Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

July 13, 2011

The Honorable Joel T. Chaisson, II, President
Louisiana State Senate
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

The Honorable Jim Tucker, Speaker
Louisiana State House of Representatives
P.O. Box 94062, Capitol Station
Baton Rouge, LA 70804-9062

Dear President Chaisson and Speaker Tucker:

In response to Senate Concurrent Resolution No. 77 (SCR 77) of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. SCR 77 requested that DHH and the Department of Education (DOE) collaborate to examine the adequacy of current practices for ensuring the preventative health and well-being of adolescents in Louisiana and submit a report to the legislature of its findings.

Louisiana has some of the worst health rankings in the nation for adolescents. Adolescence is a period of significant physical, intellectual, and emotional growth, making it a critical time for providing optimal health support and services. DHH and DOE are the two primary public providers of health services to adolescents in Louisiana. Both agencies are committed to strengthening and improving services and current practices to ensure the health and well-being of adolescents in Louisiana. To that end, in the enclosed report, both DHH and DOE recommend a number of strategies to improve health outcomes and increase capacity for health care for adolescents. Our young people deserve the best health care that we can give them.

Thank you for giving us the opportunity to present this report to you. Kathy Kliebert, DHH's deputy secretary, is available to discuss the report with you should you have any questions or comments. Please feel free to contact her at (225) 342-7092 with any questions or comments that you may have.

Sincerely,

Bruce D. Greenstein
Secretary

Enclosures

Cc: The Honorable Members of the House Health and Welfare Committee
The Honorable Members of the Senate Health and Welfare Committee
David R. Poynter Legislative Research Library

DEPARTMENT OF HEALTH AND HOSPITALS

ADEQUACY AND AVAILABILITY OF PREVENTIVE HEALTH SERVICES FOR ADOLESCENTS IN LOUISIANA

REPORT PREPARED IN RESPONSE TO SCR 77 OF THE 2009 REGULAR SESSION

JULY 2011

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Executive Summary

Louisiana has some of the worst health rankings in the nation for adolescents. According to the 2010 National Kids Count Data Book, Louisiana ranks 49th for "Indicators of Child Well-Being" in the United States. Factors contributing to Louisiana's poor ranking relate to the high percentage of low birth-weight infants, high infant mortality rate, high percentage of children living in families where no parent has full time year-round employment, high percentage of children in single-parent families, high percentage of children living in poverty, and high percentage of teens who drop out of high school. Louisiana ranks 47th in teen deaths; 44th for teen birth rate; and 47th for the percentage of teens that are high school dropouts. Adolescents often engage in behaviors that jeopardize not only their current state of health, but their health for years to come.

Adolescence is a period of significant physical, intellectual, and emotional growth, making it a critical time for ensuring optimal health supervision and other supports to promote health and development. Programs to support adolescent health must address physical, mental, emotional, and social well-being. To this end, the Centers for Disease Control and Prevention (CDC) developed and implemented the Coordinated School Health Program (CSHP) model in the late 1980s. CSHP consists of eight components: Health Education; Physical Education; Health Services; Nutrition Services; Counseling, Psychological, and Social Services; Healthy School Environment; Health Promotion for Staff; and Family/Community Involvement. This model provides comprehensive health services in collaboration with schools and recognizes the importance of holistic care as critical to improving academic performance.

The Louisiana Department of Education's (LDOE) school health services and the Department of Health and Hospitals' (DHH) Adolescent School Health Program (ASHP) are the two primary public providers of health services to adolescents in Louisiana. LDOE offers a variety of direct health care through school nursing services and preventive health programming. ASHP supports 65 School Based Health Centers (SBHCs) statewide that provide convenient access to comprehensive primary and preventive physical and behavioral health care for children and adolescents who might otherwise have limited or no access to health care.

However, it is recognized that there are gaps and capacity issues in the current system of care. In an effort to address these gaps, the following are offered as key recommendations:

- Implement and expand the CSHP model in all Louisiana schools.
- Establish a task force to identify new and existing funding that can support CSHP.
- Preserve flexibility in the approaches that school districts utilize to ensure student access to health services as defined in the CSHP model and mandate coordination with existing primary care networks and resources.
- Coordinate efforts to expand health services in schools with the implementation of Medicaid Managed Care/Coordinated Care Networks (CCNs).
- Enforce implementation and monitoring of existing mandated policies and programs, including the enforcement of 30 minutes of quality moderate to vigorous physical activity per day in grades K-8.

ADEQUACY AND AVAILABILITY OF PREVENTIVE HEALTH SERVICES FOR ADOLESCENTS IN LOUISIANA

In 2009, the Senate passed Concurrent Resolution Number 77, which urged the Department of Health and Hospitals (DHH) to collaborate with the Department of Education (LDOE) to examine the adequacy of current practices for ensuring the preventive health and well-being of adolescents in Louisiana. Over the course of the last year, DHH and LDOE gathered relevant information from their respective programs as well as from other state and community programs. The report below is the product of their collaborative efforts.

Critical Adolescent Health Issues in Louisiana

Adolescent morbidity

The major causes of morbidity (illnesses) and mortality (death) in the adolescent population are unintentional and intentional injury, tobacco use, substance abuse, reproductive health, mental health, chronic disease and access to care (Williams, 2002).

According to the 2010 Kids Count Data Book, Louisiana ranks 49th for "Indicators of Child Well-Being" in the United States (The Annie E. Casey Foundation). Factors contributing to Louisiana's poor ranking relate to high percentage of low birth-weight infants, high infant mortality rate, high percentage of children living in families where no parent has full time year-round employment, high percentage of children living in poverty, high percentage of children in single-parent families, and high percentage of teens who are high school dropouts. Specifically, Louisiana ranks 47th for teen death rate; 44th for teen birth rate; and 47th for percent of teens not in school and not high school graduates (ages 16 to 19) (2010 Kids Count Data Book).

Adolescent utilization of health care services

Based on data from a 2007 study, the 1994-2003 National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey examined health care utilization across an age spectrum of adolescents 11 to 21 years old. In 2000, adolescents comprised 15.7 percent of the U.S. population, but only accounted for 9.1 percent of all outpatient visits in the U.S. from 1994 to 2003. The study found that most outpatient visits occurred for adolescents 14 years or younger, with fewer visits for those older than 14 years (Rand, Shone, et. al.). Only nine percent of all adolescent visits were for preventive care. Early adolescents (11 to 14 years old) had three times more preventive visits than late adolescents. Pediatricians were more likely to see adolescents who were younger, male, black, and urban. Late adolescent females (18 to 21 years old) had the most overall visits, 36 percent of which were to obstetrician-gynecologists. Adolescent males had fewer health care visits at older ages, with a sharp decline in visits after the age of 16. Many adolescents lack comprehensive care. Results varied across data sets, but the data generally showed that black adolescents receive less primary care than white adolescents, and one sixth to one third of all adolescents do not see a physician within a one year period.

