Kentucky Department for Public Health
January 2012 Public Health Practice Reference Revisions

The following revisions have been approved to incorporate in the Public Health Practice Reference, with an effective date of January 31, 2012.

VOLUMES I and II

Section	Description of Revision/Addition	Replace Page(s)
Abbreviations	Added annual family planning (ANF) and initial family planning (INP).	Pages 2, 16.
Consent for Services	Added guidance related to DCBS Foster Care, Department of Juvenile Justice, involving a minor child in a divorce, legal guardianship, Power of Attorney, and other methods of acquiring appropriate signatures for consent.	All pages.
Contact Information	Updated section contact information for Consent for Services, Diabetes, Physical Assessment/Vital Signs (Child), Preventive Guidelines (Pediatric), and Sexually Transmitted Diseases.	Page 2.
Emergencies	• Modified Emergency Equipment inventory list. • Revised protocol for treatment of anaphylaxis. • Added Tables 1, 2, and 3 to facilitate appropriate dosages of epinephrine and diphenhydramine HCL.	All pages.
Family Planning	Page 2: Added to use pre-pregnancy BMI for MNT referral to the Pregnancy Test visit matrix as directed in the Nutrition section Page 9. Pages 25-26: There was no guidance for the importance of encouraging contraceptive use for all postpartum women to prevent unintended pregnancy; the existing information only covered breastfeeding women. Kentucky's unintended pregnancy rate for all births is 60%. The unintended pregnancy rate is higher for uninsured (77%) and Medicaid (74%) women [2009 KY Pregnancy Risk Assessment Monitoring System (PRAMS), statewide survey of women who had a live birth within the past year]. Additionally, 23% of all the total births in KY were spaced less than 18 months from a previous birth (KY Vital Statistics, 2009). **Changes are bolded.** New title: " **POSTPARTUM,** BREASTFEEDING, AND CONTRACEPTIVES**"** General information for PP women and contraceptives added or rearranged: **Planning for postpartum (PP) contraception should begin during pregnancy and use of birth control should be initiated as early as possible. Encourage women to have a contraceptive plan.** • Initiate contraception 2-4 weeks after delivery because most couples resume intercourse within a few weeks after delivery • Spacing of pregnancies is important to maternal and child health. **Pregnancies spaced at least 18-23 months apart are less likely to have preterm delivery, low birth weight, and small for gestational age infants.** • Ovulation may precede first menses. **Pelvic rest (no douching, no sex, and no tampons) is generally recommended for 4-6 weeks and/or lochia stops. Lochia is normal uterine discharge of blood, tissue and mucus from the vagina. Non breastfeeding women can become pregnant 3 weeks from delivery.** • **Encourage breastfeeding. Reinforce education about lactational amenorrhea, if patient is interested. Pregnancy is possible 3 months after delivery even if fully breastfeeding.** • **Refer to the CDC "US Medical Eligibility Criteria for Contraceptive Use 2010: Revised Recommendations for the Use of Contraceptive Methods During the Postpartum Period", MMWR July 8, 2011** http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6026a3.htm. Matrix changed to identify when to start contraception in non breastfeeding and breastfeeding woman: Added to the METHOD list in column 1 **Vasectomy, Natural Family Planning or Fertility Awareness Method, and Lactational Amenorrhea Method**; changed column 2 to "**NOT BREASTFEEDING"**; column 3 changed to "BREASTFEEDING". Some of the original information was	Pages 2, 25-28; however, additions add one page to the total pages in section.

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	moved to general information regarding PP contraception or to the appropriate column for non breastfeeding or breastfeeding or deleted.	
Lead	Program name has changed from Kentucky Childhood Lead Poisoning Prevention Program to Kentucky Healthy Homes and Lead Poisoning Prevention Program (KHHLPPP). Page 1: • Changed: in second row box down: the word Issue to Review *Verbal Lead Risk Assessment (added) to determine patient risks, Form available under teaching sheets/ ACH 25. • Removed: provided by the KY Childhood Lead Poisoning Prevention Program , now reads Review * Verbal Lead Risk Assessment to determine patient risks, Form available under teaching sheets/ Lead. • Combined the 4 boxes and combined to make a 1 Yes and 1 No box, Added: Lead to the Verbal Risk Assessment boxes to read Verbal Lead Risk Assessment. • In High Risk box: Changed: Test child at age 9-12 and 24months of age or any time under the age of 72 if not previously tested to Test all at-risk patients with a blood test. Upon receipt of the results notify parents(Added) prenatal patient and follow case management and health education guidelines set forth by the KY Department for Public Health and the (Added) Healthy Homes and Lead Poisoning Prevention Program in PHPR. (Added) ALL Medicaid children require a blood lead test at ages 12 and 24 months and any time 25-72 months of age if not previously tested. • In Low Risk box: added Lead to read Verbal Lead Risk Assessment • Added box with AAP recommendations. • In Note box: Removed the word Classification Chart for to read Lead Guidelines. • Added box with note to see Prenatal Section for prenatal patients. Page 2: 1st row: 1. Changed Finding/Condition/Need to Blood Lead Levels a. Under Finding/Condition/Need: Now Blood Lead Level: Removed Class I and added 0-0.9µg/dL b. Under Assessment: Removed *A Class I and replaced with Even low blood lead levels can cause (Added) adverse neurological effects such as loss of IQ points and learning disabilities. It is very important that education on ways to prevent lead poisoning begin at this level.* c. Under Interventions: Added*:* Complete routine blood lead testing for at-risk patients (Medicaid, Targeted Zip Code areas, and "+" or "don't know" verbal lead risk assessment responses Changed: State CLPPP Case Manager (CLPPP CM) to State HHLPPP NCI. d. Follow-Up: Changed levels to **test** 2nd Row: a. Under Blood Lead Level: Removed Class II, changed 10-14 to 10-14.9 b. Under Interventions: Changed CLPPP CM to HHLPPP NCI; Removed within 2 weeks, **** as this is not required for 1st BLL, it is optional; Changed specimen to BLL: *If 2nd BLL remains at this level, nurse and/or local environmentalist **must make a home visit* for visual investigation within…; Changed: 2 weeks to 30 days ****to follow CDC environmental management recommendations c. Under Follow-up: Changed: A blood lead level will need to be repeated…….; Repeat blood lead level in 12 weeks of the initial, if BLL is still……***Many LHD's were repeating in 2-3 weeks and not allowing time for preventive education strategies to take effect and to see if strategies will bring the child's BLL down.	All pages.

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	Page 3: 3rd Row: a. Under Finding: Removed Class III; Separated 15-44 into 15-29.9 and 30-44.9 …as U of L's lead specialist would like to be consulted with BLL's 30µg/dL and greater 3rd/now 4th Row: Added: Blood lead level/ 30-44.9 a. Under Assessment: Moved from Intervention column to Assessment column: For levels >30µg/dL, refer patient to a PCP, PCP then to consult with*Lead Specialist, if PCP has not consulted *Lead Specialist within one week, please contact HHLPPP NCI. b. Under Interventions: Changed Contact CLPPP CM to HHLPPP NCI if guidance needed; Line: Refer to a *Certified Risk Assessor to perform a lead risk assessment within 2 weeks of LHD receiving confirmed EBLL results. Moved from below …*Contact Changed CLPPP to KY* HHLPPP ….. *if your HD does not have a Certified Risk Assessor*; Lead Risk Assessment to be (changed done to) completed within 30 days of Risk Assessor receiving referral from LHD, removed: with final reports…….and added: 'Environmental' Guidance can be found in AR; Mail or fax report to Changed CLPPP CM to HHLPPP NCI c. Under Follow Up: Submit (Changed second) to confirmation specimen within one week , removed if capillary; ADDED: As ordered by the physician Page 4: 4th Row now 5th row: Under Finding/changed Finding/to Blood Lead Level Added: .9 to 69 to read -69.9; Removed: Class IV a. Under Assessment: Removed Same as Class III; Added BLL> 15µg/dL; Moved and added from Intervention column: For levels >30µg/dL, refer patient to a PCP, PCP then to consult with *Lead Specialist, if PCP has not consulted *Lead Specialist within one week, please contact HHLPPP NCI. b. Under Interventions: Removed Same as Class III and added: as listed above; removed: referral to and added should consult with…. Now reads: Same as listed above except refer to a PCP for medical evaluation and PCP should consult with *Lead Specialist within 48 hours. 5th row now 6th Row: Under Blood Lead Level: Removed: Class IV a. Under Assessment: Added BLL> 15µg/dL; Moved to and added from Intervention column: For levels >30µg/dL, refer patient to a PCP, PCP then to consult with *Lead Specialist, if PCP has not consulted *Lead Specialist within one week, please contact HHLPPP NCI. b. Under Interventions: Removed Same as Class III and added: as listed above and to PCP; removed: refer to and added consult with…. Now reads: Same as listed above except refer medical evaluation immediately to PCP for medical evaluation and PCP should consult with *Lead Specialist within 48 hours. Pages 5-6: • Changed Header From KY Childhood Lead Poisoning Prevention Program to Kentucky Healthy Homes and Lead Poisoning Prevention Program (KHHLPPP) • Added: Line 1: -- 1. Case Management: • Changed in first paragraph: 9-72 months to 6-72 months …to follow AAP guidelines • Added: to last sentence of paragraph 1…included in the Prenatal Section of the PHPR. • Added to beginning of Paragraph, first line: According to the Centers for Disease Control and Prevention (CDC), case management…. Added lead and to: …..to reduce lead levels to below a level of concern. • Moved from bottom of original page 5 to paragraph 4: Children and pregnant women with elevated blood lead levels become "health department patients" when their cases are brought to the attention of staff, even if they are or have	

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	been receiving direct clinical services elsewhere. They will remain a health department patient until patient case closure. • REMOVE INTIAL REPORT FORM INSTRUCTIONS FROM THE FORMS AND TEACHING SHEETS/LEAD SECTION AND REPLACE THIS INFORMATION IN THE LEAD SECTION • Added Paragraph: The report forms are used to coordinate communication between the LHD lead case managers and the state HHLPPP NCI in an effort to assure that all children with an EBLL receive appropriate and timely care. The KHHLPPP NCI monitors incoming lab data and compares this with identified EBLL children reports sent from the LHD. A HHLPPP Initial Report Form includes demographics including *zip code, contact information, social security and a Medicaid number if relevant, actions/interventions marked for appropriate BLL's, dated, and initialed where appropriate, as soon as the health department case manager becomes aware of a child with a BLL of 10µg/dL or greater. **A zip code must be included to enter the data into the system.* • Original Paragraph 5: Changed CLPPP to KHHLPPP; Changed CLPPPP Case Manager to KHHLPPP NCI; Added: -14 to 10 to read 10-14µg/dL; Added: or confirmed BLL of 15 µg/dL: to read: The KHHLPPP initial report form must be filled out for all children with a 2nd blood lead level of 10-14µg/dL or confirmed BLL of 15 µg/dL or greater and greater and for every pregnant woman with a venous BLL of 5µg/dL or greater. The original report is to be placed in the patient's chart and a copy of this form may be faxed or mailed to the KHHLPPP NCI. • Removed words: **CLPPP Initial and Monthly Report Form • Original paragraph 7: After the completed Initial Report Form has been sent ….REMOVE ***Monthly Report Form (CLPPP Monthly Report Form), remove is to be used for CLPPP updates in patient's charts. please fax these forms as updates are made. Add to read as: to KHHLPPP, updates can be entered on the *HHLPPP Monthly Report Form.* This form should be kept in in patient's chart and updated as appropriate with follow-up BLL's and necessary interventions noted. Copies of the monthly report form will need to be faxed to the KHHLPPP NCI when new entries are made. • Add: Paragraph: If the patient's BLL increases, thus changing needed interventions please send updated information with appropriate interventions noted to the KHHLPPP NCI. • Remove Note: paragraph as it has been moved to beginning of this section • Move CASE CLOSURE to end of Lead section, Delete from this section Pages 6-8:VERBAL RISK ASSESSMENT FOR LEAD POISONING Children: • Changed: 9-72 months to 6-72 months to follow AAP guidelines to read: Review each of these questions at every preventive service for all children ages 6–72 months. • Added: American Academy of Pediatric (AAP) recommends verbal lead risk assessment to be performed at ages 6, 9,12,18,24,36,48,60 and 72 months of age with appropriate action to follow if blood lead level is positive. AAP recommends and Medicaid requires blood lead testing at ages 12 and 24 months. • Deleted: The: to change Questions are (added:) also included on the Health Risk Assessments (ACH 25, 90 and ACH 91). Pregnant Women • Added: to determine if patient is at-risk. • To Read: Review each of these questions at the positive pregnancy test visit or initial prenatal visit to determine if patient is at-risk. • Added: A copy of the Verbal Lead Risk Assessment is in the Forms and Teaching Sheets/Teaching Sheets/Lead/ACH 25 section of the PHPR. The questionnaire reviews potential patient risks such as: 1. Does the patient live in	

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	or visit a building built before 1978 with peeling/chipping paint or undergone recent or ongoing remodeling (dust)? 2. Added: (dust) 3. Does the patient or any other members of the household (child's playmate/ brother/sister/ patient's spouse) have a history of elevated blood lead levels or who has had lead poisoning? 4. Added who visits or: To read: Does the patient or someone who visits or in the household work in an occupation known or suspected to involve lead? Common industries using lead include but are not limited to: Added more hobbies/industries to read as ACH 25 and latest Verbal Lead Risk Assessment: Auto mechanics/bodywork Plumbing Farm/Migrant Farm Work Blowing Glass Jewelry Making/Repair Furniture Refinishing Gardening Metal Sculpting Renovation Work Painting Stained Glass Painting Roads Printing Car/Boat repair Metal Work/Welding Casting Aluminum Firing Ranges Plastics manufacturing Ceramic Making Firearms/Firing Range Radiator Repair Battery Recycling/Smelting/Recycling Making Bullets/Sinkers/lead toys High Construction Area Electronic soldering Home Repairs/Remodeling Bridge Repair/Painting Smelting Metals/ Scrap yards; 5. Does the patient use any folk remedies that may contain lead or use pottery or ceramic ware for cooking, eating, or drinking or participate in hobbies that may involve lead such as ceramic pottery, jewelry making, gardening or stained glass? ADDED: LIST OF COSMETICS/FOLK REMEDIES: AS TO BE CONGRUENT ACH 25 IMPORTED COSMETICS: ▪ Middle East, India, Pakistan, Africa ▪ Kohl, Surma, Al Koh: a powder used both as a cosmetic eye make-up and applied to skin infections and the navel of a newborn child. And can be ingested when on hands ▪ Kajal: eye cosmetic when used can be ingested if on hands. ▪ Sindoor: a powder applied to face or scalp during ceremonies, mistakenly used as food FOODS: ▪ Middle East: ▪ Lozeena: a bright orange powder used by Iraqis to color rice and meat▪ Mexico ▪ Chapulines (dried grasshoppers): can be chocolate coated; grasshoppers eat chilies that are contaminated with lead from soil and area silver mine fallout FOLK REMEDIES: ▪ Hispanic ▪ Azarcon aka: Ruedo, Corol, Maria Luiso, Alarcon, Ligo: used for intestinal illness. ▪ Mexico ▪ Greta: a yellow powder used for intestinal illness. ▪ Dominican Republic ▪▪ Litargirio: yellow peach powder used as a deodorant, foot fungicide, treatment for burns and wound healing. ▪ Vietnam/ Hmong Community ▪ Pay-loo-ah- a red powder given for rash or fever. ▪ Asian/ Tibet/ India/Thailand ▪ Ayurvedic medicine, ▪ Tibetan Herbal Vitamin ▪ China▪ Jin Bu Huan: used to relieve pain, ▪Po Ying Tan: used to treat minor ailments in children, ▪ Ba-Baw-San. ▪ India ▪ Ghasard: a brown powder given as an aid to digestion. ▪Thailand▪ Daw Tway is a digestive aid used in Thailand and Myanmar (Burma). ▪ Iran ▪ Bint Al Zahab: Rock ground into a powder and mixed with honey and butter given to newborn babies for colic and early passage of meconium after birth. ▪ Saudi Arabia ▪ Traditional Saudi Medicine: Orange powder prescribed by a traditional medicine practitioner for teething; also has an antidiarrheal effect, ▪Santrinj: An amorphous red powder containing 98% lead oxide used principally as a primer for paint for metallic surfaces, but also as a home remedy for "gum boils" and "teething."▪ Bint Dahab: A yellow lead oxide used by local jewelers and as a home remedy, ▪ Kuwait ▪ Bokhoor: A traditional practice of burning wood and lead sulphide to produce pleasant fumes to calm infants. Other: ▪Bala Goli: a round, flat, black bean dissolved in 'gripe water' and used for stomach ache. ▪Kandu: a red powder used to treat stomach ache. ; 6. Added: To be congruent with ACH 25: Does the patient live near a busy road/ highway? Soil around your home could be contaminated by the leaded gasoline fallout, on your soil or in water (cisterns/wells) for many years following contamination and can get on your child's hands. Lead can also be absorbed in fast growing plants such as Kale, spinach, and other garden vegetables from the soil and then consumed by animals and humans and can lead to increase in blood lead levels.	

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	• Paragraph: Deleted the word done and changed to completed to read as: Document in the medical record at every visit that the assessment was completed, any positive response(s) and action(s) taken: Added (s) to action. Moved Blood Lead Specimen Collection Guidelines to end of Lead Section: Added: to Blood Lead Testing, last line: *See Blood Lead Specimen Collection Guidelines in the Lead Section and also the Lab Section Pages 8-17: • DELETED the Entire: Lead Management Home Visits Section on original page 13; REPLACED with new information combined from original Lead Management Home Visits section and the Instruction Sheets for Home Visits, Follow-Up Home Visits and Onsite Visual Investigation, LHD's complained it was confusing to go back and forth to lead section to the instruction sheets to the forms… • SECTION MOVED FROM ORIGINAL PAGE 6: Changes noted: Changed: Case closure is defined according to the initial elevated level of classification (See Lead Classification Chart) Classess II, III,, IV, and V: to read: Case closure is determined according to the initial blood lead level and can be closed as follows: ADDED:BLL 10-14 µg/dL – Case closure is when BLL is less than 10µg/dL, repeat BLL as indicated; BLL 15µg/dL and greater–Case closure is when BLL is less than 10µg/dL for at least 6 months; environmental hazards have been; Changed "Removed" to addressed; and there are no new environmental hazards. • ADDED: When a child is closed to follow-up, according to PHPR guidelines, the date and reason for case closure, and any actions/interventions or comments should be recorded on the case management report in area provided. • Added on this line: A case may also be designated as *administrative closure* if all directives, as enumerated in the "Follow-up/Internal Tracking/Referral" section of the PHPR, have been completed. Added: The case manager must follow all procedures for closure in a lost to follow up case closure.nal (If a case has been closed and at a later date is reopened, send a new Initial Report Form with initial BLL and updated information. Please do not continue on old file and write reopened.) • Added: This information originally in the Lead Home Management section: Forms available @ http://chfs.ky.gov/dph/info/dpqi/PHPR.htm. and then go to Forms and Teaching Sheets and in this section go to Lead/ Report and Home Visit Forms/Onsite Visual Investigation Form. • MOVED BLOOD LEAD SCREENING GUIDELINES TO THIS NEXT SECTION PRIOR TO THE TARGETED ZIP CODES • ADDED: AFTER NOTE: The finger stick collection technique is more prone to environmental contamination than the venous and will affect specimen results. Special precautions are needed to prevent contamination. CDC recommends confirmation on all lead poisoned results with a venous specimen.	
Preventive Guidelines: Pediatric	Per AAP Preventive Guidelines, the following changes have been made: Page 2: Review verbal lead risk assessment and perform blood testing for at risk patients at age 9 months; lead lab testing to be performed at age 12 months; HCT/HGB lab testing to be performed at age 12 months. Page 4: Review verbal lead risk assessment and perform blood testing for at risk patients at age 6.	Pages 2, 4.
Sexually Transmitted Diseases	Page 4: Counseling – addition of "Pregnancy prevention". Reason: Integration of family planning services. Source: Kentucky Family Planning Program. Pages 8, 20-23: Requirements for STD Examinations – Removed "A single treatment regimen effective against gonorrhea can be used if NAATs test has ruled out Chlamydia infection" Reason: To remain consistent with CDC 2010 STD Treatment Guidelines:	Pages 4, 8, 12-13, 16, 20-24, 26-28, 36.

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	Provide dual therapy for gonococcal infections at all anatomic sites due to concerns about the possible emergence of cephalosporin resistance GC. Source: 2010 CDC STD Treatment Guidelines, pg 50. Page 12: Requirements of an STD Visit – General-Section 1.5.5: Changed "should provide partner services" to "shall provide partner services". Reason: Disrupt transmission of STDs Source: 2010 CDC STD Treatment Guidelines, pg 7. Page 13: Suggested Questions: Added "What are you doing to prevent pregnancy?" Reason: Integration of family planning services. Source: Kentucky Family Planning Program. Page 16: Requirements of an STD Visit – 4.7/5.7: Removed "Dependent upon availability at the LHD to submit to a private lab". Reason: Division of Laboratory Services has the ability to process CT/GC pharyngeal and rectal specimens. Source: Kentucky Division of Laboratory Services Pages 20-21: Protocols for Treatment – GC – Tests: Removed "APTIMA is not approved by the FDA for rectal or pharyngeal specimens. Culture is the preferred method of detection". Added: "APTIMA-DLS offers this molecular test on rectal and pharyngeal specimens". Reason: The Division of Laboratory Services validated rectal and pharyngeal specimens. Source: Kentucky Division of Laboratory Services Page 21: Protocols for Treatment – GC-Pharynx – Alternative RX: Changed language from "should have a pharyngeal culture" to " shall have a test of cure(NAAT) 3 weeks after completion of therapy". Reason: Strengthen adherence in performing tests of cure if the only alternative regimen for pharyngeal gonorrhea is a quinolone. Source: 2010 CDC STD Treatment Guidelines, pg 50; 2006 CDC STD Treatment Guidelines, pg 45. Page 22: Protocols for Treatment – Gonococal Infections –Children – Tests: Removed "Culture is preferred method of detection." Reason: "Culture is preferred method" – redundant. Page 24: Protocols for Treatment – Chlamydia – Tests: Removed "APTIMA is not approved by the FDA for rectal or pharyngeal specimens. Culture is the preferred method of detection". Added: "APTIMA-DLS offers this molecular test on rectal and pharyngeal specimens". Reason: The Division of Laboratory Services validated rectal and pharyngeal specimens. Source: Kentucky Division of Laboratory Services Pages 26-27: MPC – Partner Services: Added - Sex partners exposed during the previous 60 days should be examined and tested for gonorrhea and chlamydia on their initial visit. They shall also be screened for syphilis and HIV. "Asymptomatic sex partners should be preventively treated on their initial visit if the original patient's lab results are pending or positive." "Symptomatic sex partners should be empirically treated on their initial visit." Reason: Clarity. Source: 2010 CDC STD Treatment Guidelines, pg 44.	

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	Page 28: NGU – Partner Services: Added "***Empiric treatment for partners with a drug regimen effective against chlamydia is recommended for women exposed to NGU regardless of whether a specific etiology is identified in the original patient. Empiric gonorrhea treatment for partners may be omitted if ruled out by Gram Stain or NAATS testing in the original patient".*** Reason: Clarity. Source: 2010 CDC STD Treatment Guidelines, pg 42. Page 37: Footnotes – 4. Quinolones: Changed "Quinolones should not be used for treatment of gonorrhea" to "In most situations Quinolones should not be used for the treatment of gonorrhea. If a quinolone is the only alternative regimen available for gonorrhea, a test of cure is required. A test of cure can be performed using the APTIMA CT/GC Combo 2 (NAAT) Test 3 weeks after completion of therapy." Reason: Supporting documentation for the limited use of Ciprofloxacin to treat gonococcal infection of the pharynx and clarification regarding type of test for test-of-cure. Source: 2010 CDC STD Treatment Guidelines, pg 50; 2006 CDC STD Treatment Guidelines, pg 45.	
Tuberculosis	Pages 1, 3-6, 10, 32-33: The Centers for Disease Control published a new edition of the "Core Curriculum on Tuberculosis" in 2011. The edition of that reference was updated to 2011. Page 4: Assessment column: Added bullet "If chest x-ray is abnormal, obtain sputums and consider a suspect case." Page 5: • Condition column: "Positive lab test" and added "M. tuberculosis complex demonstrated in Nucleic Acid Amplification (NAA) test or PCR test." • Assessment column: Adherence section: Added "If more than 3 doses are missed, contact KY DPH TB staff." • Assessment column: Adherence section: Added bullet "Obtain baseline weight and monitor weights monthly." • Assessment column: Adherence section: Revised bullet: "Chest x-rays initially, at two months after starting therapy, and at 0 to 60 days after completion of therapy." • Assessment column: Adherence section: Added bullet: "Consult with DPH if the patient's status changes while on treatment." Page 7: Added second row to table: "NAA testing should be performed on at least one respiratory specimen from each patient with signs and symptoms of pulmonary TB for whom a diagnosis of TB is being considered but has not yet been established, and for whom the test result would alter case management or TB control activities.*" and revised Source listed in footnote. Page 36: Directly Observed Therapy: Revised fourth line in first paragraph: "All active TB disease, whether pulmonary or extrapulmonary, should be treated with DOT. The DOT method should be conveyed . . ." Page 48: Contact Investigation and Concentric Circle Approach. Revised the reference at the bottom, to list p. 91 Page 63: References: multiple revisions to update Weblinks and remove duplicate references.	All pages.
Women, Infants, and Children (WIC)	Page 14: Updated examples of encouraging healthy foods to include 5 fruits and vegetables and avoid sugar sweetened drinks Pages 14,23, 25, 27, 31: Updated Counseling Materials to include the 2011 My Plate Dietary Guideline Tip Sheets Page 21: Updated Nutrition Risk Code Criteria for Referral with current Fed Risk Code and	All pages.

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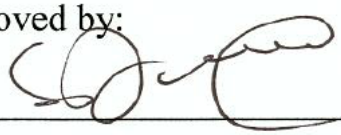
	clarified exceptions for referrals for Nutrition/Metabolic Conditions Page 22: Updated WIC Follow Up Counseling Guidelines to clarify assignment to group nutrition education must be made by the health professional; Updated WIC Follow Up Counseling Guidelines to assure MNT services are referred and appointed Pages 50-55: Updated Certificate of Medical Necessity Forms with current formula names and option to omit Formula/Medical Food from a food package Pages 56, 59: Removed Enfagrow Toddler Products from WIC approved Non-contract Formulas Page 57: Updated Formula/Medical food Names (Elacare Jr Vanilla, Elecare Jr Unflavored, Pediasure Peptide 1.0 Cal) Pages 58, 61, 64, 65, 66, 68, 69, 72, 81, 82, 83, 90: Updated Formula Names, Product size, package codes and Issuance in Food Package Tables Pages 73- 78, 80: Updated Package Codes to reflect Codes in CMS Portal Page 81: Relocated Whole Milk packages for older child and woman - moved packages to Food Package III table (removed from pages 74-78) Pages 73-79: Added Kosher Designated Food Packages Pages 84-87: Updated table title to include terminology "Medical Foods" Page 88: Corrected table to remove 1 pound whole wheat bread from Post Partum Package Pages 97-102: Corrected/ Clarified Federal risk codes on WIC 75 for 3010 and 6020 risk codes	

Forms and Teaching Sheets

Form	Description of Revision/Addition
ACH-25b	Added revision date to footer. No content changes.
BC-1	Added lines for notes above provider signature.
EM-1	Added new form Emergency Flow Sheet in the 'General' Folder in Forms and Teaching Sheets.
H&P 13/14	Adult forms have Colorectal Screening added and Developmental Screening deleted.
Lead	Removed all instruction forms. This information is now located within the Lead Section. Updated fax number on forms.

Approved by:



Commissioner, KDPH

1/12/12

Date