Advisory Board on Athletic Training

Virginia Board of Medicine

May 23, 2019

10:00 a.m.

Advisory Board on Athletic Trainers

Board of Medicine
Thursday, May 23, 2019 @ 10:00 a.m.
9960 Mayland Drive, Suite 201, Henrico, VA
Training Room 2

Page

Call to Order – Mike Puglia, AT, Chair

Emergency Egress Procedures – William Harp, MD i

Roll Call – Denise Mason

Approval of Minutes of October 3, 2018 1

Adoption of the Agenda

Public Comment on Agenda Items (15 minutes)

New Business

1. Report of the 2019 General Assembly 5
2. Legality of AT's possessing and administering naloxone 14
3. AT statutory protection 48
4. Sudden cardiac arrest in secondary schools 49
5. BOC disciplinary reporting 56
6. Regulations governing the licensure of Athletic Trainers 58

Announcements

Adjournment

Next Scheduled Meeting: October 3, 2019 @ 10:00 a.m.

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound.

When the alarms sound, leave the room immediately. Follow any instructions given by Security staff

Training Room 2

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the doors, turn **LEFT**. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

DRAFT UNAPPROVED

ADVISORY BOARD ON ATHLETIC TRAINING
MINUTES

October 4, 2018

The Advisory Board on Athletic Training met on Thursday, October 4, 2018, at 10:00 a.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT:	Sara Whiteside, AT, Chair Michael Puglia, AT Jeffrey Roberts, MD
MEMBERS ABSENT:	Deborah B. Corbatto, AT, Vice-Chair Trilizsa Trent
STAFF PRESENT:	William L. Harp, MD, Executive Director Colanthia Morton Opher, Deputy for Administration Elaine Yeatts, DHP Senior Policy Analyst
GUESTS PRESENT:	Scott Powers, VATA Chris Young, VATA Tanner Howell, VUU/VATA Kristian Hill, VATA Chris Jones Caitlin Carnell, MD, PGY-4

CALL TO ORDER

Sara Whiteside called the meeting to order at 10:07 a.m.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the Emergency Egress Instructions.

ROLL CALL

Colanthia Opher called the roll, and a quorum was declared.

APPROVAL OF MINUTES OF JUNE 7, 2018

Mr. Puglia moved to approve the minutes of June 7, 2018 as presented. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

Mr. Puglia asked that the agenda be amended to include a discussion of the CDC Recommendations from the 2018 Guidelines on the Diagnosis and Management of Mild Traumatic Brain Injury Among Children. The motion was seconded and carried unanimously.

PUBLIC COMMENT ON AGENDA ITEMS

All comments received were from VATA members requesting clarity on the definition of direction by a physician of an athletic trainer.

Ms. Yeatts stated that there is language in the regulation that provides direction to students, but no definitive definition of what the physician, the athletic trainer and the patient can expect in terms of "direction."

It was noted that there has been some difficulty with third party reimbursement. Some payers view the AT practice act to be too vague with medical direction poorly defined, and do not see AT services as being medically supported.

Dr. Harp stated that there are advantages to the scope of practice being vague; making it too specific could have unintended consequences.

After discussion, Ms. Yeatts stated that the fact that there is no language to define "direction" is problematic. She suggested that during the review of the regulations, the Advisory Board should recommend language to address this issue, and as long as the definition does not restrict the practice and would protect the public, it should be able to be added. She also noted that once the proposal has been adopted by the Board of Medicine, it may help the AT community with their issue.

NEW BUSINESS

1. Periodic review of regulations

Ms. Yeatts advised that the Board is required to review the regulations every 4 years. Notice of the review was posted, and one comment was received. However, it was noted that the comment was not in direct relation to the periodic review, but a concern about oversight of AT's that travel with teams.

After a brief discussion, Ms. Yeatts walked the members through each section of the regulations and the following notations were made:

18VAC85-120-30. Current name and address.

Ms. Yeatts advised that to permit the Board of send an electronic renewal notice to the licensee, the word "mailed" would be changed to "sent".

18VAC85-120-35. Fees.

Ms. Yeatts stated that due to a significant surplus held by the Board of Medicine, the upcoming renewal fees for the next biennium have been reduced.

18VAC85-120-10. Definitions.

Ms. Yeatts suggested that the definition of direction be included as **noted** below:

"Practice of athletic training" means the prevention, recognition, evaluation, and treatment of injuries or conditions related to athletic, recreational or occupational activity that requires physical skill and utilizes strength, power, endurance, speed, flexibility, range of motion or agility immediately upon the onset of such injury or condition; and subsequent treatment and rehabilitation of such injuries or conditions **under the direction of the patient's physician or under the direction of any doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry,** while using heat, light, sound, cold, electricity, exercise or mechanical or other devices.

Mr. Puglia moved that the above language be submitted to the full Board of Medicine for approval. The motion was seconded and carried unanimously.

There were no additional proposed amendments to the regulations.

2. **Board Member Badges**

Dr. Harp announced that badges will no longer be issued to Board members. Members will be provided a badge to use while they are onsite and will turn them in prior to leaving the building.

3. **2019 Meeting Calendar**

Ms. Opher asked that any conflicts be given to her as soon as possible so she can find an alternate date.

4. **Election of Officers**

Ms. Whiteside nominated Mr. Puglia for Chair; the nomination was seconded and carried unanimously. Mr. Puglia nominated Ms. Corbatto as Vice-Chair; the nomination was seconded and carried unanimously.

5. **CDC Recommendation from 2018 Guidelines on the Diagnosis and Management of Mild Traumatic Brain Injury Among Children**

Mr. Puglia advised that the recommendations follow what athletic trainers already know. The one change was in the language. It was decided that the word "concussion" be replaced with the term "mild traumatic brain injury" across the board.

This topic was for informational purposes only and did not require any action.

ANNOUNCEMENTS

Ms. Opher provided the license count for ATs.

NEXT MEETING DATE

January 24, 2019 at 10 a.m.

ADJOURNMENT

The meeting adjourned at 11:37 a.m.

Sara Whiteside, AT, Chair

William L. Harp, M.D., Executive Director

Colanthia M. Opher, Recording Secretary

Board of Medicine
Report of the 2019 General Assembly

HB 1952 Patient care teams; podiatrists and physician assistants.

Chief patron: Campbell, J.L.

Summary as passed House:

Patient care team podiatrist definition; physician assistant supervision requirements. Establishes the role of "patient care team podiatrist" as a provider of management and leadership to physician assistants in the care of patients as part of a patient care team. The bill modifies the supervision requirements for physician assistants by establishing a patient care team model. The bill directs the Board of Medicine to adopt emergency regulations to implement the provisions of the bill and is identical to SB 1209.

02/22/19 Governor: Acts of Assembly Chapter text (CHAP0137)

HB 1970 Telemedicine services; payment and coverage of services.

Chief patron: Kilgore

Summary as passed:

Telemedicine services; coverage. Requires insurers, corporations, or health maintenance organizations to cover medically necessary remote patient monitoring services as part of their coverage of telemedicine services to the full extent that these services are available. The bill defines remote patient monitoring services as the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload. The bill requires the Board of Medical Assistance Services to include in the state plan for medical assistance services a provision for the payment of medical assistance for medically necessary health care services provided through telemedicine services. This bill is identical to SB 1221.

03/05/19 Governor: Acts of Assembly Chapter text (CHAP0211)

HB 1971 Health professions and facilities; adverse action in another jurisdiction.

Chief patron: Stolle

Summary as introduced:

Health professions and facilities; adverse action in another jurisdiction. Provides that the mandatory suspension of a license, certificate, or registration of a health professional by the Director of the Department of Health Professions is not required when the license, certificate, or registration of a health professional is revoked, suspended, or surrendered in another jurisdiction based on disciplinary action or mandatory suspension in the Commonwealth. The bill extends the time by which the Board of Pharmacy (Board) is required to hold a hearing after receiving an application for reinstatement from a nonresident pharmacy whose registration has been suspended by the Board based on revocation or suspension in another jurisdiction from not later than its next regular meeting after the expiration of 30 days from receipt of the reinstatement application to not later than its next regular meeting after the expiration of 60 days from receipt of the reinstatement application.

02/22/19 Governor: Acts of Assembly Chapter text (CHAP0138)

HB 2169 Physician assistants; licensure by endorsement.

Chief patron: Thomas

Summary as passed:

Physician assistants; licensure by endorsement. Authorizes the Board of Medicine to issue a license by endorsement to an applicant for licensure as a physician assistant who (i) is the spouse of an active duty member of the Armed Forces of the United States or the Commonwealth, (ii) holds current certification from the National Commission on Certification of Physician Assistants, and (iii) holds a license as a physician assistant that is in good standing, or that is eligible for reinstatement if lapsed, under the laws of another state.

03/12/19 Governor: Acts of Assembly Chapter text (CHAP0338)

HB 2184 Volunteer license, special; issuance for limited practice.

Chief patron: Kilgore

Summary as passed:

Volunteer dentists and dental hygienists. Removes certain requirements for dentists and dental hygienists volunteering to provide free health care for up to three consecutive days to an underserved area of the Commonwealth under the auspices of a publicly supported nonprofit organization that sponsors the provision of health care to populations of underserved people.

03/08/19 Governor: Acts of Assembly Chapter text (CHAP0290)

HB 2228 Nursing and Psychology, Boards of; health regulatory boards, staggered terms.

Chief patron: Bagby

Summary as introduced:

Composition of the Boards of Nursing and Psychology; health regulatory boards; staggered terms. Alters the composition of the Board of Nursing and replaces the requirement that the Board of Nursing meet each January with the requirement that it meet at least annually. The bill also removes specific officer titles from the requirement that the Board of Nursing elect officers from its membership. The bill replaces the requirement that a member of the Board of Psychology be licensed as an applied psychologist with the requirement that that position be filled by a member who is licensed in any category of psychology. The bill also provides a mechanism for evenly staggering the terms of members of the following health regulatory boards, without affecting the terms of current members: Board of Nursing, Board of Psychology, Board of Dentistry, Board of Long-Term Care Administrators, Board of Medicine, Board of Veterinary Medicine, Board of Audiology and Speech-Language Pathology, Board of Pharmacy, and Board of Counseling.

02/27/19 Governor: Acts of Assembly Chapter text (CHAP0169)

HB 2457 Medicine, osteopathy, podiatry, or chiropractic, practitioners of; inactive license, charity care.

Chief patron: Landes

Summary as passed:

Practitioners of medicine, osteopathy, podiatry, or chiropractic; retiree license. Provides that the Board of Medicine may issue a retiree license to any doctor of medicine, osteopathy, podiatry, or chiropractic who holds an active, unrestricted license to practice in the Commonwealth upon receipt of a request and submission of the required fee. The bill provides that a person to whom a retiree license has been issued shall not be required to meet continuing competency requirements for the first biennial renewal of such license. The bill also provides that a person to whom a retiree license has been issued shall only engage in the practice of medicine, osteopathy, podiatry, or chiropractic for the purpose of providing charity care or health care services to patients in their residence for whom travel is a barrier to receiving health care.

03/14/19 Governor: Acts of Assembly Chapter text (CHAP0379)

HB 2557 Drug Control Act; classifies gabapentin as a Schedule V controlled substance.

Chief patron: Pillion

Summary as passed:

Drug Control Act; Schedule V; gabapentin. Classifies gabapentin as a Schedule V controlled substance. Current law lists gabapentin as a drug of concern. The bill also removes the list of drugs of concern from the Code of Virginia and provides that any wholesale drug distributor licensed and regulated by the Board of Pharmacy and registered with and regulated by the U.S. Drug Enforcement Administration shall have until July 1, 2020, or within six months of final approval of compliance from the Board of Pharmacy and the U.S. Drug Enforcement Administration, whichever is earlier, to comply with storage requirements for Schedule V controlled substances containing gabapentin.

03/05/19 Governor: Acts of Assembly Chapter text (CHAP0214)

HB 2559 Electronic transmission of certain prescriptions; exceptions.

Chief patron: Pillion

Summary as passed House:

Electronic transmission of certain prescriptions; exceptions. Provides certain exceptions, effective July 1, 2020, to the requirement that any prescription for a controlled substance that contains an opioid be issued as an electronic prescription. The bill requires the licensing health regulatory board of a prescriber to grant such prescriber a waiver of the electronic prescription requirement for a period not to exceed one year due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the prescriber, or other exceptional circumstances demonstrated by the prescriber. The bill provides that a dispenser is not required to verify whether one of the exceptions applies when he receives a non-electronic prescription for a controlled substance containing an opioid. The bill requires the Boards of Medicine, Nursing, Dentistry, and Optometry to promulgate regulations to implement the prescriber waivers. Finally, the bill requires the Secretary of Health and Human Resources to convene a work group to identify successes and challenges of the electronic prescription requirement and offer possible recommendations for increasing the electronic prescribing of controlled substances that contain an opioid and to report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2022.

03/21/19 Governor: Acts of Assembly Chapter text (CHAP0664)

HB 2731 Lyme disease; disclosure of information to patients.

Chief patron: Edmunds

Summary as passed House:

Lyme disease; disclosure of information to patients. Requires every laboratory reporting the results of a test for Lyme disease ordered by a health care provider in an office-based setting to include, together with the results of such test provided to the health care provider, a notice stating that the results of Lyme disease tests may vary and may produce results that are inaccurate and that a patient may not be able to rely on a positive or negative result from such test. Such notice shall also include a statement that health care providers are encouraged to discuss Lyme disease test results with the patient for whom the test was ordered. The bill also provides that a laboratory that complies with the provisions of the bill shall be immune from civil liability absent gross negligence or willful misconduct.

03/18/19 Governor: Acts of Assembly Chapter text (CHAP0435)

SB 1004 Elective procedure, test, or service; estimate of payment amount.

Chief patron: Chase

Summary as passed:

Advance estimate of patient payment amount for elective medical procedure, test, or service; notice of right to request. Provides that every hospital currently required to provide an estimate of the payment amount for an elective procedure, test, or service for which a patient may be responsible shall also be required to provide each patient with written information regarding his right to request such estimate, to post written information regarding a patient's right to request such estimate conspicuously in public areas of the hospital, and to make such information available on the hospital's website.

03/21/19 Governor: Acts of Assembly Chapter text (CHAP0671)

SB 1106 Physical therapists & physical therapist assistants; licensure, Physical Therapy Licensure Compact.

Chief patron: Peake

Summary as introduced:

Licensure of physical therapists and physical therapist assistants; Physical Therapy Licensure Compact. Authorizes Virginia to become a signatory to the Physical Therapy Licensure Compact. The Compact permits eligible licensed physical therapists and physical therapist assistants to practice in Compact member states, provided they are licensed in at least one member state. In addition, the bill requires each applicant for licensure in the Commonwealth as a physical therapist or physical therapist assistant to submit fingerprints and provide personal descriptive information in order for the Board to receive a state and federal criminal history record report for each applicant. The bill has a delayed effective date of January 1, 2020, and directs the Board of Physical Therapy to adopt emergency regulations to implement the provisions of the bill.

03/08/19 Governor: Acts of Assembly Chapter text (CHAP0300)

SB 1167 Medicaid recipients; treatment involving opioids or opioid replacements, payment.

Chief patron: Chafin

Summary as passed:

Medicaid recipients; treatment involving opioids or opioid replacements; payment. Prohibits health care providers licensed by the Board of Medicine from requesting or requiring a patient who is a recipient of medical assistance services pursuant to the state plan for medical assistance to pay out-of-pocket costs associated with the provision of service involving (i) the prescription of an opioid for the management of pain or (ii) the prescription of buprenorphine-containing products, methadone, or other opioid replacements approved for the treatment of opioid addiction by the U.S. Food and Drug Administration for medication-assisted treatment of opioid addiction. The bill requires providers who do not accept payment from the Department of Medical Assistance Services (DMAS) who provide such services to patients participating in the Commonwealth's program of medical assistance services to provide written notice to such patient that (a) the Commonwealth's program of medical assistance services covers such health care services and DMAS will pay for such health care services if such health care services meet DMAS's medical necessity criteria and (b) the provider does not participate in the Commonwealth's program of medical assistance and will not accept payment from DMAS for such health care services. Such notice and the patient's acknowledgement of such notice shall be documented in the patient's medical record. This bill is identical to HB 2558.