Preventive health services

Progress has been made in the delivery of preventive health services to Louisiana adolescents. Louisiana Medicaid-eligible children ages 15 to 18 years who received at least one initial or periodic screen increased from 52 percent in state fiscal year 2005 to 67 percent in state fiscal year 2009 and from 52 percent to 72 percent for ages 10 to 14 years. According to the 2007 National Survey of Children's Health (NSCH) report, a greater number of Louisiana children received a preventive medical care visit in the past year compared to 2003 data. (88.6 percent in 2007; 72.2 percent in 2003) (NSCH, Louisiana 2007 and 2003 Results Comparison).

The American Academy of Pediatrics (AAP) believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them. These characteristics define the "medical home." It appears some significant improvements were gained in Louisiana in the percent of children ages 12-17 years who received one or more preventive medical care visists in 2007 (85%) than in 2003 (65.5%) (DHH OPH Maternal and Child Health Program, 2010 Needs Assessment). However, only 49.1 percent of children ages 12-17 years received health care that meets the AAP definition of medical home in 2007 compared to 65.8 percent in 2003 (DHH OPH Maternal and Child Health Program, 2010 Needs Assessment).

While not all adolescents receive the recommended course of immunizations in Louisiana, estimated immunization coverage for Louisiana adolescents ages 13 to 17 years was at or above the national average for Tetanus/Diphtheria/Pertussis/Adult Tetanus and Diphtheria (TDaP/TD), Meningococcal Vaccine (MCV4), and Measles/Mumps/Rubella (MMR) (2008). Louisiana adolescents were just below the national average for coverage for Varicella Vaccine (VAR), hepatitis B and Human Papilloma Virus (DHH OPH Maternal and Child Health Program, 2010 Needs Assessment).

Teen births

Nationally, the rate of birth among teens 15 to 17 years of age decreased from 1991 to 2005, with a slight upward turn reported in 2006. In Louisiana, there has also been a decrease in the rate of teen births age 15 to 17 years, from 34.8 per 1,000 female teens in 2000, to 26.8 per 1,000 in 2005, with an increase to 29.5 per 1,000 in 2006. In 2007, 13.8 percent of all Louisiana resident births were to teens (DHH OPH Maternal and Child Health Program, 2010 Needs Assessment).

Sexually transmitted diseases

Gonorrhea and chlamydia are more prevalent among adolescents and young adults than other age groups. Of all reported Louisiana gonorrhea cases, 29.6 percent occurred among 15-19 year olds and 35.4 percent occurred among 20 to 24 year olds. Of all reported Louisiana chlamydia cases, 37.7 percent occurred in the 15 to 19 year age group, and 39.5 percent among 20-24 year olds (Louisiana DHH, OPH, Sexually Transmitted Disease (STD) Program).

Behavioral health and substance abuse

According to the 2008 Caring Communities Youth Survey (CCYS), alcohol is the most commonly used substance among adolescents in Louisiana. The average age for initiation of alcohol use was 12.5 years. Cigarettes were the second most commonly used substance, with 12.1 years as the average age of initiation. Approximately 26.8 percent of 6th, 8th, 10th, and 12th graders surveyed stated that they had used alcohol and 10.7 percent had smoked cigarettes at least once in the past month (DHH OPH Maternal and Child Health Program, 2010 Needs Assessment).

The 2008 CCYS also reports that statewide, 8.5 percent of 6th graders, 12.9 percent of 8th graders, 13.3 percent of 10th graders and 10.2 percent of 12th graders in Louisiana seriously considered attempting suicide in the past 12 months. In 2008, 2.7 percent of 6th graders, 4.3 percent of 8th graders, 3.7 percent of 10th graders, and 2.5 percent of 12th graders reported a high rate of depressive symptoms. Rates of moderate depressive symptoms were 79.2 percent for 6th graders, 75.5 percent for 8th graders, 75.4 percent for 10th graders, and 72.1 percent for 12th graders (Louisiana CCYS Survey Results for 2008). According to the 2007 NSCH report for Louisiana, only 55.3 percent of children age two to 17 years who reported behavioral health problems requiring counseling actually received counseling compared to the national average of 60 percent.

Family system issues

The rate of child abuse and neglect is used as an indicator of the breakdown in the parent/child family system. Cases of child abuse and neglect are reported through the Louisiana Department of Children and Family Services, Office of Community Services. Rates of child abuse and neglect decreased from 9.3 per 1,000 in the population under 18 year olds in 2006 to 9.2 per 1,000 in 2008 (DHH, OPH, MCH Program, 2010 Needs Assessment). Absenteeism and children's participation in activities outside of school setting are also indicators of a breakdown in the parent/child and family system. In 2007, the percentage of children age six to 17 that missed 11 or more days of school in the previous year was 6.8 percent compared to 5.3 percent in 2003. In 2007, 75 percent of children age six to 17 participated in activities outside of school compared to 80.6 percent in 2003 (Louisiana DHH, OPH, MCH Program, 2010 Needs Assessment).

Oral health

Children from low-income families who are Medicaid-eligible have more untreated dental caries than children from higher income families. These children suffer from dental disease at a rate almost five times greater than their more affluent counterparts (GAO, *Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but More Can Be Done*).

There are many factors that contribute to poor oral health, including access to fluoridated water, access to dental care, and poverty. Only 41 percent of Louisiana residents receive the benefits of fluoridated water, which is one of the most effective, safe, and economical ways to provide caries prevention to the population. Of the seven urban population centers, only three have fluoridated water. Access to dental care is challenging due to a large rural population with few Medicaid dental providers. In Louisiana, 56 parishes (87.5 percent of the state) are designated as Dental Health Professional Shortage Areas with the state, having on average, 40 percent less dentists and 42

percent less dental hygienists than other states (*Louisiana Health Professional Shortage Area (HPSA) Designations)* (Louisiana DHH, OPH, MCH Program, 2010 Needs Assessment).

Nutrition

During the 2007-2008 school year, height and weight measures were taken on approximately 12,000 children (two to 19 years old) seen in School Based Health Centers in Louisiana. Results revealed 46.5 percent are considered overweight or obese. Also, in 2007, Louisiana had the 7th highest rate of overweight youths (ages 10 to 17) in the nation (Louisiana DHH, OPH, MCH Program, 2010 Needs Assessment). On the 2009 Louisiana Report Card on Physical Activity and Health for Children and Youth, Louisiana was graded D overall and F in the category of Overweight/Obesity. The Report Card states that one third of Louisiana youth are overweight or obese (Louisiana's Report Card on Physical Activity & Health for Children & Youth, 2009).

