LOUISIANA STATE BOARD OF MEDICAL EXAMINERS
www.lsbme.la.gov

BOARD MEETING AGENDA

CALL O ORDER

	Time	Date	Location
Business Meeting	8:30 a.m.	August 24, 2026	630 Camp Street, New Orleans, 5th Floor Board Room

1.	**MINUTES/PRIOR MEETINGS/CONFERENCES PUBLIC COMMENT**
	Approval of public session minutes for Board meetings held on June 22, 2026
2.	**NEW BUSINESS**
	DRAFT Nutrition Course Act 463 - Companion Resource Guide
3.	**FOLLOW-UP ACTION ITEMS** DRAFT Cost Recovery NOI DRAFT Obesity Rules Repeal NOI DRAFT Restricted Licensure
4.	**GENERAL ADMINISTRATIVE MATTER**
	President's Report Executive Director's Report Director of Investigations' Report Financial Report Future Meeting Dates
	REGULATORY REPORT
	August 2026

EXECUTIVE SESSION

1	**MINUTES/PRIOR MEETINGS**
	Approval of executive session minutes for Board meeting held on June 22, 2026.
2	**LITIGATION**
	Nancy Lynn Rogers MD v. LSBME and Michael Francis MD No. 2025-10384, Civil District Court, Parish of Orleans Paula Pigford v. LSBME Civil Action No. 2:25cv02552 United States District Court, Eastern District of Louisiana Birthmark Doula Collective, LLC, et al. v. State of Louisiana, et al. No. 755,217 19th Judicial District Court (Parish of East Baton Rouge) Do No Harm v. Edwards, USDC-WDLA, No. 5:24-cv-00016 – JE,Jr. – JMH - Susie Soe, et al v. LSBME, et al, CDC Parish of Orleans, State of Louisiana, 2024-00172
3	**GENERAL ADMINISTRAVE MATTERS**
	Attorney Advice re: Employment Policy Attorney Advice as Needed
4	**LICENSURE, PERMITS AND CERTIFICATION**
	Licensee/Permit/Certification Applicant Request/Waivers
5	**REPORTS INVESTIGATIONS/ADJUICATIONS/LITIGATION**
	Docket Calendar Request to Initiate/Extend Preliminary Review and/or Ratify Interim Approval to Extend Preliminary Review. Request to Extend Formal Investigation and/or Ratify Interim Approval to Extend Formal Investigation Request for Board Approval of Consent Orders. Malpractice Report
6	**CLOSED CASE REPORT**
	June and July 2026
7	**PROBATION MATTERS**
	General Request – Licensee Request

PUBLIC SESSION

Section 1.1 Approval of Minutes

01.01.01 - DRAFT Public Minutes Meeting June 22, 2026

THE LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

MINUTES OF MEETING

June 22, 2026

NEW ORLEANS, LOUISIANA

A meeting of the Louisiana State Board of Medical Examiners, pursuant to lawful notice, was convened and called to order, at 8:30 a.m., June 22, 2026, by order of the President, at the anchor location of the Board, 630 Camp Street, New Orleans, Louisiana.

Board Members Present:

Roderick V. Clark, MBA, M.D., President
Rita Horton, M.D., Vice President
Leonard Weather, M.D., R.Ph., Secretary-Treasurer
Wyche Coleman, M.D.
John Hamide, M.D. - Absent
Leonel Lacayo, M.D.
Noelle Montgomery
James Taylor, M.D.
Terrie R. Thomas, M.D.
Cheryl Williams, M.D.

Board Staff present:

Vincent A. Culotta, Jr., M.D., Executive Director
Patricia Wilton, Esq., Executive Counsel
Lauryn Sudduth, Esq., General Counsel
Jacintha F. Duthu, Executive Staff Officer
Aloma L. James, Director of Licensing
Alan W. Phillips, IT Director
LaKenya Collins, CPA, CFO
Susie Allen, DrPH, MBA, Director of Education and Research
Michael Francis, M.D., Director of Investigation
James Tebbe, M.D., Assistant Director of Investigation
Lillie Rodgers, Investigations Program Director
Patricia Dufrene, Compliance Investigator
Darryl Albert, Compliance Investigator
Theresa Lockhart, Compliance Investigator
Angela Matherne, Compliance Investigator
Brittany LeBlanc, Compliance Investigator
Ron Cayette, Compliance Investigator
Joe Bonke, Compliance Investigator
Pat Tillman, Compliance Investigator
Jonell Deshotel, Compliance Investigator
Elizabeth Fallen, Compliance Investigator
Jamie Folse, Compliance Investigator
Noel Rome, Compliance Investigator

(1.) General Administrative Matters; Dr. Clark opened the meeting with the Pledge of Allegiance and a moment of silence for our country and the citizens of this state.

Dr. Clark introduced Mrs. Noelle Montgomery and welcomed her to the Board.

Dr. Culotta read the LSBME mission statement.

At this time the President asked if there were any Public Comments.

. The meeting was called to order and Dr. Culotta did a roll call, confirming there was a quorum of 9 members present.

(2.) Minutes of May 18, Meeting; The Board reviewed and discussed the minutes of the May 18, 2026, meeting. On the motion of Dr. Horton, duly seconded by Dr. Weather, the Board voted unanimously to approve the minutes of the May 18, 2026, meeting, with amendments.

(3.) New Business; Scope of Practice; Respiratory Therapist; Controlled Substance Medications; The Board was presented with a request from David Miller, Willis Knighton, for a ruling as to whether Respiratory Therapist (RT) who are part of a pediatric transport team be able to witness for the "wasting" of controlled medications. On the motion of Dr. Coleman, duly seconded by Dr. Weather, the Board voted unanimously to approve RTs ability to witness.

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(4.) Follow-up Action Items; Proposed Updates to APRN Collaborative Practice; The Board reviewed the proposed updates to the APRN collaborative practice. On the motion of Dr. Weather, duly seconded by Dr. Coleman, the Board voted unanimously to approve the updates.

(5.) Rulings and Advisory Opinions; Discussion Relevant to SB 30 (ACT 345) and SB 253 (Act 374) Request for Advisory Opinion re: Peptides; The Board received information regarding the recent passing of SB 30 and SB 253.

After formal discussion the Board convened in executive session to receive attorney advice. Upon return to public session, on the motion of Dr. Taylor duly seconded by Dr. Coleman, the Board voted 8 YEAS 1 NAY to begin promulgating rules for SB 30 and amend rules currently in process. When a draft of the proposed rules is complete, it will be returned to the Board.

The Board discussed SB 253, after discussion, on the motion of Dr. Tylor, duly seconded by Dr. Lacayo, the Board voted unanimously to begin drafting a statement of position.

(6.) General Administrative Matters; President's Report; The President encouraged public commentary regarding the amendments and best practices regarding collaborative practice agreements and what the advisory opinions need to look like. He stated that we will be working closely with the Nursing Board and may be able to create joint statements of position.

The President informed everyone that he has asked Drs. Weather and Hamide to take a look at our financial situation and give a five-year projection of what that would like and make a recommendation to the Board.

The President also asked Dr. Horton to take a look at the bylaws that were proposed last year and work with Ms. Wilton to formulate improvements if necessary and that Dr. Horton sees appropriate.

He again welcomed Ms. Montgomery to the Board.

(7.) General Administrative Matters; Executive Director's Report; The Executive Director reported that the legislature has ended and three of the four bills we wanted to pass were enacted into law.

HB 1182 regarding occupational therapy nomenclature updates and permissive change to temporary license passed. This bill was carried by Rep Peter Egan for the board. Rep Egan also successfully carried HB 405 to change nomenclature in the field of acupuncture.

Despite the great efforts of Rep Egan HB 1216 with an 89% chance of passing was deferred buy the Senate Health and Welfare committee effectively killing this legislation for the 2026 session. Rep Egan worked after the deferral and was close to getting it passed but one senator remained unalterably opposed to the bill.

The fourth bill affecting the Medical Prescribing Psychologists was carried by Rep. Dustin Miller for the MP association and was successfully enacted into law. This simplifies licensing two types of Medical Psychologist to a standard and advanced and makes the renewal process easier for the advanced practice providers. This is also anticipated to remedy the problems of CE tracking for the advanced license class.

We tracked 137 bills that had the potential to affect the LSBME or its licensees in some way, either as written or as possibly amended. In the end we list 37 bills that affect the agency or our licensees. I have attached a full tracking report for these 37 bills and the one study resolution that affects the board.

We are working to design the HCR 114 study and hope to have it operational for August 1, 2026.

(8.) General Administrative Matters; Director of Investigations' Report; Dr. Francis, DOI reported:

INVESTIGATIVE DIVISION BOARD REPORT

May 1st – 31st 2026

Number of complaints received: 111

Percentage of Complaints Resolved within 7 days: 46%

Number of cases closed: 72

Total number of cases opened in May still open: 39

Total number of all complaint cases closed in May: 88

Total number of open cases as of May 31st, 2026: Approximately 174

(9.) General Administrative Matters; Financial Report; The Board reviewed the financial report for April 2026. On the motion of Dr. Horton, duly seconded by Dr. Weather, the Board voted unanimously to approve the financial report.

(10.) **Administrative Matters; Next Meeting Dates;** The Board reviewed the 2026 meeting dates. No further action was needed or taken on this matter.

(11.) Rules and Regulations. Rules/Amendments; The Board reviewed the Rules Chart for June 2026 updates. No further action was needed or taken on this matter.

[12.] Minutes of Executive Sessions. Upon the motion of Dr. Coleman, duly seconded by Dr. Weather, the Board voted unanimously to convene in executive session pursuant to La. R.S. 42:17A to receive and review the executive minutes of the Board's May 18, 2026, meeting. Following the review, the Board returned to the Public Session. Upon the motion of Dr. Coleman, duly seconded by Dr. Lacayo, the Board voted unanimously to approve the minutes of the May 18, 2026, meeting with amendments.

[13.] Report on Pending Litigation. Upon the motion of Dr. Thomas duly seconded by Dr. Lacayo, the Board voted unanimously to convene in executive session pursuant to La. R.S. 42:17A(2, 4 and 10), La. C.E. art. 508, and/or La. R.S. 44:4.1C, to receive and review the report of legal counsel on pending litigation to which the Board is a party, the unauthorized practice of medicine cases assigned for injunction, and the status of proceedings for judicial review of prior Board decisions.

Nancy Lynn Rogers, M.D. v. LSBME and Michael Francis, M.D., No. 2025-10384, Civil District Court, Parish of Orleans

Paula Pigford v. LSBME Civil Action No. 2:25cv02552 United States District Court, Eastern District of Louisiana

Birthmark Doula Collective, LLC, et al. v. State of Louisiana, et al. No. 755,217 19th Judicial District Court (Parish of East Baton Rouge)

Do No Harm v. Edwards, USDC-WDLA, No. 5:24-cv-00016 – JE,Jr. – JMH –

Susie Soe, et al v. LSBME, et al, CDC Parish of Orleans, State of Louisiana, 2024-00172

[14.] General Administrative Matters; Licensure Matters; The Board reviewed the licensee's request for a waiver of licensing requirements, namely ACGME accredited training in Agenda No. 05.00.01. Upon returning to public session, on the motion of Dr. Horton, duly seconded by Dr. Coleman, the Board voted unanimously to approve the waiver.

[15.] General Administrative Matters; Licensure Matters; The Board reviewed the request for a one-month short-term program in Agenda No. 05.00.02. Upon returning to public session, on the motion of Dr. Horton, duly seconded by Dr. Coleman, the Board voted unanimously to the waiver of examination attempts.

[16.] Personal Appearances/Docket Calendar. On the motion of Dr. Coleman, duly seconded by Dr. Horton, and passed by unanimous voice vote, the Board convened in executive session to review the calendar of personal appearances and docketed hearings, as matters relating to investigations, the character and professional conduct of a licensee and allegations of misconduct, pursuant to La. R.S. 42:17(A)(1), (4) & (10), La. C.E. art. 508, and/or La. R.S. 44:4.1C. No further action was needed or taken on this matter.

Formal Hearing 24-A-006 was held at the May meeting with licensee via Zoom. The Board sustained the suspension.

After the conclusion of the meeting, there was a hearing of Adjudication File No. 25-A-004. No other action was needed or taken at this time.

