ARTICLE 20:78

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Chapter

20:78:01 Operation of board.

20:78:02 Declaratory rulings.

20:78:03 Application procedures.

20:78:04 Complaint procedures.

20:78:05 Contested case hearing procedures.

20:78:06 Opioid overdose prevention

CHAPTER 20:78:06

OPIOID OVERDOSE PREVENTION

Section

20:78:06:01 Definitions.

20:78:06:02 Criteria for training a first responder.

20:78:06:03 Standing order.

20:78:06:04 Protocols

20:78:06:01 Definitions. Words used in this section mean:

(1) "Board," the South Dakota Board of Medical and Osteopathic Examiners;

(2) "First responder training," a training program that follows the criteria set by the Board;

(3) "Protocols," a standardized plan for medical procedures or administration of medications;

(4) "Opioid overdose," means a medical condition that causes depressed consciousness and mental functioning, decreased movement, depressed respiratory function, and the impairment of vital functions as a result of ingesting opioids in any amount larger than can be physically tolerated;

(5) "Standing order," ongoing authorization for a first responder to obtain, possess, and administer opioid antagonists.

Source:

General Authority: SDCL 34-20A-102

Law Implemented: SDCL 34-20A-100

20:78:06:02. Criteria for training a first responder. Training programs shall meet the following criteria:

(1) Course content includes:

a. The signs and symptoms of an opioid overdose;

b. The protocols and procedures for administration of an opioid antagonist;

c. The signs and symptoms of an adverse reaction to an opioid antagonist;

d. The protocols and procedures to stabilize the patient if an adverse response occurs;

e. The procedures for storage, transport, and security of the opioid antagonist.

(2) The method of opioid antagonist administration being taught.

(3) Training will be overseen by a physician licensed pursuant to SDCL chapter 36-4.

(4) Subject to the oversight required in section (3) of this rule, training may be provided by the employer of the first responder.

(5) First responders trained to possess and administer opioid antagonists must be retrained at least every three years.

Source:

General Authority: SDCL 34-20A-102

Law Implemented: SDCL 34-20A-101

20:78:06:03. Standing order. A physician licensed under SDCL chapter 36-4 may issue a standing order to first responders authorizing a prescription for the possession of an opioid antagonist. The standing order shall:

(1) Authorize a first responder who has completed training as listed in section 2 to possess and administer opioid antagonists;

(2) Determine the method of opioid antagonist administration;

(3) Be kept on file by the first responder, the issuing physician, and the first responder's employer.

The standing order shall expire three years after the date it is issued. First responders must complete the retraining requirements pursuant to ARSD 20:78:06:02.

Source:

General Authority: SDCL 34-20A-102

Law Implemented: SDCL 34-20A-98

20:78:06:04. Protocols. One copy of the physician's written protocol shall be maintained by each of the following persons or parties:

(1) The issuing physician;

(2) The first responder.

Source:

General Authority: SDCL 34-20A-102

Law Implemented: SDCL 34-20A-101

IN THE MATTER OF THE
PROMULGATION OF
ADMINISTRATIVE RULES

ADMISSION OF SERVICE

Personal service of

(1) the Department of Health's proposed rules §§ 20:78:06 is admitted at Pierre, South Dakota, this 29th day of October, 2015.

Kim Malsam-Rysdon
Kim Malsam-Rysdon
Secretary of Health

IN THE MATTER OF THE
PROMULGATION OF
ADMINISTRATIVE RULES

AUTHORIZATION TO PROCEED

Pursuant to SDCL subdivision 1-26-4(2), I, Kim Malsam-Rysdon, Secretary of the Department of Health, authorize the Department of Health to proceed with the promulgation of the proposed rules §§ 20:78:06.

Dated this 29th day of October, 2015.

Kim Malsam-Rysdon
Kim Malsam-Rysdon
Secretary of Health

IN THE MATTER OF THE
PROMULGATION OF
ADMINISTRATIVE RULES

ADMISSION OF SERVICE

Personal service of

(1) the Department of Health's proposed rules §§ 20:78:06

(2) the Notice of Hearing

(3) the Fiscal Note, and

(4) the Small Business Impact Statement

is admitted at Pierre, South Dakota, this 2nd day of Nov, 2015.

Kris Schneider
Legislative Research Council

For these rules, the Agency contact person is: Tyler Klatt

Phone Number: 367-7781

IN THE MATTER OF THE
PROMULGATION OF
ADMINISTRATIVE RULES

ADMISSION OF SERVICE

Personal service of

(1) the Department of Health's proposed rules §§ 20:78:06

(2) the Notice of Hearing

(3) the Fiscal Note, and

(4) the Small Business Impact Statement

is admitted at Pierre, South Dakota, this 2 day of November, 2015.

Barb Nuechterlein
Bureau of Finance and Management

(NOTE: A copy of this form may be obtained from the Bureau of Finance and Management. If your rules have a negative fiscal impact on a local government, such as a county or a school district, you must direct the Bureau of Finance and Management to send a copy of its fiscal note to the organizations listed in SDCL 1-26-4.2.)

ADMINISTRATIVE PROCEDURES ACT
FISCAL NOTE
Prepared by Submitting Agency

	CODE	NAME
DEPARTMENT	*09*	*Health*
DIVISION	*2*	*Boards*
PROGRAM	*05*	*Board of Med & Osteo*

PROPOSED RULE: §§ 44:05:07, 20:78:03, 20:78:04, and 20:78:05

Hearing Date: December 3, 2015

FISCAL IMPACT STATEMENT:
Pursuant to SDCL 1-26-4.2, these rules have minimal impact on all entities. No additional staffing or resources are required.

FISCAL NOTE SUMMARY:
The proposed rules provide administrative procedures and clarifications. No governmental subdivisions will be impacted.

COST INCREASES (DECREASES)

State Agencies:	***First-Year Impact***	***Continuous-Yearly Impact***
TOTAL		
Local Subdivisions:		
TOTAL		
Small Business Increases (Decreases)		
TOTAL		

REVENUE INCREASES (DECREASES)

Revenue Increases (Decreases) State, Local & Small Business :		
TOTAL		

APPROVED Margaret B. Hansen *DATE* 10/21/15
Signature Department Secretary or Board or Commission Chairman

ATTACH*: Copy of proposed rules; separate sections for: 1) explanation of rules effect, i.e. what procedures, schedules, activities, etc. will change with its adoption 2) statistics used, and their source, 3) assumptions that were made to arrive at fiscal impact, 4) computations that were made, and 5)small business impact statement*

Revised June 2004

FORM 14

SMALL BUSINESS IMPACT STATEMENT FORM

See SDCL 1-26-2.1

(NOTE: This form must be signed by either the head of the agency or the presiding officer of the board or commission empowered to adopt the rules. Check your statutes to see who is authorized to promulgate rules. A small business is defined as any business with 25 or fewer full-time employees. When a set of rules is proposed, a general summary shall be provided; each proposed rule amendment shall also be explained thoroughly. In the case of a large set of proposed rules which all have a single purpose and impact, one explanation is sufficient. The law makes it clear that agencies or commissions shall use readily available information and existing resources to prepare the impact statement.)

1. Our agency has determined that the rule/s we are proposing have the following type of impact on small businesses:
   - ☐ Direct impact *(please complete remainder of form)*
   - ☐ Indirect impact *(please provide a brief explanation, then sign, date, and submit form. Questions 2 through 8 do not need to be answered)*
   - **X** No impact *(please provide a brief explanation, sign, date, and submit form - Questions 2 through 8 do not need to be answered)*
     The proposed rules focus on administrative procedures and do not create or change any requirements related to small businesses.

2. A general narrative and overview of the effect of the rule(s) on small business - written in plain, easy to read language:

3. What is the basis for the enactment of the rules(s)?
   - ☐ Required to meet changes in federal law
   - ☐ Required to meet changes in state law
   - ☐ Required solely due to changes in date (i.e. must be changed annually)

   Other: _____

4. Why is the rule(s) needed?

5. What small businesses or types of small businesses would be subject to the rule?

6. Estimate the number of small businesses that would be subject to the rule.
   ☐ 1-99 ☐ 100-499 ☐ 500-999 ☐ 1,000-4,999 ☐ More than 5,000
   ☐ Unknown - please explain _____

7. Are small businesses required to file or maintain any reports or records under this rule?
   ☐ Yes ☐ No

   a. If "yes," how many reports must a small business submit to the state on an annual basis?

   b. If "yes," how much ongoing recordkeeping within the business is necessary?

   c. If "yes," what type of professional skills would be necessary to prepare the reports or records?

      ☐ The average owner of a small business should be able to complete the reports and/or records with no assistance
      ☐ It is likely that a bookkeeper for a small business should be able to complete the reports and/or records
      ☐ It is likely that a small business person would need the assistance of a CPA to complete the reports and/or records
      ☐ It is likely that a small business person would need the assistance of an attorney to complete the reports and/or records
      ☐ Other _____
      ☐ Unknown - please explain _____

8. Are there any less intrusive or less costly methods to achieve the purpose of the rule (i.e. fewer reports, less recordkeeping, lower penalties)?
   ☐ No - please explain _____
   ☐ Yes - please explain _____

10/21/2015	Margaret B. Hansen	Board of Medical and Osteopathic Examiners
Dated	Authorized Signature	Name of Agency

South Dakota Department of Health
Notice of Public Hearing to Adopt Rules

A public hearing will be held at 101 N. Main Ave, in the First Dakota National Bank building in room 215, Sioux Falls, South Dakota on December 3, at 9:00 a.m., to consider the adoption and amendment of proposed rules numbered:

Chapter 20:78:06

The effect of the rules will be the addition of administrative rules regarding opioid overdose prevention.

The reason for adopting the proposed rules is to provide criteria for training a first responder in the use of opioid antagonists, provide the requirements for physicians who issue standing orders authorizing first responders to possess opioid antagonists, and provide the requirements for protocols and procedures related to opioid antagonists.

Persons interested in presenting data, opinions, and arguments for or against the proposed rules may do so by appearing in person at the hearing or by sending them to the South Dakota Board of Medical and Osteopathic Examiners, 101 N. Main Ave, Ste. 301, Sioux Falls, South Dakota 57104 or by email to SDBMOE@state.sd.us. Material sent by mail must reach the Department of Health by December 2, 2015, to be considered.

After the hearing, the board will consider all written and oral comments it receives on the proposed rules. The Department of Health may modify or amend a proposed rule at that time to include or exclude matters that are described in this notice.

Notice is further given to individuals with disabilities that this hearing is being held in a physically accessible place. Please notify the Board of Medical and Osteopathic Examiners at least 48 hours before the public hearing if you have special needs for which special arrangements must be made. The telephone number for making special arrangements is (605) 367-7781.

The text of the proposed rules is available on the Boards website at: www.sdbmoe.gov and on South Dakota's Administrative Rules website: rules.sd.gov. Copies of the proposed rules may be obtained without charge from the following address, the Health Department website at doh.sd.gov/News or rules.sd.gov.

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

Published at the approximate cost of $_____.

From:	SDBMOE
To:	"americannews@aberdeennews.com"
Subject:	Notice of Hearing
Date:	Friday, October 30, 2015 2:53:34 PM
Attachments:	Notice of Hearing.pdf Aberdeen News Cover letter.pdf
Importance:	High

Please find the attached in reference to a notice of hearing. On the notice of hearing, please fill in the dollar amount at the very end of what the cost of publication is. Please send an affidavit with your invoice. If you have any questions please contact me.

Sincerely,

Tyler Klatt, MPA
Management Analyst
South Dakota Board of Medical and Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104
Phone 605-367-7781

From:	SDBMOE
To:	"allegals@argusleader.com"
Subject:	Notice of Hearing
Date:	Friday, October 30, 2015 2:53:42 PM
Attachments:	Notice of Hearing.pdf Argus Leader Cover Letter.pdf
Importance:	High

Please find the attached in reference to a notice of hearing. On the notice of hearing, please fill in the dollar amount at the very end of what the cost of publication is. Please send an affidavit with your invoice. If you have any questions please contact me.

Sincerely,

Tyler Klatt, MPA
Management Analyst
South Dakota Board of Medical and Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104
Phone 605-367-7781

From:	SDBMOE
To:	"legals@rapidcityjournal.com"
Subject:	Notice of Hearing
Date:	Friday, October 30, 2015 2:53:35 PM
Attachments:	Notice of Hearing.pdf Rapid City Journal Cover Letter.pdf
Importance:	High

Please find the attached in reference to a notice of hearing. On the notice of hearing, please fill in the dollar amount at the very end of what the cost of publication is. Please send an affidavit with your invoice. If you have any questions please contact me.

Sincerely,

Tyler Klatt, MPA
Management Analyst
South Dakota Board of Medical and Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104
Phone 605-367-7781

IN THE MATTER OF THE
PROMULGATION OF
ADMINISTRATIVE RULES

AFFIDAVIT OF MAILING NOTICE
TO INTERESTED PARTIES

I, Tyler Klatt, under oath, do swear, that on October 30, 2015, I mailed a copy of the notice attached to this affidavit to the list of persons attached to this affidavit. I further swear that the attached list is a true and correct list of all persons who have requested advance notice of rule-making proceedings by the Department of Health.

Tyler Klatt

Subscribed and sworn to
before me this 30 day
of October, 2015.

Notary Public - South Dakota

(SEAL)

My Commission expires
1-16-2020.

RANDI STERLING
Notary Public
SEAL
South Dakota

From: SDBMOE
Bcc: "Michael.Farritor@sanfordhealth.org"; "Kim.Patrick@sanfordhealth.org"; "scott.duke@sdaho.org"; Damgaard, Gloria; "pmcinerney@regionalhealth.com"; "bsmith@sdsma.org"; "meast@sdsma.org"; Shanard-Koenders, Kari; "diedrich@regionalhealth.com"; "TME@magt.com"; "sdpha@sdpha.org"; "Ann.Roemen@independentcare.org"; "jonellis@argusleader.com"; "jcleland@ksfy.com"; "jacob.iverson@ksfy.com"; "a_anderson@kdlt.com"; "jandrews@keloland.com"; "Tryg.Odney@gmail.com"; "quinn.stein@sanfordhealth.org"; "Janice@brandenburgerconsulting.com"; "Julie.Kalahar@lakeareatech.edu"; "yorkdrew@hotmail.com"; "mrs_hagen@yahoo.com"; "dawn.rost@bunl.com"
Subject: Public Hearing for Proposed Administrative Rules
Date: Monday, November 09, 2015 9:27:24 AM
Attachments: Notice of Hearing.pdf

Please find attached a notice of public hearing for proposed administrative rules.

If you wish to participate in the hearing, please contact the Board staff by December 2nd, 2015, and provide your comments, materials, and indicate whether you wish to testify in front of the Board at the hearing on Thursday December 3rd, 2015 at 9:00 AM.

Copies of the proposed rules may be obtained from the South Dakota Administrative Rules website https://rules.sd.gov/detail.aspx?Id=235 or by contacting the Board of Medical and Osteopathic Examiners.

Sincerely,
Board Staff from General Email
South Dakota Board of Medical & Osteopathic Examiners
sdbmoe@state.sd.us
www.sdbmoe.gov

From: SDBMOE
Bcc: "president@sdemsa.org"
Subject: Public Hearing for Proposed Administrative Rules
Date: Tuesday, November 10, 2015 11:01:17 AM
Attachments: Notice of Hearing.pdf

Please find attached a notice of public hearing for proposed administrative rules.

If you wish to participate in the hearing, please contact the Board staff by December 2nd, 2015, and provide your comments, materials, and indicate whether you wish to testify in front of the Board at the hearing on Thursday December 3rd, 2015 at 9:00 AM.

Copies of the proposed rules may be obtained from the South Dakota Administrative Rules website https://rules.sd.gov/detail.aspx?Id=235 or by contacting the Board of Medical and Osteopathic Examiners.

Sincerely,
Board Staff from General Email
South Dakota Board of Medical & Osteopathic Examiners
sdbmoe@state.sd.us
www.sdbmoe.gov

Form + Style

ARTICLE 20:78

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Chapter

20:78:01 Operation of board.

20:78:02 Declaratory rulings.

20:78:03 Application procedures.

20:78:04 Complaint procedures.

20:78:05 Contested case hearing procedures.

20:78:06 Opioid overdose prevention

CHAPTER 20:78:06

OPIOID OVERDOSE PREVENTION

Section

20:78:06:01 Definitions.

20:78:06:02 Criteria for training a first responder.

20:78:06:03 Standing order.

20:78:06:04 Protocols

20:78:06:01 Definitions. ~~Words~~ Terms used in this ~~section~~ chapter mean:

(1) "Board," the South Dakota Board of Medical and Osteopathic Examiners;

(2) "First responder training," a training program that ~~follows~~ meets the criteria ~~set~~ established by the Board in § 20:78:06:02;

(3) "Protocols," a standardized plan for medical procedures or administration of medications;

(4) "Opioid overdose," ~~means~~ a medical condition that causes depressed consciousness and mental functioning, decreased movement, depressed respiratory function, and the impairment of vital functions as a result of ingesting opioids in any amount larger than can be physically tolerated;

(5) "Standing order," an ongoing authorization for a first responder to obtain, possess, and administer opioid antagonists.

Source:

General Authority: SDCL 34-20A-102

Law Implemented: SDCL 34-20A-100

20:78:06:02. Criteria for training a first responder. ~~Training programs shall meet the following criteria:~~

~~(1) Course content includes:~~ Each first responder training program shall teach/include: (pick one term)

~~a.~~(1) The signs and symptoms of an opioid overdose;

~~b.~~(2) The protocols and procedures for administration of an opioid antagonist;

~~c.~~(3) The signs and symptoms of an adverse reaction to an opioid antagonist;

~~d.~~(4) The protocols and procedures to stabilize the patient if an adverse response occurs; and.

~~e.~~(5) The procedures for storage, transport, and security of the opioid antagonist.

~~(2)~~ [The method of opioid antagonist administration being taught.] - specify. This is very broad and if it is part of course criteria, include as (6).

Each first responder training program shall be overseen by a physician licensed pursuant to SDCL chapter 36-4. The employer of a first responder may provide training for a first responder if the training meets each requirement in this section.

~~(3) Training will be overseen by a physician licensed pursuant to SDCL chapter 36-4.~~

~~(4) Subject to the oversight required in section (3) of this rule, training may be provided by the employer of the first responder.~~

~~(5)~~ A First responder~~s~~ trained to possess and administer opioid antagonists must ~~be retrained~~ complete a first responder training program at least every three years.

Source:

General Authority: SDCL 34-20A-102

Law Implemented: SDCL 34-20A-101

20:78:06:03. Standing order. A physician licensed under SDCL chapter 36-4 may issue a standing order to a first responder~~s~~ authorizing a prescription for the possession of an opioid antagonist. The standing order ~~shall~~:

(1) Authorize~~s~~ a first responder who has completed training ~~as listed in section 2~~ a first responder program to possess and administer opioid antagonists;

(2) ~~D~~shall Determine (or specify) the method of opioid antagonist administration; and

(3) ~~B~~shall Be kept on file by the first responder, the issuing physician, and the first responder's employer.

The standing order ~~shall expire~~ expires/is valid for three years after the date it is issued. ~~First responders must complete the retraining requirements pursuant to ARSD 20:78:06:02.~~ [This requirement is included in the previous rule]

Source:

General Authority: SDCL 34-20A-102

Law Implemented: SDCL 34-20A-98

20:78:06:04. Protocols. ~~One copy of the physician's written protocol shall be maintained by each of the following persons or parties:~~

~~(1) The issuing physician;~~

~~(2) The first responder.~~

The issuing physician and the first responder shall each maintain one copy of the issuing physician's written protocol.

Source:

General Authority: SDCL 34-20A-102

Law Implemented: SDCL 34-20A-101

SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Values. Ethics. Advocacy.

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

November 24, 2015

Walter Carlson, M.D., Board President
South Dakota Board of Medical & Osteopathic Examiners
101 N. Main Avenue, Ste 301
Sioux Falls, SD 57104-6411

RE: Opioid Overdose Prevention

Dear Dr. Carlson:

As President of the South Dakota State Medical Association (SDSMA), I am writing to express our appreciation for the South Dakota Board of Medical & Osteopathic Examiners' (SDBMOE) efforts to develop guidelines for first responder possession and administration of opioid antagonists to combat opiate overdose and death.

On behalf of the SDSMA, I present the following concerns:

1. Proposed Rule 20:78:06:01 (3). The definition of "protocols" includes, "a standardized plan for medical procedures or administration of medications." Can the SDBMOE define, "administration of medications?" The SDSMA is concerned that as proposed, this rule would grant "first responders" the authority to give injections, while many are not licensed or authorized to do so. Many states limit the "administration of medications" by first responders to that of the administration of Narcan (naloxone) via nasal spray – which was recently approved by the Food and Drug Administration (FDA).

2. Proposed Rule 20:78:06:02 (1). The SDSMA recommends that first responder course content include information and education regarding naloxone duration as its effect is shorter than most opiates and therefore, the patient must be monitored continuously for the return of life-threatening symptoms and the onset of violent behavior.

3. We also believe while that any first responder who administers naloxone shall be immune from liability per SDCL 20-9-3 or 20-9-4, we recommend the inclusion of language that specifically states immunity from liability for anyone who fails to administer naloxone. We believe the precedence for this protection was set

Chief Executive Officer
Barbara A. Smith

President
Tim M. Ridgway, M.D.
Sioux Falls

President-Elect
H. Thomas Hermann, Jr., M.D.
Sturgis

Vice President
Robert E. Van Demark, Jr., M.D.
Sioux Falls

Secretary
Christopher T. Dietrich, M.D.
Rapid City

Treasurer
Michelle Baack, M.D.
Sioux Falls

with SDCL 20-9-4.4, which grants civil immunity for emergency use or nonuse of an AED.

On behalf of the SDSMA, I present the following questions for clarification:

1. Proposed Rule 20:78:06:03. "The standing order shall expire three years after the date it is issued." Typically, standing orders are not time limited and we question the need for the three-year duration. We would also ask if the rule should include guidelines regarding proper storage and maintenance of supplies to ensure naloxone efficacy.

2. Proposed Rule 20:78:06:04. Please define or provide additional clarification to this protocol maintenance requirement which states, "One copy of the physician's written protocol shall be maintained by each of the following persons or parties: 1) the issuing physician; 2) the first responder.

In closing, we thank you for the opportunity to express our concerns and look forward to hearing from you in regard to our suggestions on the proposed administrative rules on opioid overdose prevention.

Sincerely,

Tim M. Ridgway, M.D.
President

cc: Margaret Hansen, Executive Director, SDBMOE
Barbara Smith, CEO, SDSMA

12-~~3~~-15

Public Hearing: Please sign in if you want to testify:

1 Tim Engel SDSMA
2 Mark East SDSMA
3 [illegible]
4
5
6
7
8
9
10

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS
Board Meeting
Board Conference Room
101 N. Main Ave., **Suite 215**
Sioux Falls, SD

Unapproved Draft Minutes[i]

Regular Board Meeting 4:00 pm (CT) Thursday, September 10, 2015

Board Members:
Kevin Bjordahl, MD, Ms. Deborah Bowman; Walter Carlson, MD; Mary Carpenter, MD; David Erickson, MD; Brent Lindbloom, DO; Mr. David Lust; Jeffrey Murray, MD

Absent: Laurie Landeen, MD

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

Counsel: Craig Kennedy, Staff Counsel; William Golden, Staff counsel
James McMahon, Board counsel; Steven Blair, Board Counsel

1. Dr. Carlson, President of the Board, called the meeting to order at 4:00 pm. Roll was called and a quorum was confirmed. A motion: to approve the agenda as amended was ratified by voice vote (Murray/unanimous).

2. A motion: to approve the minutes from the June 11th Regular Board meeting and the July 21st Special Board meeting was ratified by voice vote (Murray/unanimous)

3. A motion: to approve the new licenses, permits, certificates, and registrations issued from June 1, 2015 through August 31, 2015, was ratified by voice vote (Lindbloom/unanimous).

4. Confidential Physician Hearings (Closed Session pursuant to SDCL 36-4-31.5 unless privilege is waived by physician). Board members assigned to a case are recused and do not deliberate or vote in that case (ARSD 27:78:05:05).
   a. Dr. Annette M. Bosworth appeared before the Board pro se and waived her confidentiality privilege.
      i. A motion: to enter into Executive Session based upon SDCL 1-25-2(3) to consult with legal counsel was ratified by a roll call vote (Murray/unanimous).
      ii. The Public Meeting resumed. A motion: to adopt the Hearing Examiner's Findings of Fact and Conclusions of Law including the stated recommendation, and revoke Dr. Bosworth's South Dakota medical license #6055 based upon SDCL 36-4-29 and 36-4-30 (6)(22), effective ten (10) days from the date of this order was ratified a roll call vote (Murray/unanimous). Dr. Carpenter, the Board member assigned to this matter, abstained from the deliberation and the vote.

5. A motion: to instruct the Board staff to move forward with the Public Administrative Rules process and schedule a hearing was ratified by voice vote (Bjordahl/unanimous).

6. Confidential Physician Hearings (Closed Session pursuant to SDCL 36-4-31.5 unless privilege is waived by physician). Board members assigned to a case are recused and do not deliberate or vote in that case (ARSD 27:78:05:05).
   a. Dr. Christiana M. Lietzke. A motion: to grant a six (6) month extension to March 10, 2016, for Dr. Lietzke to complete her fitness to practice evaluation at an entity approved in advance by the Board, and release the results and findings of the evaluation to the Board for consideration

to determine whether a South Dakota medical license may be issued was ratified by a roll call vote (Erickson/unanimous). Dr. Landeen, the Board member assigned to this matter, was not present at the meeting.

b. Dr. Robert W. Beattie. A motion: to accept the voluntary and immediate surrender of Dr. Beattie's South Dakota medical license #3623 based upon SDCL 36-4-29.1, 36-4-30(6)(22), and ARSD 20:47:08:03 effective August 13, 2015 was ratified by a roll call vote. (Erickson/unanimous). Dr. Carpenter abstained from the deliberation and the vote.

c. Dr. Sudhir E. Finch. A motion: to approve his Stipulation and Agreement and grant the reinstatement and renewal of his South Dakota medical license #9646 and the temporary approval order was ratified by a roll call vote (Bowman/unanimous). Dr. Landeen, the Board member assigned to this matter, was not present at the meeting.

d. Dr. Michael L. Moeller A motion: to remove the probationary conditions from his South Dakota medical license #4137 and grant him an unrestricted medical license was ratified by a roll call vote (Erickson/unanimous).

e. Dr. Jack Leon-Max Mutnick. A motion: to approve his Stipulation and Agreement with Reprimand of his South Dakota medical license #8102 was ratified by a roll call vote (Bowman/unanimous). Dr. Landeen, the Board member assigned to this matter, was not present at the meeting.

7. A motion: to enter into Executive Session based upon SDCL 1-25-2(3) to consult with legal counsel was ratified by voice vote (Murray/unanimous). The Public Meeting resumed. A motion: to adjourn the meeting was ratified by a voice vote (Erickson/unanimous).

These unapproved draft minutes are respectfully submitted 2:00 pm (CT) on September 11, 2015 by Jane T. Phalen, Board Coordinator.

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[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.

New Licenses issued from September 1, 2015 through November 30, 2015

Advanced EMT: 5

Athletic Trainer: 7

Dietician/Nutritionist: 10

Dietician/Nutritionist Temporary Permit: 1

EMT Student Status: 19

Genetic Counselors: 11

Genetic Counselor Temporary: 0

Medical Assistants: 16

Medical Corporations: 0

Medical License (MD/DO): 76 (Petition for Waiver of Examination Requirements: Dawn Heasely, DO ABMS Board Certified in Pathology)
(Petition for Waiver of Examination Requirements: Dona Murphey, MD ABMS Board Certified in Neurology)

Occupational Therapists: 8

Occupational Therapist Temporary Permit: 0

Occupational Therapy Assistants: 7

Occupational Therapy Assistants Temporary Permit: 0

PA Corporation Registration: 1

Paramedics: 18

Physical Therapist Assistants: 7

Physical Therapists: 10

Physician Assistants: 17

Physician Assistant Temporary: 0

Physician Locum Tenens (60-Day Certificates): 14

Resident License: 1

Respiratory Care Practitioners: 10

Respiratory Care Practitioners Temporary Permit: 13

Total: 251

Advanced EMT License Total 5

License Number	Name	Address	Specialty	Issue Date
1993	Erik Jon Eversman	713 5th Ave S., Clear Lake, SD 57226		11/18/2015
1996	Afton Elizabeth Leichtnam	5334 Williams St. , Rapid City, SD 57703		11/23/2015
1979	Isnalawica Belt	175 Antelope Court, P.O. Box 1327 Eagle Butte, SD 57625		9/16/2015
1992	Ashley Elizabeth Brunick	514 Lee Street, Vermillion, SD 57069		11/16/2015
1995	Katie Jane Betts	107 Buffalo Run, Eagle Butte, SD 57625		11/23/2015

Athletic Trainer License Total 7

License Number	Name	Address	Specialty	Issue Date
0511	Amanda Kaye Swallow	507 N Skylane RD, Pinetop, AZ 85935		9/30/2015
0514	Lora Jennifer Clark	406 Columbia Street, Harrisburg, SD 57032		11/25/2015
0510	Sara Ann Bortscheller	105 1/2 Jolly Street, Louisburg, NC 27549		9/23/2015
0513	Magdalena Anna Wieser	47548 SD Hwy 127, Rosholt, SD 57260		10/28/2015
0508	James Royce Day	3601 W Houghes Place, Sioux Falls, SD 57108		9/16/2015
0509	Brandon Irving Peterson	PO Box 105, 110 Florida Street Centerville, SD 57014		9/16/2015
0512	Michelle Marie Buechner	7170 Clover Hill Drive, Waunakee, WI 53597		10/5/2015

Dietician/Nutritionist License Total 10

License Number	Name	Address	Specialty	Issue Date
0544	Jody Jeanne Johnson Burt	1215 S Holly Drive, Sioux Falls, SD 57105		11/2/2015
0538	Abbey Kathleen Schlenker	404 Samara Avenue, PO Box 363 Volga, SD 57071		9/30/2015
0535	Elizabeth Hanna Kuckuk	W9756 Dakota Avenue, Wautoma, WI 54982		9/18/2015
0542	Emily Jo Hofer	43980 267th St, Bridgewater, SD 57319		10/14/2015
0537	Sarah Jean Tomsche	1930 Arona Street, Roseville, MN 55113		9/28/2015
0534	Lauren Rae Uttecht	903 Jackson Street, Apt. 2, Yankton, SD 57078		9/9/2015
0540	Teresa Beth Blauwet	3905 Mesquite Avenue, Sioux Falls, SD 57110		10/9/2015
0541	Janet Larsen Deloughery	1401 5th Ave Apt 6, South Sioux City, NE 68776		10/14/2015
0539	Lynette Lea Packard-Fales	8274 142nd Street West, Apple Valley, MN 55124		10/6/2015
0543	Brett Joseph Delaney	500 E 52nd Street N, Sioux Falls, SD 57104		10/27/2015

EMT Student Status Total 19

License Number	Name	Address	Specialty	Issue Date
3683	Kye Daniel Gabbert	PO Box 19, Hermosa, SD 57744-0019		9/22/2015
3678	Kyle Christopher Lineweber	1125 Range View Circle, Rapid City, SD 57701		9/8/2015
3682	Richard Alden Pendleton	1001 Allen Avenue, Rapid City, SD 57701		9/17/2015
3680	Melissa Jean Johnson	1855 Harmony Heights Lane, Apt 105, Rapid City, SD 57702		9/11/2015
3691	Tyler Joseph Hageman	110 Santee Trail, Brookings, SD 57006		10/14/2015
3684	Marne Jean Lamb	#3 East Anderson Trailer Court , Box 26 Eagle Butte, SD 57625		9/23/2015
3687	Karl Lee Bodensteiner	4190 Dyess Avenue, Rapid City, SD 57701		10/7/2015
3679	Cristy Jill Hawk	138 Hawk Road, PO Box 287 Oglala, SD 57764		9/9/2015
3685	Robert Talmadge Todd	104 Kami Ave, Oacoma, SD 57365		9/28/2015
3694	Justin Ray Sadler	119 N. Dakota St., Vermillion, SD 57069		11/6/2015
3686	Nathaniel James Rollins	934 N. Harth Ave., Madison, SD 57042		9/30/2015
3695	Nicholas Lee Tieszen	2704 E 12th Street, Sioux Falls, SD 57103		11/13/2015
3696	Carli Gayle Hoffman	5235 S Sweetbriar Court, Sioux Falls, SD 57108		11/13/2015
3688	Cole David Nordmeyer	601 5th Street NW, Pipestone, MN 56164		10/7/2015
3690	Paul Anthony Wiener Gile	7316 W Strabane Street, Sioux Falls, SD 57106		10/14/2015
3692	Erika Rachelle Oddy	4115 W Newcomb Drive #105, Sioux Falls, SD 57106		10/19/2015
3689	Derek Beau Dickerson	29782 385th Avenue, Lake Andes, SD 57356		10/9/2015
3681	Carl Thomas Brakke	48346 224th Street, Elkton, SD 57026		9/17/2015
3693	Mitchell Walker Witt	5201 S Mayo Avenue, Sioux Falls, SD 57106		10/20/2015