Adolescent mortality

The top three leading causes of death for adolescents in Louisiana from 2005 to 2007 were unintentional injury (44% of deaths, rate = 41.8 per 100,000), intentional injury/homicide (30% of deaths, rate = 28.4/100,000), and diseases of the circulatory system (4% rate = 4.2/100,000). Injury data show that among children ages one to 14 years, external causes of mortality were the leading causes of death from 2002 to 2007. In this category, the primary causes of mortality were motor vehicle accidents, accidental suffocation, accidental drowning and accidents caused by exposure to smoke, fire and flames. While death rates for each of these causes of death declined from 2005 to 2007 when compared to the 2002 to 2004 time period, adolescent mortality rates remain well above 2006 U.S. averages (DHH, OPH, MCH Program, 2010 Needs Assessment).

Key Components of Coordinated School Health Programs

Adolescence is a period of significant physical, intellectual, and emotional growth and a critical time for ensuring optimal health supervision and other supports to promote health and development. As described in the preceding section, adolescents often engage in behaviors that jeopardize not only their current state of health, but also their health for years to come. Programs to support adolescent health must address physical, mental, emotional, and social well-being. To this end, the Centers for Disease Control and Prevention (CDC) developed the Coordinated School Health Program (CSHP) model in the late 1980s. This model provides comprehensive health services in collaboration with schools and recognizes the importance of holistic care as critical to improving academic performance. When students are healthy and fit, they are more receptive to learning and achieving success in all areas of their lives.

In Table 1 are brief descriptions of the eight components of CDC's CSHP model:

Table 1:	Eight Component Model
Health Education	A planned, age appropriate, K-12 curriculum that addresses the physical, mental, emotional and social dimensions of health. The curriculum is designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors. The comprehensive health education curriculum includes a variety of topics such as personal health, family health, community health, consumer health, environmental health, sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, and substance use and abuse.
Physical Education	A planned, sequential K-12 curriculum that provides cognitive content and learning experiences through a variety of activities such as basic movement skills; physical fitness; rhythms and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics. Quality physical education should promote activities and sports that students enjoy and can pursue throughout their lives.
Health Services	Services provided for students to appraise, protect, and promote health. These services are designed to promote appropriate use of primary care services and ensure access to or referral to primary health care, prevent and control communicable disease and other health problems, provide emergency care for illness or injury, promote and provide safe and sanitary conditions in a school environment, and provide educational and counseling opportunities for promoting and maintaining individual, family, and community health.
Nutrition Services	Access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students. School nutrition programs reflect the U.S. Dietary Guidelines for Americans and other criteria to promote healthy eating. Additionally, nutrition standards are set for foods offered or sold on campus throughout the school day.
Counseling and Psychological Services	Services provided to improve students' mental, emotional, and social health. These services may include individual and group assessments, interventions, and referrals.
Healthy School Environment	The physical surroundings and the psychosocial climate and culture of a school are important for student success. Factors that influence the physical environment include the school building and the area surrounding it, any biological or chemical agents that are detrimental to health, and physical conditions such as temperature, noise, and lighting.
Health Promotion for Staff	Opportunities for school staff to improve their health through activities such as health assessments, health education and health-related fitness activities. These opportunities encourage school staff to pursue a healthy lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the school's overall coordinated health program. This personal commitment also creates positive role modeling for students.
Family and Community Involvement	An integrated school, parent, and community approach for enhancing the health and well-being of students. School health advisory councils, coalitions, and broadly based constituencies for school health can help support school health program efforts. Schools actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students.

The above descriptions were adapted from multiple sources including:

- Allensworth DD, Kolbe LJ. The comprehensive school health program: exploring an expanded concept. *Journal of School Health* 1987;57(10): 409–12.
- Institute of Medicine. *Schools and Health: Our Nation's Investment.* Washington, DC: National Academy Press. 1997.
- Marx E, Wooley SF, Northrop D. "Health Is Academic: A Guide To Coordinated School Health Programs." Teachers College Press, 1998.

The CDC stresses that schools by themselves cannot and should not be expected to address the health and social problems of their students. Success is dependent on the involvement of families, health care systems, media, religious organizations, community organizations and local, state and federal partners. However, schools can provide a critical facility in which these entities might work together to improve and maintain the health and well-being of young people.

Current Capacity to Provide Adolescent Health Services in Louisiana Schools

General availability of primary care services

According to Louisiana DHH, OPH, Bureau of Primary Care and Rural Health (BPCRH), every parish has at least one Health Provider Shortage Area (HPSA) designation (2010). HPSA designations are defined by DHH as areas that lack access to primary care providers, i.e., family practice, OB/GYN, pediatrics, internal medicine, and/or general practice, dental providers, and/or mental health providers. Of Louisiana's 64 parishes, there are 42 primary care/dental/mental health HPSAs, 60 primary care HPSAs, 52 mental health HPSAs, and 56 dental HPSAs. In addition, approximately 40 percent of Louisiana medical school graduates and physicians completing graduate medical education are leaving Louisiana for residency programs and practice opportunities in other states. Therefore, access to care for adolescents, as for the population in general, has many challenges.

Access to care for adolescents has been positively impacted, however, by progress in providing health insurance coverage. The percentage of uninsured adolescents decreased from an estimated 13.8 percent in 2006 to 12.6 percent in 2008 according to the AAP State Reports 2007 and 2009 on Children's Health Insurance Status & Medicaid/CHIP Eligibility & Enrollment, respectively. The National Survey of Children's Health (NSCH) report for Louisiana also showed a decrease in the percentage of uninsured adolescents ages 12 to 17 years, from 9.5 percent in 2003 to 6.2 percent in 2007. Increased awareness of LaCHIP/Medicaid through outreach efforts has contributed to this reduction.

Adolescent health services through the Louisiana Department of Education

The Department of Education (LDOE) has multiple interventions related to health and preventive health for school-aged children and youth.

Direct health services

School nurses are the main providers of direct health services in Louisiana schools. Each city and parish school system is mandated to employ one school nurse certified by the Louisiana Board of Elementary and Secondary Education (BESE). The nurse ratio is not to exceed the statewide average of 1:1500 students. Services include:

- Health services for students with special needs as specified on Individual Education Plans (IEP)
- Triage of accidents and illnesses
- Medication administration
- Management of chronic illnesses during school hours

These nurses also implement many mandated services:

- Every student in city, parish and local schools must have hearing and vision testing. All first graders must have color screening. Testing for dyslexia is based upon referral.

- Each city, parish, and other local public school board must provide information on immunizations. Schools must provide information on the risks associated with the human papillomavirus (HPV), how HPV is spread, the link between HPV and cervical cancer, immunizations available against HPV and where to obtain them. LDOE collaborated with the Louisiana DHH-OPH-STD Program to develop information on HPV, which has been disseminated to schools.

Preventive health services

Preventative health programs in schools should not be about individualized and potentially fragmented programs, but should be about what many schools already have in place that, when combined, offer a more coordinated approach to service delivery. Primary preventive services are offered to the whole student population with secondary and tertiary services offered to smaller, specialized groups of students. Three components of the CSHP Model referenced in Table 1 of specific relevance to this report and the ongoing work at LDOE are 1) Sexual Health Education; 2) Counseling, Psychological and Social Services; and 3) Healthy School Environment.

