

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Thursday, June 2, 2016 - 9:00 am (CDT)

Public Board Meeting

The public may attend the meeting using any of the following:

1. **Pierre - Public DDN site:** CAP A, 500 E. Capitol Ave., Room B12, Pierre, SD 57105 (605-773-3333)
2. **Rapid City - Public DDN site:** University Center, 4300 Cheyenne Blvd., Room 113, Rapid City, SD 57703 (605-718-4117)
3. **Board Conference Room:** 101 N. Main Ave., Suite 215, Sioux Falls, SD 57104

Current Board Member Meeting Attendance Record¹

	KLB	DKB	WOC	MSC	LBL	BJL	DEL	JAM	EJR
3/11/15	☒	☒	☒	☒	☒	☒	☒	☐	N/A
6/11/15	☒	☒	☒	☒	☒	☒	☒	☒	N/A
7/21/15	☐	☒	☒	☒	☒	☐	☒	☒	N/A
9/10/15	☒	☒	☒	☒	R	☒	☒	☒	N/A
9/24/15	☒	☐	☒	☒	☒	☒	☐	☐	N/A
12/3/2015	☒	☒	☐	☐	☒	☒	☒	☒	N/A
3/3/2016	☒	☒	☒	☒	☒	☒	☒	☒	☒

Key: Dr. Bjordahl (KLB) Ms. Bowman (DKB) Dr. Carlson (WOC) Dr. Carpenter (MSC)

Dr. Landeen (LBL) Dr. Lindbloom (BJL) Mr. Lust (DEL) Dr. Murray (JAM), Dr. Rosario (EJR). (N/A=before appointment, R=recused)

Meeting Agenda

1. Welcome, call to order, roll call (Jane), approval of agenda – President Walter O. Carlson, MD, MBA
2. Approval of draft minutes: March 3, 2016
3. Approval of new licenses, permits, certificates and registrations issued: March 1, 2016 through May 31, 2016 (*available after June 1, 2016*)
4. Financial Report
5. Advisory Committee Business
 - a. Appointment to Physician Assistant Advisory Committee – Clint Perman, PA-C
 - b. Re-Appointment to Genetic Counselor Advisory Committee:
 - i. Dr. Maria Palmquist
 - ii. Quinn Stein, GC
 - c. ALS Petition for AEMT Scope of Practice – Yankton County EMS
6. Rapid City Fire Department - Mobile Medic
7. 11:00 a.m. - Public Hearings
 - a. Paramedic
 - b. Paramedic
 - c. CNM
8. Lunch (noon)
9. 1:00 p.m. – Confidential Physician Hearings (Closed session pursuant to SDCL 36-4-31.5 unless privilege is waived by physician).
10. Executive Director Report
11. Proposed Rule for Physician/Physician Assistant Spouses and Supervision – for Board review
12. Proposed Rule for Medical Record Documentation – Opioids – for Board review
13. Article 20:82, Chapter 20:82:04: Proposed Rule for Genetic Counselors - Continuing Education – for Board review
14. Docket Review
15. Annual Election of Officers
16. Executive session: *SDCL 1-25-2(3): consult with legal counsel*
17. Future Meeting Dates

2016: Thurs. September 8; Thurs. December 1

2017: Thurs. March 9; Thurs. June 8; Thurs. September 14; Thurs. December 14
FSMB Annual Meeting: April 20-22 Ft. Worth, TX

2018: Thurs. March 8; Thurs. June 14; Thurs. September 13; Thurs. December 13
FSMB Annual Meeting: TBA

NOTE: This meeting is being held in a physically accessible place. Individuals needing assistance, pursuant to the Americans with Disabilities Act, should contact the Legislative Research Council (605/367-7781) in advance of the meeting to make any necessary arrangements.

¹ Meeting attendance history available upon request

**South Dakota Board of Medical and Osteopathic Examiners
BOARD MEETING AND PUBLIC RULES HEARING**

Thursday, March 3, 2016

9:00 am (central time)/8:00 am (mountain time)

To participate by:

DDN Sites: Pierre: CAP A, 500 E. Capitol, Pierre, SD 57501

Rapid City: TIE Dakota Room, 1925 Plaza Blvd, Rapid City, SD 57701

Winner: Department of Transportation, 1200 E. Hwy 44, Winner, SD 57580

In person: Board Conference Room, 101 N. Main Ave., Suite 215 (on 2nd floor), Sioux Falls, SD

Unapproved Draft Minutesⁱ

South Dakota Board of Medical and Osteopathic Examiners Public Meeting and
Public Rules Hearing- 9:00 am (CT) Thursday, March 3, 2016

Boards Members Present: Kevin Bjordahl, MD; Ms. Deb Bowman; Walter Carlson, MD; Mary Carpenter, MD; Laurie Landeen, MD; Brent Lindbloom, DO; Mr. David Lust; Jeffrey Murray, MD; Elmo Rosario, MD

Board Staff Present: Margaret Hansen, PA-C; Mr. Tyler Klatt; Ms. Jane Phalen; Ms. Misty Rallis

Board Counsel: Steven Blair

Staff Counsel: William Golden

Attendees: Jason Culberson, EMT Paramedic, Rapid City Fire Department
Wade Nyberg, Assistant City Attorney, Rapid City
Mark East, South Dakota State Medical Association (SDSMA)
Dr. James Oury
Dr. Steven Myers (via phone)

1. Dr. Walter Carlson, president of the Board, called the meeting to order at 9:00 am. Roll was called and a quorum was confirmed. A motion: to approve the agenda was ratified by roll call vote (Landeen/unanimous).
2. The scheduled Public Hearing on Administrative Rules was called to order. Dr. Carlson, president of the Board, appointed Mr. Steven Blair to preside over the hearing. Mr. Blair explained the proceedings, and introduced the proposed rules.

Primarily based on LRC comments, board staff requested the withdrawal of the following proposed rules:

- a. *Article 20:47, Chapter 20:47:03, Section 20:47:03:13-Physicians and Surgeons Licensure – Locum Tenens Certificate;*
- b. *Article 20:52, Chapter 20:52:01, Section 20:52:01:03:02 – Supervision of a licensed physician assistant-separate practice location;*
- c. *Article 20:63, Chapter 20:63:01,02&03 – Athletic Trainers – General Provisions;*
- d. *Article 20:66, Chapter 20:66:03 - Physical Therapists and Physical Therapist Assistants – Continuing Education;*
- e. *Article 20:83, Chapter 20:83:04, Section 20:83:04:03 – Licensed Nutritionists – Continuing Education - Waiver.*

A motion: to enter into executive session pursuant to SDCL 1-25-2(3) to consult with legal counsel was ratified by roll call vote (Landeen/unanimous).

The public rules hearing resumed.

A motion: to withdraw *Article 20:47, Chapter 20:47:03, Section 20:47:03:13-Physicians and Surgeons Licensure – Locum Tenens Certificate*, and direct the board staff to schedule a declaratory rules hearing regarding *SDCL 36-4-20.4-Duration of locum tenens certificates-privileges of certificate holder* was ratified by roll call vote (Landeem/unanimous).

A motion: to pursue legislation for authority to amend *SDCL 36-4-20.4* to state that a locum tenens certificate may be issued one time, and may be extended one additional time for 60 days was ratified by roll call vote (Landeem/unanimous).

A motion: to withdraw *Article 20:52; Chapter 20:52:01, Section 20:52:01:03:02 – Supervision of a licensed physician assistant-separate practice location; Article 20:63; Chapter 20:63:01,02&03 – Athletic Trainers; Article 20:66; Chapter 20:66:03 - Physical Therapists and Physical Therapist Assistants – Continuing Education; and Article 20:83, Chapter 20:83:04, Section 20:83:04:03 – Licensed Nutritionists- Continuing Education – Waiver* was ratified by roll call vote (Bjordahl/unanimous).

Mr. Klatt introduced proposed rule *Article 20:83: Chapter 20:83:04, Section 20:83:04:01&02: Licensed Nutritionist – Continuing Education*. A member of the public from Yankton, South Dakota, Karley Briggs, called in to listen to the proceedings for this rule. There were no parties in attendance to offer testimony. No supporting comments were received, no opposing comments were received, and there was no further discussion. A motion: to approve *Article 20:83; Chapter 20:83:04, Section 20:83:04:01&02: Licensed Nutritionist – Continuing Education* was ratified by roll call vote (Bjordahl/unanimous).

Mr. Klatt introduced proposed rule *Article 20:64, Chapter 20:64:02,&04 – Occupational Therapist and Occupational Therapy Assistant – Licensure Requirements, Continuing Competency*. Mr. Klatt informed the Board that the Occupational Therapist Advisory Committee had requested an amendment to *Section 20:64:04:03* to change the phrase “occupational therapist” to “occupational therapist and occupational therapy assistant”. There were no parties in attendance to offer testimony. No supporting comments were received, no opposing comments were received, and there was no further discussion. A motion: to amend *Article 20:64, Chapter 20:64:02,&04* as stated above, and to approve the amended rule was ratified by roll call vote (Landeem/unanimous).

There being no further questions or discussion, the public rules hearing was closed.

3. A motion: to approve the minutes of the December 3, 2015, Board meeting was ratified by roll call vote (Murray/unanimous).
4. A motion: to approve the new licenses, permits, certificates, and registrations issued between December 1, 2015 through February 29, 2016, was ratified by roll call vote (Murray/unanimous).
5. Public Hearings:
 - a. Licensee Beau D. Braun, PA: A motion: to approve his request for discharge from the South Dakota Health Professionals Assistance Program (HPAP) and return his license to an unrestricted status was ratified by roll call vote (Bjordahl/unanimous).
 - b. Leann K. Batiz, CNP: The South Dakota Board of Nursing submitted an Agreed Disposition and Waiver of Hearing for Board consideration. A motion: to approve the Agreed Disposition and to have the President of the Board, Dr. Walter Carlson, sign the final order was ratified by roll call vote (Bjordahl/unanimous).

The petition from Dr. Nathan Long, emergency room physician and medical director for the Rapid City Fire Department, and Jason Culberson, Paramedic, Rapid City Fire Department was reviewed by the Board. The board staff expressed concerns about the possibility of the loss of immunity for paramedics, hospitals, and physicians when a call is deemed non-emergent. Mark East, South Dakota State Medical Association (SDSMA) expressed concerns he has received from other emergency physicians in Rapid City, and the process by which the primary care physicians would be included.

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A motion: that the petitioners:

- a. continue to work with the board staff and the advanced life support (ALS) advisory committee on the protocols and training;
- b. the executive director will issue a temporary approval order for approved training programs and protocols pending final consideration by the full Board at a Board meeting

The motion was ratified by roll call vote (Bowman/unanimous).

The financial report was presented by the executive director. A motion: to instruct staff to discuss the concept of using funds for education with the Department of Health prior to considering legislation was ratified by roll call vote (Landeem/unanimous).

Mr. Klatt presented the Advisory Committee Business. The reports of the advisory committees meetings were accepted for information. A motion: to approve Cara Hamilton, MD, as the new physician member of the Genetic Counselor Advisory Committee to fill the vacancy left by Dr. Steven Benn, and to re-appoint Dr. Laura Keppen-Davis and Kali Smith, GC to a second term on the Genetic Counselor Advisory Committee was ratified by roll call vote (Landeem/unanimous).

Margaret Hansen presented the executive director report. Discussion was held about the process involved to provide testimony during legislative session. A motion: that no Board member may testify on behalf of the Board without first obtaining the Board's approval by majority vote was ratified by roll call vote (Bowman/unanimous). A motion: to accept the executive director report was ratified by roll call vote (Landeem/unanimous).

Confidential Physician Hearings (Closed Session pursuant to SDCL 36-4-31.5 unless privilege is waived by physician)

- a. Dr. James Oury: A motion: to amend the Stipulation for Dr. Oury to require that he successfully complete assessment with the Center for Personalized Education for Physicians (CPEP) program located in Denver, Colorado, as a condition of receiving a conditional South Dakota medical license was ratified by roll call vote (Lust/unanimous). Dr. Carlson and Dr. Rosario were recused from the vote.
- b. Dr. Claude William Evrard Zeifman: A motion: to adopt the Findings of Fact, Conclusions of Law, and enter an order deeming his application as withdrawn under investigation was ratified by roll call vote (Landeem/unanimous).
- c. Dr. Steven C. Myers: A motion: to refer this matter back to board staff to schedule an administrative hearing was ratified by roll call vote (Lust/unanimous). Dr. Landeen was recused from the vote.

The updated mission statement for the Board was presented for review. A motion: to approve the updated mission statement was ratified by roll call vote (Landeem/unanimous).

The draft language for a rule regarding physician supervision of a physician assistant spouse, or other family member in the healthcare field, was presented to the Board for review. The staff was directed to work with other interested parties for input, and then bring the updated language to the Board meeting on June 2, 2016.

The draft language for a rule for medical record documentation when prescribing opioids was presented to the Board for review. The staff was directed to review language used by other states when addressing this issue, add a definition for "chronic pain", look at templates developed by the healthcare systems, get input from stakeholders, and then bring the updated language to the Board meeting on June 2, 2016.

The complaint and investigation docket was reviewed for information.

There being no further business, the meeting adjourned at 2:00 pm.

ⁱ 1-27-1.17. Draft minutes of public meeting to be available--Exceptions--Violation as misdemeanor. The unapproved, draft minutes of any public meeting held pursuant to § 1-25-1 that are required to be kept by law shall be available for inspection by any person within ten business days after the meeting. However, this section does not apply if an audio or video recording of the meeting is available to the public on the governing body's website within five business days after the meeting. A violation of this section is a Class 2 misdemeanor. However, the provisions of this section do not apply to draft minutes of contested case proceedings held in accordance with the provisions of chapter 1-26.

Issued Between March 1, 2016 through May 31, 2016

Advanced EMT: 3

Athletic Trainer: 2

Dietician/Nutritionist: 11

EMT Student Status: 21

Genetic Counselors: 6

Genetic Counselor Temporary: 0

Medical Assistants: 17

Medical Corporations: 2

Medical License (MD/DO): 129: Petition: Rafal Ciecierski, MD – ABMS – Internal Medicine
Petition: Lesley Wood, DO – AOA – Internal Medicine

Nutritionist Temporary Permit: 1

Occupational Therapists: 8

Occupational Therapist Temporary Permit: 0

Occupational Therapy Assistants: 3

Occupational Therapy Assistants Temporary Permit: 0

Paramedics: 15

Physical Therapist Assistants: 12

Physical Therapists: 39

Physician Assistants: 14

Physician Assistant Temporary: 0

Physician Locum Tenens (60-Day Certificates): 32

Resident License: 2

Respiratory Care Practitioners: 8

Respiratory Care Practitioners Temporary Permit: 0

325
Total

Advanced EMT License

Total 3

License Number	Name	Address	Specialty	Issue Date
2030	Sheila Joy Monnier	19061 479th Avenue, Brandt, SD 57218		3/28/2016
2033	Darrell D. West	806 3rd Street, NW, Bowman, ND 58623		4/5/2016
2027	Kimberly Kay Velk	414 Locust Street, Yankton, SD 57078		3/17/2016

Athletic Trainer License

Total 2

License Number	Name	Address	Specialty	Issue Date
0517	Allison Breann DeJong	4044 120th Street, Little Rock, IA 51243		5/24/2016
0516	Seth John Wolles	3601 Lafayette St., Sioux City, IA 51104		3/22/2016

Dietician/Nutritionist License

Total 11

License Number	Name	Address	Specialty	Issue Date
0558	Heather Jean Gerdes	41047 108th Street, Hecla, SD 57446		3/30/2016
0564	Johanna Helene Zivotic	2711 West Omaha Street Apt #4, Rapid City, SD 57702		5/17/2016
0555	Megan Anne Erickson	902 N. 3rd Street, Groton, SD 57445		3/11/2016
0554	Marie Karen Kuchta	5000 S. Macarthur Ln. Apt 212, Sioux Falls, SD 57108		3/4/2016
0562	Samantha Joy Mollica	2856 Beechwood Blvd., Pittsburgh, PA 15217		4/28/2016
0560	Deanna Jo Debruce	511 Berry Street, Conception Junction, MO 64434		4/14/2016
0559	Allison Rose Appletoft	3738 Glen Oaks Blvd. #72, Sioux City, IA 51104		4/11/2016
0553	Kendra Kay Bridgewater	9633 West Center Street, Milwaukee, WI 53222		3/4/2016
0557	Brandee Joy Grenda	11625 S. Kenneth Ave., Alsip, IL 60803		3/28/2016
0561	Mary Elizabeth Jenkins	517 Trotters Place, Franklin, TN 37067		4/15/2016
0556	Stacey Lynn Sadowski	366 Hillview Drive, Winona, MN 55987		3/18/2016

EMT Student Status

Total 21

License Number	Name	Address	Specialty	Issue Date
3737	Koni K Hicks	PO Box 745, Hot Springs, SD 57747		4/20/2016
3731	Mark D. Benton	PO Box 354, Chamberlain, SD 57325		3/17/2016
3730	Nancy J. Martinz	PO Box 847, 1105 Montgomery St. Custer, SD 57730		3/17/2016
3729	Rodney Alan Waddington	923 Crook Street Lot 1, Custer, SD 57730		3/14/2016
3733	Gary Wayne Jackson	841 West B Street, Valentine, NE 69201		3/23/2016
3721	Laura Renee Anderson	402 Harold Street, Wall, SD 57790		3/1/2016
3735	Lori Elayne Balciunas	616 Clay Street, Custer, SD 57730		3/28/2016
3727	Jesse Eugene McHargue	641 Main Street Apt 6, Hill City, SD 57745		3/8/2016
3723	Joseph John Denison	19726 455th Ave, Arlington, SD 57212		3/1/2016
3736	Eric Tyler Tuschen	4204 S. Holbrook Ave., Sioux Falls, SD 57106		4/14/2016
3739	Erin Lee Chowning	255 Stickney Ln, Custer, SD 57730		5/9/2016
3725	Elizabeth Ann Beckett	721 Pluma Drive, Rapid City, SD 57702		3/8/2016
3738	Jacob Richard Beals	4680 Zenker Place, Rapid City, SD 57702		4/22/2016
3726	Cassandra Renee Christy	601 Main Street, Apt. #2, Piedmont, SD 57769		3/8/2016
3740	Monica Michelle Ventura flores	833 Virginia Ln., Rapid City, SD 57701		5/9/2016
3722	Tiffany Marie Boehmer	201 N. Park Street, Parkson, SD 57366		3/1/2016
3728	Katie Marie Vedral	4902 S. Oxbow Ave., #201, Sioux Falls, SD 57106		3/10/2016
3734	Cody Robert Jones	6049 S. Canterbury Pl., Sioux Falls, SD 57106		3/25/2016
3724	Chad Robert Wignes	501 Cheyenne Blvd., Akron, IA 51001		3/4/2016
3732	Ashley Nicole Laman	805 N. Cleveland Ave., Apt. 201, Sioux Falls, SD 57103		3/17/2016
3741	Matthew John Boyce	823 Haines Ave., Rapid City, SD 57701		5/25/2016

Genetic Counselor License

Total 6

License Number	Name	Address	Specialty	Issue Date
0074	Megan Elizabeth Bell	3568 Spencer Blvd, Sioux Falls, SD 57103		3/23/2016
0072	Julianna Nadine Walker	16903 165th Place SE, Renton, WA 95880		3/7/2016
0076	Aishwarya Arjunan	541 W. Oakdale #405, Chicago, IL 60657		5/2/2016
0073	Craig Ryan Adamski	7801 West Lisbon Ave., Milwaukee, WI 53222		3/18/2016
0075	Catherine Flora Terhaar	2900 N. Saddle Ridge Ct. NE, Rockford, MI 49341		4/12/2016
0077	Lara Elizabeth Bagby	1711 Webster Ave., Abington, PA 19001		5/18/2016

Medical Assistant Registration

Total 17

License Number	Name	Address	Specialty	Issue Date
1246	Susannah Janet Elverud	408 Dakota Avenue, Brookings, SD 57006		4/7/2016
1248	Maggie Lorelei Olson	4301 N Alaska Ave, Sioux Falls, SD 57107		5/18/2016
1245	Joan Marie Biever	601 Ottawa St. S., Iroquois, SD 57353		4/7/2016
1239	Stephanie Leann Saucedo	1604 Kellogg Place, Rapid City, SD 57701		3/15/2016
1243	Stephanie Renae Coats	2251 Ohio Ave SW, Huron, SD 57350		3/23/2016
1242	Raven Nicole Wacholz	420 W. 10th Ave., Redfield, SD 57469		3/23/2016
1249	Gayle Elizabeth Dargatz	43232 153rd Street, Webster, SD 57274		5/19/2016
1236	Brooke Ann Kopfmann	1220 W 3rd Avenue, Mitchell, SD 57301		3/1/2016
1250	Chelsea Nicole Keeter	814 N Irene Place, Sioux Falls, SD 57107		5/19/2016
1238	Tiffany Ann Thiry	102 S. Ellis St., White Lake, SD 57383		3/2/2016
1241	Justice Erica Mehlhaff	27940 422 Ave., Olivet, SD 57052		3/23/2016
1237	Erin Kristine McDonald	1075 Naugart Drive, Athens, WI 54411		3/1/2016
1240	Dolly Gene Swearingen	308 E. 1st Street, Colton, SD 57018		3/21/2016
1244	Mikia Marie Henson	322 N. 9th Avenue, Brandon, SD 57005		4/5/2016
1247	Sammi jo Christine Rasmussen	1550 North Shore Dr., McCook Lake, SD 57049		4/14/2016
1252	Laura Anine Warnock	116 Parkview Drive, South Sioux City, IA 68776		5/27/2016
1251	Alexandra Ann Remily	40905 162nd Street, turton, SD 57477		5/25/2016

Medical Corporation Registration

Total 2

License Number	Name	Address	Specialty	Issue Date
0582	M & N Prof., LLC	6901 E Chauncey Lane, Apt 2063, Phoenix, AZ 85054	Internal Medicine (General)	4/1/2016
0583	Melody J Eide, MD, MPH, PC	2820 Mt. Rushmore Road, Rapid City, SD 57701	Dermatology	4/8/2016

Medical License (MD/DO)

Total 129

License Number	Name	Address	Specialty	Issue Date
9891	Maria Victoria Recio restrepo, MD	4210 Munger Ave., Dallas, TX 75204	Neurology	4/8/2016
9911	Rafal Grzegorz Ciecierski, MD * Petition	WA209 Jennie Lee Court, Masone, WI 53049	Neurology	4/19/2016
9877	Michael James Bauer, MD	200 South Wilcox Street #443, Castle Rock, CO 80104	Pathology	4/1/2016
9863	Paul Matthias Scheele, MD	6712 South Wolff Court, Littleton , CO 80123	Pathology	3/22/2016
9826	Ronny Tschokonte, MD	27735 Burnett Hills Lane, Fulshear, TX 77441	Internal Medicine (General)	3/1/2016
9890	Adam Kristopher Graham, MD	791 Briar Ridge Court, Castle Pines, CO 80108	Neurology	4/7/2016
9951	Robert Winthrop Pratt, MD	100 Dexter Street, Denver, CO 80220	Nephrology	5/20/2016
9953	Byron Roderick Spencer, MD	10068 Astoria Court, Lone Tree, CO 80127	Neurology	5/23/2016
9822	Thomas David Kaspari, MD	1351 51st Ave. SW, Hazen, ND 58545	Family Medicine/General Practice	3/1/2016
9858	Anne Miriam Glaser, MD	1555 Rainier Falls Dr. NE, Atlanta, GA 30329	Radiology	3/21/2016
9940	Timothy Mitchell Howard, MD	2902 Davenport Drive SE, Owens Cross Roads, AL 35763	Family Medicine/General Practice	5/17/2016
9853	Slavica Bobic, MD	100 Chatterton Ave Apt#8, White Plains, NY 10606	Internal Medicine (General)	3/17/2016
9892	Naomi Josephine Saenz, MD	2644 Roslyn St., Unit 3, Denver, CO 80238	Radiology	4/8/2016
9883	Wasseem El-Aneed, MD	1077 Hawkins Bend Dr., Fenton, MO 63026	Internal Medicine (General)	4/4/2016
9854	Fisseha Yitbarek Ghidey, MD	4509 Garfield St., Hyattsville , MD 20781	Infectious Diseases	3/17/2016
9869	Robert Stewart Collins, MD	630 Fox Trail, Jasper, TN 37347	Orthopedic Surgery	3/25/2016
9851	Mueen Ghani, DO	528 Sixth Ave., Menlo Park, CA 94025	Pulmonology	3/17/2016
9901	Wobo Bekwelem, MD	3845 Hiawatha Ave., Apt. 504, Minneapolis, MN 55406	Cardiology	4/13/2016
9835	Jeffrey Nolan Harr, MD	10350 Commonwealth St., #3102, Lone Tree, CO 80124	Surgery (General)	3/9/2016
9900	Michael Alan Adams, MD	84280 560th Ave., Norfolk, NE 68701	Family Medicine/General	4/13/2016

			Practice	
9893	Mohamad Moutaz Almawaldi, MD	5120 Hill Road E., Lakeport, CA 95453	Neurology	4/11/2016
9850	Nils Siegfried Erikson, MD	3114 Celebration Way, Longview, TX 75605	Rheumatology	3/17/2016
9884	Blake Charles Gustafson, MD	530 Harlan Blvd., Unit 816, Wilmington, DE 19801	Emergency Medicine	4/4/2016
9868	Constantine Gregory Marousis, MD	502 Pinchot Drive, Ashville, NC 28803	Gastroenterology	3/24/2016
9925	Alejandro Peralta soler, MD	200 Springfield Ave., #6025, Springfield, NJ 07081	Pathology	5/2/2016
9956	Michael Charles Chappell, MD	4924 Hillcrest Ave., Little Rock, AR 72205	Ophthalmology	5/26/2016
9918	Matthew Howard Steele, MD	6705 Whispering Creek Drive, Sioux City, IA 51106	Plastic Surgery	4/25/2016
9887	Sujatha Vuyyuru, MD	1419-B Lake Baldwin Lane, Orlando, FL 32814	Rheumatology	4/7/2016
9881	Jesse Jay Barondeau, MD	325 Keach Ct, Steilacoom, WA 98388	Pediatrics (General)	4/4/2016
9960	Steven Durham Williams, MD	1338 Funston Street, Hollywood, FL 33019	Anesthesiology	5/31/2016
9908	David Robert David, MD	305 Depot Street, Armour, SD 57313	Family Medicine/General Practice	4/18/2016
9830	Amisha Sureshchandra Chhipwadia, MD	3115 Broadmoor Drive, Sugar Land, TX 77478	Family Medicine/General Practice	3/4/2016
9949	Christopher Vincent Fanale, MD	1448 East Maplewood Court, Centennial, CO 80121	Neurology	5/20/2016
9950	Judd Martin Jensen, MD	3006 S Steele Street, Denver, CO 80210	Neurology	5/20/2016
9833	John Alvar Sundin, MD	1801 Wynkoop Street, Unit 418, Denver, CO 80202	Surgery (General)	3/8/2016
9823	Athos John Rassias, MD	14 Carriage Lane, Hanover, NH 03755	Critical Care Medicine	3/1/2016
9820	Catherine Inez Harrington, MD	265 E 100 N, Monticello, UT 84535	Family Medicine/General Practice	3/1/2016
9839	Warren Scott Spencer, MD	1270 Valentine Drive, Dubuque, IA 52003	Radiology	3/10/2016
9825	James Williard Thompson, MD	1570 Cemetery Road, Bronwood, GA 39826	Internal Medicine (General)	3/1/2016
9842	Michael Matthew Hummel, MD	3320 Sandy Beach Road NE, Solon, IA 52333	Radiology	3/10/2016
9899	Tanya Richardson, MD	7138 South Bennett Avenue, Chicago, IL 60649	Family Medicine/General Practice	4/13/2016

9872	Richard Paul Desruisseau, MD	2067 Grays Peak Drive, Unit 202, Loveland, CO 80538	Radiology	3/28/2016
9856	Azhar Hossain, MD	226-15A Union Turnpike, Oakland Gardens, NY 11364	Emergency Medicine	3/21/2016
9879	Rodney Allen Kernes, DO	11995 Singletree Lane, Suite 500, Eden Prairie, MN 55344	Radiology	4/1/2016
9932	Peter Christopher Meyer, MD	80122 Clarkson Lane , Scottsbluff, NE 69361	Family Medicine/General Practice	5/9/2016
9816	John McInnes Henderson, MD	1641 Musgrave Blvd, Room 118 Abilene, TX 79601	Psychiatry	3/1/2016
9874	Shahid Nafees Ahmad, MD	4841 N. Louis River Way, Tucson, AZ 85718	Internal Medicine (General)	3/30/2016
9817	Biagio Vincent Vultaggio, MD	243 Saint Johns Forest Blvd., Jacksonville, FL 32259	Internal Medicine (General)	3/1/2016
9831	David Charles Simon, MD	870 Castlerock Lane, Idaho Falls, ID 83404	Physical Med. & Rehab.	3/4/2016
9827	Joshua Michael McDonald, MD	2448 Dempster Dr., Coralville, IA 52241	Radiology	3/3/2016
9937	Atif Shahzad, MD	110 Deer Crossing Ct., Conroe, TX 77384	Gastroenterology	5/12/2016
9838	Kruti J Patel, MD	1903 Oro Ct, Clearwater, FL 33764	Internal Medicine (General)	3/10/2016
9840	Andrew Louis Sweeny, MD	1934 East 35th Street, Brooklyn, NY 11234	Emergency Medicine	3/10/2016
9909	William Steed VanCise, MD	202 Club Court, Warner Robins, GA 31088	Radiation Oncology	4/18/2016
9829	Robert Jon Gunderson, DO	4709 Clipper Crossing, Edmond, OK 73013	Orthopedic Surgery	3/4/2016
9819	Mitchell Scott Farber, MD	822 Drew Drive, Troy, MI 48098	Surgery (General)	3/1/2016
9886	Molly Kimbrough McAfee, MD	1111 Ridge Ave., Evanston, IL 60202	Thoracic Surgery	4/7/2016
9857	Anjali Ohri, MD	2648 Iolani Street, Makawao, HI 96768	Family Medicine/General Practice	3/21/2016
9836	Richard Arlen Howard, MD	8262 savara Streams Lane, Boynton Beach, FL 33473	Internal Medicine (General)	3/9/2016
9902	Devon Lynn Davis, MD	4079 Fearington Post, Pittsboro, NC 27312	Emergency Medicine	4/13/2016
9828	Paul Scot Wasemiller, MD	8056 182nd Ave SE, Wahpeton, ND 58075	Surgery (General)	3/3/2016
9818	Vinit Bipinkumar Amin, MD	317 East 111th Street, Apt. 4C, New York, NY 10029	Radiology	3/1/2016

9912	Kuang Hsin Kenneth Lo, MD	11927 Oak Shadow Dr., Baton Rouge, LA 70810	Radiation Oncology	4/19/2016
9913	Michael Albert Sedlacek, MD	21709 W. 99th St., Lenexa, KS 66220	Anesthesiology	4/19/2016
9834	Nazir Delawar, MD	2312 W. 300 S., Lafayette, IN 47909	Family Medicine/General Practice	3/8/2016
9843	Stacey Denise Moore-Olufemi, MD	4001 Fannin St., Houston, TX 77004	Surgery (General)	3/11/2016
9852	Patricia Ann Allamon, MD	4059 Lomita Lane, Dallas, TX 75220	Family Medicine/General Practice	3/17/2016
9848	William Glenn Masius, MD	5807 Wingate Way, Concord, NC 28027	Emergency Medicine	3/16/2016
9917	Elizabeth Dokfa Stewart, MD	343 N. Powder Mill Rd., Belleville, IL 62223	Internal Medicine (General)	4/22/2016
9865	Kyon Amiel Hood, MD	5629 Ivy Hill Dr., Fredericksburg, VA 22407	Pediatrics (General)	3/23/2016
9941	James Arthur Kuzman, MD	1962 East Hollywood Ave., Salt Lake City, UT 84108	Hematology & Oncology	5/17/2016
9871	Ashley Renee Sandeen, DO	923 Talwrn Ct., Iowa City, IA 52246	Pediatrics (General)	3/25/2016
9931	Steven Bryan Edson, MD	144 Strawberry Lane, Ashland, OR 97520	Radiology	5/9/2016
9923	Michael James Costello, MD	8720 Bally Bunion Drive, Port St. Lucie, FL 34986	Surgery (General)	4/29/2016
9821	Bradley Dean Kamstra, DO	1115 9th Ave., Rock Valley, IA 51247	Family Medicine/General Practice	3/1/2016
9943	Lawrence William Kaler, MD	4324 County Rd. 3140, Lone Oak, TX 75453	Radiology	5/18/2016
9878	Jason Ray Fought, MD	404 Almarion Drive, Austin, TX 78746	Internal Medicine (General)	4/1/2016
9844	Mary Cathleen Murphy, DO	30112 Highway 12, Sioux City, IA 51109	Occupational Medicine	3/15/2016
9924	Frank Alan Thompson, MD	188 Hidden Lake Road, Warm Springs, GA 31830	Internal Medicine (General)	5/2/2016
9880	Larry Burton Vander Woude, MD	12737 W Auburn Drive, Peoria, AZ 85383	Family Medicine/General Practice	4/1/2016
9832	Aaron Patrick Best, MD	12501 Orba Dr., Austin, TX 78739	Internal Medicine (General)	3/7/2016
9928	Lesley Elizabeth Wood, DO *Petition	3232 S. Newcombe St., Unit 10202, Lakewood, CO 80227	Internal Medicine (General)	5/3/2016
9889	Richard Bruce Evans, MD	27 Fennell Street, Suite B, #302 Skaneateles, NY 13152	Internal Medicine (General)	4/7/2016

9895	Ayham Deeb, MD	113 E. 5th Street, Apt. J, Newport, KY 41071	Internal Medicine (General)	4/11/2016
9882	Fernando Jose Bula Rudas, MD	6680 Bennett Creek Dr., Apt. 932, Jacksonville, FL 32216	Pediatrics (General)	4/4/2016
9961	John Alexander Adams, MD	955 Longtown Road, Lugoff, SC 29078	Internal Medicine (General)	5/31/2016
9955	Gordon Christopher Steinagle, DO	2883 Baseline Rd., Grand Island, NY 14072	Internal Medicine (General)	5/23/2016
9849	Joshua Taylor Silva, MD	2878 Wasatch Blvd., Sandy, UT 84092	Occupational Medicine	3/17/2016
9898	Oleksandr Kachanov, MD	1442 Carol St., Apt. B, Park Ridge, IL 60068	Pediatrics (General)	4/13/2016
9824	Donald Ray Sawdey, DO	25 South Madoc Road, PO Box 928 Scobey, MT 59263	Family Medicine/General Practice	3/1/2016
9897	Roderick Rene Boyd, MD	71 Willow Green Dr., Jackson, TN 38305	Surgery (General)	4/12/2016
9954	John Wellington Robinson, MD	7532 150th St. SE, Snohomish, WA 98296	Family Medicine/General Practice	5/23/2016
9847	Daniel Brennan Vine, MD	4020 S. 2835 E., Salt Lake City, UT 84124	Neurology	3/15/2016
9914	Edgardo Alberto Agrait-Bertran, MD	12743 Ellis Island Dr., Jacksonville, FL 32224	Radiology	4/20/2016
9929	Kristina Anna Behringer, MD	8211 Yarina Way, Cheyenne, WY 82009	Family Medicine/General Practice	5/4/2016
9845	Michael Paul Fee, MD	2607 N. 170th Ave., Omaha, NE 68116	Anesthesiology	3/15/2016
9855	Peter Thomas Olsen, MD	5003 London Road, Apt. #1, Duluth, MN 55804	Family Medicine/General Practice	3/18/2016
9837	Asma Saba Syed, MD	4201 Victory Pkwy., Apt. 915, Cincinnati, OH 45229	Internal Medicine (General)	3/9/2016
9903	Christopher Anthony Ewing, MD	10 Water Street, Ste. 210, Lebanon, NH 03766	Emergency Medicine	4/14/2016
9859	Vincent Everett Boswell, MD	3263 Belmont Glen Drive, Marietta, GA 30067	Orthopedic Surgery	3/21/2016
9942	Matthew Alan Benevich, MD	2811 Del Curto Rd., Unit E, Austin, TX 78704	Internal Medicine (General)	5/18/2016
9916	Neil Mithilesh Kumar, MD	1213 Punjab Drive, Essex, MD 21221	Radiology	4/22/2016
9866	Igor Melnychuk, MD	6 Turtledove Trail, Asheville, NC 28805	Infectious Diseases	3/23/2016
9861	Jason Scott Shapiro, MD	1020 Cove Road, Mamaroneck, NY 10543	Emergency Medicine	3/21/2016
9867	Rafael Francisco Unda rivera, MD	1710 South Shore Drive, Worthington, MN 56187	Obstetrics and	3/23/2016

			Gynecology	
9876	Vincent Cyril Thomas, MD	8200 Dodge Street, Omaha, NE 68114-4113	Pediatrics (General)	3/30/2016
9926	Oscar Vitaliano Bailon, MD	208 South 77th Ave., Yakima, WA 98908	Cardiology	5/2/2016
9885	Richard Patricij Lango, MD	7341 Poston Way, Boulder, CO 80301	Neurology	4/5/2016
9959	Janel Sue Schneider, MD	2702 Fox Grove Drive, Waterford, WI 53185	Neurology	5/26/2016
9862	Jonathan Knuth Smith, MD	5309 Sangamore Road, Bethesda, MD 20816	Neurology	3/21/2016
9873	Jerome Allen Swanson, MD	929 N. Wolfe Street, Unit 422, Baltimore, MD 21205	Radiology	3/28/2016
9888	Maysun Nuha Shahid Ali, DO	1975 19th Street, Apt. 4076, Denver, CO 80202	Neurology	4/7/2016
9841	Kuang Shah Chang, MD	530 Larkwood Drive, San Antonio, TX 78209	Hematology & Oncology	3/10/2016
9860	Thomas Philip Kennedy, MD	829 S. Shore Dr., Madison, WI 53715	Radiology	3/21/2016
9896	Andrew Dean Van Osdol, MD	2115 7th St. S., La Crosse, WI 54601	Surgery (General)	4/11/2016
9894	Kevin Edward Cahill, MD	PO Box 2419, Truckee, CA 96161	Surgery (General)	4/11/2016
9875	Lary Joseph Bocquin, MD		Internal Medicine (General)	3/30/2016
9958	Travis James Menge, MD	300 E. Lionshead Circle, Unit 407, Vail, CO 81657	Orthopedic Surgery	5/26/2016
9870	Ray Byron Jensen, DO	8639 Bluff Springs Dr. NE, Albuquerque, NM 87113	Orthopedic Surgery	3/25/2016
9846	Kenji Mark Hamanaka, MD	1211 S. Monticello Ct., Sioux Falls, SD 57106	Emergency Medicine	3/15/2016
9904	Annamaria Ruziev, MD	25 Ridge Ave., Lebanon, PA 17042	Internal Medicine (General)	4/14/2016
9915	Shavkat Rakhmatovich Ruziev, MD	25 Ridge Ave., Lebanon, PA 17042	Internal Medicine (General)	4/20/2016
9947	Toshiko Oikawa Luckow, MD	997 Vaughn St., Aurora, CO 80011	Family Medicine/General Practice	5/19/2016
9957	Kevin James McQuaid, MD	#5 Bridle Path, Longview, TX 75605	Pathology	5/26/2016
9930	Matthew John Denti, DO	790 W. Pine Street, Wytherville, VA 24382	Obstetrics and Gynecology	5/6/2016
9936	Catherine Ebinimi Mamah, MD	1525 9th Ave., Apt. #1707, Seattle, WA 98101	Neurology	5/12/2016
9944	Rene Johnykutty, MD	25 Chadwick Manor, Fairport, NY 14450	Internal Medicine	5/18/2016

9948	Vinod K. Seth, MD	1250 W. Highland Acres Rd., Bismarck, ND 58501	(General) Infectious Diseases	5/19/2016
9933	Venkata S. Dandamudi, MD	1609 Banbridge Ct., Bakersfield, CA 93311	Neurology	5/11/2016

Nutritionist Temporary Permit

Total 1

License Number	Name	Address	Specialty	Issue Date
0563	Kristin Noel Torgerson	615 N 39th St Apt 305C, Grand Forks, ND 58203		5/17/2016

Occupational Therapist License

Total 8

License Number	Name	Address	Specialty	Issue Date
1003	Kristene Renee Brown	4949 Country Club Boulevard, Sioux City, IA 51104		4/18/2016
1005	Gail Christine Waecker	1731 N. Dover Ln., Arlington Heights, IL 60004		4/28/2016
0998	Melissa Florence Brissette	11622 West Bradshaw Mtn Court, Surprise, AZ 85378		3/1/2016
0999	Maggie Louise Brown	20499 Waterford Rd., Fredericktown, OH 43019		3/1/2016
1001	Amanda Elaine Miller	2412 S. Maple, Sioux City, IA 51106		3/22/2016
1000	Michele Dawn Pearson	54 River Grove, Sanford, Manitoba, ROG 2J0		3/15/2016
1004	Jennifer Karen Harpster	62 Road 315, Glendive, MT 59330		4/26/2016
1002	Lizette Cloete	313 Hillside Drive, Greer, SC 29651		4/15/2016

Occupational Therapy Assistant License

Total 3

License Number	Name	Address	Specialty	Issue Date
356A	Traci Lynn Whittecar	3622 Walker Falls Ln, Fulshear, TX 77441		4/22/2016
354A	Emily Marie Kay	24 1st Ave. SW, Warner, SD 57479		3/17/2016
355A	Craig Allan Robbins	1532 Like Oak Street, Sulphur Springs, TX 75482		4/4/2016

Paramedic License

Total 15

License Number	Name	Address	Specialty	Issue Date
2031	Kelli Ann Craven	210 Washabaugh Ave, PO Box 341 Wanblee, SD 57577		3/30/2016
2032	Robert Eugene McNally	4404 S Cliff Ave, Sioux Falls, SD 57103		4/5/2016
2041	Drew Edward Vanvoorhis	1212 E Keystone Place, #33, Brandon, SD 57007		5/17/2016
2028	Jeremy Hamad Aleck	500 Willow Street, Harrisburg, SD 57032		3/18/2016
2037	Brian Dudley McCoy	496 Wallingford Circle, Myrtle Beach, SC 29588		4/22/2016
2038	Leanna Mae Gubbels	708 Cedar Ave., Laurel, NE 68745		5/11/2016
2040	Jacob Richard Keller	4814 Pleasonton Road, El Paso, TX 79906		5/12/2016
2029	Kendra Susan Schamber	209 South Walnut, Freeman, SD 57029		3/21/2016
2024	Benjamin Martin McKee	126 Ponderosa Avenue, Hill City, SD 57745		3/4/2016
2026	Jeffrey William Cook	1107 Elmhurst Ave, Luverne, MN 56156		3/9/2016
2025	Charles Michael Wilkins	9092 W Arden Lane, Bellemont, AZ 86015		3/9/2016
2036	Josh Dean Sneller	1785 Rathermel Dr., Fort Dodge, IA 50501		4/20/2016
2039	Brian David Hatch	6383 Kremmling Cir., Colorado Springs, CO 80919		5/12/2016
2034	Clinton Edmund Dudas	11912 Mesquite Miel Dr., El Paso, TX 79934		4/7/2016
2035	Daniel Chapman Prendable	805 Capitol Street, Yankton, SD 57078		4/8/2016

Physical Therapist Assistant Certificate

Total 12

License Number	Name	Address	Specialty	Issue Date
0464	Patty Jo Considine	2435 Mohawk Dr, Sioux City, IA 51104		5/5/2016
0471	Chelsey Anne Streich	102 13th St. NE, Apt. 4, Watertown, SD 57201		5/18/2016
0468	Mitchell Ryan Demers	410 W. 8th St., Winner, SD 57580		5/14/2016
0462	Brooke Elizabeth Tellinghuisen	1217 Morningside Ave., Apt. A, Sioux City, IA 51106		3/21/2016
0473	Tarah Leigh Anson	5509 W. 23rd St., Sioux Falls, SD 57106		5/31/2016
0469	Cortney Francis Petersen	24104 395th Ave., Letcher, SD 57359		5/14/2016
0466	Branden Thomas Schultz	764 Grace St. North, Ortonville, MN 56278		5/14/2016
0467	Kassandra Jai Schreiber	3197 Redwood Ave., Slayton, MN 56172		5/14/2016
0463	Samantha Jo Dressen	2276 120th Ave., Russell, MN 56169		5/3/2016
0472	Lexi Rae Halvorson	115 Walnut St., PO Box 42 Avon, SD 57315		5/20/2016
0470	Kelli Jo Tilbury	1745 250th St., Madison, MN 56256		5/17/2016
0465	Kacia Mary Kollman	26812 174th Ave., Glenwood, MN 56334		5/14/2016

Physical Therapist License

Total 39

License Number	Name	Address	Specialty	Issue Date
1903	Matthew Alvin Bosma	28536 390th Avenue, Armour, SD 57313		5/6/2016
1902	Paul Brian Bindert	43442 204th St., De Smet, SD 57231		5/7/2016
1916	Carey Eileen Daunt	25444 Moonlight Dr., Edgemont, SD 57735		5/14/2016
1904	Lori Agnes Hixson	940 Wynstone Rd., Jefferson, SD 57038		5/7/2016
1910	Andrea Rae Joy	610 17th Ave. NE, Aberdeen, SD 57401		5/7/2016
1892	Justin Insun Kim	13355 Choctaw Trail, Homer Glen, IL 60491		4/25/2016
1891	Shari Lyn Kim	13355 Choctaw Trail, Homer Glen, IL 60491		4/22/2016
1893	Brock Leron Bills	6021 W. Winterberry Cir., Sioux Falls, SD 57106		5/7/2016
1921	Ashley Kay Bernhardt			5/17/2016
1914	Gungeet Kaur	712 1/2 13th Avenue, Apt B, Brookings, SD 57006		5/11/2016
1913	Morgan Ann Blasius	307 Linden Lane, Aurora, SD 57002		5/14/2016
1897	Kayla Marie Wagner	35817 193rd St., Miller, SD 57362		5/5/2016
1887	Jamie Sue McMurtrey	7508 Max Court, Cheyenne, WY 82009		3/2/2016
1898	Trever Lee Wagner			5/5/2016
1895	Bryan James Olson	101 Civic Center Dr. NE, Apt 329, Rochester, MN 55906		5/28/2016
1894	Eric Jordan Fjeldheim	13018 Nebraska Ct., Kansas City, KS 66109		5/8/2016
1906	Emily Rose Divine	8990 West Branched Oak Rd., Raymond, NE 68428		5/7/2016
1911	Alissa Ann Minnaert	45827 241st St., Madison, SD 57042		5/7/2016
1900	Whitney Brooke Ebke	2364 County Road F, Hooper, NE 68031		5/7/2016
1925	Megan Janean McCormick	932 Onaka Trail #4, Brookings, SD 57006		5/25/2016
1917	Byram Joseph Nash	38547 125th St., Aberdeen, SD 57401		5/27/2016
1901	Tory Lynn Brouwer	10060 80th St. SE, Maynard, MN 56260		5/7/2016

1908	Cade Edward Kling	11473 Us Hwy 212, Belle Fourche, SD 57717	5/7/2016
1907	Caitlin Elysse Vance	4800 E. 54th St., Apt. 307, Sioux Falls, SD 57110	5/7/2016
1899	Laura Rose Barber	20363 Elm Springs Road, Enning, SD 57737	5/6/2016
1922	Nicole Jacqueline Koskovich	7700 W. Boulder Creek Place, Unit 16, Sioux Falls, SD 57106	5/17/2016
1915	Jed Simbajon Magtanong	1800 16th St. NW, Apt. 4, Minot, ND 58703	5/12/2016
1890	Adam Patrick Martin	742 N. Dundee Dr., Post Falls, ID 83854	4/14/2016
1909	Andrew Richard Menigoz	461 Garfield Street, Centerville, SD 57014	5/7/2016
1905	Jenna Alaine Stroup	2900 E. 51st Street, Sioux Falls, SD 57103	5/7/2016
1896	Emily Theresa Rausch	602 Dilger Ave., Rapid City, SD 57701	5/7/2016
1912	Jillissa Eileen Richey	1406 14th Street Place, Hawarden, IA 51023	5/7/2016
1888	Tara Lynne Domkowski	522 North Ash St., Ainsworth, NE 69210	3/7/2016
1889	Shek-Hung Keith Liao	11549 Center Lake Drive, Windermere, FL 34786	3/9/2016
1919	Mallory Michelle Hertz	912 Westview Drive, Apt. #300, Rock Valley, IA 51247	5/13/2016
1924	Jana Deanne Walker	104 Hickory Hill Place, Brandon, MS 39042	5/24/2016
1920	Melissa Erin Konold	3626 Piedmont Ave., Apt. 2, Duluth, MN 55811	5/13/2016
1923	Tyler Scott Turbak	1618 7th Street NE, Watertown, SD 57201	5/20/2016
1918	Ryan John Buchholz	500 Aspen Ave, Bismarck, ND 58503	5/13/2016

Physician Assistant License

Total 14

License Number	Name	Address	Specialty	Issue Date
1027	Richard Enniss Hanson	19416 Cade Ct., Edmond, OK 73012		3/9/2016
1038	Whitney Lavell Stull	18150 Highway 220, Casper, WY 82604		5/24/2016
1030	Timothy James Aylward	831 Saint James St., Rapid City, SD 57701		3/22/2016
1032	Karen Marie Schleiger	702 Valley Road, Yankton, SD 57078		4/8/2016
1040	Jenna Sommer Truckenbrod	964 Fawn Parkway, Omaha, NE 68154		5/27/2016
1037	Joel Alan Kraayenbrink	2821 S. Skyline, Unit 158, Mesa, AZ 85212		5/4/2016
1031	Spencer Todd Mason	127 S. Cherry St., Valentine, NE 69201		3/30/2016
1029	Andrew Richard Stowell	8280 E. 10th Street, Winona, MN 55987		3/11/2016
1028	Jordan Charles Hickman	3310 Wesson Road, Rapid City, SD 57703		3/10/2016
1036	Sandra Lee Muyskens	716 5th Avenue, Sheldon, IA 51201		5/2/2016
1035	Laurie Ann Giacoletto	976 E. Lodgepole Drive, Gilbert, AZ 85298		5/2/2016
1033	Diana Carmen Soare	117 Yukon Place, Apt. 26, Spearfish, SD 57783		4/12/2016
1034	Michael David Westerbuhr	120 Melano Street, Rapid City, SD 57701		4/12/2016
1039	Gregory David Larson	47690 223rd St., Flandreau, SD 57028		5/26/2016

Physician Locum Tenens

Total 32

License Number	Name	Address	Specialty	Issue Date
1578	Emily Marie Lampe, MD	550 S Grant Street, Denver, CO 80209	Neurology	4/8/2016
1583	Robert Winthrop Pratt, MD	100 Dexter Street, Denver, CO 80220	Nephrology	4/11/2016
1579	Byron Roderick Spencer, MD	10068 Astoria Court, Lone Tree, CO 80127	Neurology	4/8/2016
1580	Jeffrey Charles Wagner, MD	640 S Gaylord Street, Denver, CO 80209	Neurology	4/8/2016
1581	Russell Edward Bartt, MD	1235 S. Gaylord St., Denver, CO 80210	Neurology	4/8/2016
1573	Mueen Ghani, DO	528 Sixth Ave., Menlo Park, CA 94025	Pulmonology	3/14/2016
1568	Jeffrey Nolan Harr, MD	10350 Commonwealth St., #3102, Lone Tree, CO 80124	Surgery (General)	4/14/2016
1590	Ramtin Thomas Ramsey, MD	7349 E. Woodsage Lane, Scottsdale, AZ 85258	Internal Medicine (General)	5/18/2016
1596	Jim Zhengbin Lu, MD	23855 Barnswallow Lane, Wauconda, IL 60084	Pathology	5/19/2016
1571	David Robert David, MD	305 Depot Street, Armour, SD 57313	Family Medicine/General Practice	3/8/2016
1582	Christopher Vincent Fanale, MD	1448 East Maplewood Court, Centennial, CO 80121	Neurology	4/11/2016
1557	John Anthony Engler, MD	1400 Granby St., Unit 411 Norfolk, VA 23510	Neurological Surgery	3/22/2016
1560	Mitchell Scott Farber, MD	822 Drew Drive, Troy, MI 48098	Surgery (General)	3/25/2016
1562	Kuang Hsin Kenneth Lo, MD	11927 Oak Shadow Dr., Baton Rouge, LA 70810	Radiation Oncology	3/1/2016
1564	Michael James Costello, MD	8720 Bally Bunion Drive, Port St. Lucie, FL 34986	Surgery (General)	3/1/2016
1576	Carlos Frederico Rodriguez, MD	2349 E. Becker Ln., Phoenix, AZ 85028	Dermatology	4/15/2016
1567	Jessica Niewodowski, DO	120 Westlake Avenue North, Apt. 823, Seattle, WA 98109	Surgery (General)	3/15/2016
1574	Teresa Virginia Durbin, MD	2274 East 1975 North, Layton, UT 84040	Obstetrics and Gynecology	4/18/2016
1570	Lesley Elizabeth Wood, DO	3232 S. Newcombe St., Unit 10202, Lakewood, CO 80227	Internal Medicine (General)	3/21/2016
1569	Richard Bruce Evans, MD	27 Fennell Street, Suite B, #302 Skaneateles, NY 13152	Internal Medicine (General)	3/22/2016

1575	Roderick Rene Boyd, MD	71 Willow Green Dr., Jackson, TN 38305	Surgery (General)	3/22/2016
1572	Ainsley Busha Freshour, MD	412 Kittredge Ct., Knoxville, TN 37934	Surgery (General)	3/1/2016
1586	Oscar Vitaliano Bailon, MD	208 South 77th Ave., Yakima, WA 98908	Cardiology	5/1/2016
1577	Jaime Andres Nicacio, MD	2520 NE 163rd Court, Vancouver, WA 98684	Physical Med. & Rehab.	4/14/2016
1584	Andrew Lee Matthews, MD	19402 Laurel Glen Avenue, Cornelius, NC 28031	Emergency Medicine	5/27/2016
1592	Vunghi Hoang, MD	PO Box 2363, Elk Grove, CA 95759	Internal Medicine (General)	5/19/2016
1591	Thomas Henry Reif, MD	6131 Ingalls Street, Melbourne, FL 32940	Internal Medicine (General)	5/4/2016
1602	Francisco Lorenzo Padron, MD	15713 S. W. 46th Terrace, Miami, FL 33185	Internal Medicine (General)	5/9/2016
1588	Colin Adrian Meghoo, MD	2218 South 46th Street, Fort Smith, AR 72903	Surgery (General)	5/3/2016
1587	Manish Jain, MD	12674 Moonseed Drive, Carmel, IN 46032	Internal Medicine (General)	4/27/2016
1593	Rene Johnykutty, MD	25 Chadwick Manor, Fairport, NY 14450	Internal Medicine (General)	5/9/2016
1595	Hossein Ghofrani, MD	1725 Butler Ave, Apt 302, Los Angeles, CA 90025	Nephrology	5/5/2016

Resident License

Total 2

License Number	Name	Address	Specialty	Issue Date
0278	Bernardo Curi Mendes	410 6th Avenue SW, C3, Rochester, MN 55902	Vascular Surgery	4/26/2016
283	Kalyan Wagle	16410 84th Ave., Apt. 1L, Jamaica, NY 11432	Cardiology	4/29/2016

Respiratory Care Practitioner License

Total 8

License Number	Name	Address	Specialty	Issue Date
1099	Matthew David Anderson			4/22/2016
1089	Steven Grant Mortensen	11614 Crooked Oak Drive, Live Oak, TX 78233		4/19/2016
1101	Thompson Marin	111 E 7th Street Apt 407, Sioux Falls, SD 57104		5/19/2016
1104	Whitney Marie Oehlerts	5419 W 57th Street # 2, Sioux Falls, SD 57106		5/25/2016
1102	Michael Tyler Newsom	6041 Springfield Road, Rapid City, SD 57703		5/20/2016
1103	Justin Lawrence Erichsen	401 Clover Leaf Ave., Hartford, SD 57033		5/24/2016
1088	Mariana Florencia Gallardo	305 E. 33rd St., South Sioux City, NE 68776		3/11/2016
1100	Jessica Jeaninne Danko	24543 345th Ave., Chamberlain, SD 57325		5/9/2016

EXECUTIVE SUMMARY FINANCIAL REPORT

TO: THE BOARD OF MEDICAL AND OSTEOPATHIC EXMINERS
FROM: MARGARET B HANSEN
DATE: MAY 6, 2016

1. The Board has three different locations of cash on hand (page 2)

- Petty Cash, Local Checking, and State Treasury Fund

	FY16	FY15	FY14
	04/30/2016	06/30/2015	06/30/2014
Total Cash	3,063,164	2,972,287	2,656,838

2. Upcoming Anticipated Expenses (page 3)

- Total anticipated expenses.

	FY16
Total Anticipated Expenses	2,236,548

3. Revenue (page 5)

- Total revenue for licensing, services, and other sources by line detail on the report.

	FY16	FY15	FY14
	04/30/2016	06/30/2015	06/30/2014
Total Revenue	1,205,928.43	1,307,603.35	1,256,516.60

4. Income Statement – review of expense variances (Pages 6 – 7)

		FY16	FY16	FY15	FY15
		Budgeted	04/30/2016	Budgeted	06/30/2015
4-A	5203040 – Air-State Owned – Instate • Use of a state owned plane for meetings	16,000	912	16,000	7,372
4-B	5203100 - Lodging Out-Of-State • Hotel expenses for in state meetings or training attended	500	3,321	500	3,977
4-C	5204160 – Workshop Registration Fee • Registration fee for meetings or training attended	2,000	838	2,000	4,656
4-D	5204530 - Telecommunication Services • Board Member Laptop wireless • Background Reports e.g.	3,000	7,745	3,000	10,185
4-E	5205020 – Office Supplies • Supplies for daily tasks in the office	10,000	2,940	10,000	2,560
4-F	5205320 - Duplication – Private • Printed pages from leased printers • Licensure Cards ordered	300	5,253	300	6,046

5. Income Statement – Total Expenses - (page 7)

Shows total expenses and budget comparison.

	FY16	FY16	FY15	FY15	FY14	FY14
	Budgeted	04/30/2016	Budgeted	06/30/2015	Budgeted	06/30/2014
Total Expenses	1,025,703	1,008,371	1,011,493	992,155	988,618	924,257

6. Income Statement - Net Income - (page 7)

Shows earnings measured by taking total revenue and minus expenses.

	FY16	FY16	FY15	FY15	FY14	FY14
	Budgeted	04/30/2016	Budgeted	06/30/2015	Budgeted	06/30/2014
Net Income	233,797	197,558	174,257	315,639	210,382	332,261

7. Other Contractual Services Breakdown by service description (page 8)

	FY16	FY15	FY14
	04/30/2016	06/30/2015	06/30/2014
Total Other Contractual Services	41,123	36,751	60,868

SDBMOE Financial Report

05/09/2016

for

07/01/15 - 04/30/16

Page	Report Name
2	Balance Sheet (Cash Only)
3	Upcoming Anticipated Expenses
4	Revenue Summary
6	Income Statement
8	Other Contractual Services

SDBMOE
Balance Sheet (Cash Only)

Date Range: July 1, 2015 -April 30, 2016

	FY16 04/30/2016	FY15 06/30/2015	FY14 06/30/2014	FY13 06/30/2013	FY12 06/30/2012	FY11 06/30/2011
Cash						
Petty Cash	100	100	100	100	100	100
Local Checking	2,449	2,034	3,598	2,930	4,223	4,712
State Treasury Fund	3,060,615	2,970,153	2,653,139	2,300,852	1,810,978	1,370,641
1. Total Cash	3,063,164	2,972,287	2,656,838	2,303,882	1,815,301	1,375,452

SDBMOE

Upcoming Anticipated Expenses

Expense Items:	Anticipated Amount:
Operating Expense Budget (with Salaries and Benefits)	\$ 1,025,703
Technology Update:	
Update Database - rework and implantation	\$ 400,000
Technical Support for Board Members Technology	\$ 12,000
Training Expenses (outside of budgeted amount in Operating Expenses)	
Investigator Training	\$ 2,345
Licensing Staff Training and Professional Certification	\$ 3,000
Attorney Training	\$ 2,500
Policy Training	\$ 1,000
Sending 4 Board Members to the annual FSMB Meeting	\$ 10,000
HPAP yearly support costs - projections for this year	\$ 200,000
Scanning paper files to an electronic format	\$ 10,000
Lawsuit reserve fund (for 3 large cases)	\$ 370,000
Compact Licensing Funding	\$ 200,000
2. Total Anticipated Expenses	\$ 2,236,548

SDBMOE
Revenue by Item Summary

Date Range: July 1, 2015 - April 30, 2016

Type	07/01/15 - 4/30/16 Amount	07/01/14 - 06/30/15 Amount	07/01/13 - 06/30/14 Amount
Licenses			
Athletic Trainer Application	\$ 2,900.00	\$ 3,400.00	\$ 3,000.00
Athletic Trainer Reinstatement	\$ -	\$ -	\$ -
Athletic Trainer Renewal	\$ 550.00	\$ 11,350.00	\$ 9,500.00
Advanced EMT for Instate Graduate	\$ 850.00	\$ 1,400.00	\$ 850.00
Advanced EMT for out of state Graduate	\$ 300.00	\$ 300.00	\$ 225.00
Advanced EMT Renewal	\$ 300.00	\$ 1,550.00	\$ 800.00
Advanced EMT Reinstatement	\$ 50.00	\$ 50.00	\$ -
ALS-I 85 Application for Instate Graduate	\$ 50.00	\$ 50.00	\$ -
ALS-I 85 Application for Out of State Graduate	\$ -	\$ 150.00	\$ 75.00
ALS-I 85 Renewal	\$ 600.00	\$ 3,850.00	\$ 3,625.00
ALS-I 99 Application for Instate Graduate	\$ -	\$ -	\$ -
ALS-I 99 Application for Out of State graduate	\$ -	\$ -	\$ -
ALS-I 99 Renewal	\$ 50.00	\$ 250.00	\$ 225.00
ALS-I 99 Reinstatement	\$ -	\$ -	\$ -
ALS-I85 Reinstatement	\$ -	\$ 100.00	\$ 450.00
ALS-Paramedic Application for Instate graduate	\$ 1,400.00	\$ 1,300.00	\$ 1,850.00
ALS-Paramedic Application for Out of State Graduate	\$ 3,750.00	\$ 6,350.00	\$ 5,250.00
ALS-Paramedic Renewal	\$ 3,100.00	\$ 15,625.00	\$ 11,100.00
ALS-Paramedic Reinstatement	\$ 450.00	\$ 500.00	\$ 600.00
Genetic Counselor Temporary Application	\$ -	\$ 200.00	\$ 200.00
Genetic Counselor Application	\$ 5,800.00	\$ 3,800.00	\$ 1,600.00
Genetic Counselor Renewal	\$ 100.00	\$ 3,100.00	\$ 1,900.00
Licensed Nutritionist Application	\$ 3,150.00	\$ 1,610.00	\$ 1,750.00
Licensed Nutritionist Renewal	\$ 425.00	\$ 10,710.00	\$ 10,395.00
Temporary License Nutritionist Application	\$ 100.00	\$ 400.00	\$ 250.00
Licensed Nutritionist Reinstatement	\$ 200.00	\$ 300.00	\$ -
Locum Tenens Application	\$ 5,200.00	\$ 2,850.00	\$ 2,550.00
MD/DO Application	\$ 72,800.00	\$ 67,600.00	\$ 74,600.00
MD/DO Reinstatement	\$ 5,800.00	\$ 9,200.00	\$ 6,600.00
MD/DO-Renewals	\$ 773,200.00	\$ 746,600.00	\$ 729,400.00
Medical Assistant Application	\$ 640.00	\$ 840.00	\$ 1,000.00
Medical Assistant Renewal	\$ 2,760.00	\$ 20.00	\$ 2,720.00
Medical Assistant Reinstatement	\$ 205.00	\$ 40.00	\$ 300.00
Medical Corp Application	\$ 100.00	\$ 650.00	\$ 550.00
Medical Corp Reinstatement	\$ 1,050.00	\$ 700.00	\$ 1,000.00
Medical Corp Renewal	\$ 14,300.00	\$ 15,900.00	\$ 15,900.00
Occupational Therapist Application	\$ 1,700.00	\$ 1,750.00	\$ 1,950.00
Occupational Therapist Reinstatement	\$ 75.00	\$ 75.00	\$ 50.00
Occupational Therapy Assistant Application	\$ 1,000.00	\$ 1,050.00	\$ 850.00
Occupational Therapist Renewal	\$ 23,350.00	\$ 21,200.00	\$ 22,000.00
Occupational Therapy Assistant Reinstatement	\$ 50.00	\$ -	\$ -
Occupational Therapy Assistant Renewal	\$ 8,050.00	\$ 7,200.00	\$ 7,150.00
Occupational Therapist Limited Permit	\$ -	\$ 25.00	\$ 125.00
Occupational Therapy Assistant Limited License	\$ -	\$ 25.00	\$ 75.00
Physical Therapist Application	\$ 3,780.00	\$ 5,040.00	\$ 3,900.00
Physical Therapist Renewal	\$ 47,900.00	\$ 44,800.00	\$ 43,900.00
Physical Therapist Reinstatement	\$ 150.00	\$ 600.00	\$ 150.00
Physical Therapist Assistant Application	\$ 2,280.00	\$ 2,880.00	\$ 1,980.00
Physical Therapist Assistant Renewal	\$ 14,000.00	\$ 12,050.00	\$ 12,050.00
Physical Therapist Assistant Reinstatement	\$ 100.00	\$ -	\$ 50.00
Physician Assistant Corporation Application	\$ 100.00	\$ -	\$ -
Physician Assistant Corporation Renewal	\$ 300.00	\$ 200.00	\$ 200.00
Physician Assistant Corporation Reinstatement	\$ 50.00	\$ -	\$ -
Physician Assistant Application	\$ 3,975.00	\$ 3,900.00	\$ 4,425.00
Physician Assistant Temporary Permit	\$ -	\$ -	\$ 50.00
Physician Assistant Reinstatement	\$ -	\$ 75.00	\$ 125.00
Physician Assistant Renewal	\$ 42,300.00	\$ 55,700.00	\$ 52,900.00
Resident License Application	\$ 2,300.00	\$ 3,300.00	\$ 3,800.00
Resident License Renewal	\$ -	\$ 6,500.00	\$ 3,650.00
Respiratory Care Practitioner Application	\$ 2,550.00	\$ 2,175.00	\$ 3,225.00
Respiratory Care Temporary Application	\$ 720.00	\$ 520.00	\$ 520.00
Respiratory Care Practitioner Renewal	\$ 60.00	\$ 27,000.00	\$ 60.00
Respiratory Care Practitioner Reinstatement	\$ 95.00	\$ 190.00	\$ 95.00
NSF Check Board Fine	\$ -	\$ -	\$ -
USMLE Testing	\$ -	\$ -	\$ 3,150.00
Other Income	\$ -	\$ 190.00	\$ -
Total Licenses	\$ 1,055,065.00	\$ 1,107,190.00	\$ 1,054,695.00

SDBMOE
Revenue by Item Summary

Date Range: July 1, 2015 - April 30, 2016

		07/01/15 - 4/30/16 Amount		07/01/14 - 06/30/15 Amount		07/01/13 - 06/30/14 Amount	
Other							
Interest Income	\$	12,229.46	\$	24,236.35	\$	30,177.73	
Fines & Penalties	\$	-	\$	-	\$	-	
Total Services	\$	12,229.46	\$	24,236.35	\$	30,177.73	
Services							
Information Request	\$	-	\$	30.00	\$	30.00	
Online Verifications	\$	100,096.00	\$	128,857.00	\$	118,256.00	
Written Verifications	\$	38,048.00	\$	46,620.00	\$	47,940.00	
Duplicate License Card	\$	490.00	\$	670.00	\$	1,020.00	
Candian Service Fee (Skype Fee Charge)	\$	-	\$	-	\$	(2.13)	
Mailing List					\$	4,400.00	
Total Services	\$	138,634.00	\$	176,177.00	\$	171,643.87	
Total	3.	\$	1,205,928.46	\$	1,307,603.35	\$	1,256,516.60

SDBMOE
Income Statement

Date Range: July 1, 2015 - April 30, 2016

	FY16 Budgeted	FY16 04/30/2016	% of Budget FY16	FY15 Budgeted	FY15 06/30/2015	% of Budget FY15	FY14 Budgeted	FY14 06/30/2014
Ordinary Income/Expense								
Income								
License Fee Revenue	1,089,000	1,055,065	97%	1,010,000	1,107,190	110%	1,012,000	1,054,695
Fines, Penalties, and other	0	0	0%	0	190	0%	0	0
Sales and Service Revenue	150,500	138,634	92%	150,750	176,177	117%	152,000	171,646
Total Income	1,239,500	1,193,699	96%	1,160,750	1,283,557	111%	1,164,000	1,226,341
Gross Profit								
	1,239,500	1,193,699	96%	1,160,750	1,283,557	111%	1,164,000	1,226,341
5101000 - Employee Salaries	300,801	292,013	97%	288,154	326,321	113%	277,412	308,612
5101030 - Board & Community Member Fees	3,418	2,040	60%	3,275	1,620	49%	3,154	2,520
5102010 - OASI	27,812	21,320	77%	26,392	23,656	90%	24,207	22,796
5102020 - Retirement	16,133	17,516	109%	16,133	19,332	120%	16,133	18,472
5102060 - Health Insurance	60,790	46,612	77%	60,790	65,024	107%	50,963	70,193
5102080 - Worker's Compensation	889	380	43%	889	261	29%	889	216
5102090 - Unemployment Insurance	42	97	230%	42	147	350%	42	99
5201030 - Board Member Per Diem	0	0	0%	0	0	0%	0	0
5203010 - Auto - State owned - Instate	0	407		0	396		0	423
5203030 - Auto - Private - Low Rate	0	477		0	988		0	423
5203030 - Auto - Private - High Rate	2,000	577	29%	2,000	278	14%	2,000	1,412
4-A 5203040 - Air-State owned-Instate	16,000	912	6%	16,000	7,372	46%	16,000	8,473
5203060 - Air-Commercial Carrier Instate	0	0		0	5,565		0	582
5203070 - Air Travel - Charter Flights	30,000	10,325	34%	30,000	0	0%	30,000	3,750
5203100 - Lodging In-State	2,000	676	34%	2,000	323	16%	2,000	697
5203120 - Incidentals-Travel Instate	50	10	20%	50	72	144%	50	56
5203130 - Nonemployee Travel	0	1,078		0	491		0	8,827
5203140 - Taxable Meals	0	122		0	27		0	20
5203150 - Non-taxable meals In-state	600	281	47%	600	405	68%	600	353
5203230 - Auto - Private Out-of-state - High Rate	0	171		0	0		0	0
5203260 - Air-Commercial Out-of-state	1,100	4,474	407%	1,100	1,876	171%	1,100	1,795
5203280 - Other Public Out-of-state	100	275	275%	100	260	260%	100	150
4-B 5203300 - Lodging Out-Of-State	500	3,321	664%	500	3,977	795%	500	3,653
5203320 - Incidentals - Out of State	0	235		0	25		0	50
5203350 - Out of State Meals	0	998		0	640		0	436
5204010 - Subscriptions	1,000	406	41%	1,000	90	9%	1,000	270
5204020 - Membership Dues	6,000	3,900	65%	6,000	4,425	74%	6,000	4,171
5204030 - Legal Document Fees	0	0		0	0		0	10
5204050 - Computer Consultant	0	124,550		0	47,970		0	70,980
5204080 - Legal Counsel	198,000	97,851	49%	198,000	78,008	39%	198,000	37,188
5204090 - Management Consultant	0	174,242		0	173,333		0	22,655
5204100 - Consultant Fees-Medical	13,500	12,600	93%	13,500	1,500	11%	13,500	1,750
5204110 - PR & Advertising Consultant	0	4,850		0	0		0	0
5204130 - Other Consulting	0	8,738		0	9,692		0	8,820
4-C 5204160 - Workshop Registration Fees	2,000	838	42%	2,000	4,656	233%	2,000	3,280
5204180 - State Computer Services	9,359	15,753	168%	9,359	17,810	190%	9,359	15,734
5204181 - BIT Development Costs	0	0		0	155		0	12
5204190 - Private Computer Services	0	0		0	0		0	0
5204200 - Central Services	3,531	4,217	119%	3,531	5,772	163%	3,531	3,709
5204202 - Property Management	0	16		0	307		0	317
5204203 - Purchasing Central Services	0	28		0	420		0	488
5204204 - Records Management	0	96		0	112		0	131
5204207 - Human Resource Services	0	3,453		0	3,931		0	3,454
5204220 - Equipment Maintenance	0	262		0	1,670		0	35,201
5204230 - Janitorial	0	0		0	0		0	0
5204250 - Cable TV (Office Internet)	0	745		0	830		0	695
5204320 - Audit Services - Private	5,500	0	0%	5,500	0	0%	5,500	0
5204340 - Computer Software Maint.	0	29		0	0		0	0
5204350 - Advertising - Magazines	0	4,675		0	2,750		0	2,750
5204360 - Advertising Newspapers	500	359	72%	500	1,255	251%	500	207
5204400 - Advertising Internet	500	0	0%	500	294	59%	500	0
5204460 - Equipment Rental	2,000	736	37%	2,000	960	48%	2,000	1,040
5204490 - Rents - Other	0	0		0	0		0	791
5204510 - Rents - Lease	83,000	68,382	82%	83,000	82,058	99%	83,000	51,160
4-D 5204530 - Telecommunication Services	3,000	7,745	258%	3,000	10,185	339%	3,000	15,418
5204550 - Garbage and Sewer	0	1,020		0	1,118		0	1,610
5204580 - Truck-Drayage & Freight	0	3,043		0	2,095		0	857
5204590 - Professional Liability Insurance	20,000	1,216	6%	20,000	2,394	12%	20,000	2,400
5204620 - Taxes and License Fees	0	956		0	911		0	995
5204730 - Maintenance Contract	1,000	0	0%	1,000	0	0%	1,000	0
5204740 - Bank Charges	24,192	0	0%	24,192	0	0%	24,192	78
5204960 - Other Contractual Services	151,986	41,123	27%	151,986	43,306	28%	172,986	50,800
4-E 5205020 - Office Supplies	10,000	2,940	29%	10,000	2,560	26%	10,000	1,912
5205290 - Flags	0	0		0	209		0	0
5205040 - Educational & Instructional Sup	0	0		0	0		0	275
5205310 - State-Printing	0	0		0	0		0	0
4-F 5205320 - Duplication - Private	300	5,253	1751%	300	6,046	2015%	300	1,142
5205340 - Supp. Public & Ref Material	0	22		0	185		0	0
5205350 - Postage	11,000	11,204	102%	11,000	15,171	138%	11,000	11,557
5205390 - Food Stuffs	100	0	0%	100	0	0%	100	280
5207121 - Building Improvement & Remodel	0	0		0	0		0	800
5207451 - Office Furniture & Fixtures	0	0		0	1,194		0	37,742
5207495 - Telephone Equipment	10,000	0	0%	10,000	76	1%	10,000	13,138
5207531 - Household Appliances	0	0		0	0		0	875
5207675 - Audio Visual Equipment	0	167		0	4,217		0	61,152
5207791 - Police and Security Equipment	0	0		0	0		0	0
5207901 - Computer Hardware (BIT)	0	2,420		0	5,175		0	3,468
5207905 - Computer systems	6,000	0	0%	6,000	0	0%	6,000	0
5207960 - Computer Software	0	0		0	0		0	0
5207961 - Computer Software (BIT)	1,000	0	0%	1,000	0	0%	1,000	1,089
5207980 - Depreciation Expense - Computer	0	0		0	0		0	0
5207965 - Software State Contract	0	0		0	0		0	0
5208080 - Prior Year Revenue Refund	0	0		0	0		0	0
5208210 - Interest on Late Vendor Payment	0	221		0	260		0	275
Total Expense	5,	1,025,703	98%	1,011,493	992,155	98%	988,618	924,257
Net Ordinary Income	213,797	185,328	87%	149,257	291,402	195%	175,382	302,084
Other Income/Expense								
Other Income								
4491000 - Interest Income	20,000	12,229	61%	25,000	24,236	97%	35,000	30,178
Total Other Income	20,000	12,229	61%	25,000	24,236	97%	35,000	30,178
Net Other Income	20,000	12,229	61%	25,000	24,236	97%	35,000	30,178
Net Income	6,	233,797	84%	174,257	315,639	181%	210,382	332,261

SDBMOE

Other Contractual Services

Date Range: July 1, 2015 - April 30, 2016

Description	FY16 04/30/2016	FY15 06/30/2015	FY14 06/30/2014
Other Contractual Services			
Health Practitioners Assistance - HPAP	\$ -	\$ -	\$ 28,295
SDBON - CNP, CNM Co-regulation	\$ -	\$ -	\$ -
Investigator Contractor	\$ -	\$ -	\$ -
Investigations Expenses	\$ 6,736	\$ 4,625	\$ 1,521
Temporary Employment Services	\$ -	\$ -	\$ -
Other State Verifications	\$ -	\$ -	\$ -
Shredding	\$ -	\$ -	\$ -
Goods and Services	\$ -	\$ -	\$ -
Background Reports	\$ -	\$ -	\$ -
BD member Expenses	\$ 427	\$ 441	\$ 172
Board Meeting Audio	\$ -	\$ -	\$ -
Other	\$ 33,960	\$ 31,684	\$ 30,881
7. Total Other Contractual Services	\$ 41,123	\$ 36,751	\$ 60,868

Clint Perman has been a certified physician assistant since 2002 when he graduated from the University of North Dakota School of Medicine and Health Sciences. He is currently employed for Avera Medical Group. He staffs and is the sole provider for a rural clinic in Selby, SD. He also provides locum coverage at Eureka Hospital and Bowdle Hospital. Prior to his current position in Selby he worked full-time as a PA in Bowdle, staffing a Rural Health Clinic, a critical access hospital, a 24 hour emergency room, and a 26 bed nursing home/assisted living facility. Prior to his position at Bowdle, he worked as a PA for Mobridge Regional Hospital.

He was also appointed by Governor Michael Rounds to the South Dakota Commission on Health Care, serving as the only PA on the Health Care Commission. He was also appointment to the sub-committee that was instrumental in the development and implementation of South Dakota Prescription Drug Monitoring Program. In 2009, Clint served as a Delegate for the South Dakota Academy of Physician Assistants and represented SD as a delegate at the National Physician Assistant Conference in San Diego

Prior to becoming a Physician Assistant, Clint served for 6 years in the United States Army Reserves as an officer for the 311 Evac Hospital and the 4226 US Army Hospital in Bismarck, ND. He was also employed as the Director of Nursing at Beverly Healthcare in Mobridge, an operating room nurse for 8 years in Bismarck, ND, a travel nurse for 1 year in California, and worked at West River Regional Health Center in Hettinger, ND for 1 year. Prior to his nursing degree, he also received a certificate in Surgical Technology at Presentation College.

Outside of his professional career, Clint enjoys golfing, hunting, and spending time with his wife, Brenda, and three children.

Clint Perman PA-C

PO Box 57 – Selby, SD 57472
Phone (605) 649-7684 – Home
848-1085 – Cell

clint.perman@avera.org

An experienced Physician Assistant specializing in Family Practice. Providing care for Pediatrics to Geriatrics, Acute and Chronic Illnesses, Internal Medicine, Men's and Women's Health. I am also experienced in Emergency Room Services, Hospital and Nursing Home Services. Excellent communication skills and cross cultural skills.

PROFESSIONAL EMPLOYMENT

Physician Assistant – April 2011 – Present

- Family Practice, free standing community clinic
- AVERA MEDICAL GROUP – Selby, SD

Physician Assistant – April 2016 – Present

- Locums – ER Coverage
- EUREKA HOSPITAL – Eureka, SD

Physician Assistant – February 2003 – Present

- Locums – Family Practice, rural health clinic, ER Coverage, Hospital and Nursing Home Services/Rounds
- BOWDLE HEALTH CARE – Bowdle, SD

Physician Assistant April 2003 – Present

- Locums – ER Coverage
- MOBRIDGE REGIONAL HOSPITAL – Mobridge, SD

Physician Assistant – March 2002 – February 2003

- Family Practice, ER Coverage
- MOBRIDGE REGIONAL HOSPITAL – Mobridge, SD

Physician Assistant Student – January 2001 – January 2002

- UND SCHOOL OF MEDICINE – Grand Forks, ND

Director of Nursing 1999 – 2001

- BEVERLY HEALTH CARE – Mobridge, SD

Operating Room Nurse – 1991 – 1999

- MEDCENTER ONE – Bismarck, ND

Operating Room Nurse – 1992 – 1998

- 4226 US ARMY HOSPITAL, US ARMY RESERVES – Bismarck, ND

Operating Room Nurse – 1990 – 1991

- TRAVEL NURSING STAR MED STAFFING – Tampa Bay, FL

Operating Room Nurse – 1989 – 1991

- WEST RIVER REGIONAL MEDICAL CENTER – Hettinger, ND

MEDICAL EDUCATION

Physician Assistant – January 2001 – January 2002

- UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE AND HEALTH SCIENCES – Grand Forks, ND

Nursing – August 1985 – May 1989

- PRESENTATION COLLEGE – Aberdeen, SD

Surgical Technology – August 1984 – May 1985

- PRESENTATION COLLEGE – Aberdeen, SD

PROFESSIONAL ACTIVITIES

Delegate

- South Dakota Academy of Physician Assistants

South Dakota Commission on Health Care

- 3 year term, appointed by Governor Michael Rounds
- Only PA to serve on Governors Health Care Commission
- Instrumental in development of Prescription Drug Monitoring Program

AFFILIATED ASSOCIATIONS

AAPA (American Academy of Physician Assistants)

SDAPA (South Dakota Association of Physician Assistants)

NDAPA (North Dakota Association of Physician Assistants)

PROFESSIONAL QUALIFICATIONS

National Commission of Certification of Physician Assistants

- Certified Physician Assistant

South Dakota Board of Medical and Osteopathic Examiners

- Licensed Physician Assistant

American Heart Association

- ACLS – ATLS – PALS

REFERENCES

Available Upon Request

Advanced Life Support Committee met on May 25, 2016

1. Discussed progress on Mobile Medic petition from Rapid City
2. Reviewed petition from Yankton County EMS
3. Discussed how to add an AEMT to the committee

Athletic Trainer Committee met on May 5, 2016

1. Continued review of administrative rules
2. Updated members on current and remaining committee terms

Genetic Counselor Committee met on May 5, 2016

1. Introduced Dr. Cara Hamilton as the newest committee member
2. Reviewed orientation material to familiarize new member with the committee
3. Discussed the recommended language for the continuing education rule

Nutrition and Dietetics Committee met on May 10, 2016

1. Updated on the rules approved by the Interim Rules Review Committee
2. Began discussions on auditing the licensees to ensure compliance with continuing education
3. An audit plan will be reviewed at the next committee meeting

Occupational Therapy Committee met on May 9, 2016

1. Updated on the rules approved by the Interim Rules Review Committee
2. Reviewed and provided feedback on questions from licensees
3. Discussed members whose terms are up for renewal this year
4. Began discussions on auditing the licensees to ensure compliance with continuing education

Physical Therapy Committee met on May 17, 2016

1. Reviewed statutes that are over 30 years old for relevance
2. Discussed the role the FSBPT model practice act may play in revising the practice act
3. Agreed that working with the SDPTA will be important as this process continues

Physician Assistant Committee met on May 25, 2016

1. Discussed new member
2. Reviewed 90 day supervision rule
3. Reviewed the new draft of the spouse supervision rule

Respiratory Therapy Committee met on May 26, 2016

1. Updated on committee terms and upcoming reappointments
2. Discussed the impact of the memo sent to SDSRC
3. Continued discussion on medical directors

TO: SDBMOE BOARD MEMBERS
FROM: TYLER KLATT
SUBJECT: ALS PETITION FOR AEMT SCOPE OF PRACTICE – YANKTON COUNTY EMS
DATE: JUNE 2, 2016
CC:

BACKGROUND INFORMATION

- **Petitioners:** Yankton County EMS Medical Director Scott Hiltunen, MD and Yankton County EMS Paramedic Administrator Steve Hawkins, NRP
- **Additional skills requested:**
 - Diphenhydramine (IV) for allergic reactions and long rural travel times,
 - Zofran (ondansetron) (IV) for nausea and vomiting,
 - Epinephrine 1:10,000 (IV/IO) as directed for pulseless cardiac arrest per ACLS protocols.
- AEMT's whose scope will be increased:
 - Jean Scherschligt, AEMT License #1049
 - Michael Slowey, AEMT License #1964
 - Kim Velk, AEMT License #2027
- **Staff review:** The staff has researched this proposal and finds that with the proposed training plan the listed AEMT's will:
 - receive appropriate education and training
 - be able to demonstrate competency prior to performing the procedures under medical direction
 - receive continuing education and training on a regular basis to maintain competency
- **Advisory Committee Review:** The Board's ALS advisory committee reviewed the petition from Yankton County EMS. The committee provided feedback primarily that the petition mirrored the Vermillion petition and concurred with staff opinion that there were no concerns regarding this petition.

PREVIOUS PETITIONS

- **December 2015:** Vermillion/Clay County EMS petitioned to approve the following procedures:
 - Use intraosseous (IO) devices for adult therapy after failed intravenous attempts
 - Use positive pressure ventilator (CPAP)
 - Administration of the following medications:
 - Flumazenil (IV) for benzodiazepine overdoses
 - Diphenhydramine (IV) for allergic reactions and long rural travel times
 - Zofran (PO and IV) for nausea and vomiting
 - Epinephrine 1:10,000 (IV/IO) for cardiac arrest as directed by ACLS protocols
- **December 2015:** The skills requested by Vermillion/Clay County EMS were amended and approved by the Board
- The underlined skills above were approved by the board, without amendment. These are the same skills requested by Yankton County EMS



805 Capitol Street
Yankton, S.D. 57078
Phone: (605) 668-9033
Fax: (605) 668-0585



Petition to the South Dakota Board of Medical and Osteopathic Examiners (SDBMOE)

Yankton County Emergency Medical Services Medical Director Scott Hiltunen M.D. of Yankton, South Dakota, a physician practicing internal medicine at Avera McGreevy Clinic in Sioux Falls, and Steve Hawkins NRP, of Yankton, the Paramedic Administrator of Yankton County EMS, do hereby petition the South Dakota Board of Medical and Osteopathic Examiners for their decision in regard to the following:

1. Yankton County EMS is a Paramedic ambulance service that provides a full-time paramedic on the 1st crew and a full-time paramedic on the 2nd crew. Paramedics on the first two crews are partnered with an EMT, Advanced EMT or part-time paramedic, depending on part-time staff availability. Any staff needed beyond the first and second crew is paged on an as-available basis. We are requesting approval for Yankton County EMS Advanced Emergency Medical Technicians (AEMT) Jean Scherschligt, Mike Slowey and Kim Velk (SDCL 36-4B-16.2) to administer additional medications and perform additional skills to be granted and further approved by the Board.
2. The facts and circumstances which give rise to the petition or request to be decided by the Board are as follows:

The petitioners are the active medical director and the ambulance administrator for Yankton County EMS. The petitioners oversee all ambulance staff employed at Yankton County EMS.

The Emergency Medical Services Department under the National Highway Traffic Safety Administration developed the National Emergency Medical Services Standards in 2009. The current standards allow jurisdictions to allow the use of certain medications specific to their area. We recognize the deciding jurisdiction in the State of South Dakota as the South Dakota Board of Medical and Osteopathic Examiners¹.

- A. The Advanced Emergency Medical Technician Scope of Practice² allows for pediatric intraosseous (IO) infusions of medications and fluids for shock therapy. The scope does not allow for the AEMT to utilize an IO for adult therapy after failed intravenous attempts. Adult IO therapy is becoming the preferred method in resuscitation when vascular access cannot be obtained. Several peer-reviewed studies^{3,4,5,6} have been conducted proving the benefits of IO therapy in the pre-hospital setting. We are petitioning the board to approve AEMT to utilize IO devices for adult therapy in emergent situations, per our current protocol.
- B. Medications currently provided by the AEMT Scope of Practice² include: albuterol, nitroglycerin, epinephrine 1:1,000, aspirin, glucagon, dextrose 50%, naloxone, glucose, and oxygen. Medication delivery techniques taught in the National Highway Transportation

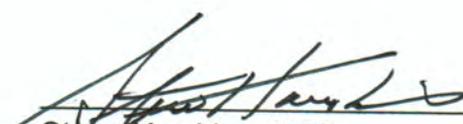
subcutaneous, intranasal, sublingual, and oral delivery. We are requesting the following nonscheduled controlled medications to be added for use by Advanced Emergency Medical Technicians: diphenhydramine (IV) for allergic reactions and long rural travel times, Zofran (ondansetron) (IV) for nausea and vomiting, and epinephrine 1:10,000 (IV/IO) as directed for pulseless cardiac arrest per ACLS protocols.

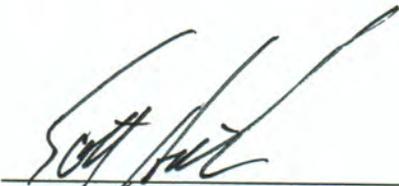
C. An education plan is attached to this petition.

3. The precise petition or request to be decided by the Board is as follows:

We request a decision by the Board to approve the aforementioned full or partial list of petitioned skills and administration of medications by Advanced Emergency Medical Technicians (SDCL 36-4B-16.2).

Dated at Yankton, South Dakota, this 27 day of May, 2016.


Steve Hawkins, NRP
Yankton County EMS Administrator


Scott Hiltunen, M.D.
Yankton County EMS Medical Director

References:

1. National Emergency Medical Services Standards in 2009, US Department of Transportation, National Highway Traffic Safety Administration, DOT HS 811 077A, January 2009.
2. National EMS Scope of Practice Model, from the National Highway Traffic Safety Administration.
3. Seigler, R., Tecklenburg, F., Shealy, R. (1989). Prehospital intraosseous infusion by emergency medical services personnel: A prospective study. *Pediatrics* 84(1), 173-177.
4. Lewis, F. (1986). Pre-hospital intravenous fluid therapy: Physiologic computer modeling. *Journal of Trauma* 26(9), 808-811.
5. Miner, W., Corneli, H., Bolte, R., et al. Pre-hospital use of intraosseous infusion by paramedics. *Pediatric Emergency Care* 5(1), 5-7, 1989.
6. LaRocco, B., Wang, H. (2003). Intraosseous infusion. *Pre-hospital Emergency Care* 7(2), 280-285.

Education Plan:

All currently certified Advanced Emergency Medical Technicians (AEMT) at Yankton County EMS will receive five (5) hours of additional training before they begin practicing additional skills. Training will be broken down as follows:

Adult IO procedures: 1.5 hours

Medications

Diphenhydramine: 1.5 hours

Ondanestron: 1 hour

Epinephrine 1:10,000: 1 hour

These employees would also be required to attend an Advanced Cardiac Life Support (ACLS) course as well as a Pediatric Advanced Life Support (PALS) course.

The proposed additional skills would be added to the monthly training topics on an annual basis to ensure competencies for the provider permitted to conduct advanced level skills. Proposed medications will be reviewed and AEMT's will be trained on an annual basis. Any AEMT not demonstrating proficiency will be remanded for a didactic review and clinical practice. Proficiency will be evaluated during the peer-reviewed committees and annual training.

PROTOCOL 9.####: Paramedic Mobile Medic-Assessment

The Paramedic Mobile Medic will need to provide a patient assessment that covers many body system areas in order to develop a field impression. The information received in the patient assessment will then be relayed to a physician for the physician's medical opinion to determine a proper patient disposition.

ASSESSMENT

If at any time the information gathered during the assessment is abnormal, the Paramedic Mobile Medic shall immediately call for an ambulance.

- A. Physical Findings - note the patient's general appearance, posture, any guarding or protective movements
 - a. Chief Complaint
 - b. Determine level of consciousness using the Glasgow Coma Score and the patient's verbal response to the AVPU mnemonic
 - c. Airway
 - i. Assess the patient's airway for patency, and any condition that may lead to loss of patency such as bleeding, emesis, edema, or trauma
 - d. Breathing
 - i. Determine the rate, depth, pattern, and effort of breathing.
 - ii. Assess patient's neck for JVD
 - iii. Assess the chest wall for symmetrical movement noting use of accessory muscles/diaphragmatic breathing
 - iv. Auscultate lungs in four fields for adventitious sounds such as wheezes, rales, or rhonchi
 - e. Circulation
 - i. Palpate the radial pulse noting the rate and strength
 - ii. Listen to heart tones. Note if S1 S2 are clear
 - iii. Assess the patient's skin color, temperature, and condition
 - Check the soft tissue and skin for deformity, contusions, abrasions, punctures, burns, tenderness, lacerations and swelling (DCAP-BTLS) and rash, irritation or breakdown
 - f. Vitals
 - i. Obtain a complete set of vitals
 - 1. B/P
 - 2. Pulse including SpO2
 - 3. Respiratory Rate
 - 4. Blood Glucose level

5. GCS

6. Temperature (oral/rectal)

- g. HEENT- Head Eyes Ears Nose Throat
 - i. Assess for Facial Symmetry
 - ii. Assess pupils and make sure they are equal round reactive to light
 - iii. Assess for masses, lesions, tenderness, pain or discharge from the eyes or ears
 - iv. Assess nose for DCAP-BTLS
 - v. Assess oral mucosa (moist and intact, able to swallow)
 - vi. Trachea midline, no harsh sounds or stridor
- h. Chest and back
 - i. Assess for DCAP-BTLS
- i. Abdomen
 - i. Assess the abdomen for DCAP-BTLS
 - ii. Note if the abdomen is distended, rigid, or painful
 - iii. Ask the patient about any recent abdominal disturbances such as nausea, vomiting, diarrhea, constipation, ability to pass flatus
 - iv. Auscultate bowel sounds
 - v. Inquire about last bowel movement (when, what was the consistency and color, continent of stool)
 - vi. Assess for bladder issues (pain with urination, color, odor, continent of urine)
- j. Extremities
 - i. Assess extremities for DCAP-BTLS and edema
 - ii. Palpate for warmth, tenderness, presence of pulses
 - iii. Note if any weakness or contractures
 - iv. Assess range of motion
 - v. Use of assistive devices (crutches, cane, walker, wheelchair)

B. History Findings

- a. Current chief complaint
 - a. O – onset of the complaint
 - b. P- Provocation. What makes the condition worse? Better?
 - c. Q- Quality. Have the patient describe the quality of the pain. Sharp? Dull? Throbbing? Burning?
 - d. R- Radiation. Does the pain radiate anywhere?
 - e. S- Severity. Have the patient describe the pain on the 10 scale.
 - f. T – Time of onset. How long has this been going on and what is worse now compared to before?
- b. Patient Past Medical History
 - a. Age

- b. What are the patient's other medical conditions?
- c. Any recent surgeries?
- d. Does the patient have allergies to medications or other substances (such as latex)?
- e. What Medications are you taking?
 - Prescribed
 - OTC
 - Herbal
 - Illegal
- f. Do you drink alcohol? How much per week or day?
- g. Do you smoke tobacco? Do you smoke any other substances and if you do, what are those?
- h. Are you pregnant? When was your LMP?

Following the patient assessment, contact the physician to communicate the assessment physical and history findings to receive the physician's medical opinion. The physician shall give the physician's medical opinion as to whether ambulance transport is necessary or not necessary. The Paramedic Mobile Medic shall relay the physician's medical opinion to the patient. The patient shall have the final decision as to whether or not to follow the physician's medical opinion. The complete patient assessment, the physician's medical opinion and the patient decision shall be documented in the patient's record.



RAPID CITY FIRE DEPARTMENT

EMS ACADEMY



Paramedic Mobile Medic Care Course Syllabus (16 hours)

Course No:

Date:

Days/Time: TBD

Classroom: RCFD Classroom

Instructor: Nathan Long, MD and Christopher Jolley, BS, NRP, CCEMTP, other faculty PRN

Phone: 605-415-3373

Email: chris.jolley@rcgov.org

Office Hours: M-F, 08:00am-05:00pm

Course Description:

This course provides students with the principles of responding to low acuity (card 26) calls. To provide an understanding of the role the Paramedic Mobile Medic has in the community and the greater healthcare system. Training includes low acuity patient assessment (protocol 9), communication of the assessment findings to the physician, relaying the physician's medical opinion to the patient, and appropriate documentation of the patient assessment and physician's medical opinion.

Prerequisite:

Rapid City Fire Department Paramedic in good standing

Student Learning Outcomes:

- Describe the characteristics and components of low acuity (card 26) calls
- Explain the roles, responsibilities, and characteristics of the Paramedic Mobile Medic
- Select behaviors that promote EMS workforce safety and wellness
- Apply principles of public health in your role as a Paramedic Mobile Medic
- Perform low acuity patient assessment (protocol 9) and relay findings to the physician
- Apply paramedic ethical principles to your work as a Paramedic Mobile Medic
- Use technology and knowledge of EMS communications systems to communicate effectively in carrying out your responsibilities as a Paramedic Mobile Medic
- Create complete, well-written reports of the patient encounter to include the assessment and physician's medical opinion

Teaching-Learning Methods:

Teaching-learning methods in this course may include, but are not limited to, assigned readings, presentations, discussion, critical thinking exercises, labs, and class activities. Evaluation procedures include quizzes, written examinations, and assignments.

Course Completion Requirements:

Successful completion of this course requires adherence to course policies, maintaining a course average of 80% percent with a minimum score of 80% on each in-class examination, a minimum score of 85% on the course final examination, and successfully demonstrating all required skills.

Course Attendance Policy:

Student attendance is required at all scheduled classes. Students may be dropped from the course for excessive absences of any kind.

If a student misses any class, student is responsible for any missed quizzes, examinations, and material covered in that class session. Prompt arrival is expected at all class activities. It is the student's responsibility to sign in on the attendance roster.

Comportment:

Students are expected to conduct themselves in accordance with the professional expectations for paramedics at all times. Students are reminded that they are representatives of the RCFD whenever and wherever they are involved with course-related activities. Professional conduct is essential to a successful course experience and EMS career.

Dress and Appearance:

Uniform as prescribed by the RCFD while on clinical rotations. Casual during classroom hours.

Academic Dishonesty:

Academic dishonesty in any form will not be tolerated and is grounds for immediate dismissal from the program and other administrative action taken by the program. Examples include, but are not limited to:

- Cheating in any form
- Falsification or forgery of academic documents, applications, clinical evaluations, lab evaluations, etc.
- Plagiarism (including copying and pasting of electronic text into assigned work)

Course Schedule

Date	Chapter	Assignments, Tests, Quizzes
Day 1:	Course Introduction and Overview Roles and responsibilities of the Paramedic Mobile Medic Technology and knowledge of EMS communication systems	
Day 2:	Assessment of the low acuity patient (protocol 9), communication with the physician Relay the physician's medical opinion to the patient Documentation of your patient encounter, including the patient assessment and physician's medical opinion	



RAPID CITY FIRE DEPARTMENT

EMS ACADEMY



Paramedic Mobile Medic Clinical Course Syllabus

Course No:
Semester:
Date:
Days/Time: Clinical times vary per personal schedules

Instructor: Nathan Long, MD
Phone: 605-755-8222
Email: nlong@regionalhealth.com
Office Hours: By appointment

Course Descriptions:

ER Clinical (40 hrs) – This clinical rotation includes observation hours to include rotations in the emergency room to become proficient with patient assessments on the low acuity patient. Focus will be placed on proper assessment and documentation of assessment findings and physician’s medical opinion. The clinical will take place on the emergent care side of the emergency room.

Prerequisite:

Paramedic in the Rapid City Fire Department, acceptance into Paramedic Mobile Medic program; Paramedic Mobile Medic Care course.

Textbook:

None.

Required Materials:

Class uniform, ID badge

Student Learning Outcomes:

- Utilize techniques taught to date
- Assess patients with low acuity (card 26) complaints
- Communicate protocol 9 assessment findings to physician
- Communicate the physician medical opinion to the patient

Teaching-Learning Methods:

- Students will be working under an assigned preceptor at clinical site.
- Students must arrive at the Scheduled Clinical Site 15 minutes early.

- Students need to follow the South Dakota paramedic scope of practice and RCFD protocol 9.
- At the end of shift, complete the required paper work, give to your preceptor (preferably an hour prior to leaving) so there is adequate time for them to evaluate and write it down.
- In class clinical evaluation will consist of case reviews, going over procedures used in current clinical setting and paperwork turned in to staff.

Course Completion Requirements:

Successful completion of this course requires adherence to course policies and successfully completing all of the assigned clinical hours.

Course Attendance Policy:

Student attendance is required at all scheduled clinicals, including class evaluation times. Students may be dropped from the course for excessive absences of any kind.

The course instructor may grant excused absences for extenuating circumstances. If three or more absences occur for any reason, the status of the student will be reviewed by the faculty to determine a disposition. Course failure is likely under these circumstances.

If a student misses any clinical, they must be made up in order to successfully complete the course.

Compartment:

Students are expected to conduct themselves in accordance with the professional expectations for paramedics at all times. Students are reminded that they are representatives of the Rapid City Fire Department whenever and wherever they are involved with course-related activities. Professional conduct is essential to a successful course experience and EMS career.

Dress and Appearance:

Uniform as prescribed by the RCFD while on clinical rotations. Casual during classroom hours.

Academic Dishonesty:

Academic dishonesty in any form will not be tolerated and is grounds for immediate dismissal from the program and other administrative action taken by the program. Examples include, but are not limited to:

- Cheating in any form
- Falsification or forgery of academic documents, applications, clinical evaluations, lab evaluations, etc.
- Plagiarism (including copying and pasting of electronic text into assigned work)

Course Grading and Grading Scale:

This course is a Pass or Fail.

Clinical Schedule:

Clinical times vary per personal schedules.

STATE OF SOUTH DAKOTA
DEPARTMENT OF HEALTH
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

In Re:

Rapid City Fire Department

TEMPORARY APPROVAL ORDER

Paramedic Mobile Medic Program

WHEREAS, the Rapid City Fire Department submitted a petition requesting approval of a paramedic mobile medic program, and

WHEREAS, the paramedic mobile medic is being authorized by the South Dakota Board of Medical and Osteopathic Examiners to perform an assessment, communicate the assessment findings to the physician for a medical opinion, and then relay the physician's medical opinion to the patient. The patient will make the final decision regarding transport. The paramedic mobile medic shall only communicate the physician's medical opinion to the patient. The paramedic mobile medic training program will ensure that the mobile medic is proficient at performing the protocol 9 assessment, and

WHEREAS, a paramedic who has successfully completed the mobile medic training program may be dispatched as a single unit to low acuity (card 26) calls in a vehicle that is not an ambulance, and is not authorized for patient transport, and perform the duties that are set forth in the scope of practice for paramedics (SDCL 36-4B) and RCFD protocol 9. This shall include providing a low acuity assessment that will allow a physician to provide a medical opinion to the patient about whether the patient needs immediate ambulance transport, or if ambulance transport can be deferred, and

WHEREAS, the paramedic mobile medic shall share the medical opinion from the physician with the patient. The patient then makes the decision about whether to be transported to the hospital or to decline ambulance transportation. Once the physician's medical opinion determines that an ambulance transport is unnecessary, the mobile medic shall cease providing care to the patient; however, if the patient disagrees with the physician's medical opinion and wants to be transported by ambulance, the mobile medic will call for the ambulance and continue to provide care to the patient until the ambulance arrives, and

WHEREAS, the RCFD will provide to the Board the requested faculty, preceptors, examination, and required skills information regarding the Paramedic Mobile Medic program prior to taking dispatch calls. At the end of each month, the RCFD will provide copies of any and all documents associated with each call that the paramedic mobile medic has attended to the board office for at least one year after they start to take dispatch calls, and

WHEREAS, the executive director of the South Dakota Board of Medical and Osteopathic Examiners is authorized by the Board to enter this temporary approval order pending review by the full Board, and

WHEREAS, this matter will be presented to the full Board for consideration at the next Board meeting.

For this reason, said paramedic mobile medic program is temporarily approved pending consideration by the full Board at the next Board meeting.

By: Margaret B. Hansen Date: May 11, 2016
Margaret B. Hansen, Executive Director

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INDEX TO WITNESSES

Direct Cross Redirect Recross

FOR THE BOARD:

MISTY RALLIS

By Mr. Golden: 4

Board rests: 8

INDEX TO EXHIBITS

BOARD EXHIBITS

NUMBER	DESCRIPTION	MARKED	OFFERED	RULED ON
1	License renewal application.	4	7	7
2	07/20/15 SDBMOE letter to Hasart.	4	7	7
3	08/02/15 Hasart letter to SDBMOE.	4	7	7
4	11/28/12 SDBMOE Final Order.	4	7	7
5	SD Unified Judicial System Record Search Report.	4	7	7
6	02/03/16 Hasart letter to SDBMOE.	4	7	7

Original transcript and exhibits provided to the South Dakota Board of Medical and Osteopathic Examiners.

1 (Board Exhibit Numbers 1 through 6, inclusive, marked
2 for identification.)

3 HEARING EXAMINER FRIEBERG: We will go on the record.
4 This is in the matter of Curt Hasart, EMT/Paramedic,
5 Board of Medical and Osteopathic Examiners File Number
6 16-10. It is 1:25 on Friday, February 12, 2016. The
7 board is present and appearing by counsel, William
8 Golden. Mr. Hasart is not present.

9 I would begin by asking Mr. Golden have you been in
10 contact with or had any discussions with Mr. Hasart prior
11 to the hearing that is scheduled for today?

12 MR. GOLDEN: Mr. Hasart had sent an email to the
13 board staff, I believe we have marked it as Exhibit 6,
14 and had requested that his license be surrendered at this
15 time. It would be our intention to continue with the
16 hearing as a matter of default.

17 The petitions that are filed by the board staff set
18 forth the provisions that if the applicant or licensee
19 does not attend that there may be a default proceedings.
20 It would be our intent to offer the exhibits in this
21 matter to support the record for the request.

22 At this point in time we would be making the request
23 that he would be under the conditions that his license --
24 or that he would need to sign up and be evaluated by the
25 Health Assistance Program, Health Professionals

1 Assistance Program, HPAP. We would also ask at that time
2 for the hearing examiner to take his request into account
3 in these proceedings.

4 HEARING EXAMINER FRIEBERG: Did you want to put on
5 any testimony then today?

6 MR. GOLDEN: Very briefly.

7 HEARING EXAMINER FRIEBERG: Okay. Why don't we
8 proceed with that at this time then.

9 MR. GOLDEN: Thank you. The State would call Misty
10 Rallis.

11 MISTY RALLIS,
12 called as a witness at 1:28 p.m., having been first duly
13 sworn, testified as follows:

14 EXAMINATION

15 BY MR. GOLDEN:

16 Q Would you please identify yourself to the Hearing
17 Examiner?

18 A My name is Misty Rallis and I am the Board Investigator
19 for the South Dakota Board of Medical and Osteopathic
20 Examiners.

21 Q How long have you held that position?

22 A Approximately two years.

23 Q Would you describe your position at the South Dakota
24 Medical Board?

25 A As investigator I'm tasked with investigating any written

1 complaint or any complaint that comes through me through
2 the application or renewal process.

3 Q At some point did you get assigned to investigate Curt
4 Hasart?

5 A I did after his renewal in July of 2015.

6 Q Why is that?

7 A He reported on his application that he had had a criminal
8 charge for disorderly conduct.

9 Q And how is Mr. Hasart licensed?

10 A Could you repeat the question?

11 Q What is his profession?

12 A He is a paramedic.

13 Q Does he currently hold a South Dakota license?

14 A He does.

15 Q And when you say a renewal application, what do you mean?

16 A He was required to renew. If he wanted to renew his
17 license, it had to have been done by July 15 of 2015 to
18 keep the license. So this was his renewal for that year.

19 Q Has Mr. Hasart ever been disciplined by this board
20 previously?

21 A He has. He was disciplined in 2012.

22 Q Do you have Exhibit 1 in front of you?

23 A I do.

24 Q What is that?

25 A Exhibit 1 is Mr. Hasart's application for renewal of his

1 paramedic license.

2 Q Do you have Exhibit Number 2 in front of you?

3 A I do. Exhibit Number 2 is the letter that I sent to
4 Mr. Hasart notifying him that his license had been placed
5 under investigation.

6 Q To your knowledge, was a Notice of Hearing sent to
7 Mr. Hasart?

8 A Yes, it was.

9 Q For today's hearing?

10 A Yes, it was.

11 Q Do you have Exhibit 3 in front of you?

12 A Yes.

13 Q What is that?

14 A Exhibit 3 is Mr. Hasart's response to my investigative
15 letter.

16 Q And what materials did he provide?

17 A He provided a brief explanation of what occurred for the
18 disorderly conduct charge and then he also provided some
19 court documents regarding the charge that took place at
20 Kansas.

21 Q Exhibit Number 4?

22 A Exhibit Number 4 is the previous South Dakota Board Order
23 for his discipline.

24 Q And could you just summarize what that was?

25 A In November of 2012 there was a Final Order signed for a

1 reprimand concerning Mr. Hasart and that was due to
2 Mr. Hasart engaging in unprofessional or dishonorable
3 conduct.

4 Q Was that related to criminal charges?

5 A Yes. It was related to simple assault and then he had an
6 arrest for obstructing law enforcement and resisting
7 arrest.

8 Q What is Exhibit Number 5?

9 A Exhibit Number 5 is a record inquiry done through the
10 South Dakota Unified Judicial System that shows
11 Mr. Hasart's criminal charges.

12 Q And Number 6?

13 A Number 6 is an email or letter that was received from
14 Mr. Hasart following the Notice of Hearing for today
15 where he is requesting to voluntarily surrender his
16 paramedic license.

17 Q And did he send anything with it?

18 A He sent his license with it as well.

19 MR. GOLDEN: I would offer Exhibits 1 through 6 at
20 this time.

21 HEARING EXAMINER FRIEBERG: Exhibits 1 through 6 will
22 be received.

23 MR. GOLDEN: Thank you. No further questions.

24 (Whereupon, the witness was excused at 1:31 p.m.)

25 MR. GOLDEN: I have a brief argument.

1 HEARING EXAMINER FRIEBERG: All right. Go ahead.

2 MR. GOLDEN: The staff had requested, as reflected in
3 the petition, since Mr. Hasart has not shown up and
4 contested anything, we ask that you take the facts in the
5 petition to be as alleged and proved by the exhibits the
6 staff has offered.

7 The recommendation from the board member on this case
8 was that Mr. Hasart enroll in HPAP in order to receive an
9 assessment and to follow the recommendations concerning
10 any mental health or anger management issues that he may
11 be experiencing based on his two convictions for a simple
12 assault and a disorderly conduct, which was actually at
13 his place of work.

14 Since Mr. Hasart has asked to surrender his license,
15 I do not believe the staff has any objections to that if
16 the board wants to order that his license is to be
17 surrendered instead of the actual recommendation for an
18 evaluation. But at this time I'm only authorized to
19 proceed on the recommendation for HPAP.

20 HEARING EXAMINER FRIEBERG: Okay. Being nothing
21 further to come before us, that will conclude this
22 hearing.

23 (Whereupon, the proceedings were concluded at 1:33
24 p.m.)

25 * * * * *

/	attend [1] 3/19	during [1] 9/11
/s/Terri [1] 9/22	attorney [4] 1/10 1/12 9/15 9/16	E
0	authorized [1] 8/18	email [2] 3/12 7/13
02/03/16 [1] 2/17	Avenue [1] 1/10	employee [2] 9/15 9/16
07/20/15 [1] 2/12	B	EMT [2] 1/5 3/4
08/02/15 [1] 2/13	based [1] 8/11	EMT/PARAMEDIC [2] 1/5 3/4
1	be [11]	enforcement [1] 7/6
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THE BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS OF THE
STATE OF SOUTH DAKOTA

IN THE MATTER OF:)	NO. 16-010
)	
Curt Hasart, Paramedic)	FINDINGS OF FACT AND
)	CONCLUSIONS OF LAW
Respondent.)	
)	
)	

This matter came on for hearing before the undersigned hearing examiner on February 12, 2016 pursuant to the Petition for Board of Medical and Osteopathic Examiners wherein it was requested that due to incidents of unprofessional conduct, Mr. Hasart be mandated into South Dakota Health Professionals Assistance Program (HPAP), and be required to follow all conditions of the program and maintain compliance with all requirements of the program. The South Dakota Board of Medical and Osteopathic Examiners, hereinafter "Board", appeared by and through their counsel, William Golden. Executive Director of the Board, Margaret B. Hansen, was also present on behalf of the Board. Mr. Hasart did not appear despite being given due and proper notice of the hearing.

The Board presented evidence by and through one of its investigators, Misty Rallis, and presented Exhibits 1 through 6 which were received into evidence and are a part of the record. At the conclusion of the testimony, the Board made a brief closing statement and relied upon the contents of the Petition and the Brief in Support of Petition which it had filed prior to the hearing.

Based upon the entirety of the record before the undersigned, the undersigned submits the following:

FINDINGS OF FACT

1. Mr. Hasart submitted his Advanced Life Support Paramedic renewal application on July 15, 2015 (Exhibit 1, Pages 3-7). On his renewal application, Mr. Hasart reported that he was investigated in Kansas for disorderly conduct and battery after a confrontation with a co-worker in April of 2015. This was in response to question 8 on the application inquiring as to whether the applicant has “been subject to a criminal or civil complaint, investigation or proceeding other than minor traffic offenses” (Exhibit 1, Page 6).
2. A notice of investigation was sent to Mr. Hasart on July 20, 2015 (Exhibit 2, Page 8). An explanation of the events and documentation of the investigation were requested in the notice letter.
3. Mr. Hasart’s response was received on August 3, 2015 (Exhibit 3, Pages 9-16). Mr. Hasart said that in April of 2015, he had a conflict with a co-worker, and he pushed his co-worker up against a wall and started yelling at him. Mr. Hasart was charged in the City of Wellington, Kansas with Battery and Disorderly Conduct (Exhibit 3, Pages 11-12).
4. Mr. Hasart signed a Diversion Agreement with the Municipal Court of Wellington wherein, as long as Mr. Hasart complies with the terms of the Diversion Agreement, the charges will be dismissed with prejudice in August of 2016 (Exhibit 3, Page 13-15).

5. On October 19, 2012, Mr. Hasart entered into a Consent Agreement with the Board agreeing to a reprimand based upon unprofessional and dishonorable conduct including, but not limited to, an arrest for a simple assault on July 25, 2011 and an arrest for obstructing law enforcement and resisting arrest on August 22, 2011 (Exhibit 4, Pages 19-20). The Consent Agreement was temporarily approved by Executive Director Margaret B. Hansen on November 20, 2012 and a final order was entered by the Board on November 28, 2012 (Exhibit 4, Pages 17-18). The reprimand indicated that Mr. Hasart had acted unprofessionally and dishonorably which led to his arrests for criminal charges (Exhibit 4, Page 20).
6. By letter dated February 3, 2016, Mr. Hasart made a decision to voluntarily surrender his EMT-Paramedic license number 0809 effective immediately. Mr. Hasart's license was returned to the Board with his letter (Exhibit 6, Pages 27-28).
7. Mr. Hasart has engaged in unprofessional conduct and has not agreed to enroll in the HPAP as recommended by Board staff.

Based upon the foregoing Findings of Fact, the undersigned does hereby make the following:

CONCLUSIONS OF LAW

1. SDCL § 36-4B-31 allows the Board to deny the issuance or renewal of a license or suspend or revoke the license of any advanced life support personnel upon satisfactory proof of the person's "incompetence, or unprofessional or dishonorable conduct as defined in § 36-4-30".

2. SDCL § 36-4-30 defines unprofessional or dishonorable conduct for purposes of SDCL Ch. 36-4B.
3. Mr. Hasart's conduct constituted unprofessional or dishonorable conduct under SDCL § 36-4-30(6) in that Mr. Hasart's assault of a co-worker involved a act of moral turpitude.
4. Mr. Hasart's conduct constituted unprofessional or dishonorable conduct pursuant to SDCL § 36-4-30(22) in that he engaged in conduct which constituted a danger to the health, welfare or safety of the public which was unbecoming a person licensed to as an advanced life support personnel.
5. Mr. Hasart's action of voluntarily surrendering his license to the Board should be accepted, provided, however, if Mr. Hasart disagrees with the revocation, the Board should take disciplinary action based upon Mr. Hasart's unprofessional and dishonorable conduct.
6. Mr. Hasart's history of conduct and assaultive behavior impacts his ability to be licensed as an advanced life support personnel and as such, he is in need of assistance to be permitted to continue to provide services for which he is licensed.
7. Any item designated herein as a Finding of Fact which is more appropriately deemed a Conclusion of Law, shall be deemed a Conclusion of Law. Any item contained herein which is identified as a Conclusion of Law and which is more appropriately deemed a Finding of Fact, shall be deemed a Finding of Fact.

RECOMMENDATION

Based upon the entirety of the record herein, it is recommended that the Board accept the voluntary surrender of license as submitted by Mr. Hasart. If Mr. Hasart disagrees with or revokes the voluntary surrender of his license, Mr. Hasart should be referred to the HPAP program and be required to participate in and follow any and all conditions of the program and maintain compliance with all requirements of the program to retain his licensure.

Dated this 3rd day of March, 2016.



Thomas H. Frieberg
Hearing Examiner

THE BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS OF THE
STATE OF SOUTH DAKOTA

IN THE MATTER OF:)	NO. 16-010
)	
Curt Hasart, Paramedic)	PETITION FOR BOARD OF
)	MEDICAL AND OSTEOPATHIC
Respondent.)	EXAMINERS
)	
)	

COMES NOW, the Executive Secretary of the South Dakota Board of Medical and Osteopathic Examiners (BMOE) and files this Petition pursuant to SDCL 36-4B-6, 31, SDCL 1-26 and South Dakota’s Administrative Rules (ARSD) 20:78:04 and 05. Respondent, Curt Hasart (Mr. Hasart) submitted a renewal application for his South Dakota Advanced Life Support Paramedic license, and reported that he was investigated in Kansas for disorderly conduct and battery after confrontation with a co-worker in April of 2015. Respondent’s address as reported to the BMOE is PO Box 575, Wellington, KS, 67152.

After investigation, a recommendation was made pursuant to ARSD 20:78:04:04 for Mr. Hasart to be mandated into the South Dakota Health Professionals Assistance Program (HPAP). Respondent has contested this recommendation. The Secretary, pursuant to ARSD 20:78:04 and ARSD 20:78:05, therefore files this Petition for a contested case hearing.

A. TIME, PLACE AND NATURE OF HEARING

Hearing. A contested case hearing on this licensure action shall be heard by a Hearing Examiner pursuant to ARSD 20:78:05:04. The hearing shall begin at 1:00 pm (central time) on Friday, February 12, 2016, in the BMOE

Conference Room, 101 North Main Avenue, Suite 215, Sioux Falls, South Dakota 57104.

Answer. Respondent may file an Answer within twenty (20) days of the date he is served with this Petition. An Answer, if filed, should specifically admit, deny, or otherwise answer all allegations contained in sections C and D of this Petition. The Answer and any other pleading must be filed with the BMOE at the following address: BMOE, 101 North Main Avenue, Suite 301, Sioux Falls, South Dakota 57104.

Presiding Officer. The Hearing Examiner will preside over the hearing and make a recommended decision consisting of proposed Findings of Fact, Conclusions of Law, and an Order, to the BMOE. ARSD 20:78:05:06. The BMOE will read the record, transcript of the contested case proceeding, and all exhibits, and make its decision thereon at a BMOE meeting following the contested case hearing. The BMOE may request that the parties appear to present oral argument and objections to the Hearing Examiner's recommended decision. ARSD 20:78:05:06.

Hearing Procedures. The procedural rules governing the conduct of the hearing are found at SDCL chs. 36-4B and 1-26, and ARSD chs. 20:78:05. The contested case proceeding is an adversarial proceeding. At the hearing, you have the right to be present, to appear personally, and/or to be represented by legal counsel at your own expense. You will be allowed the opportunity to respond to the allegations of the Petition, to produce evidence on your behalf, to present witnesses, to cross-examine witnesses, and to examine and respond

to any documents introduced at hearing. These and other due process rights will be forfeited if they are not exercised at the hearing.

The hearing is open to the public.

Any decision of the BMOE based on the contested case proceeding may be appealed to the circuit court and the State Supreme Court as provided by law.

Pre-hearing Conferences and Continuances. Any party may request a pre-hearing conference to discuss evidentiary issues related to hearing, or may request a continuance, by filing a motion for a prehearing conference with the BMOE at the address above.

Prosecution. Counsel for the Secretary is responsible for representing the public interest (the State) in this proceeding. Counsel for the Secretary is: William H. Golden, Assistant Attorney General, 101 North Main Avenue, Suite 301, Sioux Falls, South Dakota 57104. Copies of all pleadings filed in this matter must be provided to Counsel for the Secretary at this address.

Communications. You may not contact Board members in any manner, including by phone, letter, in person, or by e-mail about this Petition. Board members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the BMOE office and serve upon all parties in this case. See SDCL 1-26-26.

B. LEGAL AUTHORITY AND JURISDICTION

Jurisdiction. The BMOE has jurisdiction in this matter pursuant to SDCL 36-4B.

Legal Authority. If any of the allegations against you are founded, the BMOE has authority to take disciplinary action against you under SDCL 36-4B-6, 31 and 36-4-30, and ARSD 20:78:04 and 05.

Default. If you fail to appear at the hearing, the BMOE may enter a default decision or proceed with the hearing and render a decision in your absence in accordance with SDCL 1-26.

C. SECTIONS OF STATUTES AND RULES INVOLVED

Count I

Mr. Hasart is subject to discipline under SDCL 36-4B-6 and 36-4-30(6)(12) and (22) when he submitted his renewal application on July 15, 2015, and disclosed that he was investigated in Kansas for disorderly conduct and battery after a confrontation with a co-worker in April of 2015.

FACTUAL CIRCUMSTANCES

1. Mr. Hasart submitted his Advanced Life Support Paramedic renewal application on July 15, 2015 (Exhibit 1, Pages 3-7). On his renewal application, Mr. Hasart reported that he was investigated in Kansas for disorderly conduct and battery after a confrontation with a co-worker in April of 2015.
2. A notice of investigation was sent to Mr. Hasart on July 20, 2015 (Exhibit 2, Page 8). An explanation of the events and documentation of the investigation were requested in the notice letter.

3. Mr. Hasart's response was received on August 3, 2015 (Exhibit 3, Pages 9-16). Mr. Hasart said that in April of 2015, he had a conflict with a co-worker, and he pushed his co-worker up against a wall and started yelling at him. Mr. Hasart was charged in the City of Wellington, Kansas with Battery and Disorderly Conduct.
4. Mr. Hasart signed a Diversion Agreement with the Municipal Court of Wellington where, as long as Mr. Hasart complies with the terms of the Diversion Agreement, the charges will be dismissed with prejudice in August of 2016.
5. Mr. Hasart has been licensed in South Dakota since 2000, and has been the subject of previous Board Action in South Dakota. Mr. Hasart entered into a Consent Agreement with Reprimand with the BMOE in October of 2012 (Exhibit 4, Pages 17-20). The Reprimand was due to his unprofessional and dishonorable acts resulting in an arrest in July of 2011 for simple assault, and a second arrest for obstructing law enforcement and resisting arrest in August of 2011. According to the South Dakota Record Inquiry, Mr. Hasart pled guilty to a Count of 22-11-6 (M1) Obstruct Police, Jailer or Firefighter (Exhibit 5, Pages 21-25). The other charges were dismissed.
6. It is hereby requested that, due to his incidents of unprofessional conduct, Mr. Hasart be mandated into HPAP and be required to follow all

conditions of the program and maintain compliance with all requirements of the program.

D. SETTLEMENT

This matter may be resolved by settlement agreement. The procedural rules governing the BMOE's settlement process are found at ARSD 20:78:04:04. If you are interested in pursuing settlement of this matter, please contact William Golden, Assistant Attorney General, at (605) 201-8588.

Signed pursuant to Article 20:78:05:02: Petitions for hearing. An applicant for a license, permit, or certificate issued by the board may file a petition for hearing at any time during the processing of an application. The executive secretary may file a petition for hearing to initiate a disciplinary proceeding against a licensee. A petition for hearing shall be signed by the petitioner and contain the following information: the name and address of the applicant or licensee, the basis for the request for hearing, recitation of the applicable statutes or regulations under which the petitioner is requesting board action, and the relief requested by the petitioner.

By: Margaret B. Hansen Date: 1/21/2016
Margaret B. Hansen
Executive Director
South Dakota Board of Medical
and Osteopathic Examiners

Copies to: William Golden
Assistant Attorney General
101 M. Main Ave., Suite 301
Sioux Falls, SD 57104

Curt Hasart
PO Box 575
Wellington, KS 67152

Court of Wellington. As long as Mr. Hasart complies with the terms of the agreement the charges will be dismissed with prejudice in August of 2016.

Mr. Hasart has been licensed in South Dakota since 2000, and has previous South Dakota Medical Board Disciplinary Action. Mr. Hasart entered into a Consent Agreement with Reprimand with the BMOE in October of 2012 (Exhibit 4). The Reprimand was imposed due to the unprofessional /dishonorable acts of Mr. Hasart in an arrest in South Dakota in July of 2011 for simple assault, and in another arrest in South Dakota in August of 2011 for obstructing law enforcement and resisting arrest. According to the South Dakota Record Inquiry, Mr. Hasart pled guilty to a Count of 22-11-6 (M1) Obstruct Police, Jailer or Firefighter (Exhibit 5). The other charges were dismissed.

EVIDENTIARY GROUNDS FOR EXHIBITS

Administrative hearings are not required to follow the technical rules of evidence but are to be applied fairly to both parties. *Daily v. City of Sioux Falls*, 802 N.W. 2d 905 (S.D. 2011). Administrative hearings are controlled by the following statute for evidence to be admitted:

SDCL 1-26-19 Rules of evidence in contested cases. In contested cases:

(1) Irrelevant, incompetent, immaterial, or unduly repetitious evidence shall be excluded. The rules of evidence as applied under statutory provisions and in the trial of civil cases in the circuit courts of this state, or as may be provided in statutes relating to the specific agency, shall be followed. When necessary to ascertain facts not reasonably susceptible of proof under those rules, evidence not otherwise admissible thereunder may be admitted except where precluded by statute if it is of a type commonly relied upon by reasonably prudent persons in the conduct of their affairs. Agencies shall give effect to the rules of privilege recognized by law. Objections to evidentiary offers may be made and shall be noted in the record. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be received in written

form;

(2) A party may conduct cross-examinations required for a full and true disclosure of the facts;

(3) Notice may be taken of judicially cognizable facts. In addition, notice may be taken of generally recognized technical or scientific facts within the agency's specialized knowledge. Parties present at the hearing shall be informed of the matters to be noticed, and those matters shall be noted in the record, referred to therein, or appended thereto. Any such party shall be given a reasonable opportunity on request to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the agency.

Our Court has set out the follow require for meeting the necessary due process rights of Parties in the hearing:

Application of the technical rules of evidence is not constitutionally required. United States v. Fell, 360 F.3d 135, 144–45 (2d Cir.2004). Numerous courts have recognized that this is especially true in administrative proceedings. See, e.g., R & B Transp., L.L.C. v. U.S. Dep't of Labor, Admin. Review Bd., 618 F.3d 37, 45 (1st Cir.2010); Hardisty v. Astrue, 592 F.3d 1072, 1075 (9th Cir.2010); Lybeshia v. Holder, 569 F.3d 877, 882 (8th Cir.2009) (citing Tun v. Gonzales, 485 F.3d 1014, 1025–26 (8th Cir.2007)). Yet it cannot be doubted that the applicable rules of evidence must be applied in a fair and even-handed manner. See Withrow, 421 U.S. at 46, 95 S.Ct. at 1464 (“[A] ‘fair trial in a fair tribunal is a basic requirement of due process.’” (quoting Murchison, 349 U.S. at 136, 75 S.Ct. at 625)). Daily v. City of Sioux Falls, 802 N.W. 2d 905 (S.D. 2011).

The Executive Secretary of the BMOE will offer the following evidence:

1. Exhibit 1 and Exhibit 2 are admissible under SDCL 19-6-10 as business records.
2. Exhibit 1, Exhibit 2, and Exhibit 4 are admissible as the exception for government under SDCL 19-16-12.
3. Exhibit 3 is admissible as party admissions under SDCL 19-19-801.

BASIS FOR RECOMMENDATION TO MANDATE INTO THE SOUTH DAKOTA HEALTH PROFESSIONALS ASSISTANCE PROGRAM

The purpose of the BMOE is to “safeguard the public health and protect the public from incompetence, deception and fraud” *Katz v. South Dakota State Board of Medical and Osteopathic Examiners*, 432 N.W.2d 274. The legislature may define that which constitutes unprofessional or dishonorable conduct which may absolutely disqualify a person from the practice of medicine. *Katz v. South Dakota State Board of Medical and Osteopathic Examiners* 432 N.W.2d 274. Further, the Court has held the right to practice medicine is not a fundamental right. *Id at foot note 6*

The BMOE’s Review Panel recommends that, due to his repeated incidents of unprofessional and violent conduct and behaviors, Mr. Hasart be mandated into the South Dakota Health Professionals Assistance Program (HPAP), that he follow all conditions of the program, and that he maintain compliance with all requirements of the program. The “Health Professionals Assistance Program,” is a confidential program designed to monitor the treatment and continuing care of any regulated health professional who may be unable to practice with reasonable skill and safety if the professional's mental health issues or substance use disorder is not appropriately managed. SDCL 36-2a-1. HPAP can conduct an evaluation of the healthcare professional and determine what assistance they may need, if any. Mr. Hasart has a history of assaultive behavior which is documented in Court records and is directly related to his employment and his relationships. Mr. Hasart’s conduct is strong evidence that he fails to react to conflict in a professional manner. The Review Panel’s request for evaluation by HPAP is to detect any underlining

mental illness or substance abuse issues that may be contributing to Mr. Hasart's assaultive behavior. The review panel asks that Mr. Hasart be mandated into the program, and that he be required to follow through on any recommendation of the evaluation to ensure that his violent outbursts and behaviors are addressed to prevent future occurrences of unprofessional conduct.

Dated this 28th day of January, 2016.



William Golden
Assistant Attorney General
South Dakota Attorney General's Office
317 N. Main
Sioux Falls, SD 57104

License Renewal - Paramedic License

Number: EMTP 0809 Renewal Tracking # 52655 Submitted on: 7-15-2015

Name Information

CURT HASART

Alternates *None reported.*

Address

Type	Work Address
Public?	Y
Name/Attention	Wellington Fire/EMS
Address	200 N. C Ste 200 Wellington, KS 67152

****Default****

Type	Home Address
Public?	N
Name/Attention	Curt Hasart
Address	PO Box 575 Wellington, KS 67152

Phone and Email

Cell	620-968-7537	
Work	620-326-7444	**Public**
Home	chasart@hotmail.com	**Default**

Identification

Date of Birth	9-18-1978
Birth Place	Pierre, South Dakota UNITED STATES
Gender:	M SSN: XXXXX1485 NPI:
US Citizen	Y

Race/Ethnicity/Languages (ALL OPTIONAL)

White: Y
Black or African American: N
American Indian or Alaska Native: N
Asian: N
Native Hawaiian/Other Pacific Islander: N
Other:
No: Y
Mexican, Mexican American, Chicano/a: N
Puerto Rican: N
Cuban: N
Another Hispanic, Latino/a, or of Spanish origin:
N

What is your race? (check all that may apply):

Ethnicity: Are you Hispanic, Latino/a, or of Spanish origin? (check all that may apply)

Do you speak a language other than English at home?

What is this language? (if you answered Yes to above) N

Education

Name Prairie Lakes Hospital
Location Watertown, SD
Degree Paramedic
Status
Dates Attended 09/1997 to 06/1999
Graduated 06/1999

Practice Information

1. What is your current employment status?: ACTIVEMED
2. Are you currently providing direct clinical or patient care on a regular basis? Y
3. Which of the following best describes your primary area of practice in which you spend most of your professional time: Emergency Medicine
4. Which of the following categories best describes your primary practice or work setting(s) where you work the most hours each week? Other (specify): Pre-hospital
5. How many weeks did you work in medical related positions in the past 12 months? 52
6. For all medical related positions held in South Dakota, indicate the average number of hours per week spent on each major activity:

Clinical or patient care	0 hours/week
Research	0 hours/week
Teaching/Education	0 hours/week
Administration	0 hours/week
Volunteering (medical related only)	0 hours/week
Other (specify):	0 hours/week

7. What is the location of the site(s) where you spend most of your time providing direct clinical or patient care? Please enter the complete address for up to three locations and your direct patient care hours per week at each site.

Principal Location

Tim Hay

Wellington Fire/EMS
 200 N. C St.
 Wellington, KS 67152

Direct patient care hours per week at site: 52 hrs.

8. Would you say you work primarily in South Dakota (more than anywhere else)? N
9. If not working in South Dakota, in which states do you practice?

Supervision/Profession Relationships

No information on record.

Continuing Education

My NREMT registry is current and unexpired.

Required Disclosures

Definitions:

All questions use the following definitions whether actions were formally, informally, voluntarily or involuntarily committed: Questions refer to both you and your licensure.

A. **Adverse Action** shall refer to having been terminated, stipulated, restricted, limited, conditioned, counseled, reprimanded, suspended, revoked, refused, denied, not renewed, withdrawn or relinquished.

B. **Claim(s)** shall refer to any malpractice, administrative, civil, or criminal final judgments including any pending claims, lawsuits, judgments, and/or settlements.

C. **Complaint** shall refer to any communications which express concerns, warnings or dissatisfaction about personal or profession conduct and rising to the level that the meetings or comments are documented in a written or digital format.

D. **Entity** shall refer to any licensing or disciplinary board, professional agency or committee, academic program, clinic, hospital, or other health-related entity, or governmental agency or organization.

E. **Health related program** shall refer to private or public insurance, Medicare and Medicaid.

F. **Illegal use of drugs** shall refer to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. The term does include the unlawful use of prescription controlled substances. It does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law.

G. **Investigation** shall refer to any formal or informal inquiry to acquire and examine facts.

H. **Licensure** shall refer to type of licensure and using any licensure nomenclature such as any registration, permit, certificate, and license. Examples include the subject of this application, DEA registration, etc.

I. **Minor traffic offense** shall refer to any violation which is punishable by a maximum of 30 days in jail, a \$500 fine or both and does not result in a change of driving privileges.

J. **Proceeding** shall refer to whether you have appeared or been requested to appear in private or in public, for a meeting, counseling, hearing, administrative, civil or criminal actions, or been questioned, reviewed, charged, arrested, plead guilty, plead no contest, convicted, received a suspended imposition of sentence or suspended sentence by any entity.

K. **Sexual impropriety** shall refer to misconduct including but not limited to discrimination, complaint, assault, the possession of child pornography, sexual contact with patients or other acts, expressions or gestures that disrespect privacy and are demeaning.

L. **You** shall refer to you or any licensure held by you.

In the past year, or since your last renewal:

01 Is this a true statement for your licensure? "My licensure has not experienced adverse action." Y

*02 Is this a true statement for you? "I have not experienced adverse action." N

Explanation:Received 72 hour suspension for incident with co-worker in April 2015.

03 Has your licensure been subject to any complaint, investigation or proceeding involving any entity? N

*04 Have you been subject to any complaint, investigation or proceeding involving any entity? Y

Explanation:Investigated for disorderly conduct and battery after confrontation with co-worker in April 2015.

05 Have you been dishonorably discharged from a branch of the United States military or National Guard? N

06 Have you had any adverse action during any education, residency or training program N

07 Have you had adverse action with your membership or privileges with any entity regarding your ability to participate in any health related program? N

*08 Have you been subject to a criminal or civil complaint, investigation or proceeding other than minor traffic offenses? Y

Explanation: Investigated for disorderly conduct and battery following confrontation with co-worker in April 2015.

09 Have you had a complaint, investigation or proceeding in any manner concerning sexual impropriety? N

10 Is this a true statement for you? "I have not been reported to NPDB (National Practitioners Data Bank) or HIPDB (Healthcare Integrity and Protection Data Bank)." Y

11 Is this a true statement for you? "I have experienced no adverse action in privileges at any hospital, clinic or health related entity." Y

12 Have you had any claims paid by you or paid on your behalf for any reason? N

13 Have you had any liability insurance company, including malpractice carriers, change, deny or cancel your coverage? N

14 Have you stopped working or practicing for any period of time greater than or equal to 30 consecutive calendar days? N

15 Do you have a physical, mental or emotional condition which may adversely affect your practice? N

16 Have you been treated for or do you have a diagnosis for any Mental Health condition. (If yes, please ask your treating provider to send a status letter to the Board office). N

17 Does your use of alcohol or drugs affect your ability to provide appropriate care to patients? N

18 Are you currently using illegal drugs or prescription controlled medications in an illegal manner? N

TERMS AND CONDITIONS:

AUTHORIZATION AND RELEASE:

Any references to the terms "Users" or "Users of this Application" in this authorization shall include the following entities:

- The South Dakota State Board of Medical and Osteopathic Examiners together with its board members, staff members, legal counsels, investigators
- agents, employees, contractees, and authorized representatives hereinafter collectively referred to as SDBMOE;
- Any other state or national medical licensing, medical reporting or medical regulatory board;
- The Federation of State Medical Boards;
- Any other South Dakota or United States agency in furtherance of and in compliance with SDBMOE's duties and responsibilities under my South Dakota Medical Practices Act and its administrative regulations.

I am the person described herein. I have not engaged in any acts prohibited by the criminal or medical statutes of the State of South Dakota. I am the person named on any diploma or certificate that I have received, I am the lawful holder of said diploma or certificate, and the diploma or certificate was given to me in the regular course of instruction and examination without fraud or misrepresentation.

HIPAA AUTHORIZATION: Per 45 CRF 164.512, the Privacy Rule permits covered entities to disclose protected health information without authorization for specified public health purposes. The South Dakota Board of Medical and Osteopathic Examiners, as a health oversight agency, is legally authorized to receive protected health information without authorization for health oversight agency purposes.

THIRD PARTIES:

(The following deals with SDBMOE consulting with and receiving information from third parties.)

I authorize SDBMOE to consult with any third person or party who may have information or evidence concerning my professional, ethical, mental and physical qualifications, or any other matter that SDBMOE deems relevant regarding my continuing qualifications for licensure with SDBMOE. These third persons and parties include hospitals, institutions or organizations, my references, physicians, therapists, previous and present employers, past and present business and professional associates, and local, state, federal or foreign governmental agencies and instrumentalities, courts of any jurisdiction, associations, institutions or law enforcement agencies, together with their representatives thereof, who have custody or control of any documents, records, information or evidence that SDBMOE deems relevant to my renewal application.

I authorize such third persons and parties to unconditionally release to SDBMOE any such information, including documents, records regarding charges or complaints filed against me, formal, or informal, pending or closed, or any other pertinent data or evidence whether favorable or unfavorable that SDBMOE deems relevant to licensure, and to permit the SDBMOE to inspect, receive, and make copies of such documents, records, evidence, medical records and other information for SDBMOE's evaluation of my professional, ethical, mental and physical qualifications that SDBMOE deems relevant to licensure.

I release, discharge and exonerate from any and all claims, damages and liabilities whatsoever such third persons and parties, together with their authorized representatives, who in good faith and without malice, consult with and release to SDBMOE such information, evidence, files or records requested by SDBMOE that SDBMOE deems relevant to licensure.

AFFIDAVIT:

I, the applicant for licensure with the South Dakota State Board of Medical and Osteopathic Examiners (SDBMOE), state that I am the applicant in the above application, that I have read the foregoing application and releases and know the contents thereof, and I unconditionally declare and affirm under the penalties of perjury that the statements made in this application been examined by me, and to the best of my knowledge and belief, are in all things true and correct. I further state that should I furnish any false information in this application, such act shall constitute cause for the denial, suspension or revocation of any license issued to me by the South Dakota State Board of Medical and Osteopathic Examiners.

I understand and agree that my submission of this application and actions subsequent thereto, but prior to licensure, shall bear directly upon my qualifications for licensure, and I fully understand that the SDBMOE may consider all such actions in its determination whether to grant licensure. To that end, I agree that any unprofessional or harassing behavior on my part, or on the part of any agent of mine, with the SDBMOE's members or staff shall establish grounds for the immediate cessation of all processing of this application and disqualify me for licensure in South Dakota. A determination regarding derogatory information or of unprofessional or harassing behavior shall be the sole determination of the SDBMOE, and I will not assert that any other entity, judicial, or otherwise, may make such determination. I understand and agree that cessation of processing of this application by the users as a result of the acts of omissions by myself as described in this paragraph shall not require the SDBMOE, to offer me a hearing or any other due process right, or any other statutory or constitutional rights, and that I will not assert that I am entitled to a hearing.

Signed:

Curt Hasart 09/18/1978

</html

SOUTH DAKOTA

BOARD OF MEDICAL
AND OSTEOPATHIC
EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV



July 20, 2015

Curt Hasart
PO Box 575
Wellington, KS 67152

Dear Mr. Hasart:

According to the South Dakota administrative rules for investigations¹, you are receiving this letter to notify you of an investigation, that a file is being opened in this matter, and that a response from you is required. The investigation is in regard to the reported "investigated for disorderly conduct and battery after confrontation with a coworker". We ask that you provide an explanation of the events and any and all documentation associated with that investigation. We would appreciate receiving your response no later than August 3, 2015. Your response is your initial opportunity to be heard and this response and all data collected during this inquiry are deemed confidential by the Board in accordance with SDCL 1-27-1.5(5) and SDCL 36-4-31.5.

Ex parte communication is prohibited pursuant to SDCL 1-26-26. This means that neither you, nor any attorney(s) on your behalf, nor any other third party is to contact any Board members by phone, letter, facsimile, email, in person, or by any other method. You are entitled to due process rights during the complaint process as well as once a recommendation is made.

Thank you for your cooperation, and we anticipate your prompt response. Should you need additional time to respond, please notify this office in writing by US mail or by email to SDBMOE@state.sd.us to make other arrangements.

Sincerely,

Misty Rallis
Board Investigator

¹ SDCL 20:78:04:03. **Investigations.** The executive secretary shall initiate investigation of a complaint by notifying the license, permit, or certificate holder of the complaint and obtaining a response to the complaint. If the executive secretary determines that the complaint concerns compliance with licensing standards and requirements, the executive shall investigate the complaint. The notice shall be in writing and shall include a statement that the licensure or licensee is entitled to due process rights, including the right to notice and an opportunity to be heard and to be represented by counsel. The executive secretary may appoint a board member to assist in the investigation.

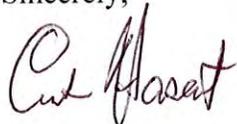
Curt Hasart
PO Box 575
Wellington, KS 67152
August 2, 2015

SDBMOE
Misty Rallis
101 N Main Ave, Ste 301
Sioux Falls, SD 57104

Dear SDBMOE:

Per your request from your letter dated July 20, 2015, I have enclosed court documents that have been presented to me at this time. Enclosed are the initial complaint and summons and the diversion agreement to the case. The Diversion Agreement is scheduled to be signed by the judge on August 9, 2015 to complete the case. In the event your office needs additional documents, (ex. Motion for discovery) your office will have to contact the prosecuting attorney's office as I am not privy to those documents.

Sincerely,

A handwritten signature in dark ink, appearing to read "Curt Hasart", written in a cursive style.

Curt Hasart

Enclosures

Curt Hasart
PO Box 575
Wellington, KS 67152
August 2, 2015

SDBMOE
Misty Rallis
101 N Main Ave, Ste 301
Sioux Falls, SD 57104

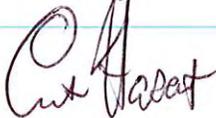
Dear SDBMOE:

Per your request from your letter dated July 20, 2015, here is a brief explanation to the charges.

On the morning of April 8, 2015, I along with my EMS crew responded to a medical emergency. Upon arrival, a patient was found to be in critical condition and additional resources were required. The call for additional assistance brought the victim, Sam Pacino, to the scene. Upon his arrival, he simply started to tell me how to run the call, telling me I was doing care wrong and doing his own treatments instead of assisting. There also had been an ongoing professional conflict between myself and Mr. Pacino. Upon returning to the fire station after the call, I confronted Mr. Pacino where I pushed him up against a wall and started yelling at him.

Since incident, there has been no further issue between myself and Mr. Pacino.

Sincerely,

A handwritten signature in black ink that reads "Curt Hasart". The signature is written in a cursive style with a large initial "C".

Curt Hasart

IN THE MUNICIPAL COURT OF WELLINGTON, KANSAS
317 S. WASHINGTON, WELLINGTON, KANSAS 67152
Court Time 6:30 P.M.

APR 23 2015

WELLINGTON, KANSAS

CITY OF WELLINGTON, Plaintiff

CODE NO. 15 PO 48

vs.

CASE NO. 15MC218

CURT CHRISTOPHER HASART,
(WM, DOB 29-18-78)
1817 North B
Wellington, KS 67152

Defendant

THE CITY OF WELLINGTON TO: Curt Hasart, 1817 North B , Wellington, KS 67152

SUMMONS

YOU ARE HEREWITH SUMMONED AND required to appear in person before the Municipal Court of Wellington, Kansas, at 317 S. Washington, Wellington, KS 67152, on the 20th day of May, 2015, at 6:30 p.m. to answer the following charge, to-wit:

On April 8, 2015, the Defendant:

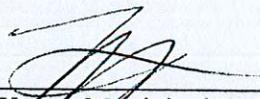
Count 1

did unlawfully knowingly cause physical contact with another person, to-wit: Sam Pacino; done in a rude, insulting, or angry manner, to-wit: during an argument, Hasart pushed and grabbed Pacino.. [BATTERY, Section 3.1, Class B Misdemeanor]

Count 2

and did then and there unlawfully engage in brawling and fighting which he knew or should have known would alarm, anger, or disturb others or provoke an assault or other breach of the peace. [DISORDERLY CONDUCT, Section 9.1, Class C Misdemeanor]

WITNESS MY HAND, at my office in the City of Wellington, in Sumner County, this 23rd day of April, 2015.



Frank L. Korté, Municipal Court Judge

Received this Summons this _____ day of _____, 2015, and served the same by _____ on _____ Date

Law Enforcement Officer

APR 22 2015

Exhibit 3

IN THE MUNICIPAL COURT OF WELLINGTON, KANSAS

WELLINGTON, KANSAS

CITY OF WELLINGTON, Plaintiff

CODE NO. 15 PO 48

vs.

CASE NO. 15MC218

CURT CHRISTOPHER HASART,
(WM, DOB 09-18-78)
1817 North B
Wellington, KS 67152

Defendant

COMPLAINT

STATE OF KANSAS, COUNTY OF SUMNER: SS

Kerwin L. Spencer, Municipal Prosecutor for the City of Wellington, being first duly sworn upon his oath, states that on or about April 8, 2015, within the corporate limits of the City of Wellington, Sumner County, Kansas, that above-named Defendant:

Count 1

did unlawfully knowingly cause physical contact with another person, to-wit: Sam Pacino; done in a rude, insulting, or angry manner, to-wit: during an argument, Hasart pushed and grabbed Pacino.. [BATTERY, Section 3.1, Class B Misdemeanor]

Count 2

and did then and there unlawfully engage in brawling and fighting which he knew or should have known would alarm, anger, or disturb others or provoke an assault or other breach of the peace. [DISORDERLY CONDUCT, Section 9.1, Class C Misdemeanor]

Witnesses: Jared Hedge Jeff Mraz Sam Pacino Jerry Preston Timothy Hay

Complainant was advised of the following facts through the written report of Officer Jared Hedge. On April 8, 2015, about 3:28 a.m., Officers Hedge responded to a report of two firefighters in a physical altercation at the fire department. Assistant Chief Mraz advised when Curt Hasart and Sam Pacino returned from a Code Blue call, Hasart yelled at Pacino, then punched, then grabbed Pacino by the neck. Hedge interviewed Hasart who confirmed that he was angry and pushed, then grabbed Pacino.

Kerwin L. Spencer

City Prosecutor

SUBSCRIBED AND SWORN to before me this 22 day of April, 2015.

Shelley S. Spencer

Notary Public



IN THE MUNICIPAL COURT OF WELLINGTON, KANSAS

CITY OF WELLINGTON, Plaintiff

vs

CASE NO 15 MC 218

CURT CHRISTOPHER HASART, Defendant

DIVERSION AGREEMENT

The Wellington Municipal Court Prosecutor has determined the diversion of the above named Defendant would be in the interest of justice and of benefit to the Defendant and the community. Therefore pursuant to K.S.A. 22-2907, et seq., the City of Wellington and Curt Hasart (WM, DOB 9-18-78 SS#xxx-xx-1485) hereby enter into the following diversion agreement for the crimes of Battery and Disorderly Conduct in violation of Sections 3.1 and 9.1 Wellington Municipal Code, on or about April 8, 2015, such charge being filed in Wellington Municipal Court in Sumner County, Kansas.

1. The Defendant hereby waives all rights under the law or the constitution of Kansas or the United States to a speedy trial and all such rights to a trial by jury.
2. The Defendant shall forthwith pay the Municipal Court the sum of \$260.50, which represents a \$200 Diversion fee and \$60.50 court costs.
3. Defendant shall maintain employment while on Diversion and notify the City Prosecutor of any change in his employment status.
4. The Defendant shall notify the Municipal Court immediately in writing of any change in address or any arrest of the Defendant during the term of this diversion, and shall continuously keep the Court informed of his current telephone number.
5. The Defendant shall not violate any Federal, State, or Local law during his diversion. Any criminal violation other than a minor traffic offense will result in revocation of this diversion.
6. The City shall dismiss the aforementioned charges with prejudice on the first Wednesday in August, 2016, provided Defendant has complied with the terms of this agreement.
7. It is hereby agreed that Defendant's case shall be continued until the date certain on the Stay of Proceedings issued by the Court upon filing this agreement and that an additional condition of this diversion is that the Defendant shall appear in Court in response to any notice to so appear sent by certified or regular mail by the Defendant at his last known address. Defendant further understands and agrees that if he shall fail to appear at any

diversion revocation hearing following notice of such hearing being attempted by mail at this last known address that a bench warrant shall be issued for Defendant's arrest.

- 8. Defendant shall send a written letter to the prosecutor thirty days prior to conclusion of the diversion which shall list all arrests and/or convictions of defendant occurring during the term of this diversion.
- 9. In the event Defendant violates this Diversion, it is hereby agreed that this case shall proceed to trial based solely upon the following factual stipulation:

The official police reports shall be received as evidence by the Court without any further foundation. Defendant stipulates that on April 8, 2015 Defendant did knowingly cause physical contact with Sam Pacino within Wellington done in a rude, insulting, or angry manner by angrily pushing Pacino during an argument. This was not done in self defense and Hasart also yelled at Pacino during this altercation which was alarming to other persons present.

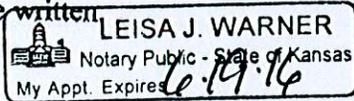
Curt Hasart

Defendant

COUNTY OF SUMNER, STATE OF KANSAS: SS

BE IT REMEMBERED, that on this 28th day of July, 2015, before me the undersigned, a Notary Public in and for the county and state aforesaid, came Curt Christopher Hasart who is personally known to me to be the same person who executed the within instrument of writing and such person duly acknowledged the execution of the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year last above written.



Leisa J. Warner
Notary Public

Attorney for Plaintiff

S. Brady Skov
Attorney for Defendant

Kerwin L. Spencer
Wellington City Prosecutor
119 E. 11th
Wellington, Kansas 67152
620-326-6199

IN THE MUNICIPAL COURT OF WELLINGTON, KANSAS

CITY OF WELLINGTON, Plaintiff

vs.

CASE NO.

CURT CHRISTOPHER HASART, Defendant

STAY OF PROCEEDINGS

Now on this _____ day of August, 2015, the above-entitled case comes before the court on Defendant's motion to Stay further proceedings herein until the first Wednesday in August, 2015, due to the parties having previously filed a Diversion Agreement herein. Defendant acknowledges he has waived his right to a speedy trial herein. Said Diversion Agreement is for the crimes of Battery, Section 3.1 Class B Misdemeanor and Disorderly Conduct, Section 9.1 Class C Misdemeanor.

Whereupon the Court hereby stays further proceedings on this case until the first Wednesday in August, 2016, at 6:30 p.m., or until such sooner time in which a Motion might be filed requesting a revocation of Diversion due to Defendant's noncompliance with the Diversion Agreement.

Municipal Court Judge

Approved by:

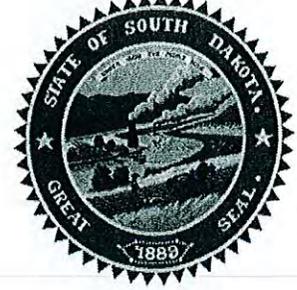
:

Approved by:

S. B. [Signature]

SOUTH DAKOTA
BOARD OF MEDICAL
AND OSTEOPATHIC
EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV



DOCUMENT Receipt or Delivery ACKNOWLEDGEMENT

Verified by Government Issued ID

8-3-15

Date



Document Title

Curt Hasart

Person Named in Document

Curt Hasart

Print Name

Person Receiving or Delivering Document - Verified by Government Issued ID

Curt Hasart

Signature

Person Receiving or Delivering Document - Verified by Government Issued ID

Lisa Anderson

Staff Member Signature

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Re: CURT HASART
EMT/Paramedic License #0809

FINAL ORDER

The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("the Board"), and Mr. Hasart having entered into a Consent Agreement with Reprimand, and the executive director, having been authorized by the Board, signed a temporary approval order on November 20, 2012, and

The Board having been fully advised in the premises thereof;
NOW; THEREFORE, the Board hereby:

APPROVES the Consent Agreement with Reprimand and the temporary order of approval and enters this Final Order. Further, these are public records of the Board and the State of South Dakota and shall be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

By:  Date: 28 Nov 12
South Dakota Board of Medical and Osteopathic Examiners

STATE OF SOUTH DAKOTA } s.s.
MINNEHAHA COUNTY

I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.

Executive Secretary
By: MBH by JTP
Date: 12-4-12

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Re: CURT HASART

TEMPORARY APPROVAL
ORDER

Curt Hasart (Mr. Hasart) and the South Dakota Board of Medical and Osteopathic Examiners (the Board) have entered into a Consent Agreement with Reprimand. The Board has authorized the executive director to execute this temporary approval order pending consideration by the Board at its next Board Meeting.

For this reason, said document has been temporarily approved pending consideration by the Board.

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By: Margaret B. Hansen Date: 11/20/2012
Margaret B. Hansen
Executive Director

STATE OF SOUTH DAKOTA }
MINNEHAHA COUNTY } s.s.

I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.

Executive Secretary
By: MJBH by TCH
Date: 11-20-12

STATE OF SOUTH DAKOTA } s.s.
MINNEHAHA COUNTY

I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Executive J...
By: [Signature] by JCH
Date: 11-20-12

IN RE: Curt Hasart

CONSENT AGREEMENT WITH REPRIMAND

This Consent Agreement with Reprimand, made and entered into by the South Dakota Board of Medical and Osteopathic Examiners, hereinafter referred to as "the Board", and Curt Hasart, hereinafter referred to as "Mr. Hasart", and the Board having been advised of the premises witnesseth:

1. Mr. Hasart is the holder of an active South Dakota EMT-Paramedic license.
2. Mr. Hasart engaged in unprofessional or dishonorable conduct, including but not limited to actions which would violate the provisions of SDCL 36-4-30(22).
3. Mr. Hasart's acts of unprofessional or dishonorable conduct include, but are not limited to the following: he was arrested for a simple assault incident that occurred on July 25, 2011, and he was arrested on August 22, 2011, for obstructing law enforcement and resisting arrest.
4. Mr. Hasart agrees that his behavior and his criminal charges constitute acts of unprofessional or dishonorable conduct.
5. Informal Agreement: It is the intent of the parties to this Consent Agreement with Reprimand to provide for the informal compromise and settlement of all issues which could be raised by a formal contested hearing. The Consent Agreement with Reprimand will be presented to the Board at a future meeting where it may accept, modify or reject the agreement.
6. Waiver of Rights: Mr. Hasart understands he has the right to consult with an attorney of his own choosing and has a right to an administrative hearing on the facts in this case. He understands and agrees that by signing this Consent Agreement with Reprimand he is waiving his rights to counsel and to a hearing. He further understands and agrees that by signing this Consent Agreement with Reprimand he is voluntarily and knowingly giving up his right to present oral and documentary evidence; to present rebuttal evidence, to cross-examine witnesses against him and to appeal the Board's decision to Circuit Court.
7. Consent Agreement, Decision and Order: Mr. Hasart agrees that the Board has the authority to issue the following Consent Agreement with Reprimand and subsequent Order.

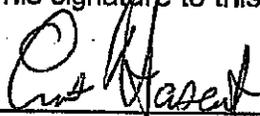
REPRIMAND

Reprimand: The following reprimand shall be placed in Mr. Hasart's file:

The Board hereby reprimands you, Curt Hasart, for the unprofessional or dishonorable conduct you exhibited which led to your arrests.

IT IS FURTHER AGREED that this Consent Agreement with Reprimand shall take effect immediately upon its adoption by the Board and is a public record of the Board and the State of South Dakota. The action taken by the Board in this Consent Agreement with Reprimand will be published on the Board's website, and reported to the national data banks, and all other entities deemed necessary by the Board in compliance with state and federal law.

Mr. Hasart has unconditionally agreed to this Consent Agreement with Reprimand by affixing his signature to this document.

By:  Date: October 19, 2012
Curt Hasart

By: _____ Date: _____, 2012
Attorney for Mr. Hasart (optional)

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By:  Date: 11-13-2012, 2012
South Dakota Board of Medical and Osteopathic Examiners



South Dakota Unified Judicial System



Record Search Report

Name: HASART, CURT	DOB: 09/18/1978	Gender: M	Party ID: 4253804	UJS ID: 1432031
Address: PO BOX 575 WELLINGTON, KS 67152				
Aliases: HASART, CURT; HASART, CURTIS CURTIS; HASART, CURTIS C; HASART, CURT C; HASART, CURTIS				

 Docket Number: 32C12000305A0 filed in Hughes County on 07/03/2012 Case Status: Terminated

Filing Name: HASART, CURTIS Arrest Date: 07/20/2012 Arrest Time: PCN:
 Plaintiff: STATE OF SOUTH DAKOTA Prosecutor: States Attorney
 Counsel Name: SCHREIBER, BRAD Counsel Type: Retained (Private) Counsel

Count of 22-18-1 (M1) DOM ABUSE - SIMPLE ASSAULT (Domestic Violence)

On 09/06/2012 the defendant pled Not Guilty **Disposed on 03/01/2013 Disposition: Dismissed-Motion by Prosecutor**

*** Warrant History ***	
Issued on 07/09/2012 for Arrest Warrant	Status: \$500.00 - Cash-Returned - 08/13/2012
*** Bond(s) Ordered ***	
Cash Bond Posted on 08/10/2012	Status: \$500.00 Returned 03/05/2013 - Posted by HASART, CURT

Proceeding Description	Judge Name	Begin Date	Begin Time	Status Description
Arraignment		09/06/2012	10:30AM	Held
Initial Appearance		08/20/2012	10:00AM	Waived
Status Hearing		11/29/2012	9:30AM	Held
Status Hearing		01/03/2013	10:00AM	Continuance-Requested by Defendant
Status Hearing		02/28/2013	10:30AM	Held
Status Hearing		03/28/2013	10:00AM	

 Docket Number: 58CIV12000053 filed in Stanley on 06/04/2012 Case Status: Terminated

Plaintiff: HASART, MARVIN
 Plaintiff: HASART, PAT
 Filing Name: HASART, CURT
 Filing Name: JONES, THERESA

Proceeding Description	Judge	Begin Date	Begin Time	Status Description
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Judgment	Judgment Status	Debtor(s)	Debtor Status	Creditor(s)
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 Docket Number: 32CIV11000493 filed in Hughes on 11/14/2011 Case Status: Terminated

Plaintiff: MIDLAND FUNDING LLC AS SUCCESSOR IN INTEREST TO CREDIT ONE BANK, N.A.
 Filing Name: HASART, CURT

Proceeding Description	Judge	Begin Date	Begin Time	Status Description
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Judgment	Judgment Status	Debtor(s)	Debtor Status	Creditor(s)
01	Active	HASART, CURTIS C	Active	
01	Active			MIDLAND CREDIT MANAGEMENT INC.

Judgment Activity	Judgment Date	Amount	Filing Date/Time	Docketing Date/Time
Original Judgment	1/9/2012	\$1,440.58	01/10/2012 01:00 PM	01/10/2012 01:28 PM
Original Cost	1/9/2012	\$95.00	01/10/2012 01:00 PM	01/10/2012 01:28 PM
Original Interest	1/9/2012	\$487.33	01/10/2012 01:00 PM	01/10/2012 01:28 PM

Docket Number: 32C11000405A0 filed in Hughes County on 08/24/2011 Case Status: Terminated
 Filing Name: HASART, CURT Arrest Date: 08/22/2011 Arrest Time: 10:54 AM PCN: 51051585669
 Plaintiff: STATE OF SOUTH DAKOTA Prosecutor: States Attorney
 Counsel Name: MAULE, THERESA Counsel Type: Retained (Private) Counsel

Count of 22-11-6 (M1) OBSTRUCT POLICE,JAILER OR FIREFIGHTER

On 09/06/2011 the defendant pled No Plea Entered **Disposed on 09/06/2011 Disposition: Dismissed-Motion by Prosecutor**
 Fine: \$336.00 Costs: \$84.00

Count of 22-11-4 (M1) RESISTING ARREST

On 09/06/2011 the defendant pled No Plea Entered **Disposed on 09/06/2011 Disposition: Dismissed-Motion by Prosecutor**

Count of 22-18-35 (M2) DISORDERLY CONDUCT

On 09/06/2011 the defendant pled Not Guilty **Disposed on 01/12/2012 Amended Disposition: Dismissed-Motion by Prosecutor**
 On 09/06/2011 the defendant pled Not Guilty **Disposed on 01/12/2012 Disposition: Dismissal-Deferred Prosecution**

Count of 22-11-6 (M1) OBSTRUCT POLICE,JAILER OR FIREFIGHTER

On 01/12/2012 the defendant pled Guilty by POA **Disposed on 01/12/2012 Disposition: Judgment on Plea of Guilty**
 Sentenced on 01/12/2012
 Incarcerated to Jail for 15 Day(s) Concurrent with 5 Day(s) suspended and credit for 10 Day(s) served.

Count of 22-11-4 (M1) RESISTING ARREST

On 09/06/2011 the defendant pled Not Guilty **Disposed on 01/12/2012 Disposition: Dismissal-Deferred Prosecution**
 Fine Due Date: 02/13/2012

*** Bond(s) Ordered ***	
Cash Bond Posted on 09/01/2011	Status: \$10500.00 Inactive 01/13/2012 - Posted by ZZRUPE, ERIC

Conditions	
1	PAY THE FINE & COSTS Condition Expiration Date: 20120213
2	LAW ABIDING CITIZEN; NO VIOLATIONS OF THE LAW Condition Expiration Date: 20130112 [COND-TIME] = 1 [COND-TIME-UNIT] = Y

Proceeding Description	Judge Name	Begin Date	Begin Time	Status Description
Motions Hearing		10/13/2011	2:00PM	Continuance-Requested by Defendant
Sentencing Hearing		01/12/2012	10:30AM	Held

Arraignment	01/12/2012	10:30AM	Held
Initial Appearance	08/26/2011	9:00AM	Held
Arraignment	09/06/2011	1:30PM	Held
Status Hearing	01/05/2012	10:30AM	Continuance-Requested by Court
Bond Hearing	08/26/2011	9:00AM	Held
Status Hearing	12/01/2011	11:00AM	Held
Status Hearing	12/08/2011	11:00AM	Held
Bond Hearing	09/06/2011	1:30PM	Held

Docket Number: 32C11000380A0 filed in Hughes County on 08/16/2011 Case Status: Terminated
 Filing Name: HASART, CURTIS Arrest Date: 08/22/2011 Arrest Time: PCN: 51051585667
 Plaintiff: STATE OF SOUTH DAKOTA Prosecutor: States Attorney
 Counsel Name: MAULE, THERESA Counsel Type: Retained (Private) Counsel

Count of 22-18-1 (M1) DOM ABUSE - SIMPLE ASSAULT (Domestic Violence)

On 01/12/2012 the defendant pled No Plea Entered **Disposed on 01/12/2012 Disposition: Dismissal-Deferred Prosecution**

*** Warrant History ***	
Issued on 08/19/2011 for Arrest Warrant	Status: \$500.00 - Cash-Returned - 08/22/2011
*** Bond(s) Ordered ***	
Cash Bond Posted on 08/24/2011	Status: \$500.00 Inactive 01/13/2012 - Posted by ZZELLER, ASHLEY

Proceeding Description	Judge Name	Begin Date	Begin Time	Status Description
Status Hearing		10/13/2011	2:00PM	Continuance-Requested by Defendant
Status Hearing		12/08/2011	11:00AM	Held
Initial Appearance		09/12/2011	10:00AM	Held
Status Hearing		12/01/2011	11:00AM	Held
Status Hearing		01/05/2012	10:30AM	Continuance-Requested by Court
Status Hearing		01/12/2012	10:30AM	Held

Docket Number: 32TPO11000342 filed in Hughes on 07/25/2011 Case Status: Terminated Disposition: Granted
 Petitioner: THERESA FRICK Counsel Name:
 Respondent: CURT HASART Counsel Name:

A Permanent Order of Protection against DOMESTIC ABUSE was issued on 08/24/2011 and expires on 08/24/2016 against CURT HASART by THERESA FRICK

Proceeding Description	Judge Name	Begin Date	Begin Time	Status Description
TPO-Ex Parte Order Hearing	Mark Barnett	7/25/2011	12:00 AM	Held
All Other Hearings	Lori Wilbur	8/8/2011	11:00 AM	Continuance-Requested by Defendant
All Other Hearings	Mark Barnett	8/22/2011	12:00 AM	Held
TPO-Permanent Order Hearing	Mark Barnett	8/24/2011	12:00 AM	Cancelled - Decision Prior To

Docket Number: 29399M1000261 filed in Hand County on 06/28/2010 Case Status: Terminated
 Filing Name: HASART, CURT C Arrest Date: 06/15/2010 Arrest Time: 6:00 PM PCN:
 Plaintiff: STATE OF SOUTH DAKOTA Prosecutor: States Attorney

Count of 32-25-1.1 (M2) SPEEDING ON A STATE HIGHWAY

On 07/13/2010 the defendant pled Guilty by POA **Disposed on 07/13/2010 Disposition: Judgment on Plea of Guilty**

Sentenced on 07/13/2010 Fine: \$56.00 Costs: \$66.00

Fine Due Date: 07/13/2010

Proceeding Description	Judge Name	Begin Date	Begin Time	Status Description
Initial Appearance		07/13/2010	12:00AM	Waived

 Docket Number: 32TPO07000240 filed in Hughes on 06/29/2007 Case Status: Terminated Disposition: TPO-Dismissed-Other
 Petitioner: CURT HASART Counsel Name: EMILY SOVELL
 Respondent: THERESA FRICK Counsel Name:

A case of STALKING was filed against THERESA FRICK by CURT HASART

Proceeding Description	Judge Name	Begin Date	Begin Time	Status Description
TPO-Ex Parte Order Hearing	James W. Anderson	6/29/2007	12:00 AM	Held
All Other Hearings	James W. Anderson	7/23/2007	3:30 PM	Held
TPO-Permanent Order Hearing	James W. Anderson	8/6/2007	9:00 AM	Held

 Docket Number: 29399M0400270 filed in Hand County on 09/07/2004 Case Status: Terminated
 Filing Name: HASART, CURTIS C Arrest Date: 09/07/2004 Arrest Time: 1:49 PM PCN:
 Plaintiff: STATE OF SOUTH DAKOTA Prosecutor: States Attorney

Count of 32-25-1.1 (M2) SPEEDING ON A STATE HIGHWAY

On 09/28/2004 the defendant pled Guilty by POA **Disposed on 09/28/2004 Disposition: Judgment on Plea of Guilty**
 Sentenced on 09/28/2004 Fine: \$55.00 Costs: \$44.00
 Fine Due Date: 09/28/2004

Proceeding Description	Judge Name	Begin Date	Begin Time	Status Description
Initial Appearance		09/28/2004	12:00AM	Waived

 Docket Number: 32CIV03000470 filed in Hughes on 11/14/2003 Case Status: Terminated
 Plaintiff: HASART, CURTIS CURTIS
 Filing Name: FRICK, THERESA

Proceeding Description	Judge	Begin Date	Begin Time	Status Description
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Judgment	Judgment Status	Debtor(s)	Debtor Status	Creditor(s)
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 Docket Number: 32REC03000467 filed in Hughes on 11/13/2003 Case Status: Terminated
 Plaintiff/obligee: STATE OF SOUTH DAKOTA EX REL
 Plaintiff/obligee: FRICK, THERESA
 Defendant/obligor: HASART, CURTIS CURTIS

Proceeding Description	Judge	Begin Date	Begin Time	Status Description
All Other Hearings		07/25/2011	9:00 AM	Held
Other Hearing		01/21/2014	9:00 AM	Held

=====
 Judgement Status Debtor(s) Creditor(s)
 =====
 HASART, CURTIS
 CURTIS

STATE OF SOUTH
 DAKOTA EX REL
 FRICK, THERESA

Judgement Activity	Judgment Date	Amount	Filing Date	Time	Docketing Date/Time
	10/17/2007				
	07/25/2011				
	02/12/2014				

Docket Number: 02399M0000806 filed in Beadle County on 05/11/2000 Case Status: Terminated
 Filing Name: HASART, CURTIS C Arrest Date: 05/03/2000 Arrest Time: 1:11 PM PCN:
 Plaintiff: STATE OF SOUTH DAKOTA Prosecutor: States Attorney

Count of 32-25-1.1 (M2) SPEEDING ON A STATE HIGHWAY

On 06/07/2000 the defendant pled Guilty by POA **Disposed on 06/07/2000 Disposition: Judgment on Plea of Guilty**
 Sentenced on 06/07/2000 Fine: \$75.00 Costs: \$33.00
 Fine Due Date: 06/07/2000

Proceeding Description	Judge Name	Begin Date	Begin Time	Status Description
Initial Appearance		06/07/2000	12:00AM	Waived

Docket Number: 19399M9700515 filed in Deuel County on 09/15/1997 Case Status: Terminated
 Filing Name: HASART, CURTIS C Arrest Date: 09/11/1997 Arrest Time: 5:40 PM PCN:
 Plaintiff: STATE OF SOUTH DAKOTA Prosecutor: States Attorney

Count of 32-25-4 (M2) SPEEDING ON INTERSTATE HIGHWAY

On 10/13/1997 the defendant pled Guilty by POA **Disposed on 10/13/1997 Disposition: Judgment on Plea of Guilty**
 Sentenced on 10/13/1997

Proceeding Description	Judge Name	Begin Date	Begin Time	Status Description
Initial Appearance		10/13/1997	12:00AM	Waived

The search you requested is a court records search based on information you provided. The search results may include criminal court data from January 1989 to present, civil court data from January 2006 to present, active money judgments for the past twenty years, and/or inactive money judgments since April 2004, DEPENDING ON THE TYPE OF SEARCH REQUESTED. Records returned are only those that precisely match this information. There may be instances where fine and cost information will appear immediately below a dismissed charge. The amounts indicated are accurate for a different charge but there should be no fine and cost information related to a dismissed charge. Based on the age of a case, not all financial information may be available in the case management system. You should contact the Clerk of Court office where an original action took place to correct any misinformation and collect any missing information.

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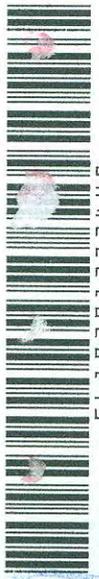
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Date Accepted (MM/DD/YY)	Scheduled Delivery Time	<input type="checkbox"/> 10:30 AM <input type="checkbox"/> 12 NOON	Return Receipt Fee
2-3-16	4:00	<input type="checkbox"/> 10:30 AM Delivery Fee	\$
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Delivery Attempt (MM/DD/YY)	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	

LABEL 11-B, SEPTEMBER 2015 PSN 7690-02-000-9996 3-ADDRESSEE COPY

February 3, 2016

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

Dear South Dakota Board of Medical and Osteopathic Examiners:

After extensive consultation and discussion with my attorney, friends, family, and employees of the South Dakota Department of Health, I hereby voluntarily surrender my EMT-Paramedic license number 0809 effective immediately. Enclosed, please find my original certificate and card.

The decision to voluntarily surrender is in direct relation to the current investigation and hearing by the Board, No. 16-010. It is fact that I have not resided in the State of South Dakota, nor been employed by any service or institution in South Dakota since 2011. I have simply renewed my license for simplicity in event I ever returned to the State. However, the costs associated with meeting the requirements of the Board or contesting the ruling are not financially feasible or professionally feasible with the current minimal chance of ever returning to practice in the State.

In regards to the hearing set forth for February 12, 2016, neither I nor legal representation will be present to any ongoing proceedings.

Sincerely,



Curt Hasart

Enc. License 0809

South Dakota Board of Medical and Osteopathic Examiners

This is to Certify that

Curt Hasart

*Is a licensed EMT-Paramedic under the provisions of the laws of the State of South Dakota
and is entitled to practice Advanced Life Support.*

License No. 0809

Renewed on 07/15/2015

Not Valid After 07/15/2016

Brent J. Lindbloom, DO, Secretary


Initialed By

If any information on the certificate above or card below is inaccurate, contact the SDBMOE at sdbmoe@state.sd.us to report the problem. It is your responsibility to ensure your mailing address and contact information is updated with the SDBMOE office.

**SOUTH DAKOTA BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS**

EMT-Paramedic License

Name: **Curt Hasart**

Number: **0809**

Renewed: **07/15/2015**

Not Valid After: **07/15/2016**

The above named individual is a licensed EMT-Paramedic under the provisions of the laws of the State of South Dakota.

Brent J. Lindbloom, DO, Secretary


Initialed By

**To remove your card, bend
carrier back at the side.
Then lift and peel card
away from the carrier.**

STATE OF SOUTH DAKOTA
DEPARTMENT OF HEALTH

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

IN THE MATTER OF THE
SOUTH DAKOTA PARAMEDIC
LICENSE #1788 ISSUED TO:

CASE 16-058
TEMPORARY ORDER

WADE WELLS

WHEREAS, Wade Wells, Paramedic, (Mr. Wells) agreed to a Consent Agreement with Reprimand and 90-Day Suspension of License due to actions taken by other state licensing authorities, and

WHEREAS, the executive secretary of the South Dakota Board of Medical and Osteopathic Examiners (the Board) has signed a temporary approval order pending consideration by the full Board at a future Board meeting, it is therefore,

ORDERED THAT the Consent Agreement with Reprimand and 90-Day Suspension is temporarily approved pending consideration by the Board at a future Board meeting.

Dated this 12 day of May, 2016

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By: Margaret B. Hansen

Margaret B. Hansen
Executive Director

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

In Re: WADE WELLS, PARAMEDIC

CONSENT AGREEMENT
WITH REPRIMAND
90-DAY SUSPENSION OF LICENSE

CONSENT AGREEMENT

IT IS AGREED by the South Dakota Board of Medical and Osteopathic Examiners (the Board) and Wade Wells, Paramedic (Mr. Wells) as follows:

Mr. Wells has been subject of disciplinary actions imposed by the State of Wyoming and the State of Colorado, copies of which are attached hereto and incorporated herein. The Board is authorized to take disciplinary action pursuant to SDCL 36-4-30(24) and SDCL 36-4B-31 due to discipline imposed by another state licensing authority.

Informal Agreement: It is the intent of the parties to this Consent Agreement with Reprimand and 90-Day Suspension to provide for the informal compromise and settlement of all issues which could be raised by a formal contested hearing. This agreement will be presented at a future Board meeting where the Board may accept, modify or reject the agreement.

Waiver of Rights: Mr. Wells understands he has the right to consult with an attorney of his own choosing and has a right to an administrative hearing on the facts in this case. He understands and agrees that by signing this Agreement, he is waiving his rights to counsel and to a hearing. He further understands and agrees that by signing this Agreement he is voluntarily and knowingly giving up his right to present oral and documentary evidence, to present rebuttal evidence, to cross-examine witnesses against him and to appeal the Board's decision to Circuit Court.

Disclosure Waiver: Mr. Wells understands that the Board has reporting requirements and he consents to the documents relating to this matter being provided to the required entities and to state licensing authorities upon request.

Consent Agreement with Reprimand: Mr. Wells understands and agrees that the Board has the authority to enter into this Agreement and to issue the following Reprimand and impose the 90-Day Suspension:

REPRIMAND

The Board hereby reprimands Mr. Wade Wells and imposes a 90-Day suspension of his South Dakota paramedic license due to disciplinary actions imposed by the State of Wyoming and the State of Colorado, copies of which are attached hereto and incorporated herein.

It is agreed that this Consent Agreement with Reprimand and 90-Day Suspension shall take effect immediately upon final approval by the Board, and that this action is a public record of the Board and the State of South Dakota. It shall be published on the Board's website and reported to the national databanks and all other entities deemed appropriate by the Board in compliance with state and federal law.

Mr. Wells has unconditionally accepted this Consent Agreement with Reprimand and 90-Day Suspension of his paramedic license by affixing his signature to this document.

By: Wade Wells Date: 4/22/16
Wade Wells

By: _____ Date: _____
Attorney for Mr. Wells (optional)

By: Walter O. Carlson, MD Date: 4/26/2016
Walter O. Carlson, MD
President
SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS



Wyoming Department of Health

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Thomas O. Forslund, Director

Governor Matthew H. Mead

December 11, 2015

Ref: BMS-2015-265

Wade Wells
505 12th ST
Wheatland, WY 82201

COPY

Dear Wade:

Licensure Suspension Agreement

This letter is to confirm by your signature, the acceptance of a suspension of your Paramedic license in lieu of revocation of that same license. Information concerning this investigation and leading to this agreement is found in Case File # 2015-127-115. By accepting this agreement you are agreeing to the following terms:

1. A ninety (90) day suspension of your paramedic license, during which time you are not permitted to provide services as a paramedic.
2. Successful completion of an ethics course as approved by the OEMS Manager.
3. A one year probationary period commencing at the end of the suspension.
4. Waive your right to appeal under the Wyoming Administrative Procedures Act.

Your dated signature below will serve as your acceptance of and agreement to abide by the terms listed above. This agreement should be returned to the OEMS within 14 days of its receipt. If you choose not to exercise this agreement, you may write your decision on this same statement and return to us. In any event, if we do not receive this signature prior to 5:00 PM, on Monday, December 28, 2015, this Office will proceed with a permanent revocation of your paramedic license.

The effective date of this suspension will be established on receipt of your signed statement accepting this agreement, and will be communicated to you by letter and email.

Respectfully,

Andy Gienapp, MS, NRP
Manager
Office of Emergency Medical Services
Public Health Division

I agree to the terms stated above.

Signature and Date

c: Travis Kirchhefer, Senior Assistant Attorney General, Wyoming Attorney General's Office

6101 Yellowstone Road, Suite 400 • Cheyenne WY 82002
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Thomas O. Forslund, Director

December 28, 2015

Governor Matthew H. Mead

Ref.: EMS-2015-286

Wade Wells
505 12th ST
Wheatland, WY 82201

Dear Wade:

COPY

Licensure Suspension Term

This letter is to confirm the receipt of the signed letter of acceptance of suspension of your Paramedic license, and to clarify the stipulations. The letter of agreement with your signature was received in the Office of Emergency Medical Services and Trauma (OEMST) via email December 18, 2015. The effective start date of your ninety (90) suspension then is December 18, 2015, and the suspension will end on March 17, 2016. The OEMS will then review the status of your suspension on that date and a letter indicating either a successful or unsuccessful completion of your suspension will be sent to you via both email and certified mail.

With regard to the completion of an ethics course, we did not specify a time requirement for completion. We recognize that this training may be difficult to identify and complete within the 90 day suspension, but feel that completion by June 30, 2016, is reasonable.

Additionally, you should contact the OEMS with any questions that arise during your suspension period.

Sincerely,

Andy Gienapp, MS, NRP
Manager
Office of EMS and Trauma
Public Health Division
Wyoming Department of Health

c: Travis Kirchhefer, Senior Assistant Attorney General, Wyoming Attorney General's Office

6101 Yellowstone Road, Suite 400 • Cheyenne WY 82002
E-Mail: andy.gienapp@wyo.gov • WEB Page: <http://health.wyo.gov/sho/ems/index.html>
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COLORADO
 Department of Public
 Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

COPY

VIA CERTIFIED MAIL AND ELECTRONIC MAIL

January 19, 2016

Mr. Wade Wells
 17 Rick Road
 Wheatland, WY 802201

RE: EMT Certification #057722

Dear Mr. Wells:

Pursuant to authority granted to the Colorado Department of Public Health and Environment ("Department") in C.R.S. §§ 25-3.5-203 and 205, the Department has concluded an investigation initiated after receipt of your disclosure that your paramedic license issued by the State of Wyoming is suspended for 90 days, effective Dec. 18, 2015. It was the Department's decision, based upon this investigation, that there is good cause to issue a Letter of Admonition in accordance with Department rules at 6 CCR 1015-3, Chapter One, Section 6.2.10. This Letter of Admonition is based on the following conduct:

The State of Wyoming suspended your paramedic license for 90 days following a determination that you altered an expired CPR card to indicate that it was still valid.

By this letter, the Department hereby admonishes you and cautions you that any repetition of similar behavior or practice may lead to the commencement of disciplinary proceedings up to and including suspension and/or revocation of your Paramedic certification, wherein this Letter of Admonition may be entered into evidence as aggravation.

In addition to this Letter of Admonition being maintained with your EMT certification file within the Department of Public Health and Environment, you understand and agree that upon a valid request pursuant to the applicable public disclosure laws, including, but not limited to, the provisions of C.R.S. § 24-72-101, et seq., the Department is obligated to provide the requesting person a copy of this Letter of Admonition.

As required under sections 1921 and 1128E of the Social Security Act (SSA), this Letter of Admonition (and any subsequent actions as applicable) shall be reported to the Healthcare Integrity and Protection Data Bank (HIPDB) and/or National Practitioner Data Bank (NPDB).

By signing below and returning this letter to the Department, you agree to this Letter of Admonition. If we have not received your signature to this Letter of Admonition (Initially, at least via fax or e-mail) by close of business on January 29, 2016, this Letter of Admonition will be deemed vacated, and the matter may be processed by means of a formal complaint and hearing.

Sincerely,

D. Randy Kuykendall
 Division Director
 Health Facilities and Emergency Medical Services Division



Wade Wells

Mr. Wade Wells
17 Rick Road
Wheatland, WY 802201

3/15/16

Date Signed

Return this signed Letter of Admonition via U. S. Mail to:

Colorado Department of Public Health and Environment
ATTN: EMTS Branch Chief
Health Facilities and Emergency Medical Services Division
4300 Cherry Creek Drive South
Denver, Colorado.80246-1530



STATE OF SOUTH DAKOTA
DEPARTMENT OF HEALTH
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Re: SUZANNE M. RYAN

TEMPORARY APPROVAL
ORDER:

REINSTATEMENT OF CNM
LICENSE

WHEREAS, the South Dakota Board of Nursing approved the reinstatement of the certified nurse midwife license issued to Suzanne M. Ryan, and

WHEREAS, the executive director of the South Dakota Board of Medical and Osteopathic Examiners has entered this temporary approval order pending review by the full Board, and

WHEREAS, this matter will be presented to the full Board at the next meeting on June 2, 2016, for consideration.

For this reason, said reinstatement has been temporarily approved pending consideration by the full Board.

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By: Margaret B. Hansen Date: March 22, 2016

Margaret B. Hansen
Executive Director

WHEREAS, upon review, the Board has determined that the Licensee has met the terms and conditions of the Kansas Order and has fulfilled her remediation and continuing education obligation in regard to that Order; and

WHEREAS, the Board was advised that as of February 25, 2016, the Licensee holds a valid CNM license in Maine and Missouri.

WHEREAS, upon presentation of Licensee's reinstatement request, the Board considered the Licensee's request, the documents submitted, and being fully advised in the premises;

NOW THEREFORE IT IS HEREBY ORDERED:

1. That the Board has jurisdiction over the person of the Licensee and the subject matter of this Order.
2. That the Licensee's license to practice as a certified nurse midwife in the State of South Dakota is hereby reinstated.

IT IS HEREBY ORDERED that the above Order of Reinstatement of CNM License was adopted by the South Dakota Board of Nursing on the 19th day of February, 2016, by a vote of 8-0.

SOUTH DAKOTA BOARD OF NURSING



Gloria Damgaard, RN, MS
Executive Director

Order of Reinstatement of CNM License
Licensee: Suzanne M. Ryan

The South Dakota Board of Medical and Osteopathic Examiners met on the _____ day of _____, 2016, and approved the terms and conditions of this Order of Reinstatement by a vote of ___ - ___ and issued its Order as follows:

IT IS HEREBY ORDERED that the above Order of Reinstatement of CNM License is adopted as shown herein by the South Dakota Board of Medical and Osteopathic Examiners this _____ day of _____, 2016.

SOUTH DAKOTA BOARD OF MEDICAL &
OSTEOPATHIC EXAMINERS

Board President

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

April 2016

By BMOE Staff

LICENSING: Ensure only qualified professionals are licensed and allowed to practice.

Current/Past Events:

Training and Meetings attended

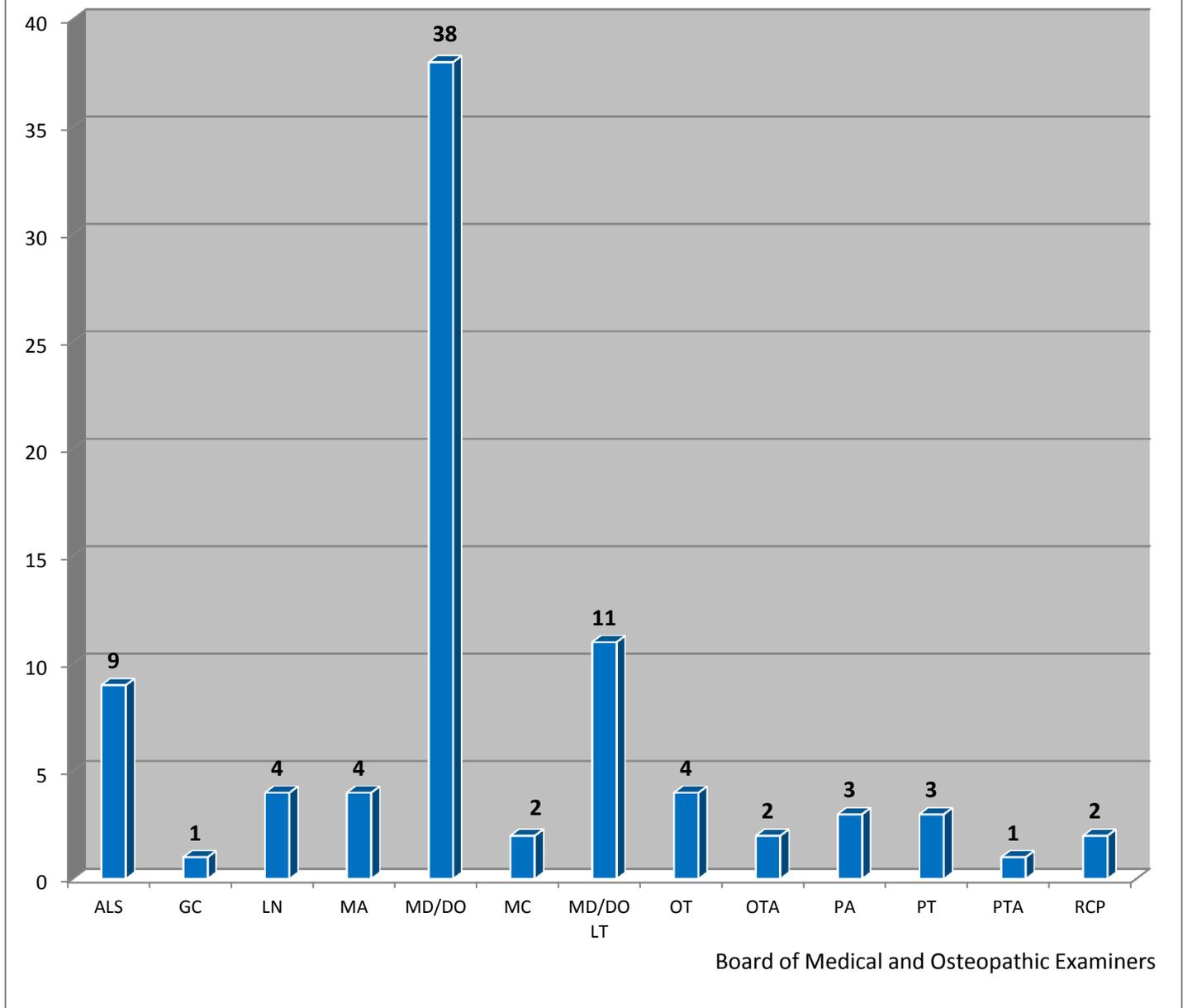
The database vendor, Albertson Consulting continues the process of transferring BMOE data to its Big Picture product. Weekly phone conference call updates continue with the Board staff and the Albertson Consulting project manager and transition team. Albertson Consulting finally agreed to a secure login for applicants, licensees and authorized agents – previously they were advocating for a login using last name, part of the social security and either license or NPI number.

Current and Upcoming Advisory Committee and Staff Meetings:

- Advisory Committee Meeting Schedule
 - Advanced Life Support Advisory Committee – May 25th
 - Athletic Trainer Advisory Committee – May 5th
 - Genetic Counselor Advisory Committee – May 5th
 - Nutrition and Dietetics Advisory Committee – May 10th
 - Occupational Therapy Advisory Committee – May 9th
 - Physical Therapy Advisory Committee – May 17th
 - Physician Assistant – May 25th
 - Respiratory Care Practitioners – May 26th
- Tyler Klatt will be attending the inaugural Regulatory Leadership Forum held by the National Board for Certification in Occupational Therapy

Statistics

84 New Licensures Issued in April 2016

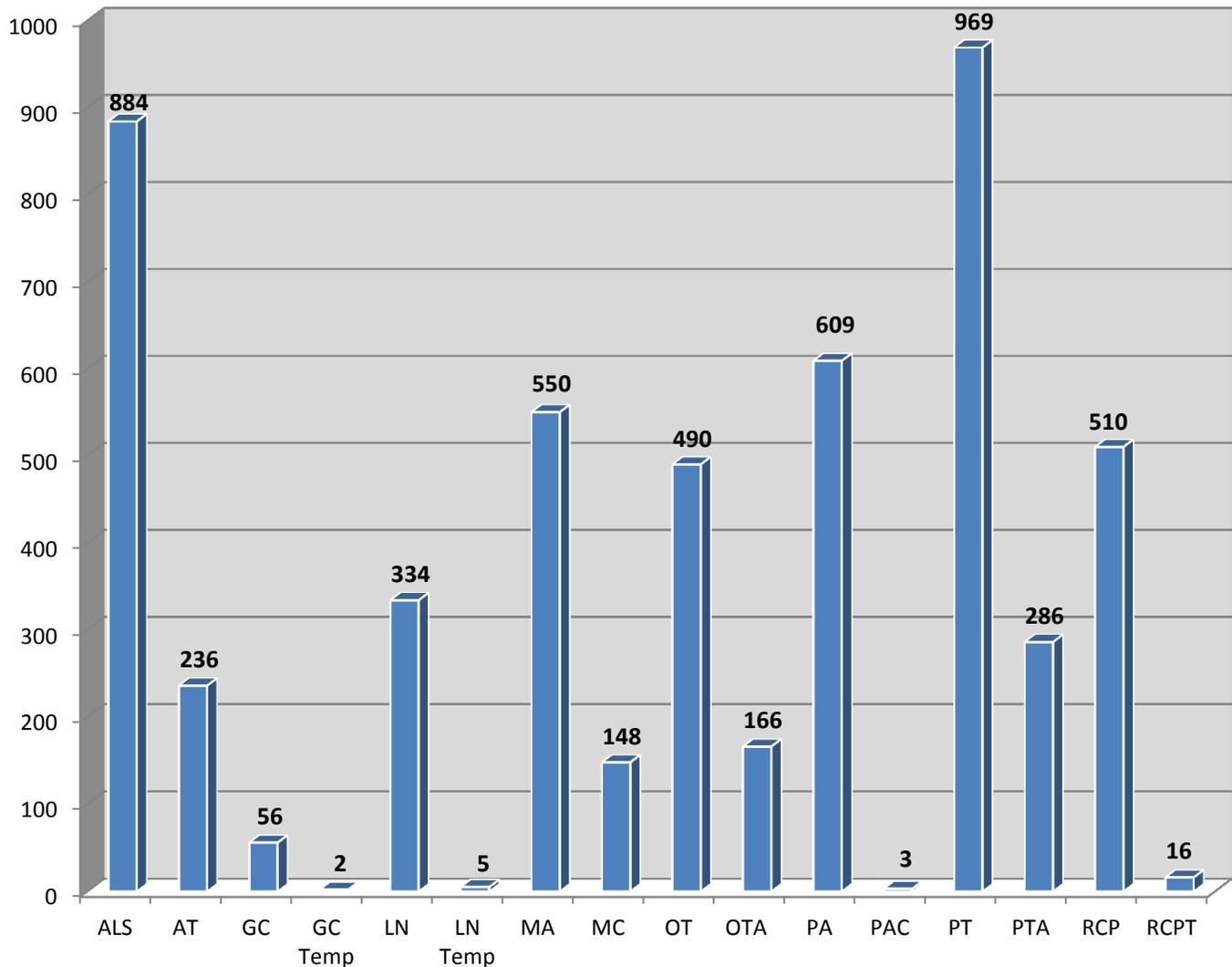


ALS – Advanced Life Support
 AT – Athletic Trainer
 GC – Genetic Counselor
 LN – Licensed Nutritionist/ Dietitian
 MA – Medical Assistant
 MD/DO – Medical License
 MD/DO LT – Physician Locums Tenens

OT – Occupational Therapist
 OTA – Occupational Therapist Assistant
 PA – Physician Assistant
 PT – Physical Therapist
 PTA – Physical Therapist Assistant
 RCP – Respiratory Care Practitioner

Current Non-Physician Counts

(As of 04/29/2016)



ALS – Advanced Life Support

AT – Athletic Trainer

GC – Genetic Counselor

LN – Licensed Nutritionist

MA – Medical Assistant

MC – Medical Corporation

OT – Occupational Therapist

OTA – Occupational Therapy Assistant

PA – Physician Assistant

PAC – Physician Assistant Corporation

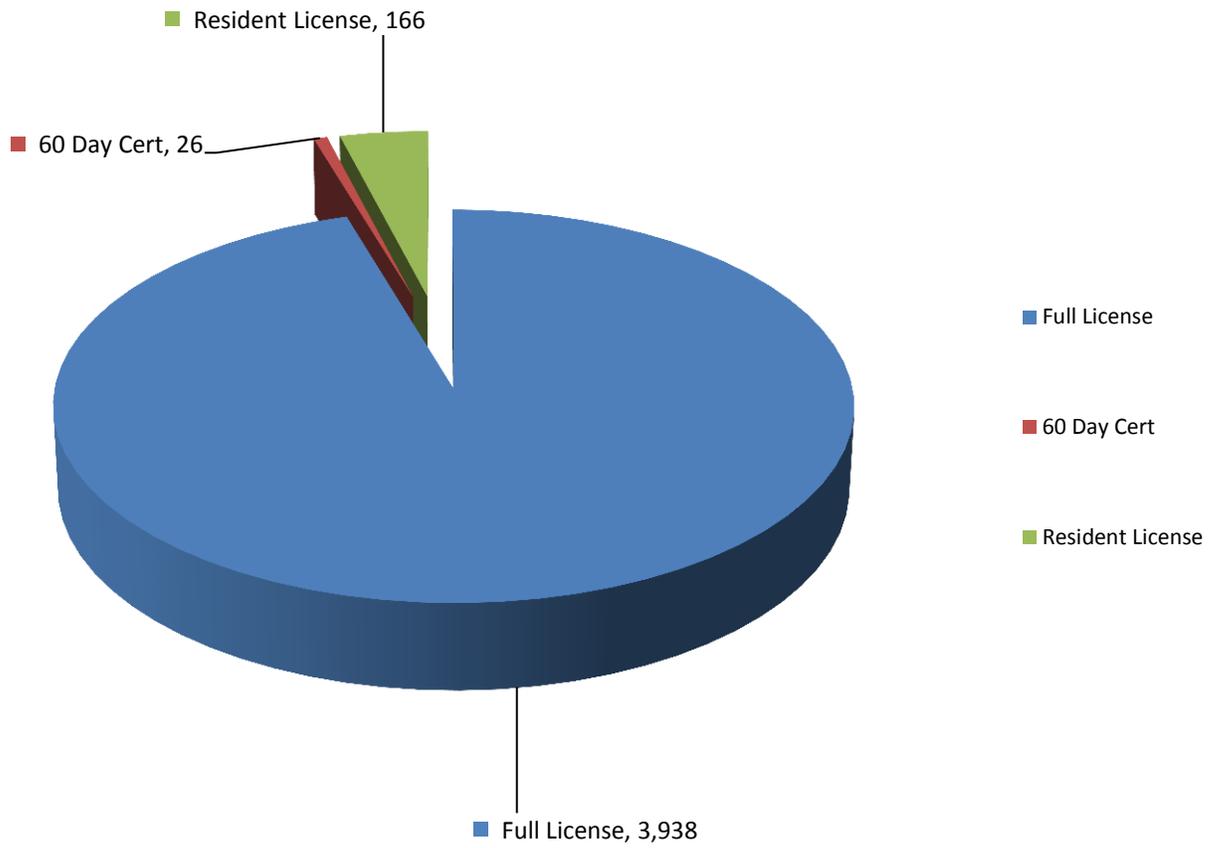
PT – Physical Therapist

PTA – Physical Therapist Assistant

RCP – Respirator Care Practitioner

Current MD/DO Counts

(As of 04/29/2016)



INVESTIGATIONS: Ensure complaints and issues are properly investigated and resolved.

Issues

Complaints:

Summary of new applications

- 1.) New Licenses were issued
 - a. 84 new licenses issued
 - b. 20 complex applications resolved or closed

Statistics

**Investigations and Complaints
(As of 04/29/2016)**

<u>Category</u>	<u>New</u>	<u>On-going</u>	<u>Resolved</u>
Complex Applications	16	86	20
Complaints/ Investigations	18	51	12
Competency (Malpractice cases)	0	410	0

**Reinstatement and Renewal Applications
(As of 04/29/2016)**

<u>Category</u>	<u>New</u>	<u>On-going</u>	<u>Completed</u>
Reinstatement and Renewal Applications	4	28	8

OUTREACH: Make life easier for our customers.

Education

The Executive Director and Board staff continues to meet and do outreach to the medical school, residency programs, healthcare recruiters, clinic managers, health system administrators, state regulatory boards and associations as well as with the SDBMOE licensees.

Outreach Efforts:

Outreach Activities

(Totals reflect activities from first to last day of month)

Activity	Organization	# Participants	Topic Covered
Training	Academic Program (Residency) Directors & Coordinators. Healthcare Systems Recruiter. Board & Advisory Members	140	Licensing discussion
Phone/General Email	Licensees/ Applicants	415	General questions
In-Office Assistance	Licensees/ Applicants	176	Renewal and general questions

Upcoming Events:

- **2016 Meeting Dates**
 - June 2, September 8 and December 1
- **2017 Meeting Dates**
 - March 9, June 8, September 14, and December 14
- **2018 Meeting Dates**
 - March 8, June 14, September 13, and December 13

Unapproved Draft Minutesⁱ

South Dakota Board of Medical and Osteopathic Examiners Public Meeting and Public Rules Hearing- 9:00 am (CT) Thursday, March 3, 2016

Boards Members Present: Kevin Bjordahl, MD; Ms. Deb Bowman; Walter Carlson, MD; Mary Carpenter, MD; Laurie Landeen, MD; Brent Lindbloom, DO; Mr. David Lust; Jeffrey Murray, MD; Elmo Rosario, MD

Board Staff Present: Margaret Hansen, PA-C; Mr. Tyler Klatt; Ms. Jane Phalen; Ms. Misty Rallis

Board Counsel: Steven Blair

Staff Counsel: William Golden

Attendees: Jason Culberson, EMT Paramedic, Rapid City Fire Department
Wade Nyberg, Assistant City Attorney, Rapid City
Mark East, South Dakota State Medical Association (SDSMA)
Dr. James Oury
Dr. Steven Myers (via phone)

1. Dr. Walter Carlson, president of the Board, called the meeting to order at 9:00 am. Roll was called and a quorum was confirmed. A motion: to approve the agenda was ratified by roll call vote (Landeen/unanimous).
2. The scheduled Public Hearing on Administrative Rules was called to order. Dr. Carlson, president of the Board, appointed Mr. Steven Blair to preside over the hearing. Mr. Blair explained the proceedings, and introduced the proposed rules.

Primarily based on LRC comments, board staff requested the withdrawal of the following proposed rules:

- a. *Article 20:47, Chapter 20:47:03, Section 20:47:03:13-Physicians and Surgeons Licensure – Locum Tenens Certificate;*
- b. *Article 20:52, Chapter 20:52:01, Section 20:52:01:03:02 – Supervision of a licensed physician assistant-separate practice location;*
- c. *Article 20:63, Chapter 20:63:01,02&03 – Athletic Trainers – General Provisions;*
- d. *Article 20:66, Chapter 20:66:03 - Physical Therapists and Physical Therapist Assistants – Continuing Education;*
- e. *Article 20:83, Chapter 20:83:04, Section 20:83:04:03 – Licensed Nutritionists – Continuing Education - Waiver.*

A motion: to enter into executive session pursuant to SDCL 1-25-2(3) to consult with legal counsel was ratified by roll call vote (Landeen/unanimous).

The public rules hearing resumed.

A motion: to withdraw *Article 20:47, Chapter 20:47:03, Section 20:47:03:13-Physicians and Surgeons Licensure – Locum Tenens Certificate*, and direct the board staff to schedule a declaratory rules hearing regarding *SDCL 36-4-20.4-Duration of locum tenens certificates-privileges of certificate holder* was ratified by roll call vote (Landeen/unanimous).

A motion: to pursue legislation for authority to amend *SDCL 36-4-20.4* to state that a locum tenens certificate may be issued one time, and may be extended one additional time for 60 days was ratified by roll call vote (Landeen/unanimous).

A motion: to withdraw *Article 20:52; Chapter 20:52:01, Section 20:52:01:03:02 – Supervision of a licensed physician assistant-separate practice location; Article 20:63; Chapter 20:63:01,02&03 – Athletic*

Trainers; Article 20:66; Chapter 20:66:03 - Physical Therapists and Physical Therapist Assistants – Continuing Education; and Article 20:83, Chapter 20:83:04, Section 20:83:04:03 – Licensed Nutritionists- Continuing Education – Waiver was ratified by roll call vote (Bjordahl/unanimous).

Mr. Klatt introduced proposed rule *Article 20:83: Chapter 20:83:04, Section 20:83:04:01&02: Licensed Nutritionist – Continuing Education*. A member of the public from Yankton, South Dakota, Karley Briggs, called in to listen to the proceedings for this rule. There were no parties in attendance to offer testimony. No supporting comments were received, no opposing comments were received, and there was no further discussion. A motion: to approve *Article 20:83; Chapter 20:83:04, Section 20:83:04:01&02: Licensed Nutritionist – Continuing Education* was ratified by roll call vote (Bjordahl/unanimous).

Mr. Klatt introduced proposed rule *Article 20:64, Chapter 20:64:02,&04 – Occupational Therapist and Occupational Therapy Assistant – Licensure Requirements, Continuing Competency*. Mr. Klatt informed the Board that the Occupational Therapist Advisory Committee had requested an amendment to *Section 20:64:04:03* to change the phrase “occupational therapist” to “occupational therapist and occupational therapy assistant”. There were no parties in attendance to offer testimony. No supporting comments were received, no opposing comments were received, and there was no further discussion. A motion: to amend *Article 20:64, Chapter 20:64:02,&04* as stated above, and to approve the amended rule was ratified by roll call vote (Landeem/unanimous).

There being no further questions or discussion, the public rules hearing was closed.

3. A motion: to approve the minutes of the December 3, 2015, Board meeting was ratified by roll call vote (Murray/unanimous).
4. A motion: to approve the new licenses, permits, certificates, and registrations issued between December 1, 2015 through February 29, 2016, was ratified by roll call vote (Murray/unanimous).
5. Public Hearings:
 - a. Licensee Beau D. Braun, PA: A motion: to approve his request for discharge from the South Dakota Health Professionals Assistance Program (HPAP) and return his license to an unrestricted status was ratified by roll call vote (Bjordahl/unanimous).
 - b. Leann K. Batiz, CNP: The South Dakota Board of Nursing submitted an Agreed Disposition and Waiver of Hearing for Board consideration. A motion: to approve the Agreed Disposition and to have the President of the Board, Dr. Walter Carlson, sign the final order was ratified by roll call vote (Bjordahl/unanimous).

The petition from Dr. Nathan Long, emergency room physician and medical director for the Rapid City Fire Department, and Jason Culberson, Paramedic, Rapid City Fire Department was reviewed by the Board. The board staff expressed concerns about the possibility of the loss of immunity for paramedics, hospitals, and physicians when a call is deemed non-emergent. Mark East, South Dakota State Medical Association (SDSMA), expressed concerns he has received from other emergency physicians in Rapid City, and the process by which the primary care physicians would be included.

A motion: that the petitioners:

- a. continue to work with the board staff and the advanced life support (ALS) advisory committee on the protocols and training;
- b. the executive director will issue a temporary approval order for approved training programs and protocols pending final consideration by the full Board at a Board meeting

The motion was ratified by roll call vote (Bowman/unanimous).

The financial report was presented by the executive director. A motion: to instruct staff to discuss the concept of using funds for education with the Department of Health prior to considering legislation was ratified by roll call vote (Landeem/unanimous).

Mr. Klatt presented the Advisory Committee Business. The reports of the advisory committees meetings were accepted for information. A motion: to approve Cara Hamilton, MD, as the new physician member of the Genetic Counselor Advisory Committee to fill the vacancy left by Dr. Steven Benn, and to re-appoint Dr. Laura Keppen-Davis and Kali Smith, GC to a second term on the Genetic Counselor Advisory Committee was ratified by roll call vote (Landeem/unanimous).

Margaret Hansen presented the executive director report. Discussion was held about the process involved to provide testimony during legislative session. A motion: that no Board member may testify on behalf of the Board without first obtaining the Board's approval by majority vote was ratified by roll call vote (Bowman/unanimous). A motion: to accept the executive director report was ratified by roll call vote (Landeem/unanimous).

Confidential Physician Hearings (Closed Session pursuant to SDCL 36-4-31.5 unless privilege is waived by physician)

- a. Dr. James Oury: A motion: to amend the Stipulation for Dr. Oury to require that he successfully complete assessment with the Center for Personalized Education for Physicians (CPEP) program located in Denver, Colorado, as a condition of receiving a conditional South Dakota medical license was ratified by roll call vote (Lust/unanimous). Dr. Carlson and Dr. Rosario were recused from the vote.
- b. Dr. Claude William Evrard Zeifman: A motion: to adopt the Findings of Fact, Conclusions of Law, and enter an order deeming his application as withdrawn under investigation was ratified by roll call vote (Landeem/unanimous).
- c. Dr. Steven C. Myers: A motion: to refer this matter back to board staff to schedule an administrative hearing was ratified by roll call vote (Lust/unanimous). Dr. Landeen was recused from the vote.

The updated mission statement for the Board was presented for review. A motion: to approve the updated mission statement was ratified by roll call vote (Landeem/unanimous).

The draft language for a rule regarding physician supervision of a physician assistant spouse, or other family member in the healthcare field, was presented to the Board for review. The staff was directed to work with other interested parties for input, and then bring the updated language to the Board meeting on June 2, 2016.

The draft language for a rule for medical record documentation when prescribing opioids was presented to the Board for review. The staff was directed to review language used by other states when addressing this issue, add a definition for "chronic pain", look at templates developed by the healthcare systems, get input from stakeholders, and then bring the updated language to the Board meeting on June 2, 2016.

The complaint and investigation docket was reviewed for information.

There being no further business, the meeting adjourned at 2:00 pm.

¹ 1-27-1.17. Draft minutes of public meeting to be available--Exceptions--Violation as misdemeanor. The unapproved, draft minutes of any public meeting held pursuant to § 1-25-1 that are required to be kept by law shall be available for inspection by any person within ten business days after the meeting. However, this section does not apply if an audio or video recording of the meeting is available to the public on the governing body's website within five business days after the meeting. A violation of this section is a Class 2 misdemeanor. However, the provisions of this section do not apply to draft minutes of contested case proceedings held in accordance with the provisions of chapter 1-26.

TO: SDBMOE BOARD MEMBERS
FROM: KLATT, TYLER
SUBJECT: LOCUM TENENS STATUTE 36-4-20.4
DATE: JUNE 2, 2016
CC:

LOCUM TENENS CERTIFICATE

Staff has prepared a draft revision to SDCL 36-4-20.4. This revision will allow a locum tenens certificate holder to apply for an additional 60 day certificate, provided that the applicant has begun the application procedure for full licensure.

36-4-20.4. Duration of locum tenens certificates--Privileges of certificate holder. Locum tenens certificates shall be issued for a period of not to exceed sixty days, and in the Board of Examiners discretion may set forth requirements and conditions governing the practice under it. An applicant may apply for a second locum tenens certificate after providing proof, to the Board of Examiners, that the certificate holder has made application for licensure as provided for in chapter 36-4-11. The locum tenens certificate shall allow the holder to practice medicine in this state only for a period set forth in the certificate and according to any conditions and requirements which the board in its discretion incorporates onto the certificate.

Source: SDC Supp 1960, §27.0308A as enacted by SL 1969, ch 105, §7.

TO: SDBMOE
FROM: KLATT, TYLER
SUBJECT: PHYSICIAN-PHYSICIAN ASSISTANT SUPERVISION RELATIONSHIP
DATE: JUNE 2, 2016

PHYSICIAN-PHYSICIAN ASSISTANT RELATIONSHIP

Summary

- June 2015 – A discussion at the Board meeting prompted the question of whether or not supervision was appropriate if the supervision involved an immediate family member.
 - *The staff was directed to research how other states address this issue.*
- December 2015 – Staff research found North Dakota as the only state with a rule addressing the relationships in question.
 - *The staff was directed draft a rule using the language from the North Dakota example*
- March 2016 – Staff presented a draft rule using the language from North Dakota
 - Concerns were brought forward from the Physician Assistant advisory committee regarding:
 - What would the board be required to do with the information gathered?
 - How would they monitor the relationship differently than other supervisory relationships
 - Would this address all the non-marital relationships that exist that would have the same conflicts of interest
 - *The staff was directed to address the policy concerns and bring a new draft to the June meeting*
- **Two options**
 - Administrative Rulemaking Process– pursue rulemaking process using drafted language
 - Amend Practice Agreement – existing language in SDCL 36-4A-1.1 and ARSD 20:52:01:03 allows the Board to require other information be reported in the practice agreement

Action Required: Direct staff on the next step to pursue

ARTICLE 20:52

PHYSICIAN ASSISTANTS

CHAPTER 20:52:01

PHYSICIAN ASSISTANT LICENSE

Section

- 20:52:01:01 Application for physician assistant license.
- 20:52:01:02 Repealed.
- 20:52:01:03 Physician assistant practice agreement.
- 20:52:01:03.01 Supervision of a licensed physician assistant.
- 20:52:01:03.02 Supervision of a licensed physician assistant -- Separate practice location.
- 20:52:01:03.03 Supervision agreement requirements
- 20:52:01:04 Repealed.
- 20:52:01:05 Termination of physician assistant practice agreement.
- 20:52:01:06 Repealed.
- 20:52:01:07 Repealed.
- 20:52:01:08 Repealed.
- 20:52:01:09 Renewal of physician assistant license.
- 20:52:01:10 Repealed.
- 20:52:01:11 Fee amounts.

Section

20:52:01:03.03 Supervision agreement requirements.

20:52:01:03.03 Supervision agreement requirements. No physician may act as a supervising physician for any physician assistant who is a member of the physician's immediate family unless specific authorization for such supervision has been approved by the Board. For purposes of this section, immediate family means a spouse, parent, child, or sibling of the supervising physician or other persons with whom the physician lives or commingles assets.

Source:

General Authority: SDCL 36-4A-42

Law Implemented: SDCL 36-4A-29

TO: SDBMOE BOARD MEMBERS
FROM: KLATT, TYLER
SUBJECT: MEDICAL RECORDS DOCUMENTATION ADMINISTRATIVE RULE
DATE: JUNE 2, 2016
CC:

MEDICAL RECORDS DOCUMENTATION

- **March 2016:** Board reviewed draft at March meeting
 - The Board requested the following changes:
 - Include reference to the PDMP (section 15 of draft)
 - Define “chronic pain” (20:47:07:01.01)
- **March 2016:** Centers for Disease Control and Prevention releases CDC Guideline for Prescribing Opioids for Chronic Pain
- **April 2016:** SDSMA Ad hoc committee
 - Board staff attended SDSMA ad hoc committee on Pain Management and Prescription Drug Abuse

ARTICLE 20:47

PHYSICIANS AND SURGEONS

Chapter

- 20:47:01 Definitions, Repealed.
- 20:47:02 Operation of board, Transferred.
- 20:47:03 Licensure.
- 20:47:04 Inspections.
- 20:47:05 Declaratory rulings, Transferred.
- 20:47:06 Fees.
- 20:47:07 Medical record documentation
- 20:47:08 Ethics.

CHAPTER 20:47:07

MEDICAL RECORD DOCUMENTATION

Section

20:47:07:01 Medical record documentation.

20:47:07:01.01 Chronic pain.

20:47:07:01 Medical record documentation. Every physician who treats patients for chronic pain must maintain accurate and complete medical records, which shall include:

- (1) Copies of the signed informed consent and treatment agreement;
- (2) The patient's medical history;
- (3) Results of the physical examination and all laboratory tests;

- (4) Results of the risk assessment, including results of any screening instruments used;
- (5) A description of the treatments provided, including all medications prescribed or administered (including the date, type, dose and quantity);
- (6) Instructions to the patient, including discussions of risks and benefits with the patient and any significant others;
- (7) Results of ongoing monitoring of patient progress (or lack of progress) in terms of pain management and functional improvement;
- (8) Notes on evaluations by and consultations with specialists;
- (9) Any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors;
- (10) The records may include actual copies of, or references to, medical records of past hospitalizations or treatments by other providers;
- (11) Authorization for release of information to other treatment providers;
- (12) The medical record must include all prescription orders for opioid analgesics and other controlled substances, whether written or telephoned. In addition, written instructions for the use of all medications should be given to the patient and documented in the record;
- (13) The name, telephone number, and address of the patient's pharmacy also should be recorded to facilitate contact as needed;
- (14) Records should be up-to-date and maintained in an accessible manner so as to be readily available for review;

(15) The state prescription drug monitoring program should be consulted to determine whether the patient is receiving prescriptions from any other physicians.

The record shall be present any place where medicine or osteopathy is practiced, and access granted to the Board, or any of its officers, agents or employees so authorized, to enter and inspect during business hours.

General Authority: SDCL 36-4-35, 36-9A-41

Law Implemented: SDCL 36-4-30, 36-4-22.1, 36-9A-5

Source: Federation of State Medical Boards Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain; Federation of State Medical Boards Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office.

20:47:07:01.01 Chronic pain. Chronic pain is pain lasting longer than would be anticipated for the usual course of a given condition

General Authority: SDCL 36-4-35, 36-9A-41

Law Implemented: SDCL 36-4-30, 36-4-22.1, 36-9A-5

Phalen, Jane

From: Timothy M. Engel <tme@mayadam.net>
Sent: Tuesday, May 31, 2016 4:19 PM
To: Hansen, Margaret
Cc: Golden, William; sdsma.org, meast; Bailey, Ellie; Blair, Steven; Phalen, Jane; Klatt, Tyler
Subject: RE: SDBMOE meeting on June 2 (MAGT file: 0099)
Attachments: White Paper on Pain Management and Prescription Drug Abuse - 20160516 -doc;
0099.SDBMOE Proposed Rule 20-47-07 - Standards for Medical Records when
Prescribing Controlled.05-31-16.doc

Meg:

We've now had a chance to look at the draft documentation rule and see that it is different in some respects from the draft we discussed at the meeting among staff that was held back in April. We had intended to send you the "final" of our proposal sooner, but only recently received approval to do so. Our proposed record-keeping rule is attached. Sorry for the delay in getting this to you.

I've also attached the proposed updated white paper on opioids, along with the proposed checklist (one of the last pages of the document).

When you asked earlier about documents, I interpreted that to mean "talking points," which is why I said "none." We would appreciate it if you would share our proposed draft rule and the attached white paper with the board.

It is our intention to speak briefly in support of the concept of a record-keeping rule and because in our view it is related, to speak briefly about the updated white paper. We understand Thursday's meeting will not be a rules hearing and that we'll be given an opportunity to provide more formal input at the time of the rules hearing. We also understand that it is too late to ask the board to "endorse" the updated white paper at this meeting, but we think it would be helpful for them to have access to it.

We don't intend to comment on the proposal concerning supervision/collaboration among immediate family.

Please let me know if you have any questions.

Thanks!
Tim



Tim Engel
May, Adam, Gerdes & Thompson LLP
503 S. Pierre Street
PO Box 160
Pierre, SD 57501
(605)224-8803

Fax (605)224-6289
tme@mayadam.net

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From: Hansen, Margaret [mailto:Margaret.Hansen@state.sd.us]
Sent: Tuesday, May 31, 2016 11:49 AM
To: Timothy M. Engel
Cc: Golden, William; sdsma.org, meast; Bailey, Ellie; Blair, Steven; Phalen, Jane; Klatt, Tyler
Subject: RE: SDBMOE meeting on June 2 (MAGT file: 0099)

You can find the June 2 Board meeting agenda and public documents in 2 places:

1. Board of Medical and Osteopathic Examiners home webpage: <http://www.sdbmoe.gov/>
2. Boards and Commissions (Governors portal): <http://boardsandcommissions.sd.gov/Meetings.aspx?BoardID=65>

Tim: The documents that you are requesting can be found on pages 108-111- labeled **Public meeting materials for 06-02-2016** on 1. and **Public Documents** on 2.

From: Timothy M. Engel [mailto:tme@mayadam.net]
Sent: Tuesday, May 31, 2016 10:26 AM
To: Hansen, Margaret
Cc: Golden, William; sdsma.org, meast; Bailey, Ellie; Blair, Steven
Subject: RE: SDBMOE meeting on June 2 (MAGT file: 0099)

Meg:

Are you able to share with us a copy of the proposed opioid record-keeping rules you intend to provide to the board?

Thanks.
Tim



Tim Engel
May, Adam, Gerdes & Thompson LLP
503 S. Pierre Street
PO Box 160
Pierre, SD 57501

(605)224-8803
Fax (605)224-6289
tme@mayadam.net

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From: Hansen, Margaret [<mailto:Margaret.Hansen@state.sd.us>]
Sent: Tuesday, May 31, 2016 10:14 AM
To: Timothy M. Engel
Cc: Golden, William; sdsma.org, meast; Bailey, Ellie; Blair, Steven
Subject: RE: SDBMOE meeting on June 2

Thank you

Sincerely,
Meg
Margaret B. Hansen, PA-C, MPAS, CMBE
Executive Director
South Dakota Board of Medical & Osteopathic Examiners

Phone 605-367-7781
General Email: SDBMOE@state.sd.us
Web site: [Http://www.sdbmoe.gov](http://www.sdbmoe.gov)

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From: Timothy M. Engel [<mailto:tme@mayadam.net>]
Sent: Tuesday, May 31, 2016 10:14 AM
To: Hansen, Margaret
Cc: Golden, William; sdsma.org, meast; Bailey, Ellie; Blair, Steven
Subject: RE: SDBMOE meeting on June 2

Nothing in writing.

Thanks.
Tim



Tim Engel
May, Adam, Gerdes & Thompson LLP
503 S. Pierre Street
PO Box 160
Pierre, SD 57501
(605)224-8803
Fax (605)224-6289
tme@mayadam.net

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From: Hansen, Margaret [<mailto:Margaret.Hansen@state.sd.us>]
Sent: Tuesday, May 31, 2016 10:13 AM
To: Timothy M. Engel
Cc: Golden, William; sdsma.org, meast; Bailey, Ellie; Blair, Steven
Subject: RE: SDBMOE meeting on June 2

Ok and thank you. Did you have any written information that you wish board members to see?

Sincerely,
Meg
Margaret B. Hansen, PA-C, MPAS, CMBE
Executive Director
South Dakota Board of Medical & Osteopathic Examiners

Phone 605-367-7781
General Email: SDBMOE@state.sd.us
Web site: [Http://www.sdbmoe.gov](http://www.sdbmoe.gov)

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From: Timothy M. Engel [<mailto:tme@mayadam.net>]
Sent: Tuesday, May 31, 2016 10:12 AM
To: Hansen, Margaret

Cc: Golden, William; sdsma.org, meast; Bailey, Ellie; Blair, Steven
Subject: RE: SDBMOE meeting on June 2

Meg:

The meeting I was going to attend in Lead has been postponed, so I'll plan to participate in the SDBMOE meeting via DDN from here in Pierre.

Thanks!
Tim



Tim Engel
May, Adam, Gerdes & Thompson LLP
503 S. Pierre Street
PO Box 160
Pierre, SD 57501
(605)224-8803
Fax (605)224-6289
tme@mayadam.net

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From: Hansen, Margaret [<mailto:Margaret.Hansen@state.sd.us>]
Sent: Friday, May 27, 2016 12:07 PM
To: Timothy M. Engel
Cc: Golden, William; sdsma.org, meast; Bailey, Ellie; Blair, Steven
Subject: RE: SDBMOE meeting on June 2

Tim, Bill will not be at this meeting and his backup from the AG office, Ellie Bailey will be at the board meeting in his place. Steve Blair will be there on behalf of the board as usual. Both Ellie and Steve are copied here. Thanks, Meg

From: Hansen, Margaret
Sent: Friday, May 27, 2016 10:01 AM
To: 'Timothy M. Engel'
Cc: Golden, William; sdsma.org, meast
Subject: RE: SDBMOE meeting on June 2

Yes, it would be great to have you available. The Rapid City DDN address is on the agenda and it is Room 113. We do not have a call in number but if you give us your cell number, we can call you.

From: Timothy M. Engel [<mailto:tme@mayadam.net>]
Sent: Thursday, May 26, 2016 11:21 AM
To: Hansen, Margaret
Cc: Golden, William; sdsma.org, meast
Subject: SDBMOE meeting on June 2

Meg:

I would appreciate the opportunity to participate (on behalf of SDSMA) in the SDBMOE discussion about the opioid record-keeping rules that is set for the afternoon of June 2. I will be working in Lead that morning and am planning to drive down to the DDN site in Rapid City and participate from there. Assuming for some reason I can't get to the Rapid City DDN site in time, is there a telephone call-in number available that I could use?

By copy of this email, I'm asking Mark to keep me advised by cell phone so I know when the board is getting close to that point in its agenda.

Thank you!
Tim



Tim Engel
May, Adam, Gerdes & Thompson LLP
503 S. Pierre Street
PO Box 160
Pierre, SD 57501
(605)224-8803
Fax (605)224-6289
tme@mayadam.net

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Opiate Analgesics for Chronic Non-Cancer Pain

Recommendations from the Committee on Pain Management and Prescription Drug Abuse

South Dakota State Medical Association

May 1, 2016

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Executive Summary

When used appropriately, opiate¹ analgesics can be important tools for relieving moderate to severe pain arising from a wide range of conditions, disease states, and medical procedures. These drugs, however, may also be misused and abused, and overprescribing of opiate pain relievers can result in multiple adverse health outcomes, including fatal overdoses. In recent years there has been a shift in thinking among many pain specialists about the use of opiates for chronic non-cancer pain, and legislative efforts to more closely regulate the prescription of opiates are underway in many states, including South Dakota.

Since professional opinions on this topic have evolved, the South Dakota State Medical Association's (SDSMA) Committee on Pain Management and Prescription Drug Abuse has reviewed current literature and existing clinical guidelines in order to articulate an up-to-date set of consensus views for chronic pain management with analgesics. This paper summarizes those findings and provides South Dakota prescribers with clear, evidence-based guidance about the appropriate prescription of opiate analgesics for the treatment of chronic pain outside of active cancer treatment, palliative care, and end-of-life care. These recommendations address: when to initiate or continue opiates for chronic pain; opiate selection, dosage, duration, follow-up, and discontinuation, and assessing risk and addressing harms of opiate use. Although the practices described in these guidelines are intended to apply broadly, they are not intended to establish a "standard of care." Physicians must exercise their own best medical judgment when providing treatment, taking all relevant circumstances into account, including the potential for abuse, diversion and risk for addiction.

The key points of these recommendations include:

- *With respect to chronic pain management, maintenance of clinical and functional goals is key, and the incorporation of opiates should only be used when safer options have been deemed less effective.*

¹ The literature sometimes uses the terms "opiate" and "opioids" interchangeably. As used in this paper, the term "opiates" is intended to include, as applicable, the term "opioids."

- *Opiate analgesics are widely accepted as appropriate and effective for alleviating moderate-to-severe acute pain, pain associated with cancer, and persistent end-of-life pain.*
- *The use of opiates for chronic non-cancer pain is more problematic, and current research on the benefits and/or safety of opiates for this indication is either weak or inadequate.*
- *Opiates should be used for chronic non-cancer pain only when safer options have been deemed ineffective, and continued treatment should be based on maintenance of clinical and functional goals.*
- *Patients should utilize only one provider for the management of chronic pain.*
- *Risks increase with dose. High doses of opiates (greater than 100 morphine-equivalents/day) have been shown to be associated with higher risks for overdose and death and such use should be carefully assessed and monitored.*
- *Extended-release/long-acting opiates should not be used to treat acute pain.*
- *Opiates cause sleep-disordered breathing.*
- *Benzodiazepines and opiates together have clear risk of death from overdose.*
- *Taking other substances/drugs with opiates (e.g., alcohol) or having certain conditions (e.g., sleep apnea, mental illness) increase risk.*
- *Opiates should be used only as prescribed, should be stored securely, and when a course of treatment is altered, discontinued or stopped, any unused opiates should be disposed of properly.*

In addition to these clinical practice recommendations, the Committee came to a consensus on a number of other issues related to responsible opiate prescribing:

- *Expand and strengthen South Dakota's Prescription Drug Monitoring Program (PDMP) to facilitate rapid, accurate patient risk assessment to help improve patient care coordination, and to prevent diversion and/or "doctor shopping."*
- *Create new incentives for continuing medical education for opiate prescribers. Such education should be targeted to specific clinical practice needs, e.g., acute pain = emergency, surgery; long-acting/extended-release = pain management, etc.*
- *Create more safe medication disposal sites and promote their use.*

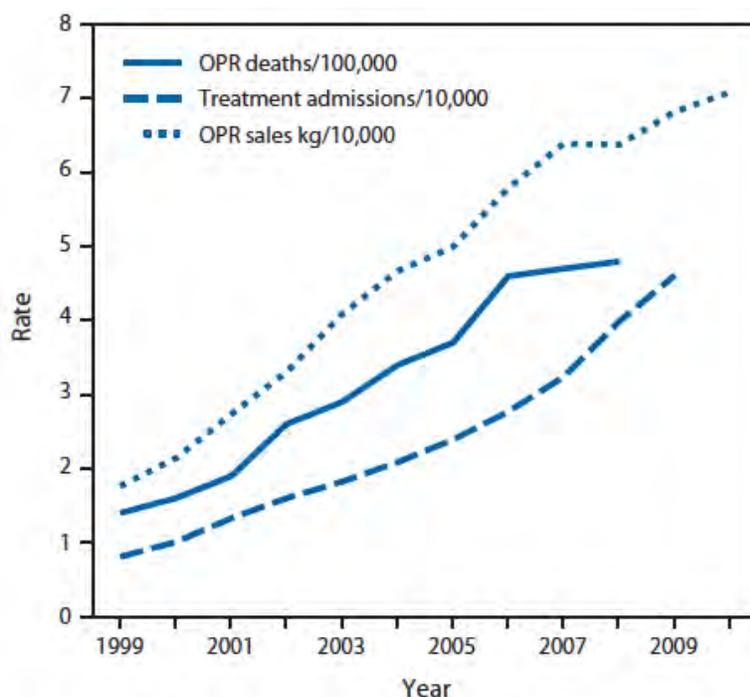
- *Expand patient education about the safe storage and use of opiates and other controlled substances to reduce the diversion of these medications for illicit use.*
- *Increase access to and education on the utilization and administration of opiate-antidote naloxone (Narcan) to reduce morbidity and mortality related to opiate and heroin overdose.*

Scope of the problem

The use of opiate analgesics has risen dramatically in the past 20 years across the U.S., including South Dakota. Between 1999 and 2010, the use of opiates quadrupled.¹⁰ Much of this increase has been for the treatment of pain beyond moderate-to-severe acute pain or intractable end-of-life pain. In the past two decades, opiates have become widely-prescribed for chronic non-cancer conditions, such as back pain, osteoarthritis, fibromyalgia, and headache,¹¹ despite an evidence base that is much weaker than has been generally appreciated by many physicians until recently.¹²

As the number of opiate prescriptions has risen, so, too, have the rates of opiate abuse, addiction, and diversion for non-medical use. The current level of prescription opiate abuse has been described as an “epidemic” by the Centers for Disease Control and Prevention.¹⁰

Figure 1.
opiate
overdose
treatment
and
in the United
2010¹⁰



Rates* of
analgesic
death,
admissions,
kilograms sold
in the United
States, 1999-

* Age-adjusted rates per 100,000 population for OPR deaths, crude rates per 10,000 population for OPR abuse treatment admissions, and crude rates per 10,000 population for kilograms of OPR sold.

Despite a 104% increase in opiate analgesic prescriptions in the U.S. (from 43.8 million in 2000 to 89.2 million in 2010) *no improvements in disability rates or health status measures* of opiate users has been demonstrated.¹³

Physicians must balance an awareness of the ongoing problems of opiate over-prescription and abuse with the equally compelling need to relieve their patients' pain. Pain remains the most common reason people seek health care.¹⁴ In fact, the incidence of chronic pain in the U.S. is estimated to be greater than that of diabetes, heart disease, and cancer combined.^{15,16}

Inadequately treating pain can lead to a wide range of adverse consequences (in addition to causing needless suffering) including diminished quality of life, and a higher risk for anxiety or depression.¹⁷ Pain is also a major cause of work absenteeism, underemployment, and unemployment.¹⁴

Pain must be treated, but many types of pain treatments exist. Opiate analgesics may – or may not – be the right choice, particularly for those suffering from chronic non-cancer pain. Opiates do not address all of the physical and psychosocial dimensions of chronic pain, and they pose a wide range of potential adverse effects, including challenging side effects and the risk of abuse, addiction, and death.

Key concepts in pain medicine

Acute and chronic pain. Traditionally, pain has been classified by its duration. In this perspective, “acute” pain is relatively short-duration (lasting for only a matter of days or, at most, a few weeks), arises from obvious tissue injury, and usually fades with healing.¹¹ “Chronic” pain, in contrast, lasts longer than would be anticipated for the usual course of a given condition. The International Association for the Study of Pain defines this as pain lasting three (3) months or longer.¹⁸ These pain labels, however, provide no information about the biological nature of the pain itself, which is often critically important for optimal treatment.

Nociceptive and neuropathic pain. Pain can also be classified on the basis of its pathophysiology. Nociceptive pain is caused by the activation of nociceptors (pain receptors), and is generally, though not always, short-lived, and associated with the presence of an underlying medical condition. This is “normal” pain: a physiological response to an injurious stimulus.

Neuropathic pain, on the other hand, results either from an injury to the nervous system or from inadequately-treated nociceptive pain. It is an abnormal response to a stimulus caused by abnormal neuronal firing in the absence of active tissue damage. It may be continuous or episodic and varies widely in how it is perceived. Neuropathic pain is complex and can be difficult to diagnose and to manage because available treatment options are limited.

All or almost all neuropathic pain involves sensitization, nociceptive often does but not always. Sensitization is a state of hyperexcitability in either peripheral nociceptors or neurons in the central nervous system. Sensitization may lead to either hyperalgesia (heightened pain from a stimulus that normally provokes pain) or allodynia (pain from a stimulus that is *not* normally painful).¹⁹ Sensitization may arise from intense, repeated, or prolonged stimulation of nociceptors, or from the influence of compounds released by the body in response to tissue damage or inflammation.²⁰ Many patients – particularly those with chronic pain – experience pain that has both nociceptive and neuropathic components, which complicates assessment and treatment.

Differentiating between nociceptive and neuropathic pain is critical because the two respond differently to pain treatments. Neuropathic pain can be difficult to treat as it typically responds poorly to non-steroidal anti-inflammatory (NSAID) agents.²¹ Neuropathic pain typically responds well to a multidrug class regime of which opiates are included. Other classes of medications, such as anti-epileptics, antidepressants, or local anesthetics, may provide more effective relief for neuropathic pain.²²

Cancer pain. Pain associated with cancer is sometimes given a separate classification, although it is not distinct, from a pathophysiological perspective. Cancer-related pain includes pain caused

by the disease itself and/or painful diagnostic or therapeutic procedures. The treatment of cancer-related pain may be influenced by the life expectancy of the patient, by co-morbidities, and by the fact that such pain may be of exceptional severity and duration.

Chronic non-cancer pain. A focus of recent attention by the public, legislators, and physicians has been chronic pain that is *not* associated with cancer. Such pain may be caused by many kinds of conditions or disease states such as musculoskeletal injury, lower back trauma, dysfunctional healing from a wound or surgery, and persistent pain arising from autoimmune system disorders. With chronic non-cancer pain, the severity of pain experienced by a patient may not correspond well – or at all – to identifiable levels of tissue damage.

