

From: [Stephen G. Eckrich](#)
To: [SDBMOE](#)
Subject: Comment on proposed rule for prescribing opioids
Date: Tuesday, February 24, 2015 5:03:03 PM

Dear SDBMOE:

As a practicing physician who prescribes opioid narcotics for the treatment of pain in the acute and post-operative setting, I am writing to oppose the proposed rule on opioid prescriptions because the rule does not differentiate between the use of opioids for the chronic treatment of pain and their use for acute and post-surgical pain. It would appear that the Board's intent was to address the use of these medications for the treatment of chronic pain, as the article referenced at the end of the rule clearly refers to chronic pain; however, there is nothing in the body of the rule which differentiates between these two, vastly different uses of narcotic pain medications. To state that in order for me to prescribe opioids post injury or post-surgery in a "best practice" manner would require that I obtain an informed consent from the patient, with an outlined treatment plan, and discussion of the alternatives, is just not realistic nor in the patient's best interest. In an acute injury scenario, it is challenge enough to impart a minimum understanding of the choices for treatment and their rationale to a patient who is already in pain, frightened, and unfamiliar with the medical system. To then add another layer of anxiety and concern over how exactly there pain will be handled is just not realistic.

If it was the Board's intent to have this rule apply only to the use of opioids to treat chronic pain, however that may be defined, then that must be clearly stated in the proposed rule. As the rule is written, it does not address these two fundamentally distinct uses of narcotics to treat pain, and should be amended to reflect that. In the absence of such an amendment, it should be rejected.

Stephen Eckrich, MD
Rapid City, SD

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From: [Steven Giuseffi](#)
To: [SDBMOE](#); [SDBMOE](#)
Subject: Concern about SD narcotic prescription proposed rule
Date: Wednesday, February 25, 2015 6:03:28 PM

South Dakota Medical Board:

I am concerned about the proposed rule for

“Best practices for the prescription of controlled substances for the treatment of pain.”

Such a rule would have broad implications for surgeons who frequently prescribe short-term opioid pain medications for acute trauma or post-operative pain management. The requirements to specifically document opioid dependence risk, develop a written and signed opioid agreement between patient and provider, and follow mandated follow-up appointment intervals would be onerous for surgeons while not benefitting patients that receive limited narcotics for acute pain.

While these rules would appear to be appropriate for long-term chronic pain management, they are inappropriate for short-term narcotic dispersal. I'm concerned that the above rule does not appear to distinguish between the prescription of narcotics for acute traumatic events and/or post-surgical pain versus chronic pain. Failure to make this distinction would dramatically affect my practice and that of my colleagues in a negative way without providing patient benefit.

Please consider revising the rule to distinguish between opioid prescription for acute versus chronic pain management and apply these requirements only for long-term opioid prescription.

Sincerely,

Steven A. Giuseffi, MD
Orthopedic Surgery
Black Hills Orthopedic and Spine Center
Rapid City, SD

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1325 S. Cliff Ave.
P.O. Box 5045
Sioux Falls, SD 57117-5045
605-322-8000

AveraMcKennen.org

March 2, 2015

South Dakota Board of Medical and Osteopathic Examiners
101 N. Main Avenue Suite 301
Sioux Falls, SD 57104

Dear SDBMOE:

I am writing this letter in response to your public hearing notice for Proposed Administrative Rules. I read with interest Chapter 20:47:07 Physician Best Practices for the Prescription of Controlled Substances for the Treatment of Pain and Best Practices for Medical Records when Prescribing Controlled Substances for the Treatment of Pain. In general, I applaud your efforts to encourage best practices and developing standardized procedures for prescribing Opioid related analgesics for pain. I do however have a couple of concerns regarding the wording of this chapter that I would like to bring to your attention.

First, I think the wording is quite broad and could create multiple challenges particularly if it is applied to non-opioid containing narcotics such as a substance like valium. Likewise with the broad generic nature of this chapter, I do not believe that it applies well at all to the inpatient prescribing of opioid and non-opioid containing analgesics and other controlled substances. Therefore, I would highly recommend that verbage be included in this chapter to make it clear that it was pertaining to the outpatient prescribing of narcotics. Additionally, the implementation of these best practices could be somewhat challenging given our current electronic medical record environment. I would hope that the folks trying to pass these best practice recommendations would be cognizant of that and allow clinics the adequate time to develop EMR templates and other workflow mechanisms to meet the requirements of these best practices.

Again, I applaud the Board of Medical and Osteopathic Examiners efforts to improve the practices around the prescribing of opioid containing analgesics for pain control and hope that you would take my comments into consideration when drafting the final recommendations.

Please do not hesitate to reach out to me should you have any questions or concerns.

Sincerely,

A handwritten signature in black ink that reads "Mike Elliott, MD".

Mike Elliott, MD
Senior Vice President Medical Affairs/CMO

ME/bkd

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and Presentation Sisters*

Avera
Mckennan Hospital
& University Health Center

1325 S. Cliff Ave.
PO Box 5045
Sioux Falls, SD 57117-5045

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2600 W. 49th Street
PO Box 7406
Sioux Falls, SD 57117-7406
605-336-1965
Fax 605-274-3274
www.sdsma.org

VIA Email and Hand Delivery

March 5, 2015



South Dakota Board Of Medical & Osteopathic Examiners
101 N Main Ave Ste 301
Sioux Falls, SD 57104-6411

RE: Proposed Rules – ARSD Ch. 20:47:07 and 20:47:08

Dear Board Members:

I am writing in my capacity as President of the South Dakota State Medical Association (“SDSMA”). SDSMA is a professional organization of more than 2,000 physicians, residents and medical students, all of whom are dedicated to protecting the health care interests of patients and advancing the effectiveness of physicians throughout South Dakota.

This is intended as SDSMA’s written testimony on the proposed rules described below. SDSMA respectfully reserves the right to appear and provide additional live testimony at the March 11, 2015 rules hearing.

While SDSMA greatly appreciates the efforts of the Board and its staff to provide guidance on the complex issues described in the proposed “Best Practices” rules, SDSMA believes the proposed rules are so generalized and vague that they are much more likely to result in unintended consequences and confusion than provide useful guidance.

SDSMA’s concerns, presented in the same order as the rules themselves, are as follows:

Proposed ARSD 20:47:07:01 – “Best practices defined.”

While this proposed rule first states that failure to comply is not a grounds for disciplinary action, it goes on to provide that a physician may be called upon to “justify” a failure to comply. The proposed rule also provides that compliance with established best practices constitutes a defense to a disciplinary action.

SDSMA believes these seemingly contradictory statements of policy will lead to confusion and cause physicians to believe they are required to comply with the generalized “best practices” established in the rules even if the physician’s well-reasoned medical judgment calls for a different approach.

Furthermore, SDSMA objects to proposed ARSD 20:47:07:01 and the adoption of best practices generally as being inconsistent with AMA policy concerning the adoption of health care standards (see policy H-450.935 - Health Care Standards), and in particular subpart 2 of that policy, wherein the AMA

supports the position that any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, whether developed or issued by government or non-government organizations, including those that result from any comparative effectiveness research or evidence-based medicine system, do not, and should expressly state that they do not, establish standard of care or create specific requirements for physicians that restrict the exercise of their clinical judgment.

Proposed ARSD 20:47:07:02 - “Best practices for the prescription of controlled substances for the treatment of pain.”

Proposed rule 20:47:07:02 includes several provisions which give rise to SDSMA’s concern that the proposal is too generalized and vague:

1. The proposed regulation makes no distinction between different types of pain – whether acute, chronic, related to a terminal illness, or other. As the Board is aware, the best course of treatment often depends on the type of pain being experienced by the patient.
2. The proposal – in steps one through nine – suggests that these steps must be followed in the order set out in the proposed rule, both in terms of “process” and “procedure.” Depending on the clinical indication, many of these “process” points make little objective or clinical sense. For example, it appears that an acute care situation (e.g., a broken arm) would require both a signed patient agreement and a trial of opioid therapy, neither of which would be indicated under the existing standard of care.
3. The following considerations and questions further demonstrate why the proposed rule should be withdrawn given its vagueness:
 - For subpart 1, how many acute situations (or terminal ones) truly require a differential diagnosis?

- For subpart 2, for example, is a hospice patient's risk of substance use disorder relevant?
- For subpart 3, what form would "informed consent" take? Again, shouldn't there be different considerations depending on the diagnosis and type of pain?
- For subpart 4, while this may make sense for long-term opioid therapy for chronic pain, it likely does not make sense for acute or terminal conditions.
- For subpart 5, even for chronic pain, is this the appropriate focus? Depending on the condition, some patients may be able to have function "restored," but that may not be the goal.
- For subpart 6, this is probably fine for long-term, chronic opioid-related therapy, but not for other pain treatment scenarios.
- For subpart 7, depending on the patient, this level of oversight may not be necessary, and it may lead to some patients not being able to obtain care. Similarly, this requirement should not apply to acute or terminal conditions.

Proposed ARSD 20:47:07:03¹ – "Best practices for medical records when prescribing controlled substances for the control of pain."

The concept of maintaining accurate and complete medical records of course makes sense, but as with proposed 20:47:07:02, this proposal appears to SDSMA to be overly broad and vague. For example, "pain" may not be the primary diagnosis; "cancer", "broken bone", "fibromyalgia", or some other condition might be the primary reason for treatment. Do the same record-keeping requirements apply when there is a primary diagnosis other than "pain?"

Proposed ARSD 20:47:07:03(1) includes cross-references to proposed ARSD 20:47:07:02(4) and (6)²; those provisions of proposed 20:47:07:02 are problematic for the reasons described above.

The proposed rule states that each of the numbered subsections must be addressed. Does that mean that risk assessments are necessary for every condition? For chronic, long-term opioid therapy, many of the listed items might make sense, but again the proposal seems to be overbroad and as a result would interfere with the practitioner's well-reasoned professional judgment.

¹ The proposed rule is numbered 20:47:07:02; SDSMA assumes it was intended to be numbered 20:47:07:03.

² The proposed rule cross-references to 20:47:07:01, but SDSMA assumes it was intended to be a cross-reference to 20:47:07:02.

General Comments Concerning Proposed Best Practices Rules

In addition to SDSMA's substantive issues about the rules themselves, SDSMA has equally-important concerns about the concept of codifying "best practices" in administrative rules. First, as noted above, inserting generalized "best practices" into rules unduly interferes with the physician-patient relationship because the physician may not feel free to craft a treatment plan that is at odds with the codified "best practices," but is best for the patient.

Second, putting "best practices" in rule means further rule-making or legislation would be required to modify those "best practices" as medicine evolves. As a result, the advance of medicine will be slowed. If the Board elects to proceed with the adoption of "best practices" as proposed, which SDSMA opposes, SDSMA joins with the AMA in urging the Board to "set and make publicly available a regular schedule for review and update and to include the level of evidence supporting the guidelines." AMA Policy H-450.935.

Third, our research and that of the AMA indicates that since the FSMB began promoting the new guidelines in July 2013, only 10 states have adopted a version of them. SDSMA respectfully submits that this lack of adoption of the guidelines is an indication of a lack of professional consensus as to the substance of the proposed guidelines.

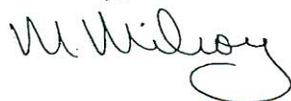
Finally, I have enclosed a copy of the full American Medical Association policy on the adoption of best practices and similar policy statements, as well as a letter from the AMA dated March 4, 2015 which expresses many of the same concerns about the substance of the proposed rules and the practice of incorporating best practices into administrative rule.

Proposed ARSD Ch. 20:47:08 – Ethics.

As to the proposed adoption of the AMA's model rules of ethics for physicians, SDSMA supports and applauds the Board's effort so to do.

Thank you for the opportunity to provide SDSMA's perspective on the proposed rules. For the reasons stated above, SDSMA strongly encourages the Board to reject proposed ARSD Ch. 20:47:07 in its entirety. SDSMA supports the adoption of proposed ARSD Ch. 20:47:08.

Sincerely,



Mary Milroy, MD, President
South Dakota State Medical Association



JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

March 4, 2015

Mary Milroy, MD
President
South Dakota State Medical Association
2600 W. 49th Street, Suite 200
PO Box 7406
Sioux Falls, SD 57117-7406

Dear Dr. Milroy:

Per your request, the American Medical Association (AMA) has reviewed the proposed amendments to Article 20:47 of South Dakota's regulations pertaining to physicians and surgeons, and we make the following observations.

The proposed "Best practices for the prescription of controlled substances for the treatment of pain," raises several areas for concern. At a threshold level, the AMA is concerned that the proposed regulation provides overly broad, vague recommendations about how physicians are expected to treat patients with pain. The proposed regulation also provides no distinction between different types of pain – whether acute, chronic, related to a terminal illness, or other condition(s).

The AMA does not believe it is appropriate to establish standards of care or create specific requirements for physicians that restrict the exercise of their clinical judgment. The highly prescriptive, overly vague directions contained in the proposed regulation, however, do just that, and are not in the best interests of South Dakota's patients or the physicians who care for them.

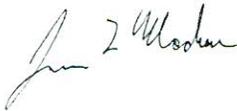
Similarly, the proposed "Best practices for medical records when prescribing controlled substances for the treatment of pain" also lacks specificity with respect to the different needs of patients who present with different conditions. The AMA certainly supports proper documentation, but the highly prescriptive processes and procedures simply may not be appropriate or applicable in all situations and therefore should not be codified as a best practice.

Mary Milroy, MD
March 4, 2015
Page 2

The AMA has worked with federal and state policymakers in support of combating prescription drug abuse, misuse, overdose and death on many levels. We strongly support efforts to enhance education and ensure appropriate prescribing of controlled substances, including for pain. While we commend the medical board for its interest in this area, we strongly recommend that the medical board withdraw the proposed regulation for the reasons stated above

If you have any questions regarding the recommendations and comments in this letter, please contact Daniel Blaney-Koen, JD, Senior Legislative Attorney, Advocacy Resource Center, at daniel.blaney-koen@ama-assn.org or 312-464-4954.

Sincerely,

A handwritten signature in cursive script, appearing to read "James L. Madara".

James L. Madara, MD

cc: South Dakota State Medical Association

From: [Michael Puumala](#)
To: [SDBMOE](#)
Subject: Comment on Best Practices proposal for 3/11/15
Date: Monday, March 09, 2015 9:12:22 AM

March 9th, 2015

To the SD Board of Medical and Osteopathic Examiners;

I am concerned about the proposed regulation concerning the Best Practice for the use of controlled substances for pain control. The reference for the proposal is taken from a protocol for treatment of chronic pain. Unfortunately, the proposal does not use the word chronic. It would therefore be applied to the treatment of pain in any situation. Thus a signed treatment plan etc. would be needed for the prescription of one narcotic pain pill. This would affect the emergency room, most clinics, and hospitals. As written, proposal would also apply to any narcotic given during anesthesia for surgery. As written, the proposal would also apply to administration of local anesthetic used for repairing lacerations, or even for an IV start.

While I realize that in the definition of Best Practices it is noted that the proposal would not apply to every situation, it is my belief that the proposal as written would not apply to most situations. It would seem counterproductive to have this on the books given this lack of usefulness.

It would seem that the proposal was written for treatment of chronic pain. I would suggest that either the proposal should be clearly identified as being for the treatment of chronic pain, or the proposal should be written in a way that better reflexes the treatment of pain in the non-chronic situation.

Sincerely,

Michael Puumala MD FAASN FACS



1 March 2015

South Dakota Board of Medical and Osteopathic Examiners
101 N Main Ave, Ste 301
Sioux Falls, South Dakota 57104

Ladies and Gentlemen:

Below for your consideration are my comments on the proposed rules under the following sections: 20:47:07, 20:47:08, 20:52:02, 20:63:04, 20:64:05, 20:66:02, 20:70:03, 20:78:05:09, 20:78:05:10, 20:82, 20:83.

Page 9: Nondiscrimination.

The text reads "...*should* not discriminate..." I wonder if the rule should be more directive (e.g. *must* not discriminate). The word "should" is more a guideline than a rule.

Page 9: Initiation and Discontinuation of Care

At the bottom of the page it says patients are entitled to access *appropriate* information contained within their medical record. I would submit that the patient is entitled not only to access, but also to **copy** *all* information in their medical record.

Page 10: Informed Consent/Page 13: Genetic Testing

A recent article in the *New England Journal of Medicine* about modern challenges in the area of informed consent (NEJM 2015;372(9):855) suggests that training in communication of informed consent information may be useful. This is particularly true in the area of genetic testing, an area of practice growing exponentially in complexity. The complexity is so daunting that few practitioners truly have the expertise to provide informed consent for many of these tests. The rule could be modified to indicate that the information provided by the PA should only be within the scope of specific training in genetic testing and counseling and that the services of a qualified genetics counselor be sought in appropriate circumstances.

Page 14: Reproductive Decision Making

The last sentence is far more legal than medical and asks the PA to interpret law rather than to make health care recommendations. I would reword the sentence to read: "...ensure the patient's access to all treatment options together with information where those options may be legally available."



Page 19: PAs and Research

One might encounter considerable disagreement over the premise that honesty is the most important ethical principle in research. *Integrity*, for example, may be a better ethical concept. One can be honest, but still “spin” information. PAs participating in research must be familiar with the ethical requirements of informed consent.

Page 36: Physical Therapists, Principle #2A

Saying one adheres to core values without specifying what those values are is an incomplete guide. There should be some reference to a description or list of those values.

Page 36: Physical Therapists, Principle #2D

The concept of collaborating “with patients/clients to empower them in decisions...” is conceptually oblique to the *obligation* of physical therapists to provide information and obtain informed consent from patients/clients about their health care. This principle should be reworded.

Thank you for the opportunity to review these rules and to offer comments to the Board.

Sincerely,

Henry Travers, MD, FACP

From: [Tom Benzoni](#)
To: [SDBMOE](#)
Subject: Re: Updated Public Hearing Notice for Proposed Administrative Rules
Date: Friday, February 20, 2015 8:26:30 PM

I can't make it in person.

Regarding physician assistant portion:

I question the wisdom of placing what appears to be an aspirational document into rules.

Thomas Benzoni, DO

On Feb 20, 2015 1:43 PM, "SDBMOE" <SDBMOE@state.sd.us> wrote:

Licensees and Interested Parties,

Please find attached an updated notice for the **Wednesday, March 11th at 9:00 AM CDT public hearing** for proposed administrative rules.

Persons interested in presenting data, opinions, and arguments for or against the proposed rules may do so by appearing in person at the hearing or by sending them to the South Dakota Board of Medical and Osteopathic Examiners, 101 N Main Ave, Ste 301, Sioux Falls, South Dakota 57104 or by email to SDBMOE@state.sd.gov by **March 10, 2015**.

Copies of the proposed rules may be obtained from the South Dakota Administrative Rules website <https://rules.sd.gov/detail.aspx?Id=168> or by contacting the Board of Medical and Osteopathic Examiners.

Sincerely,

Board Staff from General Email

South Dakota Board of Medical & Osteopathic Examiners

sdbmoe@state.sd.us

www.sdbmoe.gov

From: [Stark,Lisa](#)
To: [SDBMOE](#)
Subject: AND code of ethics
Date: Friday, March 06, 2015 3:45:17 PM

I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.

Thank you,
Lisa Stark, RD LN CDE CNSC
Sanford Health

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From: [Witte, Hope M.](#)
To: [SDBMOE](#)
Subject: code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota
Date: Friday, March 06, 2015 3:25:49 PM

I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota. Thank you.

Hope Witte, RD, LN, CDE
301 South Chicago St
Hot Springs, SD 57747
hope.witte@yahoo.com

From: [Larson,Georgia](#)
To: [SDBMOE](#)
Subject: Ethics
Date: Friday, March 06, 2015 3:23:27 PM

I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.

In fact, I have used this document in my practice and find it inclusive and to hold us to a high standard. Thank you.

Georgia Larson, RD, LN
Clinical Nutrition Manager
Sanford Medical Center
1305 W 18th Street
Sioux Falls, SD 57105
605-333-7130
Georgia.larson@sanfordhealth.org

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From: [diane_marshall](#)
To: [SDBMOE](#)
Subject: Fw: SD RD Rule proposal
Date: Friday, March 06, 2015 4:31:08 PM

"I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota".

diane_marshall

From: [Carinna Fehlman](#)
To: [SDBMOE](#)
Subject: rules for the Registered Dietitian
Date: Sunday, March 08, 2015 10:35:26 PM

I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.

Carinna Fehlman, RD, LN

From: [Shelly B](#)
To: [SDBMOE](#)
Subject: Nutritionist ethics
Date: Saturday, March 07, 2015 6:55:41 AM

Please consider the inclusion of the Academy of Nutrition & Dietetics (A.N.D.) code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota. Thank you for your consideration on this matter.

Shelly Brandenburger, Licensed Nutritionist in SD

--

*Dr. Shelly Brandenburger
1453 Sixth Street
Brookings SD 57006
(605) 692-2225
Cell: 651-0465*

From: [Kim Hepper](#)
To: [SDBMOE](#)
Subject: AND cod of ethics
Date: Friday, March 06, 2015 11:31:21 PM

To whom it may concern,
I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.

Thank you,
Kim Hepper, RD LN; Clinical Dietitian



This email has been checked for viruses by Avast antivirus software.

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From: Sturdevant.Michele
To: SDBMOE
Date: Friday, March 06, 2015 5:30:31 PM

I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.

I am working to follow these standards.

Michele Sturdevant, RD, LN
Neonatal Dietian
Neonatal Intensive Care Nursery
Sanford Children's Hospital
1305 W 18th Street
Sioux Falls, SD 57105
605.328.3061
Michele.Sturdevant@SanfordHealth.org

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From: RBrand@regionalhealth.com
To: [SDBMOE](#)
Subject: March 11th SDBMOE Meeting
Date: Friday, March 06, 2015 5:10:10 PM

SDBMOE Board Members:

I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.

Thank you for assisting with setting professional, practice and ethical standards for licensed nutritionists in South Dakota.

Respectfully,

Rene M Brand, MS RD LN

Clinical Nutrition Supervisor
Rapid City Regional Hospital
353 Fairmont Blvd
Rapid City, SD 57701
605-755-8835 or cell 605-877-1277
rbrand@regionalhealth.com

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From: [Helen](#)
To: [SDBMOE](#)
Subject: In support of the adoption of the AND Code of Ethics
Date: Monday, March 09, 2015 9:15:57 AM

SDBMOE,

I would like to extend my support for the inclusion of the AND Code of Ethics to the SD Licensed Nutritionist rules along with the proposed fee schedule.

Helen Nichols, RD LN CDE

From: EPhillips@regionalhealth.com
To: [SDBMOE](#)
Subject: AND Code of ethics
Date: Monday, March 09, 2015 8:56:41 AM

Good morning,

As I am in Rapid City, I cannot be present for the meeting with RDs from SDAND on the 11th. I would still like for the board to know that I am in favor of updating and adopting the proposed AND code of ethics into the rules for Registered Dietitian/Licensed Nutritionist in South Dakota.

Sincerely,
Elizabeth Phillips, RDN CSR LN
Regional Dialysis Center
640 Flormann St, Suite 401
Rapid City, SD 57701

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From: [Deb Brakke](#)
To: [SDBMOE](#)
Subject: AND Code of Ethics
Date: Tuesday, March 10, 2015 11:20:14 AM

I support the I cousin of the AND code of ethics in the requirements for Registered Dietitian/Licensed Nutritionist in SD.

Debra Brakke, RD/LN.

Sent via the Samsung GALAXY S@4, an AT&T 4G LTE smartphone

From: [April Sorensen](#)
To: [SDBMOE](#)
Subject: SD RD Rule Proposal
Date: Monday, March 09, 2015 2:27:00 PM

I am a dietitian in a CAH and I also own my own private practice consulting business in which I consult for another CAH and 2 long term care facilities. I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.

Thank you for your consideration in this matter!

April Sorensen
Registered Dietitian, Education Coordinator
Faulkton Area Medical Center

Nutrition Services Office
605-598-6323
605-598-6324 (fax)
605-751-9043 (cell/text)

From: [Stella Watson](#)
To: [SDBMOE](#)
Subject: Inclusion of the AND code for RDs
Date: Monday, March 09, 2015 12:07:53 PM

"I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota".

Stella Watson RD LN
"Nutrition Matters"
Visiting/Consulting Dietitian
24269 Playhouse Rd
Keystone SD 57751
Email stellasplayhouse@mt-rushmore.net

From: RDorsett@regionalhealth.com
To: [SDBMOE](#)
Subject: Statement of support for adpotion of Code of ethics
Date: Monday, March 09, 2015 1:57:41 PM

I am in favor of the adoption of the AND code of ethics in the proposed rules that set professional, practice and ethical standards for licensed nutritionists.

Rebecca Dorsett RD, LN
605-644-4043

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From: [Conti, Kibbe \(IHS/ABR/RCH\)](#)
To: [SDBMOE](#)
Subject: Support
Date: Friday, March 06, 2015 4:54:07 PM
Attachments: [image001.gif](#)
[image002.png](#)

"I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota".

Kibbe Conti MS, RD, CDE
LCDR US Public Health Service
Nutrition Specialist
Rapid City Indian Hospital

wbw2014-logo-hd



From: [riley_donna](#)
To: [SDBMOE](#)
Subject: AND Code of Ethics to the SD LN law
Date: Monday, March 09, 2015 9:51:45 AM
Attachments: [image001.png](#)

To the SDBMOE,

I would like to voice my support of the adoption of the Academy of Nutrition and Dietetics Code of Ethics to the SD Licensed Nutritionist law. The code of ethics will establish professional, practice and ethical standards that are needed for the SD licensure law to guide Licensed Nutritionists and protect the public.

Donna Riley, RD, LN, CDE
Diabetes Education Coordinator
Regional Medical Clinic
640 Flormann Street
Rapid City, SD 57701
605-755-3388



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From: [Lars Aanning](#)
To: [SDBMOE](#)
Subject: conflict of interest
Date: Friday, March 13, 2015 9:12:15 AM

Why not give complete bios, employment status, and photo of Board members as done by the Minnesota Medical Licensing Board?

Lars Aanning

From: [Lars Aanning](#)
To: [SDBMOE](#)
Subject: conflict of interest
Date: Friday, March 13, 2015 9:12:06 AM

Dear SDBMOE:

The Minnesota Board of Medical Practice lists its Board members with complete bio, employment status, photo, etc. The SDBMOE only lists the names of the Board members without further information. I suggest this process be more transparent and that the SDBMOE adopt Minnesota's practice of full openness.

Best regards,

Lars Aanning

Current Board Members



Keith H. Berge, M.D.

Policy & Planning Committee Member
Dept. of Anesthesiology
Mayo Clinic, MB2-505C
200 First Street SW
Rochester, MN 55905
Fax: 507-255-2939

Dr. Berge, of Rochester, is a board certified consultant in anesthesiology at Mayo Clinic. He also serves as an assistant professor of anesthesiology in the College of Medicine, Mayo Clinic. Berge received his Bachelor of Science degree in microbiology from the University of Minnesota and his doctor of medicine degree from the Mayo Medical School. Dr. Berge is a member of the American Medical Association, American Society of Anesthesiologists, Minnesota Medical Association, and the Minnesota Society of Anesthesiologists.

Current Board term: June 03, 2013 through January 04, 2016
Congressional District: One