- *Sexual Health*
  Louisiana remains a state with some of the highest rates of HIV and STD infections among youth as well as high rates of teen pregnancies. While research proves the connection between comprehensive sex education and decreased dropout rates and improved academic outcomes, LDOE recog nizes the gap in offering these services to school districts and mandating schools to address these issues. There is no current mandate for sexual health to be taught in Louisiana schools; however, schools may offer sex education for students in grades seven or higher. Per the state's regulatory guidance, sex education must emphasize abstinence and be integrated into an existing course of study such as biology, science and

physical education. Contraceptive or abortifacient products are prohibited from distribution at public schools.

LDOE provides training and technical assistance to interested school districts/schools on research and evidence-based HIV, STD, and Teen Pregnancy Prevention curriculums and implementation of these curriculums. LDOE also provides technical assistance to schools in the development of policies and programs to address HIV, STD, and teen pregnancy prevention.

- *Counseling, Psychological & Social Services/Healthy Environments*
  Counseling and psychological services are designed to prevent and address problems, facilitate positive learning and healthy behavior, and enhance healthy development. A healthy environment should provide a safe physical plant, as well as a healthy and supportive environment that facilitates learning. Louisiana legislative requirements related to physical, emotional, and social needs of the students and schools include:

  - Each school district is required to develop and submit a master plan for supporting student behavior and discipline that may include safe school planning, zero tolerance policies, improving classroom management with positive behavioral supports and other effective disciplinary tools.

  - Each district prescribes rules and regulations as are necessary and proper for a statewide youth suicide prevention plan in public elementary and secondary schools.

  - Schools require appropriate conduct from students and should inform students of the consequences of violent acts on campus. Student codes of conduct/disciplinary policies prohibit harassment, intimidation, bullying, fighting, drugs, and guns.

  - Schools may provide BESE-approved instruction in violence prevention, anti-bullying/fighting/gangs, conflict resolution, anger management, and substance abuse/tobacco usage prevention.

  - Tobacco use is prohibited in any school building or on school buses.

  - The establishment and implementation of school wellness policies are required for local education agencies participating in USDA Child Nutrition Programs.

  - Schools must have programs and policies that reduce the incidence of in-school and out-of-school suspensions and expulsions and truancy.

Adolescent Health Services through the Louisiana Department of Health and Hospitals Office of Public Health

The School Based Health Centers (SBHC) program helps ensure convenient access to comprehensive primary and preventive physical and behavioral health care for students who might

otherwise have limited or no access to such care. SBHCs are sponsored by various entities such as FQHCs, private hospitals, and primary health clinics that desire to provide health services within a school setting. OPH provides some limited funding to sponsors to encourage interest and to help support the sponsors in providing services in the school setting, and the sponsors are required to provide a twenty percent match to the funding OPH provides.

Services provided in SBHCs include yearly comprehensive physicals with an assessment for risky health behavior and behavioral health; acute care; and screening, treatment and management of chronic conditions, such as Type 2 diabetes mellitus, asthma, and hypertension. SBHCs also provide screening and treatment for gonorrhea, chlamydia, and other STDs; HIV prevention, testing and referral for treatment; screening and referral for cervical cancer; screening for tobacco use and referral to tobacco cessation counseling; and review of immunizations to ensure the student is current, and administration of required vaccines, if needed. SBHCs provide individual and group behavioral health counseling. They identify students with poor school performance and refer for physical evaluation and behavioral health support and provide staff to facilitate a coordinated improvement plan for these students. SBHCs also serve as Medicaid/LaCHIP enrollment centers. Oral health services are available at a few SBHCs.

There are currently 65 SBHCs in the state; therefore, coverage for all school districts through SBHCs is limited. In addition, SBHCs are generally not available during the summer or after school hours; however, every site is required to have referral information available for summer and after hour care. SBHCs are prohibited by law from distributing any type of contraception, counseling on or advocating abortion, or referring any student to any organization that counsels or advocates for abortion. ASHP publishes an Annual Report that identifies all of the SBHCs statewide and presents data on the number of students enrolled, the numbers who have accessed services and the specific services provided.

As of June 2010, there were 25 Federally Qualified Health Centers (FQHCs) in Louisiana, with approximately 55 additional satellite sites. It is important to note that eight of the SBHCs are sponsored by FQHCs. FQHCs provide primary and preventive medical care, health education and behavioral health services. Some FQHCs may also provide oral health care. FQHCs serve children, adolescents, and adults.

The Children's Bureau of New Orleans - Project LAST is another program contracted by the OPH, MCH program to provide grief and trauma intervention services to children from infancy through 17 years of age who have experienced trauma/loss, violence, or disaster. The Children's Bureau of New Orleans is a private, non-profit United Way partner which offers a variety of counseling services to children and families in New Orleans.

Adolescent Health Services through the Louisiana Department of Health and Hospitals Office of Behavioral Health

Most state run inpatient and outpatient services focus on care for the chronically mentally ill. The Office of Behavioral Health (OBH) (formerly the Office of Mental Health and the Office of Addictive Disorders) has clinics and hospitals located in each of the nine DHH regions. The hospitals continue to serve as a "safety net" for inpatient, emergency, and acute mental/behavioral health services to the uninsured and under-insured, especially in areas of the state where there is a shortage of mental health providers. The Child-Adolescent Response Team (CART) is a crisis

response service. The mission of the program is to provide crisis counseling and intervention services to children, youth, and their immediate family. CART assists the family in the stabilization of their crisis and provides the family with advocacy, referral, and support.

Louisiana is developing a statewide coordinated system of care (CSoC) for the state's at risk children and youth with significant behavioral health challenges or co-occurring disorders. This is a joint project, initiated by Governor Bobby Jindal, in collaboration with the Office of Juvenile Justice (OJJ), the Department of Children and Family Services (DCFS), DHH, and LDOE. CSoC will allow the participating state agencies and provider networks to be more responsive, flexible, and accountable to the needs of at-risk children and their families who currently face a fragmented service delivery model that lacks coordination, is often inadequate to meet their needs and is usually difficult to navigate.

Adolescent Health Services through the Louisiana Department of Health and Hospitals Medicaid Program

Medicaid funds a variety of preventive and primary care services for children and adolescents which may be provided in the school system as well as in the community. Medicaid is also in ongoing dialogue with LDOE to explore whether or not some health care services currently performed within the schools could become eligible for Medicaid reimbursement.