[17.] Investigative Reports. On the motion of Dr. Coleman, duly seconded by Dr. Weather, and passed by unanimous voice vote, the Board convened in executive session to consider the investigative reports as matters relating to the character and professional conduct of a licensee, and allegations of misconduct, pursuant to La. Rev. Stat. §42:17A(1) and (4). Following review and discussion, the Board resumed in public session as follows:

a. Initiate Formal Investigation: On the motion of Dr. Horton, duly seconded by Dr. Weather, the Board voted unanimously to initiate formal investigation in the following matters:

Investigation No.	2026-I-299
Investigation No.	2026-I-354
Investigation No.	2026-I-213
Investigation No.	2025-I-721
Investigation No.	2026-I-46
Investigation No.	2026-I-353

b. Extend Time for Preliminary Review: The Board considered granting a 90-day extension to continue preliminary review in the following matters and to authorize the DOI to request Executive Counsel to proceed with measures to enforce compliance with Board subpoenas where no response had been received within 90 days of issuance;

On the motion of Dr. Weather, duly seconded by Dr. Coleman, the Board voted unanimously to approve extending the following matters:

Investigation No.	2026-231

c. Consent Orders/Voluntary Surrender: On the motion of Dr. Horton, duly seconded by Dr. Coleman, the Board voted unanimously to approve the proposed consent order in the following matters:

Investigation No.	2025-I-307
Investigation No.	2024-I-190
Investigation No.	2021-I-1074

d. Close/Letter of Concern/Enhanced Letter of Concern: On the motion of Dr. Taylor, duly seconded by Dr. Lacayo, the Board voted unanimously to approve closing the following with a letter of concern:

Investigation No.	2026-I-183

On the motion of Dr. Lacayo, duly seconded by Dr. Weather, the Board voted unanimously to approve closing the following with a letter of concern:

Investigation Nos.	2026-I-82 2026-I-93 2026-I-94 2026-I-190 2026-I-191 2026-I-193 2026-I-195 2026-I-197

On the motion of Dr. Coleman, duly seconded by Dr. Williams, the Board voted unanimously to increase to an enhanced letter of concern with education and an added rules course in the following matter:

Investigation No.	2026-I-271

On the motion of Dr. Coleman, duly seconded by Dr. Lacayo, the Board voted unanimously to approve closing the following with a letter of concern:

Investigation No.	2026-I-251

On the motion of Dr. Taylor, duly seconded by Dr. Williams, the Board voted unanimously to approve closing the following with a letter of concern:

Investigation No.	2026-I-220

On the motion of Dr. Taylor, duly seconded by Dr. Williams, the Board voted unanimously to approve closing the following with an enhanced letter of concern:

Investigation No.	2026-I-34
Investigation No.	2026-I-120

e. Close/Dismissal with No Action: On the motion of Dr. Horton, duly seconded by Dr. Coleman, the Board voted unanimously to approve closing the following matters with no action:

Investigation No.	2026-288
Investigation No.	2026-243
Investigation No.	2026-274
Investigation No.	2025-814

Investigation No.	2026-230
Investigation No.	2026-295
Investigation No.	2026-133
Investigation No.	2026-136
Investigation No.	2026-207
Investigation No.	2025-853
Investigation No.	2026-293
Investigation No.	2026-206
Investigation No.	2026-269
Investigation No.	2026-262
Investigation No.	2026-185
Investigation No.	2026-208
Investigation No.	2026-360
Investigation No.	2026-261
Investigation No.	2026-307
Investigation No.	2026-285
Investigation No.	2026-219
Investigation No.	2026-217
Investigation No.	2026-218
Investigation No.	2026-221
Investigation No.	2026-127
Investigation No.	2026-308
Investigation No.	2026-297

f. Professional Liability Report: The Board voted unanimously to convene in executive session to consider the report on professional liability cases reviewed since the last meeting of the Board as matters relating to the character and professional conduct of a licensee and allegations of misconduct, La. Rev. Stat. § 42:17A(1) and (4). Upon returning to public session, on the motion of Dr. Coleman, duly seconded by Dr. Williams, the Board voted unanimously to accept the June 2026 report.

g. Closed Case Report: The Board voted unanimously to convene in executive session to review allegations of misconduct pursuant to La. Rev. Stat. § 42:17A(4), as part of the closed case report. The Board returned to public session and upon the motion of Dr. Horton duly seconded by Dr. Coleman, the Board voted unanimously to approve the May 2026 closed case summary report.

[18.] Probationary Matter; On the motion of Dr. Horton, duly seconded by Dr. Lacayo, the Board voted unanimously to approve terminating probation in Agenda No. 09.02.01.

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Next Meeting of the Board. The President reminded the members that the next meeting of the Board is scheduled for July 27, 2026, but may be cancelled.

I HEREBY CERTIFY that the foregoing is a full, true, and correct account of the proceedings of the meeting of the Louisiana State Board of Medical Examiners, save for executive session, conducted therein, held on June 22, 2026, and approved by the Board on the 24th day of August 2026.

Leonard Weather, M.D., R.Ph,
Secretary-Treasurer

Roderick Clark, M.D., MBA
President

Section 1.2 New Business

01.02.01 DRAFT Nutrition Course Act 463 - Companion Resource Guide

The Nutrition Essentials course as required by Act 463-2025 of the Louisiana legislature consists mostly of a video that may be viewed by clicking the link below.

Review Link: HTTP://vimeo.com/reviews/cc868ee3-ec3d-4d4b-b67a-82d94f6993e8/videos/1212130330

There is also a companion resource guide that will be included as part of the course, please review the following document.

LOUISIANA STATE BOARD
OF MEDICAL EXAMINERS

Nutrition Essentials for Clinical Practice

COMPANION RESOURCE GUIDE

Developed by

Alice Hoyt, MD
Molly Kimball, RD, CSSD

JULY 2026

01 Why This Moment in Nutrition Matters

Clarify why nutrition matters in clinical practice and when physicians should refer.

WHY IT MATTERS

A 2024 JAMA Network Open consensus statement identified 36 core nutrition competencies for physician training, underscoring nutrition as a recognized gap in medical education and a growing part of modern clinical care.

KEY TAKEAWAYS

Nutrition affects nearly every specialty

Patients are asking more nutrition questions

Dietary patterns matter more than single nutrients

Physicians should recognize nutrition risk and refer

CITATIONS

Louisiana nutrition CME legislation
Act No. 463: legis.la.gov/legis/ViewDocument.aspx?d=1426851

Nutrition Competencies for Physician Training
Eisenberg DM, et al. Proposed Nutrition Competencies for Medical Students and Physician Trainees. JAMA Network Open. 2024. doi:10.1001/jamanetworkopen.2024.38718

Physician Nutrition Knowledge and Confidence
Vrkatić A, Grujičić M, Jovičić-Bata J, Novaković B. Nutritional Knowledge, Confidence, Attitudes towards Nutritional Care and Nutrition Counselling Practice among General Practitioners. Healthcare. 2022;10(11):2222. doi:10.3390/healthcare10112222

Nutrition Misinformation and Social Media
Nutrition misinformation and social media: R. Diyab, et al. “Exploring Nutrition Misinformation on Social Media Platforms.” Proceedings of the Nutrition Society, vol. 84, no. OCE1, 1 Apr. 2025, doi:10.1017/S0029665125000187

02 What Good Nutrition Looks Like

Define practical, evidence-based nutrition principles for clinical conversations.

WHY IT MATTERS

A 2024 umbrella review found no single “best diet” for cardiometabolic health. The consistent themes were diet quality, minimally processed foods, adequate protein, fiber-rich plants and eating patterns patients can sustain.

KEY TAKEAWAYS

Good nutrition does not require perfection

Protein, fiber and whole foods matter

Dietary patterns matter more than single nutrients

Small improvements create meaningful benefits

CITATIONS

Federal Dietary Guidance

U.S. Departments of Health and Human Services and Agriculture. 2025–2030 Dietary Guidelines for Americans. 2025. cdn.realfood.gov/DGA.pdf

Scientific Foundation for the Dietary Guidelines

U.S. Departments of Health and Human Services and Agriculture. Scientific Report of the 2025–2030 Dietary Guidelines Advisory Committee. December 2025. dietaryguidelines.gov/2025-advisory-committee-report

Dietary Patterns and Cardiometabolic Health

Chatzi CA, Basios A, Markozannes G, Ntzani EE, Tsilidis KK, Kazakos K, Agouridis AP, Barkas F, Pappa M, Katsiki N, et al. Effect of Different Dietary Patterns on Cardiometabolic Risk Factors: An Umbrella Review of Systematic Reviews and Meta-Analyses. Nutrients. 2024;16:3873. doi:10.3390/nu16223873

RESOURCES

Evidence-Based Resources

Harvard Nutrition Health Hub
Evidence-based nutrition articles from Harvard Medical School covering dietary patterns, protein, fiber, healthy fats and nutrition for chronic disease prevention.

Academy of Nutrition and Dietetics Health Hub
Consumer-friendly nutrition guidance from the Academy of Nutrition and Dietetics, including healthy eating, meal planning and condition-specific nutrition resources.

Practical Tools

Eat Fit Mobile App
Find Eat Fit-approved restaurant meals across Louisiana with full nutrition facts, plus recipes, educational videos and practical tools to support everyday healthy eating.

Brand-Specific Shopping Guide
Practical guide comparing grocery products by brand, helping patients identify higher-protein, higher-fiber and lower-added-sugar options while shopping.

03 Dietary Guidelines:

What Changed + What's Misunderstood

Review how Dietary Guidelines influence clinical and public health conversations.

WHY IT MATTERS

Dietary Guidelines influence school meals, federal nutrition programs, food policy and the broader food environment. Recent policy reviews highlight food insecurity, diet quality and ultra-processed foods as major public health priorities.

KEY TAKEAWAYS

Guidelines shape policy and food environments

They influence schools, programs and manufacturing

Current discussions include protein, UPFs and alcohol

Nutrition guidance evolves with the evidence

CITATIONS

2025-2030 Dietary Guidelines
U.S. Departments of Health and Human Services and Agriculture. 2025–2030 Dietary Guidelines for Americans. 2025. cdn.realfood.gov/DGA.pdf

Nutrition Policy and Population Health
Levy LC, Perez-Velazco X. Impacts of Nutrition Policy on Food Insecurity and Individual Health in the United States: A Narrative Review. The Journal of Nutrition. 2026;156(1):101233. doi:10.1016/j.tjnut.2025.10.043

Ultra-Processed Food Policy
Pomeranz JL, et al. U.S. Policies Addressing Ultra-Processed Foods. Milbank Quarterly. 2024;102(1):120-154. doi:10.1111/1468-0009.12689

RESOURCES

Scientific Report: 2025 Dietary Guidelines Advisory Committee
Comprehensive evidence review and scientific foundation supporting 2025–2030 Dietary Guidelines, including research that informed recommendations on dietary patterns, protein, ultra-processed foods and public health nutrition.

Ochsner Foodservice Wellness Commitment
Eat Fit at Ochsner Health, a health-system initiative designed to increase access to healthier foods and beverages through cafeterias, vending and micromarkets. Reduces cost barriers via discounted pricing of Eat Fit items. An example of how healthcare systems can align food environment with nutrition goals encouraged in clinical practice.

04 Protein: Reframing Adequacy

Review protein needs across aging, illness and weight loss.

WHY IT MATTERS

Protein requirements, especially for older adults, remain an active research area. Reviews highlight adequate protein and resistance exercise as key strategies for preserving muscle, strength and function with aging.

KEY TAKEAWAYS

Protein needs may be higher than expected

Protein supports muscle, recovery and satiety

Needs increase with aging and weight loss

Adequate intake differs from optimal intake

CITATIONS

Protein Requirements in Older Adults
Nishimura Y, et al. Dietary Protein Requirements and Recommendations for Healthy Older Adults: A Critical Narrative Review of the Scientific Evidence. Nutrition Research Reviews. 2023;36(1):1-48. doi:10.1017/S0954422421000329

Protein and Sarcopenia Prevention
Rogeri PS, et al. Strategies to Prevent Sarcopenia in the Aging Process: Role of Protein Intake and Exercise. Nutrients. 2022;14(1):52. doi:10.3390/nu14010052

Protein During GLP-1 Therapy
Arslan S. Medical Nutrition in the Glucagon-Like Peptide-1 (GLP-1) Era: Protein Strategies, Micronutrient Monitoring, and Lean Mass Preservation. Clinical Nutrition ESPEN. 2026;73:103305. doi:10.1016/j.clnesp.2026.103305

Protein and Exercise Position Statement
Jäger R, et al. International Society of Sports Nutrition Position Stand: Protein and Exercise. Journal of the International Society of Sports Nutrition. 2017;14:20. doi:10.1186/s12970-017-0177-8

RESOURCES

Patient Education

Harvard Health Publishing. High-Protein Foods: The Best Protein Sources to Include in a Healthy Diet. Practical overview of protein-rich foods, protein quality and strategies for meeting protein needs through everyday eating.

Practical Tool

MyFitnessPal Protein Calculator. Interactive calculator; estimates daily protein needs based on age, weight, activity level and health goals. Reviewed by registered dietitians, informed by ISSN Position Stand and Academy recommendations. Designed to support individualized protein goals rather than a one-size-fits-all approach.

05 Ultra-Processed Foods

Review how ultra-processed foods affect diet quality and health outcomes.

WHY IT MATTERS

Ultra-processed foods now provide more than half of U.S. calories. A randomized feeding study found higher calorie intake and weight gain on an ultra-processed diet, while newer studies link higher intake with cardiometabolic, mental health, cognitive and cancer risks.