03/18/19 Governor: Acts of Assembly Chapter text (CHAP0444)

SB 1439 Death certificates; medical certification, electronic filing.

Chief patron: McClellan

Summary as passed:

Death certificates; medical certification; electronic filing. Requires the completed medical certification portion of a death certificate to be filed electronically with the State Registrar of Vital Records through the Electronic Death Registration System and provides that, except for under certain circumstances, failure to file a medical certification of death electronically through the Electronic Death Registration System shall constitute grounds for disciplinary action by the Board of Medicine. The bill includes a delayed effective date of January 1, 2020, and a phased-in requirement for registration with the Electronic Death Registration System and electronic filing of medical certifications of death for various categories of health care providers. The bill directs the Department of Health to work with stakeholders to educate and encourage physicians, physician assistants, and nurse practitioners to timely register with and utilize the Electronic Death Registration System.

03/05/19 Governor: Acts of Assembly Chapter text (CHAP0224)

SB 1547 Music therapists; Board of Health Professions to evaluate regulation.

Chief patron: Vogel

Summary as passed:

Music therapy. Directs the Board of Health Professions to evaluate whether music therapists and the practice of music therapy should be regulated and the degree of regulation to be imposed. The bill requires the Board to report the results of its evaluation to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by November 1, 2019.

03/21/19 Governor: Acts of Assembly Chapter text (CHAP0680)

SB 1557 Pharmacy, Board of; cannabidiol oil and tetrahydrocannabinol oil, regulation of pharmaceutical.

Chief patron: Dunnavant

Summary as passed:

Board of Pharmacy; cannabidiol oil and tetrahydrocannabinol oil; regulation of pharmaceutical processors. Authorizes licensed physician assistants and licensed nurse practitioners to issue a written

certification for use of cannabidiol oil and THC-A oil. The bill requires the Board to promulgate regulations establishing dosage limitations, which shall require that each dispensed dose of cannabidiol oil or THC-A oil not exceed 10 milligrams of tetrahydrocannabinol. The bill requires the Secretary of Health and Human Resources and the Secretary of Agriculture and Forestry to convene a work group to review and recommend an appropriate structure for an oversight organization in Virginia and report its findings and recommendations to the Chairmen of the Senate Committees on Agriculture, Conservation and Natural Resources and Education and Health and the House Committees on Agriculture, Chesapeake and Natural Resources and Health, Welfare and Institutions by November 1, 2019.

03/21/19 Governor: Acts of Assembly Chapter text (CHAP0681)

SB 1760 Diagnostic X-ray machines; operation of machine.

Chief patron: DeSteph

Summary as introduced:

Diagnostic X-ray machines; operation. Provides that no person who has been trained and certified in the operation of a diagnostic X-ray machine by the manufacturer of such machine is required to obtain any other training, certification, or licensure or be under the supervision of a person who has obtained training, certification, or licensure to operate such a diagnostic X-ray machine, provided that (i) such diagnostic X-ray machine (a) is registered and certified by the Department of Health, (b) is being operated to conduct a body composition scan, and (c) is not operated to determine bone density or in the diagnosis or treatment of a patient and (ii) the subject of the body composition scan is notified of the risks associated with exposure to radiation emitted by the diagnostic X-ray machine.

01/31/19 Senate: Passed by indefinitely in Education and Health with letter (15-Y 0-N)

SB 1778 Counseling minors; certain health regulatory boards to promulgate regulations.

Chief patron: Newman

Summary as introduced:

Health regulatory boards; conversion therapy. Directs the Board of Counseling, the Board of Medicine, the Board of Nursing, the Board of Psychology, and the Board of Social Work to each promulgate regulations prohibiting the use of electroshock therapy, aversion therapy, or other physical treatments in the practice of conversion therapy with any person under 18 years of age.

02/06/19 Senate: Left in Education and Health

Board of Medicine
Regulatory/Policy Actions – 2019 General Assembly

EMERGENCY REGULATIONS:

Legislative source	Mandate	Promulgating agency	Board adoption date	Effective date Within 280 days of enactment
HB1952	Patient care team – PAs	Medicine	6/13/19 or 8/2/19 (signed 2/22)	**11/25/19**
HB2559	Waiver for electronic prescribing	Medicine	6/13/19 or 8/2/19 (signed 3/21)	**12/24/19**

APA REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB2457	Retiree license	Medicine	NOIRA – 6/13/19	?

NON-REGULATORY ACTIONS

Legislative source	Affected agency	Action needed	Due date
HB1970	Department	Review of telehealth; practice by adjacent physicians	11/1/19
HB2169	Medicine	Review/revision of application content & process to identify & expedite military spouse apps	7/1/19
SB1557	Medicine/Pharmacy/Department	Inclusion of NPs and PAs for registration to issue certifications Participation in workgroup to study oversight organization	7/1/19
SB1760 (not passed)	Department (Medicine)	Study of Xrays in spas – VDH	11/1/19
HJ682 (not passed)	Department	Study of foreign-trained physicians to provide services in rural areas	11/1/19

Future Policy Actions:

HB793 (2018) - (2) the Department of Health Professions, by **November 1, 2020,** to report to the General Assembly a process by which nurse practitioners who practice without a practice agreement may be included in the online Practitioner Profile maintained by the Department of Health Professions; and (3) the Boards of Medicine and Nursing to report information related to the practice of nurse practitioners without a practice agreement that includes certain data, complaints and disciplinary actions, and recommended modifications to the provisions of this bill to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health and the Chairman of the Joint Commission on Health Care by **November 1, 2021**.

HB2559 (2019) - requires the Secretary of Health and Human Resources to convene a work group to identify successes and challenges of the electronic prescription requirement and offer possible recommendations for increasing the electronic prescribing of controlled substances that contain an opioid and to report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by **November 1, 2022**.

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 29. Medicine and Other Healing Arts

§ 54.1-2900. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Acupuncturist" means an individual approved by the Board to practice acupuncture. This is limited to "licensed acupuncturist" which means an individual other than a doctor of medicine, osteopathy, chiropractic or podiatry who has successfully completed the requirements for licensure established by the Board (approved titles are limited to: Licensed Acupuncturist, Lic.Ac., and L.Ac.).

"Auricular acupuncture" means the subcutaneous insertion of sterile, disposable acupuncture needles in predetermined, bilateral locations in the outer ear when used exclusively and specifically in the context of a chemical dependency treatment program.

"Board" means the Board of Medicine.

"Certified nurse midwife" means an advanced practice registered nurse who is certified in the specialty of nurse midwifery and who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957.

"Certified registered nurse anesthetist" means an advanced practice registered nurse who is certified in the specialty of nurse anesthesia, who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957, and who practices under the supervision of a doctor of medicine, osteopathy, podiatry, or dentistry but is not subject to the practice agreement requirement described in § 54.1-2957.

"Genetic counselor" means a person licensed by the Board to engage in the practice of genetic counseling.

"Healing arts" means the arts and sciences dealing with the prevention, diagnosis, treatment and cure or alleviation of human physical or mental ailments, conditions, diseases, pain or infirmities.

"Medical malpractice judgment" means any final order of any court entering judgment against a licensee of the Board that arises out of any tort action or breach of contract action for personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.

"Medical malpractice settlement" means any written agreement and release entered into by or on behalf of a licensee of the Board in response to a written claim for money damages that arises out of any personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.

"Nurse practitioner" means an advanced practice registered nurse who is jointly licensed by the Boards of Medicine and Nursing pursuant to § 54.1-2957.

"Occupational therapy assistant" means an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed occupational therapist to assist in the practice of occupational therapy.

"Patient care team" means a multidisciplinary team of health care providers actively functioning as a unit with the management and leadership of one or more patient care team physicians for the purpose of providing and delivering health care to a patient or group of patients.

"Patient care team physician" means a physician who is actively licensed to practice medicine in the Commonwealth, who regularly practices medicine in the Commonwealth, and who provides management and leadership in the care of patients as part of a patient care team.

"Physician assistant" means an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed doctor of medicine, osteopathy, or podiatry.

"Practice of acupuncture" means the stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain ailments or conditions of the body and includes the techniques of electroacupuncture, cupping and moxibustion. The practice of acupuncture does not include the use of physical therapy, chiropractic, or osteopathic manipulative techniques; the use or prescribing of any drugs, medications, serums or vaccines; or the procedure of auricular acupuncture as exempted in § 54.1-2901

when used in the context of a chemical dependency treatment program for patients eligible for federal, state or local public funds by an employee of the program who is trained and approved by the National Acupuncture Detoxification Association or an equivalent certifying body.

"Practice of athletic training" means the prevention, recognition, evaluation, and treatment of injuries or conditions related to athletic or recreational activity that requires physical skill and utilizes strength, power, endurance, speed, flexibility, range of motion or agility or a substantially similar injury or condition resulting from occupational activity immediately upon the onset of such injury or condition; and subsequent treatment and rehabilitation of such injuries or conditions under the direction of the patient's physician or under the direction of any doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry, while using heat, light, sound, cold, electricity, exercise or mechanical or other devices.

"Practice of behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Practice of chiropractic" means the adjustment of the 24 movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy, but does not include the use of surgery, obstetrics, osteopathy or the administration or prescribing of any drugs, medicines, serums or vaccines. "Practice of chiropractic" shall include performing the physical examination of an applicant for a commercial driver's license or commercial learner's permit pursuant to § 46.2-341.12 if the practitioner has (i) applied for and received certification as a medical examiner pursuant to 49 C.F.R. Part 390, Subpart D and (ii) registered with the National Registry of Certified Medical Examiners.

"Practice of genetic counseling" means (i) obtaining and evaluating individual and family medical histories to assess the risk of genetic medical conditions and diseases in a patient, his offspring, and other family members; (ii) discussing the features, history, diagnosis, environmental factors, and risk management of genetic medical conditions and diseases; (iii) ordering genetic laboratory tests and other diagnostic studies necessary for genetic assessment; (iv) integrating the results with personal and family medical history to assess and communicate risk factors for genetic medical conditions and diseases; (v) evaluating the patient's and family's responses to the medical condition or risk of recurrence and providing client-centered counseling and anticipatory guidance; (vi) identifying and utilizing community resources that provide medical, educational, financial, and psychosocial support and advocacy; and (vii) providing written documentation of medical, genetic, and counseling information for families and health care professionals.

"Practice of medicine or osteopathic medicine" means the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method.

"Practice of occupational therapy" means the therapeutic use of occupations for habilitation and rehabilitation to enhance physical health, mental health, and cognitive functioning and includes the evaluation, analysis, assessment, and delivery of education and training in basic and instrumental activities of daily living; the design, fabrication, and application of orthoses (splints); the design, selection, and use of adaptive equipment and assistive technologies; therapeutic activities to enhance functional performance; vocational evaluation and training; and consultation concerning the adaptation of physical, sensory, and social environments.

"Practice of podiatry" means the prevention, diagnosis, treatment, and cure or alleviation of physical conditions, diseases, pain, or infirmities of the human foot and ankle, including the medical, mechanical and surgical treatment of the ailments of the human foot and ankle, but does not include amputation of the foot proximal to the transmetatarsal level through the metatarsal shafts. Amputations proximal to the metatarsal-phalangeal joints may only be performed in a hospital or ambulatory surgery facility accredited by an organization listed in § 54.1-2939. The practice includes the diagnosis and treatment of lower extremity ulcers; however, the treatment of severe lower extremity ulcers proximal to the foot and ankle may only be performed by appropriately trained, credentialed podiatrists in an approved hospital or ambulatory surgery center at which the podiatrist has privileges, as described in § 54.1-2939. The Board of Medicine shall determine whether a specific type of treatment of the foot and ankle is within the scope of practice of podiatry.

"Practice of radiologic technology" means the application of ionizing radiation to human beings for diagnostic or therapeutic purposes.

"Practice of respiratory care" means the (i) administration of pharmacological, diagnostic, and therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease prevention, pulmonary rehabilitative, or diagnostic regimen prescribed by a practitioner of medicine or osteopathic medicine; (ii) transcription and implementation of the written or verbal orders of a practitioner of medicine or osteopathic medicine pertaining to the practice of respiratory care; (iii) observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing, including determination of whether such signs, symptoms, reactions, behavior or general physical response exhibit abnormal characteristics; and (iv) implementation of respiratory care procedures, based on observed abnormalities, or appropriate

reporting, referral, respiratory care protocols or changes in treatment pursuant to the written or verbal orders by a licensed practitioner of medicine or osteopathic medicine or the initiation of emergency procedures, pursuant to the Board's regulations or as otherwise authorized by law. The practice of respiratory care may be performed in any clinic, hospital, skilled nursing facility, private dwelling or other place deemed appropriate by the Board in accordance with the written or verbal order of a practitioner of medicine or osteopathic medicine, and shall be performed under qualified medical direction.

"Qualified medical direction" means, in the context of the practice of respiratory care, having readily accessible to the respiratory therapist a licensed practitioner of medicine or osteopathic medicine who has specialty training or experience in the management of acute and chronic respiratory disorders and who is responsible for the quality, safety, and appropriateness of the respiratory services provided by the respiratory therapist.

"Radiologic technologist" means an individual, other than a licensed doctor of medicine, osteopathy, podiatry, or chiropractic or a dentist licensed pursuant to Chapter 27 (§ 54.1-2700 et seq.), who (i) performs, may be called upon to perform, or is licensed to perform a comprehensive scope of diagnostic or therapeutic radiologic procedures employing ionizing radiation and (ii) is delegated or exercises responsibility for the operation of radiation-generating equipment, the shielding of patient and staff from unnecessary radiation, the appropriate exposure of radiographs, the administration of radioactive chemical compounds under the direction of an authorized user as specified by regulations of the Department of Health, or other procedures that contribute to any significant extent to the site or dosage of ionizing radiation to which a patient is exposed.

"Radiologic technologist, limited" means an individual, other than a licensed radiologic technologist, dental hygienist, or person who is otherwise authorized by the Board of Dentistry under Chapter 27 (§ 54.1-2700 et seq.) and the regulations pursuant thereto, who performs diagnostic radiographic procedures employing equipment that emits ionizing radiation that is limited to specific areas of the human body.

"Radiologist assistant" means an individual who has met the requirements of the Board for licensure as an advanced-level radiologic technologist and who, under the direct supervision of a licensed doctor of medicine or osteopathy specializing in the field of radiology, is authorized to (i) assess and evaluate the physiological and psychological responsiveness of patients undergoing radiologic procedures; (ii) evaluate image quality, make initial observations, and communicate observations to the supervising radiologist; (iii) administer contrast media or other medications prescribed by the supervising radiologist; and (iv) perform, or assist the supervising radiologist to perform, any other procedure consistent with the guidelines adopted by the American College of Radiology, the American Society of Radiologic Technologists, and the American Registry of Radiologic Technologists.

"Respiratory care" means the practice of the allied health profession responsible for the direct and indirect services, including inhalation therapy and respiratory therapy, in the treatment, management, diagnostic testing, control, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system under qualified medical direction.

Code 1950, § 54-273; 1950, p. 110; 1958, c. 161; 1960, c. 268; 1966, c. 657; 1970, c. 69; 1973, c. 529; 1975, cc. 508, 512; 1977, c. 127; 1980, c. 157; 1986, c. 439; 1987, cc. 522, 543; 1988, cc. 737, 765; 1991, c. 643; 1994, c. 803; 1995, c. 777; 1996, cc. 152, 158, 470, 937, 980; 1998, cc. 319, 557, 593; 1999, cc. 639, 682, 747, 779; 2000, cc. 688, 814; 2001, c. 533; 2004, c. 731; 2007, c. 861; 2008, cc. 64, 89; 2009, cc. 83, 507; 2010, cc. 715, 725; 2011, cc. 121, 187; 2012, cc. 3, 110, 168, 213, 399; 2014, cc. 10, 266; 2015, c. 302; 2016, c. 93; 2017, c. 171.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

5/15/2019

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 34. Drug Control Act

§ 54.1-3408. Professional use by practitioners.