In addition, Medicaid staff is working with OJJ, DCFS, DHH and LDOE on CSoC. As stated above, the concept of CSoC is to offer an integrated approach to providing behavioral health and substance abuse services for at-risk children and youth who have significant behavioral health challenges or co-occurring disorders and are in, or at imminent risk of, out of home placement. Out of home placement may be defined as detention, secure care facilities, psychiatric hospitals, residential treatment facilities, addiction facilities, alternative schools, homeless, and foster care. The goal is to reduce the state's cost of providing services to this population by leveraging Medicaid and other funding sources for services that have been traditionally paid by all state funds. Medicaid staff is also working with LDOE to make some nursing services already performed by schools payable by Medicaid.

Gaps in State Capacity in Adolescent Health Services

Louisiana Department of Education

LDOE programs are available to every public school and every student; however, not all of the services reach every public school and every student. Every Local Education Agency (LEA) has its own governing body; therefore, individual district policies are created to implement mandated programs. As a result, LDOE's authority to standardize programs and ensure continuous quality assurance is compromised. In addition, many legislatively-mandated policies and programs remain unfunded, posing an additional barrier to addressing health and behavioral issues.

Regular monitoring of LDOE initiatives is required only for those programs supported through federal funds. For example, the required wellness policy implementation has been a challenge for LEAs. While schools are expected to report compliance, many supportive programs have no state-

mandated monitoring component. However, LDOE continues to craft informal means to monitor programs to ensure districts are implementing interventions with fidelity.

The most recent state by state comparison report compiled by the National Association of School Nurse indicates the nurse to student ratio in Louisiana is approximately 1:1868, more than the legislatively required maximum of 1:1500. According to the National Association of School Nurses, the national standard is 1:750 for students in the general population; 1:225 for students that may require daily professional school nursing services or interventions; 1:125 for students with complex health care needs, and 1:1 may be necessary for individual students who require daily and continuous professional nursing services. The Louisiana nurse to student ratio is inadequate to meet the growing medical needs of students. Few of the many services school nurses provide are supported by outside funding, such as Medicaid reimbursement for the development of Individualized Health Plans (IHPs) and the health services provided through the implementation of IHPs. Increased Medicaid billing capacity and support would potentially fund additional school nurses and improve the sustainability of school health services.

With implementation of comprehensive sexual health education in schools being positively linked to decreased rates of high school dropouts, teen pregnancies, and sexually transmitted infections, best practices support the implementation of such programs in schools. Research by Hawkins et al. (1999) "found that students who had participated in a comprehensive school health education program had fewer sex partners and lower pregnancy rates than students who did not participate. They also had academic improvement in the form of higher reported grade point average, and they were less likely to have repeated a grade." Louisiana's current law (Title 28, Part LIX, § 109) is inadequate to address the needs of our schools and students. Without the implementation of a mandated comprehensive sexual health education program, Louisiana's youth may be ill prepared to make healthy decisions and abstain from risky behaviors which impact their academic and future success.

School Health Advisory Councils are a vital tool in implementing the many health-related policies at the local school level. These councils are needed to advise local school boards on physical activity for students, health and physical education, nutrition and overall student health. The development of these advisory councils will assist districts in having active wellness policies by allowing the multi-disciplinary team to begin to manage school health within a resource-oriented approach.

Act 256 of the 2009 Regular Session encourages school districts to conduct health-related fitness assessments of students in public schools. The Act includes the review and expansion of current health-related physical fitness assessment programs throughout the state. Results from these assessments could be used to support implemention of intervention strategies in each school. Assessment would include indicators that track health improvements and its impact on academic performance.

Louisiana Department of Health and Hospitals

Access to primary health, oral health, and behavioral health for the general adolescent population remains a challenge in Louisiana given the extensive medical, dental and behavioral health shortage areas in the state and adolescents' utilization of primary and preventive care in general. FQHCs and SBHCs offer care to underserved children and youth in shortage areas, but the number of both

types of clinics is insufficient to serve the adolescent population in need. To address the basic issue of access, SBHCs serve children and youth at school where they spend most of their time. However, expanding the number of SBHCs is challenged by the sponsor's ability to provide a financially sustainable SBHC program, limited number of interested sponsors, as well as a community perception of the role and services that should be provided by SBHCs.

Medicaid and other third party reimbursement are key to the sustainability of current SBHC sponsors and could contribute to expanded health and behavioral services within existing SBHCs. One issue of concern is that SBHCs are required to get a referral from the primary care provider for all children 10 and under in order to bill Medicaid for the services provided. Many SBHCs often experience difficulty securing the referral despite multiple attempts.

DHH successfully petitioned the Centers for Medicare and Medicaid Services and made state policy changes to permit Medicaid reimbursement for behavioral health services provided in SBHCs. Fiscal constraints have prevented DHH from moving forward on this initiative. However, the health department is optimistic about reforms in behavioral health service delivery in Louisiana. This optimism is due to the development of CSoC in the state.

Some SBHCs have been able to support oral health programs through grant funding or through partnerships with local dentists. However, many SBHCs have been unable to provide dental services to students because of limitations such as scarcity of dentists in their areas, limited number of dentists that accept Medicaid, and restrictions on the type of setting where dental services may be provided. The recent determination by the Louisiana House Health and Welfare Committee to uphold the State Board of Dentistry's rule that allows mobile dental clinics may assist SBHCs and schools themselves to provide dental care to Medicaid eligible students.

RECOMMENDATIONS

1. **Coordinate existing funding streams and clinical staffing resources across agencies supporting school health.** Support implementation and expansion of Coordinated School Health Program (CSHP) model for children and adolescents in all Louisiana schools. This may be accomplished by adopting an approach similar to that of the Coordinated System of Care (CSoC), which is a multi-agency effort of the Office of Juvenile Justice (OJJ), Department of Children and Family Services (DCFS), Department of Health and Hospitals (DHH), and Department of Education (LDOE). Although components of CSHP should already exist in every school, LDOE lacks the authority and funding to make CSHP a basic, integrated, and potent force in every school. By doing an assessment of funding currently supporting components of the CSHP across these agencies, opportunities for leveraging, streamlining and coordinating these efforts could be identified.

2. **Connect existing clinical care providers and create opportunities for additional access points in schools.** Foster a system that ensures access to health services as defined in the CSHP model and allow school districts the flexibility to provide these services through a variety of models including but not limited to the following:
    a. The school functions as an extension of the primary care network for students by providing some health services directly, and by coordinating students' care on behalf of the primary care network;
    b. The school partners with medical providers in the community to set up a primary care clinic in a school environment to serve both the school and the community; or
    c. The school partners with a medical provider in the community that is interested in setting up a SBHC to provide medical services to the students at the school.

3. **Create a task force to identify streams of funding that that can be used to support the comprehensive CSHP program model**. For example, additional services may be able to be supported by utilizing funding from school districts as match to maximize Medicaid reimbursable services. Task force members should include representatives from LDOE, Medicaid, OBH, OPH, House Appropriations staff, Senate Finance staff, House and Senate health and welfare committee staff, experts from school districts, and providers/stakeholders. Further support from the task force members would include:
    a. If additional funding is identified, the task force should explore the feasibility of expanding the number and types of services provided in schools that are Medicaid reimbursable, including behavioral health services.
    b. Provide technical assistance to all school districts and school based health center sponsors on billing and maximizing Medicaid and other third party reimbursement.

4. **Coordinate efforts to expand health services in schools with the implementation of Medicaid Managed Care/Coordinated Care Networks (CCNs)**. Health care providers in schools may serve as an extension of the network by providing care directly, as well as by serving in a care coordination role. The role of CCNs within school settings must be negotiated when CCNs are implemented.

5. **Enforce implementation and monitoring of mandated policies and programs.** Particular focus should be given to enforcement of 30 minutes of quality moderate to vigorous physical activity per day in grades K-8 (Act 286 of the 2009 Regular Session), implementation of comprehensive sexual health education programs in schools, implementation of wellness policies, development of School Health Advisory Councils, and statewide implementation of health-related fitness assessments.

6. **Encourage school districts to utilize health-related fitness assessment results** as a measure for student, teacher, and school performance, and consider the adoption of the American Medical Association recommended annual risk assessment, utilizing one of many available standardized instruments.

7. **Reduce the nurse to student ratio to a maximum of 1:1500** as legislated, and aim to adopt the National Association of School Nurses (NASN) recommendations regarding student nurse ratios in the coming years.

Acknowledgments

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APPENDIX

A: Applicable Laws and Statutes
B: Department of Education Programs and Services: Louisiana Revised Statutes Reference
C: School-Based Health Center Services

APPLICABLE LAWS/STATUES

ADOLESCENT SCHOOL HEALTH INITIATIVE ACT R.S. 40:31.3

To enact R.S. 40:31.3, relative to adolescent school health; to require the Department of Health and Hospitals, Office of Public Health, to establish an adolescent school health initiative; and to provide for related matters. Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 40:31.3 is hereby enacted to read as follows:

31.3. Adolescent school health initiative; health centers in schools

A. The Department of Health and Hospitals, Office of Public Health, shall establish an adolescent school health initiative to facilitate and encourage development of comprehensive health centers in public middle and secondary schools in Louisiana which shall provide preventive health services, counseling, acute health services, and appropriate referral for acute health services. Such initiative shall be subject to the approval of the local school systems.

B. The Office of Public Health shall:

(1) Coordinate efforts to facilitate and encourage establishment of health centers in schools by providing information, technical assistance, direction, and, to the extent appropriate, funds to locally based entities for the establishment and operation of health centers in middle and secondary schools.

(2) Convene and participate in an intergovernmental coordinating council which shall be composed of representatives from the department of education, social services, health and hospitals, and other governmental entities or programs related to health services to assist in implementation, oversight, and funding assistance for health centers in schools.

(3) Apply for and assist local efforts to apply for all available public and private funds to establish and operate health centers in schools.

(4) Establish procedures for allocation of funds appropriated or otherwise available to the program in a manner which prioritizes funding according to the urgency and degree of health care needs among the various middle and secondary school populations.

(5) Establish criteria to be considered in selection of locations or placement of health centers in schools.

C. Health centers in schools are prohibited from:

(1) Counseling or advocating abortion in any way or referring any student to any organization for counseling or advocating abortion.

(2) Distributing at any public school any contraceptive or abortifacient drug, device, or other similar product.

D. The provisions of this Section shall be applicable only to the extent that funds are made available for this purpose from public or private sources.

Section 2. This Act shall become effective upon signature by the governor or, if not signed by the governor, upon expiration of the time for bills to become law without signature by the governor, as provided in Article III, Section 18 of the Constitution of Louisiana.

Appendix B

Department of Education Programs and Services: Louisiana Revised Statutes Reference List

Health Education	
Law/Policy	**Description**
RS 17:154 (1998)	Requires every secondary school to teach health education, including alcohol, tobacco, drug, and substance abuse prevention and education.
RS 17:404 (1994)	Requires a minimum of 16 hours per year of substance abuse prevention education per year for grades K-9 and a minimum of 8 hours of substance abuse prevention education for students in grades 10-12.
RS 17:275 (1980)	Requires all public junior and senior high schools to provide instruction to all female students in the proper procedure for breast self-examination and the need for an annual Pap test for cervical cancer, although no student shall be required to take such instruction if her parent or tutor submits a written statement indicating that such instruction conflicts with religious beliefs of the student.
RS 17:170.2 (2006)	Requires all city, parish and local school boards to disseminate information on meningococcal meningitis and vaccines to parents and guardians; LDOE and DHH shall develop and make available information.
RS 17:81 (Q)	Each city, parish, or other local public school board shall provide each school year, to high school students enrolled in health education, at least 30 minutes of age-and-grade appropriate classroom instruction relative to the state's safe haven relinquishment law, Children's Code Articles 1149 through 1160, which provides a mechanism whereby any parent may relinquish the care of an infant who is not more than 30 days old to the state in safety and anonymity and without fear of prosecution.
	See Health graduation requirements in PE section below.
	See ROTC substitutions below.
Physical Education	
Law/Policy	**Description**
RS 17:197.1 (K.1-7.)(2005)	Requires each elementary and secondary school to provide improved physical activity and fitness in schools by encouraging innovative physical education programs.
RS 17:17.2 (2004)	Allows one public elementary or secondary school to be selected from each of the education service center regions in the state to be recognized and receive an award for its outstanding program of physical activity implemented at the school. The State Board is instructed to establish a selection process in collaboration with the Department of Education, Department of Health and Hospitals, and the Governor's Council on Physical Fitness and Sports.
RS 17:276 (1980)	Requires each public secondary school to offer, as part of the physical education program, sexually segregated contact sports and sexually integrated non-contact sports with the options for students to choose either or both.
RS 17:17.5 (2009)	Calls for the expansion of health-related fitness assessments that are currently being conducted in 12 districts identified as coordinated school health pilot sites. It is the goal of the Legislature that positive results of these assessments can be used to implement a statewide fitness assessment and intervention strategies in each school that provides positive feedback vital to improved health and