Genetic Counselor License Total 11

License Number	Name	Address	Specialty	Issue Date
0060	Maureen Michelle Palmer	4501 Oxbow Drive, Sacramento, CA 95864		9/16/2015
0069	Sharon Louise Namaroff	6 Burnham Road, Wenham, MA 01984		11/24/2015
0066	Jennifer Lara Lemoine	3830 Hillbrook Drive, Pearland, TX 77584		11/19/2015
0059	Stephanie Conradt Laniewski	333 Spencer Road, Rochester, NY 14609		9/1/2015
0062	Michelle Rachel Gilats	1060 Lincoln Avenue, Saint Paul, MN 55105		10/26/2015
0064	Jody Pamela Wallace	8404 Lakevalley Dr., Cincinnati, OH 45247		11/2/2015
0065	Amy Ruth Stettner	6803 Cooper Avenue, Middleton, WI 53562		11/16/2015
0061	Amelia Rose Mroch	3161 Pinedale Dr SW, Grandville, MI 49418		9/23/2015
0068	Xinxin Yao	801 Aspen Drive, Plainsboro, NJ 08536		11/20/2015
0063	Ellen Jean Thomas	4102 Amy Court, Springfield, IL 62711		10/26/2015
0067	Christa Sherburne Adusei	43 Brothers Road, Stormville, NY 12582		11/19/2015

Medical Assistant Registration Total 16

License Number	Name	Address	Specialty	Issue Date
1216	Renae Lynn Hartsook	6200 W 43rd Street #605, Sioux Falls, SD 57106		10/5/2015
1211	Allison Nichole Novotny	31747 286 St., Colome, SD 57528		9/22/2015
1206	Heather Jean Melius	301 North Forest St., Witten, SD 57584		9/1/2015
1208	Rebecca Lynn Otto	111 Alena Drive, Madison, WI 53718		9/4/2015
1221	Meghan Siobhan Steele	2831 Willow Avenue, Rapid City, SD 57701		11/13/2015
1215	Sarah Mae Leonhardt	220 South Illinois Street, Aberdeen, SD 57401		10/1/2015
1218	Kelsie Lee Somsen	1934 10th Ave SW, Watertown, SD 57201		10/6/2015
1219	Samantha Ann Hommel	43493 143rd Street, Webster, SD 57274		10/19/2015
1217	Paula Jo Schmidt	44821 310th Street, Gayville, SD 57031		10/5/2015
1207	Kayla Mae Gukeisen	703 Rolling Hills Drive, Yankton, SD 57078		9/3/2015
1212	Amanda Rose Smith	706 8th Avenue NE Apt 2, Aberdeen, SD 57401		9/24/2015
1213	Alexandra Vazquez ramirez	116 Sivill Court, South Sioux City, NE 68776		9/28/2015
1220	Tami Lee Hawkins	3017 Falls Dr., Rapid City, SD 57702		11/13/2015
1210	Dana Jane Spear	1215 N Dakota Apt 12, Aberdeen, SD 57401		9/22/2015
1214	Jessie Therese Vonderlieth	1709 E 6th Street, Sioux Falls, SD 57103		9/28/2015
1209	Shawn Marie Flatebo	3904 Carnigie Circle, Sioux Falls, SD 57106		9/18/2015

Medical License (MD/DO) Total 76

License Number	Name	Address	Specialty	Issue Date
9663	Nimal Joe Ponnezhan, MD	5001 W Equestrian Pl #3103, Sioux Falls, SD 57106	Internal Medicine (General)	9/8/2015
9671	Shakil Ismail Hafiz, DO	6400 N Northwest Hwy Apt 315, Chicago, IL 60631	Family Medicine/General Practice	9/15/2015
9662	Hayley Irene Sheldon, MD	1324 Laura Street, St. Paul, MN 55118	Radiology	9/8/2015
9701	David Ti Meadows, MD	707 West Divide, Bowman, ND 58623	Family Medicine/General Practice	11/3/2015
9655	Jeanne Marie Richardson, MD	100 Egret Lane, Marine on St. Croix, MN 55047	Pediatrics (General)	9/2/2015
9681	Larissa Lee Sanger, MD	312 Burlington Ave., Billings, MT 59101	Family Medicine/General Practice	9/30/2015
9669	Todd Gunnar Holmes, MD	5328 Brookview, Edina, MN 55424	Physical Med. & Rehab.	9/15/2015
9680	Jennifer Lori Cunningham-Farbstein, MD	6142 Piping Rock, Houston, TX 77057	Critical Care Medicine	9/25/2015
9660	Mohammad Humayoun Khan, MD	474 North Lake Shore Drive Apt 4510, Chicago, IL 60611	Internal Medicine (General)	9/8/2015
9657	Deborah Ann Weems, MD	520 South 11th Street, St. Joseph, MO 64501	Emergency Medicine	9/3/2015
9685	Robert Frederick Dons, MD	5617 S Dorchester Avenue #4N, Chicago, IL 60637	Endocrinology	10/5/2015
9664	Barry Don Martin, MD	9816 Kensington Pkwy, Kensington, MD 20895	Plastic Surgery	9/10/2015
9682	Sarvesh Smiley Thakur, MD	5314 189th Avenue NE, Sammamish, WA 98074	Nephrology	10/2/2015
9692	Robert James Lotstein, MD	233 Triangle Drive, Fort Collins, CO 80525	Family Medicine/General Practice	10/16/2015
9658	Steven Sung-Ho Suh, MD	13874 Boyle Lane, Frisco, TX 75035	Internal Medicine (General)	9/3/2015
9716	Wendell Torrance Bobb, MD	510 S LaSalle Street Apt 1106, Durham, NC 27705	Neurology	11/16/2015
9677	Gregory Raphael Kotnis, MD	1274 Steele Street, Denver, CO 80206	Pathology	9/24/2015
9695	Mihir Kishorchandra Patel, MD	30 Fall Creek Drive, Jackson, TN 38305	Internal Medicine (General)	10/19/2015

9712	Joseph Wendell Olivere, MD Diane	2410 Ulster Street, Denver, CO 80238-2558	Pathology	11/13/2015
9723	Dawn Heasley, DO (Petition)	3426 Willow Street, Denver, CO 80238	Pathology	11/20/2015
9711	Melissa Marie Meier, MD Michael	6083 S Biscay Street, Aurora, CO 80016	Pathology	11/13/2015
9688	James Priola, DO	314 West Taylor Street, Savannah, GA 31401	Orthopedic Surgery	10/9/2015
9666	Ute Wagner Rosa, MD	20 Pierrepont Street #3C, Brooklyn, NY 11201	Pulmonology	9/11/2015
9689	Vernon Day Smith, MD Christopher	10852 East Betony Drive, Scottsdale, AZ 85255	Emergency Medicine	10/14/2015
9694	Henry Rajkumar, MD	1601 6th Place SE, Apt. 8-D, Mason City, IA 50401	Internal Medicine (General)	10/16/2015
9670	Andrew Morris Sebby, DO	616 Unbridled Lane, Keller, TX 76248	Preventive Medicine/Public Health	9/15/2015
9687	Dan Marian Danila, MD	7111 Woodmont Avenue, Apt 511, Chevy Chase, MD 20815	Internal Medicine (General)	10/7/2015
9651	Andrea Christine Seurer, MD	1910 W. 69th Street, Sioux Falls, SD 57108	Family Medicine/General Practice	9/7/2015
9696	Haresh Kumar, MD	125 Pine Cone Lane, Hinsdale, MA 01235	Internal Medicine (General)	10/22/2015
9708	David John Inda, MD	2427 S. 97th Ave., Omaha, NE 68124	Orthopedic Surgery	11/13/2015
9725	Snehal Ramkrishna More, MD	6710 Morningside Drive, Houston, TX 77030	Radiology	11/23/2015
9673	Jeni Anne Shull, MD	0098 E. Northport Rd., Rome City, IN 46784	Family Medicine/General Practice	9/17/2015
9713	Peter paul Chang Lim, MD	1327 West 23rd Ave. Apt 319, Mitchell, SD 57301	Pediatrics (General)	11/13/2015
9710	Leila Langston, MD	6424 Central City Boulevard #915, Galveston, TX 77551	Pathology	11/13/2015
9674	Amit Jain, MD	69 Tweed Road, Levittown, PA 19056	Pediatrics (General)	9/22/2015
9678	Christopher Patrick O'brien, MD	7101 Cresthill Drive, Knoxville, TN 37919	Ophthalmology	9/24/2015
9693	Robert Floyd Nuss, MD	1125 S Ebenezer Ave, Apt 304, Sioux Falls, SD 57106	Psychiatry	10/16/2015
9690	Tara Lynn Smith , DO	1886 Ladbrook Lane, Saint Cloud, MN 56303	Obstetrics and Gynecology	10/15/2015
9697	Michael Lamar Ruppenthal, MD	515 Trotters Ridge, Roswell, GA 30075	Physical Med. & Rehab.	10/26/2015

9727	Sundara Chandrakaladhar Nalla, MD	950 W Venture Place #333, Sioux Falls, SD 57105	Family Medicine/General Practice	11/23/2015
9703	John Kennedy Tannous, MD	410 East Royal Palm Road, Phoenix, AZ 85020	Pediatrics (General)	11/3/2015
9659	Maksim Aleksandrovich Fedarau, MD	70 Miller Lane, Apt #116, Rochester, NY 14617	Anesthesiology	9/4/2015
9728	Sara Rebecca Eckloff, MD	4817 Lakeview Drive, Edina, MN 55424	Radiology	11/23/2015
9665	Carl Norsworthy Schofield, MD	732 Legends Crest Drive, Franklyn, TN 37069	Radiology	9/11/2015
9706	Shalini Chahal, MD	8077 East 31st Avenue, Denver, CO 80238	Pathology	11/13/2015
9683	Richard Allan Guest, MD	15478 Duomo Via Street, Los Angeles, CA 90077	Surgery (General)	10/2/2015
9700	Aydamir Galeb Alrakawi, MD	95 Berry Patch Lane, Auburn, NH 03032	Gastroenterology	11/3/2015
9729	Daniel S Shih, MD	7213 Othello Cove, Austin, TX 78735	Internal Medicine (General)	11/23/2015
9676	Bruce Marvin Hansen, DO	4821 Vista Way, Casper, WY 82601	Anesthesiology	9/24/2015
9667	Joanna Carolyn Carlson, MD	7505 Metro Blvd. Ste. 400, Edina, MN 55439	Radiology	9/14/2015
9714	Gregory Thomas Peters, MD	120 S 31St Ave #5202, Omaha, NE 68131	Radiology	11/13/2015
9675	Leah Dorine Day, MD	2693 E. Cedar Avenue, Denver, CO 80209	Obstetrics and Gynecology	9/23/2015
9679	Sara Lynn Zoelle, MD	2640 E. 9th Street, Sheldon, IA 51201	Family Medicine/General Practice	9/24/2015
9656	Kyla Ann Helm-Swanson, MD	13457 Old Sheridan Rd, Rapid City, SD 57702	Family Medicine/General Practice	9/3/2015
9709	Lois Archer Killewich, MD Nathaniel	919 North Heritage Drive, Ridgecrest, CA 93555	Vascular Surgery	11/13/2015
9704	David McLean, MD	1404 Fern Street, Cambridge, MN 55008	Emergency Medicine	11/6/2015
9702	Dona Kim Murphey, MD (Petition)	3835 Hanberry Lane, Pearland, TX 77584	Neurology	11/3/2015
9717	Andrea Kristine Baier, MD	407 Rolling Road, Salisbury, MD 21801	Internal Medicine (General)	11/19/2015
9698	Johnny Lee Mayes , MD	6226 Datewest Circle, San Antonio, TX 78240	Obstetrics and Gynecology	10/28/2015
9661	Parshant Sagar, MD	529 12 Street , West Des Moines, IA 50265	Internal Medicine (General)	9/8/2015

9721	Christopher Edward Price, MD	2902 Gingerberry Drive, Norfolk, NE 68701	Anesthesiology	11/19/2015
9720	Edward Doyle Zimmerman, MD	313 Hillcrest, Worland, WY 82401	Family Medicine/General Practice	11/19/2015
9724	Aman Arora, MD	1106 Grogans Mill Dr., Cary, NC 27519	Internal Medicine (General)	11/23/2015
9699	Christopher Bibbo, DO	1101 W 5th Street, Marshfield, WI 54449	Orthopedic Surgery	10/29/2015
9684	Patrick Reed Finkbone, MD	15102 W Highland Ave, Goodyear, AZ 85395	Orthopedic Surgery	10/5/2015
9705	Kunut Kijsirichareanchai, MD	100 S 19th Street Apt 907, Omaha, NE 68102	Internal Medicine (General)	11/10/2015
9668	Eyal Ron, MD	7505 Metro Blvd, Suite 400 Edina, MN 55439	Radiology	9/14/2015
9686	Steven Day Correa, MD	3517 Carlton Street, Grapevine, TX 76902	Cardiology	10/5/2015
9691	Bruce Harlan, MD	1000 4th Street SW, Mason City, IA 50401	Internal Medicine (General)	10/16/2015
9715	Benjamin Joseph Shives, MD	1545 15th Ave. SE, Apt 11, Saint Cloud, MN 56304	Emergency Medicine	11/13/2015
9718	Sudhir Babu Movva, MD	2080 US Route 4, Mendon, VT 05701	Internal Medicine (General)	11/19/2015
9719	David Eric Strang, MD	14 Copp Road, Gilmanton, NH 03237	Internal Medicine (General)	11/19/2015
9722	Roy Robert Danks, DO	268 NE 140th Street, Saint John, KS 67576	Surgery (General)	11/20/2015
9707	Abbas Afif Chamsuddin, MD	1501 Clairmont Road, Apt 1731 Decatur, GA 30033	Radiology	11/13/2015
9672	Randolph Alexander Hennigar, MD	10810 Executive Center Drive, Suite 100 Little Rock, AR 72211	Pathology	9/15/2015
9726	Gregory Paul Danielson, MD	20 Lebreux Street, Brentwood, NH 03833	Otolaryngology	11/23/2015

Nutritionist Temporary Permit Total 1

License Number	Name	Address	Specialty	Issue Date
0536	Megan Jo Bren	2200 S. Chesapeake Cir., Sioux Falls, SD 57106		9/24/2015

Occupational Therapist License Total 8

License Number	Name	Address	Specialty	Issue Date
0972	Heidi Jensen Fennel	47755 324th Street, Elk Point, SD 57025		9/22/2015
0975	Ann Terese Frisbie	1491 Buchanan Avenue, Sioux City, IA 51106-5467		10/20/2015
0973	Michelle Kay Connor	474 16th Street SE, Le Mars, IA 51031		9/28/2015
0976	Kyle Anthony Donner	7 Kara Circle, Sundance, WY 82729		10/22/2015
0977	Chloe Elizabeth Phillips	2541 W Lynette Drive, Flagstaff, AZ 86001		11/6/2015
0979	Joni Marie Raisbeck	18771 373 Avenue, Tulare, SD 57576		11/19/2015
0974	Laurel Hibbard Prusak	2318 Lockwood Drive, Rapid City, SD 57702		10/8/2015
0978	Toshifumi Araki	1211 Semoran Blvd, Suite 227, Casselberry, FL 32707		11/16/2015

Occupational Therapy Assistant License Total 7

License Number	Name	Address	Specialty	Issue Date
343A	Katie Jean Cozine	405 East King Avenue, Chamberlain, SD 57325		9/11/2015
346A	Haley Rose Donahue	707 10th Avenue S, Clear Lake, SD 57226		10/19/2015
345A	Kristin Kay Stuckey	2307 Hillcrest Drive, Apt. 6, Brainerd, MN 56401		10/16/2015
345A	Kristin Kay Stuckey	2307 Hillcrest Drive, Apt. 6, Brainerd, MN 56401		10/16/2015
344A	Penny Barb Weiss	810 Pine Avenue, PO Box 372 New Salem, ND 58563		9/15/2015
348A	Lindsey Jean Johnson	27301 476th Avenue, Harrisburg, SD 57032		11/6/2015
347A	Christina Louise Kanuscak	1228 Mayer Street, Menasha, WI 54952		11/2/2015

PA Corporation Registration

Total 1

License Number	Name	Address	Specialty	Issue Date
0580	Stellar Medical Solutions, Prof. LLC	704 South 5th Avenue, Brandon, SD 57005	Geriatric Medicine	10/14/2015

Paramedic License Total 18

License Number	Name	Address	Specialty	Issue Date
1994	Kelcey Katherine Hanson	100 Pasque Drive, Pierre, SD 57501		11/18/2015
1986	Alexis Ladine Manolovits	14981 139th Place, Piedmont, SD 57769		9/28/2015
1984	Alan Keith Browne	1915 10th Ave SE, Apt 1, Aberdeen, SD 57401		9/25/2015
1977	Megan Elizabeth Brown	2315 32nd Street West, Apt. 304 Williston, ND 58801		9/9/2015
1985	Chad Evans Reid	419 Sundance Circle, PO Box 661 Wright, WY 82732		9/28/2015
1988	Ethan Robert Dean Thaut	3804 South Grand Slam Place #3, Sioux Falls, SD 57110		10/2/2015
1978	Ryan Carl Killion	1006 South 4th Ave, Sioux Falls, SD 57103		9/15/2015
1876	James Jonathan Johnson	3900 Airport Road, Rapid City, SD 57709		9/9/2015
1991	Anthony William Anderson	305 E Pine Street, Norfolk, NE 68701		11/16/2015
1976	Christopher Dale Woods	12332 Stampede Road, Whitewood, SD 57793		9/2/2015
1982	Travis Sean Rup	3910 Pointe West PL, #344 Rapid City, SD 57702		9/18/2015
1981	Kasia Anne Kramer	915 S 4th Street, Aberdeen, SD 57401		9/17/2015
1983	Glenn Alan Skala	2009 1/2 3rd Avenue, Rapid City, SD 57702		9/18/2015
1990	Branden Nickolas Glaser	4301 W. 57th Street Apt 217, Sioux Falls, SD 57108		11/5/2015
1987	Andrea Marie Beckman	2501 Mary Knoll Drive, Siouox Falls, SD 57105		9/30/2015
1980	Cydney Jordan Breitag	5004 West Equestrian Place Apt 320, Sioux Falls, SD 57106		9/16/2015
1989	Gregory Andrew Weaver			11/2/2015
1997	Michael Davis Barbosa	PO Box 282, Ridgeview, SD 57652		11/30/2015

Physical Therapist Assistant Certificate Total 7

License Number	Name	Address	Specialty	Issue Date
0451	Cassie Le Bobzin	12282 Gilt Crest Place, Hill City, SD 57745-6595		10/23/2015
0450	Tanner Cole Siegling	2021 Grant Drive, Watertown, SD 57201		10/23/2015
0452	Rachel Ann Wieseler	56299 896 Rd., St. Helena, NE 68774		10/30/2015
0449	Julie Elizabeth Smith	19445 446th Avenue, Lake Norden, SD 57248		10/15/2015
0453	Andrew Michael Bortnem	303 19th Ave South, Brookings, SD 57006		11/6/2015
0448	Taylor Beth McMenamy	1111 Anamosa Street, Apt 2, Rapid City, SD 57701		10/15/2015
0454	Rebecca Mae Waugh	1001 Holy Trail Court, Saint Louis, MO 63125		11/16/2015

Physical Therapist License Total 10

License Number	Name	Address	Specialty	Issue Date
1871	Alison Lea Olson	18977 E Crestridge Cir, Aurora, CO 80015-5155		9/15/2015
1868	Kayla Jo Findlay	252 Minnesota Street S, Ortonville, MN 56278-1608		9/1/2015
1874	Alexa Jesse Edman	603 N Jackson, Pierre, SD 57501		10/1/2015
1870	Josh Michael VanRiper	1405 W. Creekside Drive , Brandon, SD 57005		9/10/2015
1873	Alyssa Marie Azan	111 Orion Avenue, Pierre, SD 57501		9/22/2015
1877	Katie Elizabeth Sandvig	4865 Cliff Drive, Rapid City, SD 57702		11/23/2015
1869	Stevi Sheree Glass	1654 Palmetto Street, Clearwater, FL 33755		9/1/2015
1872	Joshua Michael Anderson	6590 30th Avenue NE, Rugby, ND 58368		9/15/2015
1876	Thomas Jordan Kranda	1201 5th Avenue NE, Mandan, ND 58554		11/5/2015
1875	Kayla Lynn Wetch	4072 Sunny Lane South, Mandan, ND 58554		11/2/2015

Physician Assistant License Total 17

License Number	Name	Address	Specialty	Issue Date
1005	Molly Elizabeth Schooley	1900 S Bluff Road, Hubbard, NE 68741		9/10/2015
1013	Kirsten Lynn Persson	1111 Honeysuckle Drive, Apt. 6, Harrisburg, SD 57032		10/9/2015
1008	Mitch Gaylord Leroy Grieve	244 Texas Street, Building 244 Apt #316 Rapid City, SD 57701		9/15/2015
1012	Chelsea Ann Van Dyke	7709 W. Snapdragon St., Unit 4, Sioux Falls, SD 57106		10/9/2015
1003	Rachele Nicole Vietor	31869 US Hwy. 18, Winner, SD 57580		9/3/2015
1011	Amber Kay Evenson	29657 418th Ave., Scotland, SD 57059		10/7/2015
1009	Bryant Greg Wieking	2609 Evergreen Drive, Rapid City, SD 57702		9/17/2015
1004	Wendy Kay Peterson	6932 Ainsdale Ct., Rapid City, SD 57702		9/8/2015
1002	Marc Joseph Tobin	6312 S Heatherridge Avenue, Sioux Falls, SD 57108		9/3/2015
1010	Emily Jean Kruse	4500 Wellington Ave., Sioux City, IA 51106		9/28/2015
1017	Roxana Bibi Karimzadeh	143 Bruneau Srive, Apt 11, North Sioux City, SD 57049-4077		11/19/2015
1001	Therese Joan Campbell	325 E Park Rd, Garnett, KS 66032		9/1/2015
1007	Ashley Lyn Neisen	1221 Range View Circle, Rapid City, SD 57701		9/14/2015
1006	Lisa Rae Milbrandt	27494 Read Ave., Worthington, MN 56187		9/14/2015
1014	Jacqueline Emily Evernham	268 Levee Trl., Dakota Dunes, SD 57049		10/16/2015
1015	Brenna Elizabeth Davis	420 Iowa Street, Centerville, SD 57014		10/22/2015
1016	Alyssa Marie Roche	1862 Plaza Del Sur Drive, Apt 148, Santa Fe, NM 87505		11/2/2015

Physician Locum Tenens Total 14

License Number	Name	Address	Specialty	Issue Date
1505	Kelley Marie Struble, DO	8001 S Mingo Road #2701, Tulsa, OK 74133	Infectious Diseases	11/4/2015
1511	Mihir Kishorchandra Patel, MD	30 Fall Creek Drive, Jackson, TN 38305	Internal Medicine (General)	9/2/2015
1520	Kenneth James Welch, MD	1222 Pump Station Road, Kannapolis, NC 28081	Emergency Medicine	11/16/2015
1518	Higinio Rodrigo Lopez, MD	4 Scottfield Drive, Newark, DE 19713	Internal Medicine (General)	10/12/2015
1515	Chad Andrew Hamilton, MD	4504 Avamere Street, Bethesda, MD 20814	Obstetrics and Gynecology	10/9/2015
1517	Lois Archer Killewich, MD	919 North Heritage Drive, Ridgecrest, CA 93555	Vascular Surgery	10/2/2015
1527	Sarah Jane Fryberger, MD	15387 Fields-Denio Road, Fields, OR 97710	Pediatrics (General)	11/14/2015
1514	Christopher Bibbo, DO	1101 W 5th Street, Marshfield, WI 54449	Orthopedic Surgery	9/1/2015
1524	Timothy Edward Hopkins, MD	6133 Sherwood Way Apt 6116, San Angelo, TX 76901	Neurological Surgery	11/6/2015
1519	David Eric Strang, MD	14 Copp Road, Gilmanton, NH 03237	Internal Medicine (General)	10/19/2015
1521	John Lewis Thayer, MD	1898 77th Avenue NE, Medina, WA 98039	Orthopedic Surgery	11/6/2015
1516	Roy Robert Danks, DO	268 NE 140th Street, Saint John, KS 67576	Surgery (General)	9/30/2015
1522	Jehad Mohamed Haggiagi, MD	1420 Centre Avenue, Apt 1506, Pittsburgh, PA 15219	Critical Care Medicine	11/16/2015
1523	Howard Edward Bowers, MD	2295 American Legion Blvd, Mountain Home, ID 83647	Surgery (General)	11/12/2015

Resident License

Total 1

License Number	Name	Address	Specialty	Issue Date
0275	Karla Marie Polito	16394 Red Cedar Rd, Piedmont, SD 57769	Family Medicine/General Practice	10/20/2015

Respiratory Care Practitioner License Total 10

License Number	Name	Address	Specialty	Issue Date
1065	Julie Mae Bromwich	12920 Larene Drive, Black Hawk, SD 57718		10/19/2015
1075	Ronald Kenneth Beeson	209 N. La Salle Avenue, Sioux Falls, SD 57110		11/19/2015
1063	Scarlett Rowene Chear	5200 S Solono Avenue, Sioux Falls, SD 57108		10/19/2015
1056	Derick Wayne Johnson	417 2nd Street NW, Watertown, SD 57201		9/9/2015
1057	Nicole Allison Reich	411 W Stonewall Avenue, McAlester, OK 74501		9/16/2015
1074	Judy Ann Franklin	1700 Kickingbird Road, Apt. 1792, Edmond, OK 73034		11/18/2015
1071	Amber Leigh Maharrey	6076 Blocker St., Olive Branch, MS 38654		10/29/2015
1069	Mary Louise Churchill	4800 W. Uniontown St., Broken Arrow, OK 74012		10/20/2015
1070	Priscilla Ariel Sheldon	2409 N Maury Arch, Burlington, NC 27215		10/20/2015
1066	Michelle Marie Farber			10/19/2015

Respiratory Care Practitioner Temporary Permit Total 13

License Number	Name	Address	Specialty	Issue Date
1077	Stephanie Erin Torkelson	432 Box Elder Road W, Box Elder, SD 57719		11/23/2015
1072	Emma Marie Johnson	1030 N Lincoln Ave #101, Madison, SD 57042		11/10/2015
1058	Thompson Marin	111 E 7th Street Apt 407, Sioux Falls, SD 57104		10/2/2015
1076	Galata Bullo Dube	1227 Fulton Street, Rapid City, SD 57701		11/23/2015
1062	Ashlynn LaChelle Kampa	1314 West 33rd Street, Sioux Falls, SD 57105		10/8/2015
1064	Jessica Rose Gifford	8746 W 32nd St #5, Sioux Falls, SD 57106		10/19/2015
1059	Logan Marie Herman	417 W Crawford, Luverne, MN 56156		10/5/2015
1068	Nicole Rae Grosshuesch	6216 W 66th Street, Sioux Falls, SD 57106		10/19/2015
1060	Shelby Clair Thomas	706 S Egan Avenue, Madison, SD 57042		10/6/2015
1073	Michael Tyler Newsom	6041 Springfield Road, Rapid City, SD 57703		11/13/2015
1061	Justin Lawrence Erichsen	401 Clover Leaf Ave., Hartford, SD 57033		10/7/2015
1067	Kallie Ann Brown	2718 S Apline Avenue, Sioux Falls, SD 57110		10/19/2015
1078	Ashley Fay Skaare	2310 5th St., Rapid City, SD 57701		11/24/2015

SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Values. Ethics. Advocacy.

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September 28, 2015

Walter Carlson MD, Board President
South Dakota Board of Medical & Osteopathic Examiners
101 N Main Ave, Ste 301
Sioux Falls, SD 57104-6411

RE: Opiate Analgesics for Chronic Non-Cancer Pain

Dear Dr. Carlson:

As president of the South Dakota State Medical Association (SDSMA), I am writing to express our appreciation of the South Dakota Board of Medical & Osteopathic Examiners' (SDBMOE) willingness to work with us to develop guidelines for pain management and the utilization of opiate analgesics for chronic, non-cancer pain.

On behalf of the SDSMA, we believe that opiate medications such as oxycodone are important tools for providing pain relief to patients. We further believe that while it is not appropriate to establish specific standard of care regulations that restrict clinical judgement, more must be done to reduce the variation from one prescriber to another, and to increase the use and incorporation of South Dakota Prescription Drug Monitoring Program (SD PDMP) data into everyday practice.

Enclosed you will find a copy of our whitepaper, *Opiate Analgesics for Chronic Non-Cancer Pain*, and proposed language for rulemaking designed to improve documentation of patient pain and treatment.

We believe that adoption and promotion of guidelines for the management and treatment of chronic, non-cancer pain along with education for primary care providers who often manage complex patients with chronic pain due to a lack of pain medicine specialists in our state, will reduce prescription drug abuse and diversion in South Dakota. The SDSMA Council of Physicians adopted the enclosed whitepaper at its meeting on September 18. Additionally, we discussed the need for education about the guidelines. We respectfully request the SDBMOE to also adopt the whitepaper; however, to not promulgate care guidelines in administrative rule so it becomes a regulatory standard.

Further, we ask the SDBMOE to seek legislative authorization to use funds to provide financial support to the SDSMA to develop and offer education for providers on these care guidelines.

President
Sioux Falls

President-Elect
Surgery

Vice President
Sioux Falls

Maple City

Sioux Falls

Finally, we support the enclosed language for rulemaking to improve documentation of patient pain and treatment. It is our opinion that by adopting and promoting these guidelines, – the SDSMA, SDBMOE and prescribers of this state can make progress in addressing undertreated chronic pain and prescription misuse in South Dakota.

We look forward to hearing from you regarding your adoption of the whitepaper, funding support for education, and administrative rules for record documentation.

Sincerely,

Tim M. Ridgway, MD
President

cc: Margaret Hansen, Executive Director SDBMOE
Barbara Smith, CEO, SDSMA
Robert VanDemark Jr., MD, Chair, Committee on Pain Management and Prescription Drug Abuse

Enclosures
Whitepaper, *Opiate Analgesics for Chronic Non-Cancer Pain*
Proposed Rule – Medical Records Documentation
SDSMA Resolution RES-115-0 Opiate Analgesics for Non-Cancer Pain

Opiate Analgesics for Chronic Non-Cancer Pain

Recommendations from the Committee on Pain Management and Prescription Drug Abuse

South Dakota State Medical Association

September 11, 2015

Executive Summary

When used appropriately, opiate* 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. 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.*
- *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.*

---

* 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."

- *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.*
- *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:

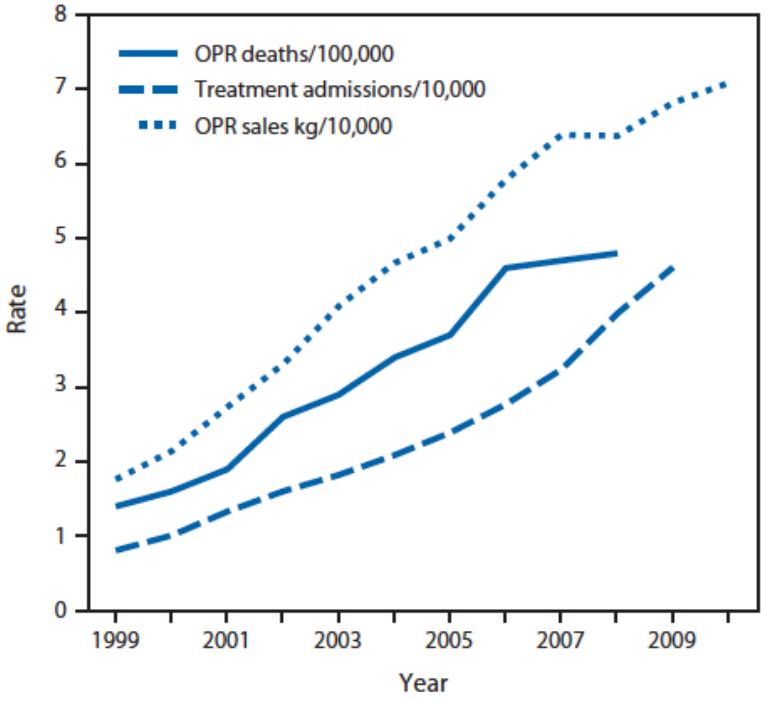
- *Expand and strengthen South Dakota's Prescription Drug Monitoring Program (PDMP) to facilitate rapid, accurate patient risk assessment to help improve patient care coordination, and to prevent diversion and/or "doctor shopping."*
- *Create new incentives for continuing medical education for opiate 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. Rates* of opiate analgesic overdose death, treatment admissions, and kilograms sold in the United States, 1999-2010[10]



* 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.

A key aspect of both nociceptive and neuropathic pain is the phenomenon of sensitization, which 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, for example, typically responds poorly to both opiate analgesics and non-steroidal anti-inflammatory (NSAID) agents.[21] 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. Related to the nomenclature of pain itself are continuing confusions, by the public, but also in the medical community, about terms used to describe the effects of drugs on the brain and on behavior. 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.* A primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving. In brief, addiction is a short-circuiting of the reward system of the brain – instead of having a job, a family, religion, friends, exercise, and/or a hobby to feel good, "addicts" decide to dispense those in favor of drugs.