A. A practitioner of medicine, osteopathy, podiatry, dentistry, or veterinary medicine or a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 shall only prescribe, dispense, or administer controlled substances in good faith for medicinal or therapeutic purposes within the course of his professional practice.

B. The prescribing practitioner's order may be on a written prescription or pursuant to an oral prescription as authorized by this chapter. The prescriber may administer drugs and devices, or he may cause drugs or devices to be administered by:

1. A nurse, physician assistant, or intern under his direction and supervision;

2. Persons trained to administer drugs and devices to patients in state-owned or state-operated hospitals or facilities licensed as hospitals by the Board of Health or psychiatric hospitals licensed by the Department of Behavioral Health and Developmental Services who administer drugs under the control and supervision of the prescriber or a pharmacist;

3. Emergency medical services personnel certified and authorized to administer drugs and devices pursuant to regulations of the Board of Health who act within the scope of such certification and pursuant to an oral or written order or standing protocol; or

4. A licensed respiratory therapist as defined in § 54.1-2954 who administers by inhalation controlled substances used in inhalation or respiratory therapy.

C. Pursuant to an oral or written order or standing protocol, the prescriber, who is authorized by state or federal law to possess and administer radiopharmaceuticals in the scope of his practice, may authorize a nuclear medicine technologist to administer, under his supervision, radiopharmaceuticals used in the diagnosis or treatment of disease.

D. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered nurses and licensed practical nurses to possess (i) epinephrine and oxygen for administration in treatment of emergency medical conditions and (ii) heparin and sterile normal saline to use for the maintenance of intravenous access lines.

Pursuant to the regulations of the Board of Health, certain emergency medical services technicians may possess and administer epinephrine in emergency cases of anaphylactic shock.

Pursuant to an order or standing protocol issued by the prescriber within the course of his professional practice, any school nurse, school board employee, employee of a local governing body, or employee of a local health department who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of a school for students with disabilities, as defined in § 22.1-319 and licensed by the Board of Education, or any employee of a private school that is accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of a public institution of higher education or a private institution of higher education who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of an organization providing outdoor educational experiences or programs for youth who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order issued by the prescriber within the course of his professional practice, an employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services may possess and administer epinephrine, provided such person is authorized and trained in the administration of epinephrine.

Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize pharmacists to possess epinephrine and oxygen for administration in treatment of emergency medical conditions.

E. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed physical therapists to possess and administer topical corticosteroids, topical lidocaine, and any other Schedule VI topical drug.

F. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed athletic trainers to possess and administer topical corticosteroids, topical lidocaine, or other Schedule VI topical drugs; oxygen for use in emergency situations; and epinephrine for use in emergency cases of anaphylactic shock.

G. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, and in accordance with policies and guidelines established by the Department of Health pursuant to § 32.1-50.2, such prescriber may authorize registered nurses or licensed practical nurses under the supervision of a registered nurse to possess and administer tuberculin purified protein derivative (PPD) in the absence of a prescriber. The Department of Health's policies and guidelines shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention for preventing transmission of mycobacterium tuberculosis and shall be updated to incorporate any subsequently implemented standards of the Occupational Safety and Health Administration and the Department of Labor and Industry to the extent that they are inconsistent with the Department of Health's policies and guidelines. Such standing protocols shall explicitly describe the categories of persons to whom the tuberculin test is to be administered and shall provide for appropriate medical evaluation of those in whom the test is positive. The prescriber shall ensure that the nurse implementing such standing protocols has received adequate training in the practice and principles underlying tuberculin screening.

The Health Commissioner or his designee may authorize registered nurses, acting as agents of the Department of Health, to possess and administer, at the nurse's discretion, tuberculin purified protein derivative (PPD) to those persons in whom tuberculin skin testing is indicated based on protocols and policies established by the Department of Health.

H. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the parents as defined in § 22.1-1, an employee of (i) a school board, (ii) a school for students with disabilities as defined in § 22.1-319 licensed by the Board of Education, or (iii) a private school accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education who is trained in the administration of insulin and glucagon to assist with the administration of insulin or administer glucagon to a student diagnosed as having diabetes and who requires insulin injections during the school day or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia. Such authorization shall only be effective when a licensed nurse, nurse practitioner, physician, or physician assistant is not present to perform the administration of the medication.

Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize an employee of a public institution of higher education or a private institution of higher education who is trained in the administration of insulin and glucagon to assist with the administration of insulin or administration of glucagon to a student diagnosed as having diabetes and who requires insulin injections or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia. Such authorization shall only be effective when a licensed nurse, nurse practitioner, physician, or physician assistant is not present to perform the administration of the medication.

Pursuant to a written order issued by the prescriber within the course of his professional practice, such prescriber may authorize an employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services to assist with the administration of insulin or to administer glucagon to a person diagnosed as having diabetes and who requires insulin injections or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia, provided such employee or person providing services has been trained in the administration of insulin and glucagon.

I. A prescriber may authorize, pursuant to a protocol approved by the Board of Nursing, the administration of vaccines to adults for immunization, when a practitioner with prescriptive authority is not physically present, by (i) licensed pharmacists, (ii) registered nurses, or (iii) licensed practical nurses under the supervision of a registered nurse. A prescriber acting on behalf of and in accordance with established protocols of the Department of Health may authorize the administration of vaccines to any person by a pharmacist, nurse, or designated emergency medical services provider who holds an advanced life support certificate issued by the Commissioner of Health under the direction of an operational medical director when the prescriber is not physically present. The emergency medical services provider shall provide documentation of the vaccines to be recorded in the Virginia Immunization Information System.

J. A dentist may cause Schedule VI topical drugs to be administered under his direction and supervision by either a dental hygienist or by an authorized agent of the dentist.

Further, pursuant to a written order and in accordance with a standing protocol issued by the dentist in the course of his professional practice, a dentist may authorize a dental hygienist under his general supervision, as defined in § 54.1-2722, to possess and administer topical oral fluorides, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions, as well as any other Schedule VI topical drug approved by the Board of Dentistry.

In addition, a dentist may authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia.

K. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered professional nurses certified as sexual assault nurse examiners-A (SANE-A) under his supervision and when he is not physically present to possess and administer preventive medications for victims of sexual assault as recommended by the Centers for Disease Control and Prevention.

L. This section shall not prevent the administration of drugs by a person who has satisfactorily completed a training program for this purpose approved by the Board of Nursing and who administers such drugs in accordance with a prescriber's instructions pertaining to dosage, frequency, and manner of administration, and in accordance with regulations promulgated by the Board of Pharmacy relating to security and record keeping, when the drugs administered would be normally self-administered by (i) an individual receiving services in a program licensed by the Department of Behavioral Health and Developmental Services; (ii) a resident of the Virginia Rehabilitation Center for the Blind and Vision Impaired; (iii) a resident of a facility approved by the Board or Department of Juvenile Justice for the placement of children in need of services or delinquent or alleged delinquent youth; (iv) a program participant of an adult day-care center licensed by the Department of Social Services; (v) a resident of any facility authorized or operated by a state or local government whose primary purpose is not to provide health care services; (vi) a resident of a private children's residential facility, as defined in § 63.2-100 and licensed by the Department of Social Services, Department of Education, or Department of Behavioral Health and Developmental Services; or (vii) a student in a school for students with disabilities, as defined in § 22.1-319 and licensed by the Board of Education.

In addition, this section shall not prevent a person who has successfully completed a training program for the administration of drugs via percutaneous gastrostomy tube approved by the Board of Nursing and been evaluated by a registered nurse as having demonstrated competency in administration of drugs via percutaneous gastrostomy tube from administering drugs to a person receiving services from a program licensed by the Department of Behavioral Health and Developmental Services to such person via percutaneous gastrostomy tube. The continued competency of a person to administer drugs via percutaneous gastrostomy tube shall be evaluated semiannually by a registered nurse.

M. Medication aides registered by the Board of Nursing pursuant to Article 7 (§ 54.1-3041 et seq.) of Chapter 30 may administer drugs that would otherwise be self-administered to residents of any assisted living facility licensed by the Department of Social Services. A registered medication aide shall administer drugs pursuant to this section in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; in accordance with regulations promulgated by the Board of Pharmacy relating to security and recordkeeping; in accordance with the assisted living facility's Medication Management Plan; and in accordance with such other regulations governing their practice promulgated by the Board of Nursing.

N. In addition, this section shall not prevent the administration of drugs by a person who administers such drugs in accordance with a physician's instructions pertaining to dosage, frequency, and manner of administration and with written authorization of a parent, and in accordance with school board regulations relating to training, security and record keeping, when the drugs administered would be normally self-administered by a student of a Virginia public school. Training for such persons shall be accomplished through a program approved by the local school boards, in consultation with the local departments of health.

O. In addition, this section shall not prevent the administration of drugs by a person to (i) a child in a child day program as defined in § 63.2-100 and regulated by the State Board of Social Services or a local government pursuant to § 15.2-914, or (ii) a student of a private school that is accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education, provided such person (a) has satisfactorily completed a training program for this purpose approved by the Board of Nursing and taught by a registered nurse, licensed practical nurse, nurse practitioner, physician assistant, doctor of medicine or osteopathic medicine, or pharmacist; (b) has obtained written authorization from a parent or guardian; (c) administers drugs only to the child identified on the prescription label in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; and (d) administers only those drugs that were dispensed from a pharmacy and maintained in the original, labeled container that would normally be self-administered by the child or student, or administered by a parent or guardian to the child or student.

P. In addition, this section shall not prevent the administration or dispensing of drugs and devices by persons if they are authorized by the State Health Commissioner in accordance with protocols established by the State Health Commissioner pursuant to § 32.1-42.1 when (i) the Governor has declared a disaster or a state of emergency or the United States Secretary of Health and Human Services has issued a declaration of an actual or potential bioterrorism incident or other actual or potential public health emergency; (ii) it is necessary to permit the provision of needed drugs or devices; and (iii) such persons have received the training necessary to safely administer or dispense the needed drugs or devices. Such persons shall administer or dispense all drugs or devices under the direction, control, and supervision of the State Health Commissioner.

Q. Nothing in this title shall prohibit the administration of normally self-administered drugs by unlicensed individuals to a person in his private residence.

R. This section shall not interfere with any prescriber issuing prescriptions in compliance with his authority and scope of practice and the provisions of this section to a Board agent for use pursuant to subsection G of § 18.2-258.1. Such prescriptions issued by such prescriber shall be deemed to be valid prescriptions.

S. Nothing in this title shall prevent or interfere with dialysis care technicians or dialysis patient care technicians who are certified by an organization approved by the Board of Health Professions or persons authorized for provisional practice pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.), in the ordinary course of their duties in a Medicare-certified renal dialysis facility, from administering heparin, topical needle site anesthetics, dialysis solutions, sterile normal saline solution, and blood volumizers, for the purpose of facilitating renal dialysis treatment, when such administration of medications occurs under the orders of a licensed physician, nurse practitioner, or physician assistant and under the immediate and direct supervision of a licensed registered nurse. Nothing in this chapter shall be construed to prohibit a patient care dialysis technician trainee from performing dialysis care as part of and within the scope of the clinical skills instruction segment of a supervised dialysis technician training program, provided such trainee is identified as a "trainee" while working in a renal dialysis facility.

The dialysis care technician or dialysis patient care technician administering the medications shall have demonstrated competency as evidenced by holding current valid certification from an organization approved by the Board of Health Professions pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.).

T. Persons who are otherwise authorized to administer controlled substances in hospitals shall be authorized to administer influenza or pneumococcal vaccines pursuant to § 32.1-126.4.

U. Pursuant to a specific order for a patient and under his direct and immediate supervision, a prescriber may authorize the administration of controlled substances by personnel who have been properly trained to assist a doctor of medicine or osteopathic medicine, provided the method does not include intravenous, intrathecal, or epidural administration and the prescriber remains responsible for such administration.

V. A physician assistant, nurse or a dental hygienist may possess and administer topical fluoride varnish to the teeth of children aged six months to three years pursuant to an oral or written order or a standing protocol issued by a doctor of medicine, osteopathic medicine, or dentistry that conforms to standards adopted by the Department of Health.

W. A prescriber, acting in accordance with guidelines developed pursuant to § 32.1-46.02, may authorize the administration of influenza vaccine to minors by a licensed pharmacist, registered nurse, licensed practical nurse under the direction and immediate supervision of a registered nurse, or emergency medical services provider who holds an advanced life support certificate issued by the Commissioner of Health when the prescriber is not physically present.

X. Notwithstanding the provisions of § 54.1-3303, pursuant to an oral, written, or standing order issued by a prescriber or a standing order issued by the Commissioner of Health or his designee authorizing the dispensing of naloxone or other opioid antagonist used for overdose reversal in the absence of an oral or written order for a specific patient issued by a prescriber, and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, a pharmacist may dispense naloxone or other opioid antagonist used for overdose reversal and a person may possess and administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose. Law-enforcement officers as defined in § 9.1-101, employees of the Department of Forensic Science, employees of the Office of the Chief Medical Examiner, employees of the Department of General Services Division of Consolidated Laboratory Services, employees of the Department of Corrections designated as probation and parole officers or as correctional officers as defined in § 53.1-1, and firefighters who have completed a training program may also possess and administer naloxone in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health.

Y. Notwithstanding any other law or regulation to the contrary, a person who is authorized by the Department of Behavioral Health and Developmental Services to train individuals on the administration of naloxone for use in opioid overdose reversal and who is

acting on behalf of an organization that provides services to individuals at risk of experiencing an opioid overdose or training in the administration of naloxone for overdose reversal and that has obtained a controlled substances registration from the Board of Pharmacy pursuant to § 54.1-3423 may dispense naloxone to a person who has completed a training program on the administration of naloxone for opioid overdose reversal approved by the Department of Behavioral Health and Developmental Services, provided that such dispensing is (i) pursuant to a standing order issued by a prescriber, (ii) in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, and (iii) without charge or compensation. The dispensing may occur at a site other than that of the controlled substance registration provided the entity possessing the controlled substances registration maintains records in accordance with regulations of the Board of Pharmacy. A person to whom naloxone has been dispensed pursuant to this subsection may possess naloxone and may administer naloxone to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose.

Z. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the parents as defined in § 22.1-1, an employee of (i) a school board, (ii) a school for students with disabilities as defined in § 22.1-319 licensed by the Board of Education, or (iii) a private school accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education who is trained in the administration of injected medications for the treatment of adrenal crisis resulting from a condition causing adrenal insufficiency to administer such medication to a student diagnosed with a condition causing adrenal insufficiency when the student is believed to be experiencing or about to experience an adrenal crisis. Such authorization shall be effective only when a licensed nurse, nurse practitioner, physician, or physician assistant is not present to perform the administration of the medication.

Code 1950, § 54-497; 1956, c. 225; 1970, c. 650, § 54-524.65; 1973, c. 468; 1976, cc. 358, 614; 1977, c. 302; 1978, c. 224; 1980, cc. 270, 287; 1983, cc. 456, 528; 1984, cc. 141, 555; 1986, c. 81; 1987, c. 226; 1988, c. 765; 1990, c. 309; 1991, cc. 141, 519, 524, 532; 1992, cc. 610, 760, 793; 1993, cc. 15, 810, 957, 993; 1994, c. 53; 1995, cc. 88, 529; 1996, cc. 152, 158, 183, 406, 408, 490; 1997, cc. 272, 566, 806, 906; 1998, c. 112; 1999, c. 570; 2000, cc. 135, 498, 861, 881, 935; 2003, cc. 465, 497, 515, 794, 995, 1020; 2005, cc. 113, 610, 924; 2006, cc. 75, 432, 686, 858; 2007, cc. 17, 699, 702, 783; 2008, cc. 85, 694; 2009, cc. 48, 110, 506, 813, 840; 2010, cc. 179, 245, 252; 2011, c. 292; 2012, cc. 787, 803, 833, 835; 2013, cc. 114, 132, 183, 191, 252, 267, 328, 336, 359, 617; 2014, cc. 88, 491; 2015, cc. 302, 387, 502, 503, 514, 725, 732, 752; 2016, c. 144; 2017, cc. 3, 55, 107, 168, 174, 182, 294, 304, 713; 2018, cc. 62, 247.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

5/15/2019

Virginia Board of Pharmacy

Protocol for the Prescribing of Naloxone and Dispensing by Pharmacists and Distribution to Authorized Entities

Pharmacists shall follow this protocol when dispensing naloxone pursuant to an oral, written or standing order to a person to administer to another person believed to be experiencing or about to experience a life-threatening opioid overdose as authorized in subsection X of §54.1-3408.