	academic performance.
RS 17:17.1 (A.1.)(2009) (D) (2009)	Each public elementary school that includes any of the grades K - 8 shall provide at least 30 minutes each school day of quality moderate to vigorous physical activity for students. Each city, parish, and other local public school board shall establish a school health advisory council to advise the board on physical activity for students, physical and health education, nutrition, and overall student health.
RS 17:24.4 Bulletin 741	§2319 Requires 1.5 units of physical education and .5 units of health education for public high school graduation.
RS 17:24.4 Bulletin 741 Non-Public	§2109 Requires 1.5 units of physical education and .5 units of health education for non-public high school graduation.
BESE Waiver Policy Bulletin 741	§2357 allows an approved Junior Reserve Officer Training Corp program to be substituted for the 2 credits of health and physical education upon board approval.
HIV Prevention Education	
Law/Policy	**Description**
RS 17:281	Allows schools to offer instruction in sex education for students in grade three or higher. It also states that "no contraceptive or abortifacient drug, device, or other similar product shall be distributed at any public school; no sex education course offered in the public schools of the state shall utilize any sexually explicit materials depicting male or female homosexual activity; and, emphasize that abstinence from sexual activity is a way to avoid unwanted pregnancy, sexually transmitted diseases, including acquired immune deficiency syndrome, and other associated health problems." Prohibits students from being tested, quizzed, or surveyed about their personal or family beliefs or practices in sex, morality, or religion.
RS 17:437	BESE shall develop and adopt not later than 1992-1993 school year and thereafter an in-service training program to educate all school employees on generally accepted practices and precautions to prevent the occurrence and/or spread of communicable diseases in the school setting.
Health Services	
Law/Policy	**Description**
RS 17:436.2	Prohibits teachers from making recommendations for students to be administered psychotropic drugs; specifying or identifying any specific mental health diagnosis for a student; and using a parent or guardian's refusal to consent to administration of a psychotropic drug or evaluation, screening or examination as grounds for prohibiting the student from attending class or participating in any school related activities.
RS 17:28	Each city and parish school system shall employ at least one school nurse certified by BESE. Nurse to student ratio shall not exceed statewide average of 1:1500 students.
RS 17:436.1	Provides for the definition of medication, no medication shall be administered to any student without an order from a licensed physician, dentist or authorized prescriber; provides for acceptable containers; employee training; assessment of

	student health status; delegation. Students, with permission, may self-administer asthma medications or auto-injectable epinephrine.
RS 17:436	Provides for the definition of non-complex health procedures; training and requirements; requirements and conditions for delegation; requires city and parish school boards shall provide necessary safety equipment, materials and supplies.
RS 40:5.12	Provides for DHH/OPH to establish advisory board to develop standardized school health forms; purpose of standardized health forms; defines members of the board; requires standardized school health forms to be implemented in schools by August 2007.
RS 17:2112	Requires the testing of hearing and vision by every city, parish and local school board of each student and additionally color screening of first graders; testing for dyslexia based upon referral; records of examinations, follow up for deficiencies; adoption of rules by BESE for 2005-2006 school year.
RS 17:170.3	Each city, parish, and other local public school board that provides information relative to immunizations shall provide to the parent or legal guardian of each student in grades six through twelve information relative to the risks associated with human papillomavirus and the availability, effectiveness, and known contraindications of immunization against human papillomavirus. The information shall describe the link between human papillomavirus and cervical cancer, the means by which human papillomavirus is spread, and where a person may be immunized against human papillomavirus. The information shall be updated annually if new information on human papillomavirus becomes available.
RS 17:170.4	Beginning with the 2009-2010 school year and continuing thereafter, a student shall provide satisfactory evidence of current immunization against meningococcal disease as a condition of entry into the sixth grade at any city, parish, or other local public school or nonpublic school.
Nutrition	
Law/Policy	**Description**
Bulletin 741 RS 17:82	§2103 Allows any public high school grade and under to participate in a school food service program. Law applies the same to non-public school students.
RS 17:192	States that all school children under the supervision and regulation of the state shall be given lunches that take into consideration the nutritional needs of the children. Breakfast must be offered in all public schools if at least 25 percent of the students enrolled are eligible for free or reduced priced meals. If at least 50 percent of the eligible students refuse to participate during any year as demonstrated by sufficient proof to the Louisiana Department of Education (LLDOE), the State Board of Elementary and Secondary Education (BESE) may grant a waiver from the requirement.
RS 17:194	Allows the BESE to prescribe regulations, employ personnel, and take other necessary action to establish a school lunch program.
RS 17:197.1	Except for foods sold as a part of the school food program, the following items are prohibited beginning one half-hour before school begins until one-half hour

	after the school ends: Foods of Minimal Nutritional Value; snacks or desserts that exceed 150 calories per serving, have more than 35 percent calories from fat or more than 30 grams of sugar per serving (except for unsweetened or uncoated nuts); fresh pastries.
RS 17:197.1 Act 306 (2009)	In high schools, beverages shall include: bottled water; no-calorie or low-calorie beverages that contain up to 10 calories per eight ounces; up to 12 ounce servings of beverages that contain 100 percent fruit juice with no added sweeteners and up to 120 calories per eight ounces; Up to 12 ounce servings of any other beverages that contains no more than 66 calories per eight ounces; at least 50 percent of non-milk beverages shall be water and no-calorie or low-calorie options that contain up to 10 calories per eight ounces; and low-fat milk, skim milk, and non-dairy milk.
Bulletin 1196 Chapter 7, §741	Allows only extra items to be sold to those who have received a complete meal and must occur when the meal is received and must meet the regulations for Child Nutrition Programs. The code further prohibits a la carte meal service. The state may withhold reimbursement for lunch, special milk and/or breakfast from schools if concessions, canteens, snack bars, or vending machines are operated for profit before the end of the last lunch period for grades K-6. Similarly, reimbursements will be withheld if competitive foods are sold before the last 10 minutes of each lunch period for grades 7-12. This includes all lunch periods including those schools with multiple lunch periods. School districts are required to establish local rules or regulations necessary to control the sale of foods in competition with meals served under the National School Lunch and Breakfast programs. Lastly, the State Board recommends that all schools provide a minimum of 30 minutes per lunch period.
Counseling Psychological, & Social Services	
Law/Policy	**Description**
RS 17:252	Requires each school district to develop and submit a master plan for supporting student behavior and discipline that may include safe school planning, zero tolerance policies, improving classroom management with positive behavioral supports and other effective disciplinary tools.
RS 17:282.4	BESE shall prescribe rules and regulations as are necessary and proper for a statewide youth suicide prevention plan in public elementary and secondary schools.
RS 17:282.2	States that any city or parish school system may offer character education curriculum that focuses on the development of character traits such as honesty, fairness, respect for self and others in grades K-12.
Healthy Environments	
Law/Policy	**Description**
Child Nutrition and WIC Reauthorization Act of 2004	Wellness Policy: On June 30, 2004, Congress passed Section 204 of Public law 108-265, of the Child Nutrition and WIC Reauthorization Act of 2004. This law requires each local education agency participating in a program, authorized by the Richard B. Russell National School Lunch Act (42 U.S. 1751 et seq.) or the Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.), to establish a local school

	wellness policy by July 1, 2006. Nutrition guidelines must be established for all foods available on campus including vending, fundraisers, etc. The Louisiana Department of Education approved a wellness policy template that was used by local districts in developing their policies and includes a plan for measuring policy implementation.
RS 17:416.12	Requires each local public school to require students in K - 12 to exhibit appropriate conduct including using the respectful terms "Yes Ma'am" and "No Ma'am" or "Yes Sir" and "No Sir."
RS 17:416.14	Requires each local public school board to require each school to have a special program to inform students of the consequences of violent acts committed on school property, at a school-sponsored function, or in a firearm-free zone.
RS 17:416.15	Allows any local public school to implement a zero tolerance policy for fighting in schools.
RS 17:176	Requires the superintendent of each school system to review all co-curricular and extracurricular activities and programs and urge principals and faculty of middle, junior high, and high schools to appropriately upgrade the standards of student athletes. The statute allows the right to film, videotape or otherwise record an extracurricular event so long as it LDOEs not cause significant disruption or distraction to the participants in the activity.

