Advisory Board on Athletic Training

Virginia Board of Medicine

October 7, 2021

10:00 a.m.

Advisory Board on Athletic Training

Board of Medicine

Thursday, October 7, 2021 @ 10:00 a.m.

9960 Mayland Drive, Suite 201, Henrico, VA

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

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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

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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 >>

ADVISORY BOARD ON ATHLETIC TRAINING
Minutes
October 8, 2020
Electronic Meeting

The Advisory Board on Athletic Training held a virtual meeting on Thursday, October 8, 2020 hosted at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Mike Puglia, AT, Chair
Deborah Corbatto, AT, PhD, Vice-Chair
David Pawlowski, AT
Trilizsa Trent, Citizen Member

MEMBERS ABSENT: Jeffrey B. Roberts, MD

STAFF PRESENT: William L. Harp, M.D., Executive Director
Michael Sobowale, LLM, Deputy Director, Licensure
Colanthia Morton Opher, Deputy Director, Administration
Elaine Yeatts, DHP Senior Policy Analyst
Beulah Baptist Archer, Licensing Specialist

GUESTS PRESENT: None

Call to Order

Mike Puglia called the meeting to order at 10:01 a.m.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions.

Roll Call

The roll was called, and a quorum was declared.

Approval of Minutes from February 6, 2020

Dr. Corbatto moved to approve the minutes with a minor edit to list her academic title beside her name. David Pawlowski seconded. By roll call vote, the minutes were approved as amended.

Adoption of Agenda

Dr. Corbatto moved to adopt the agenda. David Pawlowski seconded. By roll call vote, the agenda was adopted.

Public Comment on Agenda Items

None

NEW BUSINESS

1. **Regulatory Update and Report from the 2020 General Assembly**

   Mrs. Yeatts provided a regulatory update and report of the 2020 General Assembly. She discussed bills that were of interest to members, including House Bill 1683, which defines the practice of diagnostic medical sonography and provides that only a certified and registered sonographer may be qualified to perform diagnostic medical sonography. The bill did not pass in the 2020 General Assembly and was referred for study to the Board of Health Professions (BHP). Ms. Yeatts indicated that the BHP did not recommend licensure. However, since the BHP study is only advisory to the General Assembly, the bill may be introduced again in the 2021 Session.

   Mr. Puglia expressed concern that this bill, if passed, may affect the scope of practice of Athletic Trainers, and requested that this item be placed on the agenda for the next Advisory Board meeting to review the findings from the BHP study.

2. **Approval of 2021 Meeting Calendar**

   Dr. Corbatto moved to approve the 2021 proposed meeting dates on the calendar. David Pawlowski seconded the motion. By roll call vote, the schedule of meetings for the Advisory Board in 2021 was approved.

3. **Election of Officers**

   Dr. Corbatto nominated David Pawlowski as Chair. Mike Puglia seconded the nomination. Mike Puglia nominated Dr. Corbatto as Vice-Chair. Dr. Corbatto declined due to her term limit as Vice-Chair. She nominated Trilizsa Trent as Vice-Chair. Mike Puglia seconded the nomination. By roll call vote, David Pawlowski was elected Chair, and Trilizsa Trent was elected Vice-Chair.

Announcements

Beulah Archer gave the licensing report. The total number of AT's licensed by the Board is 1,739. There are 1,441 with current active licenses in Virginia and 4 out-of-state. In Virginia, 287 licensees are currently inactive, and 7 are inactive out-of-state. Since May 2019, 286 licenses have been issued.

Next Scheduled Meeting:

January 28, 2021 at 1:00 p.m.

Adjournment

With no other business to conduct, Mike Puglia adjourned the meeting at 10:40 a.m.

Michael J. Puglia, Chair
Director

William L. Harp, M.D., Executive

Beulah Baptist Archer, Licensing Specialist

NCBATE Dry Needling Statement

"Dry Needling", also referred to as Intramuscular Manual Therapy, is defined as a technique to treat myofascial pain using a dry needle (without medication) that is inserted into a trigger point with the goal of releasing / inactivating the trigger points and relieving pain. Dry needling is also described as the use of solid filiform needles for the treatment of musculoskeletal pain and soft tissue dysfunction. The insertion of needles into specific targets may increase local blood flow to tissue and relax trigger point related muscular tension resulting in decreased pain and improved function. Dry needling is a treatment technique that has been utilized by in the United States since 1984.

Dry needling is not Acupuncture, which is defined by N.C. Gen. Stat. § 90-451 (1) as "A form of health care developed from traditional and modern Chinese medical concepts that employ acupuncture diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease." Dry needling is an insertion by dry needle into a trigger point without medication or injection.

Many sports medicine and athletic training staff are beginning to utilize dry needling as a treatment technique. There has been a significant increase in dry needling certification programs and continuing education courses. Athletic trainers are typically in a good position to administer dry needling as a treatment technique in the performance of their duties. The Board has received a number of questions from licensed athletic trainers about the use of dry needling in the performance of their duties. The North Carolina Athletic Trainers Licensing Act ("Act") does not exclude dry needling from the athletic training plan of care. North Carolina law allows athletic trainers to carry out the prevention and rehabilitation of injuries through physical modalities, including heat, light, sound, cold, electricity, or mechanical devices related to rehabilitation and treatment. North Carolina law does not allow an athletic trainer to undertake medical diagnosis. But again, based on currently available resource information, nothing in the Act prohibits or excludes dry needling from the athletic training plan of care.

The athletic trainer must satisfy certain educational and training requirements prior to providing dry needling for the treatment of musculoskeletal pain and soft tissue Dry needling is an advanced skill that requires additional training beyond entry-level education and should only be performed by athletic trainers who have demonstrated knowledge, skill, ability, and competence as follows: Completion of a dry needling course of study at a program approved by the Board with a minimum of 54 hours of classroom education, which must also include instruction in the clinical application of dry needling.

The Board will accept any dry-needling courses *which are approved by the Board of Certification (BOC)* that would provide the athletic trainer the necessary education and training. A BOC approved program can be found HERE.

Athletic trainers will have to produce evidence of successful completion of approved education and training curriculum in dry needling before the Board would approve a protocol that contains dry needling.

The athletic trainer should ensure their written protocol includes the ability to perform dry needling and/or intramuscular manual therapy, and the circumstances where dry needling can be utilized. If properly trained, the administration of dry needling would be within the knowledge, skill, and competencies of an athletic trainer, and therefore, its administration falls within the scope of practice of an athletic trainer providing athletic training services, provided it is properly delegated by a physician to the athletic trainer through a written agreement/protocol. Therefore, the athletic trainer should include the administration of dry needling and/or intramuscular manual therapy in the written protocol, where such administration is within the education, training, experience and continued competency of the athletic trainer.

If the athletic trainer would like to carry solid filiform needles in the athletic trainer's own equipment, the athletic trainer should consult with and have written permission from the location or entity where they are assigned (if any), and should have a written protocol that is approved by his/her physician supervisor allowing this practice.

In conclusion, athletic trainers are typically in a good position to administer treatment in the performance of their duties. Dry needling is an effective technique to treat of musculoskeletal pain and soft tissue dysfunction. The insertion of needles into specific targets may increase local blood flow to tissue and relax trigger point related muscular tension resulting in decreased pain and improved function. Athletic trainers should follow all requirements of their employing or contracting agency, ensure they comply with any and all training requirements in statutes and as required by their employing entity, and follow their protocol from their sponsoring physician in the performance or use of dry needling as a part of their athletic training plan of care.

Effective Date of Statement: October 2019
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Current Athletic Training Educational Preparation for Dry Needling

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Current Athletic Training Educational Preparation for Dry Needling

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Purpose: Dry needling is an advanced practice skill that many athletic trainers are being trained to perform. The purpose of this study is to determine the degree to which the current athletic training educational competencies and standards prepare practitioners for the performance of dry needling tasks. **Methods:** An expert panel review was used to verify which of the dry needling tasks are currently taught through entry-level athletic education as defined by the 5th edition competencies and 2020 standards. **Results:** Results demonstrated that 11% of the tasks were dry needling specific and these were regarded as not provided through entry-level education. However, 89% of the tasks were provided through entry-level education. **Conclusions:** It is clear that current athletic training education adequately prepares an athletic trainer to learn dry needling as an advance practice skill as a large number of the Competencies for Dry Needling are taught within athletic training entry-level education. **Keywords:** Dry Needling, Athletic Training

INTRODUCTION

Dry needling is becoming a common treatment technique in orthopedic sports medicine. Dry needling refers to the insertion of a thin monofilament needle/s to penetrate the skin and/or underlying structures to affect changes in body structure and function targeted toward various treatment goals.[1-3] Dry needling is used to treat various tissues of the body including muscles, ligaments, tendons, myofascial structures, scar tissue, perineural and neurovascular bundles for the management of a variety of conditions.[1-6] A recent review of dry needling literature has demonstrated that there is evidence that the technique is effective for a wide range of areas and conditions including; the reduction of pain and disability in knee osteoarthritis, hip osteoarthritis, piriformis syndrome, carpal tunnel syndrome, migraines, tension type headaches, temporomandibular disorder, shoulder pain, neck pain, low back pain, and plantar fasciitis.[1]

As dry needling has increased in its popularity, so too has the questioning of the practice by state licensing boards and professional organizations. Questions regarding educational preparation, safety of the public and training are familiar conversation points across and among professions and licensing boards when dry needling is performed by athletic trainers, physical therapists and other healthcare providers. In response to the questions raised by these professions and state licensing boards the Federation of State Boards of Physical Therapy recently set out to define the knowledge and skills necessary for safe performance of dry needling. As a result of this work the Taskforce went through a job tasks analysis and identified 123 discrete tasks required for the competent performance of dry needling. The findings were published in the Analysis of Competencies for Dry Needling by Physical Therapists.[7] The report concluded that "86% of the knowledge requirements needed to be competent in dry needling is acquired during the course of PT entry-level education, including knowledge related to evaluation, assessment, diagnosis and plan of care development, documentation, safety, and professional responsibilities."[7] This provided the kind of direction Physical Therapy licensing boards were looking for in terms of clarifying the practice. While this process provided clarity for physical therapy, it does not speak to other professions preparation even though the APTA recognizes that no one profession should be taking ownership of dry needling- "it is very clear that no single profession owns any procedure or

intervention".[8] Continued clarity is still necessary for state licensing boards of other professions.

Athletic Trainers are healthcare professionals who render service or treatment, under the direction of or in collaboration with a physician, in accordance with their education and training and the states' statutes, rules and regulations. As a part of the healthcare team, services provided by Athletic Trainer's include injury and illness prevention, wellness promotion and education, emergent care, examination and clinical diagnosis, therapeutic intervention, and rehabilitation of injuries and medical conditions.[9] To date, federal regulations and state practice acts vary on athletic trainers performing dry needling. However, many states prohibit the performance of general invasive procedures. The NATA Dry Needling fact sheet states that "currently, there is no profession-wide standard that defines athletic trainer competence in dry needling. Prior to performing dry needling, athletic trainers must ensure their state practice act does not prohibit them from performing dry needling as part of the athletic training plan of care. Additionally, athletic trainers must satisfy any requisite educational and training necessary to provide dry needling."[10] Athletic trainers may have to produce evidence of appropriate training and demonstrate knowledge and competency in dry needling. It is recommended that employers require appropriate documentation proving competency in the training and technical ability to perform dry needling.[11] While the Board of Certification (BOC) for Athletic Trainers, the national organization that establishes and reviews the standards for the practice of athletic training, has not offered an official statement regarding the legality of athletic trainer's performing dry needling, several states have determined that dry needling is within athletic trainer's scope of practice.

There are many questions about the educational preparation of athletic trainers as it relates to dry needling practice. Athletic training education has been clearly defined by the Commission on Accreditation of Athletic Training Education through two documents the 2020 Standards for Accreditation of Professional Athletic Training Programs as well as the Athletic Training Education Competencies - 5th Edition.[12-13] These documents outline the knowledge, skills, and clinical abilities to be mastered by students enrolled in professional athletic training education programs. By reviewing the Analysis of Competencies for Dry Needling by Physical Therapists in comparison with the 2020 Standards for Accreditation of Professional Athletic Training Programs as well as the Athletic Training Education Competencies - 5th Edition, clarity could be provided to the question of whether or not athletic trainers possess the required knowledge and skills to safely perform the dry needling.[7, 13] This is important as this is the primary concern for state licensing boards who focus on public safety issues.

The purpose of this study is to determine the degree to which the 123 tasks outlined in the Analysis of Competencies for Dry Needling by Physical Therapists are covered within Athletic Training Education as defined by the 2020 Standards for Accreditation of Professional Athletic Training Programs as well as the Athletic Training Education Competencies - 5th Edition.[7, 12, 13]

METHODS

Instrument Development

In order to accurately discern the degree to which athletic training education prepares an athletic trainer to perform the 123 discrete tasks required for the competent performance of dry needling, a survey was developed. The first step of the research methodology was to obtain institutional review board approval for development of the survey. The research team and two expert dry needling instructors used

a two-round process of matching the 2020 Standards for Accreditation of Professional Athletic Training Programs as well as the Athletic Training Education Competencies - 5th Edition to each of the 123 tasks outlined in the tasks outlined in the Analysis of Competencies for Dry Needling by Physical Therapists.[7, 12, 13] Once there was consensus that the corresponding tasks were matched with appropriate standards and competencies, the instrument was finalized and sent back to the IRB for approval to be sent to the expert panel.

Expert Panel Review

The survey was sent to 18 identified experts. Nine of which were athletic training dry needling experts the other nine were program directors identified as AT competency experts. These experts were identified using the Dreyfus five stage skill acquisition model.[14] According to Dreyfus, an expert is someone who not only has experience being a proficient performer of the skill, but also in accordance with his or her vast experience, has situational discrimination. It is this subtle and refined discriminatory capability that distinguishes the expert from the proficient performer. Thus, the expert has a depth of experience in a wide range of diverse application scenarios, enabling their decision making to be instinctive, intuitive and focused more on subtle and refined discriminations of clinical application.

Following Dreyfus's model, dry needling experts were identified based upon the following criteria; three or more years of consistent "daily" dry needling experience and multiple dry needling certifications. Additionally, one third of those identified as dry needling experts currently teach dry needling classes. In looking for experts on the competencies and standards using the Dreyfus's model, we identified program directors with more than 10 years of experience. This provided program directors with more than 10 years' experience who had participated in multiple program accreditations, many were current CAATE site visitors.

Sixteen experts responded to the survey, an 88% response rate. All responses were anonymous, and the sixteen responses were recorded and analyzed. The expert panel was given two choices in the survey. They were presented a single task and asked to either; agree/disagree that each individual competency and standard prepared an athletic trainer for the given task. Next, they were asked to respond if they would agree or disagree that the given task was a dry needling specific task not covered by entry-level competencies or standards. Lastly, they were given a comment box to give the competency or standard that they believed was a match to the given task if they believed there was one not listed or to make general comments to the research team. Decision making criteria were established by the research team prior to summarizing responses. An 80% agreement was necessary for a competency or standard to be accepted as a match for the task. If there were one or more competencies and/or standards that matched the task was deemed "provided through entry-level education". If 80% or more agreed that the task was dry needling specific, then it was deemed "dry needling specific".

RESULTS

After analyzing the data, the 123 tasks could be grouped into one of two categories: represented in the entry-level competencies and standards or dry needling specific tasks. The experts had 80% or more agreement that 110 of the 123 tasks were "provided through entry-level education" within the AT 5th Edition Competencies/will be taught through the CAATE 2020 Standards (Appendix A).[12-13] The second category contained the remaining 13 of the 123 tasks, and these were regarded as not "provided through entry-level education" by AT 5th Edition Competencies/CAATE 2020 Standards and were therefore deemed "dry needling specific" (Appendix B).[12-13] After completion

of the expert panel review, results demonstrated that 89% of the dry needling tasks were "provided through entry-level education" within the AT 5th Edition Competencies/will be taught through the CAATE 2020 Standards and 11% were not "provided through entry-level education" by AT 5th Edition Competencies/CAATE 2020 Standards and were therefore deemed "dry needling specific".[12-13]

DISCUSSION

It would appear from this expert panel review that solid evidence can be presented regarding Athletic Trainers entry-level education and their preparation for dry needling practice. Of the 123 discrete tasks required for the competent performance of dry needling as described in the Analysis of Competencies for Dry Needling by Physical Therapists the expert panel deemed 89% of the tasks "provided through entry-level education" within the AT 5th Edition Competencies/going to be taught through the CAATE 2020 Standards.[7] This would then provide evidence to state licensing boards that in states where Physical Therapists are deemed as able to be competently trained to dry needle, so should athletic trainers, given the entry level knowledge and skills taught through the 5th Edition Competencies and CAATE 2020 Standards. This would further add credence to the APTA statement that recognizes that no one profession should be taking ownership of dry needling - "it is very clear that no single profession owns any procedure or intervention" as it is clear that athletic trainers are adequately prepared to learn dry needling as a large number of the competencies for dry needling are covered within AT entry-level education.[8]

This research should provide further direction for state licensing boards in clarifying the types of tasks dry needling continuing education courses for athletic trainers should be teaching to adequately prepare an athletic trainer to dry needle competently (Appendix B). This should serve to help state licensing boards in the evaluation of adequate educational preparation of an athletic trainer regarding this advanced practice skill. It should also serve to help these licensing boards understand that a large amount of knowledge and skills (evaluation, assessment, diagnosis and plan of care development, documentation, safety etc.) necessary for this advanced practice skill are taught through the 5th Edition of the Athletic Training Education Competencies which has served as the foundation of entry-level education for the last decade.

Lastly, when looking at the comments from the expert panel many comments were made that even the tasks in the "dry needling specific" list had some congruence with many of the 5th Edition of the Athletic Training Education Competencies or 2020 Standards however, they felt that there was a dry needling specific application or additional content needed to adequately state the athletic training competency covered the task. An example of this is task 103 "Implement emergency response procedures to treat patient/client injuries sustained during dry needling (e.g., perforation of hollow organs, heavy bleeding, broken needles)". Certainly Athletic Trainers are educated in dealing with life threatening conditions such as abdominal trauma and internal bleeding from other sources of trauma, but the dry needling specific issues are not taught. There should be an understanding that the reason the Athletic Training Education Competencies or 2020 Standards are listed in appendix B was to reflect this idea of partial coverage of some of the content needed.

LIMITATIONS

This study provides evidence of current educational preparation in Athletic Training related to the practice of dry needling. As such, anyone educated prior to the 5th Edition Competencies may look at their individual educational experience and scope of practice differently than what is described here. Each athletic trainer should evaluate their ability to

engage dry needling practice relative to their scope and educational background. However, the 5th Edition Educational Competencies were published in 2011 and there was a transition of programs implementing them that lasted until the 2013-14 accreditation cycle. Therefore, this transition time had some number of certified Athletic Trainers educated on the 5th Edition Competencies, but there is no way to know how many. What we do know after contacting the board of certification (e-mail communication, September 2018) is that 25,610 or 48% of the total 53,609 certified athletic trainers were certified after the publication of the 5th Education Competencies and 17,596 or 33% were certified after the full transition. Therefore, state boards should know this reflects current education and that roughly a third or more athletic trainers reflect this entry-level educational preparation.

IMPLICATIONS FOR CLINICAL PRACTICE

Clinical practice of dry needling is an advanced skill being used by many athletic trainers in states where it is allowed by law. The expert panel review presented here lends credence to the addition of dry needling to the clinical practice of athletic trainers. Given the fact that dry needling is used to treat various tissues of the body muscles, ligaments, tendons, myofascial structures, scar tissue, perineural, and neurovascular bundles for the management of a variety of pathologic conditions.[1-6] It should be of great use to athletic trainers who upon training could use this skill on patients for which there is evidence that the technique is effective, such as (the reduction of pain and disability in knee osteoarthritis, hip osteoarthritis, piriformis syndrome, carpal tunnel syndrome, migraines, tension type headaches, temporomandibular disorder, shoulder pain, neck pain, low back pain, and plantar fasciitis).[1] Continued education in dry needling could be of benefit to the athletic trainer's patient population and is within the scope of practice for athletic trainers who are adequately trained.

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Appendix A: Tasks identified as "provided through entry-level education" and their corresponding competency and/or standard.

Tasks Number	Task (as identified by APTA)[7]	AT 5th Edition Competency	CAATE 2020 Standard
1	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to establish prior and current level of function.	CE-7 and CE-20	60 and 71
2	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to establish general health status (e.g. fatigue, fever, malaise, unexplained weight change).	CIP-1	71
3	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to identify risk factors and needs for preventative measures.	PHP-2 and PHP-3	79 and 80
4	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to identify patient/client's, family, caregiver's goals.	CIP-1	59, 69, 80, and 82
5	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to determine if patient/client is appropriate for therapy.	CE-22	70, 76, and 77
8	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to review medical records (e.g., lab values, diagnostic tests, specialty reports, narrative, consults).	CE-13 and HA-9	69, 71, and 89
9	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to gather information/ discuss client/ patient's current health status with interprofessional/interdisciplinary team members (e.g., teacher, physicians, rehabilitation member).	CE-13	59, 69, and 71
10	Perform screen of the patient/client current affect, cognition, communication, and learning style (e.g., ability to make needs known, consciousness, orientation, expected emotional/ behavioral responses, learning preferences).	CE-21 and PS-1	71 and 77
11	Perform screen of the patient/client's quality of speech, hearing, vision (e.g., dysarthria, pitch/tone, use corrective lenses, use of hearing aid).	CE-21	71
12	Perform screen of the vestibular system (e.g., dizziness, vertigo).	CE-20 and CE-21	76
13	Perform screen of the gastrointestinal system (e.g., difficulty swallowing, heartburn, indigestion, change in appetite/diet).	CE-21	71
14	Perform screen of the genitourinary system (e.g., frequency, volume, urgency, incontinent episodes).	CE-21	71
15	Perform screen of the genital reproductive system (e.g., sexual and/or menstrual dysfunction).	PHP-43	71

16	Perform screen of the cardiovascular/pulmonary system (e.g. blood pressure, heart rate.	CE-20 and CE-21	71
17	Perform screen of the integumentary system (e.g. presence of scar formation, skin integrity, edema).	CE-b	71
18	Perform screen of the musculoskeletal system (e.g., gross symmetry, strength, weight, height, range of motion).	CE-21	71
19	Perform screen of the neuromuscular system (e.g., gross coordinated movements, motor function, locomotion).	CE-21	71
20	Select and perform tests and measures of cardiovascular function (e.g., blood pressure, heart rate, heart sounds).	CE-21	71 and 72
21	Select and perform tests and measures of pulmonary function (e.g., respiratory rate, oxygen saturation, breathing patterns, breath sounds, chest excursion).	CE-21	71 and 72
22	Select and perform tests and measures of peripheral circulation (e.g., peripheral pulses, capillary refill, blood pressure in upper versus lower extremities).	CE-20	71 and 72
23	Select and perform tests and measures of physiological responses to position change (e.g., orthostatic hypotension, skin color, blood pressure, heart rate).	CE-20, CE-21, and TI-11	71 and 72
24	Quantify edema (e.g., palpation, volume test, circumference).	CE-20 and CE-21	69, 71, and 72
25	Select and perform tests and measures of attention and cognition (e.g., ability to process commands).	CE-20 and CE-21	71 and 76
26	Select and perform tests and measures of patient's/client's ability to communicate (e.g., expressive and receptive skills, following instructions).	CE-20 and CE-21	71
27	Select and perform tests and measures of arousal and orientation to time, person, place, and situation.	CE-20 and CE-21	71 and 76
28	Select and perform tests and measures of recall (including memory and retention).	CE-20 and CE-21	71 and 76
29	Select and perform tests and measures of neural provocation (e.g., tapping, tension/stretch).	CE-20 and CE-21	71
30	Select and perform tests and measures of cranial nerve integrity (e.g., facial asymmetry, oculomotor function, hearing).	AC-36 and CIP-4	70, 71, and 76
31	Select and perform tests and measures of peripheral nerve integrity (e.g., sensation, strength).	CE-21	71
32	Select and perform tests and measures of spinal nerve integrity (e.g., dermatome, myotome).	CE-21	71
33	Select and perform test and measures of postural alignment and position (static and dynamic).	CE-21 and TI-11	71
34	Select and perform tests and measures of balance (dynamic and static) with or without the use of specialized equipment.	CE-20 and CE-21	71
35	Select and perform tests and measures of gait and locomotion (e.g., ambulation, wheelchair mobility) with or without the use of specialized equipment.	CE-21, AC-39, and TI-17	71 and 73
36	Select and perform tests and measures of mobility during functional	CE-21	71

	activities and translational movements (e.g., transfers, bed mobility).		
37	Assess skin characteristics (e.g., blistering, continuity of skin color, dermatitis, hair growth, mobility, nail growth, sensation, temperature, texture, and turgor).	CE-21	71
38	Assess scar tissue characteristics (e.g., banding, pliability, sensation, and texture).	CE-21	71
39	Select and perform tests and measures of spinal and peripheral joint stability (e.g., ligamentous integrity, joint structure).	CE-21	71
40	Select and perform tests and measures of spinal and peripheral joint mobility (e.g., glide, end feel).	CE-21	71
41	Select and perform test and measures of range of motion (e.g., functional and physiological).	CE-21	71
42	Select and perform test and measures of active and passive joint range of motion (e.g., goniometry).	CE-21	71
43	Select and perform test and measures of flexibility (e.g., muscle length, soft tissue extensibility).	PHP-26 and CE-21	71
44	Select and perform tests and measures of muscle strength, power, and endurance (e.g., manual muscle test, isokinetic testing, dynamic testing).	PHP-26 and CE-21	71
45	Select and perform tests and measures of muscle tone (e.g., hypertonicity, hypotonicity, dystonia).	CE-20 and CE-21	71
46	Select and perform tests and measures of patient's need for assistance (e.g., during transfers, in the application of devices).	CE-7 and AC-25	60, 69, 70, 71, and 78
47	Select and perform test and measures of deep tendon/muscle stretch reflexes (e.g., quadriceps, biceps).	CE-21	71
48	Select and perform tests and measures of superficial reflexes and reactions (e.g., cremasteric reflex, abdominal reflex).	CE-21	71
49	Select and perform test and measures of upper motor neuron integrity (e.g., Babinski reflex, Hoffman sign).	CE-21	71
50	Select and perform tests and measures of pain (e.g., location, intensity, characteristics, frequency).	AC-6, AC-7, and PS-9	71
51	Select and perform tests and measures of deep sensation (e.g., proprioception, kinesthesia, pressure).	CE-20 and CE-21	73
52	Select and perform tests and measures of superficial sensation (e.g., touch, temperature discrimination).	CE-20 and CE-21	73
53	Interpret each of the following types of data to determine the need for intervention or the response to intervention of: cardiovascular/pulmonary system.	CE-d and CE-f	71, 72, and 73
54	Interpret each of the following types of data to determine the need for intervention or the response to intervention of: lymphatic system.	CE-i	72
55	Interpret each of the following types of data to determine the need for intervention or the response to intervention of: neuromuscular system.	CE-a and CE-c	71 and 72
56	Interpret each of the following types of data to determine the need for intervention or the response to intervention of: vestibular system.	CE-c and CE-i	71 and 72
57	Interpret each of the following types of data to determine the need for	CE-a	71 and 72

	intervention or the response to intervention of: musculoskeletal system.		
58	Interpret each of the following types of data to determine the need for intervention or the response to intervention of: integumentary system.	CE-b	71 and 72
59	Interpret each of the following types of data to determine the need for intervention or the response to intervention of: anthropomorphic.	PHP-26, PHP-43, PHP-44, and CIP-1	79, 80, and 82
60	Interpret each of the following types of data to determine the need for intervention or the response to intervention of: genitourinary.	CE-g and CE-j	71 and 72
61	Interpret each of the following types of data to determine the need for intervention or the response to intervention of: pain.	CE-13, AC-6, AC-7, TI-14, and PS-9	71, 73, 74, and 75
62	Interpret each of the following types of data to determine the need for intervention or the response to intervention of: imaging, lab values, and medication.	CE-13	71, 72, and 74
63	Interpret each of the following types of data to determine the need for intervention or the response to intervention of: develop therapy diagnosis by integrating system and non-system data.	CIP-4 and CIP-5	71 and 72
64	Establish therapy prognosis based on information gathered during the examination process.	CE-11	62, 71, and 72
65	Develop plan of care based on data gathered during the examination process, incorporating information for the patient/client, caregiver, payer, family members, and other professionals.	PS-18 and CIP-5	58 and 71
66	Revise treatment intervention plan based on treatment outcomes, change in patient/client's health status, and ongoing evaluation.	EBP-13, EBP-14, CE-14, TI-12, and CIP-1	62, 63, 69, 71, and 73
67	Develop goals based on information gathered during examination process, incorporating information from the patient/client, caregiver, payers, family members, and other professionals.	TI-11, CIP-1, and CIP-4	71, 73, 80, and 82
68	Select interventions based on information gathered during the examination process, incorporating information from the patient/client, caregiver, payer, family members, and other professionals.	TI-11, CIP-4, and CIP-5	71 and 73
71	Position the patient/client to reduce the risk of harm to the patient/client and/or therapist.	PHP-2, PHP-3, and TI-11	73 and 80
73	Position the patient/client to perform palpation techniques to identify the area(s) to be needled.	CE-20 and TI-11	71, 73, and 80
74	Position the patient/client to apply needle handling techniques that ensure compliance with relevant and current professional standards (e.g., wash hands, wear gloves, minimize needle contamination).	TI-11 and HA-16	66 and 88
75	Position the patient/client to apply draping materials (e.g., linens, towels) to minimize unnecessary exposure and respect patient privacy.	TI-11	73
79	Position the patient/client to facilitate homeostasis as necessary.	AC-36 and TI-11	70
80	Position the patient/client to dispose of medical waste (e.g., needles, gloves, swabs) in accordance with regulatory standards and local	TI-11 and HA-16	66 and 88

	jurisdictional policies and procedures (e.g., sharps container).		
81	Position the patient/client to discuss post-treatment expectation with the patient/client or family/caregiver.	TI-11	73
82	Discuss therapy evaluation, interventions, goals, prognosis, discharge, planning, and plan of care with interprofessional/interdisciplinary team members (e.g., teacher, physician, rehabilitation member).	PS-18, HA-11, and CIP-9	58, 59, and 77
83	Discuss therapy evaluation interventions, goals, prognosis, discharge planning, and plan of care with patient/client and caregivers.	PS-18, HA-11, and CIP-9	58, 59, and 77
84	Provide written and oral information to the patient/client and/or caregiver.	PS-18, HA-11, and CIP-9	59
85	Document examination results.	CIP-9	64,65, 66, and 89
86	Document evaluation to include diagnosis, goals, and prognosis.	CIP-4	64, 65, 66, and 89
87	Document intervention(s) and patient/client response(s) to intervention.	CIP-4	64, 65, 66, and 89
88	Document patient/client and caregiver education.	HA-11	64, 65, 66, and 89
89	Document outcomes (e.g., discharge summary, reassessments).	HA-12	64, 65, 66, and 89
90	Document communication related to the patient/client's care (e.g., with the doctor, teacher, case manager).	HA-11	64, 65, 66, and 89
91	Assign billing codes for therapy diagnosis and treatment provided.	HA-12	64, 88, and 89
92	Document disclosure and consent (e.g., disclosure of medical information, consent for treatment).	CIP-9	66
93	Document letter of medical necessity (e.g., wheelchair, assistive equipment, continued therapy).	HA-11	89
94	Educate patient/client about current condition and health status (e.g., treatment outcomes, plan of care, risk and benefit factors).	PS-18	58
95	Educate caregivers about patient/client current condition and health status (e.g., treatment outcomes, plan of care, risk and benefit factors).	PS-18	58
96	Educate healthcare team about role of the therapist in patient/client management.	PD-11	68
97	Educate patient/client and caregiver on lifestyle and behavioral changes to promote wellness (e.g., nutritional interventions, physical activity, tobacco cessation).	PHP-33	77, 83, and 84
101	Implement emergency life support procedures.	CIP-6	70
102	Perform first aid.	AC-22 and CIP-6	70
104	Implement emergency response procedures to treat practitioner injuries sustained during dry needling (e.g., needle stick).	CIP-6	70
105	Perform regular equipment inspections (e.g., modalities, assistive devices).	TI-20	73 and 88
106	Prepare and maintain a safe and comfortable environment for	HA-5	88

	performing dry needling (e.g., unobstructed walkways, areas for patient/client privacy).		
107	Perform regular equipment inspections (e.g., modalities, needle expiration, sharps containers).	TI-20	88
108	Stock dry needling supplies and equipment in safe proximity during treatment.	HA-6	88
109	Perform activities using appropriate infection control practices.	HA-16	66
110	Create and maintain an aseptic environment for patient/client interaction.	HA-16	66
111	Implement infection control procedures to mitigate the effects of needle stick injuries.	HA-16	66
112	Clean and disinfect blood and bodily fluids spills in accordance with regulatory standards and local jurisdictional policies and procedures.	PHP-7	66
113	Replace surfaces that cannot be cleaned.	PHP-7	66
114	Integrate current best evidence, clinical experience, and patient value in clinical practice (e.g., clinical prediction rules, patient preference).	EBP-2, EBP-10, EBP-14, and CE-12	62, 64, and 69
115	Discuss ongoing patient care with the interprofessional/interdisciplinary team members.	PS-18	58 and 77
116	Refer patient/client to specialist or other healthcare providers when necessary.	CE-22 and PD-9	69, 71, 72, and 77
117	Disclose financial interest in recommended products or services to patient/client.	PD-5	65
118	Provide notice and information about alternative care when the therapist terminates provider relationship with the patient/client.	CE-22 and PD-9	69, 71, 72, and 77
119	Document transfer of patient/client care to another therapist (therapist of record).	CE-22 and PD-9	64, 65, 66, 69, 71, 72, 77, and 89
120	Determine own need for professional development (i.e., continued competence).	PD-7	67
121	Participate in learning and/or development activities to maintain the currency of knowledge, skills, and abilities.	PD-7	67
122	Practice within the jurisdiction regulations and professional standards.	PD-4 and PD-6	66

Dry needling tasks that the expert panel agreed were "provided through entry-level education" and their corresponding competencies and standards from AT 5th Edition Competencies and CAATE 2020 Standards respectively (EBP – Evidence-Based Practice, PHP – Prevention and Health Promotion, CE – Clinical Examination and Diagnosis, AC – Acute Care of Injuries and Illnesses, TI – Therapeutic Interventions, PS – Psychosocial Strategies and Referral, HA – Healthcare Administration, PD – Professional Development and Responsibility, CIP – Clinical Integration Proficiencies).[7]

Appendix B. Tasks identified as "dry needling specific" and their corresponding competency and/or standard.

Task Number	Task (as identified by APTA)[7]	AT 5th Edition Competency	CAATE 2020 Standard
6	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to identify prior experience with and tolerance for dry needling (e.g., needle phobia, response to treatment, ability to comply with treatment requirements).	CE-13	69 and 71
7	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to identify contraindications and precautions related to dry needling (e.g., age, allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medication).	TI-11a	73
69	Sequence dry needling with other procedural interventions and techniques (e.g., therapeutic exercise, neuromuscular re-education, manual therapy, physical modalities) to augment therapeutic effects and minimize risk due to adverse outcomes and/or contraindication.	TI-11	73
70	Position the patient/client to expose the area(s) to be needled.	TI-11	73
72	Position the patient/client to educate the patient/client on the impact of movement during treatment.	TI-11 and PS-18	58 and 73
76	Position the patient/client to perform dry needling techniques consistent with treatment plan (i.e., place, manipulate, and remove needles).	TI-11	73
77	Position the patient/client to manage needle removal complications (e.g., stuck needle, bent needle).	TI-11	73
78	Position the patient/client to monitor patient/client's emotional and physiological response to dry needling.	TI-1, TI-8, TI-11, and PS-6	58, 73, and 77
98	Educate patient/client or family/caregiver about dry needling (e.g., purpose, techniques, methods of action, benefits, tools and equipment).	None	None
99	Educate patient/client or family/caregiver about potential adverse effects associated with dry needling (e.g., fainting, bruising, soreness, fatigue).	TI-11	73
100	Educate patient/client or family/caregiver about precautions and contraindications for dry needling (e.g., age, allergies/sensitivities, disease/conditions, implants, areas of acute inflammation, acute systemic infections, medications).	TI-11	73
103	Implement emergency response procedures to treat patient/client injuries sustained during dry needling (e.g., perforation of hollow organs, heavy bleeding, broken needles).	CIP-6	70
123	Determine own ability to perform dry needling safely and effectively.	PD-7	67

Dry needling tasks that the expert panel agreed were not "provided through entry-level education" and their corresponding competencies and standards from AT 5th Edition Competencies and CAATE 2020 Standards respectively (CE – Clinical Examination and Diagnosis, TI – Therapeutic Interventions, PS – Psychosocial Strategies and Referral, PD – Professional Development and Responsibility, CIP – Clinical Integration Proficiencies).[7]

Department of Health Professions
Regulatory/Policy Actions – 2021 General Assembly
Board on Medicine/Advisory Boards

EMERGENCY REGULATIONS:

Legislative source	Mandate	Promulgating agency	Board adoption date	Effective date Within 280 days of enactment
SB1189	Occupational therapy compact	Medicine	8/6/21	**By 12/23/21**

EXEMPT REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB2039	Conform PA regs to Code	Medicine	6/24/21	9/15/21
HB2220	Change registration of surgical technologists to certification	Medicine	6/21/21	9/1/21
SB1178	Delete reference to conscience clause in regs for genetic counselors	Medicine	6/24/21	

APA REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB1953	Licensure of certified midwives	Nursing & Medicine	NOIRA Nursing – 7/20/21 Medicine – 8/6/21	Unknown

NON-REGULATORY ACTIONS

Legislative source	Affected agency	Action needed	Due date
HB793 (2018)	Medicine & Nursing	To report data on the number of nurse practitioners who have been authorized to practice without a practice agreement, the geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement	November 1, 2021
Budget bill	Department	To study and make recommendations regarding the oversight and regulation of advanced practice registered nurses (APRNs). The department shall review recommendations of the National Council of State Boards of Nursing, analyze the oversight and regulations governing the practice of APRNs in other states, and review research on the impact of statutes and	November 1, 2021

		regulations on practice and patient outcomes.	
HB1953	Department	To convene a work group to study and report on the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives to determine the appropriate licensing entity for such professionals.	November 1, 2021

Future Policy Actions:

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**.

Virginia Department of
Health Professions

STUDY INTO THE NEED TO REGULATE DIAGNOSTIC MEDICAL SONOGRAPHERS IN THE COMMONWEALTH OF VIRGINIA

2020

VIRGINIA BOARD OF HEALTH PROFESSIONS
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AUTHORITY

At the June 25, 2020 Board of Health Professions Full Board meeting, the Board considered a request to review the need to regulate diagnostic medical sonographers in the Commonwealth of Virginia. At this meeting, the Regulatory Research Committee (RRC) received approval to move forward with the study. The same day, the RRC adopted the work plan and requested staff to begin work on the study. The study was conducted pursuant to the following authority:

Code of Virginia Section 54.1-2510 assigns certain powers and duties to the Board of Health Professions. Among them are the power and duty:

7. To advise the Governor, the General Assembly and the Director on matters relating to the regulation or deregulation of health care professions and occupations; and

12. To examine scope of practice conflicts involving regulated and unregulated professions and advise the health regulatory boards and the General Assembly of the nature and degree of such conflicts.

Pursuant to these powers and duties, the Board of Health Professions and its Regulatory Research Committee conducted a sunrise review evaluating the need to regulate diagnostic medical sonographers in the Commonwealth of Virginia.

THE CRITERIA AND THEIR APPLICATION

The Board of Health Professions has adopted the following criteria and guidelines to evaluate the need to regulate health professions. Additional background information on the Criteria are available in the Board of Health Professions Guidance Document 75-2 *Appropriate Criteria in Determining the Need for Regulation of Any Health Care Occupations or Professions, revised February 2019* available on the Board's website: Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions

CRITERION ONE: RISK FOR HARM TO THE CONSUMER

The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

CRITERION TWO: SPECIALIZED SKILLS AND TRAINING

The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

CRITERION THREE: AUTONOMOUS PRACTICE

The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

CRITERION FOUR: SCOPE OF PRACTICE

The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

CRITERION FIVE: ECONOMIC IMPACT

The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

CRITERION SIX: ALTERNATIVES TO REGULATION

There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

CRITERION SEVEN: LEAST RESTRICTIVE REGULATION

When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.

APPLICATION OF THE CRITERIA

In the process of evaluating the need for regulation, the Board's seven criteria are applied differently, depending upon the level of regulation that appears most appropriate for the occupational group. The following outline delineates the characteristics of licensure, certification, and registration (the three most commonly used methods of regulation) and specifies the criteria applicable to each level.

- Licensure - Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state licensure typically endows a particular occupation or profession with a monopoly in a specified scope of practice.
    - Risk: High potential, attributable to the nature of the practice.
    - Skill & Training: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.
    - Autonomy: Practices independently with a high degree of autonomy; little or no direct supervision.
    - Scope of Practice: Definable in enforceable legal terms.
    - Cost: High
    - Application of the Criteria: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

- Statutory Certification - Certification by the state is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.
    - Risk: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.
    - Skill & Training: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.
    - Autonomy: Variable; some independent decision-making; majority of practice actions directed or supervised by others.
    - Scope of Practice: Definable, but not stipulated in law.
    - Cost: Variable, depending upon level of restriction of supply of practitioners.
    - Application of Criteria: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, & 6.

- Registration - Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.
    - Risk: Low potential, but consumers need to know that redress is possible.
    - Skill & Training: Variable, but can be differentiated for ordinary work and labor.
    - Autonomy: Variable.
    - Application of Criteria: When applying for registration, Criteria 1, 4, 5, & 6 must be met.

EXECUTIVE SUMMARY

MAJOR FINDINGS OF THE STUDY

1. The diagnostic medical sonographer provides patient care services using ultrasound and related diagnostic procedures.
2. Diagnostic medical sonography educational programs include classroom instruction, lab work, and clinical exposure. Competency is demonstrated through certification by a nationally recognized sonography credentialing organization.
3. There are approximately 1,500 diagnostic medical sonographers credentialed in Virginia.
4. Some medical sonographers work in a specialized area of the field: abdominal sonography, breast sonography, cardiac sonography, obstetrics/gynecology, pediatric sonography, phlebology sonography, vascular technology/sonography, and other emerging clinical areas.
5. Four states currently license diagnostic medical sonographers.
6. Resultant harm to a patient because of improper sonographic technique has not been reported.
7. Diagnostic medical sonographers function as a delegated agent of the licensed healthcare provider; they do not practice independently.

RECOMMENDATION

At its August 20, 2020 meeting, the Regulatory Research Committee found no evidence of harm attributable to the practice of diagnostic medical sonography by credentialed individuals and noted that they do not practice independently. Hence, the Committee voted unanimously that state regulation was not justified. The Committee did have concerns about the emerging use of 3D sonography for "Keepsakes" being offered by some photographers and recommended referral of the issue to the Full Board for further discussion.

The Regulatory Research Committee's recommendation to not regulate or license diagnostic medical sonographers was provided to the full Board of Health Professions for review and consideration at the August 20, 2020 meeting. At that meeting, after discussion, the Board voted unanimously to accept the Committee's findings. The Board tabled the discussion of the non-medical fetal imaging until the November 10, 2020 meeting.

The Board of Health PRofessions does not recommend additional state regulation of medical sonographers.

Excerpt of Minutes on Discussion of Dry Needling at the February 6, 2020 AT Advisory Board Meeting

2. Follow-up on previous discussion of Dry Needing

Mr. Puglia stated that questions had been posed to him as to what an athletic trainer can and cannot do in regards to dry needling. Ms. Yeatts pointed out that dry needling is not in the scope of practice for athletic trainers. It was determined that dry needling is not an entry level skill. Dr. Roberts stated that prior to proposing any legislation to include dry needling in the AT scope of practice, it would be good to first determine the core competencies of athletic trainers in the use of dry needling as a treatment modality for injuries.

Excerpt of Minutes on Discussion of Dry Needling at the June 7, 2018 Advisory Meeting

2. Dry Needling by Athletic Trainers

Elaine Yeatts started the discussion with the history of dry needling saying that it is not an entry level skill, that adoption of regulations would be required, and that such expansions of scope have been met with legal challenges in a number of states. The Advisory Board understood the issue and took no action.

Profession	Pre-COVID Process	COVID Process per Executive Order 57 Effective March 12, 2020	Recommendation(s)
Athletic Trainer	• Form B / Employment Verification • BOC Verification – **Primary source verified** • Other state license verification(s) – **Primary source verified** • NPDB Self-Query Report - Mailed **in a sealed, unopened envelope only.** • Non-routine questions 7-20 answered on application require supporting documentation from the applicant. • Required documents received at the Board must be primary source verified, and may be electronically transmitted from the source to the licensing specialist	Waived • Form B / Employment Verification	

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 5, 2020

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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.

"Direction" means authorization by a doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry for care and treatment by a verbal order if the doctor or dentist is present or by written order, telecommunication, plans of care, protocols, or standing orders if the doctor or dentist is not present.

"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 handling fee for a returned check or a dishonored credit card or debit card shall be $50.

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 2021, 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.

A. 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.

B. An athletic trainer practices under the direction of the individual's physician or under the direction of any doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry.

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.

Rev. 08/21 Athletic Trainer

Virginia Department of Health Professions

Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
Phone: (804) 367-4600
Fax: (804) 527-4426
Email: medbd@dhp.virginia.gov

Application for License to Practice Athletic Training

To the Board of Medicine of Virginia:

I hereby make application for a license to practice athletic training in the Commonwealth of Virginia and submit the following statements:

1. Name in Full (Please Print or Type)

Last	First	Middle
Date of Birth ____ ____ ____ MO DAY YEAR	Social Security No. or VA Control No.*	Maiden Name if applicable
Public Address: This address will be public information:	House No. Street or PO Box	City State and Zip
Board Address: This address will be used for Board Correspondence and may be the same or different from the public address.	House No. Street or PO Box	City State and Zip
Work Phone Number	Home/Cell Phone Number	Email Address

Please submit address changes in writing immediately to medbd@dhp.virginia.gov

Please attach check or money order payable to the Treasurer of Virginia for $130.00. Application will not be processed without the fee. Do not submit fee without an application. **IT WILL BE RETURNED.**

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

APPROVED BY

_____

Date

LICENSE NUMBER	PROCESSING NUMBER	FEE
0126-		**$130**

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number** issued by the *Virginia* Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.

**In order to obtain a Virginia driver's license control number, it is necessary to appear in person at an office of the Department of Motor Vehicles in Virginia. A fee and disclosure to DMV of your Social Security Number will be required to obtain this number.

2. List in chronological order all professional practices including each location of service since graduation, including internships, residencies, hospital affiliations and absences from work. Also list all periods of non-professional activity or employment. **PLEASE ACCOUNT FOR ALL TIME**. If engaged in private practice, list all clinical affiliations.

From	To	Name and Address of Location Where Service was Provided	Position Held

3. I hereby certify that I studied athletic training and received the degree of _____ on
(degree)
_____ from _____.
(Date) (Name of School)

4. Do you intend to engage in the active practice of athletic training in the Commonwealth of Virginia? ☐ Yes ☐ No

If Yes, give location _____

5. List all jurisdictions in which you have been issued a license to practice athletic training: include all active, inactive, expired, suspended or revoked licenses. Indicate number and date issued.

Jurisdiction	Number Issued	Active/Inactive/Expired

		Yes	No
6.	Are you BOC certified?	☐	☐
	QUESTIONS MUST BE ANSWERED. If any of the following questions (7-19) is answered **Yes**, explain and substantiate with documentation.		
7.	Have you ever been denied a license or the privilege of taking a licensure/competency examination by any testing entity or licensing authority?	☐	☐
8.	Have you ever been convicted of a violation of/or pled Nolo Contendere to any federal, state, or local statute, or regulation or ordinance, or entered into an plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) **Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed.**	☐	☐
9.	Have you ever been denied privileges or voluntarily surrendered your clinical privileges for any reason?	☐	☐
10.	Have you ever been placed on a corrective action plan, placed on probation or been dismissed or suspended or Requested to withdraw from any professional school, training program, hospital, etc?	☐	☐
11.	Have you ever been terminated from employment or resigned in lieu of termination from any training program, hospital, healthcare facility, healthcare provider, provider network or malpractice insurance carrier?	☐	☐
12.	Do you have any pending disciplinary actions against your professional license/certification/permit/registration related to your practice of athletic training?	☐	☐
13.	Have you voluntarily withdrawn from any professional society while under investigation?	☐	☐
14.	Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner?	☐	☐
15.	Within the past five years, have you been disciplined by any entity?	☐	☐
16.	Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing athletic trainer.	☐	☐

17. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing athletic trainer. ☐ ☐

18. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing athletic trainer. ☐ ☐

19. Within the past 5 years, have you any condition or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? ☐ ☐

20. Have you had any malpractice suits brought against you in the past ten (10) years? If so, please provide a narrative for each closed or pending case during this time period. ☐ ☐

Military Service:

21. Are you a spouse of someone who is on a federal active duty orders pursuant to Title 10 of the U.S. Code or of a veteran who has left active-duty service within one year of submission of this application and who is accompanying your spouse to Virginia or an adjoining state or the District of Columbia? ☐ ☐

22. Are you active duty military? ☐ ☐

23. **AFFIDAVIT OF APPLICANT**

I, _____, am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of individuals and groups listed above, any information which is material to me and my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice as an athletic trainer in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of my profession which are available at www.dhp.virginia.gov and I understand that fees submitted as part of the application process shall not be refunded.

_____
Signature of Applicant

Advisory Board on:

Behavioral Analysts			10:00 a.m.
Mon –January 31	May 23	September 19	
Genetic Counseling			1:00 p.m.
Mon - January 31	May 23	September 19	
Occupational Therapy			10:00 a.m.
Tues – February 1	May 24	September 20	
Respiratory Care			1:00 p.m.
Tues - February 1	May 24	September 20	
Acupuncture			10:00 a.m.
Wed - February 2	May 25	September 21	
Radiological Technology			1:00 p.m.
Wed - February 2	May 25	September 21	
Athletic Training			10:00 a.m.
Thurs - February 3	May 26	September 22	
Physician Assistants			1:00 p.m.
Thurs - February 3	May 26	September 22	
Midwifery			10:00 a.m.
Fri - February 4	May 27	September 23	
Polysomnographic Technology			1:00 p.m.
Fri - February 4	May 27	September 23	
Surgical Assisting			10:00 a.m.
Mon - February 7	Tues – May 31	September 26	