1) **Procedure:** When someone requests naloxone, or when a pharmacist in his or her professional judgment decides to advise of the availability and appropriateness of naloxone, the pharmacist shall:
   a) Provide counseling in opioid overdose prevention, recognition, response, administration of naloxone, to include dosing, effectiveness, adverse effects, storage conditions, shelf-life, and safety. Recipient cannot waive receipt of this counseling unless the pharmacist is able to verify successful completion of the REVIVE! training program. If the naloxone is dispensed upon discharge from a hospital or delivered by a pharmacy to an alternate delivery site, e.g., a local health department, and the recipient has not completed the REVIVE! training program, the aforementioned counseling shall be provided by a pharmacist, physician, nurse practitioner, physician assistant, nurse, or an approved trainer of the REVIVE! training program within the hospital or at the alternate delivery site.
   b) The pharmacist shall provide the recipient with the current REVIVE! brochure available on the Department of Behavioral Health and Developmental Services website at http://www.dhp.virginia.gov/Pharmacy/docs/osas-revive-pharmacy-dispensing-brochure.pdf If the recipient indicates interest in addiction treatment, recovery services, or medication disposal resources at this time, the pharmacist may provide information or referrals to appropriate resources.

2) **Product Selection:** The pharmacist who dispenses naloxone pursuant to an oral, written or standing order shall dispense the drug and other items, if applicable, as prescribed and in accordance with this protocol.

3) **Standing Order:** In addition to dispensing naloxone pursuant to an oral or written order issued to a specific individual, a pharmacist may dispense naloxone pursuant to a standing order. The standing order may be issued by an individual prescriber to a specific pharmacy or pharmacies, or the standing order may be issued by the Health Commissioner to all pharmacies located and permitted in Virginia. The standing order authorizes a pharmacist to dispense one or more of the specified naloxone formulations to any person seeking to obtain naloxone. A standing order shall be valid for no more than two years from the date of issuance and shall contain the following information at a minimum:
   a) Name of pharmacy authorized to dispense naloxone pursuant to standing order if the standing order is issued by a prescriber for a particular pharmacy or pharmacies;
   b) Contents to be dispensed, to include quantity of drug and directions for administration;
   c) Prescriber's signature; and
   d) Date of issuance.

4) Dispensing Requirements for Intranasal or Auto-Injector Administration:

Intranasal	Auto-Injector	Intranasal
Naloxone 2mg/2ml prefilled syringe, # 2 syringes SIG: Spray one-half of the syringe into each nostril upon signs of opioid overdose. Call 911. Additional doses may be given every 2 to 3 minutes until emergency medical assistance arrives. Mucosal Atomization Device (MAD) # 2 SIG: Use as directed for naloxone administration. Must dispense with 2 prefilled syringes and 2 atomizers and instructions for administration.	Naloxone 2 mg #1 twin pack SIG: Use one auto-injector upon signs of opioid overdose. Call 911. Additional doses may be given every 2 to 3 minutes until emergency medical assistance arrives.	Narcan Nasal Spray 4mg, #1 twin pack SIG: Administer a single spray intranasally into one nostril. Administer additional doses using a new nasal spray with each dose, if patient does not respond or responds and then relapses into respiratory depression. Call 911. Additional doses may be given every 2 to 3 minutes until emergency medical assistance arrives.

Optional items include rescue breathing masks, and latex-free gloves.

5) Labeling and Records:

Each vial or syringe of naloxone shall be dispensed and labeled in accordance with §54.1-3410 with the exception that the name of the patient does not have to appear on the label. The pharmacist shall maintain a record of dispensing in accordance with recordkeeping requirements of law and regulation. A standing order issued by an individual prescriber or the Health Commissioner shall be maintained by the pharmacist for two years from the date of the last dispensing prior to expiration or discontinuation of the standing order.

Protocol for Distributing to Law-Enforcement Officers, Firefighters, and Employees of the Department of Forensic Science, Office of the Chief Medical Examiner, and Department of General Services Division of Consolidated Laboratory Services

Alternatively, a pharmacy, wholesale distributor, third party logistics provider, or manufacturer may distribute naloxone via invoice to:

1. Designated employees of the Department of Forensic Science, employees of the Office of the Chief Medical Examiner, and employees of the Department of General Services Division of Consolidated Laboratory Services who have successfully completed a training program developed by the Department of Behavioral Health and Developmental Services; or

2. Designated law enforcement officers or firefighters who have successfully completed a training program developed by the Department of Behavioral Health and Developmental Services in consultation with the Department of Criminal Justice Services or Department of Fire Programs, respectively, at the address of the law enforcement agency or fire department.

Training shall be conducted in accordance with policies and procedures of the law enforcement agency, fire department, Department of Forensic Science, Office of the Chief Medical Examiner, or the Department of General Services Division of Consolidated Laboratory Services.

Resources:

a. REVIVE! Opioid Overdose Reversal for Virginia Training Curriculum "Understanding and Responding to Opioid Overdose Emergencies Using Naloxone", available at http://www.dhp.virginia.gov/pharmacy/docs/osas-revive-training-curriculum.pdf
b. Substance Abuse Mental Health Services Administration's "Opioid Prevention Toolkit" (2014), available at http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-4742
c. Prescribe to Prevent, http://prescribetoprevent.org/pharmacists
d. Harm Reduction Coalition, http://harmreduction.org/issues/overdose-prevention/tools-best-practices/od-kit-materials

Protocol for the Prescribing of Naloxone and Dispensing by Trainers

Persons authorized by the Department of Behavioral Health and Developmental Services to train individuals on the administration of naloxone for opioid overdose reversal shall follow this protocol when dispensing naloxone, and the hypodermic needles and syringes required for injecting such naloxone, to a person, without charge or compensation, for administration to another person believed to be experiencing or about to experience a life-threatening opioid overdose as authorized in § 54.1-3408 (Y), §54.1-3466(F), and §54.1-3467(C). ***Note: Only those DBHDS-approved trainers who have successfully completed DBHDS-approved training on proper drug administration with, and disposal of hypodermic needles and syringes, and who are otherwise authorized to dispense injectable naloxone through a standing order issued in compliance with this protocol may dispense injectable naloxone with hypodermic needles and syringes.***

1) **Controlled Substances Registration:** An organization that provides services to individuals at risk of experiencing an opioid overdose or training in the administration of naloxone for overdose reversal on whose behalf an authorized trainer may dispense naloxone pursuant to a standing order shall apply for a controlled substances registration certificate from the Board of Pharmacy. The person authorized by the Department of Behavioral Health and Developmental Services to train individuals on the administration of naloxone and dispense naloxone for opioid overdose reversal must serve as the responsible party on the application. The prescriber issuing the standing order must serve as the supervising practitioner. An alarm system is not required for the controlled substances registration certificate.

2) **Standing Order:** An authorized trainer may dispense naloxone, and the hypodermic needles and syringes required for injecting such naloxone, pursuant to a standing order. The standing order must be issued by an individual prescriber to the organization on whose behalf the authorized trainer is acting. The standing order authorizes a trainer to dispense one or more of the specified naloxone formulations, and may authorize the dispensing of hypodermic needles and syringes for injecting such naloxone, to any person seeking to obtain naloxone following completion of a training program on the administration of naloxone for opioid overdose reversal approved by the Department of Behavioral Health and Developmental Services. A standing order is valid for no more than two years from the date of issuance and must contain the following information at a minimum:
   a. Name of organization that provides services to individuals at risk of experiencing an opioid overdose or training in the administration of naloxone for overdose reversal and that has obtained a controlled substances registration from the Board of Pharmacy on whose behalf the authorized trainer may dispense naloxone pursuant to the standing order;
   b. Drug name, strength, quantity of naloxone to be dispensed, and directions for administration. If hypodermic needles and syringes are to be dispensed for administering such naloxone, the standing order must also specify the kind and quantity of hypodermic needles and syringes to be dispensed as outlined in part 3 of this protocol;
   c. Prescriber's signature; and

d. Date of issuance.

3) Dispensing Requirements for Intranasal, Auto-Injector, or Injectable Administration:

Intranasal	Auto-Injector	Intranasal	Injection*
Naloxone 2mg/2ml prefilled syringe, # 2 syringes SIG: Spray one-half of the syringe into each nostril upon signs of opioid overdose. Call 911. Additional doses may be given every 2 to 3 minutes until emergency medical assistance arrives. Mucosal Atomization Device (MAD) # 2 SIG: Use as directed for naloxone administration. Dispenser must dispense 2 prefilled syringes and 2 atomizers and instructions for administration.	Naloxone 2 mg #1 twin pack SIG: Use one auto-injector upon signs of opioid overdose. Call 911. Additional doses may be given every 2 to 3 minutes until emergency medical assistance arrives.	Narcan Nasal Spray 4mg, #1 twin pack SIG: Administer a single spray intranasally into one nostril upon signs of opioid overdose. Administer additional doses using a new nasal spray with each dose, if patient does not respond or responds and then relapses into respiratory depression. Call 911. Additional doses may be given every 2 to 3 minutes until emergency medical assistance arrives.	Naloxone 0.4mg/ml #2 single-use 1ml vials SIG: Inject 1ml in shoulder or thigh upon signs of opioid overdose. Call 911. Repeat after 2-3 minutes if no or minimal response. #2 (3ml) syringe with 23-25 gauge 1-1.5 inch IM needles SIG: Use as directed for naloxone administration. Dispenser must dispense 2 single-use 1ml vials, 2 (3ml) syringes and 2 (23-25 gauge) hypodermic needles for administration.

**** Only those DBHDS-approved trainers who have successfully completed DBHDS-approved training on proper drug administration with, and disposal of hypodermic needles and syringes, and who are otherwise authorized to dispense injectable naloxone through a standing order issued in compliance with this protocol may dispense injectable naloxone with hypodermic needles and syringes.***

Optional items include rescue breathing masks, and latex-free gloves.

Trainers may obtain kits to have on-hand for dispensing naloxone from the REVIVE! program at the Department of Behavioral Health and Developmental Services. To request kits, contact REVIVE@dbhds.virginia.gov

4) Storage, Labeling, Dispensing, and Recordkeeping:

A. Persons authorized by the Department of Behavioral Health and Developmental Services to train individuals on the administration of naloxone and dispense naloxone, and hypodermic needles and syringes for injecting such naloxone, for opioid overdose reversal pursuant to §54.1-3408(Y), §54.1-3466(F), and §54.1-3467(C) shall maintain the following records:

1. The prescriber's standing order issued in accordance with §54.1-3408(Y), §54.1-3466(F), and §54.1-3467(C) authorizing the trained individual to dispense naloxone, and hypodermic needles and syringes for injecting such naloxone.
2. Invoices or other records showing receipts of naloxone, hypodermic needles, and syringes must be maintained, but may be stored in an electronic database or record as an electronic image that provides an exact, clearly legible, image of the document or in secured storage either on or off site. All records in off-site storage or database shall be retrieved and made available for inspection or audit within 48 hours of a request by the board or an authorized agent.
3. A manual or electronic log indicating the name, strength, lot, expiration date, and quantity of naloxone, description and quantity of hypodermic needles, and syringes transferred to and from the controlled substances registration location to the off-site training location, along with date of transfer, name of trained individual approved by the Department of Behavioral Health and Developmental Services.
4. Record of dispensing indicating name of person receiving naloxone, address or contact information if available, date of dispensing, drug name, strength, quantity, lot number, expiration date, description and quantity of hypodermic needles and syringes, if dispensed, and name of trained individual approved by the Department of Behavioral Health and Developmental Services to dispense naloxone.

B. The naloxone, hypodermic needles, and syringes shall be labeled with directions for use in accordance with prescriber's standing order, date of dispensing, name of person receiving drug, drug name, strength, name and telephone number for the entity associated with the controlled substances registration.

C. The trainer shall provide the recipient with the current REVIVE! brochure available on the Department of Behavioral Health and Developmental Services website at http://www.dhp.virginia.gov/Pharmacy/docs/osas-revive-pharmacy-dispensing-brochure.pdf Additionally, when dispensing injectable naloxone with hypodermic needles and syringes, the trainer shall provide the current REVIVE! brochure on proper disposal of hypodermic needles and syringes.

D. The naloxone, hypodermic needles, and syringes shall be stored and transported under appropriate storage conditions in accordance with the manufacturer's directions to protect from adulteration and unlawful use.

E. In the event of a manufacturer recall, the supervising practitioner or responsible party associated with the controlled substances registration certificate must ensure compliance with any recall procedures as issued by the manufacturer, United States Food and Drug Administration, or Board to

ensure affected drug is transferred to a person or entity authorized to possess the drug for return or destruction.

F. Except for a prescriber's standing order which must be maintained on-site for a period of not less than two years from the date of the last dispensing, records must be filed chronologically and maintained for a period of not less than two years from the date of transaction.

Resources:

a. REVIVE! Opioid Overdose Reversal for Virginia Training Curriculum "Understanding and Responding to Opioid Overdose Emergencies Using Naloxone", available at http://www.dhp.virginia.gov/pharmacy/docs/osas-revive-training-curriculum.pdf
b. Substance Abuse Mental Health Services Administration's "Opioid Prevention Toolkit" (2014), available at http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-4742
c. Prescribe to Prevent, http://prescribetoprevent.org/pharmacists
d. Harm Reduction Coalition, http://harmreduction.org/issues/overdose-prevention/tools-best-practices/od-kit-materials

REVIVE!
OPIOID OVERDOSE AND NALOXONE EDUCATION FOR VIRGINIA

Training Curriculum

Version 3.0, Revised: June 17, 2015

Understanding and Responding to Opioid Overdose Emergencies Using Naloxone: A Guide for REVIVE! Program Trainers

Virginia Department of Behavioral Health & Developmental Services

McShin a Recovery Resource Foundation

One Care of Southwest Virginia, Inc.

SAARA of Virginia

Introduction

This curriculum is designed to provide content, guidance, and assistance for volunteers leading REVIVE! Lay Rescuer training events. REVIVE! is Virginia's Opioid Overdose and Naloxone Education (ONE) program, led by Department of Behavioral Health and Developmental Services (DBHDS), the Department of Health (VDH), and the Department of Health Professions (DHP) in conjunction with One Care of Southwest Virginia, the McShin Foundation and the Substance Abuse and Addiction Recovery Alliance (SAARA) of Virginia.

The 2015 Session of the Virginia General Assembly passed House Bill 1458 (http://1.usa.gov/1Le9WvR) expanding REVIVE! from a pilot project to a statewide program. This bill also expands immunity from civil liability for anyone who prescribes, dispenses, or administers naloxone. It also allows for pharmacies to work with prescribers to establish a standing order which would allow individuals to obtain naloxone from that pharmacy without a prescription or prior training. Finally, it also explicitly allows law enforcement officers and firefighters to carry and administer naloxone.

Additionally, the 2015 Session of the General Assembly passed House Bill 1500 (http://1.usa.gov/1IH6Kse) and Senate Bill 892 (http://1.usa.gov/1J1BMhu). These bills allow for individuals to assert an affirmative defense against certain charges if those charges are the result of law enforcement are responding to a 911 call reporting an overdose emergency. This "Safe Reporting" law is described in more detail herein.

The goal of REVIVE! is to save lives by reducing the number of deaths resulting from opioid overdose emergencies in the Commonwealth. The purpose of the training is to teach individuals as Lay Rescuers, providing them with the knowledge necessary to respond an opioid overdose emergency with the administration of naloxone (Narcan®). Naloxone is a prescription medication that reverses the effects of an opioid overdose emergency.

This curriculum is a guide for you as a trainer of this training. The training is designed to last approximately 45 minutes. The training is divided into modules, and includes approximations of how long each of those sections should last. Please keep in mind that each group of trainees will be different, so some of the suggested time frames will need to be adjusted to respond to the needs of your trainees. This curriculum provides suggestions and prompts that you can use to help guide you through preparing for and leading this training. Notes for Trainers will appear in *italics* throughout this curriculum, and key points of emphasis will appear in ***bolded italics***. Suggested dialogue for Trainers will appear in red text.

As a trainer, please remember that no one is going to have the answer to every question that may come from your trainees. If you don't know the answer, acknowledge that and simply collect that person's contact information and assure them that you or someone else will get back to them with an answer as soon as possible. To obtain help in answering your questions, please email REVIVE@dbhds.virginia.gov or call (804)786-0464.

The training is most effective when performed with a group no larger than 20-25 persons. If you're hosting an event with multiple trainers, you can accommodate more trainees. The room

should be well-lit and comfortable. If the room is large, ensure that everyone can hear you clearly. You may need to use a microphone. Feel free to arrange the room as you like, but make sure that everyone has seating where they will be able to see and hear you as well as to be able to see the table where you will perform the demonstrations on the CPR mannequin and be able to participate in the role play scenarios.

For information about planning and preparing for your Lay Rescuer training event, including a list of all the supplies you will need for a successful training, please consult the REVIVE! Training Agreement that was included in your Trainer Handbook.

Before the training begins, pass out the sign-in sheet so that attendants can sign-in. Also, if anyone needs to complete a registration form, you can pass those out before the training as well. Registration forms should be completed and collected before the training begins. To ensure that trainees stay for the entire event, it is recommended that you do not pass out kit bags until the portion of the training where they will be used.

Welcome and Introductions **~3 Minutes (depending on group size)**

Trainer: Welcome your trainees and introduce yourself, providing a brief description (one to two minutes) of your background and interest in naloxone that led you to be a trainer.

Trainer Script:
"Welcome and thank you for attending this REVIVE! training event. Today we're going to learn about opioid overdose emergencies and how to respond to them using naloxone. We have a lot of important information to cover and I want to make sure we finish as close to the end time that we gave you as we can."

Trainer: Cover housekeeping issues, including silencing mobile devices and bathroom locations. You will then provide a short overview about the creation of REVIVE! by sharing the following:

Trainer Script:
"In 2013, the Virginia General Assembly passed House Bill 1672, directing the Virginia Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with the Virginia Department of Health, the Virginia Department of Health Professions, law enforcement and the recovery community, to conduct a pilot project on the administration of naloxone to counteract the effects of an opioid overdose emergency. In 2015, the General Assembly passed House Bill 1458, which expanded REVIVE! to a statewide program; broadened immunity from civil liability to include anyone who prescribes, dispenses, or administers naloxone; allowed for an oral, written, or standing order that would allow an individual to obtain naloxone from a pharmacy without a prescription; and explicitly allowed law enforcement officers and fire fighters to carry and administer naloxone. Virginia is one of more than 25 states (plus the District of Columbia) that has enacted laws to allow for some form of naloxone access.

The 2015 General Assembly also passed House Bill 1500 and Senate Bill 892 which allow for the safe reporting of overdoses. These bills allow a person to assert an affirmative defense against the following charges:

- *unlawful purchase, possession, or consumption of alcohol pursuant to § 4.1-305*
- *possession of a controlled substance pursuant to § 18.2-250*
- *possession of marijuana pursuant to § 18.2-250.1*
- *intoxication in public pursuant to § 18.2-388, or*
- *possession of controlled paraphernalia pursuant to § 54.1-3466.*

An affirmative defense is a defense that alleges additional facts that defeats or mitigates the legal consequences of otherwise unlawful activity. You can still be charged with these crimes, but you can assert an affirmative defense against them if you are responding to an overdose emergency. To be able to assert an affirmative defense, ALL of the following criteria must be met:

1. *You must in good faith seek or obtain medical attention for yourself or someone else experiencing an overdose emergency by reporting the event to a firefighter, emergency medical services personnel, a law enforcement officer, or an emergency 911 system;*
2. *You must remain at the scene of the overdose or an alternate location which you or the person who suffered the overdose has been transported until a law enforcement official responds to the reported overdose. If no law enforcement officer responds, you must cooperate with law enforcement as indicated and described in the other sections;*
3. *You must identify yourself to the law enforcement officer who responds;*
4. *If requested by a law enforcement officer, you must substantially cooperate in any investigation of any criminal offense reasonably related to the controlled substance or alcohol that led to the overdose; and*
5. *The evidence for the prosecution of an offense was obtained as a result of the individual seeking or obtaining emergency medical attention.*

Finally, an affirmative defense may not be asserted if you sought or obtained emergency medical attention during the execution of a search warrant or during a lawful search or arrest."

***Trainer NOTE:** Trainers should not offer legal advice to trainees concerning affirmative defenses and the safe reporting law. If trainees have further questions concerning the Safe Reporting laws, recommend that they consult legal counsel. If they cannot afford counsel, they should contact their local legal aid society.*

Training Overview ~5 Minutes

Trainer: Lead a discussion concerning the objectives of this training session by reading the following and then asking for questions (it could be useful to have these listed on newsprint and posted on the wall or have the relevant PowerPoint slide displayed before your training begins):

Trainer Script:
"Today, we will learn about the following:"

- Understand the REVIVE! program, including lay administration of naloxone, protection from civil liability, and the safe reporting of overdoses law
- Understand how opioid overdose emergencies happen and how to recognize them
- Understand how naloxone works

- Identify risk factors that may make someone more susceptible to an opioid overdose emergency
- Dispel common myths about how to reverse an opioid overdose
- Learn how to respond to an opioid overdose emergency with the administration of naloxone
- Registering Lay Rescuers

Does anyone have any questions about these objectives?"

Trainer: Some of the discussion items in this training may provoke strong emotions for some participants. Syringes may trigger some people in recovery, and discussions about overdose and death may evoke anxiety, stress, sadness, anger, or other emotions. As the training is progressing, please pay attention to your audience to monitor for signs of these emotions. If you see someone becoming distressed, stop the training and take a break. If the person is not there with anyone else who can comfort or assist them, approach them as you feel comfortable and see if there is any way you can assist them.

Understanding and Recognizing Opioid Overdose Emergencies ~5 Minutes

Trainer: Lead a short discussion on what opioids are and how opioid overdoses work. Try and keep the discussion on a level that all attendees can understand, avoiding highly scientific or technical language.

"An opioid overdose emergency happens when a toxic amount of a drug, or a combination of drugs, overwhelms the body and causes it to shut down. With drugs such as alcohol, heroin, and many prescription pain medications (which many people refer to as downers or depressants), breathing slows and stops, and the heart stops beating.

Opioids include heroin as well as prescription pain medications that have generic, trade, and slang or street names:

Generic	Trade	Street
Hydrocodone	Lortab, Vicodin	Hydro, Norco, Vikes, Watsons
Oxycodone	Oxycontin,	Ox, Oxys. Oxycotton, Kicker, Hillbilly Heroin
Morphine	Kadian, MSContin	M, Miss Emma, Monkey, White Stuff
Codeine	Tylenol #3	Schoolboy, T-3s
Fentanyl	Duragesic	Apache, China Girl, China White, Goodfella, TNT
Hydromorphone	Dilaudid	Dill, Dust, Footballs, D, Big-D, M-2, M-80s, Crazy 8s, Super 8s
Oxymorphone	Opana	Blue Heaven, Octagons, Oranges, Pink, Pink Heaven, Stop Signs
Meperidine	Demerol	Dillies, D, Juice

Methadone	Dolophine, Methadose	Meth, Junk, Fizzies, Dolls, Jungle Juice
Heroin	N/A	Dope, Smack, Big H, Black Tar
Buprenorphine	Bunavail, Suboxone, Subutex,	Sobos, Bupe, Stops, Stop Signs, Oranges

Trainer: Street or slang names for opioids can vary across different regions, and sometimes the same names are used for multiple substances. Ask your trainees if they know any of the names on this list or if they have other names for any of these substances?

Trainer: Next, lead a short discussion on how to determine if someone is just high or is experiencing an opioid overdose emergency. Ask the question and allow time for trainees to respond. You may want to write down responses on the dry erase board or easel if available.

"Do you know what the signs are that you can look for to tell if someone is just really high or overdosing?

The main difference between someone who is high and someone who is overdosing is that someone who is overdosing is UNRESPONSIVE. Other differences:

REALLY HIGH	OVERDOSED
Muscles become relaxed	Pale, clammy skin
Speech is slowed or slurred	Breathing is infrequent or has stopped
Sleepy-looking	Deep snoring or gurgling (death rattle)
Responsive to shouting, ear lobe pinch or sternal rub	Unresponsive to any stimuli
Normal heart rate and/or pulse	Slow or no heart rate and/or pulse
Normal skin tone	Blue lips and/or fingertips

Keys to look for if you suspect someone has overdosed:

- Unresponsiveness to verbal or physical stimulation, such as pinching their ear lobe or rubbing your knuckles up and down the person's sternum. Whether or not they respond to this stimulation effectively draws the line between being really high versus overdosed.
- Slow, shallow, or no breathing
- Turning pale, blue or gray (especially lips and fingernails)
- Snoring, gurgling or choking sounds
- Very limp body
- Vomiting

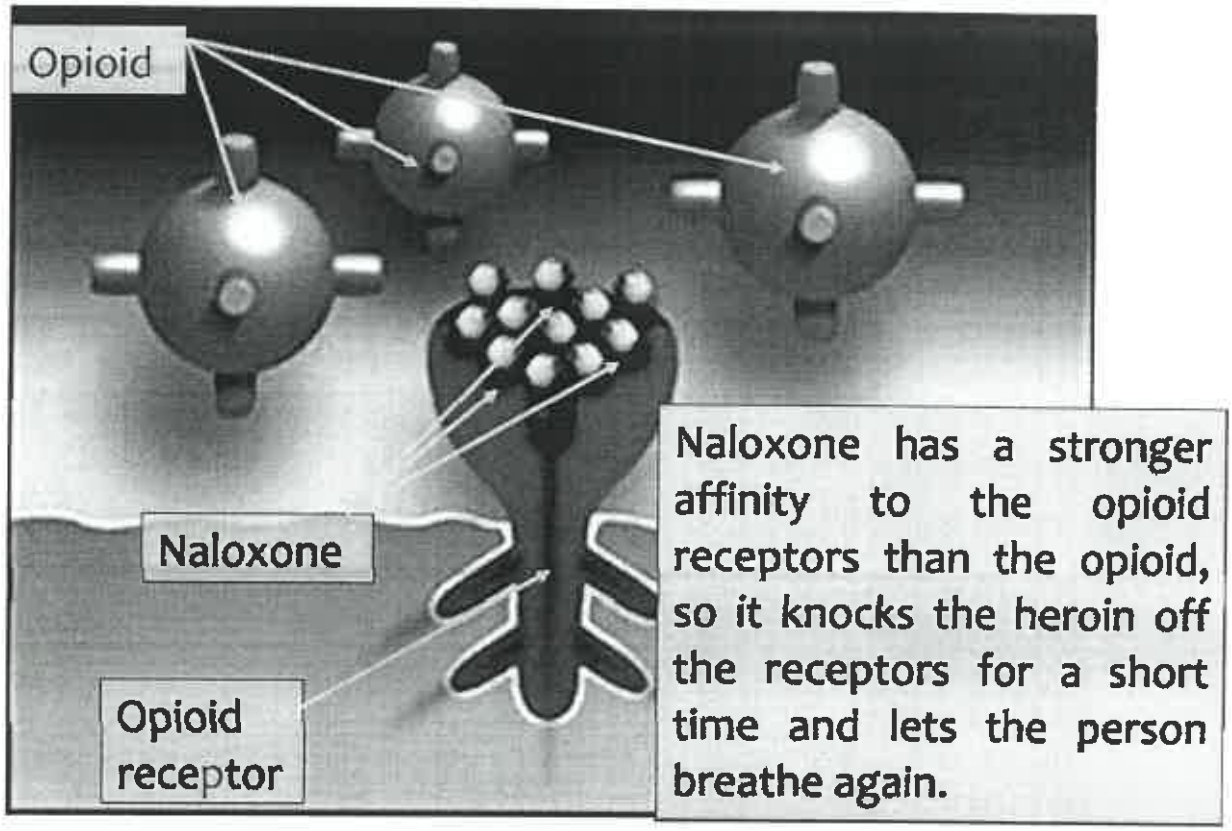
If the person shows any of these symptoms, especially lack of response to stimulus or no breathing/pulse, the person may be experiencing an opioid overdose emergency. Today you will learn how you can respond to an opioid overdose emergency and save someone's life."

It is important to remember that naloxone will only work to reverse an opioid overdose emergency that is the result of opioids. It will have no impact on someone that has overdosed on alcohol, cocaine, benzodiazepines (such as Valium, Klonopin, or Ativan), or methamphetamine."

Trainer NOTE: *Administration of naloxone to someone who is not experiencing an overdose may lead to acute withdrawal, which may include agitated or combative behavior. Therefore, these differences between being high and experiencing an overdose are a* ***critical part*** *of the REVIVE! training, and it is worth the extra time to ensure that trainees know and understand these differences.*

How does naloxone work? ~2 Minutes

Trainer: Lead a short discussion on how naloxone works to reverse an opioid overdose emergency. Use the image in the PowerPoint presentation to facilitate this discussion. Try and keep the discussion on a level that all attendees can understand, avoiding highly scientific or technical language.



Trainer Note: *Some people feel that receiving naloxone reflects on them in a bad way, that it is an implication that they will relapse or overdose at some point. Remind everyone that naloxone is for anyone who is using any opioid, and is important to have as it could save their life or the life of someone they know or love.*

Risk Factors for Opioid Overdose ~5 Minutes

Trainer: Lead a discussion on risk factors for opioid overdoses. You can start this discussion by asking trainees if they know of any risk factors that people may have for opioid overdose. Allow opportunities for trainees to respond. You may want to write down responses on the dry erase board or easel if available.

"There are a number of factors that can place someone at increased risk for opioid overdose. Does anybody know what any of these risk factors are?

- Prior overdose
- Reduced tolerance – previous users who have stopped using due to abstinence, illness, treatment, or incarceration. (***Trainer NOTE**: You may want to ask if all the trainees understand what tolerance is and provide a brief explanation if they do not).*
- Mixing drugs – combining opioids with other drugs, including alcohol, stimulants or depressants. Combining stimulants and depressants DO NOT CANCEL EACH OTHER OUT.
- Using alone
- Variations in strength/quantity or changing formulations (e.g., switching from quick acting to long lasting/extended release)
- Medical conditions such as chronic lung disease or kidney or liver problems."

***Trainer Note:** Emphasize prior overdose and reduced tolerance as the key risk factors.*

What NOT to do During an Opioid Overdose Emergency ~5 Minutes

Trainer: Lead a short discussion on myths about overdose reversal by asking participants if they have heard about different ways to help someone who is overdosing. Allow opportunities for trainees to respond. You may want to write down responses on the dry erase board or easel if available.

"Has anyone heard of different ways people have tried to revive someone who is overdosing?"

There are many myths about actions you can take to reverse an overdose. Here are some, and why you should NOT DO THEM.

- DO NOT put the individual in a bath. They could drown.
- DO NOT induce vomiting or give the individual something to eat or drink. They could choke.
- DO NOT put the person in an ice bath or put ice in their clothing or in any bodily orifices. Cooling down the core temperature of an individual who is experiencing an opioid overdose emergency is dangerous because it can further depress their heart rate.
- DO NOT try and stimulate the individual in a way that could cause harm, such as shaking them, slapping them hard, kicking them, or other more aggressive actions that may cause long-term physical damage.

- DO NOT inject them with any foreign substances (e.g., salt water or milk) or other drugs. It will not help reverse the overdose and may expose the individual to bacterial or viral infection, abscesses, endocarditis, cellulitis, etc."

***Trainer NOTE:** After discussion, it is **extremely important** to reinforce the fact that all the items below – and any others that they have mentioned that are not accurate - are all **MYTHS** about reversing an overdose.*

Opioid Overdose Emergency Response Overview ~2 Minutes

Trainer: Lead the trainees through a quick, step-by-step overview of the administration of naloxone. Use PowerPoint slides (or handouts as appropriate).

"Now that we know more about opioid overdose emergencies and their risk factors, I will go over the steps for how to respond to an actual opioid overdose emergency by calling 911 and administering naloxone. There are six steps in responding to an opioid overdose emergency. It is important to do these in order. I will also be demonstrating these and giving you an opportunity to practice them before we finish today."

1. Check for responsiveness and administer rescue breaths if person is not breathing.
2. Call 911.*
3. Continue rescue breathing if person is not breathing.
4. Administer naloxone.
5. Resume rescue breathing if the person has not started breathing yet.
6. Conduct follow-up and administer a second dose of naloxone if no response after three minutes.

* If you have to leave the person, put the person in the recovery position (as described below)."

Responding to an Opioid Overdose Emergency ~10 Minutes

"We will now go though the steps in detail. In this portion of the training, we will utilize the mannequin (when appropriate) to provide real-life examples of how to perform each step. It is important to follow the steps in the training exactly as listed and scripted."

***Trainer NOTE:** During this portion of the training, continue to repeat and emphasize the important of following the directions in order and exactly as listed. **When demonstrating, do not take shortcuts or shorten any of the demonstrations. These steps have been reviewed by subject matter experts and medical professionals to be the most efficient and effective steps to ensure a comprehensive response to an opioid overdose emergency.** Therefore, please perform the demonstrations exactly as indicated.*

1. CHECK FOR RESPONSIVENESS AND ADMINISTER RESCUE BREATHS IF PERSON IS NOT BREATHING

a. Try to stimulate them. You can shout their name, tap their shoulder, or pinch their ear lobe.
b. Give a sternal rub. Make a fist and rake your knuckles hard up and down the front of the person's sternum (breast bone). This is sometimes enough to wake the person up.
c. Check for breathing. Put your ear to their mouth and nose so that you can also watch their chest. Feel for breath and watch to see if the person's chest rises and falls.
d. If the person does not respond or is not breathing, proceed with the steps listed below.

Trainer: Use the mannequin to demonstrate a safe distance for yelling at the person, as well as for demonstrating the sternal rub and breathing check.

e. Put on latex-free gloves from the REVIVE! kit.
f. Check the person's airway for obstructions and remove any obstructions that can be seen. Clear any obstructions with a sweeping (NOT POKING OR STABBING) motion.
g. Tilt the person's forehead back and lift chin (see diagram below).
h. Place breathing mask on person's face, covering their mouth and nose. Ensure that the plastic piece is in the person's mouth. The mask has a nose printed on it to guide proper placement.
i. Pinch the person's nose and give normal breaths – not quick or overly powerful breaths.
j. Give three breaths, one breath every five seconds.

Image courtesy of the Chicago Recovery Alliance

Trainer: It is helpful to have the gloves and rescue breathing mask inside the kit bag before this step so that you can demonstrate the process exactly as it will be experienced by a trainee in a real-world situation. Demonstrate the whole process, administering rescue breathing for 15 seconds, again so that trainees receive a full demonstration of the entire process exactly as they will perform it when responding to an opioid overdose emergency. Make sure everyone is able to clearly see and hear you during this demonstration.

2. CALL 911 [If you have to leave the person, put the person in the recovery position – see details below].

1. CALL 911

a. Quiet down the scene, or move to a quieter location. Speak calmly and clearly. State that someone is unresponsive and is not breathing.
b. You DO NOT have to mention drugs or overdose when calling 911 unless specifically asked by the 911 dispatcher.
c. Give the exact address and location. If you're outside, use an intersection or landmark.
d. When first responders arrive, tell them it is an overdose and what drugs the person may have used, and what you have done so far to respond.

NOTE: COMPLICATIONS MAY ARISE IN OVERDOSE CASES. ALSO, NALOXONE ONLY WORKS ON OPIATES, AND THE PERSON MAY HAVE OVERDOSED ON SOMETHING ELSE, E.G., ALCOHOL OR BENZODIAZEPINES. **EMERGENCY MEDICAL SERVICES ARE CRITICAL.**

Trainer Note: Calling 911 is an absolutely necessary and vital part of responding to an opioid overdose emergency. *Naloxone can reverse the overdose, but medical attention* ***will be required.*** ***Reinforce*** *the importance of calling 911 to trainees.*

* If you have to leave the person while they are still unresponsive, put the person in the **recovery position**.

a. If necessary, place the overdose victim flat on their back.
b. Roll the person over slightly on their side.
c. Bend their top knee.
d. Put their top hand under their head for support.
e. This position should keep the person from rolling onto their stomach or back and prevent them from asphyxiation in case of vomiting.
f. Make sure the person is accessible and visible to first responders: don't close or lock doors that would keep first responders from being able to find the person.

Trainer: You may want to ask for two volunteers to demonstrate – one to be the overdose victim and one to put that person's body in the rescue position.

3. CONTINUE RESCUE BREATHING IF THE PERSON IS NOT BREATHING ON THEIR OWN.

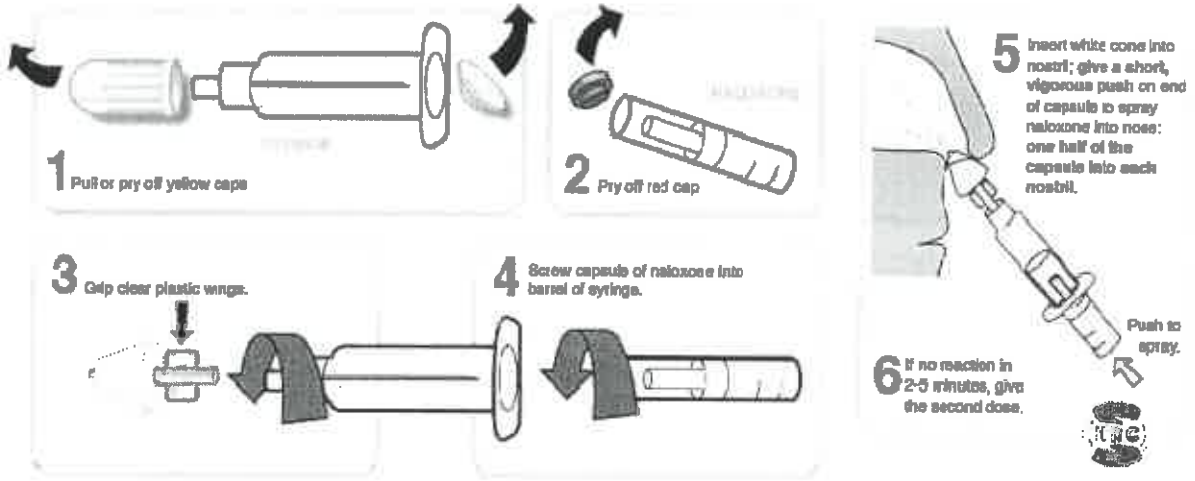
a. Tilt the person's forehead back and lift chin (see diagram above, page nine).
b. Place breathing mask back on persons face, covering their mouth and nose. Ensure that the plastic piece is in the person's mouth. You can still do mouth-to-mouth rescue breathing if a mask is not available.
c. Pinch the person's nose and give normal breaths – not quick or overly powerful breaths.
d. Give one breath every five seconds.
e. Continue rescue breathing for approximately 30 seconds.

Trainer: Make sure trainees understand that the proper orientation for the rescue breathing mask, including the plastic mouthpiece and that this plastic mouthpiece will keep any saliva, vomit, or other bodily fluids from being transferred from one person to another.

4. ADMINISTER NALOXONE.

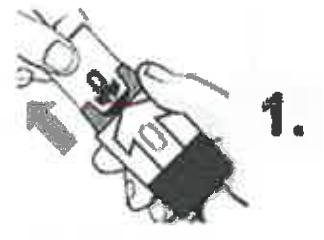
INTRANASAL

a. Pull the yellow caps off the syringe.
b. Pull the purple (may also be red or gray) cap off the naloxone capsule.
c. Screw the atomizer, which looks like a white cone, onto the threaded end of the syringe.
d. Gently screw the naloxone capsule into the syringe, open end first, until you feel it catch.
e. Put the tip of the spray device into one nostril and push on the capsule to spray half of the naloxone into the nostril; immediately switch to the other nostril and spray the other half of the naloxone into the nostril (see diagram below). The capsule has gradient marks to indicate when you have sprayed half of the medication.



EVZIO

EVZIO is designed to be easy to use for patients, their family members, and other caregivers. It contains the Intelliject® Prompt System (IPS™) with visual and voice instructions that help guide the user through the injection process. You should use EVZIO exactly as prescribed by your healthcare provider. Each EVZIO auto-injector contains only one dose of medicine. Caregivers should pinch the thigh muscle when injecting EVZIO into a child under the age of one.



Pull EVZIO from the outer case.

Do not go to Step 2 (Do not remove the **red** safety guard.) until you are ready to use EVZIO.

If you are not ready to use EVZIO, put it back in the outer case for later use.

Pull off the red safety guard.

To reduce the chance of an accidental injection, do not touch the **black** base of the auto-injector, which is where the needle comes out. If an accidental injection happens, get medical help right away.

Note: The **red** safety guard is made to fit tightly. **Pull firmly to remove. Do not replace the red safety guard after it is removed.**

Place the black end against the middle of the outer thigh, through clothing (pants, jeans, etc) if necessary, then press firmly and hold in place for 5 seconds.

If you give EVZIO to an infant less than 1 year old, pinch the middle of the outer thigh before you give EVZIO and continue to pinch while you give EVZIO.

Note: EVZIO makes a distinct sound (click and hiss) when it is pressed against the thigh. This is normal and means that EVZIO is working correctly. Keep EVZIO firmly pressed on the thigh for 5 seconds after you hear the click and hiss sound. The needle will inject and then retract back up into the EVZIO auto-injector and is not visible after use.

"Note: If someone is dependent on opiates, giving them naloxone may result in temporary withdrawal. This response can include abrupt waking up, vomiting, diarrhea, sweating, and nausea, and in rare cases agitated or combative behavior. While withdrawal can be dramatic and unpleasant, it is not life threatening and will only last until the naloxone has worn off."

Trainer Note: *You will have a naloxone prescription to use in the kit bag, but the trainees won't have one until they obtain a prescription.* ***IT IS IMPORTANT TO SLOWLY AND CLEARLY DEMONSTRATE THE PROCESS OF PREPARING THE NALOXONE SYRINGE FOR ADMINISTRATION, PAYING CAREFUL ATTENTION TO THE DIFFERENT CAPS THAT NEED TO BE REMOVED AND WHAT COLOR THEY WILL BE.*** *If a trainee encounters an opioid overdose emergency in a real-world*

setting, it will be this training and the time you spend on helping them understand the process that may save someone's life. After demonstrating with the naloxone syringe, pass it around for everyone to try themselves.

5. RESUME RESCUE BREATHING IF THE PERSON HAS NOT YET STARTED BREATHING.

"Brain damage can occur after three to five minutes without oxygen. Rescue breathing gets oxygen to the brain quickly. Once you give naloxone, it may take some time for it to be take effect. so the person may not start breathing on their own right away. Continue rescue breathing for them until the naloxone takes effect or until emergency medical services arrive."

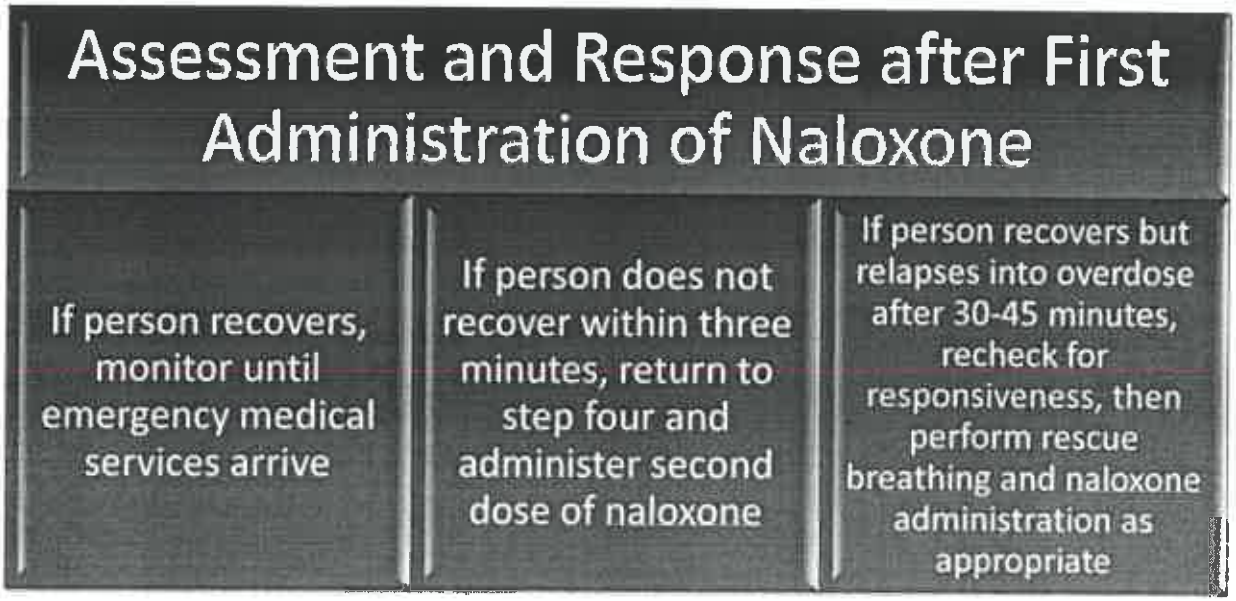
***Trainer Note**: It is important to remind trainees that **ONE ADMINISTRATION OF NALOXONE MAY NOT BE SUFFICIENT TO REVERSE AN OVERDOSE.** It is important for the trainee to check the individual after the first naloxone administration for breathing and responsiveness. Assistance with breathing and/or a second administration of naloxone may be necessary to completely reverse the overdose.*

6. CONDUCT FOLLOW-UP ASSESSMENTS AND TAKE NEXT STEPS.

Trainer: Your follow-up assessment conversation should cover the following items, in order: opioid withdrawal after naloxone administration, possible second administration of naloxone, using stickers, and other next steps. These are presented below:

"Most individuals will recover after a single dose of naloxone is administered. When this occurs. the person will be in withdrawal. which may include abrupt waking up. vomiting. diarrhea. sweating. and nausea. They may not remember overdosing. In rare cases, the person may recover into acute withdrawal, which in addition to the above. may include aggressive. combative. or violent behavior. In this case. the Lay Rescuer needs to ensure their own safety. The chart below describes the different outcomes possible after administering the first dose of naloxone.

Trainer: Review the chart below with trainees to discuss effective assessment and response.



If person recovers after the first dose of naloxone, continue to monitor them until emergency medical services arrive.

- Do what you can to calm and soothe them
- They may be agitated and will want to take more drugs
- Do not allow them to take more drugs or eat or drink anything
- Emphasize the importance of waiting for emergency medical services to arrive so they can be assessed
- Tell them that opioid withdrawal is not life-threatening and that naloxone will wear off in 30-45 minutes
- Depending on what substances they were taking, they could relapse into overdose once the first dose of naloxone wears off

There are **two cases** in which you may need to administer a second dose of naloxone:

SITUATION A: If the individual has not responded to the initial dose within three minutes

SITUATION B: If the individual has relapsed into an overdose again after having previously recovered with the initial dose.