Appendix C

SCHOOL –BASED HEALTH CENTER SERVICES

TYPES OF SERVICE	High School Students (9-12)		Middle School Students (5-8)		Elementary School Students (PreK-4)	
	Essential	Preferred	Essential	Preferred	Essential	Preferred
MEDICAL SERVICES						
Comprehensive medical and psychosocial histories	✓		✓		✓	
Immunizations	✓		✓		✓	
Comprehensive physical examinations (EPSDT/KIDMED guidelines)	✓		✓		✓	
Developmental assessment	✓		✓		✓	
Assessment of educational achievement & attendance problems	✓		✓		✓	
Vision screening	✓		✓		✓	
Hearing screening	✓		✓		✓	
Dental screening	✓		✓		✓	
Referral for dental care	✓		✓		✓	
Dental care		✓		✓		✓
Diagnosis/treatment of minor problems	✓		✓		✓	
Diagnosis/treatment of acute problems	✓		✓		✓	
Management of chronic problems	✓		✓		✓	
Prescription of meds. for minor problems	✓		✓		✓	
Prescription of meds. for acute problems	✓		✓		✓	
Prescription of meds. for chronic problems	✓		✓		✓	
Administering meds. for minor problems	✓		✓		✓	
Administering meds. for acute problems	✓		✓		✓	
Administering meds. for chronic problems	✓		✓		✓	
CLIA waived Laboratory testing	✓		✓		✓	
Provider Performed Microscopy Procedures (PPMP) or equivalent testing approved by OPH-ASHP	✓		✓			✓
Referral to medical specialty services	✓		✓		✓	
Twenty-four hour coverage	✓		✓		✓	
Referral for gynecological/urological care	✓		✓		✓	
Gynecological	✓		✓			
Urological care	✓		✓			✓
Pregnancy testing referral	✓		✓		✓	
	✓		✓			

Pregnancy testing						
Referral for STD diagnosis & treatment	✓		✓		✓	
STD diagnosis & treatment	✓		✓			
HIV testing & counseling		✓		✓		
Referral for HIV pre/post-test counseling	✓		✓		✓	
Referral for HIV/AIDS treatment	✓		✓		✓	
Case management	✓		✓		✓	

HEALTH EDUCATION PROMOTION						
One-on-one patient education	✓		✓		✓	
Group targeted education at Center (e.g. smoking cessation, teen parenting)	✓		✓		✓	
Family & community health education	✓		✓		✓	
Supplemental classroom presentations	✓		✓		✓	
Resource support for comprehensive health education	✓		✓		✓	
BEHAVIORAL HEALTH SERVICES						
Individual assessment, treatment, & follow-up	✓		✓		✓	
Physical/sexual abuse ID & referral	✓		✓		✓	
Physical/sexual abuse counseling		✓		✓		✓
Substance abuse assessment	✓		✓		✓	
Substance abuse counseling		✓		✓		✓
Substance abuse referral	✓		✓		✓	
Group & family counseling	✓		✓		✓	
Crisis intervention	✓		✓		✓	
Mental health referral	✓		✓		✓	
Case Management	✓		✓		✓	
Sample Programs:						
♦ Conflict resolution skills						
♦ Anger Management						
♦ Teen Parents						
SOCIAL SERVICES						
Social service assessment	✓		✓		✓	
Referrals to and follow-up with social service & other agencies for assistance	✓		✓		✓	
Case management	✓		✓		✓	
Transportation		✓		✓		✓

Regular Session, 2009 **ENROLLED**

SENATE CONCURRENT RESOLUTION NO. 77

BY SENATOR MOUNT

A CONCURRENT RESOLUTION

To urge and request the Department of Health and Hospitals to collaborate with the Department of Education to examine the adequacy of current practices for ensuring the preventative health and well-being of adolescents in Louisiana.

WHEREAS, during the transition from childhood to adulthood, adolescents may make poor lifestyle choices that lead to unhealthy patterns of behavior that could have a lasting effect on their health and well-being; and

WHEREAS, although healthy behaviors, such as eating nutritiously, engaging in physical activity and choosing not to use tobacco, would reduce the incidence of chronic disease in adulthood, adolescents face many factors, including peer pressure, fractured families, school issues, and poverty, that challenge their ability to choose such behaviors; and

WHEREAS, the national association of county and city health officials is an advocate for the development of an adolescent health platform, including health screenings, age appropriate immunizations, injury prevention, obesity prevention, and mental health screening, in multiple settings, including school-based health centers; and

WHEREAS, the American Academy of Pediatrics, the advisory committee on immunization practices, the American Academy of Family Physicians, and the American Medical Association all endorse a routine health care visit for adolescents aged eleven to twelve to receive recommended immunizations and other evidence-based preventative health care services; and

WHEREAS, the health resources and services administration of the federal Department of Health and Human Services has developed, in conjunction with the American Academy of Pediatrics, the Bright Futures Initiative, a national health promotion and disease prevention initiative that includes a set of guidelines and recommendations regarding immunizations and routine health screening for adolescents; and

WHEREAS, the advisory committee on immunization practices recommends the use of United States Food and Drug Administration approved vaccines for pertussis, tetanus, and

meningitis and the federal centers for disease control and prevention has launched a national campaign to raise public awareness regarding adolescent health and immunizations; and

WHEREAS, a national immunization survey conducted by the federal centers for disease control and prevention found that immunization coverage levels among adolescents in 2006 did not meet the immunization goals of Healthy People 2010; and

WHEREAS, parents and parental awareness are very important determinants of adolescents receiving preventive health care services; and

WHEREAS, the society for adolescent medicine has found that preventative health care services are among the best tools to ensure continued good health from childhood to adulthood, and adolescents who regularly visit a primary care health care provider are less likely to have emergency room visits and preventable hospitalizations.

THEREFORE, BE IT RESOLVED that the Legislature of Louisiana does hereby urge and request the Department of Health and Hospitals to collaborate with the Department of Education to examine the adequacy of current practices for ensuring the preventative health and well being of adolescents in Louisiana.

BE IT FURTHER RESOLVED that the Department of Health and Hospitals shall make a written report of its findings, including recommendations for legislation, to the legislature on or before February 1, 2010.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the secretary of the Department of Health and Hospitals and the Department of Education.

_____

PRESIDENT OF THE SENATE

_____

SPEAKER OF THE HOUSE OF REPRESENTATIVES