unusual and unexpected expenses; or

c. more than 20 chargeable services are required by the family unit during any month.

D. Medication. All Medicaid patients are to be provided their medication. Any patient whose adjusted fee is 15 percent or less of the full cost may also be considered eligible to receive medication from the center or clinic. The facility administrator may authorize provision of medication for other patients on presentation of evidence that cost of medication ordered by center physicians will present a serious hardship and exceed three percent of the family's gross income. Documentation of such exceptions and their justification shall be made in the patient's chart and signed by the administrator. This should be reviewed in 90 days or whenever the amount of medication prescribed is reduced appreciably. It will be the responsibility of the physician and nurse reviewing medication orders to so notify the administrator.

E. Failure to Pay Fees. No person shall be denied service because of ability or inability to pay. However, when a patient becomes delinquent in his account, the delinquency shall be handled in accordance with the Department of Health and Human Resources' Policy on Collections. Whenever possible, center or clinic staff shall make an effort to negotiate a plan of payment prior to referring the account to the Department of Health and Human Resources, Bureau of Central Collections. Any negotiated plan of payment shall be approved by the center or clinic administrator and OPRADA fiscal office.

F. Definitions

1. Gross Income means the monthly sum of income received from sources identified by The U.S. Census Bureau in computing the median income and defined in the CFR, Volume 45, Section 228.66.

2. Dependent means all persons dependent on the household income as accepted by the Internal Revenue Service (IRS) for federal income tax purposes. In the case of a minor not claimed as a dependent for income tax purposes, the parents are still responsible for a contribution based on the fee schedule but may increase the dependent deductions by the client(s) in question.

3. Family means the basic family unit consisting of one or more adults and children, if any, related by blood, marriage, or adoption, and residing in the same household. Where related adults, other than spouses, or unrelated adults reside together, each will be considered a separate family, unless they are included as part of the family unit for federal income tax reporting purposes. Children living with nonlegally responsible relatives, emancipated minors, and children living under the care of unrelated persons will be considered as separate family units and will be charged according to the minor's own income whether the source is allowance or earnings.

4. Responsible persons means the client's parents or legal guardians if the client is under the age of 18, unless someone else claims the client as a dependent for federal income tax purposes, in which case it is that person. If the client is over 18, he is responsible for his contribution based on his gross family income and allowed deductions, unless he is claimed as a dependent for income tax purposes, in which case the claimant becomes responsible for the fee toward the cost of care based on the claimant's family income.

G. General Regulations

1. Documentation of income shall include federal and state income tax reports, Medicaid eligibility records, W-2 forms and employer's statements.

2. A person responsible for the payment of charges for services rendered who refuses to supply the information necessary for an accurate determination of the required rate of charges for services rendered shall be presumed to be able to pay the full cost of services rendered and shall be billed accordingly. Any person who is potentially eligible for medical assistance benefits from any federal or state program who refuses to apply for and follow through with application for said benefits shall be presumed to be able to pay the full cost of services rendered and shall be billed accordingly.

3. An insurance company that the responsible party alleges has issued a policy or contract covering the charges for treatment and services rendered shall be billed the full cost of services rendered. Billings shall be made directly to the insurer by the treating facility after securing execution of the forms necessary, including an assignment of benefits to the treatment facility, by the responsible person. The responsible party shall be billed in accordance with the applicable fee schedule up to the amount of charges not covered and paid by insurance. If the responsible person refuses to execute the forms necessary to assign the benefits and the forms necessary to file an insurance claim in accordance with that policy, it shall be presumed that the responsible person is able to pay at the full cost of services rendered and shall be billed accordingly.

4. Collection Procedure

a. If the payment agreement is not kept, a notice shall be mailed 15 days after the due date reminding the responsible party that payment was not received when due.

b. If payment has not been received within 15 days after the first notice was mailed, a second notice shall be sent.

c. If results have not been received within 15 days after the second notice was mailed, a third notice shall be mailed advising the patient that this account will be referred to the Department of Health and Human Resources, Central Collections if payment is not received within 15 days.

d. If payment has not been received 15 days after the third notice was mailed, the account is to be referred to Central Collections for collection. In addition, the following documents and information should be sent: all demographic information accumulated (intake interview sheet); copy of signed agreement; copy of itemized bill; and a copy of the patient's ledger.

e. Only accounts in excess of $25 will be referred to Central Collections for handling. The admitting facility will make every effort to collect outstanding accounts of $25 or less. Only the manager of a facility or his designee may charge off an account in the amount of $25 or less. If the account is in excess of $25, the request for charge off must be submitted through the Central Collections Section for approval by the Office of Management and Finance.

AUTHORITY NOTE: Promulgated in accordance with R. S. 36:258(J).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (April 1987).

§117. Copayment Fee for Driving While-Intoxicated Program

A. A standard copayment fee of $10 per session shall be assessed every patient in a driving while intoxicated program to whom OPRADA provides treatment services. A patient whose treatment is provided by OPRADA through a private contractor shall not be assessed a copayment fee. Private providers can assess fees otherwise allowable under applicable federal and state laws.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:258(J).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (April 1987).

§119. Solicitation of Proposal and Distribution of Non-allocated Funds for the Provision of Alcohol and Drug Abuse Services

A. Solicitation of Proposals

1. Propositions for Services Costing Less Than $150,000

a. When the proposal is in response to a federal categorical grant announcement which is published in the Federal Register, the announcement which is published shall be distributed to the 10 alcohol and drug abuse regional managers and to the members of the Louisiana Commission on Alcohol and Drug Abuse for further distribution to persons and organizations known to have interest in providing substance abuse services.

b. Proposal requests initiated by the Division of Alcohol and Drug Abuse shall be consistent with the division's state plan and shall be advertised through public announcements known as requests for Community Services (RCS) in accordance with the Division of Alcohol and Drug Abuse Contracts Procedure Manual available at each of the division's 10 regional offices.

2 Proposal requests for Services Costing $150,000 or More

a. When the proposal is in the response to a federal categorical grant announcement which is published in the Federal Register, the announcement shall be distributed to the 10 alcohol and drug abuse regional members and to the members of the Louisiana Commission on Alcohol and Drug Abuse for further distribution to persons and organizations known to have interest in providing substance abuse services.

b. Proposal requests initiated by the Division of Alcohol and Drug Abuse shall be consistent with the division's state plan and shall be in accordance with the state rules for Requests for Proposals (RFP). Proposal requests shall also be distributed to each of the 10 Division of Alcohol and Drug Abuse for further distribution to persons

known to have interest in providing substance abuse services.

B. Responding to Solicitations

1. Each public announcement for RCS or RFP shall state the nature of the service sought the address of the offices from which application packets can be obtained, and time lines for the application procedure.

2 In the case of federal categorical grants all relevant application information shall conform to the federal announcement guidelines as published in the Federal Register.

C. Allocation of Funds

1. Distribution of Non-allocated Block Grant Funds and Other Non-allocated Funds

a.i Proposals of less than $150,000 in value will undergo an initial review at the regional office level by a Proposal Evaluation Committee of not more than 10 members, including:

(a). a provider of service;

(b). a consumer of service;

(c). an employee of the Division of Alcohol and Drug Abuse;

(d). a member of the Louisiana Commission on Alcohol and Drug Abuse;

(e) a local parish or municipal official;

(f). an individual from the community at large, professionally knowledgeable of the network of community health and social services available in the region;

(g). the Division of Alcohol and Drug Abuse regional manager hwo will serve as the ex-officio chair of the committee.

ii. The Proposal Evaluation Committee shall report its approval/disapproval and priority recommendations on each proposal to the Division of Alcohol and Drug Abuse headquarters office. The evaluation decision must be consistent with the Division of Alcohol and Drug Abuse state plan and the Division of Alcohol and Drug Abuse Contracts Procedure Manual.

iii. A five-person evaluation team at the headquarters office shall review all proposals and accompanying recommendations from the regional offices and all proposals which are not geographically specific and shall make a final determination on approval of proposals in accordance with the Division of Alcohol and Drug Abuse state plan and with criteria contained in the Division of Alcohol and Drug Abuse Contracts Procedure Manual.

b. Proposals of $150,000 or more in value shall be allocated in accordance with the state's RFP procedure.

c. Rights to Protest and Appeal. Any contractor/applicant who is aggrieved in connection with the proposal review or award may exercise the rights of protest and appeal as set forth in the Department of Health and Hospital's Contract Manual.

2. Categorical Grant Funds. Funds becoming available through federal categorical grants shall be allocated in accordance with the guidelines contained in the issue of the Federal Register announcing the grant and in the notice of grant award.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258(E)(3).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Human Services, Division of Alcohol and Drug Abuse, LR 17:669 (July 1991).

§121. Drug Treatment Fund

A. Upon notification by the Department of the State Treasury that monies have become available in the Drug Treatment Fund for appropriation, the Division of Alcohol and Drug Abuse shall follow the rules for solicitation of proposals and for the distribution of non-allocated funds ads outlined in Chapter 1, Section 119 which is published as a separate rule in this Louisiana Register. The solicitation of proposals will be for the provision of treatment, care and rehabilitation services for persons abusing controlled dangerous substances. The monies in the Drug Treatment Fund shall be appropriated annually by the legislature to be used solely to fund drug treatment and rehabilitation programs as follows:

1. ninety-five percent to the Department of Health and Hospitals, Office of Human Services, to be distributed annually to state funded programs;

2. five percent to the Department of Revenue and Taxation for the cost of administration.

B. Accountability for monies appropriated to the Division of Alcohol and Drug Abuse from the Drug Treatment Fund shall be in accordance with accepted standard accounting procedures for governmental agencies and contractors.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:2609(C).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Human Services, Division of Alcohol and Drug Abuse, LR 17:668 (July 1991).

Chapter 3. Louisiana Commission on Alcohol and Drug Abuse

§301. Composition of Commission

A. The commission shall be composed of 13 members who are appointed by the governor and confirmed by the senate. Members serve at the pleasure of the governor until their respective successor has been appointed and commissioned. One member shall be elected chairman and other officers elected as deemed necessary. The assistant secretary of the Office of Prevention and Recovery from Alcohol and Drug Abuse serves as executive director of the commission. The executive director shall be an ex-officio member of the commission, but shall not have voting privileges.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:258(J).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (April 1987).

§303. Duties and Responsibilities

A. The commission shall advise the Office of Prevention and Recovery from Alcohol and Drug Abuse and officers of any other state department concerning the policy of the state with respect to alcohol and drug abuse. This does not, however, apply to the substance abuse prevention education program of the Department of Education and the Highway Safety Act of 1966 (Public Law 89-564) administered by the Highway Safety Commission of the Department of Public Safety and Corrections.

B. The commission shall recommend an annual state plan to the Office of Prevention and Recovery from Alcohol and Drug Abuse. The state plan shall set forth proposed policy, program initiatives and goals for each fiscal year relative to the prevention and treatment of alcohol and drug abuse in Louisiana.

C. The commission shall serve as liaison among state and local governmental entities concerned with the prevention and treatment of alcohol and drug abuse.

D. The commission may solicit and accept private and public funds in the form of donations and grants.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:258(J).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (April 1987).

§305. Annual Report to the Governor

A. An annual report shall be prepared by the commission for submission on March 1 to the governor, the house and senate committees on health and welfare and the secretary of the Department of Health and Human Resources. This report shall advise of its activities for the previous year and recommendations as to future programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2500-2504.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (April 1987).

Chapter 5. Methadone Maintenance Program

§501. State Methadone Authority

A. OPRADA is the designated State Methadone Authority (SMA). Approval to operate by the SMA is required of all methadone maintenance programs in Louisiana.

B. SMA requirements include, but are not limited to:

1. State licensure as a substance abuse facility.

2. Evidence of need/community support for methadone maintenance program, including letters of support from medical community (medical society), law enforcement agencies, and other substance abuse treatment facilities.

3. Once in operation, SMA approval is required for medication exceptions whereby frequency of clinic visits is reduced and a take home supply of medication is dispensed. The request for medication exception shall be submitted in writing to the SMA and shall be co-signed by the patient's primary counselor, the physician, the clinic administrator and include the following information:

a. The specific reduction in frequency of clinic visits requested for this patient.

b. Reason given by clinic for requesting a decrease in frequency of patient's clinic visits.

c. The patient's chemical dependency/narcotics addiction history.

d. Date of most recent admission to clinic and cumulative treatment history.

e. Addiction indicators exhibited at time of most recent admission for treatment.

f. Past detoxification or withdrawal attempts and clinic's assessment of reason(s) for failure of these attempts.

g. Reason detoxification and drug free treatment is not recommended at this time.

h. Current medication dosage level.

i. The physician's eight point clinical evaluation of the patient's responsibility for handling methadone.

j. Date of the most recent treatment plan revision.

k. The current short and long term treatment plan goals for the patient.

AUTHORITY NOTE: Promulgated in accordance with 21 CFR, Part 291, Volume 45, No. 184, pages 62694-62718, September 19, 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Prevention and Recovery from Alcohol and Drug Abuse, LR 13:246 (April 1987).

Chapter 7. Group Homes for Recovering Substance Abusers

§701. Introduction

A. The Anti-Drug Abuse Act of 1988, (Public Law 100-690) established a program entitled Group Homes for Recovering Substance Abusers. This program requires the state to create a revolving fund of at least $100,000 to make loans of up to $4,000 to non-profit private entities to provide housing for six or more individuals recovering from alcoholism or other drug abuse. This self-help group housing service is intended to enable recovering persons to sustain a chemical free lifestyle by accepting responsibility for operating a democratically run and self-supported alcohol and drug free recovery house.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258(E)(3).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Human Services, Division of Alcohol and Drug Abuse, LR 15:1081 (December 1989) amended by the Office of Alcohol and Drug Abuse, LR 19:346 (March 1993).

§703. Definitions

Bridge Loan—a short-term, rapid-access loan to private, non-profit corporations for the purpose of binding a lease for a planned recovery home.

Group Recovery Home—a private residence, apartment complex or other type housing, with sleeping facilities for not less than six individuals in semi-private quarters, with bathing and kitchen facilities.

Lender—the Department of Health and Hospitals, Bureau of Fiscal Services, Financial Management Bureau, Box 3797, Baton Rouge, LA 70821.

Organization Loan—a loan to a chartered or unchartered non-profit entity (as described in §709.A.1 and 2 hereinafter) for the purpose of enabling a group of not less than six individuals to establish a group recovery home.

Private Entity—non-profit agencies or organizations or groups of six or more individuals. It may include a single individual, provided such individual provides evidence of recovering status from a treatment organization, and meets other requirements of these guidelines. This definition does not include public (governmental) agencies.

Self-Governing—the required method of management of a group recovery home. Residents are responsible for the democratic operation of the home, the maintenance of rules and regulations including admission guidelines and management of finances. The group may require sponsorship or affiliate with treatment, rehabilitation, or other groups.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258(F)(3).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Human Services, Division of Alcohol and Drug Abuse, LR 15:1081 (December 1989), amended LR 17:603 (June 1991), amended by the Office of Alcohol and Drug Abuse LR 18:845 (August 1992), LR 19:346 (March 1993).

§705. Regulations

A. All applicants for group recovery home loans must agree to abide by the following regulations in the operation of the home.

1. Homes may have no more than 10 individuals in residence unless granted a specific waiver by the Department of Health and Hospitals, Office of Human Services.

2. Homes must maintain a home-like atmosphere, providing adequate individual privacy for the residents.

3. Homes shall be self-governing to the extent that its members are not governed by any outside source or person. One resident shall be elected to be responsible for administering rules, convening the group, collecting assessments and paying bills. The term of office for the principal officer shall be set by the residents.

4. Homes shall assure that the following required policies are maintained and adhered to:

a. admission to the home shall be on the basis of a majority of residents voting;

b. residents shall remain alcohol and drug-free. There will be no alcohol or drugs (other than those prescribed by a licensed physician) on the premises;

c. residents shall pay their monthly assessments for rent, utilities, food, and other expenses of the home on a regular basis;

d. any resident using alcohol or drugs which have not been prescribed for a bone-fide medical condition will be expelled, and such expulsion documented as to time, date, and reasons thereof;

e. homes may not discriminate in admission practices on the basis of race, religion or ethnic origin. Homes established for men only may deny admission of female applicants and vice-versa;

f. residents shall establish through a majority vote governing policies which regulate admission, application process and approval, committees, duties of residents, attendance at self-governing meetings, self-help activities, employment, etc., as the group may deem appropriate.

5. Homes shall be maintained in a safe and sanitary manner. Residents shall assure that regular buildings and grounds maintenance occurs so that the existence of the home in the neighborhood does not attract undue attention or result in discord with neighbors.

6. Homes shall establish policies in regard to relapse-prevention, and residents shall insure that relapse-prone members are promptly referred for appropriate intervention.

7. Homes shall assure that new residents are made fully aware of their duties and responsibilities, of the rules of the house, and the conditions for expulsion.

8. Homes established pursuant to these regulations must meet current local housing codes for private residences with respect to kitchen facilities, bathrooms, water heaters, venting and ventilation, fire-safety exits, etc. Irrespective of those codes, there shall be at least one ABC rated fire extinguisher in each kitchen and in each hallway adjacent to sleeping areas.

9. Recovery homes shall maintain the following documents for review by the leading authority and/or quality assurance monitoring group:

a. cash receipt book;

b. cash disbursement journal;

c. written and posted house rules;

d. written admission/expulsion policies.

10. Loans made pursuant to these regulations must be repaid in accordance with the schedule in §711.C, but must be repaid within 24 months of issuance.

a. Late payment fees shall be assessed in the amount of $25 or 20 percent of the amount past due, whichever is less.

b. A group home which defaults on payment will be subject to recovery process in accordance with law, and with costs of recovery assessed against the home.

c. Any proceeds recovered from defaulted loans, except costs associated with the recovery proceedings, shall be deposited to the credit of the revolving fund for recovery homes in the state treasury.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258(E)(3).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Division of Alcohol and Drug Abuse, LR 15:1082 (December 1989), amended LR 17:603 (June 1991).

§707. Purpose of the Fund

A. The group homes for recovering substance abusers' program will make available start-up loans of up to $4,000 per applicant group for the following type of expenses:

1. security deposits for rent/lease and utilities;

2. up to two months rent for each individual in the group;

3. purchase or rental of household furniture and equipment such as beds, dressers, dining tables, chairs, lounge furniture, washer, dryer, range, refrigerator;

4. household amenities (television, appliances, linens, utensils);

5. raw food supplies (stables, canned goods, groceries, condiments, etc.);

6. facility modifications of non-extensive nature including materials (paint, lumber);

7. local transportation expenses/employment related but as part of a loan only;

8. employment related clothing (uniform rental, purchase);

9. bridge loans for applicants.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258(E)(3).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Human Services, Division of Alcohol and Drug Abuse, LR 15:1081 (December 1989), amended LR 17:603 (June, 1991), amended by the Office of Alcohol and Drug Abuse, LR 19:346 (March 1993).

§709. Eligibility Requirements

A. Eligible entities include:

1. private non-profit corporations;

2. non-chartered groups of six or more recovering persons;

3. established recovery homes.

4. individuals accepted into established recovery homes.

B. Lender shall require all applicants to provide the following assurances:

1. intended use of the founds derived from the loan (budget);

2. to maintain the recovery home as an alcohol and drug-free environment;

3. residents will remain alcohol and drug-free;

4. residents who violate this pledge will be expelled from the home;

5. costs associated with operation of the home, including rent, utilities food, will be borne by the residents;

6. home will be operated as a self-managed democracy.

C. Lender may require an applicant consisting of an unchartered group or an individual to provide assurances that each resident is:

1. recovering from chemical dependency;

2. continuing in treatment or has been discharged from treatment;

3. attending self-help (AA, NA, CA) organizations at least once a week;

4. employed, or if not currently employed is actively seeking employment and is registered with the local employment office or a union employment office, or is receiving income on a regular basis from retirement, disability or other source;

5. accepted into an existing group recovery home, or is establishing one.

D. Lender may require a chartered non-profit corporation to provide the following:

1. evidence of the charter;

2. evidence of authority to borrow money, i.e., Board Resolution;

3. documented purposes for loan;

4. assurances regarding recovery home residents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258(E)(3).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Human Services, Division of Alcohol and Drug Abuse, LR 15:1081 (December 1989), amended LR 17:603 (June 1991), amended by the Office of Alcohol and Drug Abuse, LR 19:346 (March 1993).

§711. Application Procedures

A. Applications and guidelines for group recovery home loans may be obtained from any regional alcohol and drug

abuse treatment program operated by the Department of Health and Hospitals.

B. Completed applications consist of:

1. application form;

2. assurances form;

3. statement of sobriety;

4. budget;

5. acceptance statement (individual);

6. evidence of available rental property including address and ownership.

C. Application Review Process

1. The completed application package shall be hand-carried to the issuing office by the applicant. The application will be reviewed by the Regional Alcohol and Drug Abuse Treatment Program Manager along with the applicant. The regional manager will determine with the applicant a suitable repayment schedule within the 24-month limit of the loan. Interest shall be calculated at five percent simple interest except that bridge loans to establish chartered non-profit corporations shall be interest free. The regional manager shall compute the payment, and enter it on the Application Form in the box designated "For Office Use Only."

2. If approved, the application shall be forwarded to the Department of Health and Hospitals (DHH) Office of Human Services, Division of Alcohol and Drug Abuse, Special Projects Branch. If approved, it will be forwarded to the DHH, Bureau of Fiscal Services, Financial Management Section for issuance of a check to the applicant. The Bureau of Fiscal Services will forwards a copy of its transmittal letter to the approving officer in the Division of Alcohol and Drug Abuse.

3. Limits on Loan Amounts and Duration of Loans

a. Organizational (group) loans shall be limited to a maximum amount of $4,000 for each loan made to be repaid within 24 months or less.

b. Bridge loans shall be limited to a maximum of $2,000 per loan, to be repaid within three months or less.

c. Individual loans shall be limited to a maximum of $500 to be repaid within 12 months or less.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258(E)(3).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Division of Alcohol and Drug Abuse, LR 15:1083 (December 1989), amended LR 17:604 (June 1991).

§712. Organizational Loan

A. Organizational loans are those made to non-profit entities or groups of six or more individuals for the purpose of enabling recovering persons to establish a group recovery home.

B. Restrictions on Organizational Loans

1. must provide for housing for six or more residents in recovery;

2. limited to not less than $500 nor more than $4,000 per group;

3. must be repaid within 24 months of issuance;

4. each loan subject to five percent simple interest rate;

5. may not be used for purchases of property of a personal nature, nor for personal expenses other than as approved by the department and/or the applicant group; uniforms and travel expense to attend work, excepted;

6. any personal property purchased (such as home furnishings) becomes the property of the group recovery home;

7. must be used to defray rental costs, security utility and other required deposits, and basic furnishings required for occupancy;

8. a portion of the proceeds from an organizational loan amy be used to liquidate a prior "bridge loan" made to a sponsoring organization on behalf of the resident group;

9. applicant group must meet eligibility requirements established in §709;

10. chartered organizations applying on behalf of a group of six or more individuals must provide assurance of compliance with §703.C and §705 above, and may impose no other regulation on the group recovery home or its residents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258 (F)(3).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Division of Alcohol and Drug Abuse, LR 15:1081 (December 1989), amended LR 17:603 (June 1991), amended by the Office of Alcohol and Drug Abuse, LR 18:845 (August 1992), LR 19:346 (March 1993).

§713. Bridge Loans

A. Bridge loans are restricted, short-term loans to private, non-profit chartered organizations in an amount equal to anticipated or quoted security deposits and first month rent. Bridge loans are for the purpose of having funds available at the time of consummating a lease arrangement for a recovery home under sponsorship of that organization.

B. Restrictions on Bridge Loans

1. Private, chartered, non-profit corporations which have been in existence three months or more prior of the date of application for the loan.

2. Ninety-day payback

3. Maximum amount limited to $2,000 for each loan applied for, to cover security, rental and other deposits, lease costs, and for basis furnishings required for occupancy

4. Non-interest bearing

5. Application for loan must state "Bridge Loan"

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258(E)(3).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Division of Alcohol and Drug Abuse, LR 15:1083 (December 1989), amended LR 17:604 (June 1991).

§714. Individual Loans

A. Individual loans are restricted loans to individuals in recovery who are accepted into an already existing, functional group recovery home which requires, as an admission criterion, an advance deposit for his/her share of the first month(s) operational costs.

B. Individual loans are provided only to individuals who:

1. are recovering from a substance abuse disorder;

2. can provide proof that they have been accepted into an existing viable group recovery home;

3. can provide proof that the group recovery home into which they have been accepted required the applicant to pay his/her share of the first month's operational costs as an admission criterion;

4. do not have the funds to meet this criterion of admission;

5. provides evidence of employment, employability, registration for employment, or recipient of other monetary benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258(E)(3).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Division of Alcohol and Drug Abuse, LR 15:1083 (December 1989), amended LR 17:604 (June 1991).

§715. Quality Assurance Requirements

A. Quality assurance/monitoring requirements are approached from the perspective that group recovery homes are intended to provide residences for recovering individuals, and are not designed as treatment or rehabilitation programs. Therefore, oversight on the part of DHH shall be limited to the following determinants, as reflected in periodic, but not less than annual, site visits by an agent of DHH.

1. Group recovery homes are required to maintain registration with the Department of Health and Hospitals, Office of Human Services, Division of Alcohol and Drug Abuse on a current basis.

2. Registration shall consist of the following in written form:

a. name of home or group;

b. location, including address and zip code;

c. name of principal officer/manager/organizer;

d. expected capacity;

e. telephone number of available;

f. name of landlord/owner.

3. For the duration of any outstanding group or individual recovery home loan, site visits shall monitor the following areas to assure:

a. the facility is maintained in a clean, safe and sanitary condition;

b. cash receipts and disbursement journal are maintained and current;

c. a policy on admissions and rules of conduct has been established;

d. a record of admissions and expulsions is maintained;

e. residents continue to be involved in either an agency recognized treatment program or a self-help support group;

f. employable residents are employed or actively seeking employment.

B. At the monitor's option, and based upon observations, inspections may be requested by other state or local officials regarding sanitation, health, safety, and fire code compliances.

C. The agency-designated monitor will file a written report, in brief form, within 30 days of any site visit/inspection with the Department of Health and Hospitals, Office of Human Services, Division of Drug and Alcohol Abuse, with a copy to the Bureau of Fiscal Services, Box 3797, Baton Rouge, LA 70821.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258(E)(3).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Division of Alcohol and Drug Abuse, LR 15:1084 (December 1989).

Chapter 9. Co-payment for Urine Drug Screening

§901. Statement of Purpose, Scope and Eligibility

A. The Department of Health and Hospitals (DHH), Office of Alcohol and Drug Abuse (OADA), will determine a patient's ability to pay a co-payment for Urine Drug Screening (UDS) according to the co-payment sliding fee scale.

B. Any active patient of OADA shall pay a co-payment for a urine drug screen of not more that $12 per screen to be determined based on the UDS co-payment sliding fee schedule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 28:771 and R.S. 36:258(E).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Alcohol and Drug Abuse, LR 23:200 (February 1997).

§903. Exemptions

A. Any patient eligible to receive Medicaid shall be exempt from the provisions of the UDS co-payment requirements.

B. The UDS co-payment fees shall be exempt from the provisions of R.S. 49:971(A)(3) which provide that no state agency shall increase any existing fee or impose any new fee unless the fee increase or fee adoption is expressly authorized pursuant to a fee schedule established by statute or specifically authorized by federal law, Rule or regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36: 258(E).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Alcohol and Drug Abuse, LR 23:200 (February 1997).

§905. Definitions

A. The following definitions shall apply to the OADA urine drug screening co-payment for patient billing:

Dependent—all persons dependent on the household income as accepted by the Internal Revenue Service (IRS) for federal income tax purposes. In case of a minor not claimed as a dependent for income tax purposes, the parents are still responsible for payment.

Family—the basic family unit consisting of one or more adults and children, if any, related by blood, marriage, adoption or residing in the same household.

Gross Income—income as determined under Title XIX, Medicaid, guidelines. Gross income shall be rounded down to the nearest $1,000.

Responsible Person—the patient's parent(s) or guardian if the patient is under the age of 18, unless someone else claims the patient as a dependent, in which case it is that person. If the patient is 18 years of age or older, the patient is responsible for his/her co-payment based on his/her gross family income and allowable deductions, unless claimed as a dependent in which case the claimant becomes responsible for the fee based on the claimant's family income.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258(E).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Alcohol and Drug Abuse, LR 23:200 (February 1997).

§907. General Provisions

A. Billing for the UDS co-payment shall be made to the patient or responsible party.

B. A person responsible for the payment of charges for services rendered who refuses or fails to supply the information necessary for accurate determination of the urine drug screen co-payment shall be billed accordingly. Any person who is potentially eligible for Medicaid who refuses to provide evidence of application for said benefits shall be presumed to be able to pay the full charge for services rendered, and shall be billed accordingly.

C. Eligibility will be good for one year. Periodic checks may be made with the responsible person to make charge adjustments as necessary. The responsible person shall be advised of his responsibility to report any change in the family unit composition, income, and employment.

D. Wherever applicable, billing for services rendered shall be sent monthly to the client or responsible person in accordance with the co-payment bill. When a patient's account becomes delinquent, it shall be handled in accordance with DHH Policy Number 4300-76, regarding collection procedures for patient bills.

E. OADA has developed internal management procedures for billing. A copy of these procedures are housed in the Assistant Secretary's Office of OADA.

F. Any individual or family unit who is indigent, as defined herewith shall be eligible for reduced co-payment fees based on the urine drug screen co-payment sliding fee scale. When documented medical bills incurred within the 12 months prior to treatment/service equal or exceed 20 percent of the annual gross family unit income, urine drug screens shall be provided at reduced cost to the family unit. The period of eligibility begins at the date at which liability reaches the 20 percent figure through the end of the calendar year. Such patients with third-party payors shall be provided reduced cost medical services or only that portion of their bill for which no third-party payor is or may be liable.

G. Exceptions may be granted at the discretion of the Assistant Secretary or his designee.

Co-payment Sliding Fee Scale for Urine Drug Screen					
	Dependents				
Income	1	2	3	4	5+
0 - 2000	$ 2	$ 2	$ 2	$2	$2
2001 - 3000	4	2	2	2	2
3001 - 4000	8	4	2	2	2
4001 - 5000	10	8	4	2	2
5001 - 6000	12	10	8	4	2
6000+	12	12	10	8	4

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:771 and R.S. 36:258(E).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospital, Office of Alcohol and Drug Abuse, LR 23:200 (February 1997).

Title 48
HEALTH AND HOSPITALS—GENERAL
Part IX. Developmental Disabilities Services

Chapter 1. Adult Day Services

§101. General Provisions

A. Definitions. For the purposes of this Chapter:

Contracted Vocational and Habilitative Services—those services which are purchased by the Office for Citizens with Developmental Disabilities through contractual arrangements with private providers. The services include, but are not limited to, supported employment and other vocational services provided in conjunction with Louisiana Rehabilitation Services (LRS), group models of community-based work, facility-based work and habilitative services as they relate to the acquisition of vocationally-related skills, community-based skills, daily life skills and behavior management.

Corrective Action Plan—a set of plans developed by a provider of vocational and habilitative services in response to findings of noncompliance with minimum standards. The plans indicate how the provider will come into compliance with minimum standards, the staff responsible for implementing such plans and the time by which the corrective actions will be in place.

Minimum Standards—those standards contained in this Chapter which are identified by the acronym "MS" and which define minimally acceptable standards of care for private providers of contracted vocational and habilitative services.

Monitor/Monitoring Team—staff employed by the Office for Citizens with Developmental Disabilities who are assigned to evaluate the practices of providers of contracted vocational and habilitative services.

Quality Indicators—those standards contained in this Chapter which are identified by the acronym "QI" and which reflect best practices in the area of vocational and habilitative services. When a contracted provider adopts the practices demanded by these standards, the Office for Citizens with Developmental Disabilities recognizes such a provider for excellence in programming.

B. Introduction

1. The present standards were developed by a committee composed of a parent representative, provider agencies, and employees of the Office for Citizens with Developmental Disabilities (OCDD). Prior to publication they were distributed for statewide input from provider agencies, OCDD employees, and legally-established OCDD State and Regional Advisory Committees.

2. The purpose of these standards is to establish and maintain high quality, individualized, vocational and habilitative services for persons with developmental disabilities and to offer these individuals choice in the types of services and supports to be rendered.

a. In order to insure the development of an instrument that addressed quality, the committee developed a set of principles on which the standards were to be based and measured against.

b. In addition, the structure of the standards and the procedures for monitoring them have been designed to recognize excellence in program practices, to provide direction for growth and a basis for the provision of technical assistance and training. Both minimum standards and quality indicators are included in the standards document. Agencies pursuing excellence will seek to achieve success on some or all of the quality indicators. The OCDD in turn will recognize such achievement by awarding a higher class certification.

C. Monitoring Procedures

1. Application. The standards and monitoring procedures will be applied to all entities contracting with the Office for Citizens with Developmental Disabilities to provide Vocational and Habilitative Services.

2. Minimum Standards and Quality Indicators. Each standard or in some cases portions of standards are preceded by the letters "MS" for Minimum Standard or "QI" for Quality Indicator. Contractors are expected to comply with all Minimum Standards (MS) and compliance with them will be measured at every formal monitoring visit. Agencies that wish to demonstrate excellence will identify the Quality Indicators (QI) they are pursuing and be prepared to provide evidence of compliance.

3. Frequency of Monitoring

a. In general, each contractor will be formally monitored by OCDD Regional staff for compliance with these standards on an annual basis. When a contractor has demonstrated a high degree of excellence during a monitoring visit (see "Rating System," §101.C.5.b.i.), the annual monitoring requirement will be waived for a one-year period.

b. Regional staff may make aperiodic, informal visits to the program site where the need for technical assistance may be assessed. Such informal visits will not be considered part of a formal monitoring procedure and consequently, will not result in a request for a corrective action plan. However, observations which are made on such visits may be documented as evidence to be cited at the time of the formal, annual monitoring visit. If in the course of an informal visit, a serious condition which endangers the

health and/or safety of a consumer is detected, proper authorities, including the Department of Social Services, Bureau of Licensing and Certification, will be notified and action taken to remove the threat.