SITUATION A: The individual has not responded to the initial dose within three minutes

When this occurs:

- Naloxone should take effect within 30-45 seconds but may take longer
- Wait three minutes (continue rescue breathing during this time)
- At three minutes, administer second dose of naloxone

If person remains unresponsive after the second dose is administered, continue rescue breathing until emergency medical services arrives.

SITUATION B: The individual has relapsed into an overdose again after having previously recovered with the initial dose.

Naloxone has a very short half life – 30-45 minutes. In some cases, there is so much opioid in the system that the person can relapse back into overdose after the naloxone has worn off.

When this occurs:

- Recheck person for responsiveness as described in Step 1 above.
- If unresponsive, administer second dose of naloxone
- Continue rescue breathing until person recovers or until emergency medical services arrives.

Trainer: This completes the administration protocol. Summarize the key points in the protocol before moving on in the training.

NALOXONE ADMINISTRATION PROTOCOL SUMMARY

"The administration of naloxone to an individual **is not the last step in responding to an opioid overdose emergency**. Further attention and action are necessary.

- Ensure the person is experiencing an opioid overdose emergency before calling 911 or administering naloxone.
- Calling 911 before administering naloxone is vital. An individual who has overdosed needs to be assessed by medical professionals.
- Withdrawal is awful but not life-threatening. Try to keep them calm, let them know what happened, and explain that help is coming and they need to wait for emergency medical personnel to respond.
- Monitor the individual to see that they start to breathe and become responsive.
- Resume rescue breathing if the person has not started breathing on their own.
- Naloxone takes several minutes to kick in and wears off in 30-45 minutes. The person may relapse into an opioid overdose emergency after the naloxone wears off. Therefore, it is STRONGLY RECOMMENDED that you watch the person for at least an hour or until emergency medical services arrive.
- Do not let them ingest food, drinks, or more drugs.
- Apply the "I've Received Naloxone" sticker from the REVIVE! kit somewhere visible on the person that can let first responders know that the person has experienced an overdose and received naloxone. If the person is in withdrawal, their skin may be sweaty or clammy. To ensure it stays, apply the sticker to the person's clothing or hair.

REPORT THE OVERDOSE REVERSAL

It is important that you report the reversal of an opioid overdose with the administration of naloxone. Information about how many lives have been saved with naloxone can be used to obtain future funding that will continue to expand the availability of naloxone in Virginia.

You can anonymously and securely report an opioid overdose reversal online or on your mobile device here:

https://www.surveymonkey.com/s/REVIVEVA

This link uses a secure connection that encrypts all information provided. Additionally, this link captures no identifying information such as your name, contact information, or the IP of the computer or device from which you are submitting the information. You are free to provide as much or as little information as you like, and all your information will be kept anonymous and only reported in aggregate, non-identifiable ways."

***Trainer NOTE:** Please emphasize the importance of reporting reversals using the link above, which is mobile-friendly, and remind trainees that their submissions are secure and confidential.*

Hands-On Training ~5 Minutes

Trainer Script:
"You now have the opportunity to try out and practice the different parts of responding to an opioid overdose emergency. Feel free to come up to one of the CPR mannequins to practice rescue breathing or the sternal rub. You can also practice assembling the syringe and administering naloxone."

***Trainer NOTE:** You will need to observe and provide feedback to your trainees during practice. Provide feedback in a positive manner and emphasize that practice is what will help this be more comfortable if they are ever in a real life crisis. Encourage them to continue to practice at home and to review the action steps regularly.*

Video Presentation ~5 Minutes

Trainer: Prepare the group for watching the video "How to Prepare Naloxone for Administration." Enlist volunteers to adjust lights, seating, etc.
Trainer Script:
"We will now watch a video that will summarize what we have discussed today."

Trainer: Play the following video. The video is also available on the CD included in your training handbook if you do not have internet access.

https://www.youtube.com/watch?v=Uq6AxrEY3Vk

Questions and Discussion ~5 Minutes

Trainer: Lead a question and answer session for trainees. Keep in mind that some people may not feel comfortable asking questions in the group and will want to approach you after the

training. If no one has questions, you may want to offer prompts. For instance, "Is everyone clear on how to prepare the naloxone syringe for administration?" or "Does everyone understand why the assessment and follow-up steps are important?" These questions may encourage or remind someone of something they want to ask about or discuss. Please allow some time for trainees to consider questions or discussion items, even if the room is quiet for a minute or two.

Trainer Script:
"That concludes our training today. Are there any final questions that you have? Please feel free to ask any question at all. You need to be comfortable with and understand everything that we have discussed today in order to effectively and efficiently respond to an opioid overdose emergency."

Trainer: Once all questions have been answered, distribute and request that trainees complete evaluation forms to provide feedback about the training

Evaluation and Wrap-Up

Trainer: At this point, you will distribute evaluations to be performed by trainees. Please be sure that you have also collected any registration forms you distributed at the beginning of the training. Thank the trainees for their time and their willingness to be a part of REVIVE!

Trainer: At the end of the training ensure that:
- You have collected the sign in sheets as well as evaluation forms and completed registrations for anyone who did not register in advance.
- The mannequin, training materials, posters, computer equipment, and any undistributed supplies are packed up.
- The training space is left clean and orderly. (Don't hesitate to ask for volunteers to help
- Mail the sign-in sheet along with all registration and evaluation forms to DBHDS using the pre-addressed, postage paid envelope provided in your Trainer Handbook.

ACKNOWLEDGEMENTS:

REVIVE! would not be possible without the help of many public and private partners, who DBHDS would like to acknowledge for their invaluable assistance.

Boston Public Health Commission
Bureau of Justice Assistance
Chicago Recovery Alliance
Delegate John O'Bannon, R-73
Joanna Eller
Harm Reduction Coalition
Kaléo
The McShin Foundation
Massachusetts Department of Public Health
Multnomah County (OR) Health Department

New York City Department of Mental Health and Hygiene
New York State Division of Criminal Justice Services
Ed Ohlinger
One Care of Southwest Virginia
Project Lazarus
SAARA Recovery Center of Virginia
San Francisco Department of Health/DOPE Project
University of Washington Alcohol and Drug Abuse Institute
Virginia Department of Criminal Justice Services
Virginia Department of Health
Virginia Department of Health Professions

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 29. Medicine and Other Healing Arts

§ 54.1-2957.4. Licensure as athletic trainer required; requisite training and educational requirements; powers of the Board concerning athletic training.

A. It shall be unlawful for any person to practice or to hold himself out as practicing as an athletic trainer unless he holds a license as an athletic trainer issued by the Board. The Board shall issue licenses to practice athletic training to applicants for such licensure who meet the requirements of this chapter and the Board's regulations.

B. The Board shall establish criteria for the licensure of athletic trainers to ensure the appropriate training and educational credentials for the practice of athletic training. Such criteria may include experiential requirements and shall include one of the following: (i) a Virginia testing program to determine the quality of the training and educational credentials for and competence of athletic trainers, (ii) successful completion of a training program and passage of the certifying examination administered by the National Athletic Training Association Board of Certification resulting in certification as an athletic trainer by such national association, or (iii) completion of another Board-approved training program and examination.

C. At its discretion, the Board may grant provisional licensure to persons who have successfully completed an approved training program or who have met requisite experience criteria established by the Board. Such provisional licensure shall expire as provided for in the regulations of the Board.

D. The Board shall promulgate such regulations as may be necessary for the licensure of athletic trainers and the issuance of licenses to athletic trainers to practice in the Commonwealth. The Board's regulations shall assure the competence and integrity of any person claiming to be an athletic trainer or who engages in the practice of athletic training.

1999, cc. 639, 682, 747; 2004, c. 669; 2013, c. 144.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

5/15/2019

Sudden death in young people: Heart problems often blamed

Print

Sudden death in young people: Heart problems often blamed

Sudden death in young people is rare, but those at risk can take precautions. Find out more about the risk factors, causes and treatments.

By Mayo Clinic Staff

Sudden death in people younger than 35, often due to undiscovered heart defects or overlooked heart abnormalities, is rare. When these sudden deaths occur, it's often during physical activity, such as playing a sport, and more often occurs in males than in females.

Millions of elementary, high school and college athletes compete yearly without incident. If you or your child is at risk of sudden death, talk to your doctor about precautions you can take.

How common is sudden cardiac death in young people?

Most deaths due to cardiac arrest are in older adults, particularly those with coronary artery disease. Cardiac arrest is the leading cause of death in young athletes, but the incidence of it is unclear. Perhaps 1 in every 50,000 sudden cardiac deaths a year occurs in young athletes.

What can cause sudden cardiac death in young people?

The causes of sudden cardiac death in young people vary. Most often, death is due to a heart abnormality.

For a variety of reasons, something causes the heart to beat out of control. This abnormal heart rhythm is known as ventricular fibrillation.

Some specific causes of sudden cardiac death in young people include:

- **Hypertrophic cardiomyopathy (HCM).** In this usually inherited condition, the walls of the heart muscle thicken. The thickened muscle can disrupt the heart's electrical system,

leading to fast or irregular heartbeats (arrhythmias), which can lead to sudden cardiac death.

Hypertrophic cardiomyopathy, although not usually fatal, is the most common cause of heart-related sudden death in people under 30. It's the most common identifiable cause of sudden death in athletes. HCM often goes undetected.

- **Coronary artery abnormalities.** Sometimes people are born with heart arteries (coronary arteries) that are connected abnormally. The arteries can become compressed during exercise and not provide proper blood flow to the heart.
- **Long QT syndrome.** This inherited heart rhythm disorder can cause fast, chaotic heartbeats, often leading to fainting. Young people with long QT syndrome have an increased risk of sudden death.

Other causes of sudden cardiac death in young people include structural abnormalities of the heart, such as undetected heart disease that was present at birth (congenital) and heart muscle abnormalities.

Other causes include inflammation of the heart muscle, which can be caused by viruses and other illnesses. Besides long QT syndrome, other abnormalities of the heart's electrical system, such as Brugada syndrome, can cause sudden death.

Commotio cordis, another rare cause of sudden cardiac death that can occur in anyone, occurs as the result of a blunt blow to the chest, such as being hit by a hockey puck or another player. The blow to the chest can trigger ventricular fibrillation if the blow strikes at exactly the wrong time in the heart's electrical cycle.

Are there symptoms or red flags parents, coaches and others should be on the lookout for that signal a young person is at high risk of sudden cardiac death?

Many times these deaths occur with no warning, indications to watch for include:

- **Unexplained fainting (syncope).** If this occurs during physical activity, it could be a sign that there's a problem with your heart.
- **Family history of sudden cardiac death.** The other major warning sign is a family history of unexplained deaths before the age of 50. If this has occurred in your family, talk with your doctor about screening options.

Shortness of breath or chest pain could indicate that you're at risk of sudden cardiac death. They could also indicate other health problems in young people, such as asthma.

Can sudden death in young people be prevented?

Sometimes. If you're at high risk of sudden cardiac death, your doctor will usually suggest that you avoid competitive sports. Depending on your underlying condition, medical or surgical treatments might be appropriate to reduce your risk of sudden death.

Another option for some, such as those with hypertrophic cardiomyopathy, is an implantable cardioverter-defibrillator (ICD). This pager-sized device implanted in your chest like a pacemaker continuously monitors your heartbeat. If a life-threatening arrhythmia occurs, the ICD delivers electrical shocks to restore a normal heart rhythm.

Who should be screened for sudden death risk factors?

There's debate in the medical community about screening young athletes to attempt to identify those at high risk of sudden death.

Some countries such as Italy screen young people with an electrocardiogram (ECG or EKG), which records the electrical signals in the heart. However, this type of screening is expensive and can produce false-positive results — indications that an abnormality or disease is present when it isn't — which can cause unnecessary worry and additional tests.

It's not clear that routine exams given before athletes are cleared to play competitive sports can prevent sudden cardiac death. However, they might help identify some who are at increased risk.

For anyone with a family history or risk factors for conditions that cause sudden cardiac death, further screening is recommended. Repeat screening of family members is recommended over time, even if the first heart evaluation was normal.

Should young people with a heart defect avoid physical activity?

If you're at risk of sudden cardiac death, talk to your doctor about physical activity. Whether you can participate in exercise or sports depends on your condition.

For some disorders, such as hypertrophic cardiomyopathy, it's often recommended that you avoid most competitive sports and that if you have an ICD, you should avoid impact sports. But this doesn't mean you need to avoid exercise. Talk to your doctor about restrictions on your activity.

Jan. 09, 2019

References

See more In-depth

Products and Services

Newsletter: Mayo Clinic Health Letter

Book: Mayo Clinic Healthy Heart for Life!

Sudden Cardiac Arrest in Athletes

Sudden Cardiac Arrest in Athletes
Liz Morris, ATC
Hughston Athletic Training Fellowship

What is sudden cardiac death?

Sudden cardiac death is a condition that results from an abrupt loss of heart function (cardiac arrest). It can occur in anyone, especially athletes with preexisting heart conditions. The athlete may or may not have diagnosed heart disease. The time and mode of death are unexpected, usually occurring minutes after symptoms appear. The most common underlying reason for adults to die suddenly from cardiac arrest is coronary heart disease (fatty buildups in the arteries that supply blood to the heart muscle).

What causes sudden cardiac death?

An estimated 1 in 200,000 young athletes develops abrupt-onset ventricular tachycardia (rapid heartbeat) or fibrillation (a chaotically abnormal heart rhythm) and dies suddenly during exercise. Males are affected 9 times more often than females. Basketball and football players in the US and soccer players in Europe may be at the highest risk. All known heart diseases can lead to cardiac arrest and sudden cardiac death. Adrenaline released during intense physical or athletic activity often acts as a trigger for sudden death when these conditions are present.

Sudden cardiac death in young athletes has many causes but the most common is undetected hypertrophic cardiomyopathy (a condition where the heart muscle thickens). Athletes with thin, compliant chest walls are at risk of commotio cordis (sudden cardiac arrest from a blunt, non penetrating blow to the chest) even when no cardiovascular disorder is present. The blow may involve a moderate-force projectile from sports with baseballs, softballs, lacrosse balls, hockey pucks, or a direct blow in boxing. Direct impact with another player triggered by chest wall impact immediately over the anatomic position of the heart may also cause this disorder. In 90 percent of adult victims of sudden cardiac death, two or more major coronary arteries are narrowed by fatty buildups. Scarring from a prior heart attack is found in two-thirds of these victims.

Management of Sudden Cardiac Arrest

- Management begins with appropriate emergency procedures including: CPR and AED training for all likely first responders, and access to an AED.

- Essential components sudden cardiac arrest management include early activation of EMS, early CPR, early defibrillation and rapid transition to advanced cardiac life support.
- High suspicion of sudden cardiac arrest should be maintained for any collapsed and unresponsive athlete.
- Young athletes who collapse shortly after being struck in the chest by a firm projectile or by contact with another player should be suspected of commotio cordis.
- Any collapsed and unresponsive athlete should be managed as a sudden cardiac arrest with application of an AED as soon as possible.
- CPR should be provided while waiting for an AED.
- Interruptions in chest compressions should be minimized and CPR stopped only when an AED is in use.
- Rapid access to the victim should be facilitated for EMS personnel.

What are treatments for survivors?

If a cardiac arrest was due to ventricular tachycardia or ventricular fibrillation, survivors are at risk for another arrest, especially if they have underlying heart disease. Survivors of cardiac arrest must have all causes corrected to prevent future episodes.

Possible tests and treatments include:

- cardiac catheterization
- electrophysiologic tests
- coronary artery bypass surgery
- balloon angioplasty or PCI (PTCA)
- antiarrhythmic medicine
- implantable cardioverter / defibrillator
- implantable pacemaker
- heart transplant

Can the cardiac arrest that causes sudden death be reversed?

Brain death and permanent death occur in just four to six minutes after someone experiences cardiac arrest. Cardiac arrest is reversible in most victims if it's treated within a few minutes with an electric shock to the heart to restore a normal heartbeat, a process called defibrillation. A victim's chances of survival are reduced by 7 to 10 percent with every minute that passes without CPR and defibrillation. CPR can double or triple a cardiac arrest victim's chances of survival. Few attempts at resuscitation succeed after 10 minutes.