KEY TAKEAWAYS

UPFs contribute substantially to poor diet quality

Higher intake is linked with chronic disease risk

Overall dietary patterns matter more than single ingredients

Reducing UPFs can improve multiple health markers

CITATIONS

Randomized Controlled Trial of Ultra-Processed Foods
Hall KD, Ayuketah A, Brychta R, et al. Ultra-Processed Diets Cause Excess Calorie Intake and Weight Gain: An Inpatient Randomized Controlled Trial of Ad Libitum Food Intake. Cell Metabolism. 2019;30(1):67-77.e3. doi:10.1016/j.cmet.2019.05.008

Ultra-Processed Foods and Mental Health
Lane MM, Gamage E, Du S, et al. Ultra-Processed Food Consumption and Mental Health: A Systematic Review and Meta-Analysis of Observational Studies. Nutrients. 2022;14(13):2568. doi:10.3390/nu14132568

Ultra-Processed Foods and Cancer Risk
Lian Y, Yang B, Li X, et al. Association Between Ultra-Processed Foods and Risk of Cancer: A Systematic Review and Meta-Analysis. Frontiers in Nutrition. 2023;10:1175404. doi:10.3389/fnut.2023.1175404

RESOURCES

Clinical Overview

Johns Hopkins Medicine. Ultra-Processed Foods: Q&A with 2 Dietitians. Evidence-based overview explaining what ultra-processed foods are, why they matter and practical ways to reduce them.

Resources and citations continue on next page →

05 Ultra-Processed Foods (Continued)

CITATIONS

Ultra-Processed Foods and Cognitive Decline
Wang L, et al. “Increased Ultra-Processed Food Consumption and Risk of Dementia, Cognitive Impairment No Dementia, and Combined Cognitive Outcomes Among Older U.S. Adults.” American Journal of Public Health. 2026. doi:10.2105/AJPH.2025.308106

Ultra-Processed Foods and Inflammation
Tristan Asensi M, Napoletano A, Sofi F, Dinu M. Low-Grade Inflammation and Ultra-Processed Foods Consumption: A Review. Nutrients. 2023;15(7):1650. doi:10.3390/nu15071650

Ultra-Processed Food Addiction
LaFata EM, Moran AJ, Volkow ND, Gearhardt AN. Now Is the Time to Recognize and Respond to Addiction to Ultra-Processed Foods. Nature Medicine. 2025. doi:10.1038/s41591-025-03858-6

Nutritional Characteristics of Ultra-Processed Foods
Gearhardt AN, et al. “Nutritional Characteristics of Ultra-Processed Foods.” American Journal of Public Health. 2026. doi:10.2105/AJPH.2025.308113

Tobacco Industry Influence on Ultra-Processed Foods
AJPH Editorial. Big Food's Tobacco Moment: Evidence on the Harms of Ultra-Processed Foods. American Journal of Public Health. 2026. doi:10.2105/AJPH.2026.308501

A Case Study of Lunchables
Laura A. Schmidt. “Tobacco Industry Contributions to the Development of Ultra-Processed Food in the United States, 1985–2007: A Case Study of Lunchables.” American Journal of Public Health 116, no. 7 (July 1, 2026): pp. 940-949. doi:10.2105/AJPH.2026.308491

Ultra-Processed Foods and Public Health Policy
Touvier M, da Costa Louzada ML, Mozaffarian D, Baker P, Juul F, Srour B. Ultra-Processed Foods and Cardiometabolic Health: Public Health Policies to Reduce Consumption Cannot Wait. BMJ. 2023;383:e075294. doi:10.1136/bmj-2023-075294

RESOURCES

Background Review
Harvard Health Publishing. What Are Ultra-Processed Foods and Are They Bad for Our Health? Explains the NOVA classification system, current evidence and why overall dietary pattern matters more than any single ingredient.

Researcher Interview
FUELED Wellness + Nutrition Podcast. Ultra-Processed Foods: What the Latest Research Reveals About Addiction, Brain Health and More. Interview with researcher Erica LaFata, PhD, discussing food addiction, cognitive decline, industry influence and practical strategies for reducing ultra-processed foods.

06 Real-World Nutrition in Everyday Life

Discuss practical strategies that fit patients' real lives.

WHY IT MATTERS

Behavior change is more sustainable when guidance feels practical, personalized and nonjudgmental. Motivational interviewing and lifestyle counseling research support patient-centered strategies that fit real life rather than rigid advice patients cannot maintain.

KEY TAKEAWAYS

- **Many patients rely on convenience foods**
- **Small changes often outperform strict restriction**
- **Nonjudgmental care improves patient disclosure**
- **Realistic guidance improves long-term adherence**

CITATIONS

Motivational Interviewing and Adherence
Palacio A, Garay D, Langer B, Taylor J, Wood BA, Tamariz L. Motivational Interviewing Improves Medication Adherence: A Systematic Review and Meta-Analysis. Journal of General Internal Medicine. 2016;31(8):929-940. doi:10.1007/s11606-016-3685-3

Lifestyle Counseling in Primary Care
Alqahtani N. Lifestyle Counseling in Primary Care: Effectiveness, Strategies, and Clinical Implications. International Journal of General Medicine. 2025;18:6741-6756. doi:10.2147/IJGM.S559996

Behavior Change and Health Outcomes
Parkinson JA. Promoting Behavioral Change to Improve Health Outcomes. Behavioral Sciences. 2025;15(4):417. doi:10.3390/bs15040417

RESOURCES

Motivational Interviewing Resource
Deliberate Practice in Motivational Interviewing. Manuel JK et al. Practical guide from American Psychological Association with evidence-based motivational interviewing techniques to support behavior change and improve patient engagement.

Practical Tools

Brand-Specific Shopping Guide
Practical guide comparing grocery products by brand, helping patients identify higher-protein, higher-fiber and lower-added-sugar options while shopping.

Fast Food Guide: Better Choices on the Go
Practical guide highlighting healthier menu options from popular restaurant chains, making it easier for patients to make realistic improvements when eating away from home

07 | Dietary Supplements: Creating Better Conversations

Provide a framework for evidence-based supplement conversations.

WHY IT MATTERS

Dietary supplement use is common, yet patients often do not disclose it. Evidence varies widely, from well-supported products to marketing-driven claims, making open discussion, safety review and trusted evaluation resources essential.

KEY TAKEAWAYS

- **Clinicians need trusted supplement resources**
- **Many patients do not disclose supplements**
- **Judgment reduces patient disclosure**
- **Some supplements have meaningful evidence**
- **Product quality varies substantially**

CITATIONS

Dietary Supplement Use Among U.S. Adults
Mishra, Shilpa, Brian Stierman, Jaime J. Gahche, and Nancy Potischman. "Dietary Supplement Use Among Adults: United States, 2017–2018." NCHS Data Brief, no. 399, National Center for Health Statistics, 2021. doi:10.15620/cdc:101131

Importance of Clinician Awareness of Supplement Use
National Center for Complementary and Integrative Health. "Complementary, Alternative, or Integrative Health: What's In a Name?" National Institutes of Health. https://www.nccih.nih.gov/health/complementary-alternative-or-integrative-health-whats-in-a-name

Evidence-Based Evaluation of Supplements
Blumberg J, Bailey R, Sesso H, Ulrich C. "The Evolving Role of Multivitamin/Multimineral Supplement Use among Adults in the Age of Personalized Nutrition." Nutrients. 2018;10:248. doi:10.3390/nu10020248

RESOURCES

Examine.com. Independent, evidence-based resource that reviews clinical research on dietary supplements, including efficacy, dosing, safety considerations and strength of evidence.

ConsumerLab.com. Independent testing service that evaluates dietary supplements for purity, potency, quality and label accuracy.

National Institutes of Health Office of Dietary Supplements. Evidence-based fact sheets for clinicians and patients covering supplement efficacy, safety, dosing and potential interactions.

National Center for Complementary and Integrative Health (NCCIH). NIH resource providing research summaries and patient education on dietary supplements, complementary therapies and integrative health.

08 Alcohol

Review alcohol's effects on health, mood and disease risk.

WHY IT MATTERS

Alcohol remains widely used, but evidence increasingly challenges assumptions about low-risk intake. The 2025 U.S. Surgeon General's Advisory identified alcohol as a preventable cancer risk, with newer research linking intake to anxiety, inflammation, cardiovascular concerns and mortality.

KEY TAKEAWAYS

Alcohol affects more than liver health

Alcohol increases cancer and sleep risks

Moderate intake may still carry risk

Reducing intake can produce measurable benefits

CITATIONS

Alcohol and Cancer Risk
Alcohol and Cancer Risk: The U.S. Surgeon General's Advisory. Washington, DC: U.S. Department of Health and Human Services; 2025.

Alcohol Intake and Mortality
Alcohol Intake and Health Study. "Alcohol Intake and Health Study: No Protective Effect at Low Levels, With Mortality Increasing to 1 in 25 at 14 Drinks Per Week." Journal of Studies on Alcohol and Drugs. 2026;87(4):621-638. doi:10.15288/jsad.25-00435

Alcohol and Cardiovascular Risk
Biddinger KJ, Emdin CA, Haas ME, et al. Association of Habitual Alcohol Intake with Risk of Cardiovascular Disease. JAMA Network Open. 2022;5(3):e223849. doi:10.1001/jamanetworkopen.2022.3849

Alcohol and Anxiety
D'Aquino S, Hamilton B, Galletly C, et al. Long-Term Effects of Alcohol Consumption on Anxiety in Adults: A Systematic Review. Addictive Behaviors. 2024;154:108011. doi:10.1016/j.addbeh.2024.108047

Alcohol and Inflammation
Tharmalingam J, Sivalingam K, Tharmalingam S, et al. Impact of Alcohol on Inflammation, Immunity, Infections, and Extracellular Vesicles in Pathogenesis. Cureus. 2024;16(3):e56923. doi:10.7759/cureus.56923

RESOURCES

#ALCOHOL FREE FOR 40

Alcohol Free for 40. Annual community challenge offering practical strategies, expert education and peer support for reducing or eliminating alcohol consumption.

National Cancer Institute. Alcohol and Cancer Risk Fact Sheet. Evidence-based overview of alcohol's role in cancer risk and practical information for patient counseling.

Centers for Disease Control and Prevention. Alcohol and Cancer. Public health overview of alcohol-related cancer risk and prevention recommendations.

09 Metabolic Dysfunction-Associated Steatotic Liver Disease (MASLD)

Review nutrition, lifestyle and early intervention in MASLD.

WHY IT MATTERS

MASLD is among the most common chronic liver diseases worldwide and closely tracks with metabolic dysfunction. Recent studies link higher diet quality with lower MASLD prevalence and higher ultra-processed food intake with greater MASLD risk.

KEY TAKEAWAYS

- MASLD is increasingly common worldwide
- It tracks closely with metabolic dysfunction
- Diet quality influences MASLD risk
- Early intervention may prevent progression
- Symptoms often appear late
- Lifestyle remains first-line therapy

CITATIONS

Diet Quality and MASLD Risk
Sualeheen A, Alkhayyat M, Mansour M, et al. Higher Diet Quality Is Associated with a Lower Prevalence of MASLD and Adverse Health Outcomes: Insights From NHANES 2005 to 2020. Nutrients. 2025;17(19):3332. doi:10.3390/nu17193332

Cardiometabolic Drivers of MASLD Progression
Song Z, Zhang Y, Wang X, et al. Associations Between Cardiometabolic Indices and the Onset of Metabolic Dysfunction-Associated Steatotic Liver Disease as Well as Its Progression to Liver Fibrosis: A Cohort Study. Frontiers in Endocrinology. 2025;16:1566938. doi:10.3389/fendo.2025.1566938

Ultra-Processed Foods and MASLD
Zhang J, Wang Y, Liu X, et al. Ultra-Processed Foods and Non-Alcoholic Fatty Liver Disease: An Updated Systematic Review and Dose-Response Meta-Analysis. Frontiers in Nutrition. 2025;12:1605005. doi:10.3389/fnut.2025.1605005

RESOURCES

Professional Guidance
AASLD MASLD Nomenclature and Guidance. Professional guidance on MASLD terminology, diagnosis and evidence-based clinical management.

Clinical Nutrition Guidance
Mayo Clinic MASLD Diet Guide. Practical nutrition recommendations for patients with metabolic dysfunction-associated steatotic liver disease.

Patient Education
American Liver Foundation – MASLD Overview.
Patient-friendly overview of MASLD, including risk factors, symptoms and treatment.

Patient Handouts
American Liver Foundation Educational Materials.
Downloadable patient education resources supporting nutrition and lifestyle management.

10 Continuous Glucose Monitors (CGM): Expanding Role

Review clinical and lifestyle applications of continuous glucose monitoring.

WHY IT MATTERS

CGM is the standard of care for many patients with diabetes. Emerging research suggests CGMs may also support lifestyle awareness, while a 2026 randomized trial found CGM-guided nutrition improved glycemic and metabolic outcomes in prediabetes and type 2 diabetes.