4. Procedures

a. The OCDD monitor(s) will evaluate compliance with Minimum Standards based on their reviews of agency policies and procedures, observation of the overall program, staff and consumer interviews, review of a predetermined sample of records based on the number of people served and other review techniques identified by the OCDD.

b. Quality Indicators will be monitored only upon the request of the contracted agency. The agency must identify specific indicators to be measured and provide documentation of success. The monitor will consider such evidence and make independent observations of program practices to verify compliance.

c. Immediately following completion of a monitoring survey the monitor/monitoring team will conduct an exit interview with the provider agency. At the exit interview an exit report will be issued which identifies deficiencies noted. Should the provider agency and the monitor disagree about particular findings, every attempt should be made to resolve the issues prior to the issuance of a confirmation report. The confirmation report will describe overall impressions of the program, particularly positive aspects, and will have the exit report attached. It will be issued within five working days of the exit interview. The agency monitored is responsible for submitting a Corrective Action Plan to the OCDD Regional Office within 10 working days after the postmarked date of the confirmation report.

5. Criteria for Certification. Upon publication of the final rule establishing these standards (July 20, 1995), provider agencies will be given one full year to modify current practices or implement the new practices the minimum standards demand. One monitoring visit will occur during this period, the purpose of which will be to identify areas in need of change. Beginning on July 20, 1996, provider agencies will be expected to comply with all minimum standards.

a. In order to achieve full certification there must be evidence of compliance with all minimum standards. Where a standard demands review of individual consumer records, 85 per cent compliance must be demonstrated within each standard.

b. Contractors who achieve full certification and who adopt practices consonant with the Quality Indicators will be awarded full certification with "Stars of Excellence." The greater the number of Quality Indicators which have been adopted, the greater the rating of the program:

i. Rating System

Number of Quality		
Indicators Adopted	**Description**	**Rating**
15 +	Three Star Program	Superior
14 - 6	Two Star Program	Outstanding
5 - 1	One Star Program	Exceeds Expectations

ii. When an agency receives one of the above ratings, a certificate will be issued noting such and monitoring against program standards will be waived for a one-year period.

c. Provisional Certification. Provisional certification will be awarded to programs achieving 72 - 84 percent compliance. Such programs will be expected to correct deficiencies within a specified time period (no longer than three months) and achieve full certification.

d. Termination Notice

i. Programs that do not meet the criteria for provisional certification or that have failed to achieve full certification three months after receiving a provisional certificate will be issued a notice of intent to terminate the contractual agreement between the provider agency and the OCDD.

ii. The OCDD may withdraw a termination notice, if within the 30 calendar days following receipt of the notice the provider agency complies with or has taken significant steps towards complying with the requirements.

iii. Payment for services provided will continue during the 30 day period, except that they may be prorated depending on the number of individuals receiving services.

iv. In the event that a violation poses an immediate and serious threat to the health or safety of the consumers, the OCDD will notify the Department of Social Services, Bureau of Licensing and Certification and notify the Contractor of the intent to temporarily terminate service provision and payments. The provider agency receiving such notice shall not accept additional consumers for services during such a period.

e. Other conditions under which certification may be denied, are as follows:

i. failure of an agency or an authorized agent of the agency to comply with requests for information regarding these standards;

ii. a knowing provision of false or misleading information to the OCDD;

iii. refusal by on-premise personnel to admit any duly authorized employee of the DHH for the purpose of inspection of the program or its records; or,

iv. any reported abuse or neglect of consumers involving program personnel which has been substantiated by appropriate authorities, the circumstances of which have not been corrected as determined by DHH.

6. Administrative Hearings

a. Findings may be grieved under two circumstances:

i. when a provisional certification has been issued and the monitor/monitoring team and provider agency disagree as to whether the corrective actions taken are sufficient or complete, and

ii. when a notice of intent to terminate a contract has been issued and the provider disagrees with the findings leading to such action.

b. All grievances must be submitted by the provider agency in writing to the Community Services Regional Administrator (CSRM) in the contracting region within 30 calendar days of receipt of the written certification report.

c. When a corrective action plan or its implementation is found to be inadequate, the provider agency may grieve specific findings on specific standards to the CSRM, who is ultimately responsible for resolving such issues. Such a grievance must demonstrate that specific findings were made in error or provide positive evidence that the deficiency was, in fact, corrected. The CSRM will issue her/his decision within 20 working days of receipt of the written request for an administrative hearing.

d. When a provider agency receives a notice of intent to terminate a contract, and wishes to grieve such, three levels within the grievance process are available.

i. The first level grievance must be made to the CSRM. The CSRM will issue her/his decision within 20 working days of receipt of the written request for an administrative hearing.

ii. Should the CSRM uphold the findings of the monitoring team, a second level request for an administrative hearing may be made to the Assistant Secretary of the OCDD. A hearing will be held within 20 working days of receipt of the request and a written ruling issued within 15 working days of the hearing. The contractor is responsible for providing evidence to the Assistant Secretary that demonstrates the decision to terminate was made in error.

iii. A final request for an administrative hearing may be made to the Secretary of the DHH. The same process used at the Assistant Secretary level applies in this case, however, the Secretary's ruling is not due until 20 working days have elapsed, and it is final.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28.380 through 444.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:685 (July 1995).

§103. Guiding Principles

A. Introduction

1. The OCDD holds that the provision of services should be based on the principles of sharing ordinary places, developing meaningful relationships, learning things that are useful, making choices, as well as increasing the status and enhancing the reputation of people served.

2. It is critical that these guiding principles be incorporated into the provision of work and work-related services.

B. Sharing Ordinary Places

1. Sharing ordinary places recognizes that when individuals with developmental disabilities participate in the daily life of their local community there are reciprocal gains for both parties. One goal, then, of Vocational and Habilitative Services is to provide opportunities and needed supports for learning and working in the community, side-by-side with people from all walks of life.

2. In expanding the principle of sharing ordinary places, it is also desirable that new skills be taught in those ordinary places that follow the usual pattern, duration and rhythm of life in the community. This means that skills are taught at the time of day at which they would ordinarily occur and for about as long as usual and as frequently. For example, if teaching the use of a telephone, an operating telephone would be used to call for a taxi when transportation is actually needed, or perhaps, to call out to order lunch or request a bus schedule.

C. Developing meaningful relationships. As a basic human trait, we rely on relationships with other people throughout our lives for friendship and support. These relationships are formed within our families, with neighbors, at work and church, where we shop and in many other places. In the delivery of services it is important that these relationships be supported and that, if desired, opportunities be created to form other relationships. These supports should be provided in sensitive, unobtrusive ways. The community offers a broad array of opportunities to meet and choose new friends.

D. Learning Useful Things

1. The utility of what we learn is broadly defined by the demands of life in our communities. But within this context, we make many choices, i.e., who to live with, the kind of work we want to do, what we do for fun, etc. The usefulness of what we learn, then, is defined not only by our ability to do certain, expected things, but also by our own choices. It is critical that individuals with developmental disabilities be given a voice in determining what they wish to learn.

2. Vocational and Habilitative Programs should teach skills that allow for full participation in the work/activities a person has chosen. The methods selected for training should reflect the chronological age of the consumer and be outcome oriented, rather than focused on a process.

E. Making Choices

1. When decisions are made that affect the lives of people, the choices of those people must be of predominate

concern. Individual program design and implementation must reflect the choices and preferences of the consumer in the decision- making process.

2. To insure that choices made are relevant and workable, the Vocational and Habilitative agency must provide individuals with the information they need and opportunities to learn and use decision-making skills. A committed agency will support the development of communication skills and modes of self- advocacy skills.

F. Increasing Status and Enhancing Reputation

1. Webster defines status and reputation in terms of the esteem in which a person is held by a community. Status and reputation are important, not only in how we are seen by the community, but also in the how we view ourselves within that community. It is critical then, that the activities undertaken in Vocational and Habilitative programs promote dignity, respect and a sense of self-worth. This is particularly true in the case of individuals with developmental disabilities as, traditionally, they have been segregated from the general population and thus, viewed as less valued members of the community.

2. To promote a sense of self-worth, activities in which consumers are involved should be ones that are valued by the community at large. Consideration should be given to the values of the community in terms of the types of work made available to consumers. It is imperative that respectful language be used when communicating with consumers and "people first" language when referring to them. In the same vein, activities, materials, training methods should enhance the value of the individual, reflecting his/her chronological age and should in no circumstances be child-like.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28.380 through 444.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:687 (July 1995).

§105. Administrative Standards

A. Governing Body

1. (MS) The agency shall adopt and implement a policy stating that no member of the immediate family of the governing body of the agency shall be an employee of, consultant to, independent contractor with or perform paid work for the agency. "Immediate family" means children, the spouses of his/her children, brothers, sister, parents, spouse and the parents of the spouse.

2. (MS) Members of the governing body are responsible for accessing orientation training regarding the guiding principles enumerated in §103 of this Chapter, services to persons with developmental disabilities, information about the programs being offered, and available funding sources.

3. (QI) The membership of the governing body should reflect the community in which the agency operates ethnically and geographically.

4. (QI) The membership of the governing body should be representative of the community and include persons with disabilities and/or families of persons with disabilities.

5. (QI) The governing body should include consumers of services.

6. (QI) Supports shall be offered and provided to consumers and family members on the governing body to insure their active participation during the meeting.

7. (MS) The governing body or its executive committee shall meet at least quarterly, and more often as needed.

8. (QI) The governing body is comprised of people who have been elected by the general membership and/or nominated by families of consumers or a nominating committee composed of consumers, other board members, and families of consumers.

9. (MS) The governing body shall ensure that the program has developed and implemented long-range goals consonant with the Guiding Principles enumerated in §103 of this Chapter.

10. (MS) The long-range goals and the plans for implementation shall be reviewed at least annually by the governing body.

11. (MS) The governing body shall review the outcome of the annual self-evaluation required by Department of Social Services, Bureau of Licensing and Certification, any resulting recommendations, and note such in its minutes.

12. (MS) The governing body shall consist of at least five members.

B. Community Relations

1. (MS) Each agency shall develop cooperative agreements and working relationships with vocational programs offering similar services and operating in or near the agency's service delivery area. Agreements shall identify a mutual referral process, shall address access to employment and alternatives to employment for the persons served.

2. (MS) Provider agencies shall use a variety of community-based generic resources to meet the needs of the individuals served and to avoid duplication of services.

3. (QI) In an effort to become an integral part of the local business community, provider agencies and/or staff should belong to and participate in civic organizations.

4. (MS) The agency shall develop and use resources for technical assistance and training.

5. (QI) The agency and/or key staff should belong to professional organizations related to the provision of services.

6. (QI) Agencies shall cooperate with existing consumer, family support, and advocacy organizations.

7. (MS) The agency may make use of volunteers in any area where such utilization will directly or indirectly enhance opportunities for the personal development of consumers. All volunteers shall receive appropriate training and be supervised by qualified mental retardation professionals. Interns and students assigned for formal work experience, and other volunteers, who are registered and have formal duty assignments, are encouraged to participate in the program but are not to be used as substitutes for staff.

C. Fiscal

1. (MS) The agency shall use of a variety of fiscal resources: Louisiana Rehabilitation Services (LRS) and Home and Community-Based Waiver funds shall be used for activities which can appropriately be funded by those sources.

2. (QI) The agency shall access work incentives offered through Social and/or Supplemental Security. Plan for Achieving Self-Support (PASS) and Impairment Related Work Expenses (IRWE) should be used for activities which can be funded by those sources, unless such use is not in the best financial interest of an individual consumer.

3. (QI) The agency shall apply for competitive funding, such as, public and private grants, and foundation funding.

D. Rights

1. (MS) The agency shall have policies and procedures which include statements that a participant has all rights afforded to citizens of the United States, the rights enumerated in R.S. 28:380 through 444, the MR/DD Law, as they apply, and in particular, the following rights:

a. receive services without regard to race, color, religion, sex, marital status, national origin, sexual orientation, age, or disability; (Restrictions based on OCDD's eligibility requirements are not prohibited.)

b. a program orientation;

c. privacy;

d. freely communicate choices, preferences, satisfaction;

e. protection from exploitation when engaged in training and productive work;

f. legal representative through referral to an advocacy organization or at their own expense; and

g. freedom from neglect and abuse.

2. (MS) The agency shall comply with the requirements of the Americans with Disabilities Act as they apply to the organization. (A lack of findings on the part of the OCDD with regard to this standard in no way implies that the OCDD has made a legal determination that the agency is in compliance with the provisions of the ADA.)

3. (MS) The majority of the members of the Human Rights Committee is external to the agency.

E. Confidentiality

1. (MS) The agency shall implement and have written policies and procedures regarding release of information. The policies and procedures shall require that the release form shall:

a. specify the name of the person or agency to whom the information is released;

b. describe the information to be released;

c. specify the purpose for the release of information;

d. specify the length of time for which the release is valid, not to exceed one year; and

e. include the date and signature of the consumer or his/her representative. The signature of a witness must be obtained, when such signature is required.

2. (MS) The agency shall have a policy which defines who has access to consumer records.

3. (MS) The agency shall maintain a record of all persons, including staff, who have accessed information from consumers records.

F. Informed Consent

1. (MS) The agency's policies and procedures and/or employee handbook shall include provisions pertaining to informed consent. Informed consent is the knowing consent of an individual or his/her legally authorized representative, so situated to be able to exercise free power of choice without undue inducement or any element of force, fraud, deceit, duress or other form of constraint or coercion. The basic elements of information necessary for informed consent include the following:

a. a fair explanation of the services to be provided and their purposes;

b. a description of any risks which may possibly exist;

c. a description of any benefits reasonably to be expected;

d. a disclosure of any appropriate alternative services that might be advantageous for the consumer; and

e. an offer to answer any inquiries concerning services.

2. (MS) The conditions under which a consumer must be provided informed consent must be described in the Policy Manual and must include, at a minimum, admission, discharge, Interdisciplinary Team meetings, and any other time that a significant change to the Individualized Program Plan is made.

G. Legal Status

1. (MS) The agency shall make reasonable efforts to determine the legal status of applicants as well as any changes in such status of applicants or current consumers (i.e., full interdiction, partial interdiction, continuing tutorship, competent major).

2. (MS) In the event that a restrictive legal action has been filed on behalf of an applicant or current consumer, the responsible individual shall be informed of the need to provide a copy of the legal document or an affidavit to that effect to the agency.

H. Personnel

1. (MS) The organization does not discriminate with regard to employment, promotion, pay or place of work because of race, sex, creed, national origin, disability or age.

2. (MS) The agency has an authorized procedure for suspension or dismissal of an employee for cause. This policy assures firm disciplinary action for employee behaviors which include, but are not necessarily limited to, abuse and neglect.

3. (MS) The immediate director of the employment/work program shall hold a bachelor's degree and have at least one year's experience in accessing employment opportunities for persons with developmental disabilities. This standard applies to employees hired on or after July 20, 1995.

4. (MS) Where certification or licensing standards exist for professional staff or consultants, these individuals shall possess up-to-date certifications and/or licenses.

I. Admissions

1. (MS) Within 30 days of admission, the agency will submit written information to the OCDD about each consumer to receive funding under the OCDD contract, including:

a. the OCDD Client Registration Form;

b. the proposed type of service to be delivered, i.e., mobile crew, individual job, enclave or facility-based services;

c. a statement that there is a vacancy and that with this admission the number of consumers to be served does not exceed the maximum number under the contractual agreement.

2. (MS) the agency must insure that the following criteria are met prior to admitting any consumer whose services will be funded by the OCDD:

a. the consumer must be 22 years old or older; and

b. there must be a diagnosis of mental retardation or some other developmental disability made in accordance with the MR/DD State Law.

J. Discharge

1. (QI) Involuntary discharges shall be reviewed by the human rights committee within 30 days after discharge. The agency shall respond to the recommendations of the committee by either following such recommendations or providing reason why not.

2. (MS) The provider shall inform the OCDD of any plans to discharge consumers at least 15 calendar days prior to the planned discharge.

K. Grievances

1. (MS) The agency shall develop policies and procedures which are consonant with the grievance requirements contained or referenced in the contract between the agency and the OCDD and include time lines for each step.

2. (MS) The agency shall inform consumers in writing of the reasons for actions taken and provide the opportunity to meet with staff to resolve any issues.

3. (QI) Prior to appeal to the governing body, the grievance procedure shall include a review of the issues incorporating input from an independent, nonpartisan person(s). Recommendations resulting from the review will be submitted to the governing body.

L. Behavior Modification. There is a need to differentiate between the normal, day to day consequences to behavior and the consequences dictated in behavior management programs. In the course of a day, positive, effective approaches which respect the dignity and reputation of individuals are used to address mild departures from expected behaviors. No formal behavior management plan is needed to use these approaches. Behavior management programs are necessary when the frequency and intensity of a behavior demands a more formal, systematic approach to insure that all relevant staff understand the program and are able to apply it appropriately.

1. (MS) The agency has written policies and procedures for behavior management which:

a. prohibit corporal punishment, chemical restraints, psychological abuse, verbal abuse, seclusion, forced exercise, mechanical restraints, and any procedure which denies food, drink, or use of rest room facilities. The exception is that per Department of Social Services, Bureau of Licensing and Certification mechanical restraints may be used on a temporary basis to safeguard against self-injurious behaviors when the agency's policy allows for such;

b. define the use of behavior modification programs, define mechanisms which authorize their use, and provide for the monitoring and control of their use;

c. define the use of restraint, define mechanisms which authorize their use, and provide for the monitoring and controlling of their use;

d. indicate that passive/physical restraint may be used only after other, less restrictive interventions/strategies have failed;

e. cover any behavioral emergency and provide documentation of the event in incident report format.

2. (MS) The agency shall inform the individual (and his/her legally-appointed guardian) of behavior management policy and procedures prior to the time that a behavior management plan is developed so that the individual can participate fully in the development of the plan.

3. (MS) The decision to implement a behavior management plan shall be made by an interdisciplinary team.

4. (MS) Behavior management plans must be:

a. reviewed by the agency administrator, (or her/his qualified designee); and

b. if the plan includes any form of punishment, it must be reviewed and approved by a specifically constituted Human Rights Committee.

5. (QI) To insure that individual's rights are not abridged, the Human Rights Committee shall review each behavior management plan prior to implementation and at least semi-annually.

6. (MS) The behavior management plan shall:

a. be developed by the Individualized Program Plan Committee in conjunction with a qualified professional (A "qualified professional" must have at least a bachelor's degree in psychology or a master's degree in counseling, social work, rehabilitation, special education or human relations and specific training in learning theory/techniques of behavior management.); and

b. be based on a written functional analysis of the behavior which is defined as:

i. a clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;

ii. a clear description of the need to alter behavior;

iii. an assessment of the meaning of the behavior, which includes the possibility that the behavior is:

(a). an effort to communicate;

(b). the result of medical conditions;

(c). the result of environmental causes; or

(d). the result of other factors; and

c. be written to address specific targeted behaviors, be time-limited, and clearly state the responses to be used by staff; and

d. emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention; and

e. use the least intervention possible; and

f. be evaluated by the service provider through review of specific data on the progress and effectiveness of the procedures on a periodic basis; and

g. be incorporated into the Individual Habilitation Plan.

7. (MS) Information regarding the behavior program shall be maintained in the Client Record and shall include the following:

a. documentation that the individual (and her/his legally-appointed guardian) and the Interdisciplinary team are informed of and consent to the program; and

b. documentation that all staff engaged in the implementation of the plan have received training pertinent to the plan; and

c. documentation that any prior behavior management plans used since admission or in the last five years, whichever is least, to develop an alternative behavior were taken into consideration in the development of a new plan (A file of these plans must be maintained in the consumer record.); and

d. a description of the conditions which precede the behavior in question; and

e. a description of what appears to reinforce and maintain the behavior; and

f. a clear, measurable and positive procedure which will be used to alter the behavior and develop the functional alternative behavior.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28.380 through 444.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:688 (July 1995).

§107. Programmatic Standards

A. Programming Guidelines

1. (MS) In its planning processes, service provision and daily routines, the agency shall:

a. provide on-going opportunities for each consumer to exercise self-determination and freedom of choice to the fullest of his/her ability in his/her work environment along with the training and supports needed to do so.

b. provide the opportunity for each consumer to work in the least restrictive and most normal setting possible.

c. address the opportunity to engage in activities which encourage and maintain the inclusion of the consumer in the community through:

i. promoting social interactions which maximize contact with other citizens in culturally typical settings;

ii. presenting a physical appearance which is appropriate to the chronological ages of the people served and the practices of the surrounding community;

iii. engaging in activities and routines which are appropriate to the consumer's chronological age, occur at appropriate times of the day and follow the practices of the surrounding community;

iv. being addressed in a manner appropriate to the chronological age of the consumer and the practices of the surrounding community;

v. freedom from program practices which produce negative impressions of the individual, i.e., use of techniques or materials which draw undue attention to the consumer.

2. (MS) If/When nonvocational group activities occur in the community, the agency should consider the preferences of the individual served, and promote natural proportions through consideration of the number of people with disabilities who will be in the setting, and the opportunities for interaction with other community members.

3. (QI) Exchanges between consumers and the management, and, when appropriate, representatives of consumers, should occur at least annually for the purpose of discussing matters of mutual concern. Purposes of such communication should, at the least, include:

a. to solicit input from persons served regarding methods, activities, service delivery and design, etc.

b. to receive suggestions from the persons served and to answer their questions.

c. to inform the persons served concerning relevant aspects of program operations and plans.

d. to enlist the informed cooperation of the persons served to achieve efficient use of resources of the program in the best interests of these persons.

4. (MS) The agency serves consumers with severe and profound disabilities.

B. Assessments

1. (MS) At a minimum the following persons shall be involved in the vocational assessment and its annual update:

a. the consumer and any representative he/she may authorize;

b. the family or residential provider, unless the consumer objects;

c. the staff person most involved with the consumer.

2. (MS) A work evaluation/assessment is conducted or up-dated annually for each consumer. It includes, but is not limited to:

a. the work interests, preferences and goals of the consumer;

b. the consumer's general and specific work abilities based on reports, screenings, checklists, etc.;

c. a work history;

d. work habits such as punctuality, attendance, etc.

e. the learning style, preferred modalities of the individual;

f. physical and/or medical issues that might limit employment;

g. adaptive equipment or modifications that might increase the likelihood of success;

h. consumer and family attitudes about work;

i. an analysis of family, residential or other supports which might be available for employment;

j. determination of transportation needs;

k. actual benefits the consumer is receiving and potential benefits available to meet the consumer's work needs.

3. (MS) recommendations for work/vocational training are contained in the Individualized Program Plan (IPP) and are based on the outcome of the assessment.

C. Individual Program Plans

1. (MS) Prior to the IPP meeting the agency must:

a. seek information from the consumer about his/her interests and preferences;

b. solicit the consumer's input about persons he/she would like to attend the meeting;

c. prepare consumers for the meeting by describing the IPP process; and

d. provide information about the choices the consumer will need to make at the meeting.

2. (MS) At a minimum the interdisciplinary team shall be composed of:

a. the consumer;

b. member(s) of his/her family, unless the consumer objects;

c. the staff person most involved with the consumer;

d. the residential service provider, unless the consumer objects; and

e. any other representative (friend/advocate) the consumer may select, if that representative agrees.

3. (QI) considering the minimum team members, the number of agency staff attending the IPP may not exceed the number of representatives (family/friends/advocates) selected by the consumer (including the consumer). Paid employees of the service provider are not considered to be "representatives" of the consumer for the purpose of this

standard. Other consumers served by the agency may serve in this capacity, if confidentiality is preserved.

4. (QI) in the development of the IPP, the program uses or participates in a person-centered planning process surrounding the vocational needs of the consumer. The process is designed around providing individualized supports and incorporates natural supports.

5. (MS) an individual program plan shall be developed for each consumer with the full participation of that person and shall include the following:

a. the personal preferences, desires and wants of the consumer;

b. consideration of the results of the vocational assessment/update, including a description of progress over the past year, and any recommendations;

c. consideration of the results of any other pertinent assessments/updates, including a statement of the current functioning level as found on the OCDD complexity scale;

d. a statement of the individual's strengths and preferences;

e. a review, and, if appropriate, an update of the OCDD complexity scale and the legal status of the consumer.

f. measurable objectives for acquiring vocationally-related skills which are oriented toward promoting maximum independence and the maximum number of vocational options for the consumer;

g. measurable objectives regarding placement in supported or competitive employment, or a statement explaining why such employment is not an objective at this time;

h. measurable objectives for acquiring functional, work-related skills;

i. a description of community-based activities in which the consumer is or will be involved, whether these activities are the responsibility of the family, the program or some other individual/group;

j. a statement outlining how the transportation needs of the consumer will be met, whether this is the responsibility of the family, the consumer or the agency;

k. a description of the generic, community resources which may be used to meet the needs of the consumer, if any;

l. a statement regarding expected monthly earnings; and (This is provided simply as another descriptor, and is not to be used to measure against actual wages for compliance purposes.)

m. for each objective:

i. training methodologies;

ii. persons responsible;

iii. projected time frame for completion; and

iv. procedures for evaluation of progress toward completion.

D. Program Content

1. (MS) The program should provide, arrange or refer the consumer for support and training in employment and when appropriate, in related areas such as:

a. functional communication skills, e.g. oral, written and nonverbal, needed on the job and in the community;

b. making choices, contingency planning, problem solving, and decision making regarding their employment, including decisions regarding the development and modification of their program plans;

c. functional skills as they relate to the workplace;

d. social skills necessary to maintain employment and function in the community;

e. mobility and transportation skills necessary to participate fully in the vocational/habilitative program;

f. safety practices as they relate to life in the community and on the job, for example, dealing with injuries, evacuating during fire drills, and handling emergencies, etc.

g. self-advocacy training needed to enable consumers to assert their human and civil rights in effective ways;

h. utilization of community services and resources, as related to work, e.g., restaurants, suppliers, etc.;

i. interactions in the community with citizens who are not paid care givers or staff.

2. (MS) The agency shall provide or assist in arranging for the transportation of consumers served by the agency to and from service sites when the family is unable to provide it or when other forms of transportation are unavailable or inaccessible.

3. (MS) If the agency restricts the provision of transportation or charges consumers for transportation, the agency has a detailed, written policy describing all restrictions and any conditions under which transportation charges may apply.

E. Work

1. (MS) All agencies receiving funding under this contract will comply with United States Department of Labor's Fair Labor Standards Act, whether or not the work performed is covered by the Department of Labor regulations, and, where applicable, by the United State Department of Labor's Wage and Hour Regulations, Part 525, Employment of Workers with Disabilities under Special Certificates. By contracting to provide vocational and habilitative services all agencies receiving funding under this contract acknowledge familiarity with, and will abide by, all applicable state and federal regulations pertinent to employment of workers with disabilities under special

certificates, including but not limited to U. S. Department of Labor, Part 525.

2. (MS) The agency prepares a handbook, which is reviewed annually, updated as needed and distributed to all consumers, stating:

a. the conditions, benefits and responsibilities of the organization and the persons served;

b. fringe benefits;

c. wage payment practices;

d. work rules;

e. nondiscrimination provisions;

f. grievance and appeal procedures for consumers;

g. an explanation of the means used by the organization to preserve human rights and the mechanism by which the person has access to that system;

h. the availability of community-based job training and placement services.

3. (MS) Wage payments are based on a system of individual performance rather than pooled and/or group wage payments.

4. (MS) Wage payments are monetary in nature, paid by check in the individual's name and not payments in-kind.

5. (MS) The pay period does not exceed 31 calendar days.

6. (MS) Each person receives a written statement for each pay period indicating gross pay, hours worked, deductions, and net pay.

7. (MS) Wages may not be withheld or delayed for disciplinary reasons or because they are contingent upon subsequent sales or payments to the organization.

8. (MS) Contractors providing employment shall comply with R.S. 23:1168, Ways of Securing Compensation to Employees. By contracting to provide vocational and habilitative services all agencies receiving funding under this contract acknowledge familiarity with, and will abide by, all applicable state and federal regulations pertinent to providing workers compensation or similar insurance to employees, including but not limited to R.S. 23:1168.

9. (QI) All consumers have equal opportunity to use equipment within the provisions of safety standards, production schedules and the physical abilities of the individual. (This applies to facility-based services only.)

10. (MS) Provisions for meeting safety standards apply uniformly to all persons employed by the agency.

11. (QI) As a part of reasonable accommodation, modified equipment, fixtures, and other techniques are used as necessary to increase the individual's productivity rate.

12. (MS) The agency accesses funding from Louisiana Rehabilitation Services for job development, placement, intensive training, and job modifications and adaptations at the job site.

13. (MS) The resources/supports available from parents, friends, co-workers, guardians, advocates, case managers, residential providers (i.e., supported living, SFC parents) and others, as determined by the consumer are considered in the coordination of supported employment services.

14. (MS) There are provisions for extended services which include:

a. a minimum of two visits per month at the job site to assess the individual's job performance both by direct observation and discussion with the consumer's co-workers and supervisors. In the case where the consumer and/or the job coach believes it is more appropriate to meet the consumer off the job site to assess the employment situation, the job coach must still contact the employment site to assess job performance;

b. periodic retraining;

c. job modifications needed to maintain employment, when not available through LRS; and

d. provision or identification of other supports needed to maintain employment.

15. (MS) When an Interdisciplinary Team determines that formal (agency-provided) extended services are not necessary for the continued maintenance of a consumer's employment, the agency shall:

a. initiate separation from OCDD services per the discharge policy;

b. provide a written description of the employer and/or generic supports that are available to the individual.

16. (MS) A separation report is completed when a person receiving agency provided extended services leaves any community job. The report documents:

a. date of separation;

b. reason(s) for separation; and

c. recommendations for future employment or other services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:691 (July 1995), LR 27:854 (June 2001).

Chapter 3. Infant Intervention Services

§301. Statement of Purposes

A. The purpose of the Standards for Infant Intervention Programs is to:

1. implement the law and comprehensive plan for mental retardation and developmental disabilities services in Louisiana; and

2. establish a minimum level of standards for Office of Mental Retardation/Developmental Disabilities (OMR/DD) Infant Intervention Program.

B. OMR/DD will establish procedures and guidelines as necessary to implement the standards.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources and the Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§303. Authority—Scope—Enforcement

A. Authority. These standards are promulgated pursuant to Louisiana R.S. 28:380 et seq.

B. Scope. These standards apply to OMR/DD funded Infant Intervention Programs as defined in Section 305 of these standards.

C. Enforcement. OMR/DD will monitor programs and provide technical assistance to ameliorate deficiencies and, when OMR/DD determines significant progress is not being made, may discontinue funds to providers found not in compliance with these standards or may take other actions as deemed necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§305. Definitions

Case Management—pursuant to R.S. 28:381(4), a department mechanism for linking, coordinating, and developing segments of a Mental Retardation and Developmental Disabilities Services System to insure appropriate residential living options or mental retardation and developmental disabilities services or both to meet a recipient's needs to the greatest extent possible, including those recipients who are served by multiple agencies or regional service center. Such case management services shall be conducted in accordance with established department procedures.

Center-Based Program—a therapies and habilitation program conducted in an out-of-home setting at a school, center or clinic.

Criterion-Referenced Assessment—a checklist of behaviors which can be directly measured, are reduced into incremental behavioral components, and include motor, communication, self-care, social and cognitive skills.

DHHR—pursuant to R.S. 28:381(9), Department of Health and Human Resources.

Diagnosable Condition—a state of health such as cerebral palsy, mental retardation, seizure disorder, autism, or a congenital disease or abnormality which is identified by a physician.

Evaluation—pursuant to LSDE Bulletin 1508, a systematic process of review, examination, and interpretation of intervention efforts, tests results, interviews, observations and other assessment information relative to predetermined criteria.

Generic Service Plan—pursuant to R.S. 28:381(24), a plan developed by a case manager, multidisciplinary evaluation team coordinator, and the individual following receipt of the recommendations of a multidisciplinary evaluation report enumerating those mental retardation and developmental disabilities services or residential living options or both that a mentally retarded or developmentally disabled individual is eligible for and should receive, if available.

Handicapped Infant—pursuant to LSDE Bulletin 1508, one who is from birth to three years of age and has a serious handicapping condition which, without intervention, will become progressively more difficult for intervention at school age.

Home Training Program—a parent training program designed to teach the parents the skills necessary to provide therapies and habilitation to their handicapped infant at home. The training can take place in the home or at a school or center.

IHP—individualized habilitation plan. This is a written plan developed by the Infant Intervention Program after the infant is admitted to the program. Such a plan shall include goals, objectives, anticipated duration of services and other requirements as specified in Section 317 of these standards.

Individualized Training—a specific program based on assessment of an infant's needs for therapies and habilitation services in accordance with the IHP.

Infant Intervention Program—therapies and habilitation services program for handicapped infants which:

1. provides individualized training in a center-based setting;

2. provides individualized training in a home training setting; and

3. provides parent training to the parents.

Infant Intervention Services—pursuant to R. S. 28:381(8), services for handicapped infants from birth to three years provided either through a center-based or home training program including, but not limited to language stimulation and development, motor development, socialization and self-help skills development, cognitive development, behavior management, parent training and other services as appropriate to individual needs.

Infant Interventionist—an individual certified by the LSDE to teach or train in such areas as handicapped infant, noncategorical preschool handicapped, mental retardation, orthopedically handicapped, severe-profound, elementary education; or a nurse, speech therapist, physical therapist, or

occupational therapist licensed in Louisiana and certified by LSDE to work in an educational setting; or a related field, who is enrolled in an approved professional plan for certification.

Infant Specialist—an employee of the Regional Service Center assigned to coordinate the Infant Intervention Services in that region.

Integrated Evaluation Report—pursuant to LSDE Bulletin 1508, the final written report following the evaluation which:

1. shall be a compilation of the data gathered during the individual evaluation;

2. shall be integrated and written in language that is clear to the individuals who will use it; and

3. shall contain all items pursuant to LSDE Bulletin 1508, Section III. I. 1-3.

LSDE—Louisiana State Department of Education.

LEA—local education agency.

Mental Retardation and Developmental Disabilities Services—pursuant to R.S. 28:381(22), programs and assistance for mentally retarded or developmentally disabled persons which include, but are not limited to, information and referral services, case management services, diagnosis and evaluation services, generic service plan development services, family support services, health services, educational services, therapies and habilitation services, vocational services, transportation services, recreation and leisure services, Special Olympics services, respite services, infant intervention services, and adult day services.

Mental Retardation and Developmental Disabilities Services System—pursuant to R.S. 28:400, the combination of private and public mental retardation and developmental disabilities services and residential living options and the process by which a mentally retarded or developmentally disabled individual is admitted, transferred, or discharged within this system which is administered by the Office through the regional service centers. Components are pursuant to R.S. 28:401.

Multidisciplinary Evaluation—pursuant to R.S. 28:381(33), an assessment of need for mental retardation and developmental disabilities services or residential living options or both, and a determination that a person is mentally retarded or developmentally disabled by a group of professionals meeting together conducting their respective evaluations on an individual who is mentally retarded or developmentally disabled or suspected of being mentally retarded or developmentally disabled. The multidisciplinary evaluation process shall be coordinated by an evaluation coordinator who shall be responsible for developing an integrated evaluation report following a group meeting with those professionals who conducted the multidisciplinary evaluation. Another purpose of the multidisciplinary evaluation is to diagnose mental retardation or developmental disabilities as defined herein.

OMR/DD—pursuant to R.S. 28:381(34), the Office of Mental Retardation/Developmental Disabilities of DHHR.

Paraprofessional Training—a person at least 18 years of age, who possesses a certificate of good health signed by a physician, who has received paraprofessional training, and who assists in the delivery of infant intervention services under the supervision of an infant interventionist.

Paraprofessional Training Unit—a training model that may be used for the self-help skill training (toilet training, dressing skills, grooming skills, feeding skills, and preacademic readiness activities) of infant, preschool, or severely and profoundly handicapped children. The unit, made up of not more than four paraprofessionals, must be supervised directly by an infant interventionist. Each paraprofessional must have a full quota of students (three) before an additional paraprofessional can be added to the unit.

Parent Training—teaching parents the skills necessary to assist their handicapped infant in therapies and habilitation services.

Regional Service Center—pursuant to R. S. 28:381(38), an administrative unit of the Office of Mental Retardation/Developmental Disabilities under its administration, supervision, and control through which the office administers and coordinates the Mental Retardation and Developmental Disabilities Services System in any given region. The center is responsible for regional planning, stimulation of the development of needed services from private or public providers; presentation of budget information to the office for all residential living options and mental retardation and developmental disabilities services or both in the region and, as appropriate, request funding for such services through normal budgetary channels; dispersal of appropriations made to the region through the office; and administration of the state schools assigned to its geographic area. The regional center shall utilize existing private and public resources to the maximum extent possible. The relationship between a private provider and a regional service center shall be defined by written agreement or contract as specified in R. S. 28:380(C) to allow for maximum permissible fiscal and administrative autonomy.

Screening—pursuant to LSDE Bulletin 1508, a process of collecting and reviewing information about the physical, developmental, or behavioral characteristics of an infant for the purpose of identifying those who are suspected of having a serious handicapping condition.

Therapies and Habilitation Services—pursuant to R.S. 28:381(46), behavioral intervention, communication training, occupational therapy, physical therapy, community living skills training, self-help skills training, socialization skills training, infant intervention training, and other related therapies and habilitation services.

Unit of Service—a minimum of three hours of planned activities a day in a center-based Infant Intervention Program, or one hour of planned activities in a home training Infant Intervention Program.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§307. Screening

A. The Infant Intervention Program shall notify the Regional Service Center within one working day to obtain a case manager for any infant referred to the Infant Intervention Program.

B. The case manager shall insure that each infant referred to the Regional Service Center shall be screened within 10 working days pursuant to LSDE Bulletins 1508 and 1633, to identify those who are suspected of having a serious handicapping condition.

C. The screening should be conducted by educators, nurses, pupil appraisal personnel, or other personnel and shall include:

1. vision and hearing screening; and

2. a developmental screening conducted by persons trained in such procedures; and

3 current medical information.

D. An infant shall be referred to the LEA of the child's residence by the case manager for an individual evaluation within three working days after the screening if the results of the screening show that the infant:

1. is functioning in the lower two-thirds (67th percentile or less) of the normal developmental distribution in two or more areas of development assessed; or

2. is functioning in the lower one-third (33rd percentile or less) of the normal developmental distribution in one or more areas of development assessed; or

3. has a diagnosable condition identified by a physician which, in the physician's judgment, would result in a serious handicapping condition if untreated with Infant Intervention Services.

E. An infant may begin receiving Infant Intervention Services with an interim IHP, valid for 60 working days, after meeting the criteria in §307.D of these standards. The interim IHP shall be developed by the parent(s) or guardian(s), case manager, and the Infant Intervention Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§309. Evaluation

A. The case manager shall insure that each infant shall have a multidisciplinary evaluation within 60 working days of referral.

B. This evaluation shall be conducted by the LEA of the child's residence, pursuant to Act 754 and LSDE Bulletins 1508 and 1633, to be determined eligible for the Infant Intervention Program.

C. The evaluation shall include the following consistent with the LSDE Bulletins 1508 and 1633 and Title XIX criteria:

1. a physical examination conducted by a pediatrician or other appropriately trained physician which specifies the impairment(s) and assess the extent to which the impairment will inhibit normal development and learning. The report should also indicate facilitators to development and learning;

2. a developmental assessment conducted by an educational consultant, assessment teacher, psychologist, or master level professional, certified in non-categorical preschool handicapped who has appropriate training in developmental assessment and medical/education implications of handicapping conditions. The assessment report shall be signed by a licensed psychologist;

3. a family interview conducted by a social worker or other appropriate pupil appraisal staff member, which addresses such factors as:

a. the needs of the family in understanding the child,

b. the child's development, and

c. the community service agencies currently providing assistance to the family in relation to the child.

C. All evaluations and the integrated evaluation report shall be conducted in accordance with the procedures pursuant to LSDE Bulletins 1508 and 1633 and Title XIX.

D. The case manager shall insure that each infant, at a minimum, receive an annual review of their evaluation and a re-evaluation as necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§311. Eligibility

A. Each infant in the Infant Intervention Program shall meet all eligibility criteria pursuant to LSDE Bulletin 1508. These criteria are:

1. from birth to three years of age; (Three years of age is specified in Section 321 A.4 of these standards.)

2. a serious handicapping condition as indicated by:

a. severe physical handicap in areas such as sensory and/or motor functioning; or

b. functioning in the lower one-third (33rd percentile or less) of the normal developmental distribution in one or more of the areas of development assessed; or

c. a diagnosable condition which could result in a serious handicapping condition if untreated; or

d. severe inability to interact with the environment whether physical or social.

3. Evidence that educational or developmental intervention is necessary to the future ability of the infant to benefit from education.

B. An infant who is determined by a physician to be at-risk for the development of a serious handicapping condition as specified in §311.A.2 of these standards may be eligible up to the age of 12 months.

C. The Infant Intervention Program shall request a determination of eligibility under Title XIX by the Office of Family Security for each applicant to the Infant Intervention Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§313. Admission

A. The case manager shall review the integrated evaluation report and determine if the infant meets the eligibility criteria for mental retardation and developmental disabilities services within five working days of the receipt of the report.

B. The case manager and the multidisciplinary evaluation coordinator shall develop the generic service plan based on the integrated evaluation report for all infants eligible for mental retardation and developmental disabilities services within five working days of the receipt of the report.

C. Each handicapped infant who meets the eligibility criteria pursuant to Section 3 of these standards, and whose generic service plan recommends an Infant Intervention Program, may apply for admission in the Infant Intervention Program.

D. Infants determined eligible for the Infant Intervention Program shall be enrolled without regard to race, color, creed, sex, national origin, or duration of Louisiana residence as program space is available.

E. Admission in a center-based program or home training program shall be determined by considerations such as the infant's age, travel distance to the center or school, severity of the handicapping condition, ability to benefit from peer interactions, medical factors, parent's ability to provide parent training in the home, and/or length of time the delay has existed without intervention.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§315. Diagnostic Assessment

A. The Infant Intervention Program shall assess each infant's performance with a criterion-referenced assessment, which should be compatible with their curriculum and the LEA'S preschool assessments and/or curriculum in their service area, for the purpose of developing the IHP.

1. The assessment shall be conducted at least twice within a calendar year for the purposes of determining infant progress and will be part of Section 319. D of these standards.

2. The assessment shall include at least the skill areas of motor, communication, self-care, social and cognition.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§317. Individual Habilitation Plan

A. The Infant Intervention Program shall develop within 30 working days of admission, and by the anniversary date thereafter, an individualized habilitation plan (IHP) for each infant which is developed in accordance with the requirements of OMR/DD.

B. The Infant Intervention Program shall plan a mutually convenient time and notify the parent(s) or guardian(s) of the date, time and place of the IHP planning conference.

C. The IHP shall meet the following criteria:

1. shall be in writing with long-term goals and short-term objectives specified;

2. shall be developed jointly by program staff and infant's parents or guardians;

3. shall be based on information from the multidisciplinary evaluation, criterion-referenced assessment and the generic service plan;

4. shall include a statement of the infant's present level of functioning;

5. shall identify therapies and habilitation services to be delivered, the person(s) and title who will provide each service and the frequency of each service;

6. shall indicate start and completion dates for each goal, therapy and/ or habilitation service;

7. shall include an evaluation component for evaluating progress;

8. shall have written consent by the parents or guardians; and

9. shall be reviewed and updated monthly with a new IHP developed on the yearly anniversary date.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§319. Program Guidelines

A. The Infant Intervention Program shall provide home training and/ or center-based services.

1. Each infant and the parent or guardian participating in home training services shall receive a minimum of one hour of therapies and habilitation services every two weeks. The exact time will be specified in the generic service plan and IHP.

2. Each infant participating in the center-based services shall receive individualized training for a minimum of three hours per day, at least two days a week. The exact time will be specified in the generic service plan and IHP.

B. The Infant Intervention Program shall use a curriculum for handicapped infants which should be compatible with their assessment and the LEA's preschool assessment and/or curriculum in their service area. The curriculum shall include at least the skill areas of motor, communication, self-care, social, and cognition.

C. The Infant Intervention Program shall develop a written program of activities based on the IHP for each infant.

D. The Infant Intervention Program shall implement a data collection system to monitor the progress of each infant in completing activities and IHP objectives and goals.

E. The Infant Intervention Program shall provide or assist in seeking adequate resources for speech therapy, physical therapy, and occupational therapy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§321. Termination of Services

A. An infant shall be terminated from the Infant Intervention Program under the following conditions:

1. if the infant makes substantial progress and no longer meets the eligibility criteria in Section 311 of these standards; or

2. if the infant develops significant life-threatening medical problems which make effective services delivery impossible; or

3. if the infant's parent(s) chooses not to participate in the program; or

4. when the child reaches three years of age. Pursuant to LSDE Act 754, each handicapped infant shall be regarded as eligible for the LEA program at the beginning of the school year if his or her third birthday occurs after the beginning of the school year but before January 1. If the third birthday occurs after January 1, then the infant may remain in the Infant Intervention Program until the beginning of the following school year.

B. The decision to terminate an infant shall be made jointly by the parent(s) or guardian(s), case manager, and Infant Intervention Program at an IHP meeting.

C. The Infant Intervention Program shall work with the parents, case manager, and the receiving program or LEA to facilitate the transition in accordance with the interagency agreements specified in Section 323.A.4 of these standards.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§323. Records

A. The Infant Intervention Program shall maintain written program records to include:

1. a program description with eligibility criteria pursuant to these standards;

2. a policy concerning confidentiality of or access to program participant records and the time period for maintaining such records;

3. an appeal procedure for infants and their parents denied admission to or terminated from the Infant Intervention Program;

4. interagency agreements with the LEA's in their area of service including, but not limited to identification, referral, evaluation and transition;

5. a policy statement describing complaint procedures;

6. a policy regarding behavior management programs in accordance with DHHR policy;

7. release forms for exchange of confidential information;

8. permission forms for field trips and publicity releases;

9. additional information as required by OMR/DD.

B. The Infant Intervention Program shall maintain an individual file for each infant to include:

1. OMR/DD approved admission form;

2. screening report;

3. integrated evaluation report which documents eligibility to include a physical examination, a developmental assessment, and a family evaluation;

4. generic service plan;

5. current IHP;

6. updated evaluation information;

7. progress reports;

8. appropriate release forms;

9. a current record of immunizations, and of all current medications administered;

10. application for Title XIX certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380et.seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§325. Reporting

A. The Infant Intervention Program shall provide OMR/DD with a monthly report which indicates the following:

1. days in attendance by each infant in center-based services;

2. units of service provided to each infant and parent(s) in home training services;

3. infants admitted during the month;

4. infants terminated during the month and to where terminated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380et.seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§327. General Staffing Provisions

A. The Infant Intervention Program shall have written job descriptions for all staff.

B. The Infant Intervention Program shall have a staff organizational chart which has been approved by its governing board.

C. The Infant Intervention Program shall hire or designate an individual to be responsible for the administration and direction of the program.

D. The Infant Intervention Program staff shall meet the following minimum qualifications:

1. Supervisor/administrator—a baccalaureate degree in administration, special education, social services, or related area and three years experience in the field.

2. Infant interventionist—a valid LSDE certificate as defined in Section 305 of these standards, or a baccalaureate degree as defined in Section 305 of these standards.

a. An infant interventionist not fully certified shall have an approved professional plan for certification.

3. Therapist (speech, occupation, physical)—a current license valid in the state of Louisiana and/or a valid certificate issued by LSDE to work in an educational setting.

4. Paraprofessional—a high school diploma or equivalent.

5. Other staff positions shall meet qualifications for employment approved by OMR/DD.

E. The Infant Intervention Program shall maintain current personnel policies for affirmative action, hiring, termination and evaluation.

1. A job performance evaluation shall be conducted annually for each staff member by his or her immediate supervisor. This shall be in writing and shall be filed.

F. The Infant Intervention Program shall maintain a staff to infant ratio as follows:

1. Home Training Program—one infant interventionist for 10 to 15 infants with traveling to the homes and/or one infant interventionist for 15 to 20 without traveling to the homes.

2. Center-Based Program—one infant interventionist and one paraprofessional for 4 to 7 infants, and/or a paraprofessional training unit for 1 to 12 infants, for a five-day-a-week program.

G. The Center-Based Infant Intervention Program shall have at least one employee on duty at all times who holds a valid certificate for successful completion of an approved first aid course; and one employee who has been trained and has certification in CPR.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§329. Inservice Training

A. The Infant Intervention Program shall work in conjunction with the Infant Specialist in the Regional Service Center to assess needs, develop and implement a plan for the inservice training of personnel each year.

B. Each full time professional, therapist and paraprofessional in an Infant Intervention Program shall participate in inservice training, technical assistance and other training functions sponsored or approved by OMR/DD each year to insure they possess sufficient skills to implement these standards and other responsibilities.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§331. Monitoring

A. The Infant Intervention Program shall be monitored at least annually by DHHR and/or OMR/DD staff.

B. The Infant Intervention Program shall be responsible for providing access to information needed to document compliance with these standards.

C. The Infant Intervention Program shall be responsible for describing corrective actions necessary to ameliorate deficiency citations in a compliance plan which will be submitted to OMR/DD for approval.

D. The Infant Intervention Program shall continue serving each infant currently enrolled when these standards are promulgated until he or she is terminated due to the termination criteria in effect at their time of enrollment or in accordance with Section 321A.4 of these standards.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§333. Licensing

A. For licensing standards for infant intervention programs refer LAC Title 48, Chapter 87.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§334. System of Payments

A. The department shall have the authority to establish a statewide system of payments in accordance with 34 CFR part 303.

B. In implementing the system of payments:

1. the department establishes a schedule of monthly cost participation for early intervention services per qualifying family. Cost participation shall be based on a sliding scale;

2. application of the family's cost share using the sliding scale will include the family's adjusted gross income, family size, financial hardship, extraordinary expenses associated with the eligible child, and Medicaid eligibility;

a. extraordinary expenses may include but are not limited to unreimbursed medical expenses, equipment, home modifications, or other costs associated with the child with a disability;

b. extraordinary expenses must have been incurred during the calendar year that the family's cost share for individualized family services plan (IFSP) services is applied;

c. the family will be required to produce invoices, receipts, or other documents which establish the costs and payment for these expenses;

d. the family may request a reassessment of their costs based on extraordinary expenses at any time if there are significant changes affecting the determination of the cost participation amount. The request will be in writing and submitted to the service coordinator;

e. the request for reassessment will be considered by the designated EarlySteps office for a determination of the family's request. The family and the service coordinator will receive the department's written response;

3. the sliding scale shall utilize the most recent federal poverty guidelines issued in the *Federal Register* by the United States Department of Health and Human Services as the basis for determining the income threshold based on family size for eligibility for cost participation;

4. the department shall not assess any fee or other charge through the cost participation schedule upon a family which has an annual income of less than 300 percent of the federal poverty level;

5. the department shall not assess fees or other charges through the cost participation schedule which totals more than 3 percent of the monthly income level for a family of four, according to the federal poverty guideline schedule which will be updated annually;

6. once the family's income has been verified with the required documentation and the IFSP services have been determined by the IFSP team, the following will occur:

a. the system point of entry office will issue the cost participation statement to notify the family of their assessed costs which will be reviewed with the family and a copy provided;

b. following the submission of service claims by the child's provider, the Central Finance Office (CFO) will mail a monthly explanation of payment statement (EOP) to the family for payment. The EOP will include a notice of the family's right for reconsideration of their financial status and their right to apply for exemption from cost participation due to financial hardship;

c. families will remit reimbursement to the CFO at the address provided in the EOP;

7. when a family is not complying with the cost participation requirements and procedures for suspending services, the following will occur related to the status of the child's services;

a. a notice will be issued to the family, to the service coordinator and to the designated EarlySteps office;

b. the CFO will notify the department when the family is in arrears for a duration of three months at which time the service coordinator will discuss the family's options with the family and assist the department with its determination of the status of the child's IFSP services;

c. if the family provides its consent, a copy of the notice that the family is in arrears with payment for three months will be sent to the representative and senator in whose district the family resides;

d. the department will make a written determination regarding the status of the child's IFSP services following review of information provided by the service coordinator and the family. Families will be offered the option to continue to receive services available at no cost if they choose according to the no-cost provisions which follow;

e. the department shall not limit early intervention services for a child in any month if the cost for the services in that month exceeds the maximum contribution from the child's family.

C. Parents who have public insurance (Medicaid) and elect not to assign such right of recovery or indemnification to the department or choose not to release financial information will be assessed the cost for each early intervention service listed on the IFSP according to the most current service rate schedule and the cost participation schedule.

D. No-Cost Provision: the following services that a child is otherwise entitled to receive will have no costs assessed to the parents:

1. child find activities;

2. evaluation and assessment for eligibility and IFSP planning;

3. service coordination, administrative and coordinative activities related to the development review, and evaluation of the IFSP; and

4. implementation of procedural safeguards and other components of the statewide system related to §464 of Act 417.

E. The department will provide written, prior notification to families for use of Medicaid according to the requirements of 34 CFR 303.414. This notice includes a statement that there are no costs charged by the department for use of the eligible child's Medicaid. The notification also includes a statement of the process for resolutions of disputes regarding decisions related to use of Medicaid, failure to pay for services and/or the state's determination of a family's ability to pay.

F. Dispute Resolution Process

1. The procedures used by the department to resolve such disputes will not delay or deny the parents' rights or the child's ability to access timely services.

2. The dispute resolution process can be initiated by the parent according to OCDD's policy for handling system complaints when the parent wishes to contest the imposition of a fee or the department's determination of the parents' ability to pay.

G. Parental Consent. The department will obtain parental consent prior to the use of the child's Medicaid according to the following.

1. EarlySteps will obtain written consent for the use of the child's Medicaid using its established consent for services form.

2. Parental consent will be obtained prior to the initial provision of an early intervention service in the IFSP.

3. Parental consent will be obtained when an increase in frequency, length, duration, or intensity of a service is determined in the child's IFSP.

4. If the parent does not provide consent for the use of the child's Medicaid, the department will make available only those early intervention services on the IFSP for which the parent has provided consent.

5. Parents may withdraw consent for use of their child's Medicaid at any time.

H. Determination of Family Cost. Families are liable for the costs of services that their child receives while enrolled in EarlySteps as follows:

1. The aggregate contributions made by the parent shall not exceed the aggregate cost of the early intervention services received by the child and family (factoring in any amount received from other sources for payment for that service).

2. At least annually, or at any time the department determines that a reassessment of the parent's financial circumstances is warranted, the department shall conduct such reassessment of financial status.

3. The parent has the right to request a reassessment at any time if there are significant changes affecting the determination of the cost participation amount.

4. Families who have the ability to pay and choose not to pay may be determined as ineligible to continue to receive services until payment is made.

5. The inability of the family of the eligible infant or toddler will not result in a delay or denial of services if the family does not meet the cost participation income requirements or for services for which there are no costs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:821 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 41:147 (January 2015).

Chapter 5. State Residential Facilities

§501. Treatment of Resident Income

A. Definitions

Resident—any individual for whom a state residential facility is responsible for ongoing 24 hour care and whose primary domicile is considered the state facility.

ICF/MR—intermediate care facility for the mentally retarded which is certified to meet federal regulations under 42CFR.

ICF/MR—eligible resident An individual who meets the state and federal eligibility criteria for Medicaid benefits and who resides in an ICF/ MR under an approved placement plan.

Income Cash—from every source which is actually available, or which can be made available, and which is regular and predictable over the period of eligibilty.

Gross Income—the total income received prior to any deductions.

Earned Income—income which the individual earns by his own efforts; that is, requires ongoing activity on his part and is received as a result of performances of services by him.

Unearned Income—all income which is not considered as earned under these definitions. This includes pensions, allotments, dividends from investments, insurance benefits, alimony payments, etc.

B. Treatment of Income. All income of an individual resident in a state residential facility is considered in determination of the amount required to be paid to the facility to assist in financing cost of care. All such income, with the exceptions outlined below, shall be paid to the facility as long as the individual is considered a resident of that facility.

C. Residents Eligible for ICF/MR Services

1. The first $20 of total monthly individual income is reserved for the resident and is not applied against the cost of care.

a. If there is earned income only, the entire $20 is subtracted from that income and reserved for the resident.

b. If there is unearned income only, the entire $20 is subtracted from that income and reserved for the resident.

c. If there is both earned and unearned income, the $20 is subtracted first from the unearned income.

2. Retention of personal care needs will be in accordance with Title XIX policy as promulgated by the Department of Health and Human Resoureces, Office of Family Security.

3. Earned Income

a. In addition to the basic $20 exemption, the next $65 and one-

half the remainder of gross monthly earnings shall be reserved for use by the individual resident. All income in excess of this amount up to the actual cost of care shall be paid to the facility. Any amount over the actual cost of care shall be reserved for the resident.

b. For those individuals who are blind or under an approved plan for achievement of self support as defined by the Social Security Administration, additional earnings may be reserved. These exemptions shall be in keeping with policy of that agency.

4. Interest Income. Interest earned from funds on deposit shall be applied against the cost of care.

D. Residents Ineligible for ICF/MR Services. For those residents who do not qualify for ICF/MR services, the same policies apply as for eligible residents in relation to income. In addition, for those residents under age 18, legally responsible relatives shall contribute toward the cost of care in accordance with Department of Health and Human Resources policy.

AUTHORITY NOTE: Promulgated June 20, 1977 in accordance with R.S. 46:1757, subsequently repealed, July 17, 1978 and replaced with R.S. 36:1 et seq., amended March 20, 1987.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§503. Treatment of Resident Resources

A. A resident of a state mental retardation/developmental disabilities residential facility shall be allowed to retain resources valued up to $1,600 as defined by the Supplemental Security Income (SSI) program. Resources valued in excess of $1,600 shall be disposed of in a manner which is acceptable for SSI determination of eligibility under that program. This includes, but is not limited to, legitimate sale or transfer of resources, payment to the facility for cost of care, and purchase of personal items. Failure to comply with this policy will subject the resident to discharge. The resident and/or family shall have six months from the date of identification of excess resources to accomplish the reduction or have an acceptable plan for reduction in effect.

B. Exceptions to this policy may be made by individual facilities with concurrence of the Mental Retardation/Developmental Disabilities Central Office under the following circumstances:

1. The individual resident is placed in the facility for a specific period of time to accomplish certain goals and there is a plan in effect for return of the resident to his own home or other community placement. Such plans would generally not exceed one year in duration.

2. There is joint ownership of property or an inviolable trust which makes access to the principal amount of the funds or resource impossible.

3. The individual would not be eligible for Title XIX even if resources were reduced.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:1 et.seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§505. Eligibility

A. For eligibility criteria for intermediate care facilities for the mentally retarded refer LAC Title 50, Part 3, Subpart A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:1 et.seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§507. Licensing

A. For licensing standards for residential facilities refer to LAC Title 48, Chapter 79.

B. For licensing standards for group homes refer to LAC Title 48, Chapter 63.

C. For licensing standards for community homes see LAC Title 48, Chapter 51.

D. For licensing standards for supervised independent living see LAC Title 48, Chapter 83.

NOTE: For licensing standards for substitute family care see LAC Title 48, Chapter 61.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:1 et. seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§509. Voting Rights

A. Voting by residents of state-operated facilities for mentally retarded/developmentally disabled persons.

B. The purpose of this policy/procedure is to assist eligible residents of state-operated residential facilities for

mentally retarded/developmentally disabled persons to register to vote and to vote.

C. This policy applies to all state-operated residential facilities for mentally retarded/developmentally disabled persons.

D. Every resident of a state-operated facility for mentally retarded/ developmentally disabled persons, upon reaching 18 years of age, shall have the right to register and vote, except that this right may be suspended while a resident is interdicted and judicially declared mentally incompetent or is under an order of imprisonment for conviction of a felony.

E. Procedures

1. All residents 18 years of age or older who have not had the right to vote suspended through interdiction and have not been convicted of a felony are eligible to vote.

2. Staff will determine whether or not a client is eligible to vote by reviewing the client's records.

3. Residents who are eligible to vote will be informed of their right to vote in accordance with Medicaid regulations 45 CFR 442.404(d).

4. Residents who are eligible to vote and who ask to register to vote or to vote will be provided transportation to and from the registrar's office or the polls.

5. If residents are to be transported in large groups (more than three per group) the registrar's office of polling place will be notified in order to minimize problems.

6. Staff will not provide assistance to residents in registering to vote or in voting while at the registrar's office or the polls. Assistance in mobility may be provided to handicapped persons in wheelchairs.

7. Nothing in this policy is intended to inhibit facilities from teaching residents the skills necessary to vote in accordance with Medicaid regulation 45 CFR 442.404(d). Rather, such training is encouraged. Such training shall not extend to any attempt to influence any resident's vote either for or against any candidate or proposition.

AUTHORITY NOTE: Promulgated in accordance with R. S. 36:1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Mental Retardation/Developmental Disabilities, LR 13:246 (April 1987).

§511. DHH Policy on Admission to State Residential Facilities

A. Effective February 20, 1998, an individual whose eligibility for participation in the MR/DD Services System has been established and whose generic service plan indicates a need for a residential living option may be voluntarily admitted to a public residential facility at which there is an available funded bed. The public facility must determine that the individual's needs, as specified in the generic service plan, can be met. The individual is formally admitted when the public facility accepts the individual as a recipient. In the process of selecting a generic living option, the team, which includes the individual and/or family, is required to consider what meets the individual's needs, and no more, and the most natural living option available, consistent with an individual's community peers. Involuntary admission is governed by R.S. 28:404.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 24:335 (February 1998).

Chapter 7. Single Point of Entry and Determination Process for System Entry

§701. Purpose

A. The Office for Citizens with Developmental Disabilities Services System is the Single Point of Entry (SPOE) for the Developmental Disabilities Services System (system).

B. Standards for the determination process for system entry establish:

1. entry into the system;

2. general support needs and resources;

3. the presence of a developmental disability;

4. the diagnostic assessment;

5. the developmental assessment for children ages birth through three years; and

6. specialized accommodations, including transportation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:454.(1)(2), Acts 2013, No. 417, §3, eff. June 21, 2013.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 32:1241 (July 2006), amended LR 41:1490 (August 2015).

§703. Definitions

A. *Developmental Disability*—defined in accordance with the Developmental Disability Law at R.S. 28:451.2(12) and 462(4)(c).

B. *Developmental Disabilities Services System*—a system of programs, services, and supports for persons with developmental disabilities that include but are not limited to information and referral services, support coordination services, system entry services, development of support profiles and plans, individual and family support services, living options, habilitation services and vocational services provided by the Department of Health and Hospitals and administered by the Office for Citizens with Developmental Disabilities. The term system is used in this document to refer to the Developmental Disabilities Services System.

C. *Entry Unit (EU)*—a section of the local governing entities (LGEs) that implements the developmental disabilities services system entry process.

D. *Entry Review Team (ERT)*—a transdisciplinary team including but not limited to, staff of the system entry unit, community services regional administrator or designee, and a psychologist. The team may also include a social worker, a nurse and/or other consultants as necessary.

E. *Protected Date*—the date that will be included on OCDD's registries for supports and services requested.

F. *Support Profile*—defined in accordance with the Developmental Disability Law at R.S. 28:451.2(28).

G. *Local Governing Entity (LGE)*—an integrated human services delivery system with local accountability and management, which provides behavioral health and developmental disabilities services.

H. *OCDD Contractors*—regional system point of entry contractors who conduct eligibility determination for the early intervention system for children ages birth to three years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:451.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 32:1241 (July 2006), amended LR 41:1490 (August 2015).

§705. Single Point of Entry

A. The OCDD has responsibility for programmatic leadership in the designing and developing of all developmental disabilities services pursuant to agreements with the LGEs and OCDD contractors as statutorily constituted by state law and with public and private providers. Throughout this Rule, the term "entry unit" is used to describe the role of the LGEs and OCDD contractors in the OCDD system entry process.

B. The local governing entities (LGEs) are the Metropolitan Human Services District, the Capital Area Human Services District, the South Central Human Services Authority, the Acadiana Area Human Services Authority, the Imperial Calcasieu Human Services Authority, the Central Louisiana Human Services District, the Northwest Louisiana Human Services District, the Northeast Delta Human Services Authority, the Florida Parishes Human Services Authority and the Jefferson Parish Human Services Authority:

1. Metropolitan Human Services District—Orleans, Plaquemines and St. Bernard parishes;

2. Capital Area Human Services District—Ascension, East Baton Rouge, East Feliciana, Iberville, Point Coupee, West Baton Rouge, and West Feliciana parishes;

3. South Central Human Services Authority—Assumption, Lafourche, St. Charles, St James, St. John, Terrebonne, and St Mary parishes;

4. Acadiana Area Human Services District—Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion parishes;

5. Imperial Calcasieu Human Services Authority—Allen, Beauregard, Cameron, Calcasieu, and Jefferson Davis parishes;

6. Central Louisiana Human Services Authority—Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn parishes;

7. Northwest Louisiana Human Services District—Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, and Webster parishes;

8. Northeast Delta Human Services Authority—Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Tensas, Union, and West Carroll parishes;

9. Florida Parishes Human Services Authority—Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington parishes; and

10. Jefferson Parish Human Services Authority—Jefferson Parish.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:454.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Human Services, Division of Mental Retardation/Developmental Disabilities, LR 16:31 (January 1990), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 32:1241 (July 2006), LR 41:1491 (August 2015).

§707. Standards for the Determination Process for System Entry

A. The LGEs shall utilize specialized entry units for the determinations of system entry and entry review teams to review those determinations, which do not clearly meet the criteria for entry into the system. OCDD contractors shall utilize their early intervention eligibility teams for children ages birth to three years of age.

B. Staff shall be trained in the use of all standardized tools, methods and procedures as required by OCDD for determining the presence of a developmental disability and for conducting an assessment of support and service needs.

C. Persons with developmental disabilities may be assisted through the system entry process by anyone of their choice.

D. Requests for entry into the system must originate from the LGE in the geographic area from which the person or legally responsible party resides and can be made from only one such LGE or OCDD contractor at a time.

E. The request for a face to face interview for system entry may be made by telephone, in person, e-mail or by other forms of correspondence.

F. A face-to-face interview shall be conducted with the person requesting supports or services at least for the initial interview unless there are extenuating circumstances preventing the person from being present. Explanations for such occurrences shall be included in the person's record.

G. The face-to-face interview will be conducted at the entry unit location or at the applicant's home for children ages birth to 3 years. If an applicant is unable to get to the entry unit location, the staff will conduct the interview at the person's home or another agreed upon location. If a person fails to keep two appointments that are scheduled at locations outside the entry unit office, future appointments will be scheduled at the entry unit office.

H. Necessary demographic information on the person seeking supports and services shall be obtained for OCDD's information management system for developmental disabilities services.

I. Determination of the legal status shall be conducted and shall be consistent with the laws of Louisiana. Copies of all legal decisions of record concerning the person's legal status will be provided by the person or his legal representative at the face-to-face interview.

J. A standardized determination for entry into the system shall be completed within 45 days of receiving information necessary for making the determination.

K. An expedited review contingent upon receipt of needed information may be conducted if it is related to:

1. the emergency needs of a person due to any of the following reasons:

a. care giver is no longer willing or able to provide care and there are no other supports available;

b. family crisis exists with no caregiver support available; and

c. intolerable temporary placement and immediate placement is needed; or

2. an urgent request concerning service(s) from a specific provider and the service(s) are available upon completion of the entry process; or

3. a court order to provide supports and services.

L. A support profile will be completed with input from the person, his legal representative or other(s) chosen by the person to assist with the interview.

M. The persons shall be asked if they wish to register to vote, and, if so, will be provided assistance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:454.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 32:1241 (July 2006), amended LR 41:1491 (August 2015).

§709. System Eligibility for Children between the Ages of 0-3 Years

A. Children from 0-3 years who are currently eligible for Louisiana's early intervention system services as verified by receipt of all required early intervention system documents, including the individualized family services plan (IFSP), will meet criteria for entering the developmental disabilities services system.

B. The entry unit staff will refer the family or legal guardian to the early intervention system point of entry to seek an eligibility determination for early intervention services if the child is between the ages of 0-3 years and is not currently receiving services from the Early Intervention Program.

C. It is the responsibility of the parent or legal guardian to initiate contact with the local LGE entry unit after the IFSP transition conference. In those cases, the family will indicate its intention to participate in eligibility redetermination and will receive a letter from the Early Intervention Program advising of the need to contact the local LGE prior to the child's third birthday.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:454.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 32:1242 (July 2006), amended LR 41:1491 (August 2015).

§711. Approval for Entry into the System

A. Protected date for entry into the system shall be one of the following:

1. the date on the signed Request for Participation Form; or

2. the original appointment date for the face-to-face interview if this date was subsequently changed by the entry unit staff and if the person is approved for entry into the system; or

3. the protected date from the early intervention system for children who previously had early intervention eligibility.

B. If the entry process is not successfully completed within six months, the original date will no longer be "protected." A new date will be assigned upon completion of a new application. For children entering with an early intervention protected date, the date will be protected until the child's fifth birthdate.

C. Approval for entry into the system shall be based on:

1. the definition of a developmental disability in the Developmental Disabilities Law, R.S. 28:451.2(12) and/or 462(4)(c); and

2. standardized assessment instruments and methodologies required by OCDD for determining a developmental disability.

D. Entry Review Team

1. The LGEs shall establish an entry review team to review the documentation of persons who do not clearly meet the criteria for system entry contained herein. The OCDD contractors will utilize the child's eligibility team members to determine eligibility for early intervention.

2. The statement of denial shall not be issued unless the entry review team has determined that the person does not meet the criteria for system entry.

3. The entry review team shall make one of the four following decisions concerning whether the person meets the criteria for system entry.

a. The person meets criteria for system entry and will receive a Statement of Approval (SOA) without re-determination.

b. The person meets criteria for system entry and will receive a SOA with a specified date for re-determination.

c. The person does not meet criteria for system entry.

d. More information is needed to make a determination.

E. Persons who meet criteria for system entry will receive a statement of approval and a copy of the *Rights of People with Developmental Disabilities* from the LGE or the *Family Rights Handbook* from the OCDD contractor from which the persons applied for services and supports.

F. Meeting criteria for participation in the system does not ensure that a person is eligible for specific supports and services.

G. Persons who are to receive services shall be provided unbiased information concerning all supports and service options and how to access information on all providers for each service option including contact information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:454.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 32:1242 (July 2006), amended LR 41:1492 (August 2015).

§713. Non-Approval for Entry into the System

A. Persons who do not meet criteria for entry will receive a Statement of Denial (SOD) with their Rights of Appeal attached.

B. Persons who are receiving services and who receive a SOD will continue to receive services for thirty calendar days from the receipt date of the SOD or until the end date of the IFSP for children in early intervention.

C. Persons who receive a SOD have the right to reapply for services at the entry unit in the area of their residence and to request and receive an administrative hearing through the Division of Administrative Law (DAL).

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:454.2 or 464(13).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 32:1243 (July 2006), amended LR 41:1492 (August 2015).

§715. Redetermination of Eligibility

A. The re-determination process follows the same format as the system entry process.

B. The face-to-face interview will not be necessary if the OCDD entry staff has met with the person in the past six months and has consulted with the person on the results of the screening tool in order to ensure the measure is fair and meaningful. For children in early intervention, a face-to-face team meeting is required annually for redetermination.

C. Re-determination for eligibility for the system shall be required under the following conditions.

1. For children in early intervention, there must be an annual redetermination.

2. If a child transitions from EarlySteps, there must be a redetermination by age 3, reflective of the change in eligibility requirements and legal definitions of developmental disability for ages 3 and up, in accordance with the Louisiana Developmental Disability Law (R.S. 28:451.2).

3. If initial eligibility is established on or after age 3, but prior to age 10, redetermination will occur within 5 years of the initial determination. If the re-determination occurs prior to the person's tenth birthday and there are no additional questions that would require an additional re-determination, then a review upon the person's tenth birthday should be conducted due to changing eligibility requirements and definitions at that age. (A person must have three substantial functional limitations versus two substantial functional limitations for ages 3 to 10 years.)

4. If at age 10, when at least two statements of approval (SOA) have been issued and the presence of a clear lifelong developmental disability exists and is expected to persist indefinitely, no additional redeterminations will be needed in adolescence and adulthood.

5. If a person does not meet criteria noted above or enters the system after age 10 but before 22 years of age, redetermination will occur within 5 years of the initial determination. If the re-determination occurs prior to the person's sixteenth birthday, and there are no additional questions that would require an additional re-determination, then a review upon the person's sixteenth birthday should be conducted to coincide with transition period from school to work and to reassess continued need for services into adulthood.

6. If at age 22, when at least two SOAs have been issued and the presence of a clear, lifelong developmental disability exists and is expected to persist indefinitely, then no additional redeterminations will be required in adolescence and adulthood.

7. If a person enters the system after age 22 (or between ages 16-22), at least two determinations must occur within 3-5 years of one another to document and confirm presence of a lifelong developmental disability that is expected to persist indefinitely. No further redeterminations will be needed if there is no concern over transient nature of existing symptoms and need for continued assessment based upon ERT review.

D. If during the course of the initial determination process the ERT can establish substantial functional limitations in at least three life areas with scores greater than three standard deviations below the mean, the prognosis of the individual is such that there is no likelihood of significant improvements in those life areas, and there are no co-occurring medical or behavioral health conditions that may impact the limitations and necessitate re-evaluation, the ERT may decide the person has no need for any further redetermination.

E. Any persons who were approved to participate in the system without requiring redetermination as of the date of adoption of this Rule will continue to be approved for entry into the system without redetermination, unless redetermination is requested as specified in this rule and/or required for participation in specific services.

F. Redetermination is required as outlined above and/or when:

1. diagnosis of a developmental disability, as defined by state law is tenuous:

a. the individual appears to have a developmental disability that is diagnosable, but further assessment is needed to verify that the disability will be life-long;

b. the individual has a co-occurring behavioral health condition that is prominent, but it is not clear that the limitations are solely attributable to mental illness, therefore further assessment is needed;

c. the individual has a medical condition and may have an accompanying developmental disability; however, it is not clear whether the limitations experienced by the individual are attributable to the developmental disability, therefore further assessment is necessary;

2. prognosis of a chronic life-long condition of a developmental disability is uncertain;

3. new assessment information is obtained that may impact prior determination of a presence of a developmental disability. (This will also apply to individuals who were granted a "lifetime SOA" prior to the adoption of this Rule.)

G. Redetermination may be requested by any one of the following parties:

1. LGE entry review team;

2. person requesting supports;

3. person's family or legal representative;

4. person's support coordinator;

5. person's service provider;

6. person's planning team;

7. person's physician determining level of care;

8. staff involved in the provision of supports;

9. state monitoring authorities;

10. courts of appropriate jurisdiction.

H. If a person requires redetermination for approval, the LGE entry unit staff will notify the person in writing, and as appropriate, the person's support coordinator and/or provider, sixty days prior to the SOA expiration date. The person then has thirty days in which to contact the EU staff to coordinate the redetermination process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:454.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 32:1243 (July 2006), amended LR 41:1492 (August 2015).

§717. Closure of Requests for Supports and Services

A. Initial requests may be "closed" due to:

1. insufficient information based upon the person/family consistently not complying with obtaining needed information and/or participating in scheduled appointments;

2. denial for system entry (SOD) has been determined; or

3. request of the individual and/or family.

B. If the person does not respond to the initial redetermination letter within 30 calendar days, at least two additional attempts to contact the individual will be made prior to case closure within the next 30 calendar days. The additional attempts to contact the individual will utilize more than one mode of contact.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:454.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 32:1243 (July 2006), amended LR 41:1493 (August 2015).

§719. OCDD Data Requirements

A. The LGEs and OCDD contractors shall provide monthly to the OCDD central office random samples of completed determinations with supporting documentation in accordance with OCDD's quality review methodologies.

B. The LGEs and OCDD contractors shall utilize OCDD's information management system for developmental disabilities to enter all information as required by OCDD's policies and procedures for system entry.

C. The LGEs and OCDD contractors shall provide additional information to OCDD as requested for the purpose of evaluating quality and compliance with state laws, policies and procedures relevant to system entry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28.454.17.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 32:1243 (July 2006), amended LR 41:1493 (August 2015).

§721. OCDD Quality Reviews

A. The OCDD central office will conduct periodic quality reviews of the LGEs and OCDD contractors

regarding the processes for the single point of entry and the determination process for system entry.

B. The purpose of the quality reviews is to assess overall accuracy in decision making, completeness of information relative to the determination reached, and adherence to the Developmental Disability Law as well as to the rules, policies, operational instructions and procedures required by the office pertaining to single point of entry and the determination process for system entry conducted by the LGEs and OCDD contractors.

C. The quality reviews may consist of analyses of the following:

1. random samplings of completed eligibility determinations;

2. on-site observations of the determination process for system entry;

3. entry review team meetings;

4. required monthly data submissions; and

5. completeness, timeliness and accuracy of information required on OCDD's information management system for developmental disabilities.

D. The review findings and subsequent recommendations along with any needed technical assistance will be provided to the LGEs and OCDD contractors. Specific recommendations for improvement or correction actions must be carried out in order to maintain compliance with all laws, rules, policies and procedures relevant to the single point of entry or determination for system entry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:454.17.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 32:1243 (July 2006), amended LR 41:1493 (August 2015).

Chapter 9. Guidelines for Certification of Medication Attendant

§901. Overview

A. R.S. 37:1021-1025 authorizes the establishment of a medication administration course for the purpose of training and certifying unlicensed personnel to administer certain medication to residents of intermediate care facilities for people with developmental disabilities (ICFs/DD) and community homes for people with developmental disabilities either operated by the Office for Citizens with Developmental Disabilities (OCDD) or funded through the Department of Health (LDH); and to individuals in programs/agencies contracting for services with LDH except as prohibited in §911.B.5. Persons who successfully complete the certified medication attendant (CMA) course and demonstrate an acceptable level of competency on a written test and a practical examination are eligible for certification as medication attendants. Use of certified medication attendants (CMAs) on the part of private providers that contract with DHH is strictly voluntary.

B. The guidelines establish:

1. qualifications for instructors and CMA applicants;

2. authorized functions and prohibitions of certified medication attendants;

3. certified medication attendant 60-hour course curriculum;

4. requirements for initial certification and ongoing re-certification of medication attendants and reciprocity;

5. decertification and appeal process;

6. provider responsibilities;

7. role and responsibilities of the Office for Citizens with Developmental Disabilities; and

8. composition and role of Certified Medication Attendant Committee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:694 (July 1995), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1525 (September 2016).

§903. Definitions

A. For the purpose of these CMA guidelines, the following definitions shall apply.

Abuse (adult/elderly)—the infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical injury, on an adult by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value (R.S. 15:503).

Abuse (child)—any of the following acts which seriously endanger the physical, mental, or emotional health and safety of the child:

a. the infliction or attempted infliction, or, as a result of inadequate supervision, the allowance or toleration of the infliction or attempted infliction of physical or mental injury upon the child by a parent or any other person;

b. the exploitation or overwork of a child by a parent or any other person;

c. the involvement of the child in any sexual act with a parent or any other person, or the aiding or toleration by the parent or the caretaker of the child's sexual involvement with any other person or of the child's involvement in pornographic displays, or any other involvement of a child in sexual activity constituting a crime under the laws of this state (*Children's Code*, article 1003).

Authorized Instructor—a registered nurse (RN), with a minimum of one-year experience working with people with developmental disabilities, who has completed the training

for instructors, and has a current authorization by OCDD to teach the 60-hour medication attendant course.

CMA Applicant—an employee of an intermediate care facility for people with developmental disabilities or an in-home Medicaid home and community-based service who is enrolled in the 60-hour course curriculum.

Certified Medication Attendant (*CMA*)—the designation given an employee who has successfully completed the 60-hour course and passed the OCDD initial certification exam and has been issued a certificate by OCDD.

Department—the Department of Health (LDH).

Exploitation (adult/elderly)—the illegal or improper use or management of the funds, assets, or property of a person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability for one's own profit or advantage (R.S. 15:503).

Extortion (adult/elderly)—the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority (R.S. 15:503).

Falsification of Participant Medical Records—includes, but is not limited to, falsification of time, dosage, date, amount, and documentation of prescribed treatment that did not occur.

Falsification or Alteration of CMA Certificate—includes, but is not limited to, altering expiration date, CMA name, OCDD coordinator's signature, or attempting to use another person's certificate.

HCBS (*Home and Community-Based Services*)—one or more of the following services:

a. *personal care attendant services*—services required by a person with a disability in order to become physically independent or to remain in or return to the community;

b. *respite care services*—the temporary care and supervision of a person with a disability or an infirm elderly person so that the primary caregiver can be relieved of such duties. Respite care services may be performed either in the home of the person with a disability or infirm elderly person or in a facility owned by the home- and community-based service provider who provides respite care services. For the purposes of this Section, person with a disability shall mean a person with a physical, mental, or medical condition or an adult who requires assistance with activities of daily living;

c. *supervised independent living services*—necessary training, social services, and medical services to enable a person who has mental illness or who has developmental disabilities and who is living in congregate or individual apartments to live as independently as possible in the community;

d. *family support services*—advocacy services, family counseling, including genetic counseling, family subsidy programs, parent-to-parent outreach, legal assistance, income maintenance, parent training, homemaker services, minor home renovations, marriage and family education, and other related programs;

e. *adult day care services*—a group program designed to meet the individual needs of functionally impaired adults which is structured and comprehensive and which provides a variety of health, social, and related support services in a protective setting for a portion of the 24-hour day. The group program shall provide for 10 or more functionally impaired adults who are not related to the owner or operator of the home- and community-based service provider. For the purposes of this Section, *functionally impaired adults* shall mean individuals aged 17 years of age and older who are physically, mentally, or socially impaired to a degree that supervision is necessary;

f. *substitute family care services*—services providing 24-hour personal care, supportive services and supervision to adults who meet the criteria for having a developmental disability;

g. *supported employment*—a system of supports for people with disabilities in regards to ongoing employment in integrated settings. Supported employment can provide assistance in a variety of areas, including:

i. job development;

ii. job coaches;

iii. job retention;

iv. transportation;

v. assistive technology;

vi. specialized job training; and

vii. individually tailored supervision;

h. *monitored in-home caregiving*—services provided by a principal caregiver to a client who lives in a private unlicensed residence. The principal caregiver shall reside with the client, and shall be contracted by the licensed HCBS provider having a monitored in-home caregiving service module.

Home- and Community-Based Service Provider—an agency, institution, society, corporation, person or persons, or any other individual or group that provides one or more home- and community-based services as defined in this Section. The term *home- and community-based service provider* shall not include any of the following:

a. any person, agency, institution, society, corporation, group, or entity that solely prepares and delivers meals, that solely provides sitter services, or that solely provides housekeeping services;

b. any person, agency, institution, society, corporation, group, or entity who provides gratuitous home- and community-based services;

c. any individual licensed practical nurse or registered nurse who has a current Louisiana license in good standing, and who provides personal nursing services in the

home to an individual, provided that the nurse has contracted with the individual or family for such services and payment of such services;

d. staffing agencies which supply contract workers to a health care provider licensed by the department;

e. any person who is employed as part of a department authorized self-direction program (R.S. 40:2120.2).

ICF/DD (*Intermediate Care Facility for People with Developmental Disabilities*)—an institution (or distinct part of an institution) that:

a. is primarily for the diagnosis, treatment, or rehabilitation of people with developmental disabilities or persons with related conditions; and

b. provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his or her greatest ability (CMS 42 CFR 435.1009).

Institutional Abuse or Neglect—any case of child abuse or neglect that occurs in any public or private facility that provides residential child care, treatment, or education (*Children's Code*, article 603).

Misappropriation of Property—to take possession, without permission, of any and all of an individual's personal belongings.

Neglect (adult/elderly)—the failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his/her well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall, for that reason alone, be considered to be neglected or abused (R.S. 15:503).

Neglect (child)—the refusal or failure of a parent or caretaker to supply the child with necessary food, clothing, shelter, care, treatment, or counseling for any injury, illness, or condition of the child, as a result of which the child's physical, mental, or emotional health and safety is substantially threatened or impaired. Whenever, in lieu of medical care, a child is being provided treatment in accordance with the tenets of a well-recognized religious method of healing which has a reasonable, proven record of success, the child shall not, for that reason alone, be considered to be neglected or abused. Disagreement by the parent regarding the need for medical care shall not, by itself, be grounds for termination of parental rights. However, nothing herein shall prohibit the court from ordering medical services for the child when there is substantial risk of harm to the child's health or welfare (*Children's Code*, article 1003).

Office—the Office for Citizens with Developmental Disabilities (OCDD).

Supports and Services Center—a state ICF/DD operated by the Office for Citizens with Developmental Disabilities.

Waiver Program Services—other services approved by the Centers for Medicare and Medicaid Services for home- and community-based waivers for the Louisiana Medicaid Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:694 (July 1995), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1525 (September 2016).

§905. Applicability

A. These guidelines shall apply only for certification of medication attendants who are:

1. employed in intermediate care facilities for people with developmental disabilities (ICFs/DD) operated by the Office for Citizens with Developmental Disabilities;

2. employed in community homes for people with developmental disabilities and/or small or large intermediate care facilities for people with developmental disabilities funded through the Department of Health;

3. employed in program/agencies, except as prohibited by §911.B.5, contracting with the Department of Health for services to people with developmental disabilities; or

4. employed in programs supporting individuals licensed in HCBS services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:695 (July 1995), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1527 (September 2016).

§907. Qualifications of Applicants to be Medication Attendants

A. Each person accepted to participate in the medication attendant course must be:

1. a citizen of the United States, a United States national, or an alien lawfully admitted for permanent residency in the United States.

2. employed in a facility operated by the Office for Citizens with Developmental Disabilities (OCDD), in a community home for persons with developmental disabilities funded through the Louisiana Department of Health (LDH) or the Department of Children and Family Services (DCFS), or in an intermediate care facility for people with developmental disabilities; or be a person who provides in-home Medicaid home and community-based services;

3. at least 18 years of age;

4. able to read, write, and comprehend the English language;

5. free of communicable diseases and in suitable physical and emotional health to administer medications safely;

6. without a known record or history of drug abuse or record of conviction of a felony.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:695 (July 1995), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1527 (September 2016), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:589 (April 2020).

§909. Qualifications of Instructors for Certified Medication Administration Courses

A. A registered nurse (RN) with a minimum of one year of clinical experience as a nurse consultant or a full-time nurse for a provider agency providing services to individuals with developmental disabilities in a day-habilitation facility, state facility, ICF/DD or HCBS setting qualifies as an instructor to teach the 60-hour course consisting of 40-hours classroom theory and 20 hours of clinical practical. The RN may delegate the 20 hours of practical training to a licensed practical nurse (LPN) with a minimum of one year of clinical experience in a developmental disability setting and knowledge of the course.

B. The RN instructor must complete training offered by the OCDD in the curriculum prior to teaching the course.

C. The DHH/OCDD may offer the medication administration instructor course on at least an annual basis, or as determined by the certified medication attendant committee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:695 (July 1995), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1527 (September 2016).

§911. Authorized and Prohibited Functions of Certified Medication Attendants

A. Authorized functions of the certified medication attendant:

1. deliver medications ordered by a physician, dentist, or authorized prescriber to individuals for self-administration verifying with the medication administration record, the correct individual, dosage, medication name, route, and time;

2. deliver and administer medications ordered by a physician, dentist, or authorized prescriber to individuals with the supervision of a registered nurse, as defined in LAC 46:XLVII.3703.A, verifying with the medication administration record, the correct individual, dosage, medication name, route, and time;

3. administer oral medications, enemas, douches, ointments, pre-measured oral inhalant aerosols, and suppositories unless otherwise indicated;

4. record in the individual's chart:

a. doses delivered to and/or administered to the individual;

b. effectiveness of the drug;

c. any adverse effect of the drug;

d. appropriate vital signs as indicated by the physician order and/or knowledge of the drug; and

e. may transfer prescribed medication information to a medication administration record (MAR); may transfer medication information using a pre-printed pharmacy label indicating the correct individual, dosage, medication name, route, and time;

5. administer prescribed pro re nata (PRN), or as needed, medications when authorized by a licensed physician, dentist, authorized prescriber, or registered nurse. The authorizing health care professional must document the authorization in writing within 24 hours.

B. Prohibited functions of the certified medication attendant:

1. may not give medications by intramuscular, intravenous, or subcutaneous routes;

NOTE: This does not include finger sticks for routine capillary blood glucose monitoring. The CMA may perform routine capillary blood glucose monitoring for clients who do not require sliding scale insulin. This also does not include epinephrine pen usage for emergency situations.

2. may not administer medications by the oral inhalant aerosol route unless administering a premeasured dosage unit provided by the manufacturer;

3. may not receive or assume responsibility for reducing to writing oral or telephone orders from a physician, dentist, or authorized prescriber;

4. may not alter medication dosages as delivered from the pharmacy unless authorized by a physician, dentist, or authorized prescriber. Alteration of a medication dosage may include giving more or less than the dosage ordered or crushing, cutting or diluting without an order to do so by the physician, dentist or authorized prescriber;

5. may not administer medications in an acute care setting, including those funded by DHH and/or operated by the OCDD;

6. may not administer any medications when there is indication that the medication has been inappropriately dispensed by the pharmacist or mishandled by other persons;

7. may not delegate medication administration to others.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:695 (July 1995), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1528 (September 2016).

§913. Certified Medication Attendant Course Curriculum

A. Each applicant must complete a 60-hour course to become a certified medication attendant.

1. The course curriculum is 40 hours of classroom theory to include at a minimum, instruction in the following topics:

a. legal aspects;

b. roles and responsibilities of drug administration;

c. definitions;

d. terminology;

e. classification of drugs;

f. measurement;

g. identification;

h. effects and side effects;

i. distribution and route;

j. care and handling of drugs;

k. skills-tasks to be completed for competency; and

l. documentation.

2. Twenty-hour practical may consist of 10 hours of classroom demonstration and 10 hours on the unit for hands-on experience. The applicant must attain proficiency in the following 26 skill areas, either by actual demonstration, or by verbally demonstrating to the satisfaction of the licensed nurse:

a. hand washing;

b. oral medications;

c. liquid medications;

d. topical medications;

e. eye medications;

f. ear drops;

g. capillary blood glucose monitoring;

h. rectal suppositories;

i. vaginal suppositories/cream;

j. disposable enemas;

k. disposable douches;

l. counting pulse;

m. counting respirations;

n. taking blood pressure;

o. taking oral temperature;

p. taking rectal temperature;

q. taking axillary temperature

r. taking tympanic temperature;

s. premeasured transdermal patches;

t. nasal atomizer;

u. oral powdered medications;

v. charting;

w. crushing tablets;

x. rectal creams;

y. premeasured dosage unit provided by the manufacturer of an oral aerosol inhalant;

z. limited sublingual medications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:696 (July 1995), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1528 (September 2016).

§915. Certification Requirements and Process

A. CMA certificates issued after rule promulgation will expire two years from the last day of the month that the certificate was printed.

1. The agency administrator/representative must complete Form CMA - 1, Profile Sheet, for each employee CMA applicant, acknowledging that all the qualifications outlined in §907 are met prior to the applicant attending the course.

2. The CMA applicant must complete the 60-hour course: 40 hours of classroom theory and 20 hours of practical with a minimum of 10 of those hours conducted in the work place.

3. The CMA applicant must demonstrate proficiency in the 26 skill areas to pass the practical portion of the course. An RN or LPN must administer the practical. Proficiency may be either verbal or physical demonstration. A pass/fail grade shall apply.

4. After completion of the 60-hour course, the CMA instructor completes Form CMA-2, initial exam and certification request, and sends it to the regional coordinator to request applicant(s) be scheduled for the written OCDD CMA certification exam. Form CMA-2 must be attached to the Form CMA-1, profile sheet, for each applicant. All forms must be received by the regional coordinator before an exam date can be scheduled.

5. The regional coordinator will:

a. establish a test date;

b. notify the central office CMA coordinator to mail or email an electronic version of the exam that cannot be modified to the regional coordinator (The exam consists of 50 questions at 2 points each for a total possible score of 100 points.);

c. administer the test;

d. return test(s) to the central office coordinator for grading and scoring;

e. notify CMA instructors as to applicants' scores;

f. notify agency about applicants' scores;

g. mail certificates to the agency;

h. assist CMA instructors regarding any questions; and

i. maintain copies of all forms submitted to the central office coordinator.

6. The central office coordinator will:

a. grade each test and determine test score:

i. a test score of 80 is required to pass the exam;

ii. a test score between 70 and 78 allows the test to be retaken once without repeating the course;

iii. a test score below 70 requires a repeat of the entire 60-hour course.

b. send the regional coordinator the exam scores and certificates.

7. Upon passing the OCDD CMA certification exam, the applicant is designated as a CMA.

8. The central office coordinator will issue two certificates; one for the CMA, and one for the requesting provider agency.

9. The certificate shall include at least the following:

a. name of CMA;

b. expiration date;

c. signature of central office coordinator.

d. an embossed seal;

e. the signature of the assistant secretary of OCDD; and

f. the official logo for the OCDD.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:696 (July 1995), amended LR 23:1147 (September 1997), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1529 (September 2016).

§917. Re-Certification Requirements and Process

A. Recertification is required every two years. Each CMA must be recertified. The requirements for re-certification are:

1. every two years a CMA must complete a total of nine hours of in-service training. Two of the nine hours must directly relate to the agency's medication administration policy and procedure. The remaining seven hours of in-service must relate to medication administration. A CMA working in multiple agencies may combine training to meet these requirements with the exception that the two-hour training on agency medication administration policy and procedure is required for each employer. Each agency must have documentation of each CMA's required nine hours of in-service training;

2. annually, the CMA must pass with proficiency, either by physical or verbal demonstration, the 26 skills on the practical checklist. The annual cycle is based on the last day of the month that the certificate was printed. If a CMA changes employers within the certification period and training records are not available for the first year, the new employer must determine competency by assessing the 26 skills upon hire, in addition to meeting these requirements for re-certification.

B. Upon successful completion of these requirements the CMA instructor sends Form CMA 3a. and Form CMA 3b. to the regional office/ developmental center coordinator requesting re-certification of each CMA. The regional office/developmental center coordinator forwards information to the central office coordinator.

C. The central office coordinator issues two certificates to the regional office/developmental center coordinator for dissemination. One certificate is for the CMA and the other is for the requesting provider agency.

D. The re-certification requirements must be met prior to the month of expiration of the CMA's certification.

E. A CMA who has not worked directly with medication administration in a facility, program, or agency for individuals with developmental disabilities for 24 months or more must take the OCDD CMA state exam again and pass with proficiency the 26 skills checklist. If the CMA does not pass the state exam, then the CMA must repeat the 60-hour course and pass the exam prior to being recertified. Failure to pass the state exam will result in de-certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:697 (July 1995), amended LR 23:1147 (September 1997), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1529 (September 2016).

§919. Decertification of Medication Attendants

A. Decertification shall occur under the following conditions:

1. falsification of participant medical records as defined in these regulations;

2. found guilty of abuse, neglect or cruelty to the infirmed as defined in these regulations;

3. found guilty of misappropriation of a resident's property as defined in these regulations;

4. falsification or alteration of CMA certificate issued by the office as defined in these regulations;

5. falsification of CMA qualifications;

6. failure to meet CMA qualifications;

B. Decertification may occur under the following conditions:

1. failure of CMA to obtain re-certification requirements results in decertification. The CMA may be reinstated if the re-certification requirements are met within six months of expiration of the certificate. During this six-month period the CMA's authorized functions shall be suspended;

2. unsatisfactory performance of CMA reported by a licensed nurse, either RN or LPN, can result in either a temporary suspension of the CMA's medication administration privileges or decertification. The RN may choose to suspend CMA medication administration privileges not to exceed three months and provide training during which time the CMA may administer medications only under RN or LPN direct observation. After completion of designated suspension and training, the RN reserves the right to re-instate medication administration privileges or decertify the CMA. If decertified, the CMA must repeat the 60-hour course and retake the OCDD CMA certification exam. The reinstatement of CMA medication administration privileges does not extend the expiration date of the certificate.

C. Based on the aforementioned criteria, the RN in consultation with the agency administrator makes the decision to decertify the CMA.

D. The RN/CMA instructor sends a confidential letter and Form CMA 4 - Decertification Form to both the CMA and the central office coordinator identifying the reasons for decertification of the individual.

E. A copy of the decertification letter and Form CMA 4 along with pertinent documentation is maintained in the provider's records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:697 (July 1995), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1529 (September 2016).

§921. Appeal Process

A. A CMA who has had privileges suspended or has been decertified has the right of appeal.

B. Notice of Violations. When there are substantiated charges against the CMA, either through oral or written evidence, the OCDD will notify the individual(s) implicated in the investigation of the following information by certified mail:

1. the nature of the violations, and the time and date of each occurrence;

2. the state's intent to report these violations to the CMA registry; and

3. The right to request an informal discussion and/or the right to an administrative hearing.

C. Right To An Informal Discussion. When a CMA feels that he/she has been wrongly accused, the following procedure should be followed:

1. Within 15 calendar days of the receipt of the office's notice of violation, the CMA may request an informal discussion.

2. Such request must be made to the office in writing. A meeting will be arranged within 20 days of such a request. The informal discussion is designed to provide an opportunity for:

a. the CMA to informally review the situation;

b. the agency to offer alternatives based on corrections or clarifications, if any; and

c. the CMA to evaluate the necessity for seeking an administrative hearing;

3. During this informal discussion, the CMA will be afforded the opportunity to talk with office personnel involved in the situation, to review pertinent documents on which the alleged violation is based, to ask questions, to seek clarifications, and to provide additional information.

D. Right to Request Administrative Hearing

1. Within 30 calendar days after the receipt of notice of the office's notice of violation or the notice of results of informal discussion, the CMA may request an administrative hearing. Such request must be in writing to the: Office of the Secretary, Attention: Bureau of Appeals. The request must contain a statement setting forth the specific charges with which he/she disagrees, and the reasons for this disagreement.

2. Unless a timely and proper request is received by the appeals section, the findings of the OCDD shall be considered a final and binding administrative determination. Notification will then be entered to the CMA registry.

E. Basic Provisions. The administrative hearing shall be conducted in accordance with the Louisiana Administrative Procedure Act, R.S. 49:965 et seq., and the provisions set forth in the procedures described therein.

F. Right to Counsel. Any party may appear and be heard at any appeals proceeding through an attorney at law or through a designated representative.

G. Appearance In Representative Capacity

1. A person appearing in a representative capacity shall file a written notice of appearance on behalf of a provider:

a. identifying himself by name, address and telephone number; and

b. identifying the party represented; and

2. Such person shall have a written authorization to appear on behalf of the provider.

H. Preliminary Conference

1. Although not specifically required, the appeals bureau may schedule a preliminary conference. The purposes of the preliminary conference include but are not limited to the following:

a. clarification, formulations and simplification of issues;

b. resolution of matters in controversy;

c. exchange of documents and information;

d. stipulations of fact so as to avoid unnecessary introduction of evidence at the formal review;

e. the identification of witnesses; and

f. such other matters as may aid disposition of the issues.

2. When the appeals bureau schedules a preliminary conference, it shall notify all parties in writing. The notice shall direct any parties and their attorneys to appear at a specified date, time, and place.

I. Results of Preliminary Conference

1. Where the preliminary conference resolves all or some matters in controversy, a summary of the findings agreed to at the conference shall be provided by the administrative law judge.

2. Where the preliminary conference does not resolve all matters in controversy, an administrative hearing shall be scheduled on those matters still in controversy. The hearing shall be scheduled within 30 calendar days following the completion of the preliminary conference, or at a time mutually convenient to all parties.

J. Notice of Administrative Hearing. When an administrative hearing is scheduled, the appeals bureau shall notify the CMA and/or his representative and the office representative, in writing of the date, time and place of the hearing. Notice shall be mailed not less than 10 calendar days before the scheduled date of the hearing.

K. Conduct of Hearing

1. The hearing shall be conducted by the administrative law judge from the appeals bureau.

2. Testimony shall be taken only on oath, affirmation, or penalty of perjury.

3. Each party shall have the right to call and examine parties and witnesses; to introduce exhibits; to question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination; to impeach any witness regardless of which party first called him to testify; and to rebut the evidence against him.

4. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduce of serious affairs regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil or criminal actions. Documentary evidence may be received in the form of copies or excerpts.

5. The administrative law judge may question any party or witness and may admit any relevant and material evidence.

6. The administrative law judge shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties. Prior to taking evidence, the administrative law judge shall explain the issues and the order in which evidence will be received.

7. A party has the burden of proving whatever facts it must establish to sustain its position.

8. The burden of producing evidence to substantiate the written charge(s) will be on the provider of services. Once the burden of producing evidence to substantiate the charges has been met, the CMA and/or his representative shall have the burden of producing evidence answering the charges.

L. Witnesses and Subpoena

1. Each party shall arrange for the presence of their witnesses at the hearing.

2. A subpoena to compel the attendance of a witness may be issued by the administrative law judge upon written request by a party and a showing of the need therefor.

3. A subpoena may be issued by the administrative law judge on his own motion.

4. An application for subpoena duces tecum for the production by a witness of books, papers, correspondence, memoranda, or other records shall be made in writing to the administrative law judge, giving the name and address of the person or entity upon whom the subpoena is to be served. The application shall precisely describe the material that is desired to be produced and shall state the materiality thereof to the issue involved in the proceeding. It shall also include a statement that, to the best of the applicant's knowledge, the witness has such items in his possession or under his control.

M. Continuance of Further Hearings

1. The administrative law judge may continue a hearing to another time or place, or order a further hearing

on his own motion of upon showing of good cause, at the request of any party.

2. Where the administrative law judge determines that additional evidence is necessary for the proper determination of the case, he may at his discretion:

a. continue the hearing to a later date and order the party to produce additional evidence; or

b. close the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any evidence so submitted shall be made available to both parties and each party shall have the opportunity for rebuttal.

3. Written notice of the time and place of a continued or further hearing shall be given except that when a continuance of further hearing is ordered during a hearing, oral notice of the time and place of the hearing may be given to each party present at the hearing.

N. Record of Hearing. A sound recording of the hearing shall be made. A transcript will be prepared and reproduced at the request of a party to the hearing provided he bears the cost of the copy of the transcript.

O. Decision

1. At the conclusion of the hearing, the administrative law judge shall take the matter under submission.

2. The administrative law judge shall prepare a written proposed decision which will contain findings of fact, a determination of the issues presented, a citation of applicable policy and regulations, and an order.

3. The appeals bureau, on behalf of the secretary of the DHH, may adopt the proposed decision or may reject it based upon the record, or it may be remanded to the administrative law judge to take additional evidence. In the latter case, the administrative law judge thereafter shall submit a new proposed decision.

4. The decision shall be final and binding upon adoption on behalf of the secretary, subject only to judicial review by the courts. Copies of the decision shall be mailed to the CMA at his last known address and to any representative thereof.

P. Failure to Appear

1. If a CMA fails to appear at a hearing, a decision may be issued by the appeals bureau dismissing the hearing. A copy of the decision shall be mailed to each party.

2. Any dismissal may be rescinded upon order of the appeals bureau if the CMA makes written application within 10 calendar days after the mailing of the dismissal, and provides evidence of good cause for his failure to appear at the hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:697 (July 1995).

§923. Reciprocity

A. A provider whose employee furnishes documentation as to successful completion of an equivalent medication administration course conducted in another state and meets other criteria stated in these guidelines and successfully passes the 26 skills checklist and the CMA initial certification exam, may on a case-by-case basis be granted reciprocity. The provider agency would complete Form CMA-5, reciprocity request, and mail to the central office OCDD coordinator. The Certified Medication Attendant Committee will review the documentation and determine if the person will be certified as a CMA in Louisiana. If reciprocity is granted, the provider is notified and the central office OCDD coordinator would issue the certificates to the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:699 (July 1995), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1530 (September 2016).

§925. Provider Responsibility

A. There will be no discrimination in selection of medication attendants for reason of race, color, creed, religion, disability, as defined in R.S. 51:2232(11), or national origin.

B. Each provider shall maintain records on each CMA. The records must include:

1. the current monitoring skills checklist required for certification and re-certification;

2. a copy of the current certificate issued to the CMA by the central office coordinator. The second copy must be provided to the CMA;

3. documentation of annual successful completion of the 26 skills checklist and completion every two years of continuing education necessary for re-certification of CMA.

C. The provider shall have policies and procedures in place regarding medication administration processes.

D. The provider is legally responsible for the level of competency of its personnel and for ensuring that unlicensed staff administering medication have successfully completed the medication administration course curriculum. Additionally, the provider is responsible for maintaining re-certification requirements of its CMAs and ensuring that its CMAs perform their functions in a safe manner.

E. The provider is responsible for providing access to RN supervision of staff through employment or through a contract with a registered nurse. This nurse should review all medication errors on a monthly basis.

F. The provider shall conduct thorough employment checks including verification of CMA certification.

G. The provider is responsible for contacting the central office to verify that a CMA is in good standing prior to

employing a CMA certified by another provider. The central office coordinator will send the provider Form CMA-6 verifying that the CMA is in good standing. Form CMA-6 must be maintained on file in the provider's records. The CMA would be responsible for providing a copy of his or her certificate to the provider.

H. If a CMA changes employers within the certification period and training records are not available for the first year, the new employer must determine competency by assessing the 26 skills upon hire, in addition to meeting the requirements for re-certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:699 (July 1995), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1530 (September 2016).

§927. Office for Citizens with Developmental Disabilities Responsibilities

A. The OCDD shall ensure the integrity of the medication administration course by:

1. implementing the CMA Law, R.S. 37:1021-1025;

2. revising guidelines;

3. issuing tests for initial certification of CMAs;

4. administer the tests for initial certification of CMAs;

5. grading the tests for initial certification of CMAs;

6. maintaining the originals of written examinations with scoring;

7. maintaining a roster of nurses who complete the CMA instructor training;

8. issuing certificates;

9. offering an instructor's course;

10. convening the Certified Medication Administration Committee as needed;

11. verifying CMAs are in good standing; and

12. maintaining a CMA registry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:700 (July 1995), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1530 (September 2016).

§929. The Certified Medication Administration Committee

A. Composition of committee as determined by the assistant secretary of OCDD:

1. authorized CMA instructors;

2. central office coordinator;

3. two OCDD regional coordinators;

4. an individual or individual's representative (e.g., family member), and

5. other representatives as determined by the office.

B. Responsibilities of the committee:

1. Provide input regarding CMA program aspects such as guidelines, course curriculum, instructor training;

2. review requests for reciprocity status; and

3. Offer assistance to CMA instructors upon request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:700 (July 1995), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 42:1530 (September 2016).

§931. CMA Forms

A. Forms to be used are as follows:

1. Form CMA - 1 is the profile sheet completed by the provider agency's administrator/representative to attest that all qualifications are met for the CMA applicant to attend the 60-hour medication administration course. This form is given to the CMA instructor.

2. Form CMA - 2 is the exam request and initial certification request form completed by the CMA instructor and sent to either the regional office or developmental center coordinator to request the office schedule CMA applicant(s) for the OCDD CMA certification exam. Form CMA - 1 must be attached to the CMA - 2 for each CMA applicant to be scheduled for the test. For those applicants that pass the test, the office will send the certificates to the CMA instructors.

3. Form CMA - 3a. and 3b. are the re-certification requests completed by the CMA instructor acknowledging that all recertification requirements are met. The CMA instructor sends these forms to the central office coordinator for issuance of certificates.

4. Form CMA - 4 is the decertification form completed by the CMA instructor identifying the reasons for decertifying the CMA and sent to the central office coordinator. Form CMA - 4 is also sent to the CMA along with a confidential letter. A copy of Form CMA - 4 must be maintained in provider agency records.

5. Form CMA - 5 is the reciprocity request form the provider agency would complete for employees that furnish documentation of successful completion of an equivalent medication administration course from another state. This form is sent to the central office coordinator for review and determination.

6. Form CMA - 6 is the form completed by the central office coordinator verifying a CMA is in good standing. This form is sent to provider agencies who employ a CMA in good standing certified by another agency. Form CMA - 6 must be keep on file in the provider records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:700 (July 1995).

Chapter 11. Individual and Family Support Program

§1101. Purpose

A. The individual and family support program is designed to meet the needs of individuals with intellectual/developmental disabilities which exceed those normally met by existing resources, entitlements, and those occurring naturally in the individual's family and community pursuant to the guiding principles of ACT 378 of the 1989 Regular Legislative Session as contained in R.S. 28:823.

B. The purposes of the individual and family support program shall be:

1. to establish, maintain and/or improve the quality of life for individuals with intellectual/developmental disabilities and their families in a manner that respects both the individual's needs and aspirations and the individual's ability to use supports in a responsible and accountable manner;

2. to link individuals with intellectual/developmental disabilities and their families to existing supports and resources and to supplement those supports as necessary to maintain and/or improve the integrity of individuals and their families.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:664 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:349 (March 2020).

§1103. Definitions

Applicant—the individual with intellectual/developmental disabilities for whom supports are requested.

Community Support Professional—a Local Governing Entity (LGE) staff person whose duties may include support coordination to applicants and participants in individual and family support program.

Developmental Disability—defined in accordance with the developmental disability law at R.S. 28:451.2(12).

Direct Service—any good, support or service purchased for or provided to an individual with intellectual/developmental disabilities directly by a service provider or secured/purchased by the individual/family through merchants and/or contractors used to assist the individual to remain in their own home in the community.

Eligible Individual—individual who has a statement of approval (SOA) to participate in intellectual/developmental disabilities services as part of the current single point of entry (SPOE) process established by the OCDD or an individual eligible for and enrolled in EarlySteps services.

Individual and Family Support Committee—the advisory committee to the individual and family support (IFS) program within each local governing entity administering the IFS program.

Local Governing Entity (LGE)—an integrated human services delivery system with local accountability and management and which provides behavioral health and developmental disabilities services through local human services districts and authorities.

Office for Citizens with Developmental Disabilities (OCDD)—the office, within the Louisiana Department of Health (LDH), that has the responsibility for developing, evaluating and guiding programs and supports for Louisiana's citizens with intellectual/developmental disabilities.

Plan of Support—the individualized plan for provision of supports for individuals and families developed utilizing the most recently approved format by the OCDD for individuals with intellectual/developmental disabilities.

Support Coordination—the provision of assistance to individuals with intellectual/developmental disabilities or their families to identify and coordinate necessary supports and to access, utilize and maintain those supports in a fiscally sound manner.

Support Coordinator—the person responsible for support coordination for an individual with intellectual/developmental disabilities and/or his/her family.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:665 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:349 (March 2020).

§1105. Participant Records

A. Each LGE will maintain a single participant record for each applicant or participant in the individual and family support program, which will comply with Louisiana Department of Health (LDH), OCDD, Health Insurance Portability and Accountability ACT (HIPAA) requirements. The record will reflect all aspects of service provision to the participant, inclusive of multiple or varied funding sources and/or fiscal year. The record shall include progress note entries that are legible and provide strict chronological documentation for all individual and family support case activity. Progress notes will also include the date written and the signature of the author of each note to be considered complete.

B. Each LGE administering the individual and family support program will comply with established policies and procedures of the LDH and the OCDD for the confidentiality of and access to participant records and the time-periods to retain those records.

C. The following additional information specific to the development of the request for individual and family support resources shall also be included in the participant record:

1. plan of support document that is current within a year or a comprehensive plan of care current within a year, which clearly identifies services requested and received from the LGE, or an EarlySteps individualized family services plan (IFSP), that is current within a year;

2. individual and family support prioritization instrument that is current within a year;

3. notice of decision for the individual and family support program;

4. individual and family support notice of right to appeal, as appropriate; and

5. individual and family support request for appeal, as appropriate.

D. When individual and family support funds are allocated and expended on behalf of participants these documents will be maintained in the participant's record in compliance with the requirements of the LDH, OCDD, and auditing authorities, and shall, at a minimum, include:

1. justification to, and approval from, the executive director of a LGE for expenditures in excess of $15,000, in a single fiscal year;

2. justification to, and approval from, the executive director of a LGE for funding of services outside these program guidelines; and

3. expenditure recap sheet, which specifies the total amount of individual and family support funds authorized, dates and amounts of expenditure of these funds and the total remaining on the initial allocation.

E. Agencies administering the individual and family support program will be required to comply with the requirements set forth and utilize forms approved for use by the OCDD.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:665 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:350 (March 2020).

§1107. Eligibility

A. The individual and family support program is a resource available to serve an individual with intellectual/developmental disabilities and his/her family as follows.

1. The individual lives in Louisiana and has a statement of approval to participate in intellectual/developmental disabilities services in accordance with the developmental disability law.

2. The individual may receive individual and family support funds to address identified needed supports to enable the person to remain in the community and/or to improve his/her quality of life.

3. The individual is at risk of being institutionalized or is institutionalized, but intends to return to the community with appropriate supports.

B. The individual and his/her family must demonstrate the ability to provide the necessary and appropriate care and supervision for the individual with intellectual/developmental disabilities who receives the support.

C. Families receiving a subsidy for the care of an individual cannot also receive IFS funds. The following are not considered subsidies: Family Independence Temporary Assistance Program (FITAP), Social Security (SS) benefits, flexible family fund, and child support; requests may be approved on an individual basis for eligible applicants receiving adoption subsidies.

D. Financial circumstances will be considered in the prioritization of individual and family support program funds. Family income will not disqualify applicants, but the applicant's ability to independently provide supports will be considered in funding decisions. Individual income will be considered for persons with intellectual/developmental disabilities who are establishing or maintaining supervised independent living in the community.

E. Requests for individual and family support funding may be approved for non-related persons when the applicant meets all other eligibility criteria, and at least one of the following:

1. The relationship and/or living arrangement is long-standing or of a permanent (not temporary) duration;

2. The person providing care is not the guardian or legally responsible representative of the applicant;

3. The applicant meets the Internal Revenue Service definition for a dependent for federal income tax purposes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:665 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:350 (March 2020).

§1109. Request for Individual and Family Support Funding

A. The request for individual and family support funding can be made by any eligible individual with intellectual/developmental disabilities, the applicant's family or representatives, a support coordination agency, or designated facility personnel for individuals residing in facilities who desire to return to the community.

B. All requests for individual and family support funding will go to the geographically appropriate LGE for determination.

C. Participants must have a current statement of approval (SOA) or meet criteria and be enrolled in EarlySteps services to receive individual and family support funds. The developmental disabilities director may provide IFS funding to applicants who do not yet have, but are likely to receive, an SOA in emergent situations. The support coordinator or community services professional will assist the individual and/or family in completing the plan of support to request individual and family support funding.

1. The support coordinator or community services professional will complete the plan of support (or comprehensive plan of care) in cooperation with the applicant and his/her family and will provide information on available supports and the type of support requested. The individual and/or family will be considered the primary decision maker.

2. The LGE administering individual and family support (IFS) funds shall have the responsibility for determination of the prioritization for allocation of IFS funds.

3. The developmental disabilities director or his/her designee will determine if the request requires an expedited response.

4. Individuals with intellectual/developmental disabilities, and/or their families, will be notified of and have the opportunity to present their requests to the individual and family support committee in person or by representation of their choice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:666 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:351 (March 2020).

§1111. Plan of Support

A. There will be a single plan of support for each applicant for individual and family support funding, regardless of the funding mechanism or LGE delivering supports.

B. The support coordinator or community services professional will meet with the individual and their family (if applicable) to generate an individualized plan of support specific to the individual's need for supports, which will include the following as defined by the OCDD: personal outcome goal of the IFS being requested, exploration of readily available resources to provide the IFS being requested, the extent and duration of the IFS service being requested, statement of the total amount of funds to be expended, and the terms of service delivery.

C. The plan of support will reflect the participant's current life situation in relation to the IFS being requested and what goal the IFS funds requested will meet. The plan of support will be reviewed and revised at least annually and also when the participant's need for the IFS increases or decreases.

D. The plan of support will be completed prior to the development of any agreement to provide individual and family support, except in the case of an emergent situation as determined by the developmental disabilities director.

E. The plan of support will specify the conditions for use of service and reporting or documentary responsibilities of the participant and/or family receiving services.

F. The comprehensive plan of care generated by the support coordination agency for waiver services may serve as the plan of support according to conditions set forth by the OCDD.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:666 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR46:351 (March 2020).

§1113. Prioritization for Individual and Family Support Funding

A. Each LGE will be responsible for the prioritization of all requests for individual and family support funding presented for a funding decision according to the following.

1. Priority 1. Without requested supports, there is an immediate or potential threat of out-of-home placement or homelessness due to:

a. the individual and/or caregiver's emergent or acute medical care needs;

b. documented abuse or neglect of the individual requiring immediate action to preserve his/her health or safety;

c. death or inability of caregiver to continue care due to his/her own age or health exposing the individual and/or caregiver to substantial jeopardy;

d. caregiver's inability to continue care without assistance due to employment or other family obligations;

e. the individual's intense or frequent challenging behavioral needs requiring immediate action to preserve his/her health; or

f. substantial threat that the individual will experience a health crisis leading to death, homelessness, hospitalization, or placement in a nursing facility without the requested supports.

2. Priority 2. Supports are needed to prevent the individual's health from deteriorating or the individual from losing his/her independence or productivity, and/or to maintain the caregiver's ability to provide supports and a stable home environment in the foreseeable future.

3. Priority 3. Supports are needed to maintain the individual's health, independence or productivity, and/or to maintain the caregiver's long-term ability to provide supports in a stable home environment.

4. Priority 4. Supports are needed to enhance the individual's quality of life and enhance the family's ability to provide a stable home environment.

B. All individual and family support allocations will be evaluated at the time of the initial application for funding and at least annually thereafter to determine the continuing need for authorized supports. Documentation shall be provided with completion of the individual and family support prioritization instrument form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:667 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:351 (March 2020).

§1115. Individual and Family Support Committee

A. Each LGE will maintain an individual and family support committee to be convened on a regular basis, but no less than quarterly, and on an as-needed basis, to serve as an advisory function to the LGE about allocation of funding.

B. The individual and family support committee shall be composed of the developmental disabilities director, or designee; the supervisor of the individual and family support program; the support coordinator/community support professional working with the applicant; at least one representative from an advocacy organization; at least one representative from the regional advisory committee; and at least one adult participant or a parent of a participant who has received supports through the individual and family support program. An adult participant or a parent may serve in a dual role on the committee.

C. The developmental disabilities director, or designee, shall report the activities of the individual and family support committee to the regional advisory committee at least quarterly. The report shall include:

1. number of persons receiving individual and family support funding;

2. types of supports provided;

3. total amount of funds budgeted and expended;

4. resolution of emergency funding requests and expenditures;

5. circumstances of imposition of fiscal controls imposed on participants in individual and family support funds, if any;

6. results of the quarterly supervisory review of at least 10 percent of active individual and family support cases completed;

7. composition of the IFS Committee and the number of times the committee met in the past quarter; and

8. number of IFS requests received by priority level and the disposition of each request.

D. The developmental disabilities director, or designee, shall maintain a record of the meetings of the individual and family support committee which shall include, minimally, those in attendance, requests discussed, and resolution of all applications. This record will be made available for review for monitoring or auditing purposes as requested by the OCDD.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:667 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:352 (March 2020).

§1117. Allocation of Individual and Family Support Funding

A. Authorization for individual and family support funding will be made by the developmental disabilities director in cases determined to require immediate action. Factors which may influence allocation of funds under these circumstances include, but are not limited to:

1. urgency of need;

2. probable consequences of failure to allocate funds and possible benefits;

3. adequacy of utilization of and exploration of alternative resources; and

4. resources readily available to the individual with intellectual/developmental disabilities and/or the family.

B. Authorization for funding in cases determined to not require immediate action by the developmental disabilities director will be prioritized by the LGE according to §1113 to determine the level of need, IFS authorized and, any limitations, stipulations or conditions to be met by the individual or family to receive individual and family support.

C. Actions which may be taken in response to applications for IFS shall be defined by the OCDD and shall include: approval (all or part), approval pending funding, deferment, or denial.

D. The LGE shall notify applicants of the action taken in response to the IFS application in writing within 10 working days of taking any action on the request.

1. Notification to applicants and/or their families shall be in writing. The letter of notification shall include notification of their right to appeal the action taken if their request was denied or funded in part. A copy of the letter will be provided to the applicant's support coordinator/community support professional and placed in the applicant's record.

2. Separate notifications will be made each time a request for supports is reviewed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:667 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:352 (March 2020).

§1119. Individual and Family Support Expenditures

A. Individual and family support expenditures will only be authorized through a plan of support which will:

1. be generated no more than 90 calendar days before the request for support is made;

2. extend for the duration of any agreement to utilize individual and family support funds;

3. define the specific type and duration of supports needed; and

4. identify the agent(s) to provide the service and any special conditions associated with service delivery.

B. The developmental disabilities director, or designee, shall be responsible for expenditures in the individual and family support program, more specifically, the amount budgeted and the number of people served, and shall ensure administration within the guidelines established by the OCDD.

C. The developmental disabilities director, or designee, shall be responsible for supplying written justification for IFS expenditures above $15,000 for a single individual within a single fiscal year to the executive director of a LGE and receive approval from the executive director prior to expenditure of funds. Plans of support approved for less than this amount will not require such notification or approval. A copy of the letter of justification and notice of approval shall be maintained in the participant record.

D. The developmental disabilities director, or designee, shall be responsible for supplying written justification of expenditures outside guidelines established by the OCDD and/or that exceed an amount specified in the program manual to the executive director of a LGE, and receiving the executive director's approval, before funds are expended. Plans of support which are within program guidelines will not require such notification or approval. A copy of the letter of justification and notice of approval shall be maintained in the participant record.

E. Services in the individual and family support program are cost reimbursements and prior authorized. The developmental disabilities director or designee may authorize expenditures for a payment prior to receipt of service if documentation is provided that justifies the individual or family's inability to provide the advance payment that is typically required for cost-reimbursement individual agreements. Individual and/or family reliance on FITAP, SS disability or SSI will be adequate justification for prior payment.

F. Each participant record will include an expenditure recap sheet, which details all individual and family support expenditures, regardless of payment mechanism.

G. Funds appropriated or allocated to the individual and family support program cannot be used for salaries of civil service or contract employees who coordinate and monitor the individual and family support services and cannot be used to fund other costs associated with administering this program. All funds appropriated or allocated to the individual and family support program shall be spent on the direct purchase of goods, supports or services to assist the individual with an intellectual/developmental disability and/or his/her family.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:668 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:352 (March 2020).

§1121. Implementing the Plan of Support

A. The support coordinator or community services professional in cooperation with the participant and the family when applicable, will implement the plan of support as approved.

B. The support coordinator or community services professional will serve as the primary resource to applicants with intellectual/developmental disabilities and/or their families in development and implementation of the plan of support.

C. Participants and families receiving supports will be expected to assume personal responsibility for use of the individual and family support funds.

D. When participants have demonstrated the need for assistance in overseeing supports, which help maintain health, safety and protection from abuse, neglect or exploitation, the LGE will be responsible to provide active support to that individual and/or family.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:668 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:353 (March 2020).

§1123. Eligible Supports

A. The individual and family support program supports are intended to maintain and/or improve maximum flexibility for eligible participants with intellectual/developmental disabilities and their families by meeting their needs to enable them to remain at home and be fully participating members of their communities. Because each individual is unique, supports will be person-centered and will change with time and the circumstances of the individual and family needing supports.

1. Examples of eligible supports include, but are not limited to:

a. special equipment/supplies;

b. special nutrition/clothing;

c. special therapies;

d. respite;

e. medical expenses;

f. medications;

g. therapeutic services;

h. personal care attendant;

i. home modifications;

j. crisis intervention;

k. family training/therapies;

l. homemaker services;

m. vehicle modifications;

n. recreation services;

o. communication services;

p. transportation;

q. counseling services;

r. home health services;

s. support coordination;

t. specialized utility costs;

u. sitter services;

v equipment and supplies;

w. adaptive equipment;

x. nutritional supplies;

y. personal assistance services;

z. companion/roommate services;

aa. special evaluations;
bb. therapeutic nursing services;
cc. family subsidy;
dd. vocational/employment supports;
ee. specialized diagnosis and evaluation; and
ff. dental/medical care.

2. Individual and family support funds shall not supplant services from a home and community-based waiver, Medicaid State Plan, EarlySteps, Louisiana Rehabilitation Services, local education agency or Medicaid funded behavioral health.

3. Individual and family support funds can be used to supplement other sources of payment only when that funding is deemed by the developmental disabilities director to be insufficient to meet the existing needs of the participant and is fully documented as such in the participant record.

4. Financial subsidy does not reflect a growth in family income and will not be used in calculations for eligibility for public entitlements, except for ineligibility to participate in the Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:668 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:353 (March 2020).

§1125. Ineligible Supports

A. Supports ineligible for payment by individual and family support funding include, but are not limited to:

1. items or supports for which an individual or family is routinely eligible under existing programs, such as home and community-based waiver, Medicaid State Plan, EarlySteps, Louisiana Rehabilitation Services, local education agency or Medicaid funded behavioral health unless there is sufficient documented justification that the specific needs of the individual and/or family are not met;

2. items or supports for which a school-aged (3-22 years) child is eligible as a “related service” under Public Law 94-142, unless there is sufficient documentation of efforts to address the need through the child's individualized education program (IEP) and to pursue due process if warranted;

3. payments made towards or payments made for FICA taxes, workman’s compensation insurance, liability insurance, etc. by a participant or their family to insure workers in their home providing IFS services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:669 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:354 (March 2020).

§1127. Payment Mechanisms

A. The developmental disabilities director, or designee, may authorize expenditures of individual and family support funds and shall have final discretion on the type of payment mechanism, with appropriate prior notification to the executive director of a LGE as specified by the OCDD.

B. Individual and family support program supports may be provided through any legitimate and appropriate funding mechanism authorized by current Louisiana Department of Health (LDH) contracting or purchasing practices or the policies and procedures established by a LGE. This may include, but not be limited to, the use of individual agreements for goods and services, purchase orders (integrated statewide information system mechanism) for purchase of goods, and contracts for supports with either individuals or external agencies.

C. Documentation will be required for all individual and family support funds expended. This may take the form of receipts for goods or services, time-sheets for service delivery, utility statements, etc.

D. When an individual receiving individual and family support services moves to a region served by a different LGE and the service is still needed at the new location, the LGEs will negotiate the continuation of the funding of the service in order to ensure continuity of service.

E. The support coordinator or community services professional will instruct the participant and/or his/her family on the means to document delivery of supports, including providing appropriate billing forms and/or special instructions, both at the point of initiation of supports and quarterly thereafter for the duration of service provision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:669 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:354 (March 2020).

§1129. Fiscal Control of Use of Individual and Family Support Funds

A. The plan of support for each participant in individual and family support shall clearly reflect the intended utilization of supports and be specific to the type and level of support to be received; conditions of delivery of service; the frequency and duration of the service.

B. The developmental disabilities director or designee shall be responsible for the appropriate use of individual and family support funds in cooperation with the support coordinator or community services professional to ensure that no support or service is funded, which is not clearly identified on an approved plan of support.

C. All individual and family support agreements will contain clear identification that any payroll and/or other taxes are the sole responsibility of the participant and not the LGE. No individual and family support sponsored reimbursement may be used in any way to defer the participant's responsibility for payroll tax payment or deferral.

D. All questions about payroll or other taxes or other fiscal responsibilities of participants of individual and family support funds are to be referred to tax specialists for advice and/or resolution of questions. No OCDD or LGE employee may answer participant questions about the legal obligations of the participant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:669 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:354 (March 2020).

§1131. Monitoring the Plan of Support

A. Support coordinator or community services professional will maintain at least quarterly contact with the participant, with documentation to the record, for the duration of supports; contact can be face-to-face or by telephone except that home or vehicle modification(s) will be viewed by the support coordinator or community services professional to ensure the modifications are completed and accepted by the participant or his/her family prior to payment. Regardless of the manner of monitoring, a record of monitoring activities shall be maintained in the participant record at the LGE office.

B. Active plans of support will be monitored for the duration of support provision; the participant record will clearly indicate the period during which monitoring will occur and the point at which monitoring can be terminated.

C. Monitoring of supports shall address fiscal issues of whether receipts satisfy and conform to the conditions of delivery of the plan of support. Processing of receipts and billing forms shall not be considered an adequate monitoring of delivery of support.

D. Monitoring of the plan of support will involve follow-up of questionable fiscal practices, including attempts to recoup inappropriate payment if necessary. Such instances will include, but not be limited to, when adequate receipts are not submitted, when eligibility is in question, or when the individual or family has demonstrated questionable compliance with program policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:670 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:354 (March 2020).

§1133. Regional Program Monitoring and Reporting

A. Each LGE will conduct a supervisory review of at least 10 percent of active plans of support of individual and family support applicants and participants on an at least quarterly basis to ensure compliance with program guidelines and quality of service delivery. This internal review shall be the responsibility of the LGE and supervisory personnel as designated by the developmental disabilities director.

B. Each LGE will monitor individual and family support funds allocated for its use and report quarterly in the format required by the OCDD. Periodic reports will be generated by the central data management system of the OCDD.

C. An annual review of LGE program operations will be completed by personnel of the OCDD, and each LGE will work cooperatively with officials of authorized state or federal agencies to satisfy audit or monitoring requirements as necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:670 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:355 (March 2020).

§1135. Terminations

A. Terminations occur when an individual and family support service has been approved and is then terminated for one of the reasons listed in Subsection B of this Section. This is not the same as a closure of request, which occurs before a service is approved.

B. Terminations may be initiated by the LGE or individual or family receiving the individual and family support service for any of the following reasons:

1. death of the participant;

2. fraud;

3. relocation of the individual receiving supports outside of Louisiana;

4. termination of program;

5. participant is placed in an ICF/IID or other institutional setting;

6. at individual's request when the individual with intellectual/developmental disabilities is of majority and legally competent;

7. substantial changes occur and are not reported by the individual and/or family that results in the participant becoming eligible for support from sources other than the individual and family support program which include, but are not limited to:

a. receipt of, or certification of, Medicaid services, or EarlySteps;

b. receipt of Louisiana Rehabilitation Services

c. change in financial circumstances; or

d. change in living arrangements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:670 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:355 (March 2020).

§1137. Appeals

A. Applicants for and participants in the individual and family support program who have had supports approved in part, reduced, denied or terminated, shall have a right to appeal to the Division of Administrative Law-Louisiana Department of Health (LDH) section.

B. Applicants and participants in the individual and family support program will be informed of their right to appeal and of the process to appeal in writing.

C. All persons receiving an adverse eligibility determination shall have 30 calendar days from the date on the letter notifying the person of the adverse eligibility decision to request an appeal.

D. To request an appeal, participants can contact either their support coordinator, community services professional or the LGE office by telephone, in writing, or in person for assistance.

E. The appellant, with or without the assistance of the support coordinator or community service professional, will be responsible for completing the appropriate documentation and forwarding it to the Division of Administrative Law-LDH section as set forth by the OCDD.

F. If the appeal is timely and services were in place at the time of the appeal, services will continue throughout the appeal process.

G. The LGE will cooperate with the Division of Administrative Law to provide information as appropriate to complete the appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:824.

HISTORICAL NOTE: Promulgated by the Department of Health, Office for Citizens with Developmental Disabilities, LR 43:671 (April 2017), amended by the Department of Health, Office for Citizens with Developmental Disabilities, LR 46:355 (March 2020).

Chapter 15. Pilot Program for Children with Developmental Disabilities Who Are Considered At-Risk Juveniles

§1501. Statement of Purpose

A. OCDD is proposing to establish a pilot program consisting of a 4-bed home in the community designed to meet the needs of at-risk juveniles with developmental disabilities who may be referred to OCDD when their families or foster families can no longer meet their needs at home.

B. The pilot program shall consist of a 4-bed home providing therapeutic supports and services to at-risk juveniles. The pilot will be in Region 3.

C. After a thorough evaluation of the accumulated data and stated outcomes of this program, OCDD may propose expansion to other areas of the state based on the availability of funding.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:385(A) and Act 858 of 2004 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 31:86 (January 2005).

§1503. Establishment of Pilot Program

A. OCDD will establish this pilot program directly or through written agreement with a provider organization in accordance with R.S. 28:385(A) who complies with all contractual provisions for establishment and the program operations and procedures for Pilot Programs for Children with Developmental Disabilities Who are Considered At-Risk Juveniles.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:385(A) and Act 858 of 2004 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 31:87 (January 2005).

§1505. Program Definition

A. At-Risk Juveniles—juveniles who are between 10 through 17 years of age inclusive, have a developmental disability which is primarily due to mental retardation, and manifest a co-occurring mental health disorder.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:385(A) and Act 858 of 2004 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 31:87 (January 2005).

§1507. Requirements of Program Participants

A. Participants to be admitted to a Pilot Program for Children with Developmental Disabilities Who Are Considered At-Risk Juveniles shall be governed by the requirements contained at LAC 48:I, Chapter 16, Section 1611 (Louisiana Register, Vol. 30, No. 1, January 2004).

B. Participants at the time of admission shall be at-risk juveniles between 10 and 16 years of age.

C. Participants to be admitted shall be at-risk juveniles who have service needs which are consistent with the therapeutic program and services offered for the current participants of the program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:385(A) and Act 858 of 2004 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 31:87 (January 2005).

§1509. Standards for Program Operations and Procedures

A. This pilot program shall meet all federal and state laws and regulations governing an Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled (ICF/MR).

B. The referrals for admissions to this pilot program shall be made by the OCDD Community Services Office located in the region where the pilot program is operated.

C. All individualized planning of supports and services needs shall be developed and implemented in accordance with the principles of person-centered planning.

D. Providers will be responsible for meeting all the specific support and service requirements for each juvenile residing in the home. The provision of such individualized services, including duration and type, which may not be available on a routine basis in a ICF/MR, are anticipated to be in the areas of nursing, psychological, psychiatric, nutritional and related services as outlined in the individual's plan of support. These additional supports and services will be those that have a clear expectation of furthering the individual's ability to meet the goals of the pilot program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:385(A) and Act 858 of 2004 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 31:87 (January 2005).

§1511. Goals

A. OCDD seeks to provide leadership in the development of a community-based model to meet the needs of at-risk juveniles with developmental disabilities. This model with be developed through a pilot program based on individualized supports and services designed to enable participants to meet the goals of the pilot program.

B. OCDD's goal for this pilot program is to avoid the institutional placements of juveniles as defined herein by providing to them the necessary time limited (projected 12-18 months) supports and services to develop the needed skills to return to their family or foster family homes or to an appropriate community based placement.

C. OCDD seeks to enhance provider and family capacity to serve at- risk juveniles with developmental disabilities by using this pilot program to develop a model for more effective service delivery.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:385(A) and Act 858 of 2004 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 31:87 (January 2005).

§1513. Evaluation

A. OCDD will conduct site visits at least quarterly and require performance reports to gather and compile information to determine the status of the program based on the goals of the Office as discussed above.

B. OCDD will evaluate the pilot program based on site reviews and, at a minimum, the accumulated data concerning the:

1. provider's performance in meeting the requirements identified in the individuals' plans of support;

2. percentage of the outcomes (as stated in the individualized plan of support) achieved for each child participating in the pilot program;

3. length of program participation required by each juvenile served who are subsequently able to return to their family or foster homes or to an appropriate community based placement; and

4. percentage of individuals remaining in the community.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:385(A) and Act 858 of 2004 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 31:87 (January 2005).