Prevention

Before participation in sports, athletes should be commonly screened to identify any risks. Screening recommendations for all children, adolescents, and college-age young adults include a medical and family history and physical examination. Family history or symptoms or signs of hypertrophic cardiomyopathy require further evaluation. Confirmation of certain disorders may exclude students from sports participation, reducing the risk of sudden cardiac arrest.

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Liz Morris, ATC is a second year graduate student and recipient of the Hughston Athletic Training Fellowship Program in Columbus, Georgia. She received her Bachelors of Science Degree in Athletic Training from Georgia College and State University in May of 2007, where she also minored in Dance. While at GC&SU Liz worked with men's and women's tennis, as well as softball, and completed a high school rotation with Tattnall Square Academy and First Presbyterian Day School both in Macon. She was a member of the Kinesiology club and received the Presidential Volunteer Service Award. She is an active member of the National Athletic Trainers Association (NATA) and the Georgia Athletic Trainers Association (GATA). Liz is responsible for the overall healthcare of the athletes at Glenwood School in Phenix City, Alabama.

SUDDEN CARDIAC ARREST

A Fact Sheet for Student Athletes

FACTS

Sudden cardiac arrest can occur even in athletes who are in peak shape. Approximately 500 deaths are attributed to sudden cardiac arrest in athletes each year in the United States. Sudden cardiac arrest can affect all levels of athletes, in all sports, and in all age levels. The majority of cardiac arrests are due to congenital (inherited) heart defects. However, sudden cardiac arrest can also occur after a person experiences an illness which has caused an inflammation to the heart or after a direct blow to the chest. Once a cardiac arrest occurs, there is very little time to save the athlete, so identifying those at risk before the arrest occurs is a key factor in prevention.

WARNING SIGNS

There may not be any noticeable symptoms before a person experiences loss of consciousness and a full cardiac arrest (no pulse and no breathing).

Warning signs can include a complaint of:

- Chest Discomfort
- Unusual Shortness of Breath
- Racing or Irregular Heartbeat
- Fainting or Passing Out

EMERGENCY SIGNS – Call EMS (911)

If a person experiences any of the following signs, call EMS (911) immediately:

- *If an athlete collapses suddenly during competition*
- *If a blow to the chest from a ball, puck or another player precedes an athlete's complaints of any of the warning signs of sudden cardiac arrest*
- *If an athlete does not look or feel right and you are just not sure*

How can I help prevent a sudden cardiac arrest?

Daily physical activity, proper nutrition, and adequate sleep are all important aspects of life-long health. Additionally, you can assist by:

- Knowing if you have a family history of sudden cardiac arrest (onset of heart disease in a family member before the age of 50 or a sudden, unexplained death at an early age)
- Telling your health care provider during your pre-season physical about any unusual symptoms of chest discomfort, shortness of breath, racing or irregular heartbeat, or feeling faint, especially if you feel these symptoms with physical activity
- Taking only prescription drugs that are prescribed to you by your health care provider
- Being aware that the inappropriate use of prescription medications or energy drinks can increase your risk
- Being honest and reporting symptoms of chest discomfort, unusual shortness of breath, racing or irregular heartbeat, or feeling faint

What should I do if I think I am developing warning signs that may lead to sudden cardiac arrest?

1. *Tell an adult – your parent or guardian, your coach, your athletic trainer or your school nurse*
2. *Get checked out by your health care provider*
3. *Take care of your heart*
4. *Remember that the most dangerous thing you can do is to do nothing*

Developed and Reviewed by the Indiana Department of Education's Sudden Cardiac Arrest Advisory Board
(1-7-15)

Public Protection

AT Lookup

Official Verification

Basic Online Verification

Standards & Discipline

Standards & Discipline

Standards of Professional Practice **Disciplinary Guidelines** **File a Complaint**

Disciplinary Action Exchange **Facility Principles** **AT Policy & Procedure Development**

The Disciplinary Action Exchange (DAE) was developed to help the BOC, states and consumers locate disciplinary actions in an efficient manner. The BOC encourages all states to participate in the DAE. The DAE contains final BOC disciplinary actions that have been deemed public, as well as disciplinary actions taken by state regulatory agencies.

- If you would like more information in regards to a disciplinary action taken by a state, please contact the State Regulatory Agency (/state-regulation#state-regulation).
- If you would like more information in regards to a disciplinary action taken by the BOC, please send an email to Stacy Arrington (http://www.bocatc.org?mail_preselect=stacy-arrington).

Launch DAE

(https://at.bocatc.org/disc_actions)

NCCA Accreditation

(http://www.credentialingexcellence.org/ncca)
The National Commission for Certifying Agencies (NCCA) is the accreditation body of Institute for Credentialing Excellence (ICE). The NCCA's mission is to ensure the health, welfare and safety of the public through the accreditation of a variety of individual certification programs that assess professional competency. The NCCA sets standards that include *Essential Elements* that must be met by organizations offering certification programs.

The NCCA *Standards for the Accreditation of Certification Programs* categories:

1. Purpose, Governance and Resources
2. Responsibilities to Stakeholders

Commonwealth of Virginia

REGULATIONS

GOVERNING THE LICENSURE OF ATHLETIC TRAINERS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-120-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised date: March 22, 2019

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TABLE OF CONTENTS

Part I. General Provisions....3
18VAC85-120-10. Definitions....3
18VAC85-120-20. Public participation....3
18VAC85-120-30. Current name and address....3
18VAC85-120-35. Fees....3
Part II. Requirements for Licensure as an athletic trainer....4
18VAC85-120-40. General requirements....4
18VAC85-120-50. Requirements for licensure....4
18VAC85-120-60. (Repealed)....4
18VAC85-120-70. (Repealed)....4
18VAC85-120-75. Temporary authorization to practice....4
18VAC85-120-80. Provisional licensure....5
18VAC85-120-85. Registration for voluntary practice by out-of-state athletic trainers....5
Part III. Renewal and Reinstatement....5
18VAC85-120-90. Renewal of license....5
18VAC85-120-95. Inactive licensure....6
18VAC85-120-100. Reinstatement....6
Part IV. Standards of Practice....6
18VAC85-120-110. Individual responsibilities....6
18VAC85-120-120. General responsibilities....7
18VAC85-120-130. Supervisory responsibilities....7
18VAC85-120-140. Violations....7
Part V. Fees....7
18VAC85-120-150. (Repealed)....7
Part VI. Standards of Professional Conduct....7
18VAC85-120-155. Confidentiality....7
18VAC85-120-156. Patient records....7
18VAC85-120-157. Practitioner-patient communication....8
18VAC85-120-158. Practitioner responsibility....9
18VAC85-120-159. Vitamins, minerals and food supplements....9
18VAC85-120-160 Anabolic steroids....9
18VAC85-120-161. Sexual contact....9
18VAC85-120-162. Refusal to provide information....10

Part I. General Provisions.

18VAC85-120-10. Definitions.

In addition to words and terms defined in §54.1-2900 of the Code of Virginia, the following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"Advisory board" means the Advisory Board on Athletic Training to the board as specified in §54.1-2957.5 of the Code of Virginia.

"Athletic trainer" means a person licensed by the Virginia Board of Medicine to engage in the practice of athletic training as defined in §54.1-2900 of the Code of Virginia.

"Board" means the Virginia Board of Medicine.

"NATABOC" means the National Athletic Trainers' Association Board of Certification.

"Student athletic trainer" means a person enrolled in an accredited bachelor's or master's level educational program in athletic training.

18VAC85-120-20. Public participation.

A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.

18VAC85-120-30. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by these regulations to be given by the board to any such licensee shall be validly given when sent to the latest address of record given to the board. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-120-35. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. The following fees have been adopted by the board:

1. The application fee shall be $130.

2. The fee for renewal of licensure shall be $135 and shall be due in the licensee's birth month, in each odd-numbered year.

3. A fee of $50 for processing a late renewal within one renewal cycle shall be paid in addition to the renewal fee.

4. The fee for reinstatement of a license that has expired for two or more years shall be $180 and shall be submitted with an application for reinstatement.

5. The fee for reinstatement of a license pursuant to §54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for a duplicate renewal license shall be $5, and the fee for a duplicate wall certificate shall be $15.

7. The fee for a returned check shall be $35.

8. The fee for a letter of verification to another jurisdiction shall be $10.

9. The fee for an inactive license shall be $70, and the fee for a late renewal shall be $25.

10. For 2019, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.

Part II. Requirements for Licensure as an athletic trainer.

18VAC85-120-40. General requirements.

No person shall practice or hold himself out as practicing as an athletic trainer in the Commonwealth unless licensed by the board except as provided in §54.1-2957.6 of the Code of Virginia.

18VAC85-120-50. Requirements for licensure.

An applicant for licensure shall submit evidence of meeting the following requirements for licensure on forms provided by the board:
1. A completed application and fee as prescribed in 18VAC85-130-150;

2. Verification of professional activity as required on the application form;

3. Evidence of current NATABOC certification; and

4. If licensed or certified in any other jurisdiction, documentation of practice as an athletic trainer and verification as to whether there has been any disciplinary action taken or pending in that jurisdiction.

18VAC85-120-60. (Repealed)

18VAC85-120-70. (Repealed)

18VAC85-120-75. Temporary authorization to practice.

Upon written request from an applicant and his employer and for good cause shown, an applicant who provides documentation of current NATABOC certification and, if licensed or certified by

another jurisdiction in the United States, documentation that his license or certificate is current and unrestricted, may be granted temporary authorization to practice as an athletic trainer for 45 days pending submission of all other required documentation and issuance of a license. At the discretion of the board, additional time, not to exceed 15 days, may be allowed to complete the application process.

18VAC85-120-80. Provisional licensure.

A. An applicant who has been approved by NATABOC to sit for the certification examination may be granted a provisional license to practice athletic training under the supervision and control of an athletic trainer.

B. The graduate shall submit an application for a provisional license to the board for review and approval by the Chair of the Advisory Board on Athletic Training or his designee.

C. The provisional license shall expire six months from issuance or upon receipt of notification of a failing score on the NATABOC certification examination or upon licensure as an athletic trainer by the board, whichever comes first.

18VAC85-120-85. Registration for voluntary practice by out-of-state athletic trainers.

Any athletic trainer who does not hold a license to practice in Virginia and who seeks registration to practice on a voluntary basis under the auspices of a publicly supported, all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people shall:

1. File a complete application for registration on a form provided by the board at least five business days prior to engaging in such practice. An incomplete application will not be considered;

2. Provide a complete record of professional certification or licensure in each state in which he has held a certificate or license and a copy of any current certificate or license;

3. Provide the name of the nonprofit organization, the dates and location of the voluntary provision of services;

4. Pay a registration fee of $10; and

5. Provide a notarized statement from a representative of the nonprofit organization attesting to its compliance with provisions of subdivision 27 of §54.1-2901 of the Code of Virginia.

Part III. Renewal and Reinstatement.

18VAC85-120-90. Renewal of license.

A. Every athletic trainer intending to continue licensure shall biennially in each odd-numbered year in his birth month:

1. Register with the board for renewal of licensure;

2. Pay the prescribed renewal fee at the time he files for renewal; and

3. Attest to current NATABOC certification.

B. An athletic trainer whose license has not been renewed by the first day of the month following the month in which renewal is required shall pay a late fee as prescribed in 18VAC85-120-150.

18VAC85-120-95. Inactive licensure.

A. An athletic trainer who holds a current, unrestricted license in Virginia shall, upon a request on the renewal application and submission of the required fee, be issued an inactive license.

1. The holder of an inactive license shall not be required to maintain NATABOC certification.

2. An inactive licensee shall not be entitled to practice as an athletic trainer in Virginia.

B. An inactive licensee may reactivate his license upon submission of:

1. The required application;

2. Payment of the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure for the biennium in which the license is being reactivated; and

3. Documentation of having maintained certification or having been recertified by the NATABOC.

C. The board reserves the right to deny a request for reactivation to any licensee who has been determined to have committed an act in violation of §54.1-2915 of the Code of Virginia or any provisions of this chapter.

18VAC85-120-100. Reinstatement.

A. In order to reinstate a license that has been lapsed for more than two years, an athletic trainer shall file an application for reinstatement, pay the fee for reinstatement of his license as prescribed in 18VAC85-120-150, and submit to the board evidence of current certification by NATABOC.

B. An athletic trainer whose license has been revoked by the board and who wishes to be reinstated shall file a new application to the board and pay the fee for reinstatement of his license as prescribed in 18VAC85-120-150 pursuant to §54.1-2408.2 of the Code of Virginia.

Part IV. Standards of Practice.

18VAC85-120-110. Individual responsibilities.

The athletic trainer's responsibilities are to evaluate the individual being treated, plan the treatment program, and administer and document treatment within the limit of his professional knowledge, judgment and skills and in accordance with the practice of athletic training as set forth in §54.1-2900 of the Code of Virginia.

18VAC85-120-120. General responsibilities.

A. An athletic trainer shall be responsible for the actions of persons engaging in the practice of athletic training under his supervision and direction.

B. An athletic trainer shall ensure that unlicensed persons under his supervision shall not perform those functions that require professional judgment or discretion in the practice of athletic training.

18VAC85-120-130. Supervisory responsibilities.

A. The athletic trainer supervising the practice of persons holding a provisional license issued by the board shall develop a written protocol with the provisional licensee to include but not be limited to the following:

1. Provisions for daily, on-site review and evaluation of services being provided, including a review of outcomes for individuals being treated; and

2. Guidelines for availability and ongoing communications proportionate to such factors as practice setting, acuity of population being served, and experience of the provisional licensee.

B. The athletic trainer supervising the practice of student athletic trainers shall:

1. Provide daily, on-site supervision and shall plan, direct, advise and evaluate the performance and experience of the student athletic trainer.

2. Delegate only nondiscretionary tasks that are appropriate to the level of competency and experience of the student athletic trainer, practice setting and acuity of population being served.

18VAC85-120-140. Violations.

Violations of Chapter 29 (§54.1-2900 et seq.) of Title 54.1 of the Code of Virginia may subject a licensee to sanctions as set forth in §54.1-2915 of the Code of Virginia.

Part V. Fees .

18VAC85-120-150. (Repealed)

Part VI. Standards of Professional Conduct.

18VAC85-120-155. Confidentiality.

A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

18VAC85-120-156. Patient records.

A. Practitioners shall comply with provisions of § 32.1-127.1:03 related to the confidentiality and disclosure of patient records.

B. Practitioners shall provide patient records to another practitioner or to the patient or his personal representative in a timely manner and in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

C. Practitioners shall properly manage patient records and keep timely, accurate, legible and complete patient records.

D. Practitioners who are employed by a health care institution, school system or other entity, in which the individual practitioner does not own or maintain his own records, shall maintain patient records in accordance with the policies and procedures of the employing entity.

E. Practitioners who are self-employed or employed by an entity in which the individual practitioner does own and is responsible for patient records shall:

1. Maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

a. Records of a minor child, including immunizations, shall be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child;

b. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or

c. Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.

E. From October 19, 2005, athletic trainers who maintain their own patient records shall post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

F. When a practitioner is closing, selling or relocating his practice, he shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.

18VAC85-120-157. Practitioner-patient communication.

A. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately present information to a patient or his legally authorized representative in understandable terms and encourage participation in decisions regarding the patient's care.

B. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure provided or directed by the practitioner in the treatment of any disease or condition.

C. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research with the exception of retrospective chart reviews.

18VAC85-120-158. Practitioner responsibility.

A. A practitioner shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent;

2. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or

4. Exploit the practitioner/patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in A 3 of this section.

18VAC85-120-159. Vitamins, minerals and food supplements.

A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.

C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.

18VAC85-120-160 Anabolic steroids.

An athletic trainer shall not sell, dispense, or administer anabolic steroids to any patient.

18VAC85-120-161. Sexual contact.

A. For purposes of § 54.1-2915 A 12 and A 19 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior which:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2915 A 19 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient.

Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient shall mean: spouse or partner, parent or child, guardian, or legal representative of the patient.

D. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

18VAC85-120-162. Refusal to provide information.

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.