KEY TAKEAWAYS

- **CGMs reveal individual glucose responses**
- **CGMs may improve lifestyle awareness**
- **Interpret data within clinical context**
- **Not every fluctuation requires action**

CITATIONS

ADA Standards of Care 2026
Bajaj M, Peters AL, Aleppo G, et al. 7. Diabetes Technology: Standards of Care in Diabetes—2026. Diabetes Care. 2026;49(Suppl 1):S150-S165. doi:10.2337/dc26-S007

Clinical Perspective
Klonoff, David C., David Kerr, Jing Li, et al. "Use of Continuous Glucose Monitors by People Without Diabetes: An Idea Whose Time Has Come?" Journal of Diabetes Science and Technology, vol. 18, no. 1, 2024, pp. 43–50. doi:10.1177/19322968221110830

CGM and Behavior Change in People Without Diabetes
Ahmed N, Khan S, Patel R, et al. Use of Continuous Glucose Monitoring in Non-Diabetic Individuals for Cardiovascular Prevention: A Systematic Review of Its Impact on Guiding Lifestyle Interventions. Cureus. 2025;17(10):e94460. doi:10.7759/cureus.94460

CGM and Prediabetes/T2D-Awareness Evidence
Chen Y, Li X, Zhang H, et al. CGM-Guided Personalized Diet Enhances Glycemic and Metabolic Outcomes in Chinese Adults with Prediabetes and T2DM: A Randomized Trial. Food Science and Human Wellness. 2026. doi:10.26599/FSHW.2026.9250961

RESOURCES

Professional Guidance
American Diabetes Association. CGM & Time in Range. Professional guidance on continuous glucose monitoring, interpretation of time-in-range data and clinical applications.

Patient Education
Continuous Glucose Monitors (CGMs) for Type 2 Diabetes: When and for Whom Are They Useful? Harvard Health Publishing. Who may benefit from CGMs and how they can support diabetes management.

Practical Implementation
Hello Lingo. Consumer-focused CGM platform designed to increase awareness of glucose responses to food, activity, sleep and lifestyle habits.

Freestyle Libre Prescribing Information. Clinical prescribing information, indications and safety details for healthcare professionals.

11 GLP-1 Medications and Nutrition

Review nutrition priorities during GLP-1 therapy.

WHY IT MATTERS

GLP-1 medications have transformed obesity and diabetes care, with benefits extending beyond weight loss. Newer research also highlights the need to prioritize protein intake, resistance training, micronutrient adequacy and muscle preservation from the start of therapy.

KEY TAKEAWAYS

- **GLP-1s have transformed obesity and diabetes care**
- **Benefits extend beyond weight loss**
- **Protein and resistance training remain essential**
- **Muscle preservation requires early attention**
- **Refer early, before complications develop**

CITATIONS

GLP-1 Benefits Beyond Weight Loss
Gonzalez-Rellan M, Drucker DJ. The Expanding Benefits of GLP-1 Medicines. Cell Metabolism. 2025;37(8):1703-1718. doi:10.1016/j.cmet.2025.06.013

Cardiovascular Benefits
Vezza T, Muscogiuri G, Colao A, et al. Beyond Weight Loss: Evaluating Cardiovascular Advantages of GLP-1 Receptor Agonists. American Journal of Cardiovascular Drugs. 2024;24(5):495-507. doi:10.1007/s40256-024-00650-8

Weight-Loss Maintenance
Aronne LJ, Sattar N, Horn DB, et al. Continued Treatment With Tirzepatide for Maintenance of Weight Reduction in Adults With Obesity: The SURMOUNT-4 Randomized Clinical Trial. JAMA. 2024;331(1):38-48. doi:10.1001/jama.2023.24945

RESOURCES

Professional Guidance
Obesity Medicine Association. Professional guidance on obesity treatment, including nutrition, lifestyle interventions and anti-obesity medications.
Endocrine Society. Evidence-based clinical practice guidelines for obesity, diabetes and endocrine disorders.

Safety Guidance
American Diabetes Association Announces Statement on Compounded Incretin Products. Safety guidance regarding compounded GLP-1 medications and clinical considerations for healthcare professionals.

Resources and citations continued on next page →

11 GLP-1 Medications and Nutrition (Continued)

CITATIONS

Lean Mass Loss
Neeland IJ, Marso SP, Ayers CR, et al. Changes in Lean Body Mass with Glucagon-Like Peptide-1-Based Therapies and Mitigation Strategies. Diabetes, Obesity and Metabolism. 2024;26(10):4458-4470. doi:10.1111/dom.15728

Protein and Sarcopenia Considerations
Memel ZN, D'Souza A, Batsis JA. Impact of GLP-1 Receptor Agonist Therapy in Patients High Risk for Sarcopenia. Current Nutrition Reports. 2025. doi:10.1007/s13668-025-00649-w

Micronutrient Monitoring
Sibal R, Alqahtani N, Arslan S, et al. Macronutrient, Micronutrient Supplementation and Monitoring for Patients on GLP-1 Agonists: Can We Learn from Metabolic and Bariatric Surgery? Nutrients. *2025;17(23):3659. doi:10.3390/nu17233659*

Food Noise
Dhurandhar EJ, Thomas CE, Lowe MR, et al. Food Noise: Definition, Measurement, and Future Research Directions. Nutrition & Diabetes. 2025;15(1):58. doi:10.1038/s41387-025-00382-x

Addiction & Reward Pathways
Amorim Moreira Alves G, Leffa DT, Tavares RG, et al. Mechanisms of GLP-1 in Modulating Craving and Addiction: Neurobiological and Translational Insights. Geriatrics. 2025;13(3):136. doi:10.3390/geriatrics13030136

RESOURCES

Clinical Considerations
GLP-1 Diabetes and Weight-Loss Drug Side Effects: "Ozempic Face" and More. Harvard Health Publishing. Overview of side effects associated with GLP-1 medications.

Patient Education
Cleveland Clinic GLP-1 Diet Guidance. Practical nutrition strategies to help patients meet protein, hydration and nutrient needs during GLP-1 therapy.

JAMA Patient Page. Patient-friendly overview of GLP-1 medications and role in obesity and diabetes treatment.

Emerging Topic
Five Things to Know About GLP-1s and Addiction. Stanford Medicine. Explores emerging evidence on GLP-1 medications and reward-related behaviors, including alcohol and food cravings.

FUELED Wellness + Nutrition Podcast
GLP-1 Medications and Nutrition: What to Know Before, During and After Treatment. Interview with Amanda Fontenot, MD, obesity medicine specialist. Practical discussion of GLP-1 therapy, protein intake, resistance training, micronutrient needs and lean mass preservation.

12 Creatine

Review creatine's role in performance, aging and cognition.

WHY IT MATTERS

Creatine is one of the most studied and well-supported supplements in sports nutrition. Research now extends beyond athletics to healthy aging, muscle preservation, physical function and emerging cognitive benefits.

KEY TAKEAWAYS

Creatine is extensively studied

Benefits extend beyond athletics

Creatine may support strength and aging

Safety data are strong in healthy adults

CITATIONS

ISSN Position Stand
Kreider RB, Kalman DS, Antonio J, et al. International Society of Sports Nutrition Position Stand: Safety and Efficacy of Creatine Supplementation in Exercise, Sport, and Medicine. Journal of the International Society of Sports Nutrition. 2017;14:18. doi:10.1186/s12970-017-0173-z

Creatine Safety
Gualano B. A Short Review of the Most Common Safety Concerns Regarding Creatine Ingestion. Frontiers in Nutrition. 2025;12:1682746. doi:10.3389/fnut.2025.1682746

Creatine and Aging
Stares A, Bains M. The Additive Effects of Creatine Supplementation and Exercise Training in an Aging Population: A Systematic Review of Randomized Controlled Trials. Journal of Geriatric Physical Therapy. 2020;43(2):99-112. doi:10.1519/JPT.0000000000000222

Creatine and Sarcopenia Prevention
Młynarska E, Leszto K, Katańska K, Prusak A, Wieczorek A, Jakubowska P, Rysz J, Franczyk B. Creatine Supplementation Combined with Exercise in the Prevention of Type 2 Diabetes: Effects on Insulin Resistance and Sarcopenia. Nutrients. 2025;17(17):2860. doi:10.3390/nu17172860

Creatine and Cognition
Avgerinos KI, Spyrou N, Bougioukas KI, Kapogiannis D. Effects of Creatine Supplementation on Cognitive Function of Healthy Individuals: A Systematic Review of Randomized Controlled Trials. Experimental Gerontology. 2018;108:166-173. doi: 10.1016/j.exger.2018.04.013

RESOURCES

Professional Overview
Why Everyone's Talking about Creatine. UCLA Health. Overview of creatine's emerging role in healthy aging, muscle preservation and cognitive health.

Patient Education
What Is Creatine? Potential Benefits and Risks of This Popular Supplement. Harvard Health Publishing review of creatine's benefits, safety and practical considerations.

13 High-Interest Nutrition Controversies: Seed Oils and Synthetic Food Dyes

Help clinicians address common nutrition controversies with balance.

WHY IT MATTERS

Questions about seed oils and synthetic dyes are increasingly common. A 2021 California evidence review examined potential neurobehavioral effects of synthetic dyes in some children, while evidence around seed oils remains more mixed and context-dependent.

KEY TAKEAWAYS

- **Patients ask about controversial ingredients**
- **Avoid all-or-nothing messaging**
- **Dietary pattern matters most**
- **Reducing UPFs addresses multiple concerns**
- **Clinicians can separate evidence from marketing**

CITATIONS

Synthetic Food Dyes and Children
Akintunde M, Shao K, Ghosh M, et al. Potential Neurobehavioral Effects of Synthetic Food Dyes in Children. Sacramento, CA: Office of Environmental Health Hazard Assessment; 2021.

Heating and Oxidation Byproducts
Perumalla Venkata R, Subramanyam R. Evaluation of the Deleterious Health Effects of Consumption of Repeatedly Heated Vegetable Oil. Toxicology Reports. 2016;3:636-643. doi:10.1016/j.toxrep.2016.08.003

RESOURCES

CSPI Resources

Synthetic Food Dyes: Health Risk, Policy and Safety. Evidence-based overview of synthetic food dyes, current research and recent policy developments.

Chemical Cuisine: Food Additive Safety Ratings. Consumer-friendly database from Center for Science in the Public Interest; reviews and summarizes available safety evidence.

14 Food Allergies and Other Adverse Reactions to Foods

Differentiate food allergies, intolerances and other food reactions.

WHY IT MATTERS

Food allergies, intolerances and sensitivities are often confused. Accurate diagnosis helps prevent unnecessary food avoidance while ensuring true food allergies and other clinically significant reactions receive appropriate evaluation and management.

KEY TAKEAWAYS

- **Differentiate immune and non-immune reactions**
- **Testing should support clinical history**
- **Broad food panels can mislead**
- **Refer when allergy evaluation is appropriate**
- **Accurate diagnosis prevents unnecessary restriction**

CITATIONS

Food Allergy Prevalence
Gupta RS, Warren CM, Smith BM, Jiang J, Blumenstock JA, Davis MM, Schleimer RP, Nadeau KC. Prevalence and Severity of Food Allergies Among US Adults. JAMA Network Open. 2019 Jan 4;2(1):e185630. doi:10.1001/jamanetworkopen.2018.5630

Food Allergy Guidelines
"Food Allergy | AAAAI." Aaaai.org, 2020, aaaai.org/tools-for-the-public/conditions-library/allergies/food-allergy-ttr

FDA. "Food Allergies." U.S. Food and Drug Administration, 17 Sept. 2024, fda.gov/food/nutrition-food-labeling-and-critical-foods/food-allergies

Food Allergy Diagnosis
"Allergy Testing | Skin Testing | AAAAI." Aaaai.org, 2022, aaaai.org/tools-for-the-public/conditions-library/allergies/allergy-testing

"Common Questions | Food Allergy Research & Education." foodallergy.org, foodallergy.org/resources/common-questions

Oral Food Challenges
What You Need to Know about Oral Food Challenges. Aaaai.org

Distinguishing Allergy from Intolerance
Food Intolerance versus Food Allergy. Aaaai.org, 2021

RESOURCES

AAAAI. Professional and patient education resources on food allergy diagnosis, testing, treatment and oral food challenges from the American Academy of Allergy, Asthma and Immunology.

ACAAI. Clinical guidance and patient education from the American College of Allergy, Asthma & Immunology.

FARE. Patient education, advocacy resources and practical guidance for living with food allergies from Food Allergy Research & Education.

Navigating Food Allergies by Alice Hoyt, MD. Johns Hopkins University Press, 2026. Comprehensive guide for families covering diagnosis, treatment, insurance and practical management.

Food Allergy and Your Kiddo podcast by Alice Hoyt, MD, exploring practical topics in pediatric food allergy care.

15 Malnutrition and Food Insecurity

Recognize malnutrition, food insecurity and referral opportunities.

WHY IT MATTERS

Food insecurity remains a major U.S. public health issue and is linked with worse chronic disease outcomes. Malnutrition can occur at any body size, including obesity, making nutrition risk easy to miss when weight is the primary focus.

KEY TAKEAWAYS

- **Food insecurity and malnutrition differ**
- **They can occur at any body size**
- **Weight alone misses nutrition risk**
- **Malnutrition is often underrecognized**
- **Nutrition risk affects recovery and function**
- **Screening helps identify missed patients**

CITATIONS

Food Insecurity Prevalence
Hales L, Reed-Jones M. Food Security in the U.S. - Key Statistics & Graphics. USDA Economic Research Service. 2026.

Food Insecurity and Health Outcomes
Odoms-Young A, Singleton CR, Springfield S, et al. Food Insecurity, Neighborhood Food Environment, and Health Disparities: State of the Science, Research Gaps and Opportunities. Current Obesity Reports. 2024;13(1):1-13. doi:10.1007/s13679-023-00567-8

Malnutrition Prevalence and Underdiagnosis
Guenter P, et al. Malnutrition Diagnoses and Associated Outcomes in Hospitalized Patients: United States, 2018. Nutrition in Clinical Practice. 2021;36(5):957-969. doi:10.1002/ncp.10771

Malnutrition in Obesity
Kobylińska M, Antosik K, Decyk A, Kurowska K. Malnutrition in Obesity: Is It Possible? Obesity Facts. 2022;15(1):19-25. doi:10.1159/000519503

Malnutrition Screening and Assessment
Serón-Arbeloa C, Labarta-Monzón L, Puzo-Foncillas J, et al. Malnutrition Screening and Assessment. Nutrients. 2022;14(12):2392. doi:10.3390/nu14122392

Food Insecurity Screening Tools
U.S. Department of Agriculture Economic Research Service. U.S. Household Food Security Survey Module: Three-Stage Design, with Screeners

RESOURCES

Clinical Screening Tools

- **ASPEN Nutrition Screening Tools.** Validated screening tools and clinical guidance for identifying patients at risk for malnutrition.
- **MST Malnutrition Screening Tool.** Validated screening tool designed for rapid identification of patients at risk for malnutrition.

Louisiana Resources

- **Louisiana Snap Resources.** Information on eligibility, enrollment and nutrition assistance available through SNAP.
- **Feeding Louisiana – Find Food**. Directory of food banks and community food assistance resources throughout Louisiana.

Technology + Resource Support

Junum Malnutrition. Clinical decision support platform that helps healthcare systems identify malnutrition risk, improve documentation and support nutrition referrals.

16 How To Refer: Practical Clinical Guidance

Clarify when and how to refer for nutrition care.

WHY IT MATTERS

Medical nutrition therapy improves outcomes in conditions including, but not limited to, diabetes and chronic kidney disease. Professional organizations increasingly recognize registered dietitian involvement as part of comprehensive chronic disease management.

KEY TAKEAWAYS

Refer early, before complications develop

Nutrition supports medications and procedures

Dietitians translate evidence into action

Referral can start before coverage is confirmed; coverage varies on plan and patient diagnosis

CITATIONS

MNT in Diabetes and Prediabetes
Briggs Early K, Stanley K. Position of the Academy of Nutrition and Dietetics: The Role of Medical Nutrition Therapy and Registered Dietitian Nutritionists in the Prevention and Treatment of Prediabetes and Type 2 Diabetes. Journal of the Academy of Nutrition and Dietetics. 2018;118(2):343-353. doi:10.1016/j.jand.2017.11.021

MNT in Chronic Kidney Disease
Rhee CM, Ahmadi SF, Kovesdy CP, Kalantar-Zadeh K. Medical Nutrition Therapy for Diabetic Kidney Disease. Journal of Renal Nutrition. 2021;31(3):229-232. doi:10.1053/j.jrn.2021.03.004

Lifestyle Intervention as First-line Therapy
Gibbs BB, Hivert MF, Jerome GJ, et al. Physical Activity as a Critical Component of First-Line Treatment for Elevated Blood Pressure or Cholesterol: Who, What, and How? A Scientific Statement From the American Heart Association. Hypertension. 2021;78(2):e26-e37. doi:10.1161/HYP.0000000000000196

RESOURCES

For Louisiana-specific referral pathways and insurance considerations, consult your local health-system referral team, care coordinator and/or registered dietitian.

Professional Referral Tools

- **Academy of Nutrition and Dietetics – Find a Nutrition Expert.** Searchable directory to help clinicians and patients locate registered dietitians by specialty and location.
- **HealthProfs Dietitian Directory.** Directory of registered dietitians offering in-person and telehealth nutrition counseling.

Disease-Specific Referral Programs

ADCES Program Finder. Locate accredited diabetes self-management education and support programs nationwide.

Coverage Resources

Medicare MNT Coverage. Coverage information and eligibility requirements for Medicare Medical Nutrition Therapy benefits.

Section 1.3 Follow-Up Action Items

01.03.01 - DRAFT Cost Recovery NOI

01.03.02 - DRAFT Obesity Rules Repeal NOI

01.03.03 - DRAFT Restricted Licensure

NOTICE OF INTENT
Department of Health
Board of Medical Examiners
Adjudication
(LAC 46:XLV.9935)

Notice is hereby given that in accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 *et seq*., and pursuant to the authority vested in the Louisiana State Board of Medical Examiners (the board) by the Louisiana Medical Practice Act., R.S. 37:1270 *et seq*., the board proposes to amend its rules governing assessment of costs and fines.

§9935. Assessment of Costs and Fines

A. Assessment. As part of a decision, consent order, or other agreed order, the board may require a respondent to pay all costs of the board proceedings. If costs are assessed in a consent or other agreed order, the amount shall be stated in the order.

B. Special Definition. *Costs of the Proceedings*—for the purposes of this rule, shall mean a reasonable charge to meet all obligations incurred by the board in the performance of its duties, including but not limited to investigators', stenographers', and attorneys' fees, witness fees and expenses, and the per diem and expenses of the members of the board's hearing panel.

C. Notice. Notice of the application of this Section shall be provided to a respondent with the written notice of filing of an administrative complaint, pursuant to 9905.

D. Timing; Content; Service; Scope and Limitations; Exceptions and Requests for Modification; Disposition. Statements of Costs shall be processed as follows:

1. Timing. A statement of costs shall be compiled by the board within 20 days from the date on which the board's decision is served on the respondent.

2. Content. A statement of costs must state with particularity the nature and amount of the costs assessed. The statement must be signed and certify that all reasonable attempts have been made to ensure the statement's accuracy.

3. Service. A statement of costs shall be served on respondent by regular and certified mail at the last known address on file with the board not later than 20 days from the date on which the board's decision is served on the respondent.

4. Scope and Limitations. A statement of costs shall be assessed in any decision following an administrative hearing, in which a respondent is found guilty of a violation of a law or rule administered by the board. The statement shall include those costs actually incurred by the board from the time of filing of an administrative complaint until the issuance of a final decision or order; ~~provided, however, and except as provided below, that such costs shall not exceed for a respondent:~~

~~a. physician, the sum of $75,000;~~

~~b. allied health care practitioner, as to whom the board is authorized by law to assess the costs of the proceeding, the sum of $25,000.~~

5. Exceptions; Requests for Modification. Within 20 days of the date of service of the statement of costs:

a. the respondent may file an exception to, or submit a request for modification of, a statement of costs. Each such exception or request shall be accompanied by a concise statement of the grounds on which the exception or request is based and any supporting legal or other authority. Within 10 days of such filing or submission, a response may be filed by the complainant;

b. the complainant may request an assessment of costs above the amounts specified above. Such a request shall be made only when the complainant contends a respondent unreasonably increased the costs of the proceedings

by activities undertaken to harass or create undue burden, or by the repetitive, unduly burdensome, or unwarranted filing of meritless motions or discovery requests. Within 10 days of the filing of such a request, a response may be filed by the respondent.

6. Disposition of Exceptions and Requests for Modification. Upon timely filing:

a. an exception or request shall be referred to the presiding officer of the hearing panel with respect to the proceeding for a ruling. The presiding officer, in his or her discretion, may refer an exception or request to the entire hearing panel which considered the case for disposition, and any party aggrieved by the ruling of a presiding officer may request, within 10 days of receipt of the ruling, that the exception or request be reconsidered by the entire panel which heard the case;

b. the matter shall ordinarily be decided on by the presiding officer or the hearing panel, as the case may be, on the papers filed, without hearing. On the written request of respondent or complainant, however, and on demonstration that there are good grounds therefor, the presiding officer may grant opportunity for hearing by oral argument;

c. the president of the board or presiding officer of the hearing panel, as the case may be, may delegate the task of ruling on such exceptions or request to the board's independent legal counsel appointed pursuant to §9921D, who is independent of complaint counsel and who has not participated in the investigation or prosecution of the case.

E. Payment of Costs and Expenses; Periodic Payment Plan; Waiver

1. A statement of costs must be satisfied within 30 days of receipt unless the statement of costs provides otherwise or the respondent enters into a periodic payment plan with the board's compliance officer assigned to the matter or with another individual designated by the board.

2. The board's compliance officer or designee may enter into an agreement with a respondent for a reasonable periodic payment plan if the respondent demonstrates in writing the present inability to pay such costs or provides other satisfactory cause to support the request.

3. A respondent may ask the board to review an adverse determination by its compliance officer or designee regarding specific conditions for a periodic payment plan. Such review shall be conducted in accordance with §9935.D.6.

F. Fine. As part of a decision, consent order, or other agreed order, the board may require the payment of a fine; provided, however, that such fine shall not exceed, as to a respondent:

a. physician, the sum of $5,000;

b. allied health care practitioner, the amount authorized by law, but in no event more than $5,000.

G. Waiver; Adjustment. A statement of costs or amount of a fine, or both, may be waived or reduced by the board, in its discretion, in whole or part, upon a request submitted in writing that evidences to the board's satisfaction a significant medical, physical, financial or similar extenuating circumstance precluding the individual's payment of costs or fine or where it appears to the board in the interests of justice to do so.

H. Failure to Comply with Assessment of Costs or Fine**.** A respondent who fails to timely pay a statement of costs or fine, or who fails to comply with the terms of a periodic payment plan, shall be notified in writing of non-compliance ~~by first class and certified mail at his or her last known address on file with the board~~. A respondent's failure to comply with such notice within 30 days ~~of mailing~~ may provide a basis for further action by the board, including ~~,~~referral to the Office of the Attorney General for collections. Only one 30-day grace period will be granted, any subsequent failure to timely pay or failure to comply with the terms of the payment plan, will result in immediate referral to the AGs.

I. Nothing in this Section shall delay, suspend, extend, or otherwise affect the time authorized by law within which a respondent may file a petition for judicial review of a final decision or order issued by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 37:1270, 37:1285.
HISTORICAL NOTE: Promulgated by the Department of Health, Board of Medical Examiners, LR 47:726 (June 2021).

NOTICE OF INTENT

Department of Health
Board of Medical Examiners

Physicians; Obesity Medication
(LAC 46:XLV.6901 et seq.)

Notice is hereby given that in accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 et seq., and pursuant to the authority vested in the Board of Medical Examiners (the board) by the Louisiana Medical Practice Act., R.S. 37:1270 et seq., the board proposes to repeal its rules governing the medications used in the treatment of obesity.

The proposed amendments are set forth below.

Chapter 69. Prescription, Dispensation, and Administration of Medications

Subchapter A. Medications Used in the Treatment of Obesity

§6901. ~~Scope of Subchapter~~Repealed

~~A. The rules of this Subchapter govern physician prescription, dispensation, administration, or other use of medications for weight control or weight reduction in the medical treatment of obesity.~~

~~B. These rules apply to physicians that supervise PAs and must be in accordance with R.S. 37:1360.31(C–D).~~

~~C. These rules apply to physicians that collaborate with APRNs and must comply with Chapter 79 of the rules for physicians.~~Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6), and 37:1285(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 18:744 (July 1992).

§6903. ~~Definitions~~Repealed

~~A. As used in this Subchapter, the following terms shall have the meanings specified.~~

~~*Anorectic*—a drug, medication, or substance used or intended for use as an anti-obesity medication.~~

~~*Schedule II Controlled Substance*—any substance so classified under and pursuant to regulations of the Drug Enforcement Administration (DEA), U.S. Department of Justice, 21 CFR §1308.12, or any substance which may hereafter be so classified by amendment or supplementation of such regulation.~~

~~*Schedule III Anti-Obesity Medication*—benzphetamine, phendimetrazine, and any other substance now or hereafter classified as a Schedule III controlled substance under and pursuant to Federal DEA regulations, 21 CFR §1308.13, and which is indicated for use in the treatment of exogenous obesity by express approval of the U.S. Food and Drug Administration (FDA).~~

~~*Schedule IV Anti-Obesity Medication*—fenfluramine, dexfenfluramine, phentermine, diethylpropion, mazindol, and any other substance now or hereafter classified as a Schedule IV controlled substance under and pursuant to federal DEA regulations, 21 CFR §1308.14 and which is indicated for use in the treatment of exogenous obesity by express approval of the FDA.~~Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6), and 37:1285(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 18:744 (July 1992), amended LR 23:1146 (September 1997).