Title 48
HEALTH AND HOSPITALS—GENERAL
Part XI. Hospitals
Subpart 1. General Provisions

Chapter 1. Authority

§101. Establishment of State Operated General Hospitals

A. Act 18 of 1948 amended Act 69 of 1930 to authorize the establishment of the E. A. Conway Memorial Hospital in the City of Monroe, Parish of Ouachita, to be maintained at the expense of the state for the reception and medical and surgical treatment of the indigent and destitute sick and wounded persons.

B. Act No. 137 of 1874 authorized the establishment of the Charity Hospital of the City of Baton Rouge, later named Earl K. Long Memorial Hospital, and provided that all destitute sick persons should be admitted and receive such aid and medical attention as their condition may require.

C. Act 160 of 1938 provided that a charity hospital under construction at Pineville, Louisiana by the State Hospital Board be known and designated as the Huey P. Long Hospital.

D. Lallie Kemp Charity Hospital was opened in 1938 under the authority of the State Hospital Board to provide general medical care to the indigent in the Florida Parishes of Southeast Louisiana.

E. Act 38 of 1973 authorized the establishment of South Louisiana Medical Center to be used for public health work within the state for the reception and medical and surgical treatment of indigent sick and wounded persons.

F. University Medical Center was opened as the Lafayette Charity Hospital in 1937 under the authority of the State Hospital Board as a general hospital to serve the indigent population.

G. Act 219 of 1956 authorized the creation and establishment of the Lake Charles Charity Hospital, later renamed the Dr. Walter Olin Moss Regional Hospital, to be used for public health work within the state for the reception and medical and surgical treatment of indigent, sick, and wounded persons.

H. Act 210 of 1948 authorized the operation of Washington-St. Tammany Charity Hospital as a hospital not to exceed 50 beds and with adequate physical facilities for an outpatient service to care for the requirements of the area served.

I. Establishment of Charity Hospital at New Orleans Hospital. Act 155 of 1855 created Charity Hospital at New Orleans and provided a revenue for its support. Any bona fide resident of the state of Louisiana shall be eligible to be admitted for any form of treatment by any general hospital owned and operated by the state of Louisiana. Those persons who are determined not to be medically indigent or medically needy shall be admitted only on a space available basis and shall be reasonably charged for any treatment or services received. However, in no event shall emergency treatment be denied to anyone; and in no event shall any person housed in any parish jail facility or state prison in the state of Louisiana, irrespective of his state of residency, be denied any form of medical treatment in the nearest general hospital owned and operated by the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:259 and R.S. 36:851, 46:6.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Subpart 3. General Hospitals

Chapter 5. House Officers

§501. Compensation and Benefits

A. Regular Pay. House Officers' salaries are determined by the Southeast regional average of house officers' salaries (as determined by COTH) plus six percent except that the six percent factor may vary with inflation and compensation at this level will be dependent on sufficient funds being appropriated by the legislature.

B. Annual, Sick, and Educational Leave

1. Annual leave may be provided to a House Officer I, up to but not more than a period of two calendar weeks. A House Officer II and above may be provided up to, but not more than four calendar weeks per training year.

2. Sick leave is not governed by a firm policy, but is the responsibility of each program director to administer.

3. Educational leave is determined by each program director.

C. Hospitalization Insurance and Life Insurance

1. House officers may participate in hospitalization and life insurance benefits under the state Employees Group Benefit Program with a portion of the cost paid by the state as provided to all other employees. Participation in these benefits is subject to the option of each house officer.

2. Whenever a house officer is assigned by his training program to a teaching hospital outside the state hospital system he must contact the payroll office in the state teaching hospital handling his payroll account and repay the

total insurance premium if he desires the hospitalization and/or life insurance to remain in force while assigned outside the state hospital system.

3. Should a house officer refuse to accept benefits as provided by the teaching hospital he shall not be eligible to receive, nor shall he receive any other thing of value in place of his option not to accept the hospitalization and life insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:259.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§503. Medical Malpractice

A. For purposes of professional liability house officers are included in the Louisiana Medical Malpractice Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1756.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 7. Patient Involvement

§701. Patient Rights

A. Each patient shall expect the following as an integral part of the healing process.

1. The patient has the right to considerate and respectful care.

2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care.

3. The patient has the right to refuse treatment to extent permitted by law and to be informed of the medical consequences of his action.

4. The patient has the right to every consideration of his privacy to the extent consistent with providing adequate medical care to the patient. This shall not preclude discrete discussion of a patient's case or examination of patient by appropriate health care personnel. Those not directly involved in his care must have the permission of the patient to be present.

5. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential, except as otherwise provided by law or third party payment contract.

6. The patient has the right to expect that within its capacity a hospital must make a reasonable response to the patient's request for services customarily rendered by the hospital consistent with the patient's treatment. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

7. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.

8. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.

9. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.

10. The patient has the right to examine and receive an explanation of his bill, regardless of source of payment.

11. The patient has the right to know the hospital rules and regulations that apply to his conduct as a patient.

12. The patient has the right to treatment without discrimination as to race, color, religion, sex, national origin or source of payment.

AUTHORITY NOTE: Promulgated in accordance with guidelines issued by American Hospital Association on February 6, 1973.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Charity Hospital at New Orleans, LR 13:246 (April 1987).

Chapter 9. Patient Satisfaction

§901. Patient Satisfaction

A. It is the policy of the Office of Hospitals for each acute care hospital to institute an internal procedure for determining patient satisfaction.

B. A suitable questionnaire must be developed and utilized by each acute care hospital for the purpose of gathering patient satisfaction data and the sample size should be sufficiently large to insure validity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:6 et. seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§903. Voluntary Sterilization

A. Voluntary sterilization can be performed only after the fulfillment of all requirements prescribed by the Uniform Consent Law.

B. In the case of patients eligible for medicaid, not only must all requirements of the Uniform Consent Law be fulfilled, but all conditions set forth in Title 14, Chapter IV, Subpart F must be met as well.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.4 and CFR 42:Ch IV, F.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§905. Visiting of Patients by Attorneys

A. All attorneys desiring to visit a patient in any capacity other than that of a personal visitor must report to the medical director's office or to the acting clinical director (ACD) on week-ends or after 5:00 p.m. on week days.

B. The attorney will be asked to identify himself and to state the purpose of his visit to the patient.

C. The patient will be asked by nursing staff if he desires the visit by the attorney.

D. If the answer is in the affirmative, the physician in charge of the case or the acting clinical director (ACD) shall be asked if the visit by the attorney shall be disturbing to the patient or the care being provided. The physician in charge or ACD shall authorize the visit.

E. Upon receipt of an affirmative statement by the patient and approval by an appropriate physician, the attorney shall be given written authorization by the medical director's office or the acting clinical director to visit the patient in a designated patient care area.

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2794, R.S. 40:1299.29 and R.S. 13:3734.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Charity Hospital at New Orleans, LR 13:246 (April 1987).

Chapter 11. Medical Care for State and Parish Prisoners

§1101. Prisoners' Care

A. R.S. 46:6 requires that person housed in any parish jail facility or state prison in the state of Louisiana, irrespective of his state of residency, shall not be denied any form of medical treatment in the nearest general hospital owned and operated by the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:6.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Subpart 5. Special Care Facilities

Chapter 15. Geriatric Hospitals

§1501. Authorization

A. The Office of Hospitals may establish and administer geriatric hospitals or units to receive and care for infirm persons who have been discharged by a hospital for the mentally ill and for other elderly and infirm persons who are in need of nursing and medical care. Such hospitals or units may be established on sites designated by the department, provided that no such geriatric hospital or unit may be established on any site located more than five air miles from the administrative office of East Louisiana State Hospital or more than one air mile from the administrative office of Central Louisiana State Hospital.

B. The geriatric hospital at Jackson, Louisiana, known as Villa Feliciana, is created and established. The hospital shall be under the administration of the state Department of Hospitals, but shall constitute a separate budget unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:259.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§1503. Payment for Care

A. Patients admitted to geriatric hospitals established under the authority of this part or the responsible relatives of such patients shall pay the cost of the patients' maintenance and care.

B. Any funds received from this source, as well as any funds made available to the geriatric hospitals by the Department of Public Welfare on behalf of the patients in these facilities, shall be paid into a fund established by the state treasurer and named Villa Feliciana Geriatric Fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:22.7 and R.S. 36:259.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 17. New Orleans Home and Rehabilitation Center

§1701. Authorization

A. Act 230 of 1979 provided for the purchase and renovation of New Orleans Home and Rehabilitation Center. The facility provides inpatient, long-term health care to the indigent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:259.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 19. Bureau of Anatomical Services

§1901. Creation of Bureau

A. Act No. 260 of 1944 created the Anatomical Board to administer the collection, storage, and distribution of dead human bodies for anatomical purposes and to have exclusive charge and control of the disposal and delivery of dead human bodies among the state's several educational institutions. The Anatomical Board was abolished and its functions transferred to the Department of Health and Human Resources, Office of Hospitals by Act No. 513 of 1976. These functions are now lodged in the Bureau of Anatomical Services of the Office of Hospitals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:2271 and R.S. 36:259.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§1903. Purposes of Bureau

A. The purposes of the Bureau of Anatomical Services are to regulate the collection, storage and distribution of unclaimed bodies of deceased persons required to be buried at public expense, or parts or organs of such bodies, for the purpose of advancing medical science.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:2272 and R.S. 36:259.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§1905. Authority of the Bureau

A. Superintendents or wardens of hospitals, asylums, penitentiaries or other similar institutions, and all state, parish, or city officials or other persons having custody of bodies of deceased persons required to be buried at public expense shall notify the Bureau of the availability of these bodies and that there exists no legal prohibition against their release. This notice must be given not later than 36 hours from the time of death of the deceased person.

B. Upon receipt of this notice the bureau may take the following actions:

1. It may accept the available bodies.

2. It or its authorized agent may transport the body from any point within the state to its domicile in the City of New Orleans or its resident offices elsewhere in the state.

3. It may authorize and allow the immediate removal of eyes from the body by qualified medical practitioners when the removed eyes are to be used for the purpose of advancing medical science or for the replacement or rehabilitation of eyes in a living person.

C. No claim or right of action of any sort against any doctor, nurse, hospital, or any other person or organization shall arise out of or result from the removal of the eyes made available to the bureau under the terms of this Section.

D. All expenses incurred in connection with the notice, delivery and transportation of the bodies referred to in this Section shall be paid by the bureau. The bureau shall also assume all expenses incurred in disposing of the remains of these bodies after they have been used in accordance with the provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:2274.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 21. Distribution of Bodies

§2101. Allocation of Bodies

A.1. Bodies received by the bureau shall be allocated by it to the following three departments of anatomy:

a. Tulane University School of Medicine

b. Louisiana State University School of Medicine at New Orleans combined with the Louisiana State University School of Dentistry.

c. Louisiana State University School of Medicine at Shreveport.

2. Bodies are allocated to each in proportion to the number of students enrolled in human anatomy courses.

B. Bodies received by a department of anatomy from the bureau must be held for a period of at least 90 days during which time any relative or friend of the person deceased may claim the body for interment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:2275.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§2103. Bonds Required

A. All educational institutions receiving bodies under provisions of this part shall give a bond, in a form approved by the Attorney General, in favor of the bureau and in the amount of $1,000, conditioned that the bodies received by them shall be used for the promotion or application of anatomical knowledge or science.

B. The bureau shall also furnish a bond of $1,000 in favor of the secretary of state subject to the same conditions and stipulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:2277.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§2105. Transportation of Bodies

A. In the distribution and transportation of bodies, as provided for in this part, the bureau may employ any public carrier having a transmittal permit issued by the local registrar of vital statistics authorizing the removal of the

body. All bodies being transported must be properly encased and concealed from public observation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:2279.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 23. Financial Participation

§2301. Financial Contribution of Schools

A. Each educational institution accepting the provisions of this Part will be assessed a sum, fixed by the Bureau, that is proportionate to the total number of anatomy students in attendance or is a per capita amount for each student enrolled in the semester. Each educational institution must remit the assessed amount within 60 days after the beginning of each academic session.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:2278.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 25. Poison Control Center

§2501. Authorization of the Poison Control Center

A. The Department of Health and Human Resources is authorized to establish, operate, and maintain a statewide poison control center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1296.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 27. School of Nursing

§2701. Establishment and Purpose

A. Charity Hospital School of Nursing was established in 1894, through the cooperative efforts of the Board of Administrators Charity Hospital of New Orleans and the Daughters of Charity of St. Vincent de Paul.

B. The primary aim of the school is to provide education that is essential to persons who receive the diploma in nursing. The graduate is qualified to write the Louisiana State Board of Nursing licensing examination to become a registered nurse. Graduates are prepared to assume first level staff nurse positions in hospitals and similar community agencies.

C. Admission requirements, grading and promotion policies, curriculum and fees are published in the school bulletin.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1012, R.S. 46:925-929.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 29. Authorization and Cooperation of Other State Departments

§2901. Authorization

A. The Department of Health and Human Resources shall establish, maintain and operate an effective program which will provide adequate emergency medical services for persons injured on the roads and highways of the state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2017.10.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§2903. Cooperation of Other State Departments

A. The program shall be administered by the department, with such assistance and use of facilities of other agencies of the state and its political subdivisions as will best and most efficiently serve the interests of public health and safety of the citizens of Louisiana. To this end the Department of Public Safety and Corrections, the Civil Defense Agency and such other boards, commissions, departments and agencies of the state and its political subdivisions as the department shall deem necessary therefore shall cooperate with and assist the department, at its request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2017.10.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 31. Standards

§3101. Definitions

A. When used in this Part, the following words shall have the meanings as indicated.

Ambulance—any enclosed or open vehicle for carrying sick or injured persons operated as part of a regular course of conduct or business for any such purpose.

First Aid Certificate—a certificate in the Advanced First Aid and Emergency Care Course issued by the American National Red Cross or to any certificate issued by the Bureau of Mines wherein it is stated that the person to whom it is issued has successfully completed the required training and met the established standards of such organizations.

Certified Emergency Medical Technician—any person who has successfully completed an 81 hour basic emergency medical technician training course approved by the Department of Transportation and Department of Health and Human Resources and is currently state certified by the Louisiana State Board of Medical Examiners.

Certified Advanced Emergency Medical Technician—any person who has successfully completed an advanced emergency medical technician training course approved by the Department of Transportation, the Department of Health and Human Resources and the Louisiana State Board of

Medical Examiners and is currently state certified by the Louisiana State Board of Medical Examiners. However, all or any part of the required training program may be waived by the Department of Health and Human Resources if the applicant has documentation for an equivalent level of training and successfully completes the performance and written examinations required for certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§3103. Qualifications to Operate Ambulances; Equipment; Penalty

A. No person shall conduct, maintain, or operate an ambulance for hire unless it is under the immediate supervision and direction of a person holding either a first aid certificate, a registered nurse's license issued under the provisions of Title 37 of the Louisiana Revised Statutes of 1950, an emergency medical technician certificate, or a valid and unrevoked physician's and surgeon's certificate, issued under the provisions of Title 37 of the Louisiana Revised Statutes of 1950.

B. No person shall be employed in any capacity on any ambulance unless he is the holder of a first aid certificate or is a state certified emergency medical technician.

C. No person shall conduct, maintain, or operate an ambulance which does not carry with it as part of its regular equipment the minimum essential equipment for ambulances as recommended by the American College of Surgeons.

D. Whoever violates this Section shall be fined not more than $10 or imprisoned for not more than 10 days. The penalty prescribed by this Section shall be doubled for the second or any subsequent offense.

E. The provisions of this Section shall apply to all parishes or municipalities except those electing not to comply as expressed to the Department of Health and Human Resources in a written resolution by the governing body of such parish or municipality. The election of any parish to be included or excluded shall in no way affect the election of any municipality to be included or excluded. If any parish or municipality elects to be excluded from this Section, they may later elect to be included by resolution.

F. All financial grants administered by the state for emergency medical services pertaining to this Part shall be made available to those parishes and municipalities which are governed by the provisions of this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1232.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§3105. Advanced Emergency Medical Technicians

A. In addition to the requirements of R.S. 40:1232, any hospital, ancillary medical facility or ambulance service, whether public or private, may conduct a program utilizing any certified emergency medical technician—intermediate or certified emergency medical technician-paramedic to supervise and direct the delivery of emergency medical care to the sick and injured at the scene of an emergency during transport to a hospital, while in the hospital emergency department, and until care responsibility is assumed by the regular hospital staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1233.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 33. Damages

§3301. Immunity from Civil Damages

A. Any basic, intermediate, or paramedic emergency medical technicians certified pursuant to the terms of this Part who renders emergency medical care to a person while in the performance of his medical duties and following the instructions of a physician shall not be individually liable to such a person for civil damages as a result of acts of omissions intentionally designed to harm, or for grossly negligent acts or omissions which result in harm to such person. Nothing herein shall relieve the driver of the emergency vehicle from liability arising from the operation or use of such vehicle.

B. The immunity granted herein to basic, intermediate, and paramedic emergency technicians by the provisions of this Part shall extend to parish governing authorities, police departments, sheriff's offices, fire departments, or other public agencies engaged in rendering emergency medical services and its insurers with respect to such emergency medical services unless the emergency medical technician employed by said agencies would be personally liable under the provisions of Subsection B.

C. Any physician or surgeon who is a licensed practitioner of medicine in the state of Louisiana, who provides instructions to basic, intermediate, or paramedic emergency medical technicians certified by the provisions of this Part by use of electronic or other means of transmission in connection with the rendering of emergency medical services shall not be liable unto such person for civil damages arising from his opinion, judgments, actions, or duties while exercising that degree of skill and care ordinarily employed by member of his profession in good standing in the same community or locality considering the circumstances of providing emergency instructions.

D. No hospital facility which allows the use of telemetry or other equipment to maintain contact between the basic, intermediate, and paramedic emergency medical technicians and physicians shall be liable for any civil damages arising out of the use of such equipment except for acts of omissions by hospital personnel that are grossly negligent which result in harm to a person.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§3303. Impersonation of an Emergency Medical Technician

A. Whoever shall impersonate, refer to himself, or otherwise hold himself out as a basic, intermediate, or paramedic emergency medical technician without maintaining a current certification as such shall be fined up to $1,000, or imprisoned for six months, or both.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1236.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 35. Emergency Medical Technician Training

§3501. Fee Schedule

A. The Office of Hospitals, Emergency Medical Services will begin to charge fees for the following services performed.

Certification Fees				
	First Responder	**EMT Basic**	**EMT Intermediate**	**EMT Paramedic**
In State Certification	$10	$15	$20	$25
Reciprocity Certification	N/A	$50	$75	$100
Recertification	$5	$10	$15	$20

Examination Fees			
	EMR Basic	**EMR Intermediate**	**EMT Paramedic**
Written Exam*	$10	$10	$10
Entire Practical**	$30	$40	$50
Retest Practical**	$15	$20	$25

*Does not include National Registry fee
**Currently being charged

Application Fee	$25 per provider	
Certification Fee	Basic Level Intermediate Level Paramedic Level	$30 per vehicle $40 per vehicle $50 per vehicle

B. Continuing Education

1. A fee of $5 shall be charged for application to participated in various continuing education workshops, seminars, and courses offered by the Office of Hospitals, Emergency Medical Services. There shall also be a tuition for of $10 per day of instruction for all individuals accepted into these programs.

2. Exclusions. In accordance with R.S. 40:1232.2, fees shall not be required for certification or recertification of any certified emergency medical technician who services as such on a voluntary basis and who receives no compensation of any kind for said services.

C. The Bureau of Emergency Medical Services shall set fees for emergency medical personnel under the following conditions.

1. Volunteers. The bureau shall not require or collect any fee or charges for certification or recertification of emergency medical personnel who:

a. serve as such on a voluntary basis; and

b. receive no compensation of any kind for such services.

2. Public Exceptions. The bureau shall not set the fee for certification of an emergency medical technicianXbasic to exceed $15 for any individual who:

a. is an employee of a municipal law enforcement agency; or

b. fire service; or

c. fire protection district, who does not perform emergency medical services outside of the individual's official governmental responsibilities for any form of compensation.

3. The bureau shall not set the fee for recertification of an emergency medical technician-basic to exceed $10 for any individual who:

a. is an employee of a municipal law enforcement agency; or

b. fire service; or

c. fire protection district, who does not perform emergency medical services outside of the individual's official governmental responsibilities for any form of compensation.

4. The bureau shall assess fees for testing and certification based on the following schedule:

a. test fees:

i. first responderXwritten only: $15;

ii. first responderXwritten only (out-of-state): $15;

iii. basic initial written and practical: $60;

iv. basic entire practical exam: $30;

v. basic partial practical: $15;

vi. basic testing/retestingXwritten only: $15;

vii. basic testing/retestingXwritten only (out-of-state): $15;

viii. intermediate initial written and practical: $75;

ix. intermediate initial written and practical (out-of-state): $100;

x. intermediate retest entire practical: $50;

xi. intermediate retest entire practical (out-of-state): $65;

xii. intermediate retest partial practical: $30;

xiii. intermediate retest partial practical (out-of-state): $30;

xiv. intermediate testing/retestingXwritten exam only: $15;

xv. intermediate testing/retestingXwritten exam only (out-of-state): $15;

xvi. paramedic initial written and practical: $90;

xvii. paramedic initial written and practical (out-of-state): $125;

xviii. paramedic retesting entire practical: $60;

xix. paramedic retesting entire practical (out-of-state): $75;

xx. paramedic retesting partial practical: $35;

xxi. paramedic retesting partial practical (out-of-state): $40;

xxii. paramedic testing/retesting written: $15;

xxiii. paramedic testing/retesting written (out-of-state): $15.

b.Certification fees are charged as follows:

i. first responder initial certification: $10;

ii. basic emergency medical technician initial certification: $30;

iii. intermediate initial certification: $40;

iv. paramedic initial certification: $50;

v. first responder recertification: $5;

vi. basic emergency medical technician recertification: $25;

vii. intermediate recertification: $35;

viii. paramedic recertification: $45;

ix. basic EMT reciprocity: $60;

x. intermediate reciprocity: $80;

xi. paramedic reciprocity: $100.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1232.1 (Act 515 of the 2001 Louisiana Legislature).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 15:478 (June 1989), amended by the Department of Health and Hospitals, Office of Hospitals, LR 15:627, LR 28:46 (January 2002).

Chapter 37. Reimbursements for Emergency Medical Services Courses Provided through Contract

§3701. General Conditions of Reimbursements

A. Contractors will receive reimbursements for only those services for which the contractor incurs cost. Contractor must insure medical supervision for all training programs except the refresher training activities. Medical supervision may be accomplished through gratis or a contractual agreement.

B. The course reimbursement rate is based upon utilization of the full complement of faculty as outlined in the Office of Hospitals, Emergency Medical Services Manual, and the Advanced EMT-Training Manual. Funds not claimed through the reimbursement request process shall remain with the Office of Hospitals, Emergency Medical Services.

C. The Office of Hospitals, Emergency Medical Services, shall determine if it is in the best interest of all parties involved to pay contractees during the progress of the course; payment not to exceed 25 percent of total contract, and not to be made before that segment for which payment is being made has been completed. Also, the Office of Hospitals, Emergency Medical Services, may determine whether any staff member who cannot attend 100 percent of the required hours may be reimbursed based on the number of hours of actual instruction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

§3703. Specific Reimbursement Rates and Qualifications for Emergency Medical Services Courses

A. Specific reimbursement rates and qualifications for Emergency Medical Services courses are:

1. EMT-Basic

a. Required staff and fees are:

Instructor-Coordinator	$1500
Medical Director	$ 200
Instructor-Assistant	$1000

b. Staff qualifications are:

i. Medical Director—M.D., preferably ACEP certified

ii. Instructor-Coordinator—M.D., R.N., or EMT-paramedic or MT-Intermediate plus Certified Instructor by OH-EMS

iii. Instructor-Assistant—EMT-P, I, or A; plus Certified Instructor by OH-EMS.

2. EMT-Basic Refresher

a. Required staff and fees are:

Instructor-Coordinator	$300
Instructor-Assistant	$200

b. Staff qualifications are:

i. Instructor-Coordinator—EMT-A, I, or P, R.N., M.D., plus Certified Instructor by OH-EMS

ii. Instructor-Assistant—EMT-A, I or P plus Certified Instructor by OH-EMS

3. EMT-Intermediate

a. Required staff and fees are:

Medical Director	300
Instructor-Coordinator	2,500
Instructor-Assistant	2,000
Clinical Instructor	Voluntary
Field Internship Preceptors	Voluntary

b. Staff qualifications are:

i. Medical Director—M.D., plus Certified Advanced Instructor by OH-EMS

ii. Instructor-Coordinator—M.D., R.N. or EMT-P; plus Certified Advanced Instructor by OH- EMS

iii. Instructor-Assistant—M.D., R.N., or EMT-P; plus Certified Advanced Instructor by OH- EMS

iv. Clinical Instructor/Preceptor Field—M.D., or R.N.

v. Internship/Preceptor—R.N., or EMT-P

4. EMT-Intermediate Only Refresher (12 Hours)

a. Required staff and fees are:

Instructor-Coordinator	$200
Instructor-Assistant	$125

b. Staff qualifications are:

i. Instructor-Coordinator—M.D., R.N. or EMT-P

ii. Instructor-Assistant—R.N., EMT-P, or EMT-I

5. EMT-Paramedic

a. Required staff and fees are:

Medical Director	$ 1,500
Instructor-Coordinator	$10,000
Instructor	$ 6,500
Instructor-Assistant (paid at the following rates)	$ 3,000
M.D.	$30/hr.
R.N.	$20/hr.
EMP-T	$15/hr.
Clinical Instructor Preceptor	Voluntary
Field Internship/Preceptor	Voluntary

b. Staff qualifications are:

i. Medical Director—M.D., plus Advanced Instructor by OH-EMS

ii. Instructor-Coordinator—M.D., R.N., plus Advanced Instructor by OH-EMS

iii. Instructor—R.N.; plus Advanced Instructor by OH-EMS

iv. Instructor-Assistant—M.D., R.N., or EMT-P; preferably Advanced Instructor by OH-EMS.

6. Workshop Seminar

a. Required staff and fees are:

Medical Director	$ 40/hour
Registered Nurse	$ 25/hour
EMP-P	$ 15/hour
EMP-I	$12.50/hour
EMP-T-Basic	$ 10/hour
Attorney	$ 40/hour
Other	$ 15/hour

b. Staff qualifications are the credentials appropriate to the respective profession.

7. Practical Examination

a. Required staff and fees are:

Practical Stations Evaluator	$100
Make-up or Clerical Assistant	$ 50

b. Staff Qualifications are:

i. Practical Station Evaluator—must be certified at skill level for which examination is being administered.

8. For those positions requiring instructor certification by OH-EMS this requirement may be waived for the instructor for the first course in which he instructs. For any subsequent course the certification is required.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 39. Standards for Emergency Medical Technician Training

§3901. Standards for Emergency Medical Technician Training

A. The Emergency Medical Technician programs, Basic, Intermediate, and Paramedic must meet or exceed the current minimum course requirements of the United States Department of Transportation National Standard Curricula and the Department of Health and Human Resources, Office of Hospitals.

B. The Department of Health and Human Resources, Office of Hospitals adopts the program guidelines of the National Registry of Emergency Medical Technicians as the

minimum standards for the EMT-Basic, EMT-Intermediate, and the EMT-Paramedic training programs.

C. Certification for Emergency Medical Technician—Basic, Intermediate and Paramedic is contingent upon successful completion of the established criteria of the National Registry of Emergency Medical Technicians at the respective level. The Department of Health and Human Resources, Office of Hospitals will serve as the certifying agent for the Emergency Medical Technician—Basic and the Louisiana State Board of Medical Examiners shall serve as the certifying agent for the Intermediate and Paramedic.

D. The Emergency Medical Technician—Basic, Intermediate and Paramedic training program must incorporate medical involvement and supervision.

E. The Emergency Medical Technician—Basic, Intermediate and Paramedic training program must have as its lead instructor/coordinator an individual who has been certified by the Department of Health and Human Resources, Office of Hospitals to teach the particular course level involved. This requirement can be waived in the case of the first course taught by an instructor/coordinator.

F. The Emergency Medical Technician training program must be sponsored by either the Department of Health and Human Resources, Office of Hospitals, or accredited academic institution (college or university), a vocational-technical training institution certified by the Accrediting Commission of the National Association of Trade and Technical Schools approved by the Proprietory School Commission, and approved and/or operated by the Board of Education, or a hospital accredited by the Joint Commission on Accreditation of Hospitals.

G. The Department of Health and Human Resources, Office of Hospitals has established the student selection criteria as follows:

1. Ambulance
2. Provisional Ambulance
3. Law Enforcement
4. Part Time/Volunteer Personnel
5. Fire Safety
6. Health Care
7. Industrial Safety
8. U. S. Military Applicants
9. U. S. Government
10. All Other Applicants

H. There must be a signed agreement of sponsorship between the authorized agents of the sponsoring institution i.e., hospital and those agencies administering the EMB-Basic, Intermediate, and Paramedic programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Chapter 41. Establishment and Staffing

§4101. Rape Crisis Centers

A. Each state owned and operated hospital in the state shall establish, operate, and maintain a rape crisis center, such centers to be operated and administered from such funds as are provided for the operation and administration of the applicable hospitals.

B. Each rape crisis center shall have a rape counselor who shall be designated to be on call at all times to see to the needs of rape victims.

C. There shall be assigned to each rape crisis center a sufficient number of registered staff nurses to assure that a nurse is designated to be on call at all times for the rape center.

D. A physician on the staff of each hospital shall be designated to be on call to the rape crisis center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:923.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Hospitals, LR 13:246 (April 1987).

Subpart 7. Hospital Notifications

Chapter 43. Infectious Disease Notifications

§4301. Introduction

A. If, while treating or transporting an ill or injured patient to a hospital, an emergency medical technician, paramedic, firefighter, or other person who is employed by or voluntarily working with a firm, agency, or organization which provides emergency treatment or transportation comes into direct contact with a patient who is subsequently diagnosed as having a infections disease as listed below, the hospital receiving the patient shall notify the appropriate firm, agency, or organization which shall notify its emergency medical technician, paramedic, firefighter, emergency medical transportation service employer, or other person treating or transporting the patient of the individual's exposure to the infectious disease.

B. In accordance with the above, DHH defines hospital to mean any public or private health care facility which is primarily operated for the purposes of diagnosis, treatment or care of persons admitted for health care services. This definition expressly includes emergency rooms and outpatient clinics operated in connection with said health care facilities. In addition, R.S. 40:1099(B) requires to and by nursing homes.

C. The following infectious diseases are subject to notification and consultation procedures of this rule:

1. untreated pulmonary tuberculosis;

2. acute meningococcal meningitis;

3. acute hepatitis virus B infection (or diagnosed carriers of chronic hepatitis B);

4. human immunodeficiency virus (HIV) infection or acquired immune deficiency syndrome (AIDS).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1099.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, LR 14:26 (January 1988), amended by the Department of Health and Hospitals, LR 15:196 (March 1989).

§4302. Requirements

A. The following notification and consultation procedures shall be carried out in each hospital:

1. Each hospital shall maintain a registry or sign-in log which shall include the name, address and telephone number of the agency, firm, organization, and person(s) who provided emergency treatment and/or transportation of the patient, when the provider is someone other than an ambulance transportation service provider (transporting ambulance providers shall continue to use the existing ambulance transportation log). The log shall later be referred to in the event that it becomes necessary to identify and notify such providers of the exposure to a patient who is subsequently diagnosed and confirmed as having one of the above listed infectious diseases.

2. Each hospital shall post a visible sign to advise the public that Louisiana law requires the hospital to notify, within 48 hours after diagnosis confirmation, any person who has provided emergency treatment or transportation of a patient who is later diagnosed to have infectious diseases as listed in **§**4301 . In order to comply with this law, anyone transporting a patient into the hospital must register in the hospital log book with the name of the agency, firm, or organization with which he/she is affiliated. Transporting ambulance service providers, however, will continue to sign the existing ambulance log which is currently completed whenever a patient is transported by ambulance to the hospital.

3. The hospital's Infection Control Officer (ICO) or other administratively designated staff person shall be promptly notified of all cases involving confirmed diagnoses of the above listed infectious diseases. The ICO shall confidentially contact the listed firms, agencies, and organizations (which will in turn notify the individual) to advise of the exposure to a confirmed case of an infectious disease. The notification, which shall be done within 48 hours of confirmation of patient diagnosis, must include a statement that the transporting agency, firm, or organization contact a designated hospital staff person for necessary consultation. The hospital must document that the required notification and consultation, if held, has taken place.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1099.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, LR 14:26 (January 1988), amended by the Department of Health and Hospitals, LR 15:196 (March 1989).

Title 48
HEALTH AND HOSPITALS—GENERAL
Part XXV. Mergers, Acquisitions, and Re-Organization

Chapter 3. Nonprofit Hospital Acquisitions: Authorization for the Attorney General to Review Nonprofit Hospital Acquisitions

§301. Purpose

A. These rules are adopted in accordance with the public interest of assuring the continued existence of accessible, affordable health care facilities that are responsive to the needs of the communities in which they exist. In that regard, the state has a responsibility to protect the public interest in nonprofit hospitals by making certain that the charitable assets of those hospitals are managed prudently pursuant to the provisions of R.S. 40:2115.11 through 2115.22.

B. These rules are adopted to further Louisiana's goal of controlling health care costs and improving the quality of and access to health care for its citizens.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2115.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 24:1123 (June 1998).

§303. Definitions

A. As used within the rules:

Acquirer—any legal entity to which the nonprofit hospital plans to sell, merge, or otherwise contract, along with each affiliate, parent, and/or subsidiary which it directly or indirectly controls, manages, owns, or operates. The *acquirer* may be another nonprofit hospital.

Affiliate—any or all of the following: corporation; partnership; sole proprietorship; joint venture; trust; natural person; or any other entity, whether existing for commercial or noncommercial purposes, however organized, in which any person or entity owning, directly or indirectly or beneficially, 3 percent of the acquirer owns directly, or indirectly, or beneficially, 50 percent or more of the affiliates.

Attachment—each document or object sent or provided with any document or object, and includes each document or object sent with it, whether it be a letter, memorandum, contract, document or other writing or object.

Certified Mail—uninsured first class mail whose delivery is recorded by having the addressee sign for it.

Comment—a written document offering explanation, illustration, criticism, or personal opinion.

Days—consecutive calendar days.

Department—the Louisiana Department of Justice, Office of the Attorney General.

Director—the director of the Civil Division.

Documents or *Document*—all writing or any other record of any kind, including originals and each and every non-identical copy (if different from the original for any reason). *Document(s)* includes, but is not limited to:

a. correspondence, memoranda, notes, diaries, calendars, statistics, letters, telegrams, minutes, contracts, reports, studies, checks, statements, receipts, returns, summaries, pamphlets, books, and interoffice and intra office communications;

b. notations (of any sort) of conversations, telephone calls, meetings, and other communications;

c. bulletins, printed matter, computer printouts, computer generated output, teletypes, telefax, facsimiles, invoices, worksheets, drafts, alterations, modifications, changes, and amendments of any kind;

d. photographs, charts, maps, graphs, sketches, microfiche, microfilm, videotapes, video recordings, and motion pictures; and

e. any electronic or mechanical records or tapes, cassette, diskettes, audio recordings, computer hard drives and other means of storing information.

Expert—one who is knowledgeable in a specialized field, that knowledge being obtained from either education or personal experience. For example, any economist, accountant, financial advisor, investment banker, broker, valuation specialist, or other person who is consulted, relied upon, retained, or used by the nonprofit and/or acquirer.

Financial Statement—

a. any compilation or statement (audited, unaudited, or draft) of the nonprofit's financial position. *Financial statements* (regardless of precise terminology) include, but are not limited to:

i. tax returns;

ii. balance sheets;

iii. statements of income and expenses;

iv. statements of profit and loss;

v. statements of stockholders' equity; and

vi. statements of changes in financial position;

b. each and every financial statement should include each and every related footnote of the respective financial statement.

Foundation—a permanent fund established and maintained by contributions for charitable, educational, religious, or benevolent purposes.

Nonprofit Hospital or *Nonprofit Entity*—any, some, or all of the firms, companies, or entities which the notifying nonprofit hospital, any of its subsidiaries, affiliates (see *affiliate* definition), firms, companies or entities may control, manage, own or operate. The nonprofit should be the entity filing the notice with the attorney general.

Objection—a written document offered in opposition to the approval of an application which states the reason, grounds, or cause for expressing opposition.

Person—any natural person, public or private corporation (whether or not organized for profit), governmental entity, partnership, association, cooperative, joint venture, sole proprietorship, or other legal entity. With respect to the nonprofit and/or acquirer, the term *person* also includes any natural person acting formally or informally as an employee, officer, director, agent, attorney, or other representative of the nonprofit and/or acquirer.

Persons on Record—persons submitting written documentation to the director, by certified mail, stating objections, comments, or requests for notification of actions by the department involving a particular application. Persons on record status must be renewed by written request, sent by certified mail to the director, prior to December 31 of each calendar year.

Transaction or *Proposed Transaction*—the proposed sale, merger, or other agreement between the nonprofit hospital and the acquirer which resulted in the submission of the notice to the attorney general pursuant to R.S. 40:2115.11 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2115.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 24:1124 (June 1998).

§305. Notice

A. Nonprofit persons who are parties to a transaction shall give the attorney general at least 30 days notice prior to the anticipated closing of the intended transaction.

B. The written notice shall include all of the following information:

1. the names, addresses and telephone numbers of the parties to the intended transaction;

2. the names, addresses and telephone numbers of the attorneys or other persons who represent the parties in connection with the intended transaction;

3. a general summary of the intended transaction;

4. a general description of the assets involved in the intended transaction and the intended use of the assets after the closing of the intended transaction, including any change in the ownership of tangible or intangible assets;

5. a general summary of all collateral transactions that relate to the intended transaction, including the names, addresses and telephone numbers of the parties involved in the collateral transactions; and

6. the anticipated completion date of the intended transaction.

C. Giving notice shall comply with the following format.

1. The notice shall be in writing, which pages shall be numbered and printed on paper measuring 8½ inches by 11 inches. The margins shall not be less than 1 inch on all sides. Unless otherwise required, the notice shall be printed on white paper.

2. Notice shall be sent to the director by certified mail. The director shall receive notice at least 30 days prior to the proposed transaction.

3. Notice shall not be given by facsimile machine.

4. Notice which does not comply with these rules shall not be accepted and will be returned.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2115.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 24:1124 (June 1998).

§307. Filing of Applications and Additional Documents

A. Filing of Applications

1. Applications shall be filed by delivering an original and three copies to the director.

2. The filing date of a conforming application shall be the date the department determines the application to be a completed application.

3. No application shall be filed by facsimile machine.

4. Applications filed with the department become property of the state.

5. Applications shall be accompanied with the filing fee as determined by §309 in accordance with R.S. 40:2115.22.

6. The application must include the contents of application.

7. The application shall be submitted to the attorney general on the forms provided and include the information requested therein.

8. The department may at any time request any other supplemental or additional documentation, disclosures, information, etc., as it deems necessary to the evaluation. The applicant shall provide the information not later than 10 days after the date of the request.

9. The application must be in the following format.

a. Applications shall be submitted to the attorney general on the forms provided and in accordance with the instructions therein.

b. Trade secret information shall be printed on goldenrod colored paper to assist in identifying material exempt from the Louisiana Public Records Act.

c. Applications which do not comply with these rules shall not be accepted and will be returned to the applicant.

B. Forms

LOUISIANA ATTORNEY GENERAL'S APPLICATION REQUEST FOR INFORMATION FORM FOR CERTAIN NONPROFIT MERGERS, SALES, AND ACQUISITIONS

PLEASE CAREFULLY REVIEW THE INSTRUCTIONS AND DEFINITIONS FORM PRIOR TO COMPLETING THIS FORM

1. Name of Nonprofit to be Acquired: Identify each and every nonprofit entity or entities (hereinafter "nonprofit") which is the subject of an impending acquisition in accordance with R.S. 40:2115 et seq.

_____
_____
_____
_____
_____
_____
_____
_____

2. Contact Person for Nonprofit: Provide the full legal name, title, address, telephone and facsimile number for the contact person regarding this Form (this individual will also receive any requests for additional information for documents):

_____
_____
_____
_____
_____
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_____
_____

3. Directors and Officers: Identify by full legal name and title each and every director and officer of the nonprofit.

_____
_____
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_____

4. Corporate Documents of Nonprofit: Attach as Appendix A, all corporate documents relating to the nonprofit entity and selected entities filing this Request. Include corporate documents of all parents, subsidiaries, or affiliates of the nonprofit. For the purpose of this Request, "corporate documents" means the charter or articles of incorporation, bylaws, and any and all amendments to each corporate document.

5. Name of Acquirer: Identify the proposed acquirer of the nonprofit (hereinafter "acquirer") identified in Request #1. Include in your response the identity of any (a) parent, (b) subsidiary, and/or (c) affiliate of the acquirer.

_____
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6. Contact Person for Acquirer: Provide the full legal name, title, address, telephone, and facsimile number of the contact person for the acquirer.

_____
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_____

7. Corporate Documents of Acquirer: Attach as Appendix B copies of all corporate documents relating to the acquirer identified in Request #4.

8. Value of Nonprofit Assets: What is the aggregate approximate value of the nonprofit assets to be acquired in the proposed transaction?

9. Description of Proposed Transaction: Attach as Appendix C a detailed description of the proposed transaction, including a detailed explanation of what is to be acquired by the acquirer, what is to be retained by the nonprofit(s), and the resulting funds to be received by the nonprofit(s). This should also include an analysis of the purchase price, based upon the nonprofit's interpretation of the letter of intent or definitive contract. The analysis should begin with the nonprofit's balance sheet, should consider the impact of any fund balances and/or liabilities to be retained by the resulting foundation, and end with a resulting fund balance for the proposed foundation to be created. This analysis should include reasonable estimates for any proposed purchase price adjustments called for in the letter of intent or definitive agreement. The objective of this analysis is to enable the Office of the Attorney General to understand the pricing of the transaction and the capitalization of any resulting foundation.

10. Description of Negotiations of the Transaction: Attach as Appendix D a detailed description of all discussions and negotiations between nonprofit and acquirer resulting in the proposed transaction. This response should include, but not be limited to, a summary outline in date sequence of any and all meetings held with the following parties with respect to the proposed transaction:

(a)With the nonprofit's financial advisors or investment bankers related to the proposed transaction (including, but not limited to, management, committees of the board of directors or meetings of the full board);

(b) With prospective purchasers, networkers, merging partners of the nonprofit (or substantially all of the nonprofit), together with a brief summary of the results of such meetings;

(c)With the ultimate acquirer; and

(d) With other parties deemed significant to the transaction (including, but not limited to, outside experts or other consultants).

11. Closing Date: What is the expected date of closing of the proposed transaction?

12. Governmental Filings: Attach as Appendix E all filings with respect to the proposed transaction, including all amendments, appendices, and attachments, and each report or document provided to each federal, state, or local governmental entity regarding the proposed transaction. Include copies of forms to be provided to each such entity, the answer to information or questions on such forms, and each attachment submitted in connection therewith.

13. Meetings with Governmental Officials: Attach as Appendix F summaries of all meetings with federal, state, or local authorities regarding any filings or documents referenced in Request #12. Also, include each and

every document which memorializes or discusses any and all meetings or other communications with the United States Department of Justice, Federal Trade Commission, or any other state, federal or local governmental entity in connection with the proposed transaction.

14. Acquirer's Prior Acquisitions: Identify all prior acquisitions by the proposed acquirer with the last three (3) years, including the following information for each:

(a)Date of Acquisition;

(b)Entity Acquired;

(c)City/State;

(d)Brief Description;

(e)Purchase Price; and

(f) Form of Consideration.

15. Letters of Intent: Attach as Appendix G any and all drafts and final versions of any and all letters of intent, confidentiality agreements, or other documents initiating negotiations, contact, or discussion between the acquirer and nonprofit.

16. Contracts or Purchase Agreements: Attach as Appendix H any and all drafts and final versions of asset purchase agreements, contracts or agreements to purchase the nonprofit by the acquirer. Your response must also include any attachments, amendments, schedules, or appendices to such agreements.

17. Fairness Opinions: Attach as Appendix I any and all fairness opinions analyzing the proposed transaction along with any supplemental analysis prepared by the nonprofit or its experts. Include in your response the name of the company and the person(s) who prepared the opinion, their business telephone numbers and addresses, the agreement or engagement letter with such company or person, and background information regarding the company or person's qualifications.

18. Meeting Minutes and Other Information: Attach as Appendix J the following documents with respect to each meeting, whether regular, special, or otherwise, of the board of directors or board of trustees for each nonprofit or acquirer.

(a)Announcements and the persons to whom the announcements were sent;

(b) Agenda;

(c)Minutes and/or resolutions of the board of directors or board of trustees for each nonprofit entity or acquirer which reflect or discuss the proposed transaction, including those regarding the final vote;

(d) Each written report or document provided to the board or board members, including, but not limited to, each committee report and each expert's report;

(e)Each proposal or document referencing or regarding possible or actual sale, merger, acquisitions, or distribution of assets of any nonprofit entity;

(f) Each presentation to the board or any committee to the board; and

(g) Each attachment to (a) through (f).

19. Valuation Information: Attach as Appendix K each appraisal (with each attachment), evaluation (with each attachment), and similar document (with each attachment) concerning the valuation during the last three (3) fiscal years of the nonprofit entities, their assets, their properties, their worth as a going concern, their market value, or their price for sale. This Request shall include, but not be limited to, any appraisals of the common stock of any for-profit subsidiaries of the nonprofit, any appraisals involving property held by the nonprofit.

20. Information Regarding Other Offers: Attach as Appendix K each appraisal (with each attachment), evaluation (with each attachment), and similar document (with each attachment) concerning any negotiation, proposal, or sale either initiated or received by the nonprofit regarding a sale of all or substantially all of its assets, a merger, a joint venture, a combination, an arrangement, a partnership, an acquisition, an alliance, or a networking relationship, and the dollar value of such proposed transaction.

21. Mission Statement: Attach as Appendix M any and all mission statements of the nonprofit.

22. Press Releases and Related Information: Attach as Appendix N any and all press releases, newspaper articles, radio transcripts, audiotapes and videotapes of any television commercials or reports regarding the proposed transaction and any other offers identified in Request # 20.

23. Financial Records: Attach as Appendix O all of the following for the last six (6) fiscal years for both the nonprofit and acquirer, unless otherwise indicated:

(a)Audited and unaudited financial statements. Audits are sometimes presented in abbreviated form or in fuller form, with detailed supplements. Provide the most detailed form of your audit that is available;

(b)Consolidating statements (balance sheets and income statements for each fiscal year);

(c)Year-to-date internal financial statements for the most recent month-end available during the current year. Be sure that the statements are comparative (with the same period of the previous fiscal year), otherwise provide last year's internal financial statements for the corresponding period as well;

(d)If separate audited financial statements are prepared for any of your nonprofit members or affiliates, or any parent or subsidiary of the acquirer, please provide those audits, together with comparative year-to-date financial statements for each such member, affiliate, parent or subsidiary;

(e)For the nonprofit only, projected capital expenditure requirements for the next three (3) years, assuming the nonprofit continues to operate as it has been operating;

(f) Each balance sheet, profit and loss statement, statement of change in financial position of the nonprofit, any entity or company it controls, operates, manages, or is affiliated with and also the same information for the acquirer and any entity which you reasonably believe it owns, operates, manages, or controls;

(g) For the nonprofit only, a detailed schedule of operating expenses, unless already provided with the audits;

(h) For the nonprofit only, an analysis (aging) of accounts receivable by major category, of receivables as of the most recent month-end available, indicating the amounts ultimately considered collectable by the nonprofit;

(i) For the nonprofit only, management compensation (salary, bonus, other benefits) for the five (5) officers of the nonprofit receiving the greatest amount of compensation;

(j) Identify any material off-balance sheet assets or liabilities (i.e., any assets or liabilities not reflected on the most recent audited financial statements) and provide documentation concerning such assets or liabilities. Examples of such items would include a significant under-or over-funding in the pension plan or a current litigation judgment not reflected in the most recent audit;

(k) Identify any material contingent assets or liabilities, and the conditions that must occur for any such contingent assets to be realized or for any such contingent liabilities to be incurred; and

(l) Identify all accounting firms, including the name, address, and telephone number of the accountant(s) primarily responsible for accounting and auditing of the entities for the last six (6) years.

24. Foundation Issues:

(a)Attach as Appendix P the detailed written plan of the preservation, protection, and use of any and all proceeds from the dissolution of the nonprofit, or the sale to or merger with the acquirer. State and fully explain

whether any money, property, or proceeds resulting from the transaction referred to in your Notice or the operation of the foundation will benefit any director, officer or for-profit person or entity, directly or indirectly. The detailed plan shall include bylaws, a conflict of interest statement, a defined mission, the proposed investment policy, and granting procedures.

(b) Attach as Appendix Q proof that any asset purchase agreement or other contract, by whatever name, does not incorporate or place any restrictions which any for-profit entity may place on the use of charitable or nonprofit funds and any other funds or property, either now or in the future, by any foundation created or endowed to preserve, disburse, or protect the funds.

(c)Attach as Appendix R a report indicating, showing, explaining, and discussing the properties and assets, whether cash, securities, intangible property, and all other property (listing each encumbrance), available for charitable purposes before and after the transaction and showing or discussing what entity or person will control, manage, operate, deploy, and use the charitable or nonprofit properties or assets. Include in your response the full legal name, title, business address, and telephone number of the individual preparing said report.

25. Existing Foundations or Restricted Donations: Attach as Appendix S any and all documents reflecting any existing foundations or other restricted donations, including, but not limited to, trusts that are designated or intended to benefit the current nonprofit. Include a detailed statement setting forth your intention with regard to such restricted donations.

26. Conflict of Interest, Self-Interest, and Self-Dealing Issues:

(a)Attach as Appendix T an affidavit for each officer and director of the nonprofit.

(b) Attach as Appendix U any and all documents reflecting any possible conflict of interest, self-interest, or self-dealing of any board member, officer, or director in connection with the proposed transaction. Such documents shall include evidence of any disclosures or other curative measures taken by the board and any documents suggesting or referencingfinancial or employment incentives or inducements offered to any board member, director or officer.

(c)Attach as Appendix V each memorandum, report, letter, or other document suggesting or referencing any employment or position (actual or possible) with acquirer for any officer or director of the nonprofit after the transaction is completed, as well as any assets, funds, annuity, deferred compensation or other economic or tangible benefit to be provided, whether or not in exchange for services rendered or to be rendered to any nonprofit or acquirer.

27. Persons Involved in Decision Making of Planning: Attach as Appendix W a list of the full legal names, titles, addresses, and telephone numbers of each and every officer, director, representative, manager, executive, expert or other persons having substantial input, at any phase of decision making or planning, into the decision or plan for the proposed transaction.

28. Market Studies: Attach as Appendix X each market study (and attachments) done for or by a nonprofit, or otherwise received by a nonprofit. Include an analysis of the nonprofit's market share from the perspectives which are normally tracked by the nonprofit board.

29. Registered Agents for Service or Process: Identify the registered agent for service of process, including his or her complete address, for each nonprofit and for the acquirer.

For Nonprofit:

_____

_____

For Acquirer:

_____

_____

30. Litigation and Proceedings: Attach as Appendix Y copies of any and all complaints, pleadings, memoranda, court orders, settlements, liens or other security interests, and consent decrees filed in litigation in which the nonprofit and/or acquirer was or is a party.

Please include in your response any and all complaints, pleadings, memoranda, orders, settlements, opinions, notices of investigation (including subpoenas, civil investigative demands or other requests for information), of any state, federal, local government department, court, agency, or any other legal proceeding in which the nonprofit and/or acquirer was or is a party.

CERTIFICATION AND VERIFICATION
AFFIDAVIT OF THE NONPROFIT

To be completed by President or Chief Officer

This Requests for Information Form, together with any and all appendices and attachments thereto, was prepared and assembled under my supervision in accordance with the instructions and definitions issued by the Attorney General. Subject to the recognition that, where so indicated, reasonable estimates have been made because books and records do not provide the required data, the information is, to the best of my knowledge, true, correct, and complete. If copies were submitted in lieu of originals, the documents submitted are true and exact copies. I understand that my obligation to provide information pursuant to this Request shall be continuing in nature and shall forthwith notify the Attorney General, in writing, of any representations that have been made or that might have been made in accordance with this Request which need to be updated, corrected or modified. The copies also are authentic for the purposes of Louisiana law. If copies were submitted, I also agree to retain the originals under may care, custody, and control, and I will not destroy or alter the originals without express written consent of the Attorney General or his appointed designee.

I certify, upon personal knowledge, that the attached form has been completed with true and accurate information, **under penalty or perjury**.

STATE of _____ To be completed by Affiant:

Parish/County: _____

Affiant's Name: _____

Signature: _____ Title: _____

Date: _____ Address:

Sworn and subscribed before me _____

this ___ day of _____, _____
199____ _____

Telephone No.: _____

Notary Public Facsimile No.: _____

My Commission expires: _____

AFFIDAVIT OF OFFICERS AND DIRECTORS

STATE OF _____ SOCIAL SECURITY NO. _

PARISH/COUNTY OF _____

I, _____, after first being duly sworn, do hereby depose and, upon personal knowledge, state as follows:

1 .I am an officer/director (please circle appropriate response) of _____ (insert name of nonprofit).

2. I have been an officer/director (please circle appropriate response) since _____, 199_. Please identify any committees you have served on, the length of service on each committee, and any titles you have held on such committees.

_____
_____
_____
_____

3. My home address is _____
_____
_____

4. My business telephone number is _____. My business facsimile number is _____.

5. I do/do not (circle appropriate response) own stock or options and/or warrants to purchase stock in _____ (Insert name of acquirer) or any parent, subsidiary, or affiliated company.

6. _____ (insert "no one in my immediate family," or the name[s] of family member[s], own(s) stock or options and/or warrants to purchase stock in _____ (insert name of acquirer) or any parent, subsidiary, or affiliated company.

7. I am/am not (circle appropriate response) employed by _____ (insert name of acquirer) or any parent, subsidiary, or affiliate company.

8. _____ (insert " no one in my immediate family" or the name[s] of family member[s] is/are employed by _____ (insert name of acquirer) or any parent, subsidiary, or affiliated company.

9. I will/will not (circle correct response) receive any financial benefit from the sale/merger (circle correct response) of _____ (identify nonprofit to be acquired) to _____ (insert name of acquirer).

10. _____ (insert "no one in my immediate family," or the name[s] of family member[s] will receive any financial benefit from the sale/merger (circle correct response) of _____ (identify nonprofit to be acquired) _____ (insert name of acquirer).

11. I have/have not (circle appropriate response) been contacted or otherwise requested or been offered a position on the _____ (insert name of acquirer) board or any of its subsidiaries, affiliates, or parent companies, or otherwise been offered employment of any sort with _____ (insert name of acquirer) or any of its subsidiaries, affiliates or parent companies.

12. I am/am not compensated for my services as an officer/director (circle appropriate response) of _____ (insert name of nonprofit). If your response is that you are compensated, please state the amount of your compensation per year: _____.

13. Briefly describe your education background:

_____
_____
_____
_____
_____
_____

14. Briefly describe your business or work experience:

_____
_____
_____
_____
_____
_____

15. Explain the reasons why you voted to approve the transaction to merge/sell _____ (insert nonprofit's name) to _____ (insert name of acquirer).

_____
_____
_____
_____
_____
_____

16. Please briefly explain any information you had regarding valuation of _____ (insert nonprofit's name) and other options available to _____ (insert nonprofit's name) prior to approving the transaction referenced in Item 15.

_____
_____
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_____
_____
_____

17. I do/do not (circle appropriate response) plan to become a director or officer of the foundation or other nonprofit entity to be created from the assets resulting from the sale or merger of _____ (insert nonprofit's name) to _____ (insert name of acquirer). I will/will not (circle appropriate response) receive compensation for my service in such position. If your response is that you will be compensated, please state the amount of the compensation per year: _____

18. I do/do not (circle appropriate response) have any conflict of interest, self-interest, financial interest or other self-dealing with regard to the proposed transaction with _____ (insert name of acquirer). If your answer is yes, please explain such interest in detail.

_____
_____
_____
_____
_____
_____

I certify, upon personal knowledge, that the information in this affidavit is true, accurate, and complete, **under penalty of perjury**.

Affiant's
Signature: _____
Date: _____

Sworn and subscribed

before me this _____
day of _____,
199____

Notary Public

My Commission expires: _____

CERTIFICATION AND VERIFICATION
AFFIDAVIT OF THE ACQUIRER

In order to assist _____ (insert name of nonprofit), (insert name of acquirer) provided information used to complete the Request for Information Form by _____ (insert name of nonprofit). Attached as Exhibit A to this Affidavit are _____'s (insert name of acquirer) responses to the Request for Information Form, together with any and all appendices and attachments thereto. Exhibit A was prepared and assembled under my supervision in accordance with the instructions and definitions

and definitions issued by the Attorney General. Subject to the recognition that, where so indicated, reasonable estimates have been made because books and records do not provide the required data, the information is, to the best of my knowledge, true, correct, and complete. If copies were submitted in lieu of originals, the documents submitted are true and exact copies. I understand that my obligation to provide information pursuant to this Request shall be continuing in nature and shall forthwith notify the Attorney General, in writing, of any representations that have been or that might have been made in accordance with this Request which need to be updated, corrected or modified. The copies also are authentic for the purpose of Louisiana law. If copies were submitted, I also agree to retain the originals under my care, custody, and control, and I will not destroy or alter the originals without the express written consent of the Attorney General or his appointed designee.

I certify, upon personal knowledge, that the attached form has been completed with true and accurate information, **under penalty of perjury.**

STATE of _____ To be completed by Affiant:

Parish/County: _____

Affiant's Name: _____

Signature: _____ Title: _____

Date: _____ Address:

Sworn and subscribed before me _____

this ___ day of _____, _____
199____ _____

Telephone No.: _____

Notary Public Facsimile No.: _____

My Commission expires: _____

LOUISIANA ATTORNEY GENERAL'S
REQUEST FOR INFORMATION FORM FOR CERTAIN
NONPROFIT MERGERS, SALES, AND ACQUISITIONS

INSTRUCTIONS AND DEFINITIONS

1. All responses to the Request for Information Form must be typed or clearly printed in black ink. **You must use only the official forms**.

2. All documents and appendices must be provided in compliance with the following:

(a)one set of original documents and three (3) separate sets of legible and collated copies of all documents must be submitted;

(b) each appendix shall be submitted in a separate legal size folder clearly marked with the appendix number along with the name of your nonprofit entity and the date of the Attorney General's Request for Information, set forth in Instruction #9. *For example, Nonprofit Company X, Appendix A, July 1, 1996;* and

(c)each document must be consecutively numbered and labeled along with an abbreviation for your nonprofit entity. *For example, the first document of a submission by the Nonprofit Company X, would be labeled NCX0001.* These initials and numbers should appear in the lower right-hand corner or each document.

3. All amendments or late-filed documents or responses must be clearly labeled to indicate which Request or appendix folder the document should be placed in upon receipt by the State. Such documents must be submitted in compliance with all other instructions herein.

4. Unless otherwise indicated, documents to be produced pursuant to this Request for Information Form include each and every document prepared, sent, dated, received, in effect, or which otherwise came into existence during the last three (3) years through the date of the production of documents by the nonprofit pursuant to this Request. Responses to the Request must be supplemented, corrected, and updated until the close of the transaction. **The Attorney General, at his discretion, may require the production of additional documents.**

5. For each Request calling for the production of documents, produce each and every responsive document in the nonprofit and/or acquiring entity's care, possession, custody, or control, without regard to the physical location of those documents.

6. If the nonprofit and/or acquiring entity possesses no documents responsive to a paragraph of this Request, the nonprofit and/or acquirer must state this fact, specifying the paragraph(s) or subparagraph(s) concerned, in the response. If the nonprofit and/or acquirer must submit documents at a later date than that set forth in Instruction #9, the following procedure is required: the nonprofit and/or acquirer must state this fact, specify the paragraph(s) or subparagraph(s) concerned, identify the document(s) to be produced, and state the expected date of production.

7. If the nonprofit and/or entity asserts a privilege in response to a Request, the nonprofit and/or acquiring entity must state the priviledge, the basis of the priviledge, and identify the documents and Request to which the priviledge attaches.

8. Responses to Requests not requiring the production of documents should be typed or clearly printed in black on the Request for Information Form. If additional space is required, you should attach additional 8 ½" x 11" size pages, clearly noting at the top of the page to which Request the additional information is responsive and the identity of the nonprofit providing the information. *For example: Nonprofit Company X, Continuation to Request #3.*

9. This Request for Information is dated _____. The Attorney General must receive a complete response to this initial Request for Information Form, no later than _____ 199_. If you are unable to provide the information by the date set forth above, please contact,_____ , Assistant Attorney General, at _____ within twenty-four (24) hours to discuss an extension of the statutory fifteen (15) day period in order to extend the time period for you to respond to this Request. If you request an extension of the time period, you will be provided an Extension of the fifteen (15) Day Period Form, via facsimile transmission, which must be returned within twenty-four (24) hours of your discussion with the Assistant Attorney General or paralegal in order to extend the response period for the Request for Information. All extensions are subject to the final approval of the Attorney General.

10. All responses to this Request for Information shall be sent by United States Mail, hand delivered, or a nationally recognized express delivery service to the following individual.

Assistant Attorney General

11. The Request for Information Form is not complete or valid without the Certification and Verification Affidavits executed under oath in the presence of a notary and attached to the Request for Information Form.

12. Copies may be submitted in lieu of originals as long as the nonprofit and/or acquirer indicate(s) that the documents are copies, the location of the originals, and the reason for the substitution of copies. All originals must be returned as set forth in the Certification and Verification Affidavits. Additionally, the nonprofit and/or acquirer must sign the Certification of Verification Affidavit(s), agreeing that the documents are authentic for the purposes of Louisiana law.

13. All questions regarding these forms, the scope of any Request, and instruction, or any definitions shall be directed to the Assistant Attorney General listed in Instruction #10.

14. This Request for Information Packet should include all of the following forms:

Form: Instructions and Definitions

Form: Request for Information Form

Form: Certification and Verification Affidavit of the Nonprofit

Affidavit of Officers and Directors

Certification and Verification Affidavit of the Acquirer

Extension of the fifteen (15) Day Period

If your packet is missing any of the above listed forms, please contact by telephone the Assistant Attorney General listed in Instruction #10 immediately. Your response to the Request for Information Form is not complete until the Attorney General's Office has received *all* of the above listed forms, fully completed.

15. In the lower right-hand corner of each page of the Request for Information Form, type or print the name of the nonprofit in the space provided.

16. If two (2) or more nonprofits are merging, *each* nonprofit must complete the entire Request for Information Packet.

EXTENSION OF THE FIFTEEN (15) DAY PERIOD FORM FOR CERTAIN NONPROFITS

On behalf of _____ (insert name of nonprofit., I, _____ (insert your name), hereby waive any right _____ (insert name of nonprofit) may have for the Attorney General to review the proposed application transaction between _____ (insert name of acquirer) within a fifteen (15) day period. On behalf of _____ (insert name of nonprofit), I hereby agree and consent to an extension of the fifteen (15) day period within which the Louisiana Attorney General's Office may review the transaction. Specifically, I agree that the fifteen (15) day period will be extended an additional ____ (insert number) days Thus, the Attorney General's right to review _____'s (insert name of nonprofit) proposed transaction application shall not conclude before_____, 199 __. (insert date extension will conclude). _____ (insert name of nonprofit) hereby agrees not to conclude or finalize the transaction until after _____, 199_.

(insert day after extension will conclude). I further agree to submit all documents requested by the Attorney General in the Request for Information Packet no later than _____, 199_.

The reason for this request is as follows: _____

_____

_____

On behalf of _____ (insert name of nonprofit), I, _____ (insert your name), represent and warrant that I have authority to act for and bind _____ (insert name of nonprofit).

I also understand that this Request for an Extension is subject to the final approval of the Attorney General. I certify, that this extension form has been completed with true and information, **under penalty of perjury**.

STATE of _____ To be completed by Affiant:

County of _____

Affiant's Name: _____

Signature: _____ Title: _____

Date: _____ Address:

Sworn and subscribed before me _____

this ____ day of _____, _____

199____ _____

Phone No.: _____

Notary Public Facsimile No.: _____

My Commission expires: _____

C. Filing of Additional Documents

1. Format required for filing of additional documents shall be in accord with §307.A.9.

2. Documents relating to an application shall be filed by delivering an original and three copies to the director.

3. Additional documents to an application may be accepted by facsimile machine provided that the original and three copies thereof are received by the director no later than seven days after transmission of the facsimile.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2115.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 24:1125 (June 1998).

§309. Fees

A. Remittance of Fees

1. In accordance with R.S. 40:2115.22 fees shall be remitted with the application and reports required by R.S. 40:2115.19. Fees shall be reasonably related to the costs incurred by the department in considering the application, evaluating reports, and performing other necessary administrative duties.

2. Fees shall be remitted only by certified check, cashier's check, or bank money order, and made payable to the department.

3. The fee shall be due with the application. The fee shall be $50,000. If the actual cost incurred by the department is greater, the applicant shall pay any additional amounts due as instructed by the department.

4. The fee due with the filing of the report as required by R.S. 40:2115.19 shall be $15,000. If the actual cost incurred by the department is greater, the parties involved shall pay any additional amounts due as instructed by the department.

B. If it becomes necessary for the department to file suit to enforce any provision of applicable law, these rules, or any of the terms of an approved application, then applicants/parties shall be responsible for all costs associated with any such litigation, including, but not limited to all court costs and attorneys fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2115.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 24:1130 (June 1998).

§311. Notification of Pending Application and Public Hearing

A. In accordance with R.S. 40:2115.14:

1. within five working days of receipt of a completed application, the department shall notify all persons of record by first class United States mail of the filing of such application, and publish in the official journal of the parish where the hospital is located notice of the filing. The notice shall state the following:

a. that an application has been received;

b. the names of the parties to the agreement;

c. a description of the contents of the agreement; and

d. the date by which a person may submit comments about the application to the attorney general.

B. In accordance with R.S. 40:2115.15:

1. the attorney general shall during the course of review of the application hold a public hearing in which any person may file written comments and exhibits, or may appear and make a statement;

2. the hearing shall be held no later than 30 days after receipt of a completed application. At least 10 working days prior to the scheduled public hearing, the department shall publish in the official journal of the parish where the hospital is located the location, date and time of the public hearing to be held in Baton Rouge, Louisiana;

3. at the public hearing, all interested persons shall be allowed to present testimony, facts, or evidence related to the application and shall be permitted to ask questions. The department shall also receive comments regarding the transaction from any interested person; and

4. if requested by the department, persons required to appear and testify under oath, shall include, but not be limited to:

a. any expert or consultant retained by the applicant who was directly or indirectly involved in the preparation of any financial and/or economic analysis of the proposed transaction;

b. any independent expert or consultant retained by the department to review the proposed transaction regarding his or her finding and analysis; and

c. parties to the agreement, officers, and members of the governing boards of the facilities involved;

5. the department may require additional information or testimony from other persons, including but not limited to, members of the medical staff, nursing staff, contract employees, architects, engineers, other employees, or contractors of the facilities involved.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2115.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 24:1130 (June 1998).

§313. Application Review

A. In accordance with R.S. 40:2115.14:

1. the attorney general shall, within 15 days after the date an application is received, determine if the application is complete for the purposes of review. If the department determines that an application is unclear, incomplete, or contains an insufficient basis upon which to provide a decision, the application shall be returned to the applicant;

2. if the attorney general determines that an application is incomplete, he shall notify the applicant within 15 days after the date the application was received, stating the reasons for his determination of incompleteness with reference to the particular questions for which a deficiency is noted;

3. if an application is returned to the applicant and the applicant will be resubmitting the application for further review, the filing fee shall remain deposited; and

4. if an application is returned and the applicant elects not to resubmit an amended application, the department shall return the filing fee submitted with the application less costs associated with the review process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2115.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 24:1131 (June 1998).

§315. Final Decision

A. The attorney general shall review the completed application. Within 60 days after receipt of a completed application, the attorney general shall either:

1. approve the acquisition, with or without specific modifications; or

2. disapprove the acquisition.

B. Any approval shall be conditioned upon the periodic submission of specific data relating to cost, access, and quality, and to the extent feasible, identify objective standards of cost, access, and quality by which the success of the arrangement will be measured.

1. The final decision shall be in writing and be based upon findings of fact and conclusions of law supporting the decision.

2. The department may condition approval on a modification of all or part of the proposed arrangement.

3. A copy of the final decision shall be sent, by certified mail, to the applicant. All persons on record shall be provided notice of the decision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2115.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 24:1131 (June 1998).

§317. Reports and Ongoing Supervision of Certificates

A. In accordance with R.S. 40:2115.19, the parties to the agreement shall submit information and supporting data on an annual basis regarding the current status of the agreement, including information relative to the continued benefits, any disadvantages of the agreement, and sufficient information to evaluate whether any terms and conditions imposed by the department have been met or otherwise satisfied. Reports shall be due on or before the annual anniversary date of the approval. Parties are under a continuing obligation to provide the department with any change to the information contained in the application subsequent to the approval of the application. Such information shall be provided to the department in a timely fashion or within a reasonable time that such information is known to the parties. The attorney general may subpoena

information and documents reasonably necessary to assure compliance.

B. The information and supporting data that must be submitted to the department shall include, but not be limited to, the following:

1. an update of all the information required in the application;

2. any change in the geographic territory that is served by the health care equipment, facilities, personnel, or services which are subject of the agreement;

3. a detailed explanation of the actual effects of the agreement on each party, including any change in volume, market share, prices, and revenues;

4. a detailed explanation of how the agreement has affected the cost, access, and quality of services provided by each party; and

5. any additional information requested by the department.

C. Requested data shall be in the following format.

1. The page shall be numbered and printed on paper measuring 8 1/2 by 11 inches. The margins shall not be less than 1 inch on all sides. Unless otherwise required, all data shall be printed on white paper.

2. Trade secret information shall be designated and printed on goldenrod colored paper to assist identifying material exempt under the Louisiana Public Records Act.

D. The department may, at any time, require the submission of additional data or alter the time schedule for submission of information. The parties shall be notified by certified mail of any requirement for the submission of additional information or alteration of the time for submission of materials.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2115.11 et seq.
HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 24:1131 (June 1998).

§319. Revocation

A. If at any time, the attorney general receives information indicating that the acquiring person is not fulfilling the commitment to the affected community as provided for in R.S. 40:2115.18, the attorney general shall hold a hearing upon 10 days notice to the affected parties.

1. If after the hearing the attorney general determines that the information is true, it may petition the Louisiana Department of Health and Hospitals to revoke the license issued to the purchaser.

2. Any action for license revocation shall be conducted in accordance with the provisions of R.S. 40:2109 et seq., and the regulations promulgated thereunder.

B. Notwithstanding any other provision of this part any amendment or alteration to an approved cooperative, merger, or consolidation agreement and any material change in the operations or conduct of any party to a cooperative, merger, joint venture, or consolidation shall be considered a new agreement and shall not take effect or occur until the attorney general has approved the amendment, alteration, or change.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2115.11 et seq.
HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 24:1131 (June 1998).

Chapter 5. Certificates of Public Advantage

§501. Purpose

A. These rules are adopted in accordance with the public interest of controlling health care costs and improving the quality of and access to health care. In that regard, the state has a responsibility to protect the public interest through direct supervision and control over the implementation of cooperative agreements, mergers, joint ventures, and consolidations among health care facilities for which certificates of public advantage are granted pursuant to the provisions of R.S. 40:2254.1 through 2254.12.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2254.1 et seq.
HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 36:1255 (June 2010).

§503. Definitions

A. As used within the rules:

Affiliate—any or all of the following: corporation; partnership; sole proprietorship; joint venture; trust; natural person; or any other entity, whether existing for commercial or noncommercial purposes, however organized, in which any person or entity owning, directly or indirectly or beneficially, 3 percent of the health care facility owns directly, or indirectly, or beneficially, 50 percent or more of the affiliates.

Attachment—each document or object sent or provided with any document or object, and includes each document or object sent with it, whether it be a letter, memorandum, contract, document or other writing or object.

Certificate of Public Advantage or "*Certificate*"—a written certificate issued by the department as evidence of the department's intention that the implementation of a cooperative agreement, when actively supervised by the department, receives state action immunity from prosecution by the state or by any district attorney in the state as a violation of state or federal antitrust laws.

Certified Mail—uninsured first class mail whose delivery is recorded by having the addressee sign for it.

Comment—a written document offering explanation, illustration, criticism, or personal opinion.

Cooperative Agreement or "*Agreement*"—a written agreement between two or more health care facilities for the sharing, allocation, or referral of any one or more of the following:

a. patients;

b. personnel;

c. instructional programs;

d. emergency medical services;

e. support services and facilities;

f. medical, diagnostic, or laboratory facilities or procedures; or

g. other services customarily offered by health care facilities.

Days—consecutive calendar days.

Department—the Louisiana Department of Justice, Office of the Attorney General.

Director—the Director of the Civil Division.

Documents or *Document*—all writings or any other record of any kind, including originals and each and every nonidentical copy (if different from the original for any reason). Document(s) includes, but is not limited to:

a. correspondence, memoranda, notes, diaries, calendars, statistics, letters, telegrams, minutes, contracts, reports, studies, checks, statements, receipts, returns, summaries, pamphlets, books, and interoffice and intra office communications;

b. notations (of any sort) of conversations, telephone calls, meetings, and other communications;

c. bulletins, printed matter, computer printouts, computer generated output, teletypes, telefax, facsimiles, invoices, worksheets, drafts, alterations, modifications, changes, and amendments of any kind;

d. photographs, charts, maps, graphs, sketches, microfiche, microfilm, videotapes, video recordings, and motion pictures; and

e. any electronic or mechanical records or tapes, cassette, diskettes, audio recordings, computer hard drives and other means of storing information.

Expert—one who is knowledgeable in a specialized field, that knowledge being obtained from either education or personal experience. For example, any economist, accountant, financial advisor, investment banker, broker, valuation specialist, or other person who is consulted, relied upon, retained, or used by the health care facility.

Financial Statement—

a. any compilation or statement (audited, unaudited, or draft) of the health care facility's financial position. Financial statements (regardless of precise terminology) include, but are not limited to:

i. tax returns;

ii. balance sheets;

iii. statements of income and expenses;

iv. statements of profit and loss;

v. statements of stockholders' equity; and

vi. statements of changes in financial position.

b. each and every financial statement should include each and every related footnote of the respective financial statement.

Foundation—a permanent fund established and maintained by contributions for charitable, educational, religious, or benevolent purposes.

Health Care Facility—any facility or institution, whether public or private, that offers diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons.

Objection—a written document offered in opposition to the approval of an application which states the reason, grounds, or cause for expressing opposition.

Person—any natural person, public or private corporation (whether or not organized for profit), governmental entity, partnership, association, cooperative, joint venture, sole proprietorship, or other legal entity. With respect to the health care facility, the term person also includes any natural person acting formally or informally as an employee, officer, director, agent, attorney, or other representative of the health care facility.

Persons on *Record*—persons submitting written documentation to the director, by certified mail, stating objections, comments, or requests for notification of actions by the department involving a particular application. Persons on record status must be renewed by written request, sent by certified mail to the director, prior to December 31 of each calendar year.

Transaction or *Proposed Transaction* or *Agreement*—the proposed or executed cooperative, merger, joint venture, or consolidation agreement which resulted in the submission of the notice to the attorney general pursuant to R.S. 40:2254.1 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2254.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 36:1255 (June 2010).

§505. Notice

A. Health care facilities that are parties to a transaction shall give the attorney general at least 30 days written notice prior to the anticipated closing of the intended transaction. Depending on the parties or the transaction, the Attorney General, at his sole discretion, may allow a shorter notice period.

B. The written notice shall include all of the following information:

1. the names, addresses and telephone numbers of the parties to the intended transaction;

2. the names, addresses and telephone numbers of the attorneys or other persons who represent the parties in connection with the intended transaction;

3. a general description of the intended transaction and a description of the scope of the cooperation, merger,

joint venture, or consolidation contemplated by the agreement;

4 a general description of the assets involved in the intended transaction and the intended use of the assets after the closing of the intended transaction, including any change in the ownership of tangible or intangible assets;

5. a general summary of all collateral transactions that relate to the intended transaction, including the names, addresses and telephone numbers of the parties involved in the collateral transactions; and

6. the anticipated completion date of the intended transaction.

C. Giving notice shall comply with the following format.

1. The notice shall be in writing on numbered pages and printed on paper measuring 8 ½ inches by 11 inches. The margins shall not be less than 1 inch on all sides. Unless otherwise required, the notice shall be printed on white paper.

2. Notice shall be sent to the director by certified mail. The director shall receive notice at least 30 days prior to the proposed transaction.

3. Notice shall not be given by facsimile machine.

4. Any notice that does not comply with these rules shall not be accepted and will be returned.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2254.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 36:1256 (June 2010).

§507. Filing of Applications and Additional Documents

A. Filing of Applications

1. Applications shall be filed by delivering an original and three copies to the director.

2. The filing date of a conforming application shall be the date the department determines the application to be a completed application.

3. No application shall be filed by facsimile machine.

4. Applications filed with the department become property of the state.

5. Applications shall be accompanied with the filing fee as determined by §309 in accordance with R.S. 40:2254.12.

6. The application must include the contents of application.

7. The application shall be submitted to the attorney general on the forms provided and include the information requested therein.

8. The department may at any time request any other supplemental or additional documentation, disclosures, information, etc., as it deems necessary to the evaluation. The applicant shall provide the information not later than 10 days after the date of the request.

9. The application must be in the following format.

a. Applications shall be submitted to the attorney general on the forms provided and in accordance with the instructions therein.

b. Trade secret information should be printed on goldenrod colored paper to assist in identifying material that may be considered exempt from the Louisiana Public Records Act.

c. Applications that do not comply with these rules shall not be accepted and will be returned to the applicant.

B. Filing of Additional Documents

1. The format required for filing of additional documents shall be in accord with §307.A.9.

2. Documents relating to an application shall be filed by delivering an original and three copies to the director.

3. Additional documents to an application may be accepted by facsimile machine provided that the original and three copies thereof are received by the director no later than seven days after transmission of the facsimile.

C. Forms

LOUISIANA ATTORNEY GENERAL'S

Request for Information Form for Certain Cooperative Endeavor Agreements, Joint Ventures, Mergers and Consolidations among Health Care Facilities

INSTRUCTIONS AND DEFINITIONS

1. All responses to the Request for Information Form must be typed or clearly printed in black ink. You must use only the official forms.

2. All documents and appendices must be provided in compliance with the following:

(a) One set of original documents and three (3) separate sets of legible and collated copies of all documents must be submitted.

(b) With respect to the submission of appendices, each appendix shall be submitted in a separate legal size folder clearly marked with the appendix number along with the name of the entity or entities submitting the information and the date of the Attorney General's Request for Information, set forth in Instruction #9. *For example, Company X, Appendix A, July 1, 1996 or Company X and Company Y, Appendix A, July 1, 1996;* and

(c) Each document must be consecutively numbered and labeled along with an abbreviation for the entity or entities. *For example, the first document of a submission by Company X, would be labeled CX0001 and the first document of a joint submission of Company X and Company Y would be labeled CXY0001.* These initials and numbers should appear in the lower right-hand corner or each document.

3. All amendments or late-filed documents or responses must be clearly labeled to indicate which Request or appendix folder the document should be placed in upon receipt by the State. Such documents must be submitted in compliance with all other instructions herein.

4. Unless otherwise indicated, documents to be produced pursuant to this Request for Information Form include each and every document prepared, sent, dated, received, in effect, or which otherwise came into existence during the last three (3) years through the date of the production of documents pursuant to this Request. Responses to the Request must be supplemented, corrected, and updated until the close of the transaction. The Attorney General, at his discretion, may require the production of additional documents.

5. Unless otherwise approved by the Department, for each Request calling for the production of documents, produce each and every responsive document in each entity's care, possession, custody, or control, without regard to the physical location of those documents.

6. If an entity possesses no documents responsive to a paragraph of this Request, that entity must state this fact, specifying the paragraph(s) or subparagraph(s) concerned, in the response. If an entity must submit documents at a later date than that set forth in Instruction #9, the following procedure is required: the entity must state this fact, specify the paragraph(s) or subparagraph(s) concerned, identify the document(s) to be produced, and state the expected date of production.

7. If an entity asserts a privilege in response to a Request, that entity must state the privilege, the basis of the privilege, and identify the documents and Request to which the privilege attaches.

8. Responses to Requests not requiring the production of documents should be typed or clearly printed in black on the Request for Information Form. If additional space is required, you should attach additional 8 ½" x 11" size pages, clearly noting at the top of the page to which Request the additional information is responsive and the identity of the entity providing the information. *For example: Company X, Continuation to Request #3.*

9. All responses to this Request for Information shall be sent by United States Mail, hand delivered, or a nationally recognized express delivery service to the following individual.

Director, Civil Division
State of Louisiana
Department of Justice
Civil Division
1885 North Third Street, 6th Floor
Baton Rouge, Louisiana 70802
Post Office Box 94005
Baton Rouge, Louisiana 70804-9005

10. The Request for Information Form is not complete or valid without completed Certification and Verification Affidavits for each entity executed under oath in the presence of a notary and attached to the Request for Information Form.

11. Copies may be submitted in lieu of originals as long as the entity indicate(s) that the documents are copies, the location of the originals, and the reason for the substitution of copies. All originals must be returned as set forth in the Certification and

Verification Affidavits. Additionally, the entity must sign the Certification of Verification Affidavit(s), agreeing that the documents are authentic for the purposes of Louisiana law.

12. All questions regarding these forms, the scope of any Request, and instruction, or any definitions shall be directed to the Assistant Attorney General listed in Instruction #9.

13. This Request for Information Packet should include all of the following forms:

Form	Instructions and Definitions
Form	Request for Information Form
Form	Certification and Verification Affidavit

If your packet is missing any of the above listed forms, please contact the Assistant Attorney General listed in Instruction #9 immediately. Your response to the Request for Information Form is not complete until the Attorney General's Office has received all of the above listed forms, fully completed.

14. Each entity that is a party to the Agreement must complete the entire Request for Information Packet.

LOUISIANA ATTORNEY GENERAL'S APPLICATION

REQUEST FOR INFORMATION FORM

For Certain

COOPERATIVE ENDEAVOR AGREEMENTS, JOINT VENTURES, MERGERS AND CONSOLIDATIONS AMONG HEALTH CARE FACILITIES

PLEASE CAREFULLY REVIEW THE INSTRUCTIONS AND DEFINITIONS PRIOR TO COMPLETING THIS FORM

Note: If the information is not supplied under any of the following items, provide an explanation of why the item is not applicable to the transaction or the parties.

1. **Name of each Party**: Identify each entity which is a party to the cooperative endeavor agreement, joint venture, merger, or consolidation (hereinafter referred to collectively as "Agreement") in accordance with 40:2254.1, et seq., including the address of the principal business office of each party. Include in your response the identity of any (a) parent, (b) subsidiary, and/or (c) affiliate of each entity.

2. **Contact Person for each Party**: Provide the full legal name, title, address, telephone and facsimile number for the persons authorized to receive notices and communications with respect to the application.

3. **Directors and Officers**: Identify by full legal name and title each and every director and officer of each entity.

4. **Corporate Documents**: Attach as Appendix A, all corporate documents relating to each entity filing this Request. Include corporate documents of all parents, subsidiaries, or affiliates . For the purpose of this Request, "corporate documents" means the charter or articles of incorporation, bylaws, and any and all amendments to each corporate document.

5. **Description of Proposed Agreement**: Attach as Appendix B a detailed description of the proposed agreement, including:

(a) A list of any services or products that are the subject of the proposed agreement or transaction;

(b) A description of any consideration passing to any person under the agreement or transaction, including the amount, nature, source, and recipient;

(c) A description of each party's contribution of capital, equipment, labor, services, or other value to the transaction, if any;

(d) Identification of any other services or products that are reasonably likely to be affected by the proposed agreement or transaction;

(e) A description of the geographic territory involved in the proposed agreement or transaction;

(f) If the geographic territory described in item (e) is different from the territory in which the applicants have engaged in the type of business at issue over the last five years, a description of how and why the geographic territory differs;

(g) Identification of all products or services that a substantial share of consumers would consider substitutes for any service or product that is the subject of the proposed agreement or transaction;

(h) Identification of whether any services or products of the proposed agreement or transaction are currently being offered, capable of being offered, utilized, or capable of being utilized by other providers or purchasers in the geographic territory described in item (e);

(i) Identification of the steps necessary, under current market and regulatory conditions, for other parties to enter the territory described in item (e) and compete with the applicants;

(j) A detailed explanation of the projected effects, including expected volume, change in price, and increased revenue, of the agreement or transaction on each party's current businesses, both generally as well as the aspects of the business directly involved in the proposed agreement or transaction;

(k) Each entity's estimate of their respective present market shares and that of others affected by the proposed agreement or transaction, and projected market shares after implementation of the proposed agreement or transaction;

(l) Identification of business plans, reports, studies, or other documents that discuss each entity's projected performance in the market, business strategies, competitive analyses and financial projections, including any documents prepared in anticipation of the cooperative agreement, merger or consolidation, as well as those prepared prior to contemplation of the transaction;

(m) A description of each entity's performance goals, including quantitative standards for achieving the objectives of:

(1) lower health care costs; or

(2) higher quality health care or greater access to health care in Louisiana without any undue increase in health care costs.

(n) A description of how the anticipated efficiencies, cost savings and other benefits from the transaction will be passed on to the consumers of health care services;

(o) A description of the net efficiencies likely to result from the transaction, including an analysis of anticipated cost savings resulting from the transaction and the increased costs associated with the transaction;

(p) A statement of whether competition among health care providers or health care facilities will be reduced as a result of the proposed agreement or transaction; whether there will be adverse impact on quality, availability, or cost of health care; whether the projected levels of cost, access to health care, or quality of health care could be achieved in the existing market without the proposed agreement or transaction; and, for each of the above, an explanation of why or why not;

(q) A description of why the anticipated cost savings, efficiencies and other benefits from the transaction are not likely to result from existing competitive forces in the market; and

(r) If information is not supplied under any of the above items, an explanation of why the item is not applicable to the transaction or to the parties.

6. **Description of Negotiations of the Agreement**: Attach as Appendix C a detailed description of all discussions and negotiations between each entity resulting in the proposed Agreement. To the extent practicable, this response should include, but not be limited to, a summary outline in date sequence of any and all meetings held with the following parties with respect to the proposed transaction:

(a) With each entity's financial advisors or investment bankers related to the proposed Agreement (including, but not limited to, management, committees of the board of directors or meetings of the full board);

(b) With prospective networkers, merging partners of each entity, together with a brief summary of the results of such meetings; and

(c) With other parties deemed significant to the transaction (including, but not limited to, outside experts or other consultants).

7. **Closing Date**: What is the expected date of closing of the proposed Agreement? Attach as Appendix D a copy of any proposed Agreement.

8. **Governmental Filings**: Attach as Appendix E all filings with respect to the proposed Agreement, including all amendments, appendices, and attachments, and each report or document provided to each federal, state, or local governmental entity regarding the proposed Agreement. Include copies of forms to be provided to each such entity, the answer to information or questions on such forms, and each attachment submitted in connection therewith.

9. **Meetings with Governmental Officials**: Attach as Appendix F summaries of all meetings with federal, state, or local authorities regarding any filings or documents referenced in Request #8. Also, include each and every document which memorializes or discusses any and all meetings or other communications with the United States Department of Justice, Federal Trade Commission, or any other state, federal or local governmental entity in connection with the proposed transaction.

10. **Prior Agreements**: Identify all prior Agreements between the parties within the last three (3) years, including the following information for each:

(a) Date of Agreement;

(b) City/State;

(c) Brief Description.

11. **Letters of Intent**: Attach as Appendix G any and all drafts and final versions of any and all letters of intent, confidentiality agreements, or other documents initiating negotiations, contact, or discussion between the parties to the Agreement.

12. **Contracts or Purchase Agreements**: If any assets are passed to any Party under the Agreement, Attach as Appendix H any and all drafts and final versions of asset purchase agreements, contracts or agreements to transfer assets. Your response must also include any attachments, amendments, schedules, or appendices to such agreements.

13. **Fairness Opinions**: If any assets are passed to any Party under the Agreement, Attach as Appendix I any and all fairness opinions analyzing the proposed Agreement along with any supplemental analysis prepared by any entity or its experts. Include in your response the name of the company and the person(s) who prepared the opinion, their business telephone numbers and addresses, the agreement or engagement letter with such company or person, and background information regarding the company or person's qualifications.

14. **Meeting Minutes and Other Information**: Attach as Appendix J the following documents with respect each meeting during which the proposed Agreement was discussed, whether regular, special, or otherwise, of the board of directors or board of trustees for each entity.

(a) Announcements and the persons to whom the announcements were sent;

(b) Agenda;

(c) Minutes and/or resolutions of the board of directors or board of trustees for each entity which reflect or discuss the proposed Agreement, including those regarding the final vote;

(d) Each written report or document provided to the board or board members, including, but not limited to, each committee report and each expert's report;

(e) Each proposal or document referencing or regarding possible or actual Agreement;

(f) Each presentation to the board or any committee to the board; and

(g) Each attachment to (a) through (f).

15. **Valuation Information**: Attach as Appendix K each appraisal (with each attachment), evaluation (with each attachment), and similar document (with each attachment) concerning the financial performance of each party to the transaction for the preceding five years, their assets, their properties, their worth as a going concern, or their market value. This Request shall include, but not be limited to, any appraisals of the common stock of any entity, any appraisals involving property held by any entity.

16. **Information Regarding Other Offers**: Attach as Appendix L each appraisal (with each attachment), evaluation (with each attachment), and similar document (with each attachment) concerning any negotiation, or proposal either initiated or received by any entity regarding the proposed Agreement, and the dollar value of such proposed Agreement.

17. **Mission Statement**: Attach as Appendix M any and all mission statements of each entity.

18. **Press Releases and Related Information**: Attach as Appendix N any and all press releases, newspaper articles, radio transcripts, audiotapes and videotapes of any television commercials or reports regarding the proposed transaction and any other offers identified in Request # 16.

19. **Financial Records**: Attach as Appendix O all of the following for the last six (6) fiscal years for each entity, unless otherwise indicated:

(a) Audited and unaudited financial statements. Audits are sometimes presented in abbreviated form or in fuller form, with detailed supplements. Provide the most detailed form of your audit that is available.

(b) Consolidating statements (balance sheets and income statements for each fiscal year);

(c) Year-to-date internal financial statements for the most recent month-end available during the current year. Be sure that the statements are comparative (with the same period of the previous fiscal year), otherwise provide last year's internal financial statements for the corresponding period as well;

(d) If separate audited financial statements are prepared for any of your affiliates, or any parent or, please provide those audits, together with comparative year-to-date financial statements for each such member, affiliate, parent or subsidiary;

(e) Projected capital expenditure requirements for the next three (3) years;

(f) Each balance sheet, profit and loss statement, statement of change in financial position of each entity or company it controls, operates, manages, or is affiliated with and also the same information for the acquirer and any entity which you reasonably believe it owns, operates, manages, or controls;

(g) A detailed schedule of operating expenses, unless already provided with the audits;

(h) An analysis (aging) of accounts receivable by major category, of receivables as of the most recent month-end available, indicating the amounts ultimately considered collectable;

(i) Management compensation (salary, bonus, other benefits) for the five (5) officers receiving the greatest amount of compensation;

(j) Identify any material off-balance sheet assets or liabilities (i.e., any assets or liabilities not reflected on the most recent audited financial statements) and provide documentation concerning such assets or liabilities. Examples of such items would include a significant under-or over-funding in the pension plan or a current litigation judgment not reflected in the most recent audit;

(k) Identify any material contingent assets or liabilities, and the conditions that must occur for any such contingent assets to be realized or for any such contingent liabilities to be incurred; and

(l) Identify all accounting firms, including the name, address, and telephone number of the accountant(s) primarily responsible for accounting and auditing of the entities for the last six (6) years.

(m) If information is not supplied under any of the above items, explain why the information is not applicable to the transaction or parties.

20. **Conflict of Interest, Self-Interest, and Self-Dealing Issues**:

(a) Attach as Appendix P an affidavit for each officer and director of each entity.

(b) Attach as Appendix Q any and all documents reflecting any possible conflict of interest, self-interest, or self-dealing of any board member, officer, or director in connection with the proposed Agreement. Such documents shall include evidence of any disclosures or other curative measures taken by the board and any documents suggesting or referencing financial or employment incentives or inducements offered to any board member, director or officer.

21. **Persons Involved in Decision Making of Planning**: Attach as Appendix R a list of the full legal names, titles, addresses, and telephone numbers of each and every officer, director, representative, manager, executive, expert or other persons having substantial input, at any phase of decision making or planning, into the decision or plan for the proposed Agreement.

22. **Market Studies**: Attach as Appendix S each market study (and attachments) done for or by each entity, or otherwise received by each entity. Include an analysis of an entity's market share from the perspectives which are normally tracked by the entity's board.

23. **Registered Agents for Service or Process**: Identify the registered agent for service of process, including his or her complete address, for each entity.

CERTIFICATION AND VERIFICATION AFFIDAVIT

To be completed by President or Chief Executive Officer

This Request for Information Form, together with any and all appendices and attachments thereto, was prepared and assembled under my supervision in accordance with the instructions and definitions issued by the Attorney General. Subject to the recognition that, where so indicated, reasonable estimates have been made because books and records do not provide the required data, the information is, to the best of my knowledge, true, correct, and complete. If copies were submitted in lieu of originals, the documents submitted are true and exact copies. I understand that my obligation to provide information pursuant to this Request shall be continuing in nature and shall forthwith notify the Attorney General, in writing, of any representations that have been made or that might have been made in accordance with this Request which need to be updated, corrected or modified. The copies also are authentic for the purposes of Louisiana law. If copies were submitted, I also agree to retain the originals under may care, custody, and control, and I will not destroy or alter the originals without express written consent of the Attorney General or his appointed designee.

I certify, upon personal knowledge, that the attached form has been completed with true and accurate information, **under penalty or perjury.**

STATE of_____

Parish/County_____

Affiant's
Signature: _____ _____
Date: _____ _____

Sworn and subscribed before me this _____
day of 20_____

Notary Public _____

My Commission expires:
_____
_____

To be completed by Affiant:

Name _____

Title _____
Address:_____

Telephone No._____
Facsimile No._____

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2254.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 36:1256 (June 2010).

§509. Fees

A. Remittance of Fees

1. In accordance with R.S. 40:2254.12, fees shall be remitted with the application and reports as required by R.S. 40:2254.11. Fees shall be reasonably related to the costs incurred by the department in considering the application, evaluating reports, and performing other necessary administrative duties.

2. Fees shall be remitted only by certified check, cashier's check, or bank money order, and made payable to the department.

3. The application fee shall be $50,000 and shall be due with the application. If the actual cost incurred by the department is greater, the applicant shall pay any additional amounts due as instructed by the department.

4. The fee due with the filing of the report as required by R.S 40:2254.11 shall be $15,000. If the actual cost incurred by the department is greater, the parties involved shall pay any additional amounts due as instructed by the department.

B. If it becomes necessary for the department to file suit to enforce any provision of applicable law, these rules, or any of the terms of an approved application, then applicants/parties shall be responsible for all costs associated with any such litigation, including, but not limited to all court costs and attorneys fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2254.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 36:1263 (June 2010).

§511. Notification of Pending Application and Public Hearing

A. In accordance with R.S. 40:2254.4:

1. within five working days of receipt of a completed application, the department shall notify all persons of record by first class United States mail of the filing of such application, and publish in the official journal of the parish where the health care facilities are located notice of the filing. The notice shall state the following:

a. that an application has been received;

b. the names of the parties to the agreement;

c. a description of the contents of the agreement; and

d. the date by which a person may submit comments about the application to the attorney general.

B. In accordance with R.S. 40:2254.4:

1. the attorney general shall during the course of review of the application hold a public hearing in which any person may file written comments and exhibits, or may appear and make a statement;

2. the hearing shall be held no later than 30 days after receipt of a completed application. At least 10 working days prior to the scheduled public hearing, the department shall publish in the official journal of the parish where the hospital is located the location, date and time of the public hearing to be held in Baton Rouge, Louisiana;

3. at the public hearing, all interested persons shall be allowed to present testimony, facts, or evidence related to the application and shall be permitted to ask questions, The department shall also receive comments regarding the transaction from any interested person; and

4. if requested by the department, persons required to appear and testify under oath, shall include, but not be limited to:

a. any expert or consultant retained by the applicant who was directly or indirectly involved in the preparation of any analysis of the proposed transaction;

b. any independent expert or consultant retained by the department to review the proposed transaction regarding his or her finding and analysis; and

c. parties to the agreement, officers, and members of the governing boards of the facilities involved;

5. the department may require additional information or testimony from other persons, including but not limited to, members of the medical staff, nursing staff, contract employees, architects, engineers, other employees, or contractors of the facilities involved.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2254.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 36:1263 (June 2010).

§513. Application Review

A. In accordance with R.S. 40:2254.4:

1. the attorney general shall, within 15 days after the date an application is received, determine if the application is complete for the purposes of review. If the department determines that an application is unclear, incomplete, or contains an insufficient basis upon which to provide a decision, the application shall be returned to the applicant;

2. if the attorney general determines that an application is incomplete, he shall notify the applicant within 15 days after the date the application was received, stating the reasons for his determination of incompleteness with reference to the particular questions for which a deficiency is noted;

3. if an application is returned to the applicant and the applicant will be resubmitting the application for further review, the filing fee shall remain deposited; and

4. if an application is returned and the applicant elects not to resubmit an amended application, the department shall

return the filing fee submitted with the application less costs associated with the review process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2254.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 36:1263 (June 2010).

§515. Action by Department

A. The attorney general shall review the completed application. Within 90 days after receipt of a completed application or within one 90 day extension, the attorney general shall either:

1. approve the application, with or without specific modifications and issue a certificate; or

2. disapprove the application for a certificate.

B. Any approval shall be conditioned upon the periodic submission of specific data relating to cost, access, and quality, and to the extent feasible, identify objective standards of cost, access, and quality by which the success of the arrangement will be measured.

1. The department's decision shall be in writing and be based upon findings of fact and conclusions of law supporting the decision.

2. The department may condition approval on a modification of all or part of the proposed arrangement.

3. A copy of the department's decision shall be sent, by certified mail, to the applicant. All persons on record shall be provided notice of the decision.

4. If the department does not issue a decision within 90 days after the receipt of a completed application or within one 90 day extension, the application shall be considered denied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2254.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 36:1263 (June 2010).

§516. Reconsideration

A. If the department denies an application and refuses to issue a certificate, a party to the agreement may request that the department reconsider its decision. The department shall then reconsider its decision in accordance with the provisions of R.S. 40:2254.5.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2254.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 36:1264 (June 2010).

§517. Reports and Ongoing Supervision of Certificates

A. In accordance with R.S. 40:2254.11, the parties to the agreement shall submit information and supporting data on an annual basis regarding the current status of the agreement, including information relative to the continued benefits, any disadvantages of the agreement, and sufficient information to evaluate whether any terms and conditions imposed by the department have been met or otherwise satisfied. Reports shall be due on or before the annual anniversary date of the approval. Parties are under a continuing obligation to provide the department with any change to the information contained in the application subsequent to the issuance of a certificate of public advantage. Such information shall be provided to the department in a timely fashion or within a reasonable time that such information is known to the parties. The attorney general may subpoena information and documents reasonably necessary to assure compliance.

B. The information and supporting data that must be submitted to the department shall include, but not be limited to, the following:

1. an update of all the information required in the application;

2. any change in the geographic territory that is served by the health care equipment, facilities, personnel, or services which are subject of the agreement;

3. a detailed explanation of the actual effects of the agreement on each party, including any change in volume, market share, prices, and revenues;

4. a detailed explanation of how the agreement has affected the cost, access, and quality of services provided by each party; and

5. any additional information requested by the department.

C. Requested data shall be in the following format.

1. The page shall be numbered and printed on paper measuring 8 1/2 by 11 inches. The margins shall not be less than 1 inch on all sides. Unless otherwise required, all data shall be printed on white paper.

2. Trade secret information shall be designated and printed on goldenrod colored paper to assist in identifying material that may be considered exempt under the Louisiana Public Records Act.

D. The department may, at any time, require the submission of additional data or alter the time schedule for submission of information. The parties shall be notified by certified mail of any requirement for the submission of additional information or alteration of the time for submission of materials.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2254.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 36:1264 (June 2010).

§519. Revocation

A. If at any time, the attorney general receives information indicating that agreement is not is not resulting in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement as provided for in R.S. 40:2254.6, the attorney general shall hold a hearing upon 120 days notice to the affected parties. Any action for certificate revocation shall be conducted in accordance with the provisions of RS. 40:2254.6.

B. Notwithstanding any other provision of this Part, any amendment or alteration to an approved cooperative, merger, or consolidation agreement and any material change in the operations or conduct of any party to a cooperative, merger, joint venture, or consolidation shall be considered a new agreement and shall not take effect or occur until the attorney general has approved the amendment, alteration, or change.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2254.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Justice, Office of the Attorney General, LR 36:1264 (June 2010).