Dependence and addiction. The most common error in clinical thinking about opiates is to consider *Addiction* to opiates and *Physical Dependence* on opiates to be the same thing. To help clarify and standardize understanding, the American Society of Addiction Medicine (ASAM), the American Academy of Pain Medicine (AAPM), and the American Pain Society (APS) have recommended the following definitions:²³

- *Physical Dependence.* A state of adaptation that often includes tolerance and is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, and/or administration of an antagonist. In brief, physical dependence is a physiological/automatic response of the body caused by the lack of or stoppage of treatment.
- *Addiction.* Is a neuroplastic decompensation of the mesocorticolimbic system of the brain. The mesocorticolimbic system includes the ventral tegmental area, the nucleus accumbens, and the medial prefrontal cortex. This system controls complex behaviors such as family nurturing, eating, gambling, spending, risk-for-thrill, and experimenting with drugs and solvents. There is a broad continuum from normal to pathologic mesocorticolimbic behavioral health, upon which any person may be located – simply put, some people have an increased risk for addiction based on complex biopsychosocial factors.

Of note, opiate withdrawal is not physiologically dangerous; however, it is mentally and socially an unpleasant experience that is usually preventable with a slow tapering down of the dosage/intake levels.

Managing chronic non-cancer pain in primary care

Many pharmacologic and non-pharmacologic approaches to treating painful conditions are available to primary care physicians. These options should be employed by using the following general principles:

- Identify and treat the source of the chronic pain, if possible, although treatment can begin before the source of the chronic pain is determined
- Select the most clinically appropriate approach to chronic pain management. This generally means using non-pharmacologic approaches as much as possible and/or trying medications with the least severe potential side effects first, and at the lowest effective doses
- Establish a function-based management plan if treatment is expected to be long-term

In treating chronic pain, clinicians can avail themselves of five basic modalities of chronic pain-management:

1. Cognitive-behavioral approaches
2. Rehabilitative approaches
3. Complementary and alternative therapies
4. Interventional approaches
5. Pharmacotherapy

These options can be used alone or in combinations to maximize pain control and functional gains. Only one of these options involves medications, and opiates are only one of many types of medications with potential analgesic utility. Which options are used in a given patient depends on the type of pain, the duration and severity of pain, patient preferences, co-occurring disease states or illnesses, patient life expectancy, cost, and the local availability of the treatment option.

Throughout assessment and treatment, physicians should ask themselves two basic questions: 1) who is this person, and 2) what all is going on (with them)? All answers are admissible if they are factors to the presentation and should be used in developing a treatment plan/options. Multidisciplinary treatment needs to be patient-specific and based on the physical ailments of the individual.

Cognitive-behavioral approaches

Psychological therapies of all kinds may be a key element in managing chronic non-cancer pain. Cognitive therapy techniques may help patients monitor and evaluate negative or inaccurate thoughts and beliefs about their pain. For example, some patients engage in an exaggeration of their condition called “catastrophizing” or they may have an overly passive attitude toward their recovery which leads them to inappropriately expect a physician to “fix” their pain with little or no work or responsibility on their part. Individual, group, or family psychotherapy may be extremely helpful for addressing this and other psychological issues, depending on the specific needs of a patient. In general, psychological interventions may be best-suited for patients who express interest in such approaches, who feel anxious or fearful about their condition, or whose personal relationships are suffering as a result of chronic or recurrent pain. Unfortunately, the use of psychological approaches to pain management can be hampered by such barriers as provider time constraints, unsupportive reimbursement policies, lack of access to skilled and trained providers, or a lack of awareness on the part of patients and/or physicians about the utility of such approaches for improving pain relief and overall functioning.

Rehabilitative approaches

In addition to relieving pain, a range of rehabilitative therapies can improve physical function, alter physiological responses to pain, and help reduce fear and anxiety. Treatments used in physical rehabilitation include exercises to improve strength, endurance, and flexibility, gait and posture training, stretching, and education about ergonomics and body mechanics. Exercise programs that incorporate Tai Chi, swimming, yoga, or core-training work may also be useful. Other noninvasive physical treatments for pain include thermotherapy (application of heat), cryotherapy (application of cold), counter-irritation, and electroanalgesia (e.g., transcutaneous

electrical stimulation). Other types of rehabilitative therapies, such as occupational and social therapies, may be valuable for selected patients.

Complementary and alternative therapies

Complementary and alternative therapies (CAT) of various types are used by many patients in pain, both at home and in comprehensive pain clinics, hospitals, or other facilities. These therapies seek to reduce pain, induce relaxation, and enhance a sense of control over the pain or the underlying disease. Meditation, acupuncture, relaxation, imagery, biofeedback, and hypnosis are some of the therapies shown to be potentially helpful to some patients. CAT therapies can be combined with other pain treatment modalities and generally have few, if any, risks or attendant adverse effects. Such therapies can be an important and effective component of an integrated program of pain management.

Interventional approaches

Although beyond the scope of these guidelines, a wide range of surgical and other interventional approaches to patient-specific pain management exist, including trigger point injections, epidural injections, facet blocks, spinal cord stimulators, laminectomy, spinal fusion, and deep brain implants. Treatments need to be patient-specific and based on the physical ailments of the individual.

Non-opiate analgesics

NSAIDs and acetaminophen

Non-steroidal anti-inflammatory drugs (NSAIDs), which include aspirin and other salicylic acid derivatives, and acetaminophen are used in the management of both acute and chronic pain such as that arising from injury, arthritis, dental procedures, swelling, or surgical procedures.

Although they are weaker analgesics than opiates, acetaminophen and NSAIDs do not produce tolerance, physical dependence, or addiction. Acetaminophen and NSAIDs are also frequently added to an opiate regimen for their opiate-sparing effect. Since non-opiates and opiates relieve pain via different mechanisms, combination therapy can provide improved relief with fewer side effects.

These agents are not without risk, however. Adverse effects of NSAIDs include gastrointestinal problems (e.g., stomach upset, ulcers, perforation, bleeding, liver dysfunction), bleeding (i.e., antiplatelet effects), kidney dysfunction, hypersensitivity reactions and cardiovascular concerns, particularly in the elderly.²⁴ The threshold dose for acetaminophen liver toxicity has not been established; however, the SDSMA recommends that the total adult daily dose should not exceed 3,000 mg in patients without liver disease (although the ceiling may be lower for older adults).²⁵ In 2014, new Food and Drug Administration (FDA) rules went into effect that set a maximum limit of 325 mg of acetaminophen in prescription combination products (e.g., hydrocodone and acetaminophen) in an attempt to limit liver damage and other ill effects from the use of these products.³²

Topical agents

Topical capsaicin and salicylates can both be effective for short term pain relief and generally have fewer side effects than oral analgesics, but their long-term efficacy is not well studied.^{26,27}

Topical NSAIDs and lidocaine have been reported to be effective for short-term relief of superficial pain with minimal side effects, although both are more expensive than topical capsaicin and salicylates. None of the topical agents are useful for non-superficial pain.

Antidepressants

Pain and depression are compounding – improving patient mood and/or controlling pain has a positive impact on the other. Some antidepressants, particularly tricyclics, and SNRIs, exhibit analgesic properties and may be particularly useful for treating neuropathic pain. Their analgesic actions do not depend on antidepressant activity, and antidepressants are equally effective in patients with and without depression.²⁸ While analgesia may occur at lower doses and sooner than antidepressant activity, maximum efficacy may require high antidepressant doses and trial duration.

Anticonvulsants

Antiepileptic drugs (AEDs) are increasingly used for treating neuropathic pain because they can reduce membrane excitability and suppress abnormal discharges in pathologically altered neurons.²⁹ The exact mechanism of action for their analgesic effects, however, is unclear. It does

not appear to be specifically related to their antiepileptic activity. Other drugs that suppress seizures (e.g., barbiturates) do not relieve pain, and some AEDs with effective antiepileptic activity do not necessarily have good analgesic activity.²²

Opiates for chronic non-cancer pain

The utility of opiate analgesics for treating chronic non-cancer pain is being increasingly questioned and a broad consensus is developing that these agents are not, in fact, suited for many patients with this type of pain. Clinical guidelines for the use of opiates in chronic non-cancer pain have evolved in recent years to stress the risks of opiates and strengthen procedures that prescribers should use to reduce the risk of addiction and misuse.³⁰⁻³²

Little evidence supports or belies the assertion that long-term use of opiates provides clinically significant pain relief or improves quality of life or functioning.³³ The Agency for Healthcare Research and Quality (AHRQ), for example, recently found *no studies* that compare opiate therapy with either a placebo or a non-opiate treatment for long-term (greater than 1 year) pain management.³⁴ A Cochrane review of opiates for long-term treatment of non-cancer pain found that many patients discontinue long-term opiate therapy (especially oral opiates) due to adverse events or insufficient pain relief.³³

A large – and growing – body of evidence, on the other hand, demonstrates that opiates pose significant risks for adverse effects, abuse, addiction, and accidental overdose leading to death from respiratory depression.

Estimating the risk that patients face of becoming addicted to opiate analgesics is difficult because rigorous, long-term studies of these risks in patients without co-existing substance-use disorders have not been conducted.⁵ A few surveys conducted in community practice settings, however, estimate rates of prescription opiate abuse of between 4 to 26 percent.^{35,38} Risk rises with higher doses and longer durations.³⁹

A 2011 study of a random sample of 705 patients undergoing long-term opiate therapy for non-cancer pain found a lifetime prevalence rate of DSM-5-defined opiate-use disorder of 35 percent.⁴⁰ The variability in such results probably reflects differences in opiate treatment duration, the short-term nature of most studies, and disparate study populations and measures used to assess abuse or addiction. Nonetheless, the levels of risk suggested by these studies are

significant enough to warrant extreme caution in the prescription of any opiate for a chronic pain condition.

Caution is also required because a significant portion of patients can be expected not to use an opiate medication as prescribed. Fleming et al., conducted in-depth interviews with 801 patients receiving long-term opiate therapy and found the following:³⁶

- 39 percent of patients increased their dose without direction from a health care provider
- 26 percent engaged in purposeful over-sedation
- 20 percent drank alcohol concurrent with opiate use
- 18 percent used opiates for purposes other than pain relief
- 12 percent hoarded their pain medications
- 8 percent obtained extra opiates from other doctors

The risk of overdose with opiate analgesics is significant and, as with risk of abuse/dependence, rises with both dose and duration.⁴¹ When prescribing opiates, patient management is critical.

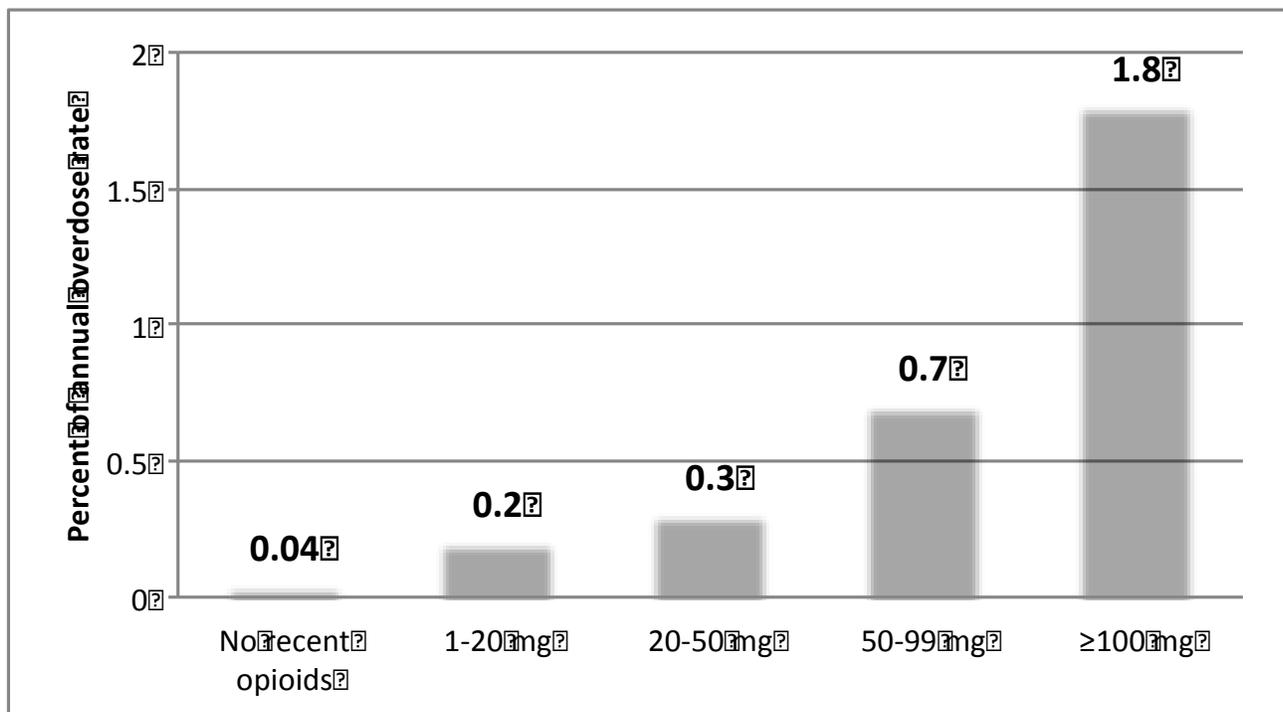


Figure 2. Percent of annual overdose rates rises with daily opiate dose⁴¹

In addition to the risks for misuse, addiction, and overdose, opiates can exert a wide range of uncomfortable or harmful adverse effects, the most common of which are neurologic (somnolence, dizziness), endocrine (hypogonadism), gastrointestinal (nausea, vomiting, and constipation), sexual (erectile dysfunction), and cutaneous (pruritus). In randomized trials of opiates, 50 to 80 percent of patients report a side effect, and about 25 percent withdraw due to an adverse event.^{33,42,43}

Although less common, there is also a dose-dependent increase in risk of fractures in opiate users compared to non-users, with risk highest in the period following initiation, particularly for short-acting opiates.^{44,45}

An area of potential concern is the possibility that chronic opiate use may have immunosuppressive effects. Evidence from cell cultures and animal models is suggestive, and this is an area requiring further investigation.⁴⁶ Dublin et al. in a population-based case-control study, found a significantly higher risk of pneumonia in immunocompetent older adults who were prescribed opiates.⁴⁷ The risk was particularly high for adults taking long-acting opiates.⁴⁷

Guidelines for responsible opiate prescribing

Given the limited evidence and risks, prescribing opiates for long-term non-cancer chronic pain should be carefully evaluated and only initiated in certain situations. For example, an opiate may be appropriate for chronic pain in certain limited circumstances, such as: when the pain is severe and refractory to other treatments; when it adversely impacts function or quality of life; and when the potential therapeutic benefits outweigh, or are likely to outweigh, potential harms.¹¹ In these cases, clinicians can take many steps to maximize the chances that the opiate will be effectively used with minimal risk to the patient and to society at large. This section reviews these steps in detail.

Patient selection and risk stratification

Prior to initiating opiate treatment for a chronic pain condition, clinicians should conduct a history, physical examination, appropriate testing, and an assessment of the patient's risk of

substance abuse, misuse, or addiction.¹¹ A risk-benefit evaluation including a history, physical examination, and appropriate diagnostic testing, should be performed and documented both before a decision to treat is made, and on an ongoing basis if opiate treatment is begun.¹¹

Patients or pain conditions unlikely to benefit from opiate therapy

Although the available evidence base is limited, professional guidelines suggest that the following patient characteristics and pain conditions are unlikely to benefit from opiate analgesics:¹¹

- Poorly-defined pain conditions
- Daily headache
- Fibromyalgia
- A likely or diagnosed somatoform disorder
- Patients with unresolved workers compensation or legal issues related to pain or injury²

Opiates must be used with extreme caution in patients with:¹¹

- Pre-existing constipation, nausea, pulmonary disease, or cognitive impairment
- A history of drug or alcohol abuse

Pain assessment tools

Unidimensional pain scales (e.g., numeric or “faces”) are seldom useful for guiding a decision to treat chronic pain because such pain is variable and scores from pain assessment tools are highly subjective. Multidimensional tools provide more information, such as the effects of pain on daily life. These tools can typically be administered in an office, examination room, or other clinical setting by either a physician or another health care professional, or they could be filled out by the patient, if appropriate. Examples of some multidimensional tools include:

- Initial Pain Assessment Tool⁴⁸
- Brief Pain Inventory⁴⁹
- McGill Pain Questionnaire (short-form available)⁵⁰

² Some evidence suggests that early treatment with opioids in this population may delay recovery and a return to work. Conflicts of motivation may also exist in patients on workers’ compensation, such as if they don’t want to return to an unsatisfying, difficult, or hazardous job.

Psychosocial evaluation

Because life stressors often underlie or co-exist with chronic pain and may warrant intervention, it is critical to assess the patient's psychosocial functioning. A thorough history should include questions about a patient's functioning at work and home, as well as how their pain might be affecting their significant relationships, sexual functioning, and recreational activities. Clinicians should be alert for signs of depression or anxiety (common in patients with chronic pain) as well as for suicidal thoughts since the risk of suicide is roughly double for patients with chronic pain.⁵¹

Instruments such as the Depression Anxiety & Positive Outlook Scale (available at www.dapos.org), the Generalized Anxiety Disorder assessment (GAD-7, available at <http://www.patient.co.uk/doctor/generalised-anxiety-disorder-assessment-gad-7>), and the Patient Health Questionnaire (www.phqscreeners.com) can facilitate a thorough psychosocial history.

These are brief (i.e., less than 5 min.) questionnaires filled out and scored by a clinician. The results can guide next steps, which may include pursuing a course of treatment, further questioning, use of additional short tools if a particular issue is uncovered (e.g., suicidality), or referral to a mental-health professional if the patient has active psychological issues that are beyond a clinician's expertise.

Evaluating patients for risk of opiate dependence or abuse

Given the demonstrated risks of abuse and addiction associated with opiate analgesics, clinicians must assess patients for their potential vulnerability to these risks. Such assessment is not completely objective, and opinions differ about which patients should be more rigorously assessed. Some favor a "universal precautions" approach, in which all pain patients are considered to have some degree of vulnerability to abuse and addiction and, hence, all patients are given the same screenings and diagnostic procedures.⁵² Some patient characteristics, however, do appear to be predictive of a potential for drug abuse, misuse, or other aberrant behaviors, particularly a personal or family history of alcohol or drug abuse.¹¹ Some studies also show that younger age and the presence of psychiatric conditions are associated with aberrant drug-related behaviors.¹¹

Relatively brief, validated tools can help formalize assessment of a patient’s risk of having a substance misuse problem (Table 1) and these should be considered for routine clinical use.¹¹ For more information on risk reduction strategies, a free online CME is available at www.opioidprescribing.com. The use of a Prescription Drug Monitoring Program may also provide some helpful information about a patient’s risk of dependence or abuse (see section on PDMPs on page 27).

Table 1. Tools for Patient Risk Assessment

Tool	Who Administers?	Length
Diagnosis, Intractability, Risk, Efficacy (DIRE)	Clinician	7 items
Opioid Risk Tool (ORT)	Clinician or patient self-report	5 yes/no questions
Screeners and Opioid Assessment for Patients with Pain, Version 1 and Revised (SOAPP, and SOAPP-R)	Patient self-report	24 items

Function-based opiate management plans

A “medication agreement” or “management plan” can serve many useful functions, including patient education, clarification of expectations, and goal-setting, all of which may help a patient adhere to a regimen of opiate pain medication.¹¹ Additionally, routine screening should be considered by clinicians and medical systems for identification and brief intervention, if required. Of note, agreements should be written and signed by the provider and the patient, and should include the elements listed in Table 2.

Table 2. Components of an opiate medication agreement

Rationale (what you are treating and why)
Risks of the drug (side effects as well as risk of dependence, tolerance, addiction, misuse, and overdose; and risk of driving, working, etc., under the influence of the drug)
Treatment goals (pain level, function level)
Monitoring plan (how often to return for follow up)
Refill policy
Action plan for suspected aberrant behavior (may include urine drug screens to ensure the patient is not diverting the medication)
Conditions for discontinuing opiates (lack of efficacy, pain resolution, aberrant behavior)

In crafting a management plan, clinicians should avoid framing the agreement in terms of punishments for possible future misbehaviors or difficulties, and should take care to avoid using language that is stigmatizing, dominating, or pejorative. Since written agreements must be clearly understood by the patient, they should be written at the sixth- to seventh-grade level, and translated into the patient’s language, if possible (in-person translators may also be used).⁵³ Time must be allowed for patients to ask questions, and for prescribers to ensure patients understand what they are being told. Some, or all, of these tasks may be handled by trained personnel (or staff members) rather than physicians (a sample agreement is provided in Appendix I of this document).

Clinicians should be aware that although the terms “agreement” or “plan” are more patient-friendly than the word “contract,” from a legal standpoint, any written or oral agreement between a prescriber and a patient may be considered a binding “contract.”⁵⁴

Since pain itself cannot be measured objectively, opiate management plans should not be framed solely in terms of pain relief; functional goals are preferable. Chronic pain often impairs functioning in daily life, such as the ability to be physically active, mentally focused, and well-rested. Even relatively modest reductions in pain can allow for functional improvements.⁵⁵

Framing treatment goals in terms of improved functioning allows prescribing decisions (or decisions to terminate treatment) to be based on objective data such as attendance at physical therapy appointments, sleeping in a bed instead of a chair, or walking a designated distance or number of steps. Another key benefit of a function-based opiate management plan is that the resulting data can help differentiate patients who are addicted to an opiate from patients who are not addicted but are nonetheless seeking an increased dose: addiction typically leads to *decreased* functioning, while effective pain relief typically improves functioning.³¹

Functional treatment goals should be realistic and tailored to each patient. Because patients with long-standing chronic pain are frequently physically deconditioned, progress in achieving functional goals can be slow or interrupted with “setbacks.” It is better to set goals slightly too low than slightly too high. Raising goals after a patient has “succeeded” is preferable – and more motivational – than lowering goals after a patient has “failed.”

Opiates for acute pain

Although the focus of this paper is on chronic non-cancer pain, opiates are widely used for acute pain as well, and a brief overview of recommended practice is appropriate here. Cautious use of opiates for moderate or severe acute pain may be considered for carefully-selected patients whose pain is not controlled with acetaminophen or NSAIDs, or for whom such medications are contraindicated. The opioid should be used at a minimum effective dose, and for a limited period of time, usually less than one week. Opiates should be used only as one part of a comprehensive pain care plan, and extended release opiates should be avoided in acute pain patients.³

Studies show that physicians routinely over-prescribe opiates for acute pain. For example, Rodgers et al. found that after outpatient orthopedic surgery, most patients were prescribed 30 pills of an opioid analgesic, although the mean patient consumption of those analgesics was only 10 pills.⁴ Another study found that 72 percent of people who had been prescribed an opioid had leftover medication.⁵ This guideline recommends that no more than a one-week supply be prescribed following surgery.

By definition, treatment of acute pain should not last longer than the time required for the healing or resolution of the trauma or condition. Hence, it is unlikely that opiates, or any other analgesic, will be needed beyond 90 days from initiation of treatment. Research shows that after 90 days of continuous opioid use, treatment is more likely to become life-long.⁶⁻⁹ The 90-day mark, therefore, should be considered a “red flag” point at which use should be re-evaluated.

Informed consent

Informed consent is a fundamental part of any medical treatment plan, but it is critically important when considering long-term opiate therapy, given the potential risks involved. Four key questions clinicians may ask when obtaining informed consent in the context of opiate treatment are:⁵⁶

1. Does the patient understand the various options for treatment?
2. Has the patient been informed of the potential benefits and risks associated with each of those options?
3. Is the patient free to choose among those options, and free from coercion by the health care professional, the patient’s family, or others?
4. Does the patient have the capacity to communicate his or her preferences – verbally or in other ways (e.g., is the patient deaf or cognitively impaired)?

Documented informed consent may best be incorporated into an opiate management agreement.

Initiating opiates

Before prescribing any opiate, clinicians may consider whether:

- Other treatment options have been exhausted – nonpharmacologic and nonopiate pharmacologic therapies are preferred for chronic pain
- The patient’s physical and psychosocial condition has been fully assessed
- Level of opiate tolerance has been determined or estimated (see below)
- Informed consent has been obtained and a management plan is in place
- Treatment goals have been established – to include realistic goals for pain and function
- Opiates will be continued after reassessment – opiates should only be continued if benefits outweigh risk and there is clinically meaningful improvements in pain and function

When initiating opiates, clinicians should prescribe the lowest effective dosage, and should only prescribe the quantity needed for the expected duration of pain severe enough to require opiates – three days or less will often be sufficient; more than seven days will rarely be needed.

Opiate selection, initial dosing, and titration must be individualized to the patient’s health status, previous exposure to opiates, and treatment plan.¹¹ Patients who are opiate-naïve or have modest previous opiate exposure should be started at a low dose, generally of a short-acting opiate because these confer a lower risk of overdose, and titrated slowly upward to decrease the risk of opiate-related adverse effects.¹¹ If it is unclear whether a patient has recently been using opiates (either prescribed or non-prescribed), the

The Special case of methadone

Methadone has some unique safety issues. It has a long and unpredictable half life and accounts for a higher proportion of accidental overdoses than any other opioid.¹ In addition, it prolongs the QTc interval, and increases the risk of fatal arrhythmias (*torsades de pointes*), especially in patients taking other QTc prolonging agents. The routine use of methadone for chronic pain in primary care should be avoided.

clinician should assume that the patient is opiate-naïve (i.e., not tolerant) and proceed as just described. Some patients, such as frail older persons or those with comorbidities, may require an even more cautious therapy initiation.

A decision to continue opiate therapy should be based on careful review of the trial outcomes. Outcomes to consider include:³¹

- Progress toward meeting functional goals
- Presence and nature of adverse effects
- Changes in the underlying pain condition
- Changes in medical or psychiatric comorbidities
- Degree of opiate tolerance in the patient
- Identification of aberrant behaviors, misuse, or diversion

Patient education

Before starting and periodically during opiate therapy, providers should discuss known risks and benefits of opiate therapy, and patient and provider responsibilities for managing therapy. Given the potentially serious risks of long-term opiate therapy, providers should ensure patients are aware of potential benefits, harms, and alternatives to opiates before starting or continuing opiate therapy. Providers are encouraged to have open and honest discussions with patients to form mutual decisions about whether to start or continue opiate therapy. Important considerations include the following:

- Be explicit and realistic about expected benefits – explaining that while opiates can reduce pain during the short-term, there is no conclusive evidence that opiates improve pain or function with long-term use, and that complete pain relief is unlikely.
- Emphasize improvement in function as a primary goal and that function can improve even while pain is present.
- Advise patients about serious adverse effects to include potentially fatal respiratory depression and development of an opiate use disorder.
- Advise patients of common effects of opiates, such as constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opiates.

- Discuss effects that opiates might have on one's ability to operate a vehicle, particularly when opiates are initiated, when dosages are increased, or when other central nervous system depressants, such as benzodiazepines or alcohol are used concurrently.
- Discuss increased risks for opiate use disorder, respiratory depression, and death at higher dosages, along with taking only the amount that is prescribed – not taking more or taking them more often.
- Review increased risks for respiratory depression when opiates are taken with benzodiazepines, other sedatives, alcohol, illicit drugs such as heroin, or other opiates.
- Discuss risks to household members and other individuals if opiates are intentionally or unintentionally shared with others from whom they are not prescribed.
- Discuss the importance of periodic reassessment to ensure that opiates are helping to meet patient goals and to allow opportunities for opiate discontinuation and consideration of additional nonpharmacologic or nonopiate pharmacologic treatment options of opiates are not effective or are harmful.
- Discuss planned use of precautions to reduce risks. Consider including a discussion of naloxone use for overdose reversal.
- Consider whether cognitive limitations might interfere with management of opiate therapy, and if so, determine whether a caregiver can responsibly co-manage opiate therapy. Discuss the importance of reassessing safer medication use with both patient and caregiver.

In addition, whenever an opiate is prescribed, the patient should be thoroughly educated about the safe storage and disposal of opiate medications. This can be done by a non-physician, if desired, and the key points can be included in patient/provider agreements or treatment plans. Safe use means following clinician instructions about dosing, reviewing and avoiding potentially dangerous drug interactions with other drugs, and assuring full understanding of how the medication should be consumed or, in some cases applied.

Safe storage means reminding patients that pain medications are sought after by many people, and, thus it is best if opiates are stored in a locked cabinet or other secure storage unit. If a locked unit is not available, patients should, at least, not keep opiates in a place that is obvious to, or

easily accessed by others, since theft by friends, relatives, and guests is a known route by which opiates become diverted.⁵⁷ Storage areas should be cool, dry, and out of direct sunlight.

Proper disposal means getting rid of unused medications. Patients should:

- Follow any specific disposal instructions on the prescription drug labeling or patient information that accompanies the medication. Do not flush medicines down the sink or toilet unless this information specifically instructs to do so;
- Return medications to a pharmacy, health center, or other organization with a take-back program; or
- Mix the medication with an undesirable substance (e.g., coffee grounds or kitty litter) and put it in the trash.

In 2014, the DEA loosened regulations to allow pharmacies, hospitals, clinics, and other authorized collectors to serve as drop-off sites for unused prescription drugs.

Opiate selection

Opiate analgesics are available in a wide range of formulations and routes of administration (i.e., oral, transdermal, transmucosal, rectal, intrathecal). Little evidence exists that specific analgesic formulations affect efficacy or addiction risk, so selection of agent should be based on the patient's pain complaint, lifestyle, and preferences.⁵⁸ Generally, if opiates are used at all, it is better to offer short-acting opiates used on an as-needed basis. Extended-release (ER) or long-acting (LA) opiates produce a more steady state of analgesia without the cycling effect of pain relief and withdrawal associated with short-acting opiates, which may be helpful for certain patients.⁵⁹ With ER/LA agents, however, patients may end up using more drug than is actually needed, and physiological adaptations to the steady state may ultimately decrease analgesic efficacy.⁶⁰ In addition, ER/LA opiates pose a higher risk for being abused. Clinicians should warn patients that oral ER/LA opiates should not be broken, chewed, or crushed. Patches should not be cut or torn prior to use, since this may lead to rapid release of the opiate and could cause overdose or death. ER/LA agents should not be used to treat acute pain.

Prescribers should educate themselves about the general characteristics, toxicities, and drug interactions for ER/LA opiate products. For detailed information on current ER/LA opiate

analgesics, see the FDA Blueprint for Prescriber Education, available at: <http://www.er-la-opioidrems.com>.

Combination products join an opiate with a non-opiate analgesic, usually for use in patients with moderate pain. Using a combination product when dose escalation is required risks increasing adverse effects from the non-opiate co-analgesic, even if an increase of the opiate dose is appropriate. In such cases, using a pure opiate is preferable. Care, in particular, must be given to not exceed maximal daily doses of acetaminophen.

Periodic review and monitoring

Regarding duration of use, patients can experience tolerance and loss of effectiveness of opiates over time. Patients who do not experience clinically meaningful pain relief early in treatment (i.e., within one (1) month) are unlikely to experience pain relief with longer-term use. Providers should evaluate benefits and harms with patients within 1 to 4 weeks of starting opiate therapy for chronic pain or dose escalation.

If an opiate medication appears to be helpful (as determined by the functional goals outlined in the management plan) and therapy is continued, regular review and monitoring should be performed for the duration of treatment. Exactly what constitutes “regular” is determined by the needs and characteristics of each patient. A physical examination, for example, may or may not be required at each follow-up visit. Clinicians must evaluate progress against agreed-upon treatment goals for both pain relief and function, assess for physical and behavioral adverse effects, and confirm adherence to prescription regimens.

The intensity and frequency of monitoring is guided, in part, by the clinician’s assessment of the patient’s risk for abuse, diversion, or addiction. Tools and techniques similar or identical to those used during an initial assessment of a patient’s risk can be used to re-assess or monitor risk on an on-going basis.

Patients who may need more frequent or intense monitoring include:

- Those with a prior history of an addictive disorder, past substance abuse, or other aberrant use
- Those in an occupations demanding mental acuity
- Older adults
- Patients with an unstable or dysfunctional social environment
- Those with comorbid psychiatric or medical conditions

Those who are taking other medications that may interact with an opiate

If benefits do not outweigh harms of continued opiate therapy, clinicians should optimize other therapies and work with patients to taper opiates to lower dosages or to taper and discontinue opiates.

Caution about dose escalation

When treating chronic pain, dose escalation has not been proven to reduce pain or increase function, but it *can* increase risks.⁶¹ Prescribing high-dose opiate therapy (greater than or equal to 120 mg morphine equivalents/day) may not be appropriate, and in such cases, referral to a provider with specialized skill or experience in dealing with high-risk patients may be prudent. A recent cohort study of 9,940 patients receiving opiate analgesics for chronic non-cancer pain found that patients receiving 100 mg or more per day had an 8.9-fold increase in overdose risk compared to patients receiving 1-20 mg of opiates per day.⁴¹ No randomized trials show long-term effectiveness of high opiate doses for chronic non-cancer pain. Many patients on high doses continue to have substantial pain and related dysfunction.⁶¹ As noted earlier, higher doses of opiates are associated with increased risks for adverse events and side effects including overdose, fractures, hormonal changes, and increased pain sensitivity.

Table 3. 100 MED equivalents*

100 morphine equivalents =

Dose of Opiate
42 mcg/hr fentanyl transdermal
100 mg hydrocodone
25 mg hydromorphone
67 mg oxycodone
33 mg oxymorphone

* This is not a chart for opiate conversion. See below regarding considerations for conversion or opiate rotation.

Urine drug screens

Urine drug testing is an imperfect science, but such testing can be a helpful component of responsible opiate prescribing. Drug testing should be conducted in a consensual manner as part of an agreed-upon opiate management plan and with the idea that such testing benefits both the patient and the provider. The potential benefits of urine drug testing include:

- Serving as a deterrent to inappropriate use
- Providing objective evidence of abstinence from drugs of abuse
- Monitoring compliance with the treatment plan

In primary care settings, unobserved urine collection is usually acceptable; however, clinicians should be aware of the many ways in which urine specimens can be adulterated. Specimens should be shaken to determine if soap products have been added, for example. The urine color should be noted on any documentation that accompanies the specimen for evaluation, since unusually colored urine could indicate adulteration. If possible, urine temperature and pH should be measured immediately after collection⁶² (a guide for dealing with suspected adulteration of a urine sample or patients suspected of misusing a prescription is available to members of the SDSMA).

Prescribers should be familiar with the metabolites associated with each opiate that may be detected in urine, since the appearance of a metabolite can be misleading. A patient prescribed codeine, for example, may test positive for morphine because morphine is a codeine metabolite. Similar misunderstandings may occur for patients prescribed hydrocodone who appear positive for hydromorphone or oxycodone and oxymorphone. In the event of an abnormal urine drug screen, prescribers should consider a differential diagnosis that includes: drug abuse or addiction; self-treatment of poorly-controlled pain; psychological issues; or diversion (which may be suggested by absence of prescribed opiates).¹¹

Protecting against opiate-induced adverse events

The Veterans Administration/Department of Defense clinical practice guideline outlines a number of evidence-based strategies to reduce opiate-related adverse effects, summarized in Table 4.⁶³ Prophylaxis for constipation, which is the most common opiate-induced adverse event, has been facilitated by the recent approval of methylnaltrexone (Relistor) subcutaneous administration and naloxegol (Movantik) oral administration for patients with chronic non-cancer pain.

Table 4: Recommendations for preventing or treating opiate-induced side effects⁶³

Constipation	Methylnaltrexone or naloxegol Prophylactic mild peristaltic stimulant (e.g., bisacodyl or senna) If no bowel movement for 48 hours, increase dose of bowel stimulant If no bowel movement for 72 hours, perform rectal exam If not impacted, provide additional therapy (suppository, enema, magnesium citrate, etc.)
Nausea or vomiting	Consider prophylactic antiemetic therapy Add or increase non-opiate pain control agents (e.g., acetaminophen) If analgesia is satisfactory, decrease dose by 25 percent Treat based on cause
Sedation	Determine whether sedation is due to the opiate Eliminate nonessential CNS depressants (such as benzodiazepines) If analgesia is satisfactory, reduce dose by 10-15 percent Add or increase non-opiate or non-sedating adjuvant for additional pain relief (such as NSAID or acetaminophen)so the opiate can be reduced Add stimulant in the morning (such as caffeine) Change opiate
Pruritus	Consider treatment with antihistamines Change opiate
Hallucination or dysphoria	Evaluate underlying cause Eliminate nonessential CNS acting medications
Sexual dysfunction	Reduce dose Testosterone replacement therapy may be helpful (for men) Erection-enhancing medications (e.g., sildenafil)

The concurrent use of benzodiazepines and opiates is particularly problematic since these agents act synergistically to depress respiratory functioning.

Opiate rotation

Switching from one opiate to another may be needed for a variety of reasons: to better balance analgesia and side effects, lack of efficacy (often related to tolerance), bothersome or unacceptable side effects, need for dose increases that exceed recommended limits (e.g., dose limitations of co-compounded acetaminophen), or inability to absorb the medication in its present form.

Opiate rotation must be done cautiously because of the many pharmacokinetic and pharmacodynamic variables involved.³¹ An equianalgesic chart should be used when changing

from one opiate to another or from one route of administration to another. Such charts must be used carefully, however. A high degree of variation has been found across the various charts and online calculators, and may account for some overdoses and fatalities.⁶⁴ The optimal dose for a specific patient must be determined by careful titration and appropriate monitoring, and clinicians must remember that patients may exhibit incomplete cross-tolerance to different types of opiates because of differences in the receptors or receptor sub-types to which different opiates bind. Do not simultaneously switch both an agent *and* a route of administration or type of release (e.g., ER/LA)

Managing pain flare-ups

Pain is dynamic, and pain intensity may sometimes rise to the point that it is not controlled by a given steady-state dose. Providing patients either paper or electronic pain diaries can help them track such pain episodes and spot correlations between the flare-ups and variables in their lives. If specific triggers are identified, patients may be able to make changes that will reduce the prevalence of episodes without recourse to increased medication.³¹

Non-opiate methods of dealing with pain flare-ups (e.g., cold or warmth, massage, yoga, acupuncture, meditation, electrical stimulation) should be tried—or at least considered—before the dose of an opiate is increased. As with the management of the underlying chronic pain condition, clinicians should use an agreed-upon set of functional goals as a way to monitor, and if necessary, adjust, the use of as-needed opiate medications for pain flares.

Using prescription monitoring programs

Potential benefits of prescription drug monitoring programs (PDMPs) and urine drug testing include the ability to identify patients who might be at higher risk for opiate overdose or opiate use disorder, and help determine which patients may benefit from great caution and increased monitoring or interventions when risk factors are present. Research indicates that most fatal overdoses could be identified retrospectively on the basis of two pieces of information – multiple prescribers and high total daily opiate dosage – both of which are available to prescribers through the South Dakota PDMP.

South Dakota's PDMP offers point-of-care access to pharmacy dispensing records of controlled substances from prescribers. From these, clinicians can quickly assess patterns of prescription drug use that can be helpful in confirming or refuting suspicions of aberrant behaviors.