§6905. ~~Prohibitions~~Repealed

~~A. Absolute Prohibitions. A physician shall not prescribe, dispense, administer, supply, sell, give, or otherwise use to or for any person for the purpose of weight control or weight reduction in the treatment of obesity any amphetamine, dextroamphetamine, methamphetamine, or phenmetrazine drug or compound; any Schedule II controlled substance; human chorionic gonadotropin (HCG); thyroid hormones; diuretic medications; or any drug, medication, compound,~~

~~or substance which is not indicated for use in the treatment of exogenous obesity by express approval of the U.S. Food and Drug Administration (FDA).~~

~~B. Schedule III-IV Anti-Obesity Medication. A physician shall not prescribe, dispense, or administer Schedule III or Schedule IV anti-obesity medication for the purpose of weight reduction or control in the treatment of obesity other than in strict conformity with each of the conditions and limitations prescribed by §6907 of this Subchapter.~~

~~C. When a non-controlled drug has been approved in the treatment of exogenous obesity by the FDA, the prohibitions in Subsection A of this Section shall not prevent the individual components of such drug from being separately prescribed, dispensed or administered for the treatment of obesity.~~

~~D. When drug has been shown to be effective in the treatment of obesity, but not specifically FDA approved for the treatment of obesity, it may be used as an off-label drug. Off-label drugs must be used with proper consent and full knowledge of the risks and benefits of the off-label use explained to the patient. This must be meticulously documented in the patient's record.~~

~~E. In situation where off-label drugs are used in periods of shortages, the drug may be FDA allowed (not approved) the drug must be provided by a vender recognized and licensed by the Louisiana Board of Drug and Device Distributors.~~

~~F. When components are used they should be provided by compounding pharmacies licensed by the Louisiana Board of Drug and Device Distributors.~~

~~G. When the anti-obesity medicine has been compounded, mixed, or otherwise provided by the physician, such medication must be prepared by a physician licensed to dispense and prepare under the dispensing rules of the Board Title 46 Part XLV Chapter 65 & 69.~~Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6), and 37:1285(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 18:744 (July 1992), amended by the Department of Health, Board of Medical Examiners, LR 42:2197 (December 2016).

§6907. ~~Use of Schedule III-IV Anorectics; Conditions; Limitations~~Repealed

~~A. Requisite Prior Conditions. Before initiating treatment utilizing a Schedule III or IV anti-obesity medication with respect to any patient, a physician shall:~~

~~1. obtain a thorough prior history, including the patient's weight loss/gain history and prior efforts at weight reduction;~~

~~2. perform a physical examination sufficient to address all of the patient's health problems;~~

~~3. rule out the presence of conditions recognized as contraindicating the use of anti-obesity medication medications, including, without limitation, pregnancy, hypertension, and hypersensitivity or idiosyncrasy to anorectics; and~~

~~4. provide the patient with a carefully prescribed diet, together with counseling on exercise and, as appropriate, other supportive or behavioral therapy.~~

~~B. Initiation of Anti-Obesity Medication Use. Upon completion and satisfaction of the conditions prescribed by §6907.A and B and upon the physician's judgment that the prescription, dispensation, or administration of an anorectic medication is medically warranted, the physician shall initiate anorectic treatment with the lowest dosage expected to be effective, as indicated by the manufacturer's FDA-approved dosage recommendation, employing a Schedule IV anorectic in preference to a Schedule III anorectic and refraining from use of Schedule III anorectics until and unless the anorectic initially used proves ineffective.~~

~~C. Continued Use of Anti-Obesity Medications. During the continued use of anti-obesity medications as permitted in this Section, and subject to the limitations prescribed in §6907.E, the physician shall monitor the patient's progress closely and frequently, shall re-examine the patient not less frequently than every twelve weeks during such continued use and shall continue use of anti-obesity medication only if, upon each such re-examination, the patient demonstrates continued clinically significant weight loss since the prior examination.~~

~~D. Limitations on Use. A physician shall not prescribe or dispense Schedule III or IV anti-obesity medications to any patient:~~

~~1. in dosage greater than the maximum dosage indicated by the anorectic manufacturer's FDA-approved dosage recommendation;~~

~~2. in number or dosage units greater than an amount sufficient for use of the anorectic for a period of 30 days; or~~

~~3. for an aggregate period in excess of 12 weeks during any 12-month period; provided, however, that this limitation shall not be applicable with respect to Schedule IV anorectics.~~

~~E. Termination of Anti-Obesity Medication Use. Without regard to the permissible limitations otherwise prescribed by §6907.E, a physician shall refuse to initiate or re-initiate or shall terminate the use of anorectics with respect to a patient on any date that the physician determines, becomes aware, knows, or should know that:~~

~~1. the patient is not a proper candidate for the use of anti-obesity medications under the conditions and limitations prescribed by this Section;~~

~~2. the patient has failed to demonstrate clinically significant weight loss since anti-obesity medications were last prescribed, dispensed, or administered to the patient by the physician;~~

~~3. the patient has developed tolerance to the appetite suppressant effect of the anti-obesity medication or has experienced euphoria followed by irritability or depression;~~

~~4. the patient has engaged in excessive use, misuse, or abuse of the anti-obesity medication or has otherwise consumed or disposed of the anti-obesity medications or any other controlled substance other than in strict compliance with the directions and indications for use given by the physician; or~~

~~5. the patient did not demonstrate clinically significant weight loss during a prior term of use of anti-obesity medications within the limitations of §6907.E.3 hereof.~~

~~F. Treatment Records. Satisfaction of each of the conditions and requirements prescribed by this Section, all material elements of the patient's history, all significant findings from physical examination and diagnostic testing, and all medication and other treatment, including diet, prescribed by the physician, shall be accurately and completely recorded, documented, and dated, in writing, by the physician in the patient's record.~~Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6), and 37:1285(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 18:744 (July 1992), amended LR 23:1146 (September 1997).

§6909. ~~Exemption of Controlled Scientific Studies~~Repealed

~~A. The prohibitions, conditions, and limitations on the use of Schedule III and Schedule IV anti-obesity medications prescribed by §6905.B and §6907 of this Subchapter shall not be applicable to a physician engaged in the conduct of a controlled scientific study of the efficacy of such medications in the medical treatment of obesity, provided that the physician is employed by or otherwise officially affiliated with an accredited medical school or college or other institution of higher learning located in the state of Louisiana, such study is conducted under the auspices of such school, college, or institution, and the interim and final results of such study are furnished to the board in writing.~~Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6), and 37:1285(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board Of Medical Examiners, LR 18:744 (July 1992).

§6911. ~~Exceptions in Individual Cases~~Repealed

~~A. Availability of Exceptions. Upon written application to the board made in accordance with this Subsection, the board may authorize a physician, with respect to an identified individual patient, to exceed or otherwise depart from the prohibitions, conditions, and limitations on the use of Schedule III or Schedule IV anti-obesity medications otherwise prescribed by §6905.B and §6907 of this Subchapter.~~

~~B. Form, Content of Application for Exception. An application for board approval of an individual exception from the provisions of this Subchapter shall be submitted to the board's medical consultant in writing and shall contain:~~

~~1. individual identification of the patient to whom the physician proposes to prescribe, dispense, or administer anti-obesity medications other than in accordance with the provisions of this Subchapter;~~

~~2. a summary of the patient's medical and weight loss/gain history;~~

~~3. a complete copy of the patient's medical record, including a record of all anti-obesity medications prescribed, dispensed, or administered to or for the patient within 24 months prior to the application;~~

~~4. a statement by the physician of the specific manner in which the physician proposes to deviate from the provisions of this Subchapter respecting the prescription, dispensation, and administration of anti-obesity medications, together with a statement by the physician of the medical facts and circumstances deemed by the physician to justify such departure; and~~

~~5. such other information and documentation as the board or its medical consultant may request.~~

~~C. Board Action. The board may deny, grant, or grant in part any application for exception in an individual case made under this Section. The board's action on any such application shall be stated in writing and shall specify the manner and extent to which the physician shall be authorized to depart from the provisions of this Subchapter and the period of time during which such authorized exception shall be effective. A physician who makes application to the board under this Section shall not deviate from the prohibitions, conditions, and limitations provided in this Subchapter except following receipt of written authorization from the board or other than pursuant to the specifications and limitations of such authorization.~~Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6), and 37:1285(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 18:745 (July 1992).

§6913. ~~Effect of Violation~~Repealed

~~A. Any violation of or failure of compliance with the provisions of this Subchapter, §§6901-6913, shall be deemed a violation of R.S. 37:1285.A(6) and (29), providing cause for the board to suspend or revoke, refuse to issue, or impose probationary or other restrictions on any license or permit held or applied for by a physician culpable of such violation.~~Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6), and 37:1285(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 18:746 (July 1992).

Chapter 71. Integrative and Complementary Medicine

Subchapter A. General Provisions

§7107. Use of Integrative or Complementary Medicine; Limitations

A. Requisite Prior Conditions. Any physician offering or utilizing integrative or complementary medicine shall comply with the following rules.

1. Evaluation of the Patient. Prior to offering integrative or complementary medicine a physician shall perform an evaluation of the patient that shall include but not be limited to any conventional methods of diagnosis which, in the judgment of the physician, are deemed necessary or appropriate to the condition of the patient. Such an evaluation shall include:

a. a relevant medical history;

b. an appropriate physical examination; and

c. a review of the results of any relevant diagnostic studies or therapies undertaken or previously attempted.

2. Medical Diagnosis. A medical diagnosis shall be established by the physician and documented in the patient's medical record, which indicates the nature of the patient's illness, disease, condition or other reason for which treatment is being sought if such is determinable.

3. Treatment Plan. A treatment plan by which progress or success can be evaluated with stated objectives shall be formulated by the physician which is tailored to the individual needs of the patient and documented in the patient's medical record. Such plan shall include documentation of:

a. whether conventional or complementary methods of diagnosis or treatment for the current complaint or condition have been considered, are being undertaken or have been attempted without adequate or reasonable success or a statement that the patient has refused such methods;

b. consideration for the need for conventional testing, consultation, referral or treatment when indicated;

c. the intended role of integrative or complementary medicine within the overall plan; and

d. whether integrative or complementary medicine offered or utilized could interfere with any ongoing conventional therapy.

4. Informed Consent. A physician shall inform a patient or his guardian of each of the following, which discussions shall be noted in some form in the patient's record:

a. his education, experience and credentials regarding any integrative or complementary medicine which is recommended; and

b. the risks and benefits of both conventional medicine and integrative or complementary medicine incorporated within each treatment plan.

B. A physician shall inform the patient that his recommendation for the use of a particular drug, substance or medical device for diagnosis or treatment of the patient's illness, disease or condition is investigational, experimental, new, unconventional or unproven.

C. Initiation of Integrative or Complementary Medicine. Upon completion and satisfaction of the conditions prescribed in §7107.A.-B, and upon a physician's judgment that integrative or complementary medicine is warranted for purposes of diagnosis or treatment, a physician shall adhere to the following rules.

1. Assessment of Treatment Efficacy and Monitoring. Patients shall be seen by the physician at intervals appropriate to the danger or safety risk of the diagnostic methods or therapy provided, to assess the efficacy thereof, assure that all treatment recommended or prescribed remains indicated and evaluate the patient's progress toward treatment objectives and any adverse effects. During each visit attention should be given to the need for additional methods of diagnosis, consultation, referral or treatment. Lack of progress from integrative or complementary medicine therapy, or a worsening of symptoms, signs or prognosis, shall indicate the need to revise the treatment plan.

2. Consultation. Physicians shall refer a patient as necessary for additional evaluation or treatment by conventional or integrative or complementary methods, particularly in those patients who are at risk from a potentially life-threatening illness, disease or condition.

3. Medication/Medical Devices Employed. A physician shall document in the patient's medical record the medical rationale for the use of any medication or substance, including a controlled substance, and any medical device employed in the diagnosis or treatment of a patient's illness, disease or condition. The use of controlled substances for ~~the treatment of obesity and~~ chronic or intractable pain shall be in conformity with ~~§6901 et seq., and~~ §6915 et seq., respectively, of the board's rules.

4. Treatment Records. A physician shall document and maintain in the patient's medical record, accurate and complete records of history, physical and other examinations and diagnostic evaluations, consultations, laboratory and diagnostic reports, treatment plans and objectives, medications, including controlled substances, informed consents, periodic assessments and the results of all conventional and integrative or complementary medicine therapies utilized.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 28:1589 (July 2002).