Of note, opiate withdrawal is not dangerous and 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. 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, SSRIs, 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 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 (great 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]

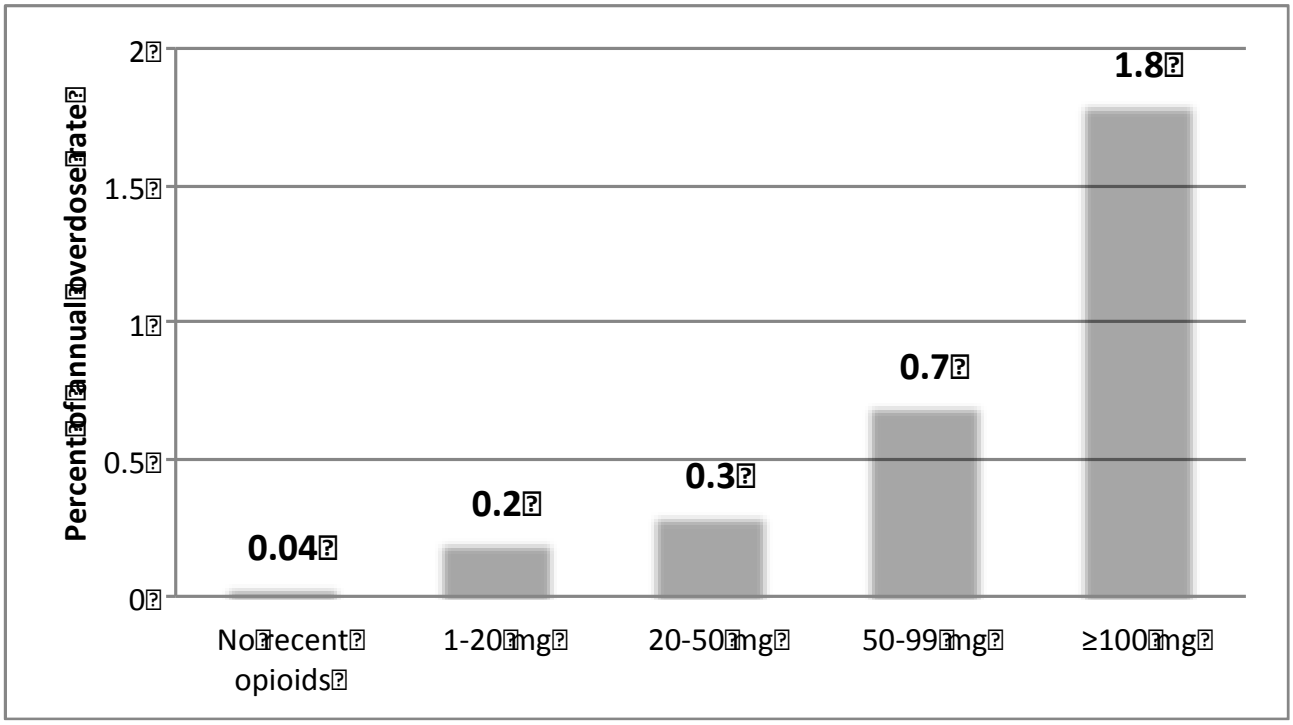
A 2011 study of a random sample of 705 patients undergoing long-term opiate therapy for non-cancer pain found a lifetime prevalence rate of DSM-5-defined opiate-use disorder of 35 percent.[40] The variability in such results probably reflects differences in opiate treatment duration, the short-term nature 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]

Figure 2. Percent of annual overdose rates rises with daily opiate dose[41]



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 injury[†]

[†] 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.

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 Tool[48]
- Brief Pain Inventory[49]
- McGill Pain Questionnaire (short-form available)[50]

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
Screener 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 plan.

Initiating opiates

Before prescribing any opiate, clinicians may consider whether:

- Other treatment options have been exhausted
- 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

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 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.

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.

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

Whenever an opiate is prescribed, the patient should be thoroughly educated about the safe use, 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 putt 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

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

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*

	Dose of Opiate
	42 mcg/hr fentanyl transdermal
	100 mg hydrocodone
100 morphine equivalents =	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 collection[62] (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] Prophylaxsis 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 effects[63]

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

South Dakota's Prescription Drug Monitoring Program (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:

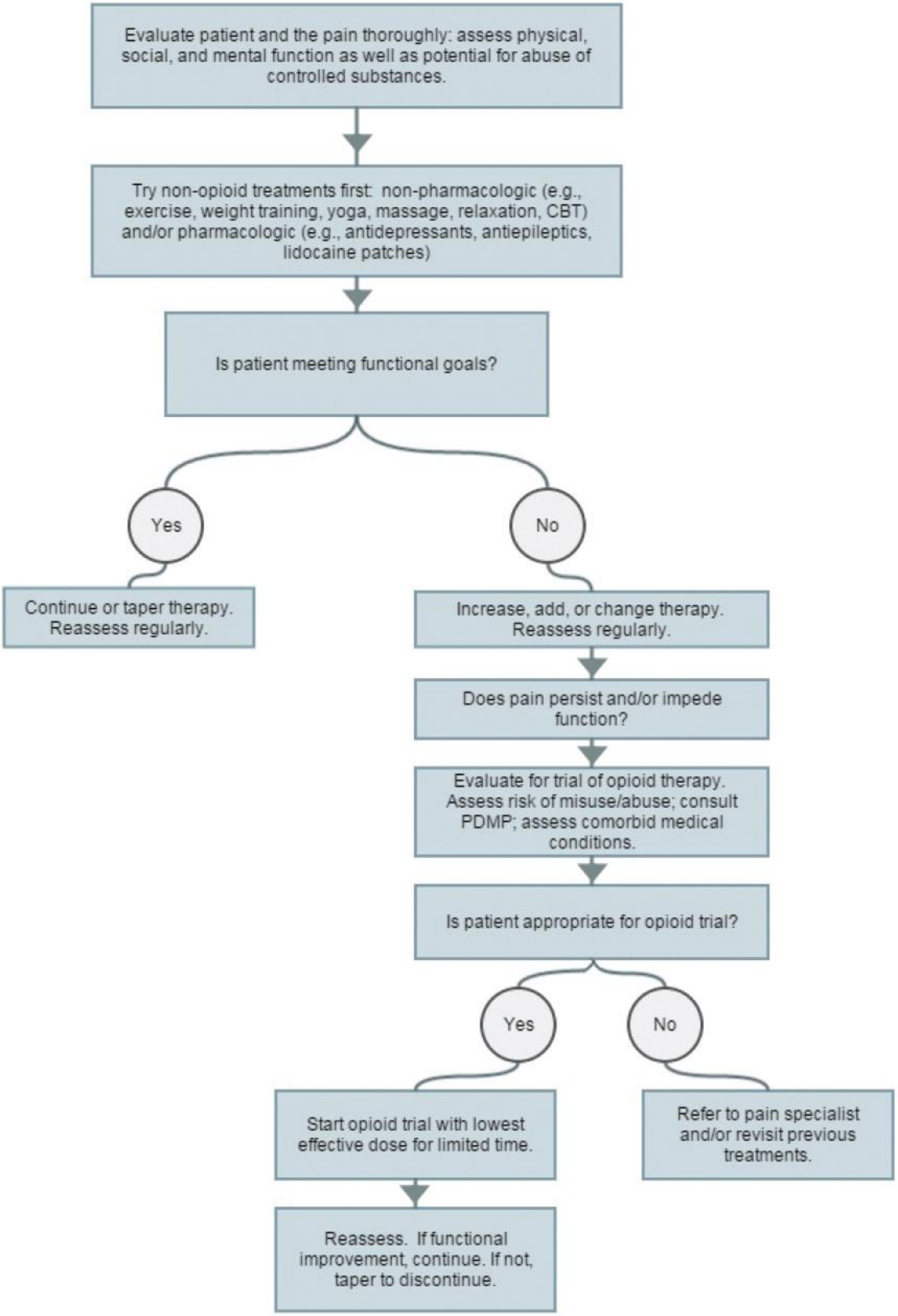
- Tapering drug therapy over several weeks to avoid withdrawal; consider incorporating non-opiate pain treatments.
- Referral to specialists, e.g., pain specialist, for evaluation of continued controlled substance prescribing
- Referral to an addiction management program

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 it.[65] For most patients, the opiate dose should be tapered by 20 to 50 percent of the current dose per week. The longer the patient has been on the drug, and the higher the initial dose, the slower should be the taper.[63]

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-opioid analgesics and non-pharmacologic therapies will be adequate for initial pain management
2. Given a lack of demonstrated evidence of superior efficacy of either opioid or non-opioid analgesics and the individual and community risks associated with opioid 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 opioid 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 opioid 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 opioid 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 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 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_____

Acknowledgements

The South Dakota State Medical Association would like to acknowledge the contributions and guidance of the California Medical Association (CMA). Portions of this paper are based on a 2014 whitepaper, *Prescribing Opioids: Care amid Controversy. Recommendations from the California Medical Association's Council on Scientific Affairs* with CMA's permission.

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20:47:07:02. Guidelines for medical records when prescribing controlled substances for the treatment of pain. When a physician prescribes controlled substances for the treatment of chronic, non-cancer pain, medical records should 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 as necessary and the date or dates of that access;

(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 record 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, 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 consideration of the use of reversal agents;

(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) Notations of relevant evaluations by and consultations with specialists;

(10) Any other information used to support the initiation, continuation, revision, or termination of treatment;

(11) Any steps taken in response to aberrant medication use by a patient and aberrant behaviors related to a prescription for an opioid analgesic;

(12) Medical records of past hospitalizations or treatments by other providers, to the extent obtained

by the physician;

(13) Authorization for release of information to other treatment providers; and

(14) 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.

SOUTH DAKOTA STATE MEDICAL ASSOCIATION
COUNCIL OF PHYSICIANS

Opiate Analgesics for Non-Cancer Pain	**RESOLUTION**

WHEREAS, the nonmedical use and abuse of prescription drugs is a serious public health problem in this country, and although most people take prescription medications responsibly, an estimated 52 million people – 20 percent of those 12 and older – have used prescription drugs for nonmedical reasons at least once in their lifetimes; and

WHEREAS, young people are strongly represented in the group who has taken prescription drugs for nonmedical reasons. In fact, a National Institute on Drug Abuse 2010 survey found that one in 12 high school seniors reported past-year nonmedical use of Vicodin, and one in 20 reported abusing OxyContin – making these medications the most commonly abused drugs in adolescents; and

WHEREAS, prescription drug abuse is a problem in South Dakota as well, In 2012, 40.5 million controlled substances were prescribed in South Dakota – which equates to approximately 55 prescriptions per man, woman, and child; and

WHEREAS, according to data published by the American Medical Association and IMS Health, South Dakota ranks 36th among the states in annual prescriptions per capita of opiate products and number 1 in growth in opiate utilization; and

WHEREAS, South Dakota ranks 46th for annual prescriptions of oxycodone and second with a 9.7 percent increase in the number of prescriptions for oxycodone products; and

WHEREAS, South Dakota ranks 29th in annual prescriptions for hydrocodone products, and first in the percent increase in number of prescriptions for hydrocodone products. South Dakota is the only state that had an increase in the prescribing of hydrocodone products from 2013 to 2014; and

WHEREAS, opiate medications such as oxycodone and hydrocodone are important tools in providing pain relief to patients; however, this drug category is too often misused, and abused, and overprescribing of opiate pain relievers can result in multiple adverse health outcomes, including fatal overdoses; and

WHEREAS, the current level of prescription opiate abuse nationwide has been described as an "epidemic" by the Centers of Disease Control and Prevention; and

WHEREAS, the potential for prescription drug abuse is substantial, and a problem some physicians contribute to through overprescribing of opiates; and

NOW, THEREFORE, BE IT RESOLVED that more be done to educate providers on the treatment and management of pain – to include alternatives to the prescription of opiates;

BE IT FURTHER RESOLVED that more be done to address the lack of prescriber participation and utilization of the South Dakota Prescription Drug Monitoring Program (PDMP) – which is an excellent resource for prescribers to aid in the detection and prevention of doctor shopping;

BE IT FURTHER RESOLVED that the SDSMA hereby adopts the recommendations from its Ad-Hoc Committee on Pain Management and Prescription Drug Abuse as outlined in the *Opiate Analgesics for Chronic Non-Cancer Pain* whitepaper and respectfully recommends that other organizations, including the South Dakota Board of Medical and Osteopathic Examiners, to do the same;

BE IT FURTHER RESOLVED that the SDSMA work with the South Dakota Board of Medical and Osteopathic Examiners to develop and adopt guidelines for opiate prescribing and medical record documentation when physicians prescribe controlled substances for the treatment of chronic, non-cancer pain.

ADOPTED by the Council of Physicians this 18th day of September, 2015.

Tim M. Ridgway, MD
President
South Dakota State Medical Association President

EXECUTIVE SUMMARY FINANCIAL REPORT

TO: THE BOARD OF MEDICAL AND OSTEOPATHIC EXMINERS
FROM: MARGARET B HANSEN
DATE: NOVEMBER 12, 2015

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

- Petty Cash
- Local Checking
- State Treasury Fund

		FY16	FY15	FY14
		10/31/15	*06/30/2015*	*06/30/2014*
Total Cash		2,805,738	2,972,287	2,656,838

2. Upcoming Anticipated Expenses and Reserve Funds (page 3)

- Total anticipated expenses and reserve funds.

		FY16
Total Anticipated Expenses and Reserve Funds		2,236,548

3. Revenue (page 5)

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

		FY16	FY15	FY14
		10/31/2015	*06/30/2015*	*06/30/2014*
Total Revenue		208,643.46	1,307,603.35	1,256,516.60

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

		FY16	FY16	FY15	FY15
		Budgeted	*10/31/2015*	Budgeted	*06/30/2015*
4-A	5203100 - Lodging In-State • Hotel expenses for in state meetings or training attended	2,000	389	2,000	323
4-B	5204160 – Workshop Registration Fee • Registration fee for meetings or training attended	2,000	200	2,000	4,656
4-C	5204530 - Telecommunication Services • Board Member Laptop wireless • Background Reports e.g.	3,000	3,404	3,000	10,185
4-D	5205320 - Duplication – Private • Printed pages from leased printers • Licensure Cards ordered	300	5,069	300	6,046
4-E	5205350 - Postage • Postage costs for mailing licensures and other communications	11,000	2,139	11,000	15,171

5. Income Statement – Total Expenses - (page 7)
Shows total expenses and budget comparison.

	FY16	FY16	FY15	FY15	FY14	FY14
	Budgeted	*10/31/2015*	Budgeted	*06/30/2015*	Budgeted	*06/30/2014*
Total Expenses	1,025,703	370,584	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	*10/31/2015*	Budgeted	*06/30/2015*	Budgeted	*06/30/2014*
Net Income	233,797	-161,941	174,257	315,639	210,382	332,261

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

	FY16	FY15	FY14
	10/31/2015	06/30/2015	06/30/2014
Total Other Contractual Services	6,643	36,751	60,868

SDBMOE Financial Report

11/12/2015

for
07/01/15 - 10/31/2015

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

SDBMOE
Balance Sheet (Cash Only)

Date Range: July 1, 2015 - October 31, 2015

		FY16	FY15	FY14	FY13	FY12	FY11
		10/31/2015	*06/30/2015*	*06/30/2014*	*06/30/2013*	*06/30/2012*	*06/30/2011*
	Cash						
	Petty Cash	100	100	100	100	100	100
	Local Checking	1,901	2,034	3,598	2,930	4,223	4,712
	State Treasury Fund	2,803,737	2,970,153	2,653,139	2,300,852	1,810,978	1,370,641
1.	**Total Cash**	**2,805,738**	**2,972,287**	**2,656,838**	**2,303,882**	**1,815,301**	**1,375,452**

SDBMOE
Upcoming Anticipated Expenses and Reserve Funds

	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 - October 31, 2015

Type	07/01/15 - 10/31/15 Amount	07/01/14 - 06/30/15 Amount	07/01/13 - 06/30/14 Amount
Licenses			
Athletic Trainer Application	$ 2,300.00	$ 3,400.00	$ 3,000.00
Athletic Trainer Reinstatement	$ -	$ -	$ -
Athletic Trainer Renewal	$ 500.00	$ 11,350.00	$ 9,500.00
Advanced EMT for Instate Graduate	$ 150.00	$ 1,400.00	$ 850.00
Advanced EMT for out of state Graduate	$ 75.00	$ 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	$ 575.00	$ 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	$ 650.00	$ 1,300.00	$ 1,850.00
ALS-Paramedic Application for Out of State Graduate	$ 1,575.00	$ 6,350.00	$ 5,250.00
ALS-Paramedic Renewal	$ 3,050.00	$ 15,625.00	$ 11,100.00
ALS-Paramedic Reinstatement	$ 350.00	$ 500.00	$ 600.00
Genetic Counselor Temporary Application	$ -	$ 200.00	$ 200.00
Genetic Counselor Application	$ 3,600.00	$ 3,800.00	$ 1,600.00
Genetic Counselor Renewal	$ 100.00	$ 3,100.00	$ 1,900.00
Licensed Nutritionist Application	$ 1,680.00	$ 1,610.00	$ 1,750.00
Licensed Nutritionist Renewal	$ 425.00	$ 10,710.00	$ 10,395.00
Temporary License Nutritionist Application	$ 50.00	$ 400.00	$ 250.00
Licensed Nutritionist Reinstatement	$ 200.00	$ 300.00	$ -
Locum Tenens Application	$ 1,550.00	$ 2,850.00	$ 2,550.00
MD/DO Application	$ 26,200.00	$ 67,600.00	$ 74,600.00
MD/DO Reinstatement	$ 1,400.00	$ 9,200.00	$ 6,600.00
MD/DO-Renewals	$ 86,000.00	$ 746,600.00	$ 729,400.00
Medical Assistant Application	$ 180.00	$ 840.00	$ 1,000.00
Medical Assistant Renewal	$ 590.00	$ 20.00	$ 2,720.00
Medical Assistant Reinstatement	$ 20.00	$ 40.00	$ 300.00
Medical Corp Application	$ 50.00	$ 650.00	$ 550.00
Medical Corp Reinstatement	$ -	$ 700.00	$ 1,000.00
Medical Corp Renewal	$ 2,700.00	$ 15,900.00	$ 15,900.00
Occupational Therapist Application	$ 400.00	$ 1,750.00	$ 1,950.00
Occupational Therapist Reinstatement	$ 25.00	$ 75.00	$ 50.00
Occupational Therapy Assistant Application	$ 700.00	$ 1,050.00	$ 850.00
Occupational Therapist Renewal	$ 2,050.00	$ 21,200.00	$ 22,000.00
Occupational Therapy Assistant Reinstatement	$ 25.00	$ -	$ -
Occupational Therapy Assistant Renewal	$ 350.00	$ 7,200.00	$ 7,150.00
Occupational Therapist Limited Permit	$ 25.00	$ 25.00	$ 125.00
Occupational Therapy Assistant Limited License	$ -	$ 25.00	$ 75.00
Physical Therapist Application	$ 720.00	$ 5,040.00	$ 3,900.00
Physical Therapist Renewal	$ 8,800.00	$ 44,800.00	$ 43,900.00
Physical Therapist Reinstatement	$ -	$ 600.00	$ 150.00
Physical Therapist Assistant Application	$ 1,020.00	$ 2,880.00	$ 1,980.00
Physical Therapist Assistant Renewal	$ 1,350.00	$ 12,050.00	$ 12,050.00
Physical Therapist Assistant Reinstatement	$ 50.00	$ -	$ 50.00
Physician Assistant Corporation Application	$ 100.00	$ -	$ -
Physician Assistant Corporation Renewal	$ -	$ 200.00	$ 200.00
Physician Assistant Corporation Reinstatement	$ -	$ -	$ -
Physician Assistant Application	$ 2,100.00	$ 3,900.00	$ 4,425.00
Physician Assistant Temporary Permit	$ -	$ -	$ 50.00
Physician Assistant Reinstatement	$ -	$ 75.00	$ 125.00
Physician Assistant Renewal	$ -	$ 55,700.00	$ 52,900.00
Resident License Application	$ 200.00	$ 3,300.00	$ 3,800.00
Resident License Renewal	$ -	$ 6,500.00	$ 3,650.00
Respiratory Care Practitioner Application	$ 1,200.00	$ 2,175.00	$ 3,225.00
Respiratory Care Temporary Application	$ 440.00	$ 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	**$ 154,130.00**	**$ 1,107,190.00**	**$ 1,054,695.00**

SDBMOE
Revenue by Item Summary

Date Range: July 1, 2015 - October 31, 2015

		07/01/15 - 10/31/15 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	$	26,344.00	$	128,857.00	$	118,256.00
Written Verifications	$	15,750.00	$	46,620.00	$	47,940.00
Duplicate License Card	$	190.00	$	670.00	$	1,020.00
Candian Service Fee (Skype Fee Charge)	$	-	$	-	$	(2.13)
Mailing List					$	4,400.00
Total Services	**$**	**42,284.00**	**$**	**176,177.00**	**$**	**171,643.87**
Total **3.**	**$**	**208,643.46**	**$**	**1,307,603.35**	**$**	**1,256,516.60**

SDBMOE
Income Statement

Date Range: July 1, 2015 - October 31, 2015

		FY16 Budgeted	FY16 10/31/2015	% 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	154,130	14%	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	42,284	28%	150,750	176,177	117%	152,000	171,646
Total Income		**1,239,500**	**196,414**	**16%**	**1,160,750**	**1,283,557**	**111%**	**1,164,000**	**1,226,341**
Gross Profit		**1,239,500**	**196,414**	16%	**1,160,750**	**1,283,557**	111%	**1,164,000**	**1,226,341**
	5101000 - Employee Salaries	300,801	126,058	42%	288,154	326,321	113%	277,412	308,612
	5101030 - Board & Community Member Fees	3,418	1,260	37%	3,275	1,620	49%	3,154	2,520
	5102010 - OASI	27,812	9,261	33%	26,392	23,656	90%	24,207	22,796
	5102020 - Retirement	16,133	7,559	47%	16,133	19,332	120%	16,133	18,472
	5102060 - Health Insurance	60,790	22,065	36%	60,790	65,024	107%	50,963	70,193
	5102080 - Worker's Compensation	889	164	18%	889	261	29%	889	216
	5102090 - Unemployment Insurance	42	49	117%	42	147	350%	42	99
	5201030 - Board Member Per Diem			0%			0%		0
	5203010 - Auto - State owned - Instate	0	146			396			
	5203030 - Auto - Private - Low Rate	0	270			988			423
	5203030 - Auto - Private - High Rate	2,000	264	13%	2,000	278	14%	2,000	1,412
	5203040 - Air-State owned-Instate	16,000		0%	16,000	7,372	46%	16,000	8,473
	5203060 - Air-Commercial Carrier Instate	0				5,565			582
	5203070 - Air Travel - Charter Flights	30,000	10,325	34%	30,000		0%	30,000	3,750
4-A	5203100 - Lodging In-State	2,000	389	19%	2,000	323	16%	2,000	697
	5203120 - Incidentals-Travel Instate	50		0%	50	72	144%	50	56
	5203130 - Nonemployee Travel		372			491			8,827
	5203140 - Taxable Meals		122			27			20
	5203150 - Non-taxable meals In-state	600	147	25%	600	405	68%	600	353
	5203260 - Air-Commercial Out-of-state	1,100	324	29%	1,100	1,876	171%	1,100	1,795
	5203280 - Other Public Out-of-state	100	13	13%	100	260	260%	100	150
	5203300 - Lodging Out-Of-State	500	471	94%	500	3,977	795%	500	3,653
	5203320 - Incidentals - Out of State		77			25			50
	5203350 - Out of State Meals		149			640			436
	5204010 - Subscriptions	1,000	314	31%	1,000	90	9%	1,000	270
	5204020 - Membership Dues	6,000	4,856	81%	6,000	4,425	74%	6,000	4,171
	5204030 - Legal Document Fees								10
	5204050 - Computer Consultant		4,550			47,970			70,980
	5204080 - Legal Counsel	198,000	42,341	21%	198,000	78,008	39%	198,000	37,188
	5204090 - Management Consultant		63,939			173,333			22,655
	5204100 - Consultant Fees--Medical	13,500	8,850	66%	13,500	1,500	11%	13,500	1,750
	5204110 - PR & Advertising Consultant		4,850						
	5204130 - Other Consulting	0			0	9,692		0	8,820

SDBMOE
Income Statement

Date Range: July 1, 2015 - October 31, 2015

		FY16 Budgeted	FY16 10/31/2015	% of Budget FY16	FY15 Budgeted	FY15 06/30/2015	% of Budget FY15	FY14 Budgeted	FY14 06/30/2014
4-B	5204160 - Workshop Registration Fees	2,000	200	10%	2,000	4,656	233%	2,000	3,280
	5204180 - State Computer Services	9,359	6,190	66%	9,359	17,810	190%	9,359	15,734
	5204181 - BIT Development Costs					155			12
	5204190 - Private Computer Services								
	5204200 - Central Services	3,531	1,452	41%	3,531	5,772	163%	3,531	3,709
	5204202 - Property Management					307			317
	5204203 - Purchasing Central Services					420			488
	5204204 - Records Management		48			112			131
	5204207 - Human Resource Services		1,297			3,931			3,454
	5204220 - Equipment Maintenance		262			1,670			35,201
	5204230 - Janitorial								0
	5204250 - Cable TV (Office Internet)		340			830			695
	5204320 - Audit Services - Private	5,500			5,500			5,500	0
	5204340 - Computer Software Maint.		29						
	5204350 - Advertising - Magazines		1,550			2,750			2,750
	5204360 - Advertising Newspapers	500			500	1,255		500	207
	5204400 - Advertising Internet	500		0%	500	294	59%	500	0
	5204460 - Equipment Rental	2,000	320	16%	2,000	960	48%	2,000	1,040
	5204490 - Rents - Other								791
	5204510 - Rents - Lease	83,000	27,353	33%	83,000	82,058	99%	62,000	51,160
4-C	5204530 - Telecommunication Services	3,000	3,404	113%	3,000	10,185	339%	3,000	15,418
	5204550 - Garbage and Sewer		505			1,118			1,610
	5204580 - Truck-Drayage & Freight		1,776			2,095			857
	5204590 - Professional Liability Insurance	20,000		0%	20,000	2,394	12%	20,000	2,400
	5204620 - Taxes and License Fees					911			995
	5204730 - Maintenance Contract	1,000		0%	1,000		0%	1,000	0
	5204740 - Bank Charges	24,192		0%	24,192		0%	24,192	78
	5204960 - Other Contractual Services	151,986	6,643	4%	151,986	43,306	28%	172,986	50,800
	5205020 - Office Supplies	10,000	800	8%	10,000	2,560	26%	10,000	1,912
	5205290 - Flags					209			
	5205040 - Educational & Instructional Sup								275
	5205310 - State-Printing								0
4-D	5205320 - Duplication - Private	300	5,069	1690%	300	6,046	2015%	300	1,142
	5205340 - Supp. Public & Ref Material					185			
4-E	5205350 - Postage	11,000	2,139	19%	11,000	15,171	138%	11,000	11,557
	5205390 - Food Stuffs	100		0%	100		0%	100	280
	5207121 - Building Improvement & Remodel								800
	5207451 - Office Furniture & Fixtures					1,194			37,742
	5207495 - Telephone Equipment	10,000		0%	10,000	76	1%	10,000	13,138
	5207531 - Household Appliances								875
	5207675 - Audio Visual Equipment		167			4,217			61,152
	5207791 - Police and Security Equipment								0
	5207901 - Computer Hardware (BIT)		1,731			5,175			3,468
	5207905 - Computer systems	6,000			6,000			6,000	0
	5207960 - Computer Software								0
	5207961 - Computer Software (BIT)	1,000			1,000			1,000	1,089
	5207980 - Depreciation Expense - Computer								0
	5207965 - Software State Contract								0
	5208080 - Prior Year Revenue Refund								0
	5208210 - Interest on Late Vendor Payment		126			260			275
Total Expense	**5.**	**1,025,703**	**370,584**	**36%**	**1,011,493**	**992,155**	**98%**	**988,618**	**924,257**
Net Ordinary Income		**213,797**	**-174,170**	**-81%**	**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**	**-161,941**	**-69%**	**174,257**	**315,639**	**181%**	**210,382**	**332,261**

SDBMOE
Other Contractual Services

Date Range: July 1, 2015 - October 31, 2015

	Description	FY16 10/31/2015	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	$ 2,347	$ 4,625	$ 1,521
	Temporary Employment Services	$ -	$ -	$ -
	Other State Verifications	$ -	$ -	$ -
	Shredding	$ -	$ -	$ -
	Goods and Services	$ -	$ -	$ -
	Background Reports	$ -	$ -	$ -
	BD member Expenses	$ -	$ 441	$ 172
	Board Meeting Audio	$ -	$ -	$ -
	Other	$ 4,296	$ 31,684	$ 30,881
7.	**Total Other Contractual Services**	**$ 6,643**	**$ 36,751**	**$ 60,868**

South Dakota BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Annual Report FY2015

A summary of Board activities from July 1, 2014 to June 30, 2015.

ABOUT THE BOARD

South Dakota Board of Medical and Osteopathic Examiners
101 N. Main Ave., Suite 301 and 215 Sioux Falls, SD 57104
Phone 605-367-7781 Fax 605-367-7786 www.sdbmoe.gov sdbmoe@state.sd.us

The Board of Medical and Osteopathic Examiners (Board) protects the health and welfare of the state's citizens by ensuring that qualified medical health care professionals are licensed to practice in South Dakota.

The Board licenses and regulates over 9,000 licenses within fourteen different medical categories. The Board also co-regulates medical professions with the Board of Nursing.

The Board supports and promotes the Health Professionals Advocacy Program which administers a program to advocate for and monitor the recovery and/or rehabilitation of impaired healthcare providers.

The Board has significant authority over licensees and establishing regulations by proposing legislation or adopting administrative rules.

The Board meets quarterly or more often as needed and the meetings are open to the public. The meeting agenda is posted to the Board website, sdbmoe.gov, and on the front door of the Board office building.

The Board has nine volunteer members appointed by the Governor: six allopathic physicians or doctors of medicine (MD) and one osteopathic physician or doctor of osteopathic medicine (DO), and two non-physicians.

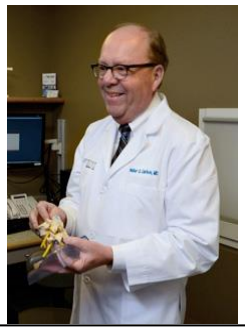
All final decisions are made by the full Board. The Board uses advisory committees, panels, and the board staff to assist with recommendations for final decisions. The advisory committees are approved by the full Board. The Board employs a professional staff comprised of an executive director and support staff to assist the Board in the regulation of its licensees.

The Board is administratively assigned to the South Dakota Department of Health. The Board does not receive a general fund appropriation. It is funded solely with the fees collected from licensing and other services provided by the Board.

MEMBERS OF THE BOARD

Kevin L. Bjordahl, MD

Deb K. Bowman



Walter O. Carlson, MD, MBA; Vice President

Mary S. Carpenter, MD: President

David K. Erickson, MD

Laurie B. Landeen, MD

Brent J. Lindbloom, DO; Secretary

David E. Lust, JD

Jeffrey A. Murray, MD

The Board has nine volunteer members: six allopathic physicians, or doctors of medicine (MD), and one osteopathic physician, or doctor of osteopathic medicine (DO), and two non-physician or lay person members (d*efined in statute as "…users of the services regulated by the board. One lay member may be a nonphysician health care professional licensed by the board").* All of the Board members are appointed by the Governor. Term limits were enacted by statute in 2005. Members may serve on the board for a three year term with the possibility of two reappointments for a nine year total term limit. In the event of a resignation or death, a board member may be appointed to complete an unexpired term prior to being appointed to their first three year term. Members receive per diem and expenses that follow state reimbursement policies. Annual officer elections are held at a May or June board meeting. Board member biographies are available on the Board's website: www.sdbmoe.gov

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS FY2015 ANNUAL REPORT

BOARD MEMBER	APPOINTMENTS and REAPPOINTMENTS	CURRENT TERM EXPIRATION DATES
Mary Carpenter, MD Winner, SD	2006, 2013	October 30, 2016
Walter Carlson, MD Sioux Falls, SD	2011, 2014	October 30, 2017
Brent Lindbloom, DO Pierre, SD	2003, 2014	October 30, 2017
Kevin Bjordahl, MD Milbank, SD	2013	October 30, 2015
Deb Bowman Pierre, SD	2014	October 30, 2016
David Erickson, MD Sioux Falls, SD	2006, 2013	October 30, 2015
Laurie Landeen, MD Sioux Falls, SD	2013	October 30, 2016
David Lust, JD Rapid City, SD	2015	October 30, 2018
Jeffrey Murray, MD Sioux Falls, SD	2012*, 2015	October 30, 2017

*Appointed to complete term of John Vander Woude, MD

JUNE 2014 -2015 OFFICERS	ELECTED – RE-ELECTED	EXPIRES
Mary Carpenter, MD, President	Acting President 2012, 2013, 2014	June 2015
Walter Carlson, MD, Vice President	2013, 2014	June 2015
Brent Lindbloom, DO, Secretary	2013, 2014	June 2015

June 2014 Federation of State Medical Board (FSMB)and CEO President Humayun J. Chaudhry, DO; Board Executive Director Margaret B. Hansen, PA-C; FSMB Liaison Director Jon Thomas, MD; Board member Jeffrey A. Murray, MD; Board member Bernie W. Christenson; Board member Deborah K. Bowman; Board member Laurie B. Landeen, MD; SDBMOE Vice President Walter O. Carlson, MD; Board Secretary Brent J. Lindbloom, DO; Board member David K. Erickson, MD; and Board member Kevin L. Bjordahl, MD.

EXECUTIVE DIRECTOR'S REPORT

The Board members and staff are committed to protecting the health and welfare of the state's citizens by assuring that only qualified medical professionals are licensed to practice in South Dakota. The regulatory responsibilities of the Board include enforcement of statutes, administrative rules, and practice standards.

