Injectable Opioid Agonist Therapy (iOAT) – Community Settings

Site Applicability

- Downtown Community Health Centre iOAT Program
- VCH – contracted iOAT programs (as a guiding resource)

Practice Level

Profession	Basic Skill	Advanced Competency Requires additional education
RN, RPN	• IM injection –HYDROmorphone, diacetylmorphine • Specimen collection – point of care testing and sending to lab	• Pre and post dose assessment • Safer injection education
LPN	• IM injection –HYDROmorphone, diacetylmorphine • Specimen collection – point of care testing and sending to lab	In a team nursing approach with: 1. the additional education required to work in MHSU and 2. education to provide care and treatment to clients enrolled in the iOAT program with stable or predictable states of health: • Pre and post dose assessment • Safer injection education

Education

- BCCSU iOAT module (Provincial Opioid Addiction Treatment Support Program)
- Resisting Stigma Online Course (Learning Hub)

Competencies for Supporting People Who Use Substances:

- Harm reduction
- Trauma Informed Practice - Equipping for Equity (Module 3)*
- Cultural safety
- Mental Health and Substance Use
- Gender inclusion
- Stigma
- Health Equity - Equipping for Equity (Modules 1 to 9)*

* indicates online, self-paced learning

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Need to Know

Injectable Opioid Agonist Therapy (iOAT) is an evidence-based treatment option for individuals diagnosed with severe opioid use disorder (OUD) who have not benefitted from oral opioid agonist treatment (OAT). As well, iOAT is available for people who are not ready to try OAT and can benefit from an alternative option to reduce or cease their non-medical use of opioids. iOAT is one part of the continuum of care in the treatment of OUD to reduce incidences of morbidity and mortality.

This guideline supports nursing clinical practice in iOAT. It is to be used in conjunction with iOAT orders, clinical training and education for nurses in an iOAT setting.

Refer to the BCCSU Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder for more comprehensive information.

To better serve Indigenous clients, it is important for health care providers to be aware of Canada's history and present impact on Indigenous health (Turpel-Lafond, 2020). Colonialism has continued to undermine Indigenous cultures, practices and resulted in devastating harms. Providers must be mindful of how these systems and structures reinforce subconscious biases that results in discriminatory health care (Martin & Walia, 2019; Turpel – Lafond, 2020). In order to provide safe care, providers must work to build trust, respect, and be of service of clients and to also work to undo the harm from colonialism in health care.

Procedure

1. Intake Assessment

RNs, RPNs or LPNs are involved in the program intake and orientation for all clients who enroll into the iOAT program. The nurses must complete the following with the client:

- Urine Drug Test within two weeks of starting the program
- Review and complete program intake forms:
    - iOAT Orientation Nursing Consult Checklist. Refer to Appendix A.
    - Program consent
- Engage client in education on:
    - Program flow
    - Harm reduction pre and post injection
        - Swabbing injection site with alcohol swab prior to injection
        - Use of tourniquet
    - Safer injection techniques. Refer to Appendix B.

2. Ensure the prescriber order is complete

Prior to providing client the iOAT medication, verify the client has an active medication order.

- Review the prescriber order in client's chart/EMR for current date range

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- Check client's MAR to confirm the order.

3. Pre-injection Assessment, Administration, Post-injection Assessment

Nursing assessment is performed pre and post injection during both titration and maintenance period.

I. Pre-injection assessment

Prior to providing the iOAT dose to the client, the nurse must perform a pre-injection assessment. The purpose of the pre-dose assessment is to ensure that the client is not intoxicated or experiencing any other acute clinical condition that would increase the risk of an adverse event with the use of injectable medication. Consider the client's usual presentation in decision-making. Pre-assessment supports the nurse's decision making to proceed with the prescribed dose. See Appendix C.

Subjective Assessment:

- Last drug use/amount
- Last alcohol use/amount

Objective Assessment:

- Severely anxious or agitated
- Dyskinetic
- Overly sedated (consider using Modified Pasero Opioid-induced Sedation Scale, see Appendix D)
- Slurred speech
- Smells of alcohol (intoxication confirmed with breathalyzer)
- Decreased respiration rate
- Safety concerns – e.g. if the client's actions are creating unsafe environment for the client, other clients or staff (work on safety plan with client and team when appropriate)

If concerns regarding slurred speech, unsteady gait, smell of alcohol, perform a breathalyzer test.

- Ensure client's Blood Alcohol Content (BAC) does not exceed 0.05%.
- If BAC exceeds 0.05%, contact prescriber for dose reduction or to defer dose.

If any of the above occur, contact the prescriber for direction on reducing, delaying, or holding dose.

Review the client's health record for:

- Response to last dose - for any adverse events e.g. sedation or intoxication
- Any missed doses - how many missed doses/days, time since last dose
    - Rationale: if the client has had a prolonged absence (more than 1 day) since last dose/use, the risk of overdose is increased.

Contact the prescriber for the following situations to establish safe dose:

- 2 or more consecutive missed doses during induction
- Over 3 days inclusive (or 6 or more consecutive doses) missed during maintenance

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II. Administration of Injectable Medications

- Nurses adhere to the BCCNM Medication Practice Standards.
- Nurse confirms two unique client identifiers as per policy.
- Check the order in EMR to confirm dose.
- Clients can at any time decide they would like a lower dose. This dose adjustment then needs to be communicated to pharmacy so that pre-waste can occur (for Downtown Community Health Centre (DCHC)) or nurses follow pre-waste procedures if pharmacy is not co-located with the iOAT program. All narcotic wasting requires two nurses witnessing and co-signed. See VCH Community Medication Standards. Notify prescriber after session if client has requested a lower dose as a new prescription will be required.
- Clients are given 10 minutes to locate injection site and administer their iOAT medication. The nurse assesses the client's needs and provides support with injection within the time period.

1. Supervised Administration

   The preferred route of administration is client self-administration (IV/IM/SC) under the supervision of nurse. For safety reasons, the following injection site selection is recommended:

   - IV injection: only allowed in the upper extremities (hands or arms, no jugular use is permitted)
   - IM injection: allowed in the deltoid, thighs, and gluteal muscles. See Appendix B
     - The nurse can support the client to identify injection sites, with the total volume of medication for injection taken into consideration for the most appropriate site e.g. maximum 2 mL into deltoid. See Appendix E.

2. Nurse Administration of IM Injection

   When clinically indicated and/or upon client request, the nurse can administer the medication intramuscularly. There may be time-limited, discrete events, such as injury, where the client requires assistance from healthcare providers to ensure continuity of care. In some circumstances there may be other clinical or psycho-social indications for healthcare provider IM injection, in order to enable a client with specific needs to access iOAT. It is recommended that clinical judgment be used in these situations to determine if iOAT with healthcare professional IM administration is the most appropriate treatment.

   Standard protocols for IM injection, including rotating sites and matching site to volume of medication should be followed. Some clients may decline to rotate sites or to match the site to the volume of medication. In these situations, nurses should provide education on the rationale for rotating sites and matching volume while respecting the client's preference. If a client declines injecting into an appropriate site, harm reduction principles would support to give the injection in their preferred site rather than not give the dose at all. Document education given and client response in EMR.

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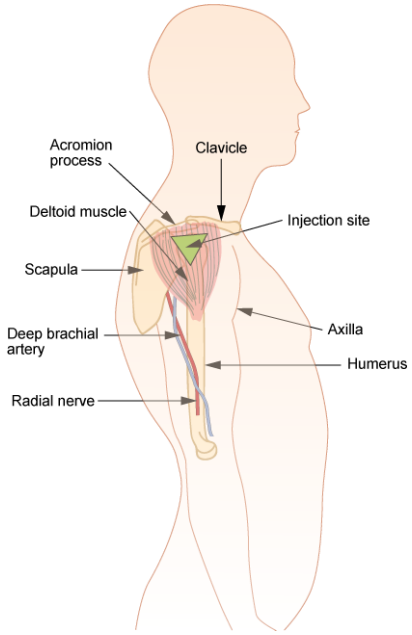
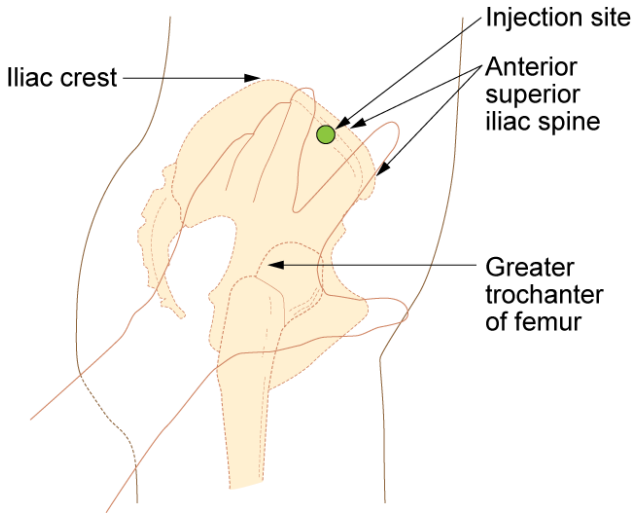
Deltoid



Ventrogluteal



III. Post-injection assessment

After the client injects the iOAT dose, the nurse will perform a post-dose assessment to determine dose tolerance and any drug interactions. See Appendix C.
The client must remain on site for 15 minutes during titration and 5 minutes during maintenance dose for post-dose for observation and assessment. Consider extending the observation period and perform assessment including vital signs if any of the following occur:

- Severely anxious or agitated
- Dyskinetic
- Overly sedated by using the POSS score (refer to Modified Pasero Opioid-induced Sedation Scale (POSS), Appendix D)
- Slurred speech
- Decreased respiration rate

Continue the post-injection assessment every 15 minutes until the above conditions are cleared which indicates the client is safe to leave. RN/RPN can determine safety to leave and LPN will do so in collaboration with them.
Based on the severity of the above assessment, notify the prescriber and document when needed.

Clinical Labs

Ensure informed consent for all clinical testing obtained from client.

Urine Drug Test (UDT)

UDT are collected within two weeks of treatment start, monthly and as per prescriber's order to confirm opioids and monitor trends.

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- UDT Point of Care (POC) tests are used when clients are new or undergoing re-titration, or if requested by the prescriber.
- UDT sent to laboratory for new enrollment, monthly during initiation and dose increase, or when requested by the prescriber for confirmation of POC testing. Complete the lab requisition to test for the following: amphetamines, benzodiazepines, cocaine, opiates, fentanyl, methadone (EDDP), morphine (6-MAM), HYDROmorphone.
- Requisition for UDT will be ordered under prescriber.
- UDT can be stored in the fridge up to 72 hours.

Note: Many clients have experienced discomfort or trauma related to UDT in the past. Clients should be asked for a UDT with a culturally safe, trauma-informed lens.

Urine human chorionic gonadotropin (HCG) when applicable

- Urine HCG sent to for laboratory testing for clients with a uterus.
- Testing performed upon program enrollment, every 6 months, and as per prescriber's order.
- Requisition for Urine HCG will be ordered by:
    - RN/RPN autonomously per this DST and under Nurse Independent Activities (NIA) and Nurse-Initiated Protocols (NIP) Policy
    - LPN requires provider order Pregnancy Testing and Results Counseling Guideline

Overdose Management

In the event of an overdose of a participant while accessing the program, nurses will respond by following: Opioid Overdose: Advanced Interventions in Supervised Consumption Settings.

Documentation

The nurse supervising or administering the injection will document in client health record.

Nurses will also meet the requirements outlined in the BCCNM Documentation Practice Standard.

The nurse will chart all assessments performed during the iOAT visit:

- **Intakes:** document completed orientation and consent forms, including education provided.
- **Pre-injection documentation:** use preioat\ typing template in the EMR encounter. Chart the pre-injection assessment that includes the client's presentation on arrival, assessment prior to injection and any interventions performed.
- **Post-injection documentation:** use postioat\ typing template in the EMR. Chart the post-injection assessment that includes medication administration documentation (including time of injection, site, route, dose, and medication name) client tolerance, client presentation, and any interventions performed (e.g. harm reduction teaching, physical assistance required, etc.) after the client's injection.

In addition to the documentation within the template, the EMR note should include:

- Any care provided and the response to treatment
- The time the client completed their injection as well as the time they left the iOAT space

A PSLS report is required if a client experiences an overdose after receiving an iOAT dose.

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Client Education

- Naloxone administration
- Clinic flow
  - Client may receive assistance from nurse to locate safer injection site. Client may also receive IM from nurse if preferred
  - Client is responsible for putting on and taking off needle tip pre and post injection
  - Client disposes of the needle tip in the sharps container
  - Client to return the used iOAT syringe/barrel and label:
    - For sites with an on-site pharmacy- return to pharmacy through window
    - For sites without an on-site pharmacy- return to nurses for disposal
- When next client can return to clinic for next dose
  - minimum 3 hours between each session in the same day
- Harm reduction pre and post injection
    - See Overdose Prevention Safety Planning SOP
- Safer use training
  - For Safe injection education see Appendix B
  - For Safer injection site education see Appendix F
- Key teaching points:
  - Rotating injection sites
  - Avoid injecting in the jugular or femoral veins
  - Aseptic technique/hand washing
  - Volume of medication matching IM site choice
  - Changing of needle tips after 1 to 2 failed attempts

Related Documents

Related Policies

- Harm Reduction Policy
- Indigenous Cultural Safety Policy
- Cultural Competency and Responsiveness
- Patient, Client, and Resident Identification

Guidelines/Procedures/Forms

- BCCSU iOAT Guidelines
- VCH Community Medication Standards
- Overdose Prevention Safety Planning SOP
- Management for Suspected Opioid Overdose
- Trauma Informed Practice Guideline

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References

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Appendix A : Nursing Initial Program Orientation Checklist

- ✓ You have the right to feel safe at this clinic and in this program. We ask that you respect this right for others as well - staff and clients.
- ✓ While we do our best to provide care in a timely manner, please be aware there may be wait times to get your injection.
- ✓ You must wait for 15 minutes after your dose during titration and 5 minutes after maintenance dose in the iOAT space. This is to ensure you aren't over-sedated, and are tolerating your dose without any complications.
- ✓ The injection is supervised. This mean staff are present and can support you during your injection.
- ✓ Nursing staff can provide assistance to find a vein or IM site as necessary. Nursing cannot inject IV or flag for you, but can inject IM for you.
- ✓ There is no jugging (jugular) or injecting in groin (femoral) in iOAT.
- ✓ Only nursing staff can perform booth help or assistance – not other clients.
- ✓ You have 10 minutes to inject your dose IV. After this, you will be asked to inject the dose via IM
- ✓ There is a minimum of 3 hours between doses. If you present at a time that will make the second session outside the hours of operation, you will only be able to receive one injection that day.
- ✓ For safety, intoxication may result in a deferred, reduced, or held dose. We have a breathalyzer that will be offered if there is a question of alcohol intoxication. This will help staff keep you safe.
- ✓ We ask everyone about street drug use.
- ✓ We want to make sure you've received naloxone teaching, that you currently have a kit, and that you're aware of supervised consumption sites and overdose prevention sites.

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Appendix B: Supporting Safer Injections in iOAT Programs

To ensure clients are injecting medication as safe as possible, it is important to provide the following information to the client. Intravenous (IV) injection for administration of medication in iOAT program is to be done by the client only. Nurses can administer intramuscular (IM) injections at the client's request.

1. Risk Education
    - Helping clients inject safely into a vein can greatly reduce potential harms, and they should be informed about the risks of not following proper techniques. Risks of improper injection can result in:
        - Infection to the site (cellulitis or abscess)
        - Painful site when drugs injected in tissue
        - Air embolism
        - Blood clot/embolism
        - Excess bleeding (arteries)
2. Choosing the injection site - Safer to less safe options (see Appendix E for diagram):
    - Vein health/ vein maintenance: Rotate sites to allow veins to rest and repair after being used, using the safest option possible. This will help prevent them from collapsing or from becoming infected with an abscess. If possible follow the Arm, Arm, Hip/Hip, Hip Thigh, (AAH/HHT) rotation.
    - Safer sites are the veins in the hands and arms (see Appendix E for a diagram of major veins in the lower arm and hands).
    - If it is difficult to locate veins in the hands and arms, the next safest option is to inject in the muscles. Possible sites include ventrogluteal area, the upper outer quadrant of the gluteal area, the vastus lateralis, and the deltoid.
    - If clients prefer to inject in the veins, then the alternate sites are lower limbs (i.e. legs and feet). Clients should be informed that there are more risks associated with injection into these areas, which include increased risk of infection, embolism, phlebitis, deep vein thrombosis (DVT) and ulceration.
    - Some parts of the body are **very dangerous** to inject into and clients should be instructed to avoid the following areas: neck, groin, penis, eyes, inner wrists and the breasts.
3. Reducing infection by skin cleaning
    - Clean the injection site with an alcohol wipe, or soap and water to prevent dirt, bacteria or germs from getting carried into the vein by the needle. Encourage the client to plan ahead so they don't have to touch the site once it's clean. For example, they can consider cleaning more than one site in case they miss the vein the first time. If there is visible dirt, they should first clean the site with soap and water as alcohol will not be effective if there is a lot of debris on the skin.
4. Tourniquet
    - Once the client is sure that the syringe is in the vein, release the tourniquet and slowly push the plunger in to inject the drug. Releasing the tourniquet before injecting or as quickly as possible after injection is important. Injecting into a tied-off vein can cause pressure in the vein and lead to vein ruptures.
5. Techniques for finding a vein
    - Use a thin, pliable tourniquet that is easy to release.

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- Run warm water over the site
- Tighten the shirt sleeve on the upper arm
- Make a pumping action with the fist
- Swing the arm in a circle

*Change needle tips after 1 or 2 failed injection attempts

6. Bevel up
   - Insertion of the needle into the vein should always be done with bevel opening facing up. The needle should be about a 15-35 degree angle and inserted in the direction of the heart (the direction of blood flow) to reduce vein damage.
7. Flagging
   - Flagging is used to confirm placement of the needle in the vein and involves pulling the plunger back slowly until a little blood flows into the syringe. When clients miss the vein during injections, it can cause abscesses and/or the client may not get the effect of the medication.
   - When flagging, if the blood is frothy or brighter red than usual, or if the plunger is pushed back by pressure from the blood, the needle has likely hit an artery. Injecting into arteries will cause intense pain and swelling at the site and potentially cause excessive blood loss as well as waste of the medication and its effects. If this occurs, remove the needle slowly and apply pressure at the site with a clean tissue to help stop the bleeding. Raising the limb can help too. If bleeding continues and there is swelling or pain after 10 minutes, notify the physician or call 911.
8. After injection
   - Slowly remove the needle at the same angle as it was inserted, to reduce vein damage. Pressure is applied on the spot for a few minutes with a clean, dry gauze, or tissue to stop the bleeding. Using an alcohol swab for this will actually cause more bleeding because the alcohol prevents the blood from clotting.

<u>Process for Clinician to Support Safer Injections</u>

1. Assess client's injection technique and their comfort level of self-injection and provide assistance/education as needed.
   - Do they seem confident injecting?
   - Are they following the education provided by the staff?
   - Do they need any assistance?
2. Ensure supplies available for injection (tourniquet, gauze, alcohol swabs).
3. Observe the client inject the medication and provide any necessary education.
4. Document the following observation and assessments in the EMR for each visit:
   - Site of injection in the EMR at each visit.
   - Any noted complication of injection (e.g. if they miss a vein, excess bleeding).
   - Adverse reaction and allergic reaction to the medication.
   - Education provided including discussion of safer alternatives and risks.

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Appendix C: Pre and Post-Injection Assessment Documentation

Table 4: Pre-Injection Assessment

Patient Name:	Assessment Date and Time:
Yes No Unknown ☐ ☐ ☐ Severely anxious or agitated ☐ ☐ ☐ Dyskinectic ☐ ☐ ☐ Overly sedated ☐ ☐ ☐ Slurred speech ☐ ☐ ☐ Smells of alcohol	
Baseline respiration rate: _____ breaths / minute Pasero Opioid-induced Sedation Scale[56] (POSS) level: Breathalyzer required: Yes ☐ No ☐ If yes, breathalyzer reading:	
Notes:	
Assessment completed by:	

Table 5: Post-Injection Assessment

Patient Name:	Assessment Date and Time:
Yes No Unknown ☐ ☐ ☐ Severely anxious or agitated ☐ ☐ ☐ Dyskinectic ☐ ☐ ☐ Overly sedated ☐ ☐ ☐ Slurred speech ☐ ☐ ☐ Smells of alcohol ☐ ☐ ☐ Decreased respiration rate	
Respiration rate: _____ Pasero Opioid-induced Sedation Scale[56] (POSS) level:	
Notes:	
Assessment completed by:	

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Appendix D: Modified Pasero Opioid-Induced Sedation Scale (POSS)

Level of Sedation	Appropriate Action
1. Awake and alert	Acceptable; no action necessary; may continue with opioid dose
2. Slightly drowsy, easily aroused	Acceptable; no action necessary; may continue with opioid dose
3. Frequently drowsy, arousable, drifts off to sleep during conversation	Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; notify prescriber for orders.
4. Somnolent, minimal or no response to verbal or physical stimulation	Unacceptable; hold opioid; consider administering naloxone; notify prescriber; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

Appendix E: Intramuscular Injection Site to Volume Per Muscle for Adults

Site	Volume per Muscle
Vastus Lateralis	**Up to 5 mL**
Deltoid	**0.5 – 2 mL**
Ventrogluteal	**2 – 5 mL**

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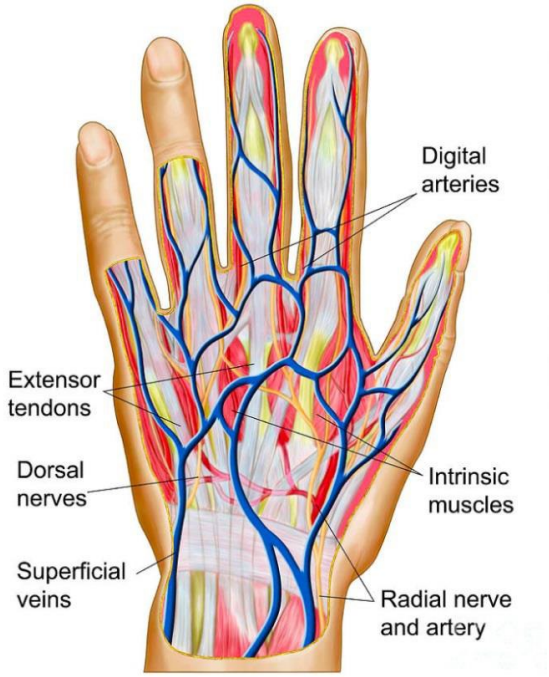
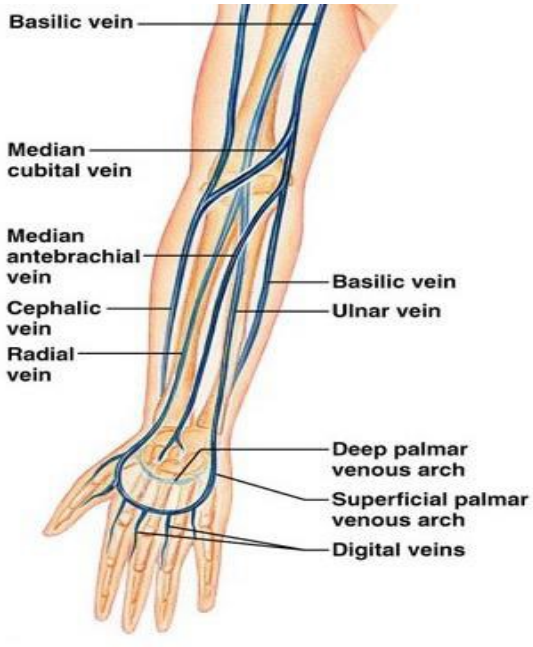
Appendix F: Injection Site Diagrams

Major Veins in Hands & Arms





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First Released Date:	03-MAY-2022
Posted Date:	03-MAY-2022
Last Revised:	03-MAY-2022
Last Reviewed:	03-MAY-2022
Approved By: *(committee or position)*	VCH
	Endorsed By: • VCH Regional SharePoint 2nd Reading • VCH Operations Directors • VCH Professional Practice Directors **Final Sign Off:** Vice President, Professional Practice & Chief Clinical Information Officer, VCH
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