Chapter 72. Consultation or Collaboration with Medical Psychologists

Subchapter A. General Provisions

§7207. General Prohibitions

A. A physician shall not consult and collaborate, as defined in §7203 of these rules:

1. if the physician is no longer engaged in the clinical practice of medicine and the provision of patient care in this state;

2. on any patient for whom the physician is not the primary or attending physician;

3. with a psychologist who is not an MP;

4. with more than one MP on the same patient;

5. if he or she is aware that more than one primary or attending physician is consulting or collaborating with the MP on the same patient at the same time;

6. with respect to the treatment of any condition other than mental and emotional disorders;

7. with respect to controlled substances if the physician's controlled substance privileges, registration or permit has been suspended, revoked or restricted by the board or other state or federal authorities;

8. with respect to narcotics; or

9. with an MP who seeks to utilize controlled substances for the treatment of:

a. non-cancer related chronic or intractable pain, as set forth in §§6915-6923 of the board's rules~~; or~~

~~b. obesity, as set forth in §§6901-6913 of the board's rules.~~

B. Physicians and MPs providing coverage call for a colleague, those providing rotating coverage for a patient in the same clinical setting, and those consulted by a physician or MP with respect to a given patient, are exempt from the limitations provided in Paragraphs A.2, 4 and 5 of this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6) and 37:2371-2378.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 35:1529 (August 2009), amended, LR 37:898 (March 2011), amended, LR

Chapter 75. Telemedicine
Subchapter A. General Provisions

§7513. Prohibitions

A. The following prohibitions apply to physicians who practice medicine in this state via telemedicine.

B. Preamble—Controlled Substances. While in most instances the board believes that an in-person visit is required prior to the issuance of a prescription for any controlled substance, provided the physician can examine the patient *via* telemedicine technologies sufficient to make a diagnosis, controlled substances may be prescribed by telemedicine within the limitations of Subsection 7513C.

C. No physician shall utilize telemedicine:

1. for the treatment of non-cancer related chronic or intractable pain, as set forth in §§6915-6923 of the board's rules;

~~2. for the treatment of obesity, as set forth in §§6901-6913 of the board's rules;~~

~~3~~2. to authorize or order the prescription, dispensation or administration of any controlled substance unless;

a. the physician has had at least one in-person visit with the patient within the past year; provided, however, the requirement for an in-person visit shall not apply to a physician who holds an unrestricted license to practice medicine in this state and who practices telemedicine upon any patient being treated at a healthcare facility that is required to be licensed pursuant to the laws of this state and which holds a current registration with the U.S. Drug Enforcement Administration;

b. the prescription is issued for a legitimate medical purpose;

c. the prescription is in conformity with the same standard of care applicable to an in-person visit; and

d. the prescription is permitted by and in conformity with all applicable state and federal laws and regulations.

34. Exceptions. The board may grant an exception to the limitations of §7513.C in an individual case that is supported by a physician's written application stating how and why he or she proposes to deviate from §7513.C. If an exception is granted by the board it shall be stated in writing and specify the manner and extent to which the physician shall be authorized to depart from §7513.C.

D. A physician who practices telemedicine by virtue of a telemedicine permit issued by the board shall not:

1. open an office in this state;

2. meet with patients in this state;

3. receive telephone calls in this state from patients; or

4. engage in the practice of medicine in this state beyond the limited authority conferred by his or her telemedicine permit.

E. No physician shall supervise, collaborate or consult with an allied health care provider located in this state via telemedicine unless he or she possesses a full and unrestricted license to practice medicine in this state and satisfies and complies with the prerequisites and requirements specified by all applicable laws and rules.

F. No physician shall utilize telemedicine to provide care to a patient who is physically located outside of this state, unless the physician possesses lawful authority to do so by the licensing authority of the state in which the patient is located.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1262, 1270, 1271, 1275 and 1276.1.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 35:1534 (August 2009), amended LR 41:2146 (October 2015), amended by the Department of Health, Board of Medical Examiners, LR 43:318 (February 2017).

Chapter 79. Physician Collaboration with Advanced Practice Registered Nurses

Subchapter B. Due Diligence; Eligibility; Requirements of Collaborative Practice Agreement and Required Information

§7917. Limitations

A. A physician shall not collaborate with an APRN:

1. except in compliance with all applicable state and federal laws and regulations;

2. when the APRN and collaborating physician, or in the physician's absence an alternate collaborating physician, do not have the capability to be in contact with each other face-to-face, by telephone or other means of direct telecommunication;

3. who treats and/or utilizes controlled substances in the treatment of:

a. non-cancer-related chronic or intractable pain, as set forth in §§6915-6923 of the board's rules; or

~~b. obesity, as set forth in §§6901-6913 of the board's rules;~~

be. one's self, spouse, child or any other family member; or

4. who distributes medication, other than free or gratuitous non-controlled substances.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6).
HISTORICAL NOTE: Promulgated by the Department of Health, Board of Medical Examiners, LR 44:274 (February 2018).

Chapter 3. Physicians

Subchapter I. License Issuance, Termination, Renewal, Reinstatement and Exemptions

§424. Exemption to Licensure; Out-of-State Physician Orders

A. Definitions. As used in this Section the following terms shall have the meanings specified.

Established Patient—a patient who is currently under the care of out-of-state physician for a diagnosed medical condition or complaint.

Out-of-state Physician—a physician who is duly licensed to practice medicine in any state or jurisdiction of the United States other than Louisiana.

Routine Diagnostic Testing—laboratory testing and radiologic studies, and such other diagnostic testing as the board may in its discretion determine to be routine upon written application, which is needed for the on-going evaluation or monitoring of the patient's condition or response to therapy.

State—any state or jurisdiction of the United States.

B. A license to practice medicine in this state shall not be required for routine diagnostic testing ordered by an out-of-state physician for an established patient provided:

1. the physician-patient relationship was initiated by an in-person, face-to-face visit in a state other than Louisiana where the out-of-state physician is duly licensed to practice medicine;

2. the order can be verified by the health care facility or provider to which or to whom it is presented. While verification need not occur in every instance, the order should be verified if:

a. the out-of-state physician or the institution from which the order was generated is unknown to the provider; or

b. there are other circumstances that would cause a prudent professional acting in the usual scope of practice to suspect non-compliance with the provisions of this Section; and

3. the results of such testing are provided directly to the ordering out-of-state physician;

C. The exemption provided by this Section shall not apply to an order of an out-of-state physician for:

1. any diagnostic test, study or evaluation other than routine diagnostic testing as defined in this Section;

2. testing of an individual who is not an established patient;

3. routine diagnostic testing of any new complaint or for any medical condition other than that for which an established patient was seen in an in-person, face-to-face visit with the out-of-state physician in another state;

4. the prescription, dispensation or administration of any drug, medication, substance or medical device;

5. screening studies or testing;

6. any therapeutic modality, treatment or care including but not limited to the, ~~:~~

~~a.~~ treatment of non-cancer related chronic or intractable pain, as set forth in §§6915-6923 of the board's Rules.~~; or~~

~~b. the treatment of obesity, as set forth in §§6901-6913 of the board's rules.~~

D. Nothing in this Section shall require a health care facility or provider to recognize an order for routine diagnostic testing by an out-of-state physician.

E. An order issued by an out-of-state physician that does not comply with the requirements of Section is not a valid order. An out-of-state physician who violates the provisions or limitations of this Section shall be deemed to be engaged in the unauthorized practice of medicine in this state and subject to the penalties prescribed by R.S. 37:1286 and 1290.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292 and 37:1291.1.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 39:3276 (December 2013).

Chapter 45. Physician Assistants

§4506. Services Performed by Physician Assistants Registered to Prescribe Medication or Medical Devices; Prescription Forms; Prohibitions

A.1. A physician assistant who is registered with the board pursuant to §§1521 and 1525 of these rules to prescribe medication and/or medical devices may, to the extent delegated by a supervising physician:

a. issue prescriptions for medication or medical devices to a patient of the supervising physician;

b. transmit orally, electronically, or in writing on a patient's record a prescription or order to an individual who may lawfully furnish such medication or medical device; and

c. request, receive, sign for and deliver to a patient a bona fide medication sample.

2. The medical record of any patient for whom the physician assistant has prescribed medication or a medical device, or delivered a bona fide medication sample, shall be properly documented by the physician assistant.

B. All prescriptions issued by a physician assistant shall include:

1. the preprinted name, address, prescriptive authority registration number (license number), and telephone number of the physician assistant;

2. the patient's name and the date the prescription is written;

3. whether generic substitution is authorized, and if not:

a. the physician assistant shall check a box labeled "Dispense as Written" or "DAW" or both; and

b. for prescriptions reimbursable by Medicare and Medicaid, the physician assistant may only inhibit equivalent drug product interchange by handwriting the words "brand necessary" or "brand medically necessary" on the face of the prescription order or on a separate sheet attached to the prescription order;

4. the number of refills, if any; and

5. for a controlled substance, a space in which the physician assistant shall legibly print his DEA number.

C. A physician assistant who has been delegated prescriptive authority shall not:

1. utilize prescriptive authority without supervision, as defined by §1503, or at any location other than specified in the supervising physician's registration of delegation of prescriptive authority filed with the board, except in life-threatening emergencies;

2. prescribe medication or medical devices:

a. except to the extent delegated by a supervising physician, as evidenced by approval of registration on file with the board in accordance with §§1507-1527 of these rules;

b. beyond the physician assistant's education, training and experience;

c. outside of his specialty or that of the supervising physician;

d. in the absence of clinical practice guidelines or protocols specified by §1527;

e. except in compliance with all applicable state and federal laws and regulations;

f. when the supervising physician, or in his absence an approved locum tenens physician, and physician assistant do not have the capability to be in contact with each other by telephone or other telecommunication.

3. treat and/or utilize controlled substances in connection with the treatment of:

a. non-cancer related chronic or intractable pain, as set forth in §§6915-6923 of the board's rules; or

~~b. obesity, as set forth in §§6901-6913 of the board's rules;~~

b~~e~~. one's self, spouse, child or any immediate family member except in a life-threatening emergency;

4. sell or dispense medication, as set forth in §§6501-6561 of the board's rules;

5. issue a prescription or order for any schedule I controlled substance contained or hereinafter included in R.S. 40:964; or

6. dispense or deliver any controlled substance sample.

D. A PA who has been delegated controlled substance prescriptive authority shall enroll in and periodically accesses the Prescription Monitoring Program (PMP) established by R.S. 40:1001 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), 37:1360.23(D) and (F), and 37:1360.31(B)(8).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 31:79 (January 2005), amended LR 41:925 (May 2015), amended by the Department of Health, Board of Medical Examiners, LR 43:1178 (June 2017), LR 45:554 (April 2019).

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of the proposed amendments on the family has been considered. It is not anticipated that the proposed amendments will have any impact on family formation, stability or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the impact of the proposed amendments on those that may be living at or below one hundred percent of the federal poverty line has been considered. It is not anticipated that the proposed amendments will have any impact on child, individual or family poverty in relation to individual or community asset development, as described in R.S. 49:973.

Provider Impact Statement

In compliance with HCR 170 of the 2014 Regular Session of the Louisiana Legislature, the impact of the proposed amendments on organizations that provide services for individuals with developmental disabilities has been considered. It is not anticipated that the proposed amendments will have any impact on the staffing, costs or overall ability of such organizations to provide the same level of services, as described in HCR 170.

Small Business Analysis

It is not anticipated that the proposed amendments will have any adverse impact on small businesses as defined in the Regulatory Flexibility Act, R.S. 49:978.1 et seq.

Public Comments

Interested persons may submit written data, views, arguments, information or comments on the proposed amendments to Jacintha Duthu, LSBME, 630 Camp Street, New Orleans, LA 70130. She is responsible for responding to inquiries. Written comments will be accepted until 4 p.m., Thursday, January 29, 2026.

Public Hearing

A request pursuant to R.S. 49:953(A)(2) for a public hearing must be made in writing and received by the Board within 20 days of the date of this notice. If a public hearing is requested to provide data, views, arguments, information or comments orally in accordance with the Louisiana Administrative Procedure Act, the hearing will be held on Thursday, January 29, 2026, at 9 a.m., at the office of the LSBME, 630 Camp Street, New Orleans, LA 70130. Any person wishing to attend should call in advance to confirm.

Vincent A. Culotta, Jr., M.D.,

Executive Director

NOTICE OF INTENT
Department of Health
Board of Medical Examiners
Physicians
Licenses
(LAC 46:XLV.315)

Notice is hereby given that in accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 *et seq*., and pursuant to the authority vested in the Louisiana State Board of Medical Examiners (the board) by the Louisiana Medical Practice Act., R.S. 37:1270 *et seq*., the board proposes to amend its rules governing waiver of qualifications and restricted licenses.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part XLV. Medical Professions
Subpart 2. Licensure and Certification
Chapter 3. Physicians
Subchapter B. Graduates of American and Canadian Medical School and Colleges

§315. Restricted Licenses

~~A. Upon request by an applicant, supported by certification from the dean of a medical school or college or chief medical officer of an academic medical center within the state of Louisiana which is approved by the board, the board may, in its discretion, waive the qualifications for licensure otherwise required by § 311.A.5 or 6, in favor of an applicant who has been formally appointed by a medical school or college to a full-time position at a rank of assistant professor or above or to a full-time position as an employee of an academic medical center whose duties and responsibilities are devoted primarily to training residents and fellows and other academic endeavors within postgraduate medical education. The practice of such an individual shall be limited to the medical school or college or academic medical center for which such person has been approved by the board, and to hospitals and clinics affiliated with such medical school or college or academic medical center within the same geographic area of the state.~~

~~B. Special Definition. For purposes of this Section, the term academic medical center shall be a hospital located in this state that sponsors four or more post-graduate medical education programs approved by the ACGME. At least two of such programs shall be in medicine, surgery, obstetrics and gynecology, pediatrics, family practice, emergency medicine or psychiatry~~.

A. Restricted Licensure in General

1. With respect to applicants who do not meet or possess all of the qualifications and requirements for licensing, the board may, in its discretion, issue such restricted licenses as are, in its judgment, necessary or appropriate to its responsibilities under law. Restricted licenses granted by this part are not punitive and shall not be viewed as the result of disciplinary actions.

2. A license restriction by the board may be either temporary or institutional, or both. Restricted licenses may impose a temporary restriction which limits the holder to engage in the practice of medicine in the state of Louisiana only for the period of time specified by such restricted license and creates no right or entitlement to licensing or renewal of the restricted license after its expiration. The Board may also issue a license with an institutional restriction which limits the holder to engage in the practice of medicine only at, in, and in association with the medical institution, clinic, or location specified by such permit or within a specified medical training program approved by the board.

B. Physician & Surgeon - Eminence/Academic

1. Upon request by an applicant, supported by certification from the dean of a medical school or college or chief medical officer of an academic medical center within the state of Louisiana which is approved by the board, the board may, in its discretion, waive the qualifications for licensure otherwise required by §311.A.5 or 6, in favor of an applicant who has been formally appointed by a medical school or college to a full-time position at a rank of assistant professor or above or to a full-time position as an employee of an academic medical center whose duties and responsibilities are devoted primarily to training residents and fellows and other academic endeavors within post-graduate medical education. The practice of such an individual shall be limited to the medical school or college or academic medical center for which such person has been approved by the board, and to hospitals and clinics affiliated with such medical school or college or academic medical center within the same geographic area of the state.

2. Special Definition. For purposes of this Section, the term *academic medical center* shall be a hospital located in this state that sponsors four or more post-graduate medical education programs approved by the ACGME. At least two of such programs shall be in medicine, surgery, obstetrics and gynecology, pediatrics, family practice, emergency medicine, or psychiatry.

C. Fully Trained Foreign Physician – Transitional

1. To be eligible for an FTFP Transitional license, a fully trained foreign physician applicant shall:

a. be at least 21 years of age;

b. be of good moral character as defined by §303.A;

c. possess a doctor of medicine or equivalent degree duly issued and conferred by a medical school or college approved by the board;

d. possess current and valid legal authority to reside and work in the United States and a valid Social Security number;

e. have completed USMLE steps 1-3;

f. have completed a residency program, or similar post-graduate medical training of 3 or more years (non-preceptorship), or practiced as a physician for no less than five years and provides a malpractice history with loss run from all liability carriers or other equivalent indemnity entities;

g. provide a detailed work history from graduation to the date of application;

h. provide a letter of current good standing from his or her home licensing agency;

i. have a current offer for two years of employment as a physician at a facility owned or operated by a hospital licensed in this state.

2. The FTFP license authorizes the licensee to work solely for the employer making the original job offer for a period of two years. Upon successful completion of two years of practice in the sponsoring employment, and upon providing a statement from the employer that the licensee has not had any deficiencies during that time, the physician is eligible for a full and unrestricted license.

D. Fully Trained Foreign Physician – Rural

1. To be eligible for a restricted rural physician license, a fully trained foreign physician applicant shall:

a. be at least 21 years of age;

b. be of good moral character as defined by §303.A;

c. possess a doctor of medicine or equivalent degree duly issued and conferred by a medical school or college listed in the World Directory of Medical Schools;

d. possess certification from the Educational Commission for Foreign Medical Graduates or equivalent credential verification approved by the board.

e. possess current and valid legal authority to reside and work in the United States and a valid Social Security number;

f. have completed USMLE steps 1-3;

g. have completed at least three years of clinical practice, postgraduate training, or residency in another jurisdiction;

h. provide a detailed work history from graduation to the date of application;

i. provide a letter of current good standing from his or her home licensing agency;

j. demonstrate proficiency in the English language sufficient to safely practice medicine;

k. have a current offer for two years of employment in hospital in a rural or medically underserved area, or a current job offer for two years of employment in a hospital to fill a chronically understaffed position.

2. A physician issued a restricted rural physician license in accordance with this section shall practice only in a rural or medically underserved area of this state or at a medical facility or clinic approved by the Louisiana Department of Health or the board.

3. Supervision. A physician issued a restricted rural physician license shall practice for a period of not less than two years under the supervision of a physician who is registered with the Board as a supervising physician. Upon successful completion of the supervision period, as documented by the supervising physician, the board may authorize the physician to continue practice without supervision within a rural or medically underserved area.

4. After five years of continuous practice in a rural or medically underserved area in accordance with this Section, the board shall grant the physician eligibility to apply for a full and unrestricted license to practice medicine in this state, if the physician meets all of the following criteria:

a. Remains in good standing.

b. Is not under investigation by the board at the time of application.

c. Has not been subject to disciplinary action.

d. Has satisfied all continuing medical education requirements.

E. Retired – Reduced Fee Licenses

1. Volunteer. The fee otherwise required for annual renewal of licensure will be reduced by one-half in favor of a physician who holds an unrestricted license to practice medicine issued by the board and who has, prior to the first day of the year for which such renewal will be effective:

a. attained the age of 70 years;

b. voluntarily surrendered to the issuing authorities his or her state license and federal registration to prescribe, dispense, or administer controlled substances; and

c. made application to the board for such reduced licensure renewal fee, upon a form supplied by the board, verifying the conditions requisite to such reduced fee and consenting to revocation of any license renewed pursuant to this Section upon a finding by the board that the licensee, following issuance of licensure renewal pursuant to this Section, continued to hold, obtained, or sought to obtain state licensure or federal registration to prescribe, dispense, or administer controlled substances.

2. No-Practice. The fee otherwise required for annual renewal of licensure will be reduced by one-half in favor of a physician who holds an unrestricted license to practice medicine issued by the board and who has, prior to the first day of the year for which such renewal will be effective:

a. ceased to engage in the practice of medicine in any form in this state as a consequence of physical or mental disability;

b. voluntarily surrendered to the issuing authorities his or her state license and federal registration to prescribe, dispense, or administer controlled substances; and

c. made application to the board for such reduced licensure renewal fee, upon a form supplied by the board, verifying the conditions requisite to such reduced fee, including independent physician verification of the applicant's physical or mental disability, and consenting to revocation of any license renewed pursuant to this Section upon a finding by the board that the licensee, following issuance of licensure renewal pursuant to this Section, engaged or sought to engage in any manner in the practice of medicine in this state or continued to hold, obtained, or sought to obtain state licensure or federal registration to prescribe, dispense, or administer controlled substances.

3. A physician whose medical license is renewed pursuant to Sub-Sections E.1. and E2. above shall not thereafter engage or seek to engage in the active practice of medicine in this state or to prescribe, dispense, or administer controlled substances or other prescription medications except upon prior application to and approval by the board, which, in its discretion, as a condition to reinstatement of full licensure, may require that:

a. the physician take and successfully pass all or a designated portion of the USMLE, COMLEX-USA, SPEX, or COMVEX-USA examination; and/or

b. the physician provide medical documentation satisfactory to the board that the physician is then physically and mentally capable of practicing medicine with reasonable skill and safety to patients.

If Applicable, The President will now deliver his report...

Executive Director's Report

EXECUTIVE DIRECTOR'S REPORT AUGUST 2026

Ms. Wilton and I met with the Attorney General and The Louisiana Right to Life group. AG Murrill reviewed the issue of telehealth prescribing and the dispensing of misoprostol and mifepristone for the induction of induced medical abortions. All agreed that the LSBME needs complaints to investigate these issues.

The Respiratory Care Advisory Committee (RCAC) met and discussed possible rule issues, and requests from licensees were reviewed.

The Clinical Laboratory Personal Committee (CLPC) met. Licensing, temporary licensing and affected processes were discussed. Temporary licenses are no longer routinely granted.

The Occupational Therapy Advisory Committee (OTAC) meet and addressed issues of licensing, new committee appointments, and discipline. Some refunds have been issued due to errors in our processing of Temporary Permits that occurred after the law change.

The Athletic Trainers Advisory Committee (ATAC) meet on the 13th of July, and the committee is working to revise the rules in response to the comments on the proposed rules presented in early 2026.

Dr Clark and I meet with the new leadership at the LSBN. We found more compatibility than disparity in addressing collaborative practice agreement and APRN Activities.

The LDH has begun a series of regular summits with healthcare licensing agencies and the LSBME was represented at the first of these summits by Dr Cark and me. LDH is working to have more interagency cooperation to address problems such as rural health care problems, med-spas, and other issues that regulatory agencies can cooperatively find solutions for problems.

The first Women's Health Consortium met on Friday the 14th of July and I attended as I was named to the consortium. The consortium approved a set of bylaws, heard from the constituency that stimulated the formation, and is scheduling times and agenda for upcoming meetings.

I participated as faculty for the July 2026 AAFP ALSO course.

Building maintenance issue.

I wish to thank the agency and the board for the support for my family and the bereavement leave afforded me during these last weeks of July and the beginning of August.

Director of Investigations' Report

INVESTIGATIVE DIVISION BOARD REPORT

June 1st – 30th 2026

Number of complaints received: 70

Percentage of Complaints Resolved within 7 days: 31%

Number of cases closed: 36

Total number of cases opened in June still open: 34

Total number of all complaint cases closed in June: 108

Total number of open cases as of June 30th, 2026: Approximately 146

1.10 Financial Report

LA State Board of Medical Examiners
Income Statement
For the Six Month Period Ending June 30, 2026

	2026	2025	2024	2023
Revenue				
Licenses & Exams	$ 4,655,049	$ 4,537,460	$ 4,212,068	$ 4,241,835
Penalties & Fines	118,876	138,218	107,592	165,428
PHP REVENUE	323,974	317,332	292,675	295,300
CME REVENUE	80,409	78,372	73,507	74,606
Other Income	129,855	99,029	117,741	178,151
Total Revenue	**5,308,164**	**5,170,411**	**4,803,583**	**4,955,320**
Expenses				
Salaries & Wages	2,290,083	2,054,334	2,062,053	1,951,501
Employee Related Benefits & Taxes	968,620	906,197	1,197,352	1,103,475
Travel Expenses	25,393	42,257	22,130	30,083
Outside Contracted Services	107,212	61,913	76,684	56,746
PHP Contract	323,974	133,955	292,675	295,300
Operating Costs Excluding Building	511,315	677,031	394,210	637,954
Building Operations	142,290	106,904	148,656	104,475
Materials & Supplies	21,709	23,978	16,295	20,376
Legal/Investigative Fees	179,046	256,161	182,986	245,539
Other Investigative Contracts	0	0	223	70,100
Total Expenses	**4,569,642**	**4,262,731**	**4,393,264**	**4,515,549**
Net Income	**$ 738,522**	**$ 907,680**	**$ 410,319**	**$ 439,771**

La. State Board of Medical Examiners
Balance Sheet
As of June 30, 2026

	Jun 30, 26
ASSETS	
Current Assets	
Checking/Savings	11,938,436.36
Accounts Receivable	
110-000 · Accounts Receivable	94,637.48
Total Accounts Receivable	94,637.48
Other Current Assets	
115-110 · Allowance for Bad Debts	-20,481.20
120-050 · Prepaid Insurance	-0.08
120-110 · Prepaid Maint-Computers/Elect	34,183.89
120-115 · Prepaid Costs-Various	38,367.74
Total Other Current Assets	52,070.35
Total Current Assets	12,085,144.19
Fixed Assets	
145-000 · Property and Equipment	6,477,362.70
Total Fixed Assets	6,477,362.70
Other Assets	
196-100 · Deferred Outflows Rel to OPEB	739,806.00
280-100 · Def. Outfl Related to Pensions	647,886.00
Total Other Assets	1,387,692.00
TOTAL ASSETS	**19,950,198.89**
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
200-100 · Accounts Payable	220,864.27
Total Accounts Payable	220,864.27
Other Current Liabilities	266,416.85
Total Current Liabilities	487,281.12
Long Term Liabilities	18,563,407.43
Total Liabilities	19,050,688.55
Equity	899,510.34
TOTAL LIABILITIES & EQUITY	**19,950,198.89**

1.11 Future Meeting Dates

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS
August 24, 2026
MEETING AGENDA

Board Meeting Dates 2026

September 21, 22
October 26, 27
December 14, 15

2.00 Regulatory Report

02.00.01 August 2026 Rules Chart

Title	Drafting Process	Committee Approval	Board Approval	FEIS Approval	NOI Publication	Summary Report Submitted to Oversight Committee and AGs	Final Rule Published	Agency Adoption
Respiratory Therapist								
Medical Psychologist								
CME - MRP								
Physician Assistants								
Private Radiological Technicians								
APRN								
Opioid								
Recovery								
Midwives								
Alternative Paths for Licensing								
Podiatrists								
Athletic Trainers								
Obesity