Information from the PDMP may also reveal that a patient is being prescribed medications whose combinations are contraindicated. By reviewing the PDMP each prescriber can identify other prescribers involved in the care of their patient. This can be especially useful for new patients to a practice on high dose opiates, with suspect or concerning behaviors.

Pharmacies and practitioners that dispense any Schedule II, III, or IV controlled substances in South Dakota, or to an address in South Dakota, must report such dispensing to the PDMP.

Addressing concerns about prescription activity

Suspicion that a patient is non-adherent to a prescription or is engaging in aberrant drug-related behaviors should prompt a thorough investigation of the situation, including an honest evaluation of the patient/provider relationship, which may be strained by such behaviors.³¹ Possible reasons for non-adherence include:

- Inadequate pain relief
- Misunderstanding of the prescription
- Misunderstandings related to lack of fluency with English
- Attempts to “stretch” a medication to save money
- Cultural or familial pressure not to take a medication
- Stigma about taking a pain medication
- Patient fears about addiction

Listed below are some possible steps to take in response to concerns about a patient's prescription activity:

- Discuss the situation with the patient: express concern over the pattern of behavior; discuss how drug abuse begins; and emphasize its negative consequences on health, employment, finances, friends and family, etc.

- Clarify expectations (e.g., receiving controlled medications from only one prescriber, using only one pharmacy) and review existing patient/provider agreements
- Increase the intensity of patient monitoring (e.g., urine toxicology, pill counts and early refills) and establish limits on refills or lost medications

For persistent non-compliance, options include one or more of the following:

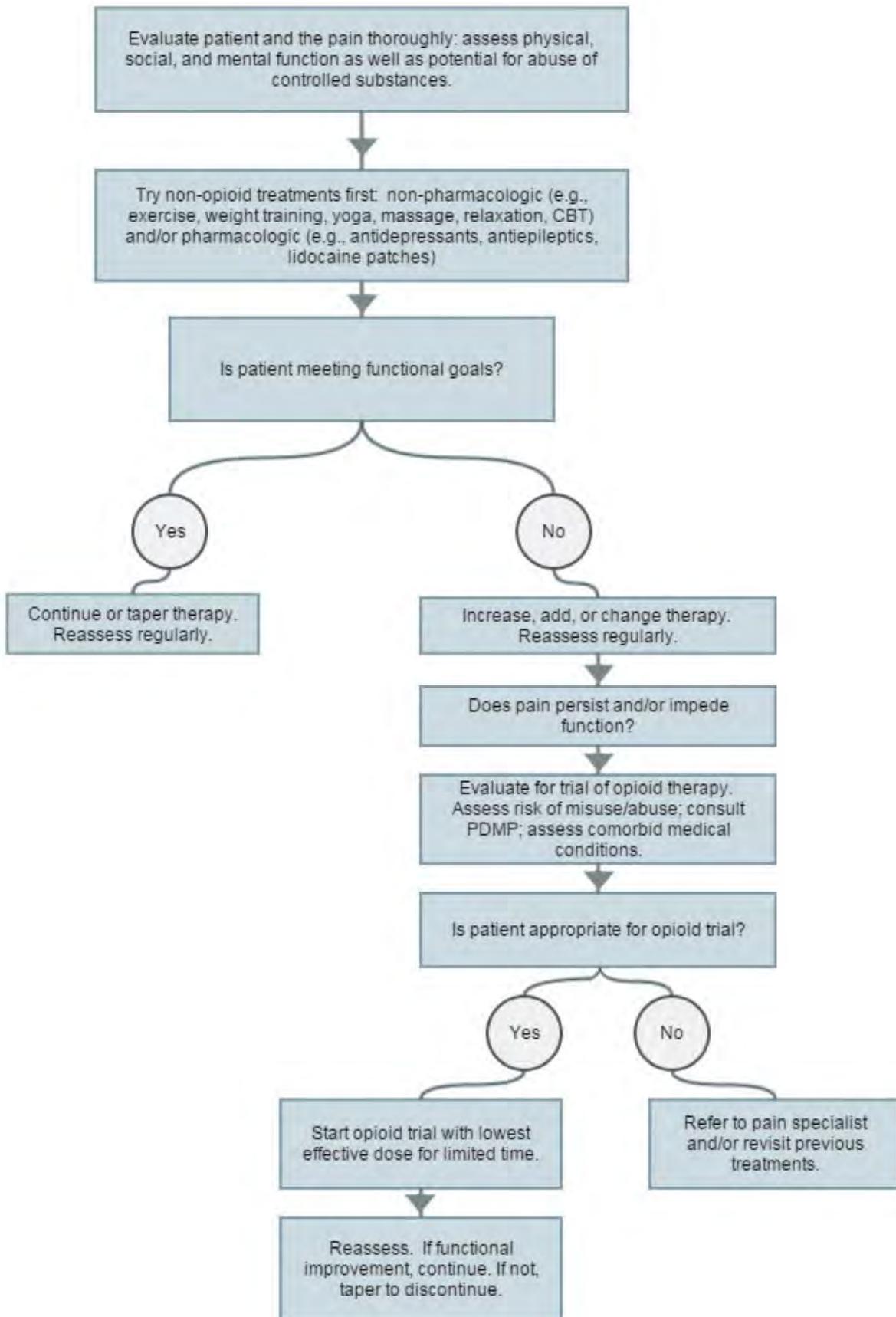
- Tapering drug therapy over several weeks to avoid withdrawal; consider incorporating non-opiate pain treatments.
- Referral to specialists, e.g., pain specialist, for evaluation of continued controlled substance prescribing
- Referral to an addiction management program

Patients with addictive disorders and/or complex chronic pain problems should maintain a relationship with a primary care provider, even if the management of the pain and/or addiction will be conducted by specialists. Providers are not required to take action that they believe to be contrary to the patient's best interests. If the provider believes that a crime has been committed, such as misrepresenting oneself to obtain controlled substance prescriptions, it is the right of the provider or staff to contact law enforcement and/or other providers. In criminal matters HIPAA restrictions generally do not apply. Legal input in difficult cases may be helpful. A Legal Brief on Reporting Patient Drug Use or Diversion is available from the SDSMA and provides more detailed information on this topic.

Roadmap for responsible opiate prescribing

The algorithm on the following page summarizes the guidance presented in this section. It emphasizes the need to pursue non-opiate therapies first, to rigorously assess patients, and to work within a function-based paradigm of care.

Figure 3. Algorithm for pain management



Discontinuing opiate therapy

Discontinuation of an opiate may be necessary for a variety of reasons, including the healing of an injury or condition, an inability to achieve adequate analgesia, the lack of progress toward functional goals, the experience of intolerable side effects, or evidence of abuse, addiction or aberrant behaviors. If inappropriate use of a prescription medication is discovered, treatment must usually be suspended, although provisions should be in place for continuation of some kind of pain treatment and/or referral to other professionals or members of a pain management team. Some clinicians may be willing and able to continue a regimen of opiate therapy even after the discovery of aberrant behavior, although this would require intensified monitoring, patient counseling, and careful documentation of all directives. This level of vigilance and risk management, however, may exceed the abilities and resources of primary care physicians. In such cases, referral to a provider with specialized skill or experience in dealing with high-risk patients may be prudent.

Stopping long-term opiate therapy is often more difficult than starting it⁶⁵ and it is important to understand what triggers withdrawal in people is highly variable. For most patients, the opiate dose may be tapered by 20 to 50 percent of the current dose per week; however, if time allows, a physician may go considerably slower to give every possible chance for success. The longer the patient has been on the drug, and the higher the initial dose, the slower the taper should be.⁶³ A taper of 10 percent every two weeks may provide the patient an opportunity to learn and deal with an increase in pain as the dosage of opiates is reduced. Of note, if diversion is in question, it may be appropriate to stop writing immediately with the recommendation that the patient report to the emergency room if they go into withdrawal.

Opiates and pregnancy

Current American Pain Society-American Academy of Pain Medicine (APS-AAPM) guidelines suggest that clinicians should avoid prescribing opiates during pregnancy unless the potential benefits outweigh risks.¹¹ Some data suggest an association between the use of long-term opiate therapy during pregnancy and adverse outcomes in newborns, including low birth weight and premature birth, though co-related maternal factors may play a role in these associations and causality is not certain.¹¹ Exposure to these medications has also been associated with birth

defects in some studies. Opiate withdrawal can be expected in up to half of newborns of opiate-dependent mothers (neonatal abstinence syndrome).¹¹ If a mother is receiving long-term opiate therapy at or near the time of delivery, a professional experienced in the management of neonatal withdrawal should be available – per ASAM, ACOG, and AAP, neonatal abstinence can be effectively treated with no long-term, harmful effects on mom or baby.

Reducing the risk of overdose

Opiate overdose is reversible through the timely administration of the medication naloxone (trade name Narcan). Narcan is a prescription drug, but it is not a controlled substance and has no abuse potential. It is regularly carried by medical first responders and, as of July 1, 2015, such use became legal in South Dakota.

As an opiate antagonist, naloxone can quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of heroin or prescription opiate overdose. As of 2010, programs that distribute naloxone to nonmedical personnel had reported more than 10,000 overdose reversals nationwide since 1996.⁶⁶ As of November 2014, 23 states have statutes that allow for “third-party” prescriptions of naloxone (i.e., the prescription can be written to friend, relative or person in a position to assist a person at risk of experiencing an opiate overdose). This kind of prescription has not yet been legalized in South Dakota.

Given the effectiveness of naloxone in overdose reversal, the FDA has encouraged innovations in more user-friendly naloxone delivery systems such as auto-injectors, made particularly for lay use outside of health care settings. The FDA approved such an auto-injector in 2014.

Special populations

A full discussion of the many non-opiate pain treatment modalities, and how those modalities can be employed to manage pain across all disease states and conditions is beyond the scope of these guidelines, which focus primarily on the use of opiates. But a brief review of pain management recommendations in some common patient populations is warranted, since these often involve decisions about whether to use opiates and, if so, how they can most optimally be prescribed.

Emergency room patients

Pain is a frequent complaint of emergency room (ER) patients, and ER physicians are among the higher prescribers of opiates to patients ages 10-40.⁶⁷ ER physicians, however, face considerable challenges in determining a patient's appropriateness for opiate therapy. A medical history is often lacking, and the physician seldom knows the patient personally. Time constraints, as well, can preclude the kinds of careful assessment and evaluation recommended for responsible opiate prescribing. Because of this, current guidelines from the American College of Emergency Physicians (ACEP) include the following recommendations:⁶⁸

1. For the patient being discharged from the emergency department (ED) with acute pain, the emergency physician should ascertain whether non-opiate analgesics and non-pharmacologic therapies will be adequate for initial pain management
2. Given a lack of demonstrated evidence of superior efficacy of either opiate or non-opiate analgesics and the individual and community risks associated with opiate use, misuse, and abuse, opiates should be reserved for more severe pain or pain refractory to other analgesics rather than routinely prescribed.
3. If opiates are indicated, the prescription should be for the lowest practical dose for a limited duration (e.g., less than 1 week), and the prescriber should consider the patient's risk for opiate misuse, abuse, or diversion.

For patients presenting to the ED with an acute exacerbation or non-cancer chronic pain, the SDSMA recommends the following:

1. Physicians should avoid the routine prescribing of outpatient opiates for a patient with an acute exacerbation of chronic non-cancer pain seen in the ED
2. If opiates are prescribed on discharge, the prescription should be for the lowest practical dose for a limited duration (e.g., less than 1 week), and the prescriber should consider the patient's risk for opiate misuse, abuse, or diversion
3. The physician should, if practicable, honor existing patient-physician pain contracts/treatment agreements and consider past prescription patterns from information sources such as prescription drug monitoring programs

The SDSMA recommends that the use of a state prescription drug monitoring program may help identify patients who are at high risk for prescription opiate diversion or doctor shopping.

Cancer pain

Pain is one of the most common symptoms of cancer, as well as being one of the most-feared cancer symptoms. Pain is experienced by about 30 percent of patients newly diagnosed with cancer, 30 to 50 percent of patients undergoing treatment, and 70 to 90 percent of patients with advanced disease.¹⁶ Unrelieved pain adversely impacts motivation, mood, interactions with family and friends, and overall quality of life. Survival itself may be positively associated with adequate pain control.⁶⁹ Opiate pain medications are the appropriate to consider for cancer patients with moderate or severe pain, regardless of the known or suspected pain mechanism.⁷⁰ ER/LA opiate formulations may optimize analgesia and lessen the inconvenience associated with the use of short-acting opiates. Patient-controlled analgesia with subcutaneous administration using an ambulatory infusion device may provide optimal patient control and effective analgesia.⁷¹ The full range of adjuvant medications covered earlier should be considered for patients with cancer pain, with the caveat that such patients are often on already complicated pharmacological regimens, which raises the risk of adverse reactions associated with polypharmacy. If cancer pain occurs in the context of a patient nearing the end of life, other treatment and care considerations may be appropriate. In these cases, patient integrated with a specialist in palliative care medicine may be advisable.

Pain at the end of life

Pain management at the end of life seeks to improve or maintain a patient's overall quality of life. This focus is important because sometimes a patient may have priorities that compete with, or supersede, the relief of pain. For some patients mental alertness sufficient to allow lucid interactions with loved ones may be more important than physical comfort. Optimal pain management, in such cases, may mean lower doses of an analgesic and the experience, by the patient, of higher levels of pain.

Since dying patients may be unconscious or only partially conscious, assessing their level of pain can be difficult. Nonverbal signs or cues must sometimes be used to determine if the patient is

experiencing pain and to what degree an analgesic approach is effective. In general, even ambiguous signs of discomfort should usually be treated, although caution must be exercised in interpreting such signs.⁷² Reports by family members or other people close to a patient should not be overlooked. In the Study to Understand Prognosis and Preference for Outcomes and Risks of Treatment (SUPPORT), surrogates for patients who could not communicate verbally had a 73.5 percent accuracy rate in estimating presence or absence of the patient's pain.⁷³

Opiates often are useful to providing effective analgesia at the end of life, and they are available in such a range of strengths, routes of administration, and duration of action that an effective pain regimen can be tailored to nearly each patient. No specific opiate is superior to another as first-line therapy. Rectal and transdermal routes of administration can be valuable at the end of life when the oral route is precluded because of reduced or absent consciousness, difficulty swallowing, or to reduce the chances of nausea and vomiting.⁷⁴ When selecting an opiate, clinicians should also consider cost, since expensive agents can place undue burden on patients and families.

Fear of inducing severe or even fatal respiratory depression may lead to clinician under-prescribing and reluctance by patients to take an opiate medication.²⁸ Despite this fear, studies have revealed no correlation between opiate dose, timing of opiate administration, and time of death in patients using opiates in the context of terminal illness.⁷⁵ A consult with a specialist in palliative medicine in these situations may be advisable.

Older Adults

The prevalence of pain among community-dwelling older adults has been estimated between 25 and 50 percent.⁷⁶ The prevalence of pain in nursing homes is even higher. Unfortunately, managing pain in older adults is challenging due to underreporting of symptoms; presence of multiple medical conditions; polypharmacy; declines in liver and kidney function; problems with communication, mobility, and safety; and cognitive and functional decline in general. Acetaminophen is considered the drug of choice for mild-to-moderate pain in older adults because it lacks the gastrointestinal, bleeding, renal toxicities, and cognitive side-effects that have been observed with NSAIDs in older adults (although acetaminophen may pose a risk of

liver damage). Opiates must be used with particular caution, and clinicians should “start low, go slow” with initial doses and subsequent titration. Clinicians should consult the American Geriatrics Society *Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults* for further information on the many medications that may not be recommended.³¹ The many challenges of pain management in older adults, only sketched here, suggest that early referral and/or consultation with geriatric specialists or pain specialists may be advisable.

Conclusions

The soaring use of opiate analgesics to treat chronic pain has led to escalating rates of opiate diversion, abuse, addiction, and overdose. The clinical evidence base supporting this use of opiates is much weaker than is often assumed, however, while the evidence for the many risks involved in long-term use of opiates is accumulating.

When used for severe acute pain in time- and dose-limited ways, or for the relief of cancer and end-of-life pain, opiates can be uniquely valuable and the risks of addiction and abuse are low. The benefits of using opiates outside of these realms, however, seldom outweigh their risks. These risks are amplified among older adults; those with impaired renal or hepatic function; individuals with COPD, cardiopulmonary disorders, sleep apnea, or mental illness; and in patients who are likely to combine opiates with other respiratory depressants such as alcohol or benzodiazepines.

These guidelines have outlined an evidence-based strategy for identifying patients for whom the benefits of long-term opiate therapy might outweigh the risks. It is intended neither as an exhaustive review nor a standard of care. Rather, it summarizes established methods for appropriately prescribing opiate analgesics. Appropriate prescribing of opiates can be challenging, but it is not inherently different from the challenges physicians face when using any other treatment option that carries significant risks of harm. It is both feasible and necessary for clinicians to treat pain effectively while minimizing risk.

Resources

American Academy of Pain Medicine
www.painmed.org

Depression Anxiety & Positive Outlook Scale
www.dapos.org

Drug Enforcement Administration Diversion Control Program
www.DEAdiversion.usdoj.gov

FDA Blueprint for Prescriber Education
<http://www.er-la-opioidrems.com>

Generalized Anxiety Disorder Assessment (GAD-7)
<http://www.patient.co.uk/doctor/generalised-anxiety-disorder-assessment-gad-7>

National Institute on Drug Abuse
Short and longer-form validate questionnaires
<http://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf>

The National Association of State Controlled Substances Authorities (NASCSA)
www.nascsa.org

Patient Health Questionnaire
www.phqscreeners.com

PainLaw.org
www.painlaw.org

Risk reduction strategies (free online CME)
www.opioidprescribing.com

University of Wisconsin Pain & Policy Studies Group
www.medsch.wisc.edu/painpolicy

Veterans Administration opioid clinical practice guidelines
<http://www.healthquality.va.gov/guidelines/Pain/cot/>

Appendix I: Sample Patient/Provider Agreement

[Directions for Use – it is recommended that the provider create a pre-printed form with the provider’s name inserted anywhere the words “your health care provider” are used; doing so should help avoid confusion and will otherwise make the form more user-friendly for both the patient and the provider.]

Opiate Pain Medication

Treatment Agreement and Informed Consent

Safe and effective treatment with opiate pain medications requires your understanding and your cooperation as is outlined below. Please read each item and check the box if you understand and agree to comply with the statement. If you do not understand the statement, or if you do not agree to it, please discuss the item with your healthcare provider.

Examples of opiate pain medications include, but are not limited to morphine, hydrocodone, oxycodone, hydromorphone, fentanyl and methadone.

I the patient understand and agree as follows:

Agreement Basics.

- 1. Your routine opiate pain medications need to be prescribed only by **your health care provider, Dr. _____**, or another healthcare provider that he/she may choose and name in writing. Do not ask for or accept opiate pain medications from other health care providers.
- 2. You may only get your opiate pain medications from one designated pharmacy. You have selected _____. Your pharmacy choice can be changed by notifying **your health care provider** in advance.
- 3. Do not take opiate pain medications at a larger dose or more often than has been prescribed. If I take too much pain medication or more often than prescribed, I understand that I could have complications and I could die. If I am not satisfied with my treatment, I am to call my **health care provider**.

- 4. Do not give or sell your opiate pain medications to anyone. Do not take opiate pain medications prescribed or otherwise obtained from any source except **your health care provider**. Do not take drugs from non-medical sources. Do not take illegal drugs.
- 5. You must give an honest and complete past medical history, including prior opiate treatment, current medications (including over-the-counter medications), current and past non-medical drug use, chemical dependency treatment, and psychiatric diagnoses and treatment. You should consent to communication among your current and past health care providers.
- 6. Inform any other healthcare provider who treats you that you have an Opiate Pain Medication Treatment Agreement with **your health care provider**.
- 7. Contact **your health care provider** before taking any outpatient opiate pain medication that may be prescribed by an emergency room or at hospital discharge. Contact **your health care provider** when you have been treated with opiate pain medications in an emergency room. This Agreement does not prevent you from being treated with opiate pain medications in an emergency room or when you have been admitted to a hospital.
- 8. You are required to undergo laboratory drug testing promptly when asked. This may include urine, blood or hair. This request may come at the start of treatment, randomly, or from time-to-time when requested by **your health care provider**.
- 9. Chronic pain treatment requires full and cooperative patient participation. Besides routine office visits, this may include physical therapy, counseling, and chemical dependency assessment. Frequent late arrivals, cancelling less than 24 hours before a scheduled appointment and/or not showing up for appointments is not acceptable.
- 10. You must accept and cooperate with **your health care provider's** prescription writing and renewal practices. This may include only receiving prescriptions at scheduled, in-person appointments.
- 11. Tell **your health care provider** if you are pregnant or may become pregnant.
- 12. The goal of opiate pain medication is to assist with pain control in order to allow for improved function and successful living. Relief of 100 percent of pain is usually not possible or necessary. Your health care provider may stop your opiate medication if your function does not improve.

Prescription and medication management safety.

- 13. Do not lose your prescription form. Immediately filling your prescription at your pharmacy of choice may be best. Do not lose or damage your pills.

- 14. Prescription form or pill loss may cause you to lose your access to opiate pain medications. Lost prescription forms or pills will not necessarily be replaced.
- 15. If your behavior causes **your health care provider** to become concerned about a chemical dependency problem, referral for a chemical dependency assessment may be made.
- 16. Keep your medications in a lock box. Do not give others access to your key or combination to your lock box. Take out a daily medication supply each day and keep it in your personal possession.
- 17. Do not handle your opiate pain medication by a sink or toilet. Only open your lock box after placing it on a table.
- 18. Some people do not tolerate opiates well and as a result may feel tired or not as alert as normal. Temporary periods of drowsiness may occur when drugs are new or when dose has been increased. In any event, there should be **no driving or operating powered machinery or equipment if there is any question of your ability to do so safely and alertly**. Discussion and agreement among you, a household or family member, and **your health care provider** is best.
- 19. Do not consume alcohol while taking opiate pain medications.

Opiate information.

- 20. Opiate medicine shouldn't be stopped suddenly. Another way of saying this is to say that routine use of opiates may cause physical dependence. Suddenly stopping opiates after prolonged routine use may cause a feeling of withdrawal over the course of several days or more. Opiate withdrawal is not dangerous, but it can be a miserable experience for some patients. Usually, it is preventable with a slow taper-down of the medication. Withdrawal symptoms can include increased pain, anxiety, sweating, yawning, difficulty sleeping, tearing, and loose stools.
- 21. Addiction is completely unrelated to physical dependence. Addiction, also called chemical dependency, is a short-circuit of the reward system of the brain. Instead of feeling good on account of family, career, religion, and recreation, people with chemical dependency substitute a drug for their reward. In a well-structured opiate prescribing program, the chance of developing a new chemical dependency problem is low.

- 22. Any of your healthcare providers can find out from the South Dakota Prescription Drug Monitoring Program (the “Program”) about all opiate medications you fill at pharmacies in South Dakota and surrounding states. **Your health care provider** is obligated to report your prescriptions to the Program. Doctor shopping is a crime in South Dakota.

- 23. Routine opiate use may suppress the pituitary gland. This is most significant in men. An annual testosterone blood level test can monitor for this in men. Decreased testosterone can cause sweating, depression, decreased libido, and it can have an adverse effect on bone health. Tapering down or off opiates returns pituitary function to normal.

- 24. Opiates can cause or aggravate sleep apnea.

- 25. Opiates do not damage organs. They do not cause stomach, liver, kidney, blood vessel, or nerve injury.

- 26. Opiates must be used cautiously if you have chronic obstructive lung disease. Opiates can cause respiratory depression if a large dose is given to someone whose body is inexperienced with opiates.

- 27. Nausea, itching and hives occur, and are more common at the beginning of treatment. Constipation is common with opiates, and must be managed on an ongoing basis. Dry mouth is occurs occasionally and is very bad for dental health. Difficulty initiating urination in men seems more common with morphine, and may be a reason to not use that drug.

- 28. What benefit opiates are providing to any individual remains under ongoing review. Establishing a correct dose at the beginning of treatment must be done by a slow taper-up. Determining what this is needed after a period of success is done by slow taper-down. High-dose opiates with poor pain control and functional result may be an indication for taper-down.

I the patient acknowledge and agree to the contents of this document and consent to treatment with opiate pain medication as proposed by **my health care provider.**

Patient Name: _____

Patient Signature: _____ Date _____

Doctor Name: _____

Doctor Signature: _____ Date _____

Checklist for Prescribing Opiates for Chronic, Non-Cancer Pain

The following checklist is designed to aid primary care providers who use opiates to improve function in patients with chronic pain. Specifically, this checklist is for treating adults (18+) with chronic pain > 3 months, excluding cancer, palliative, and end-of-life care.

CHECKLIST

When **CONSIDERING** long-term opiate therapy

- Review patient's medical and psychosocial history.
- Review results of all physical examinations and laboratory tests, including screening assessments.
- Check that non-opiate therapies tried and optimized.
- Evaluate risk of harm or misuse.
 - Confirm that the appropriate state prescription drug monitoring program (PDMP) has been accessed.
 - Check urine drug screen.
- Obtain an informed consent.
 - Discuss benefits and risks (eg, addiction, overdose) with patient.
- Assess baseline pain and function (eg, PEG scale).
- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Prescribe short-acting opiates using lowest dosage on product labeling; match duration to scheduled reassessment.
- Set criteria for stopping or continuing opiates.
- Schedule initial reassessment within 1-4 weeks.

If **RENEWING** without a patient visit

- Check that return visit is scheduled \leq 3 months from last visit. Schedule visit earlier than 3 months if patient is requesting a prescription refill earlier than prescription instruction/dosage.

Continuation versus Initiation - **REASSESSING** at return visit

- Check that non-opiate therapies optimized.
- Assess pain and function (eg, PEG); compare results to baseline.
- Evaluate progress against agreed-upon treatment for pain relief and function.
 - **Continue opiates only after confirming clinically meaningful improvements in pain and function without significant risks or harm.**
- Evaluate risk of harm or misuse:
 - Observe patients for signs of over-sedation or overdose risk. If yes – taper dose.
 - Check PDMP.
 - Check for opiate use disorder if indicated (eg, difficulty controlling use). If yes – refer for treatment.
- Determine whether to continue, adjust, taper, or stop opiates, and document reasoning in clinic record.
- Calculate opiate dosage morphine milligram equivalent (MME).
 - If \geq 50 MME/day total (\geq 50mg hydrocodone; \geq 33mg oxycodone), increase frequency of follow-up; consider offering naloxone.
 - Avoid \geq 100 MME/day total (\geq 100 mg hydrocodone; \geq 66mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals ($<$ 3 months).
- Patients who may need more frequent or intense monitoring include:
 - Those with a prior history of an addictive disorder or past substance abuse;
 - Those in occupations demanding mental acuity;
 - Older adults;
 - Patients with an unstable or dysfunctional social environment;
 - Those with comorbid psychiatric or medical conditions;
 - Those who are taking benzodiazepines; and
 - Those who are taking other medications that may interact with an opiate – to include at-risk alcohol consumers.

REFERENCE

EVIDENCE ABOUT OPIATE THERAPY

- Benefits of long-term therapy for chronic, non-cancer pain is not well supported by evidence.
- Short-term benefits small to moderate for pain; inconsistent for function.
- Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

NON-OPIATE THERAPIES

- Use alone or combined with opiates as indicated:
- Non-opiate medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.
- At-risk alcohol consumption (eg, binge drinking).

ASSESSING PAIN AND FUNCTION USING PEG SCALE

- PEG score = average 3 individual question scores
- 30% improvement from baseline is clinically meaningful

Q1: What number from 0 - 10 best describes your pain in the last week?

0 = "no pain," 10 = "worst you can imagine"

Q2: What number from 0 - 10 describes how during the past week, pain has interfered with your enjoyment of life?

0 = "not at all," 10 = "complete interference"

Q3: What number from 0 - 10 describes how, during the past week, pain has interfered with your general activity?

0 = "not at all," 10 = "complete interference"

NOTE: Always document assessments as required by applicable law, including any applicable administrative rules or regulations.

Acknowledgements

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20:47:07:01.01. Standards for medical records when prescribing controlled substances for the treatment of chronic, non-cancer pain. The standards for medical records when a physician prescribes controlled substances for the treatment of chronic non-cancer pain include each of the following listed items:

- 1) Copies of the signed informed consent and any treatment agreement required by the physician;
- 2) The patient's medical and psychosocial history;
- 3) The results of all physical examinations and all laboratory tests;
- 4) Confirmation that the appropriate state prescription drug monitoring program has been accessed, and the date of that access, or an explanation why it was not accessed; ;
- 5) The results of all risk assessments, including results of any screening instruments used;
- 6) A description of the treatments provided, including all medications prescribed or administered, with the date of prescription or administration, the name and type of the medication, and the dosage and quantity of medication prescribed or administered. The medical records must include all prescription orders for opioid analgesics and other controlled substances, whether written, telephoned, faxed, or electronically transmitted;
- 7) Instructions to the patient, including discussions with the patient and, if appropriate, significant others of the risks and benefits of opioid analgesics, including the risks of addiction, overdose, and death; proper use and storage of medication; proper disposal of unused medications; and the use of naloxone products to reverse overdose;
- 8) Results of ongoing assessments, including, when appropriate, urine drug tests, of patient progress or lack of progress in terms of pain management and functional improvement;
- 9) Notes on any evaluations by and consultations with specialists;
- 10) Any other information used to support the initiation, continuation, revision, or termination of treatment; Any steps taken in response to aberrant medication use by a patient and aberrant behaviors related to a prescription for an opioid analgesic;
- 11) Medical records of past hospitalizations or treatments by other providers, to the extent obtained by the physician;
- 12) Authorization for release of information to other treatment providers; and
- 13) Name, address, and telephone number of the patient's pharmacy.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-29, 36-4-30.

References: Federation of State Medical Boards Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain; Federation of State Medical Boards Model Policy on Data 2000 and Treatment of Opioid Addiction in the Medical Office.

TO: SDBMOE BOARD MEMBERS
FROM: KLATT, TYLER
SUBJECT: GENETIC COUNSELOR ADMINISTRATIVE RULE
DATE: JUNE 2, 2016
CC:

GENETIC COUNSELOR ADMINISTRATIVE RULE (ARSD 20:82:04)

- **August 2015** – Initial review of language for continuing education rule
- **January 2016** – HB 1069 introduced, continuing education rule delayed until further notice
- **February 2016** – HB 1069 signed, continuing education now part of the rulemaking authority
 - Committee reviewed draft language
- **March 2016** – Draft shared with potential stakeholders for comment
- **March 2016** – Legal staff reviewed language for style, form, and rulemaking authority
- **May 2016** – Committee approved draft language

Next Steps: Direct staff to pursue rulemaking process or send back to committee for revision

ARTICLE 20:82
GENETIC COUNSELORS

Chapter

- 20:82:01 Definitions.
- 20:82:02 Licensure requirements.
- 20:82:03 Ethics.
- 20:82:04 Continuing education

CHAPTER 20:82:04

CONTINUING EDUCATION

Section

- 20:82:04:01 Continuing education requirements
- 20:82:04:02 Reporting continuing education

20:82:04:01. Continuing education requirements. To qualify for renewal of a license upon its expiration as prescribed in SDCL 36-36-11, an applicant for renewal must complete 25 continuing education hours annually or maintain current certification by the ABGC or ABMGG.

Source

General Authority: 36-36-12

Law Implemented: 36-36-11

20:82:04:02. Reporting continuing education. Each genetic counselor must sign a statement to confirm compliance with the continuing education requirements of 20:82:04:01. The signed statement must be filed with the Board at the time the genetic counselor makes application for renewal of their genetic counseling license. Upon request by the board, the genetic counselor must submit proof of completion of any continuing education units or proof of current certification by the ABGC or ABMGG.

Source:

General Authority: SDCL 36-36-12

Law Implemented: SDCL 36-36-11

File Number	Profession	Applicant or Licensee	Start Date	Status	Status Date	Board Member	Concern Category
13-269	MD/DO	Licensee	12/16/2013	Investigation	02/29/2016	Admin	Incompetency
14-099	MD/DO	Applicant	04/24/2014	June 2, 2016 Board Meeting	04/29/2016	Landeen	Criminal
14-117	PA	Licensee	08/22/2014	Investigation	01/29/2016	Landeen	Incompetency
14-187	ALS	Licensee	08/08/2014	Investigation	01/19/2016	Carlson	Criminal
14-193	MD/DO	Licensee	08/11/2014	Investigation	03/02/2016	Carlson	Incompetency
15-019	MD/DO	Licensee	02/23/2015	ALJ Hearing TBA	04/06/2016	Lust	Unprofessional/Ethics
15-021	MD/DO	Licensee	02/26/2015	Investigation	02/18/2016	Pending	Unprofessional
15-031	MD/DO	Applicant	03/10/2015	June 2, 2106 Board Meeting	05/08/2016	Lindbloom	Unprofessional/Ethics
15-044	MD/DO	Licensee	04/06/2015	June 2, 2016 Board Meeting	05/08/2016	Bowman	Unprofessional
16-005	MD/DO	Licensee	07/08/2015	Investigation	04/28/2016	Bjordahl	Unprofessional/Ethics
16-010	EMTP	Licensee	07/20/2015	June 2, 2016 Board Meeting	03/04/2016	Erickson	Criminal/Unprofessional
16-012	MD/DO	Licensee	07/20/2015	Investigation	03/23/2016	Carpenter	Unprofessional/Ethics
16-016	MD/DO	Licensee	08/06/2015	June 2, 2016 Board Meeting	04/26/2016	Pending	Criminal
16-019	MD/DO	Licensee	08/11/2015	ALJ Hearing May 6, 2016	05/06/2016	Murray	Incompetency
16-020	MD/DO	Licensee	08/14/2015	Investigation	04/07/2016	Pending	Unprofessional/Ethics
16-023	MD/DO	Applicant	08/25/2015	June 2, 2106 Board Meeting	04/29/2016	Carpenter	Unprofessional/Ethics/Incompetency
16-025	MD/DO	Licensee	08/27/2015	Investigation	04/19/2016	Pending	Unprofessional/Ethics
15-066	MD/DO	Licensee	06/08/2015	Investigation	04/08/2016	Carpenter	Improper Sexual Interactions
16-042	MD/DO	Applicant	10/30/2015	Board Meeting TBA	04/29/5/18/16	Admin	Unprofessional/Ethics
16-043	MD/DO	Applicant	11/03/2015	June 2, 2016 Board Meeting	05/18/2016	Landeen	Unprofessional/Ethics/Incompetency
16-045	MD/DO	Licensee	11/17/2015	Investigation	05/06/2016	Pending	Unprofessional/Ethics/Incompetency
16-049	MD/DO	Licensee	12/01/2015	Investigation	02/19/2016	Admin	Unprofessional/ Ethics/Incompetency
16-052	MD/DO	Licensee	12/11/2015	Investigation	05/06/2016	Murray	Unprofessional/Ethics/Incompetency
16-055	MD/DO	Licensee	01/01/2016	Investigation	05/10/2016	Pending	Unprofessional/Ethics
16-058	EMTP	Licensee	01/14/2016	June 2, 2016 Board Meeting	04/26/2016	Carlson	Unprofessional/Ethics
16-059	MD/DO	Applicant	01/19/2016	Investigation	05/09/2016	Pending	Unprofessional/Ethics
16-060	MD/DO	Applicant	01/20/2016	Investigation	03/21/2016	Landeen	Unprofessional/Ethics/Incompetency
16-062	MD/DO	Licensee	01/26/2016	Investigation	02/25/2016	Admin	Unprofessional/Ethics
16-064	MD/DO	Licensee	01/27/2016	Investigation	05/09/2016	Pending	Unprofessional/Ethics
16-069	MD/DO	Applicant	02/10/2016	Recommendation - Consent Agreement with Reprimand	05/18/2016	Rosario	Unprofessional/Ethics
16-071	MD/DO	Licensee	02/25/2016	Investigation	03/23/2016	Pending	Unprofessional/Ethics
16-073	CNM	Licensee	02/26/2016	June 2, 2016 Board Meeting	04/04/2016	Landeen	Incompetency
16-074	EMTP	Applicant	02/26/2016	Investigation	04/13/2016	Lust	Criminal
16-075	CNP	Applicant	03/07/2016	June 2, 2016 Board Meeting	03/22/2016	Carlson	Unprofessional/Ethics
16-076	PA	Licensee	03/08/2016	Investigation	05/10/2016	Bjordahl	Incompetency
16-078	MD/DO	Applicant	03/15/2016	Investigation	05/09/2016	Pending	Unprofessional/Ethics/Criminal
16-081	MD/DO	Licensee	03/15/2016	Investigation	04/12/2016	Lust	Incompetency
16-082	MD/DO	Licensee	03/24/2016	Investigation	04/11/2016	Carlson	Improper Sexual Interactions
16-086	PA	Licensee	04/01/2016	Investigation	04/25/2016	Pending	Unprofessional/ Ethics/ Incompetency
16-089	MD/DO	Licensee	04/05/2016	Investigation	04/19/2016	Pending	Unprofessional/Ethics
16-090	PT	Applicant	04/06/2016	Investigation	04/20/2016	Pending	Substance Abuse
16-091	EMTP	Licensee	04/12/2016	Investigation	05/10/2016	Pending	Unprofessional/Ethics
16-092	MD/DO	Licensee	04/13/2016	Investigation	05/10/2016	Pending	Unprofessional/Ethics
16-093	PA	Licensee	04/18/2016	Investigation	05/10/2016	Pending	Unprofessional/Ethics
16-094	MD/DO	Licensee	04/19/2016	Investigation	05/10/2016	Pending	Incompetency
16-095	MD/DO	Licensee	04/19/2016	Investigation	05/03/2016	Pending	Unprofessional/Ethics
16-096	RCP	Licensee	04/27/2016	Investigation	05/10/2016	Pending	Substance Abuse
16-097	MD/DO	Licensee	04/27/2016	Investigation	05/05/2016	Pending	Unprofessional/Ethics
16-098	MD/DO	Licensee	04/27/2016	Investigation	04/27/2016	Pending	Incompetency
16-099	MD/DO	Applicant	05/05/2016	Investigation	05/09/2016	Carpenter	Incompetency
16-100	MD/DO	Applicant	05/05/2016	Investigation	05/05/2016	Pending	Incompetency/Improper Sexual Interactions
16-101	EMTSS	Licensee	05/09/2016	Investigation	05/10/2016	Pending	Unprofessional/Ethics/Substance Abuse
16-102	CNP	Licensee	05/09/2016	Investigation	05/10/2016	Pending	Incompetency
16-103	MD/DO	Applicant	05/12/2016	Investigation	05/12/2016	Pending	Unprofessional/Ethics
16-104	MD/DO	Applicant	05/16/2016	Investigation	05/16/2016	Pending	Incompetency
16-105	MD/DO	Licensee	05/18/2016	Investigation	05/18/2016	Pending	Unprofessional/Ethics
16-106	MD/DO	Licensee	05/18/2016	Investigation	05/18/2016	Pending	Unprofessional/Ethics
16-107	MD/DO	Licensee	05/18/2016	Investigation	05/18/2016	Pending	Unprofessional/Ethics
16-108	MD/DO	Licensee	05/18/2016	Investigation	05/18/2016	Pending	Unprofessional/Ethics
16-109	MD/DO	Applicant	05/26/2016	Investigation	05/26/2016	Pending	Unprofessional/Ethics/Incompetency