Through effective and efficient licensure, the Board protects the public by ensuring that these practitioners have the education, training, and skill to practice safely. By adopting and enforcing regulations, the Board responds to complaints from patients, issues regarding competency, and reports from medical entities, facilities, and other sources. The Board will impose sanctions against licensees who practice below the standards of care or act unprofessionally.

The Board currently administers over 9,200 active licensees in 14 healthcare professions, corporations and limited liability companies within South Dakota. The Board co-regulates advanced practice nurses with the South Dakota Board of Nursing. The Board's administrative functions include the issuance, renewal, and maintenance of over thirty (30) different license types including: licenses, permits, registrations, and certificates. Additional functions include the inspection and investigation of complaints regarding licensees.

From July 1, 2014 to June 30, 2015:

- A total of 1163 new licenses were issued.
- A total of 455 complaint files were opened. The Board places great emphasis on completing timely and fair investigations that result in appropriate action.
- Ten (10) administrative rules were adopted to define what constitutes a conflict of interest or a potential conflict of interest related to hearings held by the Board of Medical and Osteopathic Examiners, and to add a code of ethics to the existing rules for the professionals regulated by the Board.
- The Board held the following public meetings: four (4) regular meetings, one (1) teleconference meeting, one (1) declaratory rule hearing, and one (1) administrative rules hearing.
- There were four (4) administrative law hearings held during the year and the Board made final decisions on the recommendations during one of the public meetings mentioned above.
- OUTREACH EFFORTS: Make life easier for our customers.
    - Education: The executive director and staff continue to meet and provide outreach to medical schools, residency programs, healthcare recruiters, clinic managers, health system administrators, state regulatory boards, and associations as well as with the Board's licensees.
        - In-office assistance for applications: 1,089, requests for "renewal and general questions"
        - Phone and general email totals: 28,640
        - Training Meetings for Academic Program Directors & Coordinators, Healthcare Systems Recruiters, Board & Advisory Members: 1,671

Much has been accomplished in the past year. The Board and its staff continue to seek ways to improve, strengthen, and enhance services provided to the public and licensees. The Board and its staff remain committed to public protection and excellent customer service for South Dakota citizens.

More information about the Board's work is available in the agendas, minutes, reports and website documents.

Margaret B. Hansen

Margaret B. Hansen, PA-C, MPAS, CMBE
Executive Director

www.sdbmoe.gov
101 N Main Ave Ste 301 Sioux Falls SD 57104
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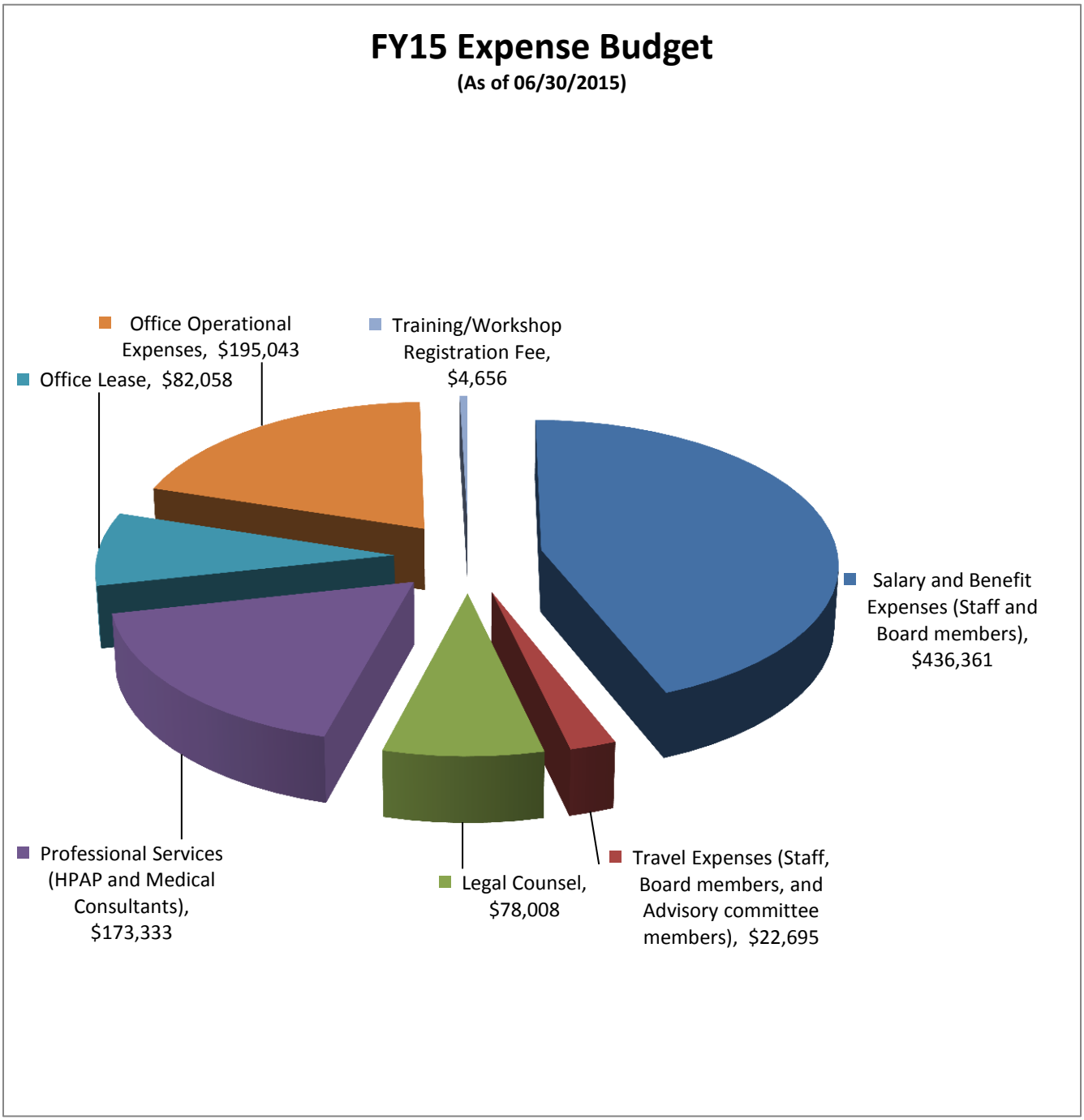
Email: Margaret.Hansen@state.sd.us

FY2015 EXPENSE BUDGET

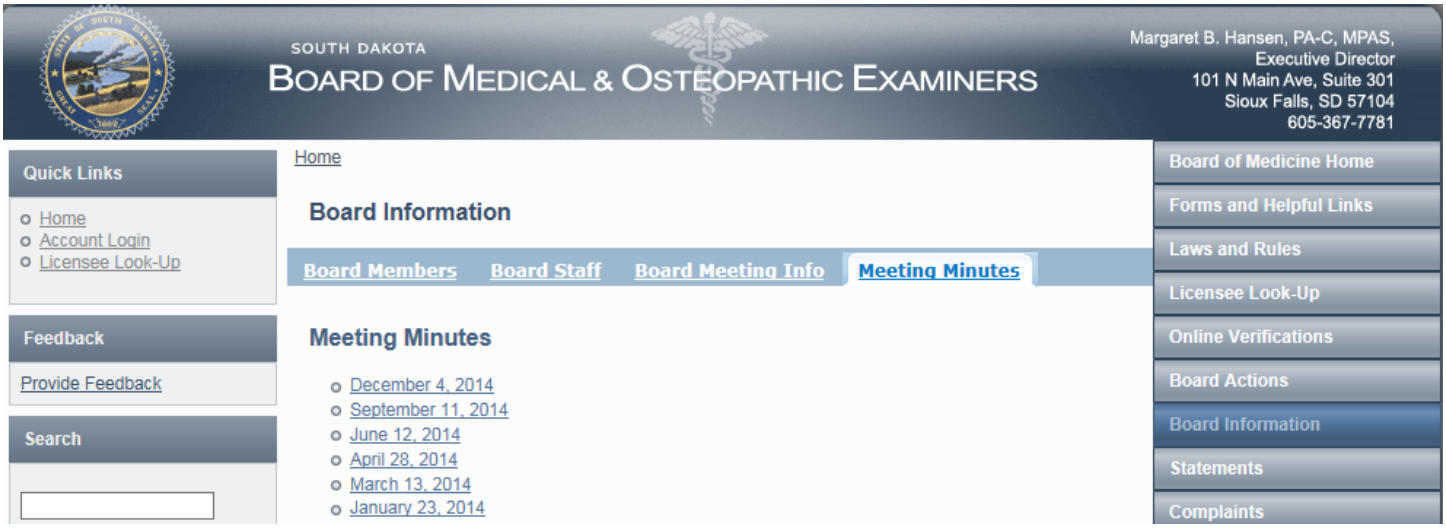


The Board of Medicine's expense budget for Fiscal year 2015 (July 1, 2014 through June 31, 2015) is $1,011,493. The FY2015 anticipated revenue is $1,185,750.

2014 MEETING SCHEDULE

MEETINGS
March 13
June 12
September 11
December 4

TELECONFERENCES
January 23
April 28
April 28



CONTESTED CASE HEARINGS

Pursuant to South Dakota Administrative Rules, an applicant for a license, permit, registration, 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, narration of the applicable statutes or regulations for which the petitioner is requesting board action, and the relief requested by the petitioner.

Upon receipt of a petition for hearing, the board president may appoint an examiner to conduct the contested case hearing, or may schedule the contested case hearing before the board, as authorized by applicable statutes. All petitions for hearing shall be filed with the executive secretary; who shall maintain the record of contested case proceedings held before the board.

Contested case hearings shall be conducted in accordance with SDCL 1-26. The parties to a hearing are the executive secretary and the applicant or licensee. A board member who has participated in investigation of the matter before the board shall disqualify himself from all deliberations and decisions. If the board hears the proceeding, it shall issue a final decision and require the parties to submit proposed findings of fact and conclusions of law for consideration at the board's next meeting. If a hearing examiner hears the proceeding, the examiner shall issue a proposed decision including findings of fact and conclusions of law. The examiner shall serve the proposed decision upon the board and the parties. The board shall issue a final decision to accept, reject, or modify the findings, conclusions, and decisions of the examiner. The board shall issue a notice of decision, accompanied by the final board decision and findings of fact and conclusions of law, to the applicant or licensee and executive secretary. The applicant or licensee may appeal a final board action to circuit court, and ultimately to the supreme court of South Dakota.

	2015
Administrative Hearings	4
Hearings before the Board of Medicine	18

ACTIONS OF THE BOARD OF MEDICINE

	FY 2015
Stipulation and Agreement	4
Consent Agreement- Voluntarily Surrender License	2
Findings of Fact, Conclusions of Law and Recommendation for Fitness to Practice Evaluation	2
Findings of Fact, Conclusions of Law and Recommendation for Monitoring	1
Findings of Fact, Conclusions of Law and Recommendation for Denial of Application	1
Consent Agreement for Revocation of license	1
Consent Agreement with Reprimand	3
Consent Agreement with Letter of Concern	1
Applications withdrawn under investigation	2
License reinstated without restrictions	1

ADMINISTRATIVE RULES

The Board of Medical and Osteopathic Examiners administrative rules, which have the weight of law, are found in Articles 20:47, 20:52, 20:61, 20:63, 20:64, 20:66, 20:70, 20:78, 20:82, 20:83 of the South Dakota Administrative Code. Before the Board can adopt a new rule or amend an existing rule, the intended action item must be publicly noticed and reviewed at a public hearing. The proposed change is also subject to review by the Interim Rules Review Committee.

These amendments were noticed and adopted by the Board in FY2015:

- **PHYSICIANS AND SURGEONS - CHAPTER 20:47:08 ETHICS**. The proposed rule will adopt the Code of Medical Ethics of the American Medical Association 2012-2013 edition in order to standardize the ethical expectations of licensees and assist in potential disciplinary proceedings. **NOTICED 3/11/15 | ADOPTED 4/20/15 | EFFECTIVE 5/21/15**

- **PHYSICIAN ASSISTANTS – CHAPTER 20:52:02 ETHICS.** The proposed rule will adopt the American Academy of Physician Assistants Guidelines for Ethical Conduct for the Physician Assistant Profession, 2013 in order to standardize the ethical expectations of licensees and assist in potential disciplinary proceedings. **NOTICED 3/11/15 | ADOPTED 4/20/15 | EFFECTIVE 5/21/15**

- **ATHLETIC TRAINERS – CHAPTER 20:63:04 ETHICS.** The proposed rule will adopt the Board of Certification Standards of Professional Practice, 2006 in order to standardize the ethical expectations of licensees and assist in potential disciplinary proceedings. **NOTICED 3/11/15 | ADOPTED 4/20/15 | EFFECTIVE 5/21/15**

- **OCCUPATIONAL THERAPY AND OCCUPATIONAL THERAPY ASSISTANTS – CHAPTER 20:64:05 ETHICS.** The proposed rule will adopt the American Occupational Therapy Association Occupational Therapy Code of Ethics and Standards, 2010 in order to standardize the ethical expectations of licensees and assist in potential disciplinary proceedings. **NOTICED 3/11/15 | ADOPTED 4/20/15 | EFFECTIVE 5/21/15**

- **PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS – CHAPTER 20:66:02 ETHICS.** The proposed rule will adopt the Code of Ethics of the American Physical Therapy Association, 2010 in order to standardize the ethical expectations of licensees and assist in potential disciplinary proceedings. **NOTICED 3/11/15 | ADOPTED 4/20/15 | EFFECTIVE 5/21/15**

- **RESPIRATORY CARE PRACTITIONERS – CHAPTER 20:70:03 ETHICS.** The proposed rule will adopt the Statement of Ethics and Professional Conduct of the American Association for Respiratory Care, 2012 in order to standardize the ethical expectations of licensees and assist in potential disciplinary proceedings. **NOTICED 3/11/15 | ADOPTED 4/20/15 | EFFECTIVE 5/21/15**

- **BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS – SECTION 20:78:05:09 BOARD MEMBER CONFLICT OF INTEREST.** The proposed rule will define relationships which constitute a conflict of interest for Board members involved in hearings of the Board of Medical and Osteopathic Examiners. **NOTICED 3/11/15 | ADOPTED 4/20/15 | EFFECTIVE 5/21/15**

- **BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS – SECTION 20:78:05:10 BOARD MEMBER POTENTIAL CONFLICT OF INTEREST.** The proposed rule will define relationships which constitute a potential conflict of interest for Board members involved in hearings of the Board of Medical and Osteopathic Examiners. **NOTICED 3/11/15 | ADOPTED 4/20/15 | EFFECTIVE 5/21/15**

- **GENETIC COUNSELORS – ARTICLE 20:82.** The proposed rules will establish a new article in the administrative rules for genetic counselors. The proposed rule includes three chapters: Definitions, Licensure Requirements, and Ethics.

The Licensure Requirements chapter includes a section on fees for licensure and the Ethics chapter will adopt the Code of Ethics of the National Society of Genetic Counselors, 2006 in order to standardize the ethical expectations of licensees and assist in potential disciplinary proceedings. **NOTICED 3/11/15 | ADOPTED 4/20/15 | EFFECTIVE 5/21/15**

- **NUTRITION AND DIETETICS – ARTICLE 20:83.** The proposed rules will establish a new article in the administrative rules for nutritionists and dietitians. The proposed rule includes three chapters: Definitions, Licensure Requirements, and Ethics. The Licensure Requirements chapter includes a section on fees for licensure and the Ethics chapter will adopt the American Dietetic Association Commission on Dietetic Registration Code of Ethics for the Profession of Dietetics, 2009 in order to standardize the ethical expectations of licensees and assist in potential disciplinary proceedings. **NOTICED 3/11/15 | ADOPTED 4/20/15 | EFFECTIVE 5/21/15**

LEGISLATION

The Board of Medical and Osteopathic Examiners will amend existing laws or establish new laws that are relevant to the professions regulated by the board.

This legislation was approved in 2015:

SENATE BILL 63 – The purpose of this legislation was to adopt the Interstate Medical Licensure Compact

INTERSTATE MEDICAL LICENSURE COMPACT

Special Board Meeting July 21, 2015 Summary:

The BMOE held a special board meeting July 21st and appointed board member Dr. Mary S. Carpenter and executive director Margaret Hansen as South Dakota's commissioners to the Interstate Medical Licensure Compact Commission which will be organized this year. On March 11th, Governor Daugaard signed legislation allowing South Dakota to join the compact

DBMOE member Deb Bowman, SDBMOE President Mary Carpenter, MD, SDBMOE Executive Director Margaret Hansen, SDAHO CEO Scott Duke, Susan Sporrer of the South Dakota Department of Health; SDSMA lobbyists Dean Krogman and Justin Bell, Sen. Deb Soholt, Secretary of Health Kim Malsam-Rysdon, Rep. Scott Munsterman, Nick Kotzea of Sanford Health with Gov. Dennis Daugaard after signing SB 63.

Interstate Medical Licensure Compact Press Conference

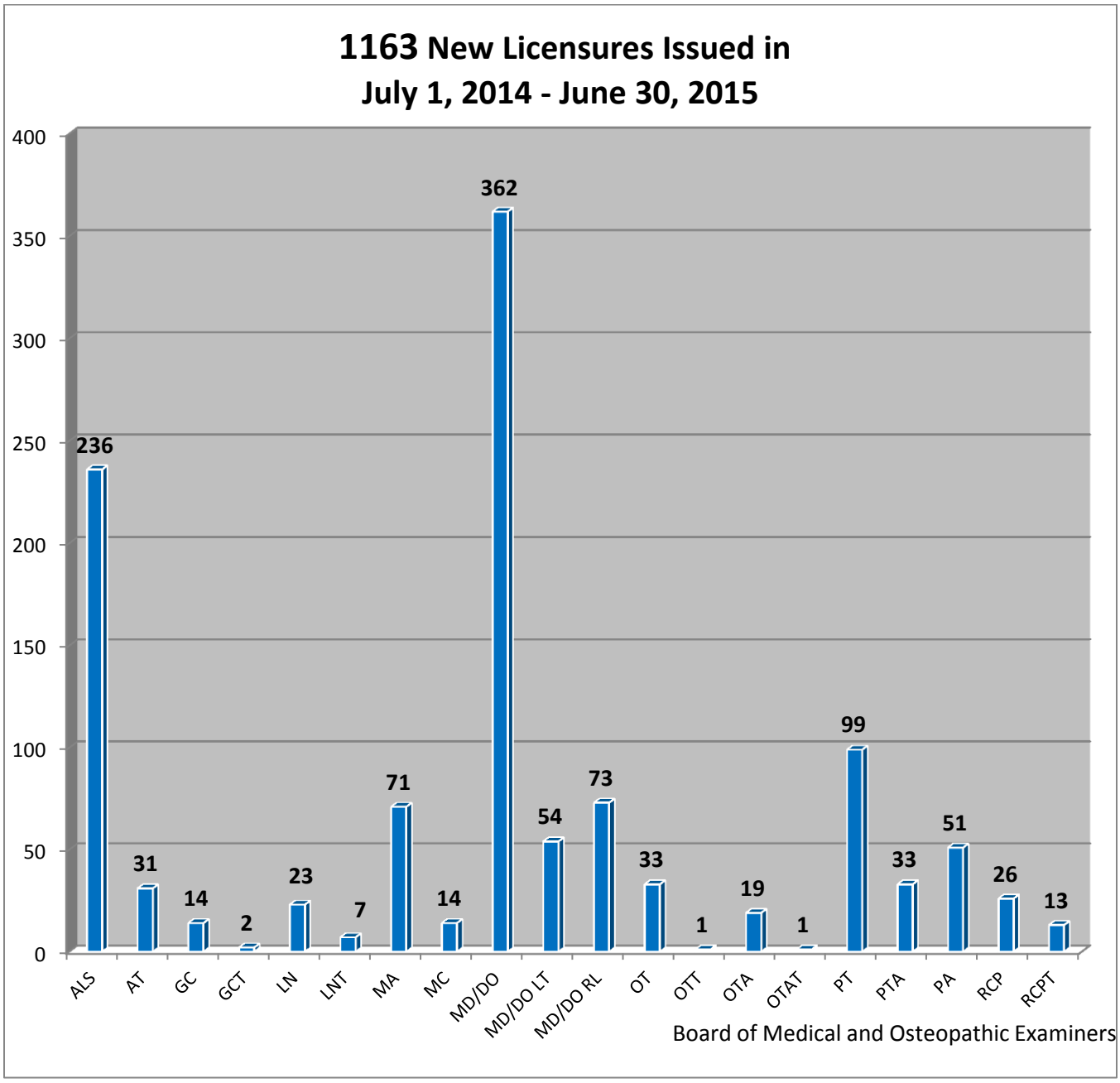
BMOE executive director Margaret Hansen was an invited panel participant for a press conference regarding the Interstate Medical Licensure Compact at the National Press Club in Washington DC on June 24, 2015.The press conference included representatives of state medical boards, policymakers and health care leaders speaking about the new Interstate Medical Licensure Compact and its impact on the U.S. health care system.

Utah State Representative Raymond Ward, MD, Minnesota Board member Jon Thomas, South Dakota BMOE executive director Margaret Hansen, Wyoming Medical Board executive director Kevin Bohnenblust and moderator Paul Larson.

Health Professionals Assistance Program

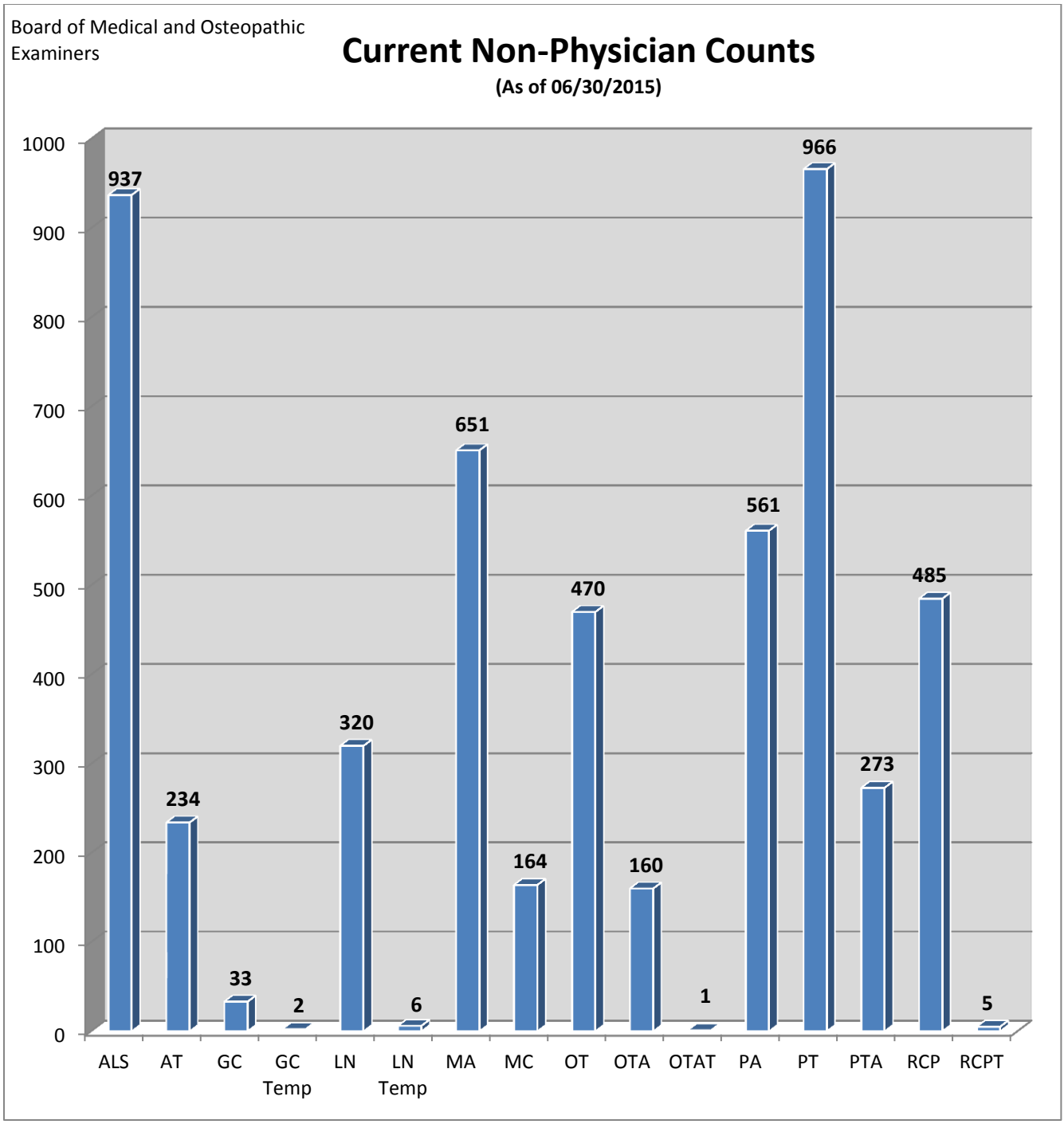
Since 1996, the South Dakota Health Professionals Assistance Program (HPAP) has assisted hundreds of healthcare providers with recovery and the ability to return to practice. HPAP believes that early intervention, and comprehensive accurate evaluations, combined with ongoing case management and support of treatment efforts, offers the best opportunity for successful outcomes. HPAP is a confidential program designed for regulated health professionals who hold, or are eligible to hold, licensure with the SD Board of Nursing, SD Board of Medical and Osteopathic Examiners, SD Board of Pharmacy and/or the SD Board of Dentistry. Services include general outreach, crisis intervention, informal assessment, treatment monitoring, and support for providers who need assistance.
For more information see: http://www.mwhms.com/ for the South Dakota statutes see http://legis.sd.gov/Statutes/Codified_Laws/DisplayStatute.aspx?Statute=36-2A&Type=Statute

Statistics

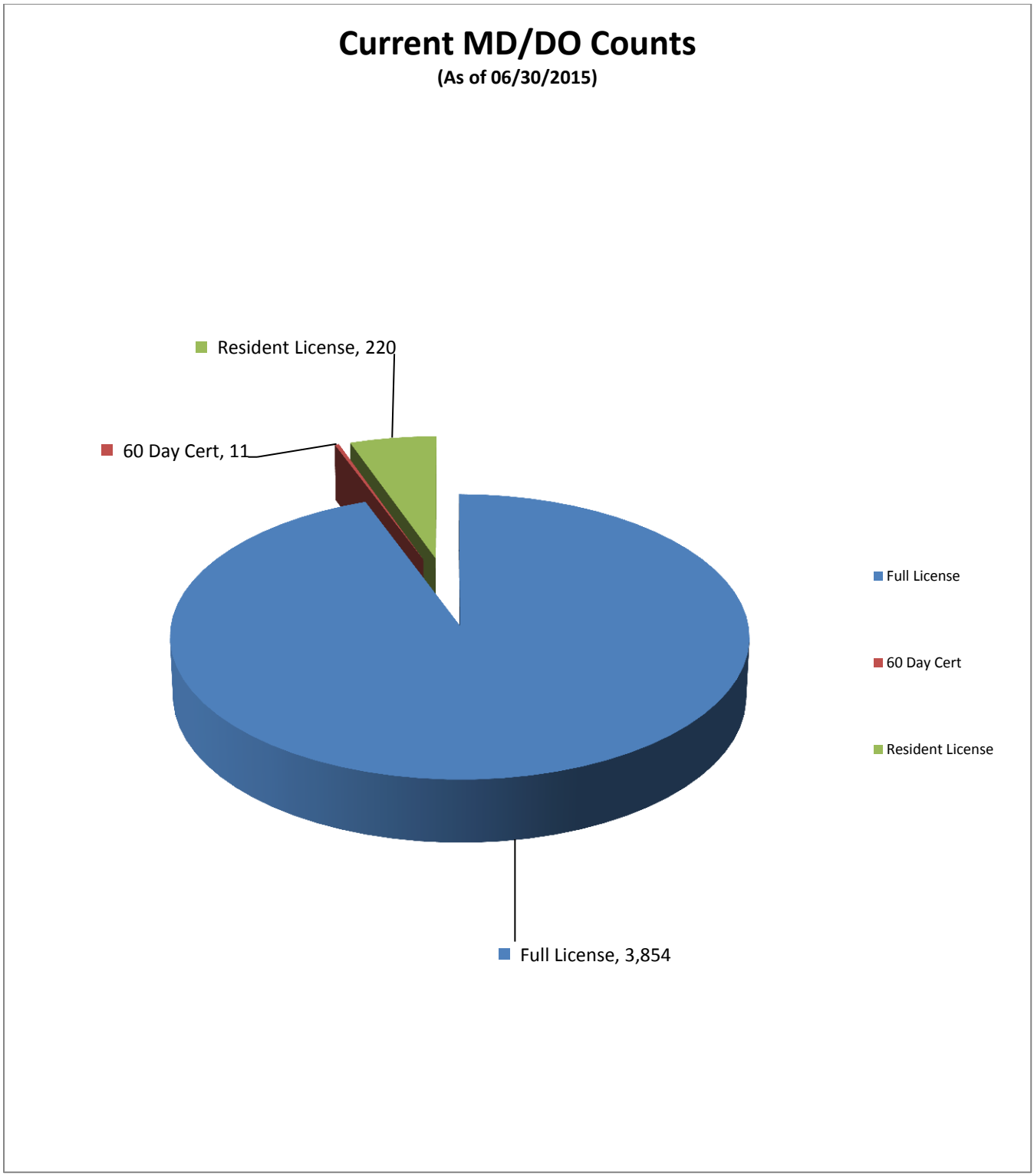


ALS – Advanced Life Support (EMT)
AT – Athletic Trainer
GC – Genetic Counselor
GCT – Genetic Counselor Temp
LN – Licensed Nutritionist
LNT – Licensed Nutritionist Temp
MA – Medical Assistant
MC – Medical Corporation
MD/DO – Medical License
MD/DO LT – Physician Locums Tenens
MD/DO RL – Resident License

OT – Occupational Therapist
OTT – Occupational Therapy Temp
OTA – Occupational Therapy Assistant
OTAT – Occupational Therapy Assistant Temp
PT – Physical Therapist
PTA – Physical Therapist Assistant
PA – Physician Assistant
PAT – Physician Assistant Temp
RCP – Respiratory Therapy
RCPT – Respiratory Therapy Temp



ALS – Advanced Life Support (EMT)
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
PT – Physical Therapist
PTA – Physical Therapist Assistant
RCP – Respirator Care Practitioner


Current MD/DO Counts
(As of 06/30/2015)
Resident License, 220
60 Day Cert, 11
Full License, 3,854
Full License
60 Day Cert
Resident License

License Type:	FY13	FY14	FY15
Advanced Life Support	808	992	937
Athletic Trainer	179	218	234
Genetic Counselor	12	17	33
Genetic Counselor Temp	1	0	2
Licensed Nutritionist	290	316	320
Licensed Nutritionist Temp	5	3	6
Medical Assistant	607	575	651
Medical Corporation	174	165	164
Medical License	3,674	3,717	3,854
Physician Locums Tenens	13	9	11
Resident License	127	162	220
Occupational Therapist	458	464	470
Occupational Therapy Temp	1	0	0
Occupational Therapy Assistant	147	148	160
Occupational Therapy Assistant Temp	0	0	1
Physical Therapist	885	906	966
Physical Therapist Assistant	237	251	273
Physician Assistant	507	530	561
Physician Assistant Temp	0	0	0
Respiratory Therapy	480	511	485
Respiratory Therapy Temp	3	9	5
Total	8,608	8,993	9,353

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS FY2015 ANNUAL REPORT

The Board of Medicine is fortunate to have dedicated, competent personnel who take their jobs – and the Board's mission – seriously. Every day, these men and women perform licensure and regulatory enforcement duties that enable the Board to protect the health of South Dakotans.

SOUTH DAKOTA BOARD OF MEDICAL & OSTEOPATHIC EXAMINERS
101 N Main Avenue, Suite 301
Sioux Falls, SD 57104
Hours: 8:00 a.m. to 5:00 p.m., Monday – Friday
Phone: 605-367-7781
Fax: 605-367-7786
Email: sdbmoe@state.sd.us
Website: www.sdbmoe.gov

ADMINISTRATION
Margaret B. Hansen, PA-C, MPAS, CMBE
Executive Director

Lisa Andersen
Secretary

Tyler Klatt, MPA
Management Analyst

Jane Phalen
Board Coordinator

ENFORCEMENT
Misty Rallis, RN
Board Investigator

LICENSURE
Elise Ellenz
Licensing Specialist

Michele Knorr
Licensing Specialist

Randi Sterling
Head Licensing and Business Specialist

SOUTH DAKOTA HEALTH PROFESSIONAL ASSISTANCE PROGRAM
Maria Eining
Program Coordinator

SOUTH DAKOTA ATTORNEY GENERAL'S OFFICE
William Golden, JD
Board staff attorney

Roxanne Giedd, JD
Board attorney

Steven Blair, JD
Board attorney

COVER ARTWORK: The medical team representing the Board's regulated professions. *Shutterstock*

BMOE staff with Secretary of Health Malsam-Rysdon (left to right): Tyler Klatt, Lisa Andersen, Margaret Hansen, Kim Malsam-Rysdon, Michele Knorr, Randi Sterling, Misty Rallis, Elise Ellenz, (Jane Phalen, absent).

Advanced Life Support Committee met on November 10, 2015

1. The committee discussed the upcoming rule hearing on opioid overdose prevention
2. Discussed future changes to the statutes and rules
3. Reviewed ways to inform the membership of the SD EMT Association

Athletic Trainer Committee met on November 4, 2015.

1. Discussed if any barriers to care exist related to athletic training
2. NATA will be presenting changes regarding educational programs – expected to be released fall 2016
3. Reviewed a question regarding displaying professional credentials

Genetic Counselor Committee met on November 16, 2015

1. Dr. Benn has stepped down from his position on the committee – the members were asked to assist in finding potential new members
2. Discussed changes to statute – it is anticipated that Sanford and Avera will be taking charge of these changes during the 2016 legislative session

Nutrition and Dietetics Committee met on November 17, 2015

1. Discussed the open position on the committee and the new nominee Mariah Weber
2. Reviewed the continuing education rule and the process for rulemaking.

Occupational Therapy Committee met on November 9, 2015

1. Reviewed questions from licensees regarding continuing education opportunities
2. Discussed comments received regarding the recommended administrative rule changes
3. Discussed supervision of OTA's and whether or not any inefficiencies exist

Physical Therapy Committee met on October 29, 2015

1. Reviewed notes from committee member who attended the FSBPT annual meeting
2. The PT interstate license compact was discussed
3. Reviewed comments from the SDPTA regarding the recommended continuing education rules

Physician Assistant Committee met on November 12, 2015

1. Discussed the upcoming hearing for rules on opioid overdose prevention
2. Reviewed the potential changes to the nurse practitioners collaboration rules

Mariah C. Weber, MS, RDN, LN, CHWC

1419 17th Ave S
Brookings, SD 57006
mariah.weber@sdstate.edu
(605) 370-8059

Education

2010 **Master of Science in Nutritional Sciences**
South Dakota State University
Thesis: *The Effect of an Education Program Encouraging Beef Consumption on Iron Status in Physically Active Females*

2007 **Bachelor of Science in Family and Consumer Sciences**
South Dakota State University
Major: Nutrition and Food Science

Dietetic Internship

2008 **University of Michigan Hospitals and Health Centers Dietetic Internship**
Successfully completed ten-month, fulltime, general dietetic internship at a large academic health system.

Professional Experience

2012-Present **Wellness Coordinator**, South Dakota State University Wellness Center
Provide educational wellness programming to SDSU and the Brookings community on topics such as nutrition, fitness, alcohol and other drug use, sexual health, disease prevention, etc. Advise the student organization HEROH (Helping Everyone Reach Optimal Health). Manage the organization budget and meet regularly with officers and committee members to provide guidance, feedback and communication. Manage the Safe Ride grant funded program by acting as a liaison between all project partners. Effectively manage the grant by securing annual funding, hiring and training monitors, and completing required reporting.

2009-Present **Registered Dietitian and Wellness Coach**, South Dakota State University Wellness Center
Provide medical nutrition therapy and wellness coaching to SDSU students, athletes, and Brookings community members. Provide individual consultations for nutritional assessment, counseling, and education to promote healthy lifestyle habits. Provide individual health coaching sessions for long term behavior change. Work as a member of a multidisciplinary team and provide referrals to other staff members when necessary.

2009-2012 **Registered Dietitian and Wellness Coach**, Avera Research Institute
Provided weight management coaching for patients enrolled in a medically managed weight loss program through motivational interviewing and nutrition counseling. Coordinated family health, wellness, and mental health services for families enrolled in the Avera Family Wellness Program. Coordinated data collection, developed training and program materials,

worked in the schools with children and in the homes of families and assisted teachers and school personnel in the proper delivery of wellness services.

2008-2010 **Nutrition Counselor**, Beresford School District
Planed and taught nutrition classes to elementary, middle and high school students. Developed educational materials and activities to teach children the importance of healthy nutrition. Held open office hours to any student/parent that wished to discuss nutrition/fitness individually.

Teaching Experience

2010- Present **Adjunct Instructor, NFS 322**, South Dakota State University
Provide dietetic majors with knowledge of nutritional assessment, cultural and therapeutic dietary modifications, interviewing and counseling, documentation in the medical record, and quality assurance. Develop curriculum, prepare teaching materials, lecture on course materials, grade and provide timely feedback on tests and projects.

Research Positions

2008-2009 **Graduate Research Assistant**, South Dakota State University
Developed eight weeks of cycle menus for the South Dakota Department of Education. Worked with schools to coordinate testing of the menus for student acceptance and adapted the menus as needed to meet student preferences while meeting the Dietary Guidelines, nutrient standards, menu patterns, and HealthierUS School Challenge.

Grant Awards

2012- Present Mariah Weber. United States Department of Transportation through the South Dakota Department of Highway Safety. "A Comprehensive Approach to Reduce High Risk Drinking and Impaired Driving," $59,201.

2014-2015 Mariah Weber and Shari Landmark. South Dakota Department of Health and Black Hills Special Services Cooperative. "A Comprehensive Approach to Educate Young Adults on Human Papillomavirus (HPV) and Cancer Risk," $6,836.

Presentations

2015 Mariah Weber. "Nutrition for Performance: STATE Fueling Plan." Presented at the Sanford Sports Medicine Symposium, South Dakota.

2013 Mariah Weber. "How Wellness Coaching Can Influence Behavior Change among College Students." Presented at the NIRSA Region IV conference, Nebraska.

Professional Development

2015 NIRSA Annual Conference, Dallas, TX

2014 The South Dakota Academy of Nutrition and Dietetics Annual Conference, Rapid City, SD

2014 American College Health Association Annual Conference, San Antonio, TX

2013	NIRSA Region IV Conference, Omaha, NE
2012 & 2013	Midwest Health Promotion conference, Minneapolis, MN
2012	NIRSA State Conference, Vermillion, SD

Professional Organizations

2014-Present	Member of NIRSA: Leaders in Collegiate Recreation
2010-Present	Member of the Sports and Cardiovascular Nutrition Dietetic Practice Group
2007- Present	Member of The Academy of Nutrition and Dietetics: South Dakota Affiliate
2013-2014	Member of the American College Health Association
2011-2014	South Dakota Dietetic Association New Member Liaison

Student Supervision

2009-Present	Dietetic Internship Preceptor: University of South Dakota
2009-Present	Dietetic Practicum Preceptor: South Dakota State University
2013- 2014	Dietetic Internship Preceptor: Iowa State University Distance Dietetic Internship

University Committees

2014- Present	South Dakota State University Athletic Department Performance Safeguards Taskforce
2012- Present	South Dakota State University Choices and Prevention Committee
2011- Present	South Dakota State University Foodservice Advisory Council

Licensures & Certifications

2015	Completed The QPRT Suicide Risk Assessment and Management Training Program.
2011- Present	Certified Wellness Coach: American College of Sports Medicine
2008- Present	Registered Dietitian Nutritionist: The Commission on Dietetic Registration (RD#: 1003112)
2008- Present	Licensed Nutritionist: South Dakota Board of Medical and Osteopathic Examiners (License # 0361)
2011	Completed CDR Certificate of Training in Adult Weight Management

Honors & Awards

2015	NIRSA Star Trac Travel Scholarship Recipient
2014	South Dakota Young Dietitian of the Year: South Dakota Academy of Nutrition and Dietetics

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

Area: Discipline
Authority: SDCL 36-9A-29 to 36-9A-31; 36-9A-41

Topic: Complaint Process for CNP and CNM Licensees
Purpose: Appropriately and efficiently conduct disciplinary proceedings

Date Approved: SD Board of Nursing: 11/20/2015
SD Board of Medical and Osteopathic Examiners:

Policy: The Board of Nursing (BON) will take the lead on all complaints involving nurse practitioners (NP) and nurse midwifes (NM) and will take the complaint through the disciplinary process as outlined in SDCL 36-9A and ARSD 20:62.

Procedure:

Board of Nursing actions.	**Board of Medical and Osteopathic Examiners actions.**
• BON staff investigates each complaint received on a NP and NM. • BON staff/attorney conduct informal meeting with the licensee as a part of the investigative process. • BON representatives review investigative materials and determine if informal disposition is warranted. • Licensee noticed, chooses to accept informal disposition option. • If not accepted, BON will proceed to notice for formal hearing. • BON members take final action on complaint. • BON staff sends investigatory materials and summary report to the BOMOE. • BON staff/attorney notices licensee of final outcome and publish accordingly.	• BOMOE staff sends complaints on NPs and NMs to the BON. • BOMOE staff/members review investigatory materials. • BOMOE members take final action on complaint within 20 days. • BOMOE sends notice to BON regarding action taken.

November 20, 2015

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

September 2015

By BMOE Staff

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

Current/Past Events:

South Dakota Board of Nursing and

Board of Medical and Osteopathic Examiners
JOINT BOARDS MEDICINE
Special Board Meeting
Thursday, September 24, 2015
12:00 noon (central time)/11:00 am (mountain time)

Unapproved Draft Minutes[i]

Regular Board Meeting 4:00 pm (CT) Thursday, September 10, 2015

Board Members:
Kevin Bjordahl, MD, Ms. Deborah Bowman; Walter Carlson, MD; Mary Carpenter, MD; David Erickson, MD; Brent Lindbloom, DO; Mr. David Lust; Jeffrey Murray, MD
Absent: Laurie Landeen, MD
Board Staff: Margaret Hansen, PA-C; Mr. Tyler Klatt; Ms. Jane Phalen; Ms. Misty Rallis
Counsel: Craig Kennedy, Staff Counsel; William Golden, Staff counsel
James McMahon, Board counsel; Steven Blair, Board Counsel

1. Dr. Carlson, President of the Board, called the meeting to order at 4:00 pm. Roll was called and a quorum was confirmed. A motion: to approve the agenda as amended was ratified by voice vote (Murray/unanimous).

2. A motion: to approve the minutes from the June 11th Regular Board meeting and the July 21st Special Board meeting was ratified by voice vote (Murray/unanimous)

3. A motion: to approve the new licenses, permits, certificates, and registrations issued from June 1, 2015 through August 31, 2015, was ratified by voice vote (Lindbloom/unanimous).

4. Confidential Physician Hearings (Closed Session pursuant to SDCL 36-4-31.5 unless privilege is waived by physician). Board members assigned to a case are recused and do not deliberate or vote in that case (ARSD 27:78:05:05).

a. Dr. Annette M. Bosworth appeared before the Board pro se and waived her confidentiality privilege.

i. A motion: to enter into Executive Session based upon SDCL 1-25-2(3) to consult with legal counsel was ratified by a roll call vote (Murray/unanimous).

ii. The Public Meeting resumed. A motion: to adopt the Hearing Examiner's Findings of Fact and Conclusions of Law including the stated recommendation, and revoke Dr. Bosworth's South Dakota medical license #6055 based upon SDCL 36-4-29 and 36-4-30 (6)(22), effective ten (10) days from the date of this order was ratified a roll call vote (Murray/unanimous). Dr. Carpenter, the Board member assigned to this matter, abstained from the deliberation and the vote.

5. A motion: to instruct the Board staff to move forward with the Public Administrative Rules process and schedule a hearing was ratified by voice vote (Bjordahl/unanimous).

6. Confidential Physician Hearings (Closed Session pursuant to SDCL 36-4-31.5 unless privilege is waived by physician). Board members assigned to a case are recused and do not deliberate or vote in that case (ARSD 27:78:05:05).

a. Dr. Christiana M. Lietzke. A motion: to grant a six (6) month extension to March 10, 2016, for Dr. Lietzke to complete her fitness to practice evaluation at an entity approved in advance by the Board, and release the results and findings of the evaluation to the Board for consideration to determine whether a South Dakota medical license may be issued was ratified by a roll call vote (Erickson/unanimous). Dr. Landeen, the Board member assigned to this matter, was not present at the meeting.

b. Dr. Robert W. Beattie. A motion: to accept the voluntary and immediate surrender of Dr. Beattie's South Dakota medical license #3623 based upon SDCL 36-4-29.1, 36-4-30(6)(22), and ARSD 20:47:08:03 effective August 13, 2015 was ratified by a roll call vote. (Erickson/unanimous). Dr. Carpenter abstained from the deliberation and the vote.

c. Dr. Sudhir E. Finch. A motion: to approve his Stipulation and Agreement and grant the reinstatement and renewal of his South Dakota medical license #9646 and the temporary approval order was ratified by a roll call vote (Bowman/unanimous). Dr. Landeen, the Board member assigned to this matter, was not present at the meeting.

d. Dr. Michael L. Moeller A motion: to remove the probationary conditions from his South Dakota medical license #4137 and grant him an unrestricted medical license was ratified by a roll call vote (Erickson/unanimous).

e. Dr. Jack Leon-Max Mutnick. A motion: to approve his Stipulation and Agreement with Reprimand of his South Dakota medical license #8102 was ratified by a roll call vote (Bowman/unanimous). Dr. Landeen, the Board member assigned to this matter, was not present at the meeting.

7. A motion: to enter into Executive Session based upon SDCL 1-25-2(3) to consult with legal counsel was ratified by voice vote (Murray/unanimous). The Public Meeting resumed. A motion: to adjourn the meeting was ratified by a voice vote (Erickson/unanimous).

These unapproved draft minutes are respectfully submitted 2:00 pm (CT) on September 11, 2015 by Jane T. Phalen, Board Coordinator.

[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.

South Dakota Board of Nursing and
Board of Medical and Osteopathic Examiners
JOINT BOARDS MEDICINE
Special Board Meeting
Thursday, September 24, 2015
12:00 noon (central time)/11:00 am (mountain time)

To participate by:
Phone: Please call phone number: (605) 773-2300 Conference password: 2000#
DDN Sites: Pierre: CAP B, 500 E. Capitol
Rapid City: TIE, 1925 Plaza Blvd. Dakota Room
In person: Board Conference Room, 101 N. Main Ave., Suite 215 (on 2nd floor), Sioux Falls, SD

Unapproved Draft Minutes[ii]

Special Meeting of Joint Boards of Medicine and Nursing 12:00 noon (CT)

Thursday, September 25, 2015

Joint Boards Members Present:
Kevin Bjordahl, MD, Walter Carlson, MD; Mary Carpenter, MD; David Erickson, MD; Laurie Landeen, MD; Brent Lindbloom, DO; Darlene Bergeleen, RN; June Larson, RN; Mr. Adrian Mohr; Jean Murphy, RN; Nancy Nelson, RN; Sharon Neuharth, LPN; Kristin Possehl, RN; Mary Schmidt, LPN.

Joint Boards Members Absent: Ms. Deb Bowman; Mr. David Lust; Dr. Jeffrey Murray; Diana Berkland, RN; Christine Callaghan, LPN; Ms. Betty Oldenkamp.

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

Nursing Board Staff Present: Gloria Damgaard, RN; Linda Young, RN; Ms. Jill Vanderbush; Ms. Erin Matthies;

Counsel: Kristine Kreiter O'Connell

1. Dr. Brent Lindbloom, presiding officer of the Joint Boards of Medicine and Nursing, called the meeting to order at 12:00 noon. Roll was called and a quorum was confirmed.
2. A motion: to approve the minutes of the September 11, 2014 Joint Boards meeting was ratified by roll call vote (Carlson/unanimous).
3. A motion: to approve the agenda was ratified by roll call vote (Possehl/unanimous)

4a. A motion: to designate the office of the Board of Nursing as the principal office for the Joint Boards was ratified by roll call vote (Carlson/unanimous).

4bi. A motion: to direct staff to move forward with the administrative rules process for medical assistants in *ARSD* Chapter 20-78 was ratified by roll call vote (Carlson/unanimous).

4bii. Ms. Damgaard provided background information on the statewide goal of improving access to healthcare for the citizens of South Dakota. The Boards were instructed by the Department of Health to review statute and rule in order to rule out any current barriers to access to healthcare. The revised draft of the definition of direct supervision for medical assistants was presented with a request that the Joint Boards move forward in the administrative rules process to define direct supervision as occurring by electronic communications. A motion to approve the draft revision was ratified by roll call vote (Carlson/unanimous). Ms. Damgaard then presented proposed revisions to ARSD 20:62 for certified nurse practitioners and certified nurse midwives rules related to collaboration by direct personal contact. It was requested that the Joint Boards consider updates to the definitions of collaboration and direct personal contact to allow the collaboration to take place by means of electronic communication. A motion to direct the staff to move forward in the administrative rules process to revise the definition of collaboration and direct personal contact as occurring by electronic communications in *ARSD* 20:62:03:03 and *ARSD* 20:62:03:04, and to repeal *ARSD* 20:78:03:05 was ratified by roll call vote (Murphy/unanimous).

4biii. A motion to instruct the staff to move forward with the administrative rules process in revising *ARSD* 20:62:01:02 to strike the requirement of a September date for the Joint Boards annual meeting was ratified by roll call vote (Carlson/unanimous).

4c. Election of officers: a motion to elect Nancy Nelson as the presiding office of the Joint Boards was ratified by roll call vote (Possehl/unanimous). A motion to elect Dr. Laurie Landeen as the secretary of the Joint Boards was ratified by voice vote (Carlson/unanimous). Dr. Landeen abstained.

5. A motion to approve the consent agenda was ratified by roll call vote (Carlson/unanimous).

There being no further business the meeting adjourned at 12:45 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.

During the South Dakota Association of Healthcare Organizations (SDAHO) 2015 Annual Meeting, Board of Medical and Osteopathic Examiners Executive Director Margaret B. Hansen was honored with the *SDAHO Distinguished Service Award – State Official*. The awards ceremony was Thursday, September 24, 2015 at the Sioux Falls Convention Center.

Additional Advisory and Staff Meetings:

Advanced Life Support Committee met on August 10, 2015

1. The committee was updated on the EMS Stakeholders meetings
2. Discussed the Interstate Compact for EMS Personnel Licensure

3. Reviewed the opioid antagonist for first responders bill and discussed suggestion for the rulemaking process

Athletic Trainer Committee met on August 12, 2015

1. Reviewed recommended changes to administrative rules – will be sharing with the SD Athletic Training Association for their feedback
2. Discussed the Sports Medicine Licensure Clarity Act of 2015 and its potential impact
3. Report was given on the Athletic Trainer Board of Certification Regulatory Conference

Nutrition and Dietetics Committee met on August 13, 2015

1. Reviewed a licensing question
2. Reviewed comments from on the recommended continuing education rules
3. Committee member Nicole Reuswaat will be leaving the committee and a search for a replacement has begun

Genetic Counselor Committee met on August 11, 2015

1. The recommended changes to statute were distributed and the committee reviewed comments
    a. The recommended changes are updates related to organizations changing names

Occupational Therapy Committee met on August 17, 2015

1. The recommended changes to the administrative rules had been shared with the state OT association. The committee reviewed those comments
    a. These rule changes are anticipated to be ready for Board review in December

Physical Therapy Committee met on August 25, 2015

1. The committee was updated on the FSBPT Leadership Issues forum attended by Tyler Klatt
2. The committee was updated on the SD Physical Therapy Associations discussion regarding the recommended continuing education rule.
    a. Changes based on that input and previous discussions will be put into a final recommendation that will be shared with the SDPTA for further input

Respiratory Therapy Committee met on August 26, 2015

1. Reviewed results of the continuing education audit

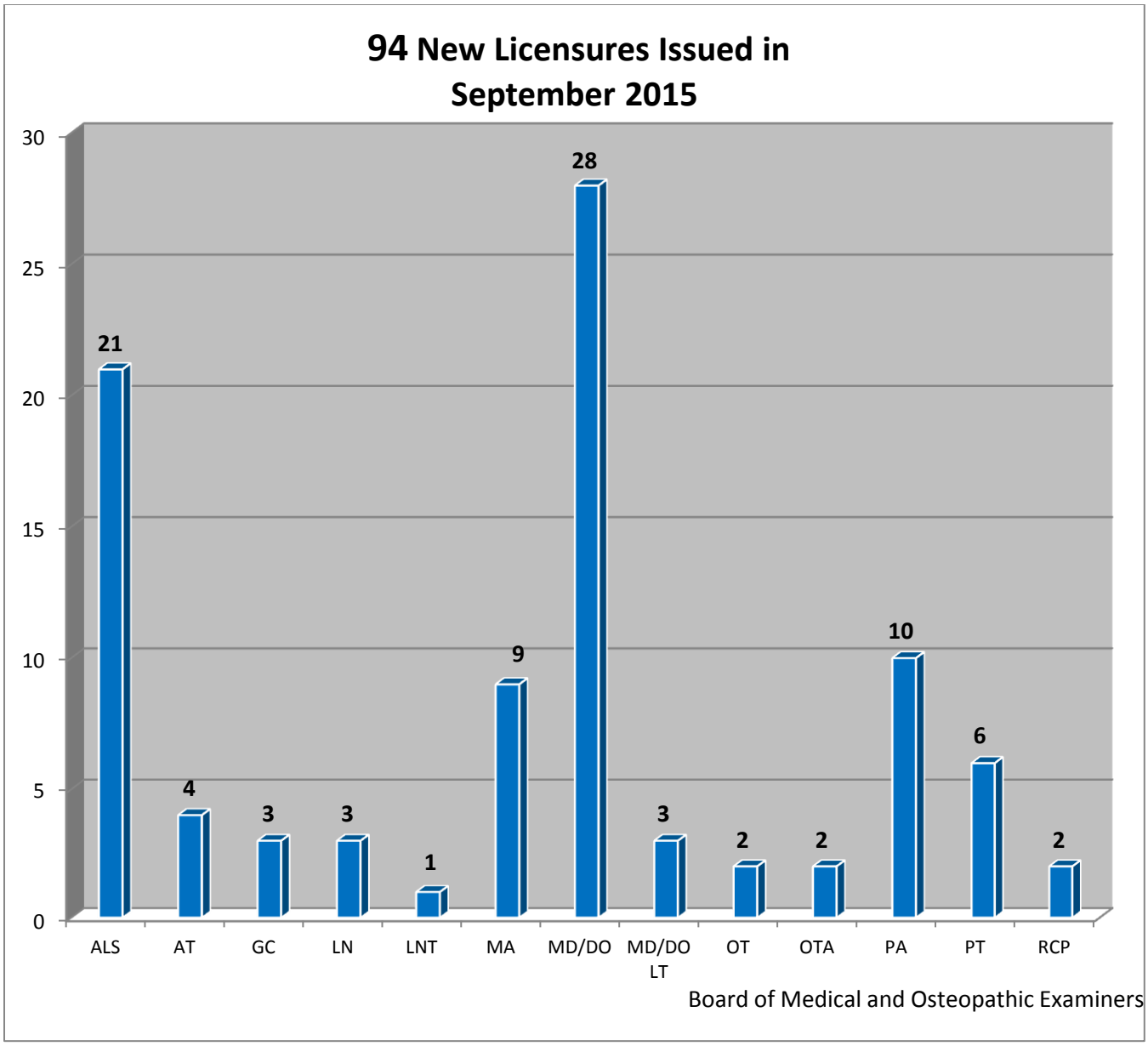
Physician Assistant Committee met on August 19, 2015

1. The committee reviewed a question regarding supervision when the supervising physician is the spouse of the physician assistant
    a. The committee found no established policy that prohibited this relationship

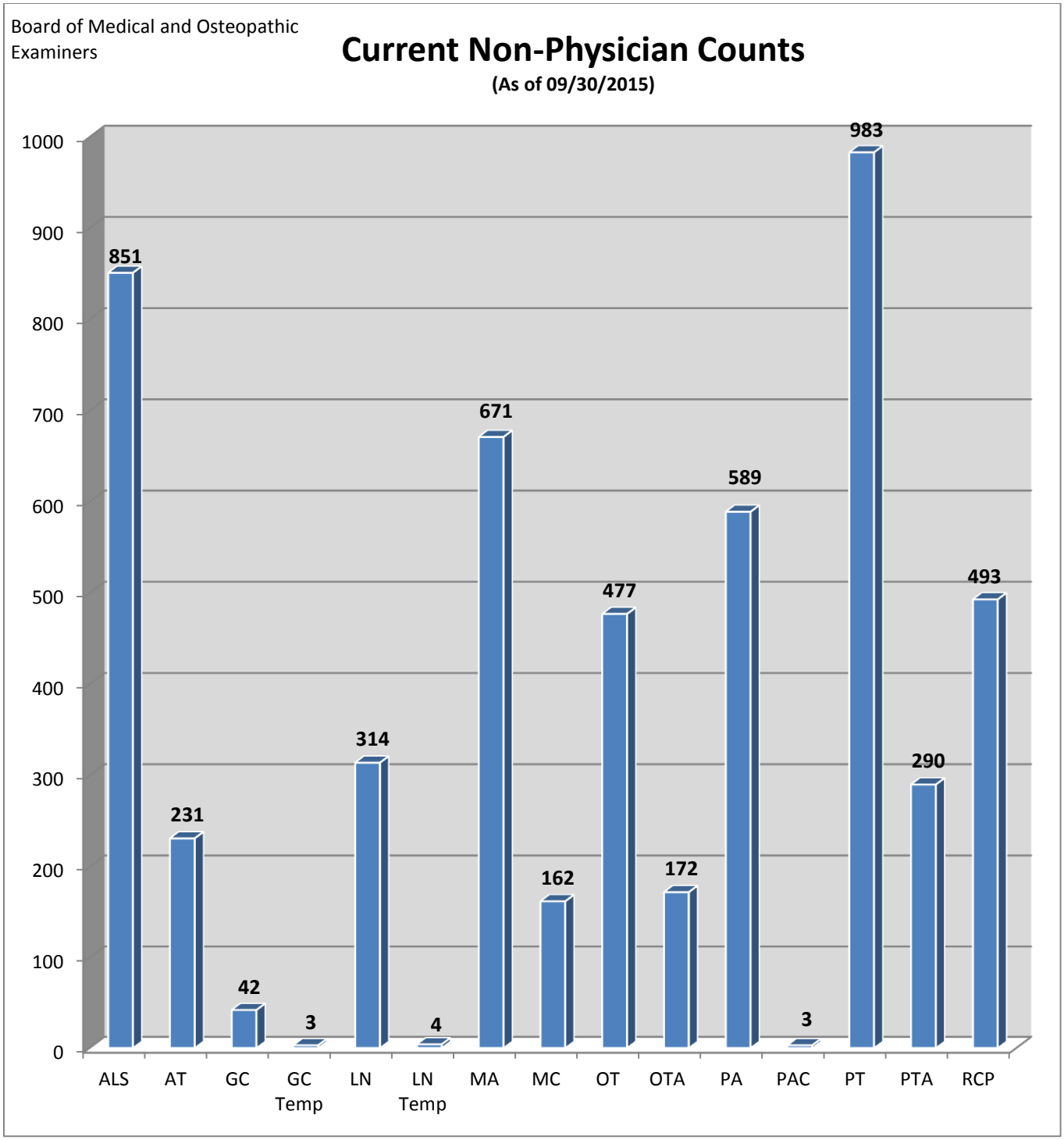
Staff from the Office of EMS and the BMOE met in Chamberlain on September 14 to meet and discuss the processes that each office uses.

Tyler Klatt attended the 50 State Meeting to Prevent Opioid Overdose and Addiction September 17-18.

Statistics



ALS – Advanced Life Support (EMT)
AT – Athletic Trainer
GC – Genetic Counselor
LN – Licensed Nutritionist/ Dietitian
LNT – Licensed Nutritionist/ Dietitian Temp
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
RCP – Respiratory Therapy



ALS – Advanced Life Support (EMT)
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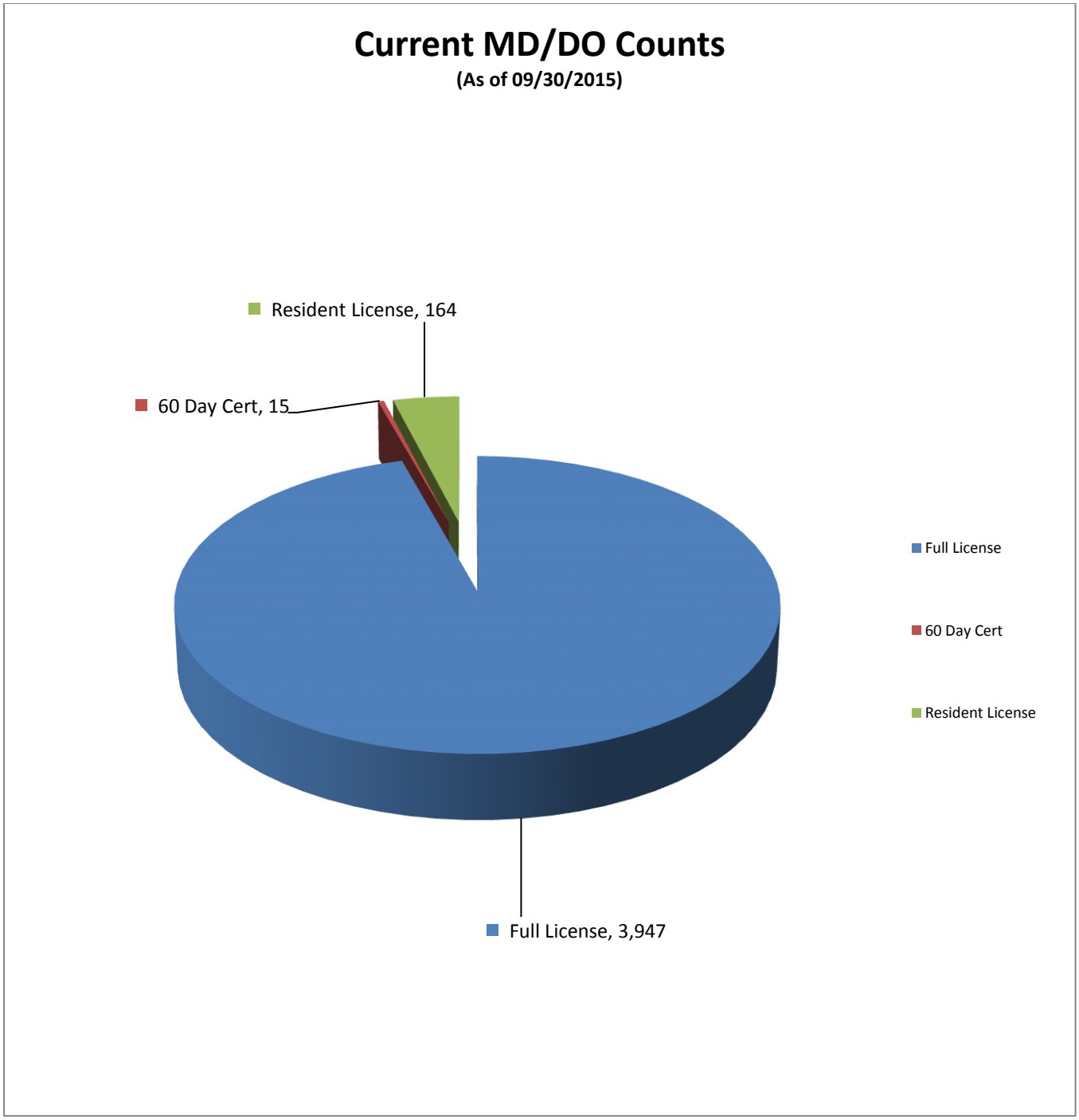
GC – Genetic Counselor
LN – Licensed Nutritionist
MA – Medical Assistant
MC – Medical Corporation
OT – Occupational Therapist
OTA – Occupational Therapy Assistant
PA – Physician Assistant
PAC – Physician Assistant Corporation
PT – Physical Therapist
PTA – Physical Therapist Assistant
RCP – Respirator Care Practitioner


Current MD/DO Counts
(As of 09/30/2015)
Resident License, 164
60 Day Cert, 15
Full License, 3,947
Full License
60 Day Cert
Resident License

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

Issues

Complaints:

Summary of new applications

1.) New Licenses were issued

a. 94 new licenses issued

b. 25 complex applications resolved or closed

Statistics

Investigations and Complaints
(As of 09/30/2015)

Category	New	On-going	Resolved
Complex Applications	28	43	25
Complaints/ Investigations	28	50	20
Competency (Malpractice cases)	0	351	0

Reinstatement and Renewal Applications
(As of 09/30/2015)

Category	New	On-going	Completed
Reinstatement and Renewal Applications	5	11	9

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	75	Licensing discussion
Phone/General Email	Licensees/ Applicants	2602	General questions
In-Office Assistance	Licensees/ Applicants	72	Renewal and general questions

Upcoming Events:

- **2015 Meeting Dates**
  - December 3
- **2016 Meeting Dates**
  - March 3, 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

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BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

October 2015

By BMOE Staff

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

Current/Past Events:

Training and Federation Meetings attended

Margaret Hansen and physical therapist Cathy Morcom attended the Federation of State Board of Physical Therapy meeting October 15 through 17.

Misty Rallis attended Board Investigator Training October 19 through October 23.

Dr. Mary Carpenter, William Golden and Margaret Hansen attended the Inaugural Interstate Medical Licensure Compact Commission Meeting October 26-28.

Current and Upcoming Advisory Committee and Staff Meetings:

Athletic Trainer Committee will meet on November 4, 2015

Nutrition and Dietetics Committee meet on a date TBD

Genetic Counselor Committee will meet on November 16, 2015

Occupational Therapy Committee will meet on November 5, 2015

Physical Therapy Committee met on November 29, 2015

1. The committee was updated on the FSBPT Annual meeting, attended by Cathy Morcom and Margaret Hanson
2. The committee was updated on the SD Physical Therapy Associations discussion regarding the recommended continuing education rule.

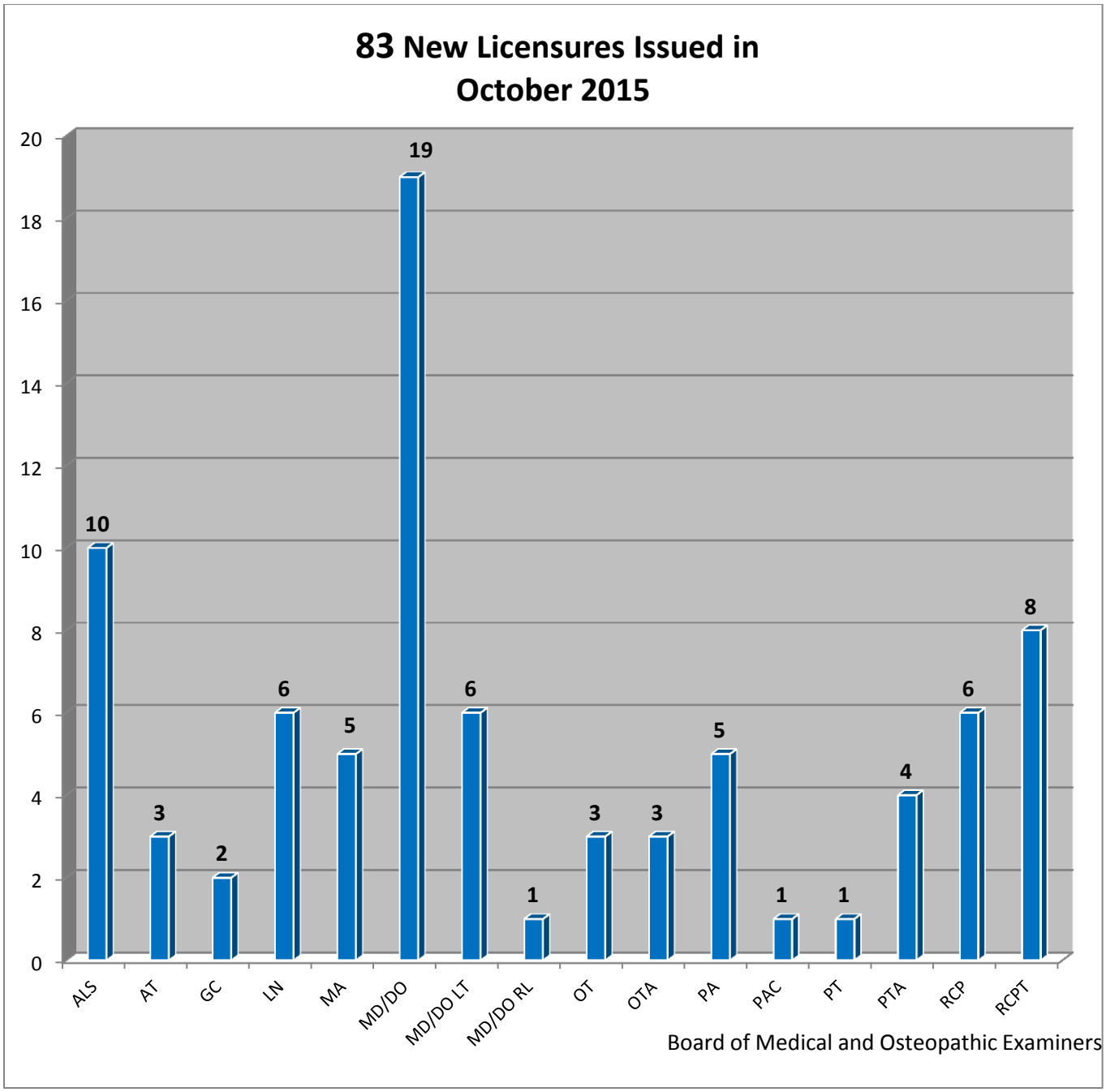
Respiratory Therapy Committee will meet on a date TBD

Physician Assistant Committee will meet on November 5, 2015

Staff from the Office of EMS and the BMOE met in Chamberlain on September 14 to meet and discuss the processes that each office uses.

Tyler Klatt attended the Lake Area Technical Institute Paramedic Program advisory meeting

Statistics



ALS – Advanced Life Support (EMT)
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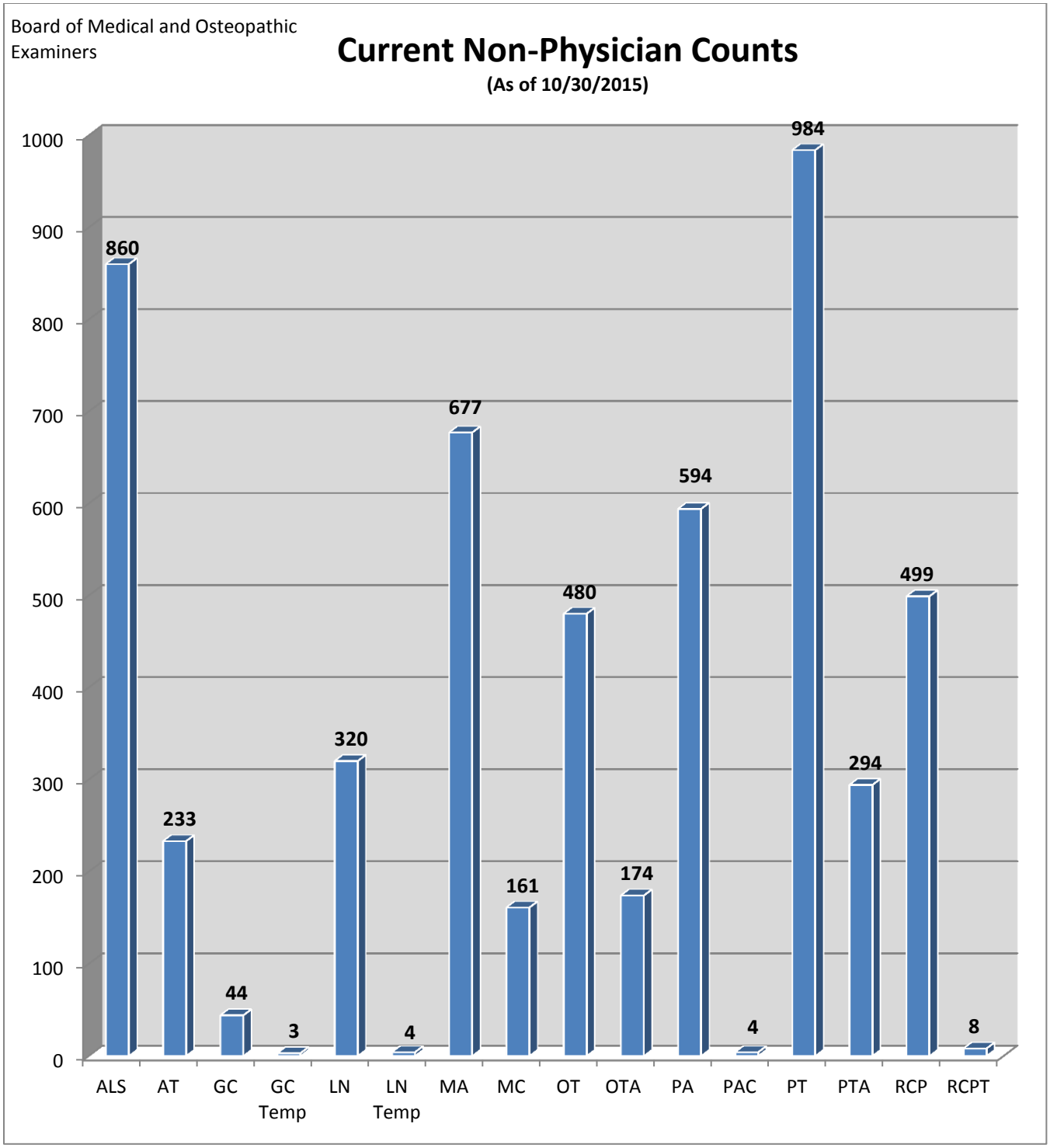
GC – Genetic Counselor
LN – Licensed Nutritionist/ Dietitian
MA – Medical Assistant
MD/DO – Medical License
MD/DO LT – Physician Locums Tenens
MD/DO RL – Resident License
OT – Occupational Therapist
OTA – Occupational Therapist Assistant
PA – Physician Assistant
PAC – Physician Assistant Corporation
PT – Physical Therapist
PTA – Physical Therapist Assistant
RCP – Respiratory Therapy
RCPT – Respiratory Therapy Temp Permit



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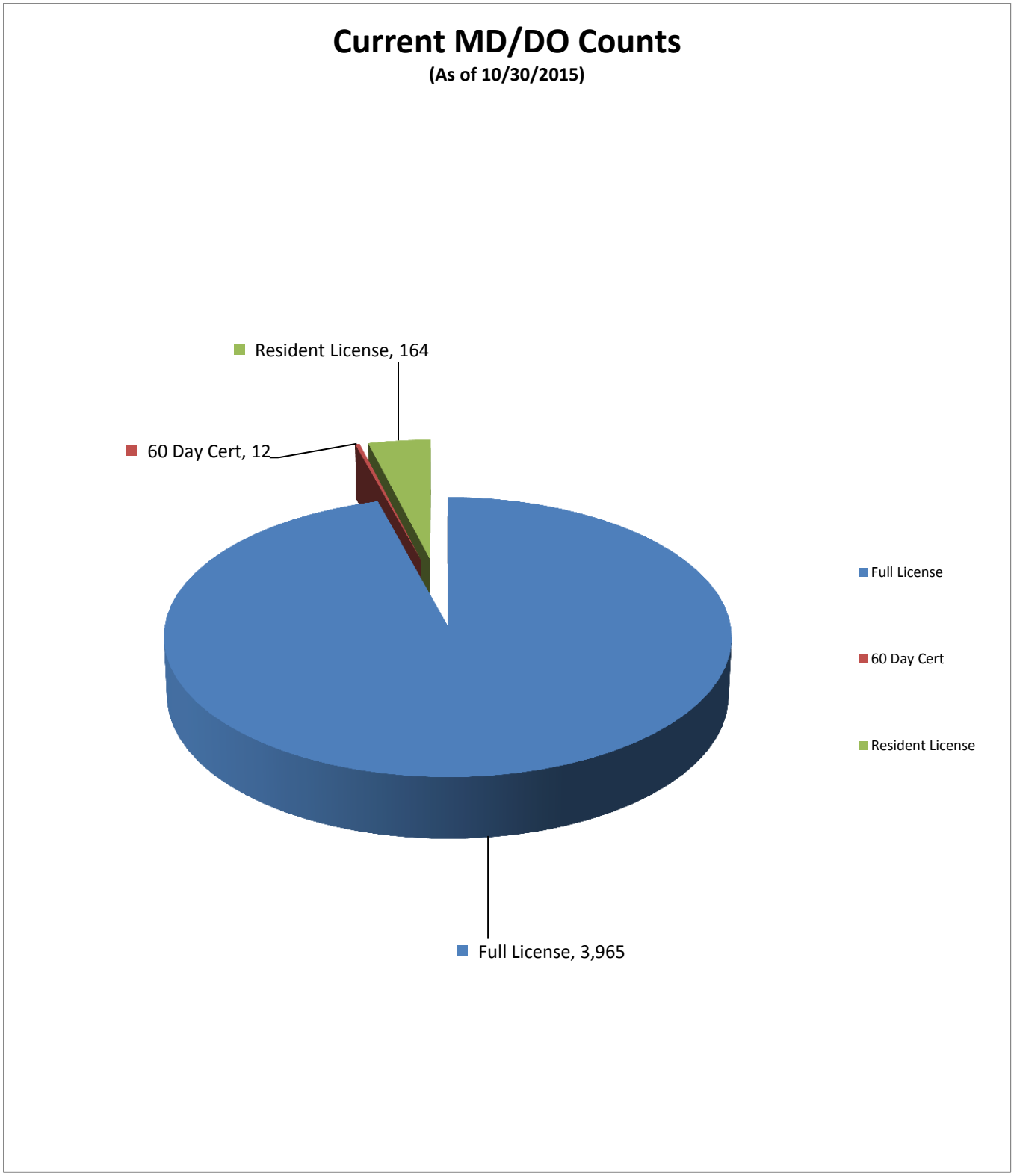
PAC – Physician Assistant Corporation
PT – Physical Therapist
PTA – Physical Therapist Assistant
RCP – Respirator Care Practitioner


Current MD/DO Counts
(As of 10/30/2015)
Resident License, 164
60 Day Cert, 12
Full License, 3,965
Full License
60 Day Cert
Resident License

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

Issues

Complaints:

Summary of new applications

1.) New Licenses were issued

a. 83 new licenses issued

b. 17 complex applications resolved or closed

Statistics

Investigations and Complaints
(As of 10/30/2015)

Category	New	On-going	Resolved
Complex Applications	21	46	17
Complaints/ Investigations	8	51	7
Competency (Malpractice cases)	0	375	0

Reinstatement and Renewal Applications
(As of 10/30/2015)

Category	New	On-going	Completed
Reinstatement and Renewal Applications	5	11	6

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	80	Licensing discussion
Phone/General Email	Licensees/ Applicants	2702	General questions
In-Office Assistance	Licensees/ Applicants	85	Renewal and general questions

Upcoming Events:

- **2015 Meeting Dates**
  - December 3
- **2016 Meeting Dates**
  - March 3, 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

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

November 2015

By BMOE Staff

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

Current/Past Events:

Training and Meetings attended

Margaret Hansen attended the Administrators in Medicine (AIM) fall workshop and board of directors meeting the first week of November. She is the current president of AIM

The Interstate Medical Licensure Compact (IMLC) committees have been actively meeting via teleconference. Margaret Hansen is the Chair of the IMLC committee, and a member of both the IMLC Bylaws and Rules and the IMLC Personnel committees. A summary of the inaugural IMLC Commission meeting is attached to last page of this report.

The database vendor, Albertson Consulting has begun the process of transferring BMOE data to its Big Picture product. The Albertson Consulting project manager and transition team will have weekly phone call updates with BMOE staff with Randi Sterling taking the lead on the project for the BMOE>

Current and Upcoming Advisory Committee and Staff Meetings:

Advanced Life Support Committee met on November 10, 2015

1. The committee discussed the upcoming rule hearing on opioid overdose prevention
2. Discussed future changes to the statutes and rules
3. Reviewed ways to inform the membership of the SD EMT Association

Athletic Trainer Committee met on November 4, 2015.

1. Discussed if any barriers to care exist related to athletic training
2. NATA will be presenting changes regarding educational programs – expected to be released fall 2016
3. Reviewed a question regarding displaying professional credentials

Genetic Counselor Committee met on November 16, 2015

1. Dr. Benn has stepped down from his position on the committee – the members were asked to assist in finding potential new members
2. Discussed changes to statute – it is anticipated that Sanford and Avera will be taking charge of these changes during the 2016 legislative session

Nutrition and Dietetics Committee met on November 17, 2015

1. Discussed the open position on the committee and the new nominee Mariah Weber
2. Reviewed the continuing education rule and the process for rulemaking.

Occupational Therapy Committee met on November 9, 2015

1. Reviewed questions from licensees regarding continuing education opportunities
2. Discussed comments received regarding the recommended administrative rule changes
3. Discussed supervision of OTA's and whether or not any inefficiencies exist

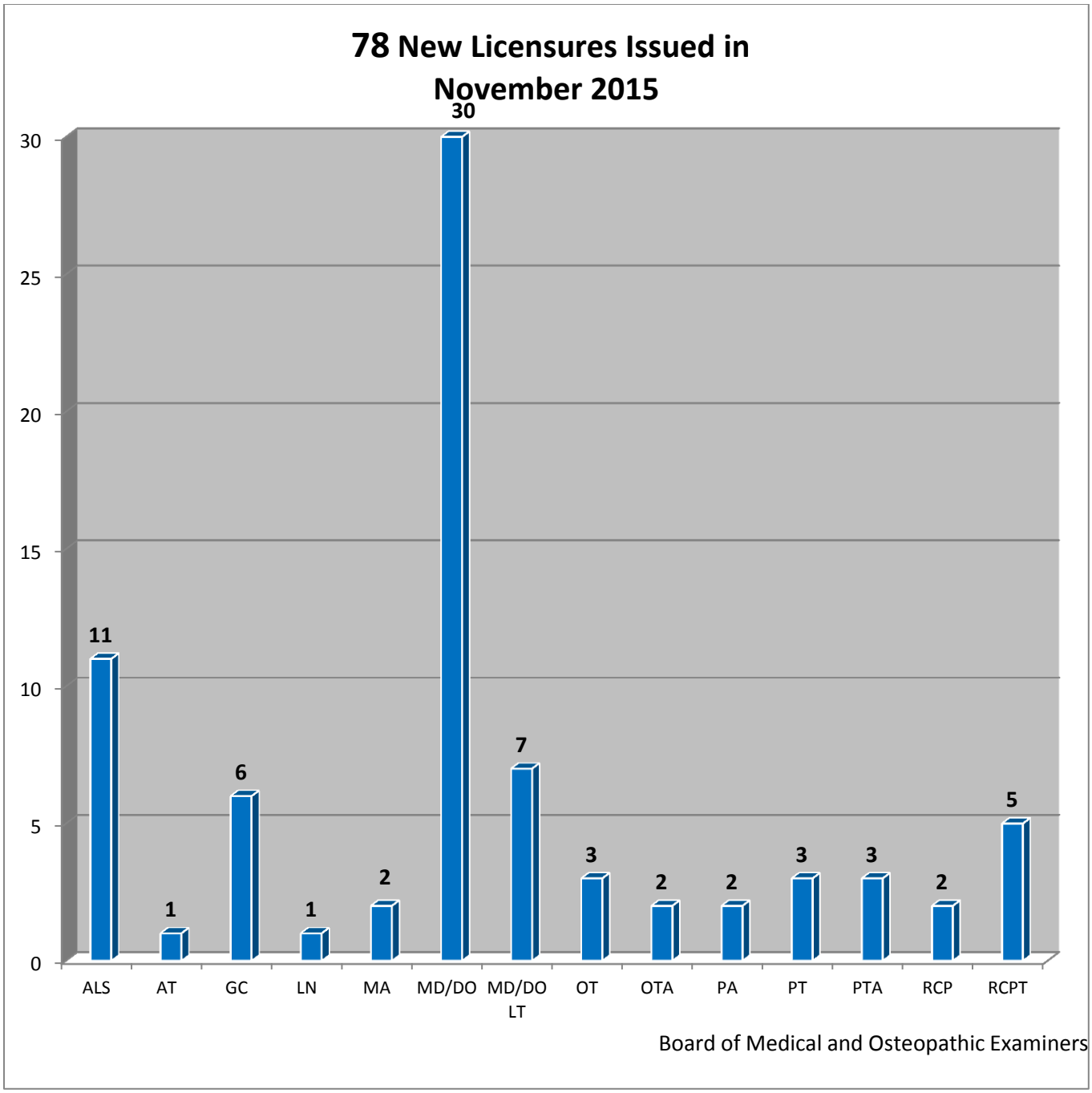
Physical Therapy Committee met on November 29, 2015

1. The committee was updated on the FSBPT Annual meeting, attended by Cathy Morcom and Margaret Hanson
2. The committee was updated on the SD Physical Therapy Associations discussion regarding the recommended continuing education rule.

Physician Assistant Committee met on November 5, 2015

1. Discussed the upcoming hearing for rules on opioid overdose prevention
2. Reviewed the potential changes to the nurse practitioners collaboration rule

Statistics



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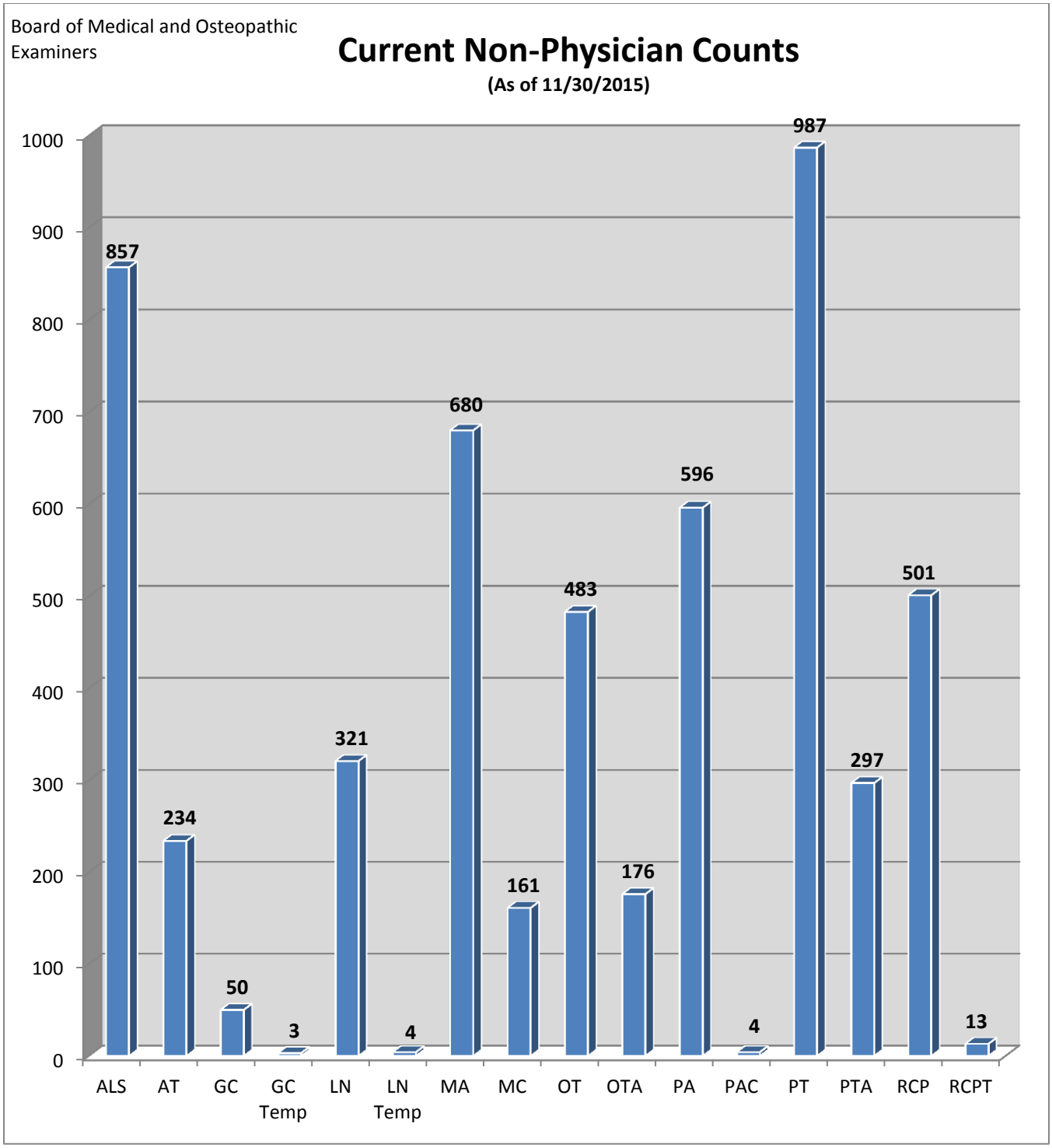

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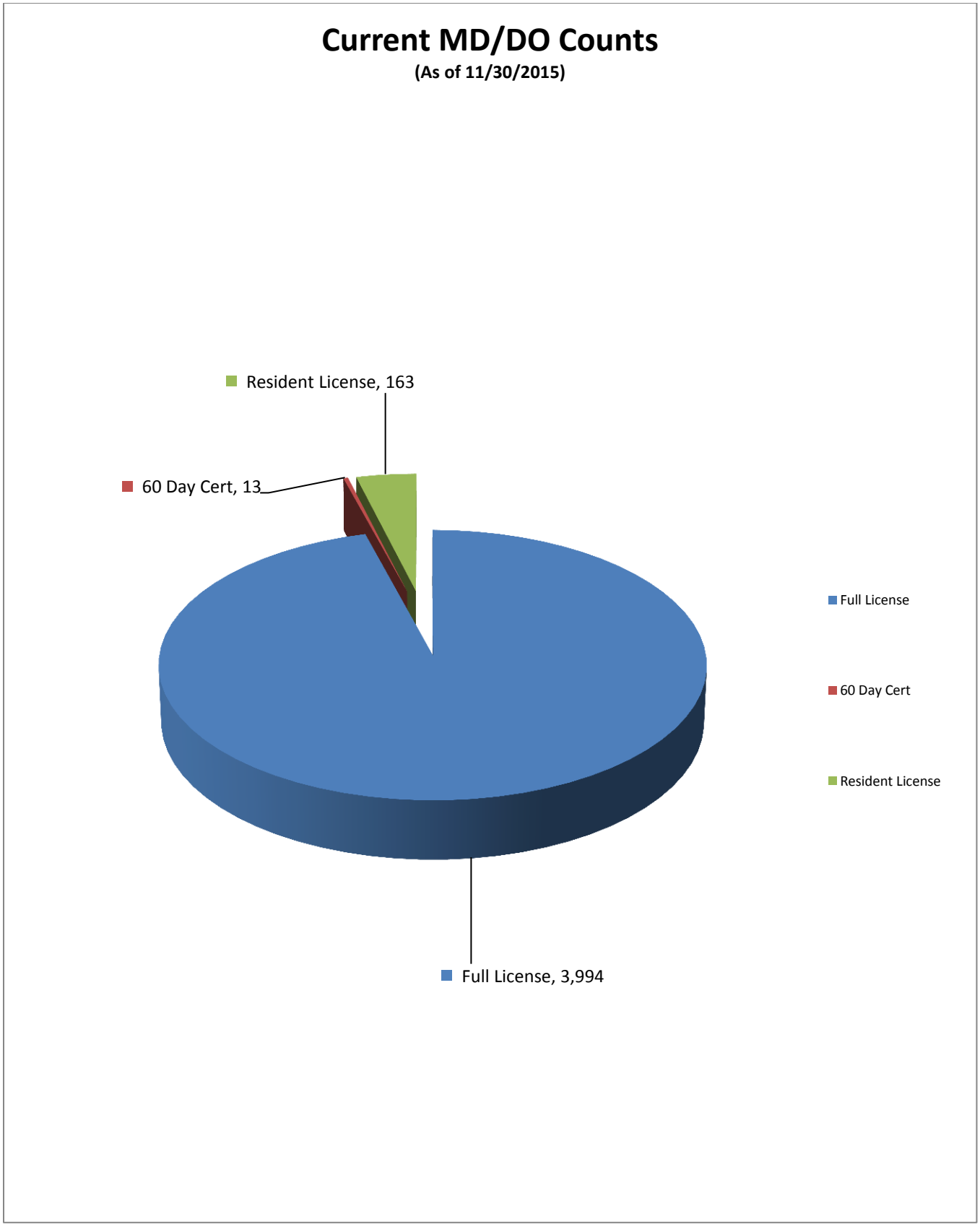
Current MD/DO Counts
(As of 11/30/2015)
Resident License, 163
60 Day Cert, 13
Full License, 3,994
Full License
60 Day Cert
Resident License

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

Issues

Complaints:

Summary of new applications

1.) New Licenses were issued

a. 78 new licenses issued

b. 15 complex applications resolved or closed

Statistics

Investigations and Complaints
(As of 11/30/2015)

Category	New	On-going	Resolved
Complex Applications	20	52	15
Complaints/ Investigations	16	46	21
Competency (Malpractice cases)	0	376	0

Reinstatement and Renewal Applications
(As of 11/30/2015)

Category	New	On-going	Completed
Reinstatement and Renewal Applications	5	15	5

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	67	Licensing discussion
Phone/General Email	Licensees/ Applicants	2525	General questions
In-Office Assistance	Licensees/ Applicants	150	Renewal and general questions

Upcoming Events:

- **2015 Meeting Dates**
  - December 3
- **2016 Meeting Dates**
  - March 3, 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

INTERSTATE MEDICAL LICENSING COMPACT COMMISSION
Inaugural Meeting Summary
October 27, 2015

The inaugural meeting of the Interstate Medical Licensure Compact (IMLC) Commission was held October 27th and 28th. The eleven member states included: Alabama, Idaho, Illinois, Iowa, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia, and Wyoming. Each member state was fully represented by both appointed commissioners.

Interested parties attended and were in the audience.

Commissioner Marquand reminded the Commission that the business of the commission would be conducted using Robert's Rules of Order and that each member state has two votes, one vote per Commissioner, that Commissioners vote as individuals and that there would be no proxy votes.

Presentations and main points:

Commissioners Mark Bowden, Margaret Hansen, Kevin Bohnenblust and Illinois Board attorney Daniel Kelber made presentations regarding parts of the Interstate Medical Licensure Compact, including these points:

- the commission must "drill down" on the application process as well as defining the rules and processes of applying
- the Commission can write rules regarding fees
- the compact recognizes the necessity of fees to serve as the operating budget for the commission.
- the commission would be responsible for the creation of a database that tracks
  - those who have been approved for licenses
  - all public disciplinary actions
  - complaints in member states
- the compact does not supersede state medical boards
- certain rules are mandated by the compact
- the commissioners were reminded that the rules are binding on all states even if a state voted against them, so long as the vote has a majority of votes in the affirmative.
- the commission must also establish rules for how member state boards provide information on investigations and disciplinary actions, and how that information is then shared.
- The commission must also raise funds and pay for the activity of the commission as well as hire an executive director and decide on a physical location for the office of the Commission.
- commissioners were reminded that they had a duty to represent the best interest of the states they were appointed to represent

The bylaws, as amended, were adopted without objection.

Elections of officers

After detailing the offices and duties, Commissioner Marquand informed the Commission that Mr. Elridge had created ballots for each office and that voting would be, per Robert's Rules, by secret ballot.

Commissioner Marquand was elected as Chairperson.
Commissioner Jon Thomas (MN) was elected as Vice-Chairperson.
Commissioner Shepard was elected as Secretary.
Commissioner Zachariah was elected as Treasurer.

Council of State Governments Presentation

Rick Masters and Colmon Elridge led the Commission in a discussion of potential funding sources and budgetary items the Commission would need to consider in their work:

- While most funds will come from licensing fees, budgeting will require assured funding sources which may include:
  - 1) a dues assessment
  - 2) grant monies
  - 3) flat fees paid by member states
  - 4) or a hybrid approach using some or all of the sources listed
- Budgetary items that must be considered include:
  - 1) accounting
  - 2) human resources for education and staffing
  - 3) legislative resources
  - 4) training
  - 5) IT services and support.

The plan must be developed by prioritizing the services to be provided with the available funding. There has to be a mechanism to track licensing data once licenses are issued, a bank account must be established, and an Executive Director should be hired within the first year with other staff as needed. The Council of State Governments has implementation guidelines that, upon the Commission's approval, can be provided.

The need to incorporate the Commission was discussed. However, for the protection of the Commission as a government body, this was not encouraged. Commission members discussed the importance of keeping the commission a separate entity and to keep its sovereign immunity through review of governmental rules and regulations.

The ability to utilize member states' resources was also discussed as well as review and comparison of other interstate compacts.

HRSA Grant Update

Lisa Robin, the HRSA Grant Administrator from the Federation of State Medical Boards,:

- The Federation applied for and received a HRSA grant in the amount of $225,446.00 for the Interstate Medical Licensing Project period of July 2015 through June 2016.
- Ms. Robin provided a breakdown of the budget established for the Interstate Compact in 2015-16 as follows:

	Grant Budget	Spent to Date	Amount Remaining
Travel:	$142,500	$36,151	$106,349

Consultant Costs:	57,946		57,946
Personnel:	25,000		25,000
TOTAL	$225,446	$36,151	$189,295

Dr. Ralph Loomis from the Federation of State Medical Boards Foundation reported that the Foundation will soon be accepting applications for a total of $60,000 for individual board members of the Interstate Medical Licensing Compact. The question was asked if the IMLC could apply for the $60,000 total and Dr. Loomis will check into this and let the Commission know.

Public comments received included:

- No state assessments; watch and consider state board fees. Many states have funding issues already and the idea of member board fees may discourage many state legislatures
- How fast and how soon can a compact license be issued
- Will fees increase for non-participating compact physicians?
- Executive Director needed as soon as possible
- Quick licensing timeline not as important as good licensing process
- Telehealth companies are different from telehealth providers
- What the licensing/renewal process will look like
- Will Maintenance of Certification be required for compact license renewal
- Some states require physician profile information
- Information technology costs
- Transparency on administrative costs
- Rule making process
- Public access to Commission progress

Day 2 agenda consisted of discussion of the work plan, open discussion by the commissioners and time for public comment.

The next Commission meeting will be December 18, 2015, at the Utah Medical Board Offices in Salt Lake City with the intention to meet again in February and April 2016.

The following committees, membership, chairs and charges were approved:

	Charge	**Chair**	**Members**
FUNDING:	Seek alternative forms of funding, sources, deadlines.	Commissioner Thomas	Commissioner Ward Commissioner Clark Commissioner Zachariah Commissioner Smith
BUDGET:	Define budgetary needs for the next six months with FSMB coordination of HRSA grant.	Commissioner Zachariah	Commissioner Knittle Commissioner Feist Commissioner Steinagle
TECHNOLOGY:	Review existing resources and needs by surveying state medical board requirements and current verification sources.	Commissioner Bohnenblust	Commissioner Goetter Commissioner Lawler Commissioner Schneider Commissioner Thomas
BYLAWS/RULES:	Survey member states on needs and potential rules required.. 30 days needed to provide member-ship with any potential bylaws	Commissioner Bowden	Commissioner Hansen Commissioner Cousineau Commissioner Martinez Commissioner McGill

	changes.		
PERSONNEL:	Job description and potential costs for Executive Director. is available and what functionality is needed.	Commissioner Marquand	Commissioner Knittle Commissioner Longo Commissioner Hansen Commissioner Schneider
	Charge	Chair	Members
COMMUNICATIONS:	Getting information out to public, imaging, what belongs on the website.	Commissioner Hansen	Chairman Marquand Secretary Shepard

The Commission Officers were designated to serve as a coordinating committee for the seven approved committees.

Committees should have their reports out to the Coordinating Committee by December 4, 2015 and reports should be out to membership by December 11, 2015.

Council of State Governments was approved to continue in their role as administrative, legal and policy support as outlined in the HRSA grant during the implementation of the Interstate Medical Licensing Compact Commission.

Council of State Governments can also act as the communication hub for the Commission during this implementation. Separate dedicated email addresses can be established for Commission members with a dedicated website for the posting of agendas, minutes, reports for public and Commission access. However, for those member states who wish to use their state email addresses, permission is granted for that method of communication. The committee chairs will communicate directly with their members via email. CSG will not need to be involved in that communication. For other Commission communication, the emails established by CSG will be utilized by the Commissioners.

All member states were mandated to post meeting agendas on their individual websites until such time as the Commission has its own dedicated website. Motion was unanimously passed.

The Coordinating Committee can address direct inquiries from external parties. Regarding general public information requests, CSG as well as FSMB can handle press releases when authorized by the Commission via their current national lists of legislators, governors, judicial branch of government, healthcare entities, etc. No decision regarding press releases were made at the inaugural meeting.

A decision was made to post draft unapproved minutes as soon as possible and then post approved minutes after the next meeting of the Commission.

Chairman Marquand called us to the task of setting timelines. An original target date of July 1, 2016 to be ready to accept the first application for medical license issued using the compact expedited process, with the caveat that, if there are significant issues, a delay would be considered. Discussion ensued regarding the amount of information that will be coming forth at the December 18th Commission meeting which would have great impact on how soon the Commission would be ready to approve a license using the compact expedited pathway. Final decision was to table the July 1, 2016, target date until the December 18th meeting.

Chairman Marquand asked each member state to report back at the December meeting on their state's readiness to implement the compact license.

Dr. Roy Mortinsen, medical director of Vermillion/Clay County Emergency Medical Services, is submitting a Petition asking that the Board approve procedures not included in the South Dakota scope of practice for the Advanced EMTs (AEMT) including:

- 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

The attached petition provides an outline of the proposed education and training plan.

The staff has researched this proposal and finds that with the proposed training plan that AEMTs will:

- receive appropriate education and training
- will be able to demonstrate competency prior to performing the procedures under medical direction
- there will be continuing education and training provided on a regular basis so that the AEMT personnel will maintain competency

The Board's ALS advisory committee reivewed the petition as well. The committee and Board staff have no concerns with the exception of the use of Flumazenil (IV) for benzodiazepine overdoses. The ALS committee members were not aware that Flumazenil was being used in emergency rooms, and they cautioned its use on patients that are on long-term benzodiazepines.

State of South Dakota
Board of Medical and Osteopathic Examiners

Petition

Pursuant to the provisions of SDCL 1-26-15, Roy Mortinsen, M.D., FAAFP, of 20 South Plum Street Vermillion, SD, a Family Practice Physician working in the emergency department and Medical Director of Vermillion/Clay County Emergency Medical Services, and Matthew Callahan, a Paramedic working as the divisional chief of Vermillion/Clay County Emergency Medical Services, do hereby petition the South Dakota Board of Medical and Osteopathic Examiners for their decision in regard to the following:

1. The Board Action in question is as follows: Due to South Dakota's rural settings and that the systems cannot support or justify full time paramedic level of care we request approval to administer medications and perform skills to be granted to Advanced Emergency Medical Technicians (A-EMT) (SDCL 36-4B-16.2) 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 division chief for the Vermillion/Clay County Emergency Medical Services (VCCEMS). The petitioners oversee all emergency medical technicians employed under VCCEMS. VCCEMS currently mandates bi-annual training on advanced airway adjuncts and epi-auto injector. The proposed skills would be added to the bi-annual training to ensure competencies for the provider permitted to conduct advanced level skills. Proposed medications will be reviewed and Advanced Emergency Medical Technician (A-EMT) trained on an annual basis. Any A-EMT not demonstrating proficiency will be remanded for a didactic review and clinical practice. Proficiency will be evaluated during the peer-reviewed committees and bi-annual training. Further education will include American Heart Association Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and International Trauma Life Support.

   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 Examiners[1].

A. The Advanced Emergency Medical Technician Scope of Practice[2] allows for pediatric intraosseous (IO) infusions of medications and fluids for shock therapy. The scope does not allow for the A-EMT 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 prehospital setting. We are petitioning the board to approve A-EMT to utilize IO devices for adult therapy in emergent situations.

B. The Advanced Emergency Medical Technician Scope of Practice[2] does not allows for continuous positive airway pressure (CPAP) ventilation devices for oxygen therapy in those patients experiencing severe respiratory distress. Several peer-reviewed studies have demonstrated improvement in the patient's condition in a prehospital setting after use of CPAP[7-9] CPAP is a safe, non-invasive therapy. There are some states allow BLS trained EMT's to use CPAP (including Illinois, Wisconsin and North Dakota). We hereby request approval for the use of a positive pressure ventilator to be utilized with appropriate patients in severe respiratory distress due to a medical issue.

C. Medications currently provided by the A-EMT Scope of Practice[2] include: albuterol, nitroglycerin, epinephrine, aspirin, glucagon, dextrose 50%, naloxone, glucose, and oxygen. Medication delivery techniques taught in the National Highway Transportation Safety Administration Scope include: intravascular, intraosseous, intramuscular, subcutaneous, intranasal, sublingual, and oral delivery. We are requesting the following nonscheduled controlled medications to be added for use by Advanced Emergency Medical Technicians: flumazenil (IV) for benzodiazepine overdoses, diphenhydramine (IV) for allergic reactions and long rural travel times, Zofran (ondansetron) (PO and IV) for nausea and vomiting, and epinephrine 1:10,000 (IV/IO) for cardiac arrests as directed by ACLS protocols.

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 Vermillion, South Dakota, this _____ day of _____, 20____.

_____ _____

Matthew Callahan, NREMT-P Roy Mortinsen, M.D., FAAFP

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). Prehospital intravenous fluid therapy: Physiologic computer modeling. *Journal of Trauma 26(9)*, 808-811.

5. Miner, W., Corneli, H., Bolte, R., et al. Prehospital use of intraosseous infusion by paramedics. *Pediatric Emergency Care 5(1)*, 5-7, 1989.

6. LaRocco, B., Wang, H. (2003). Intraosseous infusion. *Prehospital Emergency Care 7(2)*, 280-285.

7. Bruge P., Jabre P., Dru M., et al. An observational study of noninvasive positive pressure ventilation in an out-of-hospital setting. Am J Emer Med. 2008; 26:165–9.

8. Hubble MW, Richards ME, Jarvis R., Millikan T., Young D. Effectiveness of prehospital continuous positive airway pressure in the management of acute pulmonary edema. Prehosp Emerg Care. 2006;10: 430–9.

9. Kallio T., Kuisma M., Alaspaa A., Rosenberg PH. The use of prehospital continuous positive airway pressure treatment in presumed acute severe pulmonary edema. Prehosp Emerg Care. 2003;7: 209–13.

What is the reason for the request?

Vermillion is the county seat of Clay County, which lies in the southeast corner of the state. Clay County is an extremely rural area with little paramedic services available. By providing high quality education to AEMTs, they will be able to provide high quality patient care in the most emergent settings.

What duties, procedures, medications, etc. are requested?

We are requesting that AEMTs be allowed to start Adult IOs and administer CPAP. We are also requesting the following medications: Benadryl IV, Epinephrine 1:10,000 IV, Flumazenil IV, and Zofran PO/IV.

What risks are associated with the requested duties, procedures, etc?

The main risks of an Adult IO are infection and pain. The main risk to CPAP is that if a pneumothorax is present, the positive pressure may make it worse. There are many drug side effects and interactions possible. Some of the risks the AEMTs will face include: flumazenil could cause a seizure in patients that are on long-term benzodiazepines; diphenhydramine could cause sedation and confusion; Zofran may cause prolongation of the QT interval; epinephrine given for cardiac arrest during a code may cause pulmonary edema and arrhythmias.

What training must be completed?

All providers that will fall under this expanded scope of practice will be required to complete additional initial training that is beyond the standard AEMT curriculum. Training will include at minimum AHA ACLS 12 hour course, with a 4-hour minimum of Pharmacology education. Pharmacology education will be taught primarily from the Paramedic Practice Today[1]. Two hours of training will focus on medication administration and medication math from Paramedic Practice Today[1]. All personnel will have a written and practical test. The written test must be passed with a minimum score of 80% and the practical exam will be pass/fail based off the NREMT scoring sheets.

Who should provide the training?

Dr. Roy Mortinsen, MD, EMS Medical Director, and Matthew Callahan, EMS Division Chief and Paramedic Lead Instructor will conduct all initial training.

Will there be ongoing continuing education provided to the petitioners? If so, who should provide the continuing education and how often should it be provided?

A competency-based hands-on training every six months and review of procedures and drugs will be worked into monthly continuing education. Dr. Roy Mortinsen and Matthew Callahan will provide all ongoing continuing education.

Are logs required that document the number of these advanced procedures/duties performed, who performed them, the number of times the procedures/duties were performed, and description of any adverse effects for review in the event of an audit?

Running a search in our EPCR program may retrieve all statistics and data. All adverse effects are required to be documented in the EPCR.

References:

1. Paramedic Practice Today by *Aehlert, Copyright 2010 by Mosby, Inc.*

ARTICLE 20:47
PHYSICIANS AND SURGEONS

CHAPTER 20:47:03 LICENSURE

Section

20:47:03:13. Locum tenens certificate

20:47:03:13. Locum tenens certificate. A locum tenens certificate holder may extend the initial sixty day locum tenens certificate an additional sixty days if the certificate holder is in the process of applying for a full license as described in SDCL 36-4-11. The certificate holder shall be responsible for notifying the Board to extend the initial certificate.

Source:
General Authority: SDCL 36-4-35
Law Implemented: SDCL 36-4-20.4

ARTICLE 20:63

ATHLETIC TRAINERS

Chapter
20:63:01 General provisions.
20:63:02 Licensure requirements.
20:63:03 Continuing education.

CHAPTER 20:63:01

GENERAL PROVISIONS

Section
20:63:01:01 Definitions.
~~20:63:01:05 Length of internship.~~

20:63:01:01. Definitions. Words used in this article mean:

(1) "Team or treating physician," a person licensed by the South Dakota Board of Medical and Osteopathic Examiners to practice medicine or osteopathy in the state of South Dakota and designated by an athletic team as its team physician; a licensed physician treating a particular individual with whom an athletic trainer is working;

(2) "Physician's written protocol," a written statement by the team physician indicating the functions and procedures allowed to be performed by the athletic trainer under the direction of the team physician;

(3) "College or university approved by the board," an institution of higher education fully accredited by a nationally recognized accrediting agency;

(4) "Athletic training course requirements," course work in the following subject matter areas: prevention and care of athletic injuries and illnesses; evaluation of athletic injuries and illnesses; first aid and emergency care; therapeutic modalities; therapeutic exercise; human anatomy; human physiology; exercise physiology; kinesiology/biomechanics; nutrition; psychology; personal/community health; instructional methods;

~~(5) "Board-approved internship," a period of time spent developing competence in athletic training skills under the direct supervision of a licensed athletic trainer~~.

(5) "Athletic training," in addition to the skills listed in SDCL 36-29-1(1), the practice of athletic training shall include the skills as listed in the National Athletic Trainers Association Athletic Training Education Competencies, 5th Edition, 2011;

(6) "BOC," the Board of Certification, Inc., or its successor.

Source: 13 SDR 9, effective August 4, 1986.
General Authority: SDCL 36-29-17.
Law Implemented: SDCL 36-29-1, 36-29-3.

Reference: National Athletic Trainers Association Athletic Training Education Competencies, 5th Edition, 2011. Copies may be obtained from https://caate.net/wp-content/uploads/2014/06/5th-Edition-Competencies.pdf.

~~**20:63:01:05. Length of internship.** Graduates of an athletic training curriculum approved by the National Athletic Trainers Association must complete an 800 hour internship. Graduates of a training program not approved by the National Athletic Trainers Association shall complete an 1800 hour internship.~~

~~**Source:** 13 SDR 9, effective August 4, 1986.~~
~~**General Authority:** SDCL 36-29-17.~~
~~**Law Implemented:** SDCL 36-29-3.~~

CHAPTER 20:63:02

LICENSURE REQUIREMENTS

Section
20:63:02:01 Application for licensure by examination.
20:63:02:02 Application for licensure by reciprocity.
20:63:02:06 Examination

20:63:02:01. Application for licensure by examination. An applicant for licensure by examination may apply for the ~~written and oral~~ examination following successful completion of athletic training course requirements ~~and a board-approved internship~~. The examination shall test for proficiency in the area of knowledge and skill required in SDCL 36-29-1~~(2)~~(1). ~~The applicant shall apply on a form provided by the board at least seven weeks before the scheduled date of the examination. The application shall show that the applicant meets the legal requirements for licensing and shall be accompanied by the fee required by § 20:63:02:05. The board or its designated representative shall interview the candidate prior to the written~~

~~examination. An applicant who has not successfully completed a course in therapeutic modalities must demonstrate competence in therapeutic modalities to a board-approved examiner.~~

Source: 13 SDR 9, effective August 4, 1986.
General Authority: SDCL 36-29-17.
Law Implemented: SDCL 36-29-3.

20:63:02:02. Application for licensure by reciprocity. An applicant for licensure by reciprocity shall file an application with the board on forms provided by the board. The applicant shall submit a certified copy of the applicant's current valid license from another state or territory or proof of certification from the ~~National Athletic Trainers Association~~ BOC.

Source: 13 SDR 9, effective August 4, 1986.
General Authority: SDCL 36-29-17.
Law Implemented: SDCL 36-29-5.

20:63:02:06. Examination. The examination approved by the board is the Board of Certification for the Athletic Trainer certification exam, or its successor.

Source:
General Authority: SDCL 36-29-17
Law Implemented: SDCL 36-29-3

CHAPTER 20:63:03

CONTINUING EDUCATION

Section
20:63:03:01 Continuing education requirements.
20:63:03:04 Waiver of continuing education requirements.

20:63:03:01. Continuing education requirements. To qualify for renewal of a license upon its expiration as prescribed in SDCL 36-29-11, an applicant for renewal must obtain ~~four~~ fifty continuing education units (CEUs) in a ~~three~~ two-year period. Any licensee who maintains certification by the Board of Certification shall meet the continuing education requirements of this chapter.

Source: 13 SDR 9, effective August 4, 1986.
General Authority: SDCL 36-29-17.
Law Implemented: SDCL 36-29-14.

20:63:03:04. Waiver of continuing education requirements. The board may excuse an applicant from the annual continuing competency requirements if the applicant submits an affidavit to the board that the applicant was prevented from completing the requirements because of illness or undue hardship.

Source:
General Authority: SDCL 36-29-17
Law Implemented: SDCL 36-29-14

ARTICLE 20:64

OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

Chapter

20:64:01 Definitions.
20:64:02 Licensure requirements.
20:64:03 Supervision.
20:64:04 Continuing competency.

CHAPTER 20:64:02

LICENSURE REQUIREMENTS

Section

20:64:02:01 Examination.
20:64:02:03 Limited permit.
20:64:02:04 Renewal of license.
20:64:02:05 Fees.

20:64:02:01. Examination. The examination approved by the board is the certification examination of the ~~American Occupational Therapy Certification Board~~ National Board for Certification of Occupational Therapy.

Source: 14 SDR 72, effective November 23, 1987; 22 SDR 61, effective November 5, 1995.
General Authority: SDCL 36-31-13.
Law Implemented: SDCL 36-31-6.

20:64:02:03. Limited permit. An applicant for a limited permit to practice occupational therapy must file an application with the board on forms provided by the board and must submit written evidence that the applicant has completed the education and experience requirements of SDCL chapter 36-31 and is scheduled to write the next certification examination of the ~~American Occupational Therapy Certification Board~~ National Board for Certification of Occupational Therapy. The fee for a limited permit prescribed by § 20:64:02:05 must be filed with the application. If the holder of a limited permit is notified by the board that the holder has failed the examination, the permit is invalid on the date the notice is received by the holder; and the holder must immediately return the permit to the board. An application for a one-time renewal of the limited permit shall be submitted to the board on forms provided by the board together with the prescribed limited permit fee and evidence that the applicant is scheduled to write the next certification examination of the ~~American Occupational Therapy Certification Board~~ National Board for Certification of Occupational Therapy. The holder of a limited permit shall maintain on

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file with the board a current statement providing the name and address of any person or institution that employs the holder during the period the permit remains in force.

Source: 14 SDR 72, effective November 23, 1987; 22 SDR 61, effective November 5, 1995.
General Authority: SDCL 36-31-13.
Law Implemented: SDCL 36-31-5.

CHAPTER 20:64:04

CONTINUING COMPETENCY

Section
20:64:04:03 Reporting continuing education.

20:64:04:03. Reporting continuing education. To demonstrate compliance with the continuing education requirements, each occupational therapist and occupational therapy assistant shall sign a statement to confirm completion of the required CEU hours each year at renewal time, and shall present proof of completion if requested by the board. Any occupational therapist who maintains current certification by the National Board for Certification of Occupational Therapy (NBCOT) shall meet the continuing education requirements of this chapter.

Source: 14 SDR 72, effective November 23, 1987; 34 SDR 93, effective October 17, 2007.
General Authority: SDCL 36-31-13.
Law Implemented: SDCL 36-31-11.

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ARTICLE 20:83
NUTRITION AND DIETETICS

CHAPTER 20:83:04 CONTINUING EDUCATION

Section

20:83:04:01 Continuing education requirements

20:83:04:02 Reporting continuing education

20:83:04:03 Waiver of continuing education requirements

20:83:04:01 Continuing education requirements. To qualify for renewal of a license upon its expiration as prescribed in SDCL 36-10B-9, an applicant for renewal must complete at least fifteen hours of continuing education annually or an accumulation of a total of seventy-five hours of continuing education during a five year period.

Source:
General Authority: 36-10B-3
Law Implemented: 36-10B-9

20:83:04:02. Reporting continuing education. To demonstrate compliance with the continuing education requirements, each licensee under SDCL chapter 36-10B shall sign a statement to confirm completion of the required continuing education units each year at renewal time, and shall present proof if requested by the board. Any licensee under SDCL chapter 36-10B who maintains current registration by the Commission on Dietetic Registration shall meet the continuing education requirements of this chapter.

Source:
General Authority: 36-10B-3
Law Implemented: 36-10B-9

20:83:04:03 Waiver of continuing education requirements. The board may excuse an applicant from the continuing education requirements if the applicant submits an affidavit to the board that the applicant was prevented from completing the requirements because of illness or undue hardship.

Source:
General Authority: 36-10B-3
Law Implemented: 36-10B-9

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Supervision

A discussion at the June 2015 Board meeting prompted a question of whether or not supervision was appropriate if the supervision was over an immediate family member. The relationship between the supervisor and supervisee, in terms of familial relationship, is not discussed in statute or rule.

The American Academy of Physician Assistants was queried on this issue and responded that the only regulations they knew of, related to this question, are found in North Dakota.

North Dakota Administrative Code 50-03-01-03. Supervision contract requirements.

Upon undertaking the supervision of a physician assistant as contemplated by this chapter, the physician shall file with the board a copy of the contract establishing that relationship. That contract must be approved by the board of medical examiners.

The contract must be confirmed annually by completing and filing with the board such forms as are requested and provided by the board. The board must be notified within seventy-two hours of any contract termination or modification.

Every physician who supervises a physician assistant under this chapter must practice medicine in North Dakota. 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 of medical examiners. For purposes of this section, "immediate family" means a spouse, parent, child, or sibling of the supervising physician.[1]

This type of supervision is not mentioned in either The Code of Medical Ethics of the American Medical Association (ARSD 20:47:08:01)[2] or the American Academy of Physician Assistants Guidelines for Ethical Conduct (ARSD 20:52:02:01)[3].

[1] http://www.legis.nd.gov/information/acdata/pdf/50-03-01.pdf?20150813110017
[2] http://legis.sd.gov/Rules/DisplayRule.aspx?Rule=20:47:08:01
[3] http://legis.sd.gov/Rules/DisplayRule.aspx?Rule=20:52:02:01

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* * * \

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

IN THE MATTER OF:	)	NO. 14-189
	)	
COLIN JAY BOONE	)	AMENDED FINDINGS OF FACT AND
APPLICANT/EMT STUDENT STATUS	)	CONCLUSIONS OF LAW AND
	)	RECOMMENDATION
Respondent.	)	
	)	

This matter having been heard, pursuant to SDCL 36-4B-6, 31, SDCL 1-26 and South Dakota's Administrative Rules (ARSD) 20:78:04 and 05. Respondent, Colin Jay Boone, submitted an application for Advanced Life Support Student Status. Respondent's address as reported to the Board is 3409 51st St. #414 Sioux Falls 57106.

After investigation, a recommendation was made pursuant to ARSD 20:78:04:04 for the BMOE to deny his application for student status. Respondent 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.

Following findings of fact:

1. Mr. Boone submitted an application for a South Dakota Advanced Life Support Student Status on September 22 2014.
2. Mr. Boone was placed under investigation due to the federal charges and for investigation of his moral character.
3. On December 17, 2013, Mr. Boone was indicted for Unreasonable Use of Force under Title 18, United States Code, and Section 242. While acting

under the color of law as a police officer with the Des Moines Police Department he kicked O.P.H, willfully depriving him of his rights, secured and protected by the Constitution and Laws of the United States for freedom from the use of unreasonable force by a law enforcement officer.

4. BMOE staff requested copies of any and all police reports and court documents regarding the reported incident, and requested a detailed response from Mr. Boone. Mr. Boone failed to provide the requested information.
5. This matter was referred back to the hearing examiner by the Board so the parties could include addition evidence in the record.
6. The BMOE staff submitted the additional evidence of the verdict, sentencing memorandum, sentencing, and judgement of Mr. Boone.
7. Colin Boone was convicted of a felony and sentenced to sixty-three months in prison.

CONCLUSIONS OF LAW

1. Any Conclusion of Law deemed to be a Finding of Fact or vice versa shall be appropriately incorporated into the Findings of Fact or Conclusions of Law as the case may be;
2. The BMOE has subject matter jurisdiction over the parties in this matter under SDCL 36-4.
3. The allegations contained in the staff Petition are supported by clear and convincing evidence; however, Colin Jay Boone has the burden to show good moral character, and he failed to provide the information and

evidence. SDCL 36-4B-6 and 36-4B-31 *See In the Matter of Brett Jarman* 2015 S.D 8

4. Colin Jay Boone's application is not complete due to his failure to supply the requested information, and he has exceeded the time allowed by rule to complete his application.
5. Colin Boone was convicted of a felony which demonstrates a lack of good moral character, and is grounds to deny a license. *In re Benton 691 N.W. 2d 598, (2005)*
6. Timely notice has been provided to Colin Jay Boone for all hearings pursuant to SDCL 1-26 and ARSD 20:78:05:04.
7. It is recommended that Colin Jay Boone's application be denied.

Dated this 30th day of July, 2015.

Hearing Examiner: Paul Henry

1 SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

2 *

3 IN THE MATTER OF: * TRANSCRIPT OF

4 THE LICENSE APPLICATION OF * HEARING

5 COLIN J. BOONE *

6 *

7

BEFORE: Mr. Paul E. Henry, Hearing Examiner
8 300 North Dakota Avenue, Suite 216
Sioux Falls, South Dakota 57104

9

APPEARANCES: Mr. William H. Golden
10 Assistant Attorney General
317 North Main Avenue
11 Sioux Falls, South Dakota 57104

12 Attorney for the South Dakota Board of
Medical and Osteopathic Examiners.

13

ALSO PRESENT: Ms. Margaret B. Hansen, PA-C, MPAS
14 Executive Director
South Dakota Board of Medical and Osteopathic
15 Examiners

16 Ms. Misty Rallis
Board Investigator
17 South Dakota Board of Medical and Osteopathic
Examiners

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PROCEEDINGS: The above-entitled matter came on for hearing
19 on the 17th day of July, 2015, commencing
at the hour of 9:37 a.m. at the Conference
20 Room of the South Dakota Board of Medical and
Osteopathic Examiners, Sioux Falls, South
21 Dakota.

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INDEX TO WITNESSES

	Direct	Cross	Redirect	Recross
FOR THE BOARD:				
MISTY RALLIS				
By Mr. Golden:	4			
Board rests: 6				

INDEX TO EXHIBITS

BOARD EXHIBITS

NUMBER	DESCRIPTION	MARKED	OFFERED	RULED ON
1	USA v. Boone Verdict Form.	3	5	5
2	USA v. Boone Judgment.	3	5	5
3	USA v. Boone Clerk's court minutes - sentencing.	3	5	5
4	USA v. Boone Sentencing Memorandum Opinion and Order.	3	5	5

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

(Board Exhibit Numbers 1, 2, 3, and 4 marked for identification.)

HEARING EXAMINER HENRY: Let's go on the record then at this time. It's approximately 9:37 and this is the time and place set on this date, July 17, for additional hearing on the matter regarding Colin Boone. Mr. Golden is present and representing the Board.

Mr. Golden, will you lay out what we have here today, please?

MR. GOLDEN: Thank you. This matter was brought before the Hearing Examiner previously. A recommendation was made to deny his student application and that was taken to the June board meeting.

Colin Boone appeared and he requested of the Board that he be allowed to present additional information to the Board. The Board Staff made the same request because there had been additional facts that pertained to the application. So the Board went ahead and voted unanimously to send it back to the Hearing Examiner in order to take additional information.

HEARING EXAMINER HENRY: Very well. And in that regard, are you ready to proceed here today? And for the record, we should also note that Mr. Boone is not present at this juncture. The Board, of course, appears through Attorney William Golden.

1 MR. GOLDEN: And I will represent that Mr. Boone --
2 it was sent to his last address, that there was a
3 response that was sent back by his father in this matter
4 saying that he would not be attending and that he would
5 not be pursuing this. However, since it is his father,
6 he is not an attorney and didn't have any ability to
7 represent him, we are proceeding on this matter.
8 HEARING EXAMINER HENRY: Very well. Mr. Golden, you
9 may proceed.
10 MR. GOLDEN: Thank you. I would call Misty Rallis,
11 the Investigator for the Board.
12 MISTY RALLIS,
13 called as a witness at 9:39 a.m., having been first duly
14 sworn, testified as follows:
15 MR. GOLDEN: Since it is already in the record, her
16 qualifications and her position in this matter, I am
17 going to not recover those grounds and just treat this as
18 if she has been recalled, if that's acceptable.
19 HEARING EXAMINER HENRY: That is acceptable. Very
20 well, Mr. Golden, you may proceed.
21 DIRECT EXAMINATION
22 BY MR. GOLDEN:
23 Q Since the last hearing, Ms. Rallis, have you received
24 additional information concerning Colin Boone in the
25 matter before the Hearing Examiner?

1 A Yes. I requested documents from the Pacer website
2 regarding his criminal case. He appeared before the
3 Board prior to his sentencing on the criminal case. He
4 has been convicted of the felony counts according to
5 Exhibit 1, the Verdict Form.
6 Q And what other documents did you -- if you could just
7 list off what they are.
8 A Okay. Exhibit 2 is the Judgment in the criminal case for
9 the unreasonable use of force.
10 Exhibit 3 is the Clerk of Court's minutes from
11 sentencing.
12 And Exhibit 4 is the Sentencing Memorandum Opinion
13 and Order.
14 Q And you said that you obtained all of these off of the
15 Pacer website?
16 A Correct.
17 Q What is that?
18 A It's a federal court system website to obtain the
19 documents.
20 MR. GOLDEN: I have no further questions.
21 (Whereupon, the witness was excused at 9:41 a.m.)
22 MR. GOLDEN: I would offer Exhibits 1 through 4 as
23 government documents and that they are
24 self-authenticating as being judgments in this matter.
25 HEARING EXAMINER HENRY: Exhibits 1 through 4 are

received.

MR. GOLDEN: And that would conclude the State's case.

HEARING EXAMINER HENRY: Thank you. Without any further information to be had before the Court, we will now go in recess in the matter. And just prior to doing that, having received those, this Hearings Examiner will hold the documents and make any changes in the recommendation that the Board may request. At this juncture there may not be any change in the status of that matter. However, the items are received and will be considered.

Anything further before we go in recess on this matter?

MR. GOLDEN: Just simply the Staff is making the same request as previously. With this additional information, since Mr. Boone has been sentenced to 63 months in the federal penitentiary, we now also include the fact that he has been convicted of a felony, which is a disqualifier in this matter.

HEARING EXAMINER HENRY: Very well. In that regard then I will retract what I said about going in recess in the matter and let's just add this.

Based on the newly garnered information that's been presented here today, the recommendation of this Hearings

1 Examiner is in concert and is exactly the same as the
2 previous recommendation that was sent to the Board.
3 With nothing further, we will be in recess on the
4 matter.
5 MR. GOLDEN: Thank you.
6 (Whereupon, the proceedings were concluded at 9:44
7 a.m.)
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STATE OF SOUTH DAKOTA)
: CERTIFICATE
COUNTY OF LINCOLN)

I, Terri Lembcke Schildhauer, Registered Professional Reporter and Notary Public in the above-named County and State:

Do hereby certify that the witness was first duly sworn by me to testify to the truth, the whole truth, and nothing but the truth relative to the matter in hearing; and that the foregoing pages 1 - 7, inclusive, are a true and correct transcript of my stenotype notes made during the time of the proceedings of the South Dakota Board of Medical and Osteopathic Examiners.

I further certify that I am not a relative or employee or attorney or counsel of any of the parties or a relative or employee of such attorney or counsel, and that I am not financially interested in this action.

In testimony whereof, I have hereto set my hand this 20th day of August, 2015.

_/s/Terri Lembcke Schildhauer____
Terri Lembcke Schildhauer, RPR
Registered Professional Reporter
and Notary Public

My Commission Expires: 7/19/17

/

/s/Terri [1] 8/22

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317 [1] 1/10

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7/19/17 [1] 8/25

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9:39 [1] 4/13
9:41 [1] 5/21
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A

a.m [4] 1/19 4/13 5/21 7/7
ability [1] 4/6
about [1] 6/22
above [2] 1/18 8/5
above-entitled [1] 1/18
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acceptable [2] 4/18 4/19
according [1] 5/4
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add [1] 6/23
additional [6] 3/5 3/15 3/17 3/20 4/24 6/16
address [1] 4/2
ahead [1] 3/18
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also [3] 1/13 3/23 6/18
am [3] 4/16 8/14 8/17
any [5] 4/6 6/4 6/8 6/10 8/15
Anything [1] 6/13
APPEARANCES [1] 1/9
appeared [2] 3/14 5/2
appears [1] 3/24
application [3] 1/4 3/12 3/18
approximately [1] 3/4
are [7] 3/22 4/7 5/7 5/23 5/25 6/11 8/10
as [7] 4/13 4/14 4/17 5/22 5/24 6/16 7/1
Assistant [1] 1/10
attending [1] 4/4
attorney [6] 1/10 1/12 3/25 4/6 8/15 8/16
August [1] 8/19
authenticating [1] 5/24
Avenue [2] 1/8 1/10

B

back [2] 3/19 4/3
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be [7] 3/15 4/4 4/5 6/5 6/10 6/11 7/3
because [1] 3/16
been [7] 3/17 4/13 4/18 5/4 6/17 6/19 6/24
before [6] 1/7 3/11 4/25 5/2 6/5 6/13
being [1] 5/24
board [23]
BOONE [11]
brought [1] 3/10

C

call [1] 4/10
called [1] 4/13
came [1] 1/18
case [4] 5/2 5/3 5/8 6/3
CERTIFICATE [1] 8/1
certify [2] 8/7 8/14
change [1] 6/10
changes [1] 6/8
Clerk [1] 5/10
Clerk's [1] 2/14
COLIN [4] 1/5 3/6 3/14 4/24
commencing [1] 1/19
Commission [1] 8/25
concerning [1] 4/24
concert [1] 7/1
conclude [1] 6/2
concluded [1] 7/6
Conference [1] 1/19
considered [1] 6/12
convicted [2] 5/4 6/19
correct [2] 5/16 8/11
could [1] 5/6
counsel [2] 8/15 8/16
counts [1] 5/4
COUNTY [2] 8/2 8/5
course [1] 3/24
court [3] 2/14 5/18 6/5
Court's [1] 5/10
criminal [3] 5/2 5/3 5/8
Cross [1] 2/2

D

DAKOTA [12]
date [1] 3/5
day [2] 1/19 8/19
deny [1] 3/12
DESCRIPTION [1] 2/11
did [1] 5/6
didn't [1] 4/6
Direct [2] 2/2 4/21
Director [1] 1/14
disqualifier [1] 6/20
Do [1] 8/7
documents [5] 5/1 5/6 5/19 5/23 6/8
doing [1] 6/6
duly [2] 4/13 8/7
during [1] 8/11

E

employee [2] 8/15 8/16
entitled [1] 1/18
exactly [1] 7/1
EXAMINATION [1] 4/21
Examiner [6] 1/7 3/11 3/19 4/25 6/7 7/1
EXAMINERS [7] 1/1 1/12 1/15 1/17 1/20 2/24 8/13
excused [1] 5/21
Executive [1] 1/14
Exhibit [5] 3/1 5/5 5/8 5/10 5/12
exhibits [5] 2/9 2/10 2/24 5/22 5/25
Expires [1] 8/25

F

fact [1] 6/18
facts [1] 3/17
Falls [3] 1/8 1/11 1/20
father [2] 4/3 4/5
federal [2] 5/18 6/18
felony [2] 5/4 6/19
financially [1] 8/17
first [2] 4/13 8/7
follows [1] 4/14
force [1] 5/9
foregoing [1] 8/10
Form [2] 2/12 5/5
further [5] 5/20 6/5 6/13 7/3 8/14

G

garnered [1] 6/24
General [1] 1/10
go [3] 3/3 6/6 6/13
going [2] 4/17 6/22
Golden [7] 1/9 2/5 3/6 3/8 3/25 4/8 4/20
government [1] 5/23
grounds [1] 4/17

H

had [2] 3/17 6/5
hand [1] 8/18
Hansen [1] 1/13
has [4] 4/18 5/4 6/17 6/19
have [5] 3/8 4/6 4/23 5/20 8/18
having [2] 4/13 6/7
he [8] 3/14 3/15 4/4 4/4 4/6 5/2 5/3 6/19
hearing [9]
Hearings [2] 6/7 6/25
Henry [1] 1/7
her [2] 4/15 4/16
here [3] 3/8 3/22 6/25
hereby [1] 8/7
hereto [1] 8/18
him [1] 4/7
his [6] 3/12 4/2 4/3 4/5 5/2 5/3
hold [1] 6/8
hour [1] 1/19
However [2] 4/5 6/11

I

identification [1] 3/2
include [1] 6/18
inclusive [1] 8/10
INDEX [2] 2/1 2/9
information [6] 3/15 3/20 4/24 6/5 6/16 6/24
interested [1] 8/17
Investigator [2] 1/16 4/11
is [15]
it [4] 3/19 4/2 4/5 4/15
It's [2] 3/4 5/18
items [1] 6/11

J

Judgment [2] 2/13 5/8
judgments [1] 5/24
July [2] 1/19 3/5
July 17 [1] 3/5
juncture [2] 3/24 6/10
June [1] 3/13
just [5] 4/17 5/6 6/6 6/15 6/23

L

last [2] 4/2 4/23
lay [1] 3/8
Lembcke [3] 8/4 8/22 8/22
let's [2] 3/3 6/23
LICENSE [1] 1/4
LINCOLN [1] 8/2
list [1] 5/7

M

made [3] 3/12 3/16 8/11
Main [1] 1/10
make [1] 6/8

M

making [1] 6/15
Margaret [1] 1/13
marked [2] 2/11 3/1
matter [16]
may [4] 4/9 4/20 6/9 6/10
me [1] 8/8
MEDICAL [7] 1/1 1/12 1/14 1/17 1/20 2/24 8/12
meeting [1] 3/13
Memorandum [2] 2/16 5/12
minutes [2] 2/14 5/10
Misty [4] 1/16 2/4 4/10 4/12
months [1] 6/17
MPAS [1] 1/13
Mr [3] 1/7 1/9 2/5
Mr. [7] 3/6 3/8 3/23 4/1 4/8 4/20 6/17
Mr. Boone [3] 3/23 4/1 6/17
Mr. Golden [4] 3/6 3/8 4/8 4/20
Ms [3] 1/13 1/16 4/23
my [3] 8/11 8/18 8/25

N

named [1] 8/5
newly [1] 6/24
no [1] 5/20
North [2] 1/8 1/10
not [8] 3/23 4/4 4/5 4/6 4/17 6/10 8/14 8/17
Notary [2] 8/5 8/23
note [1] 3/23
notes [1] 8/11
nothing [2] 7/3 8/9
now [2] 6/6 6/18
NUMBER [1] 2/11
Numbers [1] 3/1

O

obtain [1] 5/18
obtained [1] 5/14
off [2] 5/7 5/14
offer [1] 5/22
OFFERED [1] 2/11
Okay [1] 5/8
Opinion [2] 2/16 5/12
order [3] 2/16 3/20 5/13
Original [1] 2/24
OSTEOPATHIC [7] 1/1 1/12 1/14 1/17 1/20 2/24 8/13
other [1] 5/6
out [1] 3/8

P

PA [1] 1/13
PA-C [1] 1/13
Pacer [2] 5/1 5/15
pages [1] 8/10
parties [1] 8/15
Paul [1] 1/7
penitentiary [1] 6/18
pertained [1] 3/17
place [1] 3/5
please [1] 3/9
position [1] 4/16
present [4] 1/13 3/7 3/15 3/23
presented [1] 6/25
previous [1] 7/2
previously [2] 3/11 6/16
prior [2] 5/3 6/6
proceed [3] 3/22 4/9 4/20
proceeding [1] 4/7
proceedings [3] 1/18 7/6 8/12
Professional [2] 8/4 8/23
provided [1] 2/24
Public [2] 8/5 8/23
pursuing [1] 4/5

Q

qualifications [1] 4/16
questions [1] 5/20

R

Rallis [5] 1/16 2/4 4/10 4/12 4/23
ready [1] 3/22
recalled [1] 4/18
received [4] 4/23 6/1 6/7 6/11
recess [4] 6/6 6/13 6/22 7/3
recommendation [4] 3/11 6/9 6/25 7/2
record [3] 3/3 3/23 4/15
recover [1] 4/17
Recross [1] 2/2
Redirect [1] 2/2
regard [2] 3/22 6/21
regarding [2] 3/6 5/2
Registered [2] 8/4 8/23
relative [3] 8/9 8/14 8/16
Reporter [2] 8/5 8/23
represent [2] 4/1 4/7
representing [1] 3/7
request [3] 3/16 6/9 6/16
requested [2] 3/14 5/1
response [1] 4/3
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retract [1] 6/22
Room [1] 1/20
RPR [1] 8/22
RULED [1] 2/11

S

said [2] 5/14 6/22
same [3] 3/16 6/15 7/1
saying [1] 4/4
Schildhauer [3] 8/4 8/22 8/22
self [1] 5/24
self-authenticating [1] 5/24
send [1] 3/19
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sentenced [1] 6/17
sentencing [5] 2/14 2/15 5/3 5/11 5/12
set [2] 3/5 8/18
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simply [1] 6/15
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Sioux [3] 1/8 1/11 1/20
So [1] 3/18
SOUTH [11]
Staff [2] 3/16 6/15
STATE [2] 8/1 8/6
State's [1] 6/2
status [1] 6/10
stenotype [1] 8/11
student [1] 3/12
such [1] 8/16
Suite [1] 1/8
sworn [2] 4/14 8/8
system [1] 5/18

T

take [1] 3/20
taken [1] 3/13
Terri [3] 8/4 8/22 8/22
testified [1] 4/14
testify [1] 8/8
testimony [1] 8/18
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through [3] 3/24 5/22 5/25
time [3] 3/4 3/5 8/11
today [3] 3/8 3/22 6/25
transcript [3] 1/3 2/24 8/11
treat [1] 4/17
true [1] 8/10
truth [3] 8/8 8/8 8/9

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unanimously [1] 3/19
unreasonable [1] 5/9
USA [4] 2/12 2/13 2/14 2/15
use [1] 5/9

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Verdict [2] 2/12 5/5
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WITNESSES [1] 2/1
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THE BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS OF THE
STATE OF SOUTH DAKOTA

IN THE MATTER OF:	)	NO. 14-189
	)	
COLIN J. BOONE APPLICANT/EMT STUDENT STATUS	))	AMENDED PETITION FOR BOARD OF
	)	MEDICAL AND OSTEOPATHIC
Respondent.	)	EXAMINERS
	)	

COMES NOW, the Executive Secretary of the South Dakota Board of Medical and Osteopathic Examiners ("Secretary") 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, Colin Jay Boone, submitted an application for Advanced Life Support Student Status. Respondent's address as reported to the Board is 3409 51st St. #414, Sioux Falls, SD 57106.

After investigation, a recommendation was made pursuant to ARSD 20:78:04:04 for the BMOE to deny his application for student status. 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 9:30 am (CDT) on Friday, July 17, 2015, 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, South Dakota Attorney General's Office, 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. Boone is subject to review under SDCL 36-4B-6 for failing to prove Good Moral Character when he submitted his application on September 22, 2014, and disclosed that he was charged with a civil rights violation due to an incident that occurred while he was working for the Des Moines Police Department.

D. FACTUAL CIRCUMSTANCES

1. Mr. Boone submitted an application for a South Dakota Advanced Life Support Student Status on September 22, 2014.
2. Mr. Boone was placed under investigation due to the federal charges and for investigation of his moral character.
3. On December 17, 2013, Mr. Boone was indicted for Unreasonable Use of Force under Title 18, United States Code, Section 242. While acting under the color of law as a police officer with the Des Moines Police Department he kicked O.P.H, willfully depriving him of his rights, secured and protected by the Constitution and Laws of the United States for freedom from the use of unreasonable force by a law enforcement officer.
4. BMOE staff requested copies of any and all police reports and court documents regarding the reported incident, and requested a detailed response from Mr. Boone. Mr. Boone failed to provide the requested information.
5. A hearing was conducted on February 6, 2015, by the Hearing Examiner who recommended denial of the application for student status.

6. The BMOE heard this matter at the June 11, 2015, Board meeting, and at the request of Mr. Boone, referred the matter back to the Hearing Examiner due to Mr. Boone indicating he had new evidence.
7. The staff will offer the Judgement of Conviction and Sentence of Mr. Boone at the scheduled and noticed hearing. See Exhibit 1
8. It is hereby requested that Mr. Boone's application be denied for unprofessional conduct in this matter and his failure to prove Good Moral Character.

E. 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 ARSD 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: 7/7/15
Margaret B. Hansen
Executive Director
South Dakota Board of Medical
and Osteopathic Examiners

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

Colin J. Boone
3409 51st #414
Sioux Falls, SD 57106

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA

UNITED STATES OF AMERICA,	*	
	*	4:13-cr-139
Plaintiff,	*	
	*	
v.	*	
	*	
COLIN J. BOONE,	*	VERDICT FORM
	*	
Defendant.	*	
	*	

VERDICT FORM: COUNT ONE

With regard to the crime of Unreasonable Use of Force, as charged in Count One of the Indictment, we, the jury, unanimously find the Defendant, COLIN J. BOONE:

_____NOT GUILTY X GUILTY

If you found the Defendant "Guilty" of the crime charged in Count One, answer Interrogatory #1. If you found Defendant "Not Guilty" of the crime charged in Count One, do not answer Interrogatory #1.

Interrogatory #1:

With regard to the crime alleged in Count One (Unreasonable Use of Force), do you unanimously find that the offense resulted in bodily injury to Orville Hill?

_____NO X YES

3/13/2015
DATE

AO 245B (Rev. 09/11) Judgment in a Criminal Case
v1 Sheet 1

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF IOWA

UNITED STATES OF AMERICA
v.
Colin J. Boone

JUDGMENT IN A CRIMINAL CASE

Case Number: 4:13-cr-00139-001

USM Number: 13784-273

Michael Lee Smart
Defendant's Attorney

THE DEFENDANT:

☐ pleaded guilty to count(s) _____

☐ pleaded nolo contendere to count(s) _____ which was accepted by the court.

☑ was found guilty on count(s) One of the Superseding Indictment filed May 29, 2014 after a plea of not guilty.

The defendant is adjudicated guilty of these offenses:

Title & Section	Nature of Offense	Offense Ended	Count
18 U.S.C. § 242	Unreasonable Use of Force	02/19/2013	One

☐ See additional count(s) on page 2

The defendant is sentenced as provided in pages 2 through 6 of this judgment. The sentence is imposed pursuant to the Sentencing Reform Act of 1984.

☑ The defendant has been found not guilty on count(s) Two of the Superseding Indictment filed May 29, 2014

☐ Count(s) _____ ☐ is ☐ are dismissed on the motion of the United States.

It is ordered that the defendant must notify the United States attorney for this district within 30 days of any change of name, residence, or mailing address until all fines, restitution, costs, and special assessments imposed by this judgment are fully paid. If ordered to pay restitution, the defendant must notify the court and United States attorney of material changes in economic circumstances.

June 22, 2015
Date of Imposition of Judgment

Robert W. Pratt
Signature of Judge

Robert W. Pratt, Senior U.S. District Judge
Name of Judge Title of Judge

June 22, 2015
Date

DEFENDANT: Colin J. Boone
CASE NUMBER: 4:13-cr-00139-001

IMPRISONMENT

The defendant is hereby committed to the custody of the United States Bureau of Prisons to be imprisoned for a total term of:

63 months on Count One of the Superseding Indictment filed May 29, 2014

☑ The court makes the following recommendations to the Bureau of Prisons:

That Defendant be designated to the BOP facility in Yankton, SD, or as near to South Dakota as possible.

☑ The defendant is remanded to the custody of the United States Marshal.

☐ The defendant shall surrender to the United States Marshal for this district:

☐ at _____ ☐ a.m. ☐ p.m. on _____

☐ as notified by the United States Marshal.

☐ The defendant shall surrender for service of sentence at the institution designated by the Bureau of Prisons:

☐ before on _____

☐ as notified by the United States Marshal.

☐ as notified by the Probation or Pretrial Services Office.

RETURN

I have executed this judgment as follows:

Defendant delivered on _____ to _____

a _____ , with a certified copy of this judgment.

_____
UNITED STATES MARSHAL

By _____
DEPUTY UNITED STATES MARSHAL

DEFENDANT: Colin J. Boone
CASE NUMBER: 4:13-cr-00139-001

SUPERVISED RELEASE

Upon release from imprisonment, the defendant shall be on supervised release for a term of :

One year on Count One of the Superseding Indictment filed May 29, 2014

The defendant must report to the probation office in the district to which the defendant is released within 72 hours of release from the custody of the Bureau of Prisons.

The defendant shall not commit another federal, state or local crime.

The defendant shall not unlawfully possess a controlled substance. The defendant shall refrain from any unlawful use of a controlled substance. The defendant shall submit to one drug test within 15 days of release from imprisonment and at least two periodic drug tests thereafter, as determined by the court.

☐ The above drug testing condition is suspended, based on the court's determination that the defendant poses a low risk of future substance abuse. *(Check, if applicable.)*

☑ The defendant shall not possess a firearm, ammunition, destructive device, or any other dangerous weapon. *(Check, if applicable.)*

☑ The defendant shall cooperate in the collection of DNA as directed by the probation officer. *(Check, if applicable.)*

☐ The defendant shall comply with the requirements of the Sex Offender Registration and Notification Act (42 U.S.C. § 16901, *et seq.*) as directed by the probation officer, the Bureau of Prisons, or any state sex offender registration agency in which he or she resides, works, is a student, or was convicted of a qualifying offense. *(Check, if applicable.)*

☐ The defendant shall participate in an approved program for domestic violence. *(Check, if applicable.)*

If this judgment imposes a fine or restitution, it is a condition of supervised release that the defendant pay in accordance with the Schedule of Payments sheet of this judgment.

The defendant must comply with the standard conditions that have been adopted by this court as well as with any additional conditions on the attached page.

STANDARD CONDITIONS OF SUPERVISION

1) the defendant shall not leave the judicial district without the permission of the court or probation officer;
2) the defendant shall report to the probation officer in a manner and frequency directed by the court or probation office;
3) the defendant shall answer truthfully all inquiries by the probation officer and follow the instructions of the probation officer;
4) the defendant shall support his or her dependents and meet other family responsibilities;
5) the defendant shall work regularly at a lawful occupation, unless excused by the probation officer for schooling, training, or other acceptable reasons;
6) the defendant shall notify the probation officer at least ten days prior to any change in residence or employment;
7) the defendant shall refrain from excessive use of alcohol and shall not purchase, possess, use, distribute, or administer any controlled substance or any paraphernalia related to any controlled substances, except as prescribed by a physician;
8) the defendant shall not frequent places where controlled substances are illegally sold, used, distributed, or administered;
9) the defendant shall not associate with any persons engaged in criminal activity and shall not associate with any person convicted of a felony, unless granted permission to do so by the probation officer;
10) the defendant shall permit a probation officer to visit him or her at any time at home or elsewhere and shall permit confiscation of any contraband observed in plain view of the probation officer;
11) the defendant shall notify the probation officer within seventy-two hours of being arrested or questioned by a law enforcement officer;
12) the defendant shall not enter into any agreement to act as an informer or a special agent of a law enforcement agency without the permission of the court; and
13) as directed by the probation officer, the defendant shall notify third parties of risks that may be occasioned by the defendant's criminal record or personal history or characteristics and shall permit the probation officer to make such notifications and to confirm the defendant's compliance with such notification requirement.

DEFENDANT: Colin J. Boone
CASE NUMBER: 4:13-cr-00139-001

SPECIAL CONDITIONS OF SUPERVISION

The defendant shall submit to a search of his person, property, residence, adjacent structures, office, vehicle, papers, computers (as defined in 18 U.S.C. § 1030(e)(1)), and other electronic communications or data storage devices or media, conducted by a U.S. Probation Officer. Failure to submit to a search may be grounds for revocation. The defendant shall warn any other residents or occupants that the premises and/or vehicle may be subject to searches pursuant to this condition. An officer may conduct a search pursuant to this condition only when reasonable suspicion exists that the defendant has violated a condition of his release and/or that the area(s) or item(s) to be searched contain evidence of this violation or contain contraband. Any search must be conducted at a reasonable time and in a reasonable manner. This condition may be invoked with or without the assistance of law enforcement, including the U.S. Marshals Service.

The defendant shall provide complete access to financial information, including disclosure of all business and personal finances, to the U.S. Probation Officer.

DEFENDANT: Colin J. Boone
CASE NUMBER: 4:13-cr-00139-001

CRIMINAL MONETARY PENALTIES

The defendant must pay the total criminal monetary penalties under the schedule of payments on Sheet 6.

	Assessment	Fine	Restitution
TOTALS	$ 100.00	$ 0.00	$ 0.00

☑ The determination of restitution is deferred until TBD. An *Amended Judgment in a Criminal Case (AO 245C)* will be entered after such determination.

☐ The defendant must make restitution (including community restitution) to the following payees in the amount listed below.

If the defendant makes a partial payment, each payee shall receive an approximately proportioned payment, unless specified otherwise in the priority order or percentage payment column below. However, pursuant to 18 U.S.C. § 3664(i), all nonfederal victims must be paid before the United States is paid.

Name of Payee	Total Loss*	Restitution Ordered	Priority or Percentage
TOTALS	$0.00	$0.00	

☐ Restitution amount ordered pursuant to plea agreement $ _____

☐ The defendant must pay interest on restitution and a fine of more than $2,500, unless the restitution or fine is paid in full before the fifteenth day after the date of the judgment, pursuant to 18 U.S.C. § 3612(f). All of the payment options on Sheet 6 may be subject to penalties for delinquency and default, pursuant to 18 U.S.C. § 3612(g).

☐ The court determined that the defendant does not have the ability to pay interest and it is ordered that:

☐ the interest requirement is waived for the ☐ fine ☐ restitution.

☐ the interest requirement for the ☐ fine ☐ restitution is modified as follows:

* Findings for the total amount of losses are required under Chapters 109A, 110, 110A, and 113A of Title 18 for offenses committed on or after September 13, 1994, but before April 23, 1996.

DEFENDANT: Colin J. Boone
CASE NUMBER: 4:13-cr-00139-001

SCHEDULE OF PAYMENTS

Having assessed the defendant's ability to pay, payment of the total criminal monetary penalties is due as follows:

A ☑ Lump sum payment of $ 100.00 due immediately, balance due

☐ not later than _____ , or
☐ in accordance ☐ C, ☐ D, ☐ E, or ☐ F below; or

B ☐ Payment to begin immediately (may be combined with ☐ C, ☐ D, or ☐ F below); or

C ☐ Payment in equal _____ *(e.g., weekly, monthly, quarterly)* installments of $ _____ over a period of _____ *(e.g., months or years)*, to commence _____ *(e.g., 30 or 60 days)* after the date of this judgment; or

D ☐ Payment in equal _____ *(e.g., weekly, monthly, quarterly)* installments of $ _____ over a period of _____ *(e.g., months or years)*, to commence _____ *(e.g., 30 or 60 days)* after release from imprisonment to a term of supervision; or

E ☐ Payment during the term of supervised release will commence within _____ *(e.g., 30 or 60 days)* after release from imprisonment. The court will set the payment plan based on an assessment of the defendant's ability to pay at that time; or

F ☑ Special instructions regarding the payment of criminal monetary penalties:

All criminal monetary payments are to be made to the Clerk's Office, U.S. District Court, P.O. Box 9344, Des Moines, IA. 50306-9344.
While on supervised release, you shall cooperate with the Probation Officer in developing a monthly payment plan consistent with a schedule of allowable expenses provided by the Probation Office.

Unless the court has expressly ordered otherwise, if this judgment imposes imprisonment, payment of criminal monetary penalties is due during imprisonment. All crimnal monetary penalties, except those payments made through the Federal Bureau of Prisons' Inmate Financial Responsibility Program, are made to the clerk of the court.

The defendant shall receive credit for all payments previously made toward any criminal monetary penalties imposed.

☐ Joint and Several

Defendant and Co-Defendant Names and Case Numbers *(including defendant number)*, Total Amount, Joint and Several Amount, and corresponding payee, if appropriate.

☐ The defendant shall pay the cost of prosecution.

☐ The defendant shall pay the following court cost(s):

☐ The defendant shall forfeit the defendant's interest in the following property to the United States:

Payments shall be applied in the following order: (1) assessment, (2) restitution principal, (3) restitution interest, (4) fine principal, (5) fine interest, (6) community restitution, (7) penalties, and (8) costs, including cost of prosecution and court costs.

United States District Court
Southern District of Iowa

Date: 6-22-2015
In Session at: 3:00 pm
Recessed at: 3:45 pm

CLERK'S COURT MINUTES- SENTENCING

Presiding: Honorable Robert W. Pratt
Attorney(s) for Government: Kelly Mahoney
Attorney(s) for Defendant: Michael Smart

Criminal Number: 4:13-cr-139	:	Court Reporter: Terri Martin
UNITED STATES OF AMERICA,	:	Interpreter: n/a
vs.	:	☑ Indictment ☐ Information in 2 Ct(s)
COLIN J. BOONE	:	Code Violation/Offense:
	:	1) 18 USC 242 unreasonable use of force; 2) obstruction (acquitted).

.....

Defendant appeared on _____ and pled guilty to Ct(s) _____ and reaffirms plea. Jury verdict of guilty to Ct(s) One returned on March 13, 2015 .

.....

Minutes:

Def. present with counsel, has reviewed PSIR. Gov't does not have specific information on restitution at this time; parties shall provide Court with information on restitution w/in 30 days and court will then schedule restitution hearing to occur w/in 90 days. Court makes factual findings regarding Def.'s objections to PSIR. Court declines to add two points, as recommended in PSIR, for obstruction of justice. Parties argue appropriate disposition. Orville

Court adopts findings of PSIR ☑ as revised ☐

Judgment:

Court will supplement sentencing record with a written order following sentencing. Def. stands on written allocution. Def. OL: 26, CH: I, range 63-78 months. Court declines departure or variance, finding guideline sentence is appropriate after consideration of all 3553(a) factors. Def. sentenced to 63 months incarceration, recommend designation to Yankton, SD, 1 year SR with special conditions, $100 assessment. Restitution will be ordered at a future date. Mandatory detention applies. Def. advised of right to appeal.

ORDERED, Restitution: to be determined
ORDERED, Crime Victims Fund Assessment: $100 Fine: none
ORDERED, Count(s) Dismissed: none Gov. motion ☑ Deft. motion ☐
ORDERED, Commitment withheld until _____ at _____.
BOND previously set: _____ ☐ Bond continued ☑ Deft. committed

Nova D. Janssen, law clerk
Deputy Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA

UNITED STATES OF AMERICA,	*	
	*	4:13-cr-139
Plaintiff,	*	
	*	
v.	*	
	*	
COLIN BOONE,	*	
	*	
Defendant.	*	SENTENCING MEMORANDUM
	*	OPINION AND ORDER
	*	

Before the Court is the matter of sentencing the Defendant, Colin Boone. This memorandum opinion and order supplements the findings made on the record at the sentencing hearing held June 22, 2015.

I. PROCEDURAL HISTORY

On December 17, 2013, a grand jury convened in the Southern District of Iowa issued an Indictment charging Defendant with "Unreasonable Use of Force," in violation of 18 U.S.C. § 242. Clerk's No. 2. On May 29, 2014, the grand jury issued a superseding indictment, which added a charge of "Obstruction," in violation of 18 U.S.C. § 1519. Clerk's No. 33.

Trial on the two counts of the superseding indictment commenced on October 27, 2014. Clerk's No. 67. On November 1, 2014, the jury found Defendant "not guilty" of the Obstruction charge. Clerk's No. 85. The jury was unable to reach a unanimous verdict on the Unreasonable Use of Force charge; accordingly, the Court declared a mistrial. Clerk's Nos. 84, 91. A retrial on the Unreasonable Use of Force charge commenced on March 9, 2015. Clerk's No. 151. The jury found Defendant guilty of the offense on March 13, 2015.[1] Clerk's No. 166.

[1] Defendant states in his sentencing brief:

II. FACTS

The facts are taken from the trial record and the Pre-Sentence Investigation Report ("PSR"). Where indicated, the Court has either ruled on a disputed fact based on the trial record or determined that doing so is unnecessary to the task of sentencing. *See* Fed. R. Crim. P. 32(i)(3)(b); *United States v. Wiggins*, 104 F.3d 174, 178 (8th Cir. 1997) (stating that a sentencing judge who also presided over a Defendant's trial may "base its findings of fact on the trial record"). This case arises out of an incident that occurred in the early morning of February 19, 2013. PSR ¶ 7 (Clerk's No. 182). The PSR describes the incident as follows. City of Des Moines Police Officers Trudy Simonson and Lindsey Kenkel responded to the scene of a one-vehicle accident involving a van. *Id*. They were soon joined by Officers Cody Willis and Tanner Klinge. *Id*. The driver of the van, later identified as Orville Hill, appeared to be unconscious, but as officers approached the vehicle, Hill awoke and unsuccessfully attempted to drive the van away. *Id*. The officers broke the windows of the van, pulled Hill out, and immediately took him to the ground. *Id*. Defendant, who was employed as a police officer with

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> In the first trial, the government argued [O]fficer Boone intentionally kicked Orville Hill in the head and then lied about it on his arrest incident report. The jury rejected that position and rendered a not guilty verdict on the obstruction count, but was unable to reach a verdict on the excessive use of force count. At retrial, the government took a second bite at the apple and again argued Officer Boone lied on his arrest incident report . . . ."

Clerk's No. 185 at 2.

The Court disagrees with Defendant's characterization of the Government's use of admissible evidence as constituting a "second bite at the apple." While the Government did argue to the jury that Defendant was dishonest in filling out his arrest incident report, this evidence was highly relevant to the jury's determination of the third essential element of the Unreasonable Use of Force offense–whether Defendant acted willfully. *See* Final Jury Inst. No. 14 (Clerk's No. 162 at 17). The Eighth Circuit has approved the admission of evidence of acquitted conduct when it is relevant to another offense. *See United States v. Vega*, 676 F.3d 708, 719–20 (8th Cir. 2012) (finding evidence of prior drug transaction on which defendant was acquitted was admissible to prove defendant's intent in relation to a similar crime).

the City of Des Moines at the time, responded to dispatch calls about the accident. *Id*. ¶ 8. When Defendant arrived on the scene, Officers Willis, Kenkel, and Klinge were holding Hill on the ground, and Officer Simonson was standing nearby, ready to assist. *Id*. ¶ 8. Defendant ran over and delivered a straight kick to Hill's mouth. *Id*.

Defendant objects to portions of PSR paragraphs 7 and 8 that describe what happened when he arrived on the scene. *See* Clerk's No. 179 at 1–2. Defendant maintains that Hill was not under control at the time he arrived at the scene. *Id*. at 1. Defendant also maintains that he delivered a sweep kick rather than a straight kick. *Id*. At trial, Defendant's testimony about the kick conflicted with the testimony of other officers on the scene.

Defendant testified as follows:

> At that time when I was coming around, I saw [Hill's] left hand out, kind of related back to my high school days, I want to say. I thought he was trying to push up with it. I know that from wrestling, you don't want to give them a base to push up. So I decided to try to take that arm and knock it out so he couldn't use it to push up. . . . I used a side kick and tried to sweep that arm out from underneath him. . . . I was focused on—I could see his elbow to the shoulder area. That's what I was trying to hit. . . . Hill was laying this way (indicated). His left arm would be right there (indicating), and I came up and I tried to sweep down around from underneath him.

Tr. 706 (Clerk's No. 177 at 56). In contrast, Officer Willis was "[w]ithin feet" of Hill's face, and testified that he saw Defendant kick Hill "[s]traight on." Tr. 123 (Clerk's No. 174 at 123). Officer Kenkel was by Hill's shoulder when Defendant arrived on the scene and she testified: "I seen [sic] [Defendant] do a straight kick" that landed "[i]n [Hill's] facial area." Tr. 156 (Clerk's No. 175 at 23). Officer Simonson was on the ground with Hill and saw Defendant "running" towards her and deliver a "running straight kick to [Hill's] face." Tr. 427 (Clerk's No. 176 at 20). The testimony of the other officers at the scene is consistent, and the Court finds the testimony

proves by a preponderance of the evidence that Defendant delivered a straight kick to Hill's facial area, not a sweep kick to his shoulder area.

The officers also testified that they were working on getting Hill into handcuffs, and, at the time Defendant arrived on the scene, no additional force was necessary besides the force they were already applying with their hands and body weight on top of Hill. For example, Officer Willis testified that he had Hill's right arm under control, that Hill could not get up, and that the force needed to get Hill into handcuffs included "[t]he force he was currently exerting," which included pressure from his knee and holding Hill's right arm. Tr. 77–78 (Clerk's No. 174 at 78). Officer Kenkel testified that Hill was "moving around" but that the force needed to get Hill into handcuffs was "hands on" force, including "physically holding him down." Tr. 154–55 (Clerk's No. 175 at 21–22). Officer Simonson testified that after Hill was face down on the ground she was not worried that he could get up. Tr. 425 (Clerk's No. 176 at 18). Officer Klinge testified that the level of force needed to control Hill was "[j]ust our hands." Tr. 499–500 (Clerk's No. 176 at 92–93). The Court finds the testimony of Willis, Kenkel, Simonson, and Klinge credible and thus finds by a preponderance of the evidence that no additional force was needed to gain control of Hill at the time Defendant arrived on the scene.

Finally, Defendant objects to the PSR statement that after Hill was in handcuffs and face down on the ground, Defendant "put his foot on top of Hill's head." PSR ¶ 8. Defendant instead states that Hill was raising his head and Defendant "placed the toe of his foot and pushed [Hill's] head back down." The Court finds that this difference is immaterial for purposes of sentencing. Similarly, the Court finds it is unnecessary to resolve the dispute over whether Officer Kenkel was thrown back by the force of Defendant's kick.

Defendant also disputes paragraph 9 of the PSR, which describes Hill's injuries. Defendant disputes that officers "observed blood pour from Hill's mouth and pool on the ground beneath his face." *See* Clerk's No. 179 at 2; PSR ¶ 9. The Court finds this dispute immaterial for purposes of sentencing. Defendant does not dispute that, as a result of the kick, two of Hill's teeth were broken off at the gums and a third was knocked loose and had to be removed. PSR ¶ 9. Hill also undisputedly suffered a laceration above his eye that required stitches. *Id*. However, Defendant disputes that Hill suffered a fractured nose. Clerk's No. 179 at 2; PSR ¶ 9 ("Hill also suffered a broken nose."). The emergency room doctor that treated Hill testified that the bridge of Hill's nose was swollen, and a CAT scan showed his nose was recently fractured, although the doctor could not say with certainty that the fracture had occurred that evening. Tr. 238, 241 (Clerk's No. 175 at 105, 108). The doctor also testified that "when the nose is impacted, you often times get orbital fractures. You can also get fractures up here (indicating) when you have the teeth avulsed that way." Tr. 237 (Clerk's No. 175 at 104). She further stated that Hill's injuries were consistent with a kick and that "[t]he area in which the force hit was in the mouth, pretty specifically mouth and mid face region." Tr. 243 (Clerk's No. 175 at 101). Based on this testimony, the Court finds that it has been proved by a preponderance of the evidence that Defendant's kick caused Hill's fractured nose.

Next, Defendant disputes PSR paragraphs 10–13, which describe conversations Defendant had after the kick occurred. According to the PSR, Defendant asked Officer Willis if he "was good" or "if he needed anything," which Officer Willis interpreted as an inquiry about whether or not Defendant should fill out an Arrest Incident Report. PSR ¶ 10. Defendant asserts that it was improper for Officer Willis to speculate as to Defendant's subjective intent. The Court finds that it is unnecessary to resolve this dispute for purposes of sentencing. The PSR

also states that Defendant spoke with Officers Simonson and Kenkel, and stated "I just tried to knock him out a bit." PSR ¶ 11. Both officers testified that Defendant made the statement, and the Court finds their testimony credible; the statement is proved by a preponderance of the evidence. Tr. 165, 441 (Clerk's Nos. 174 at 32, 175 at 43). Next, the PSR states that Defendant told Officer Ben Idhe that he kicked Hill in the head. PSR ¶ 12. Defendant disputes the characterization of his statement, and maintains that he told Officer Idhe he "may" have kicked Hill in the head so Officer Idhe could take that information into account when examining Hill. Clerk's No. 179 at 2. The Court finds it unnecessary to resolve this factual dispute for purposes of sentencing. Finally, the PSR states that Defendant told his then-fiancée, Angela Frye, that he "put [his] bootlaces across a guy's face," that he "took a ten foot running start" and that blood "gushed everywhere" and Hill "spit teeth out." PSR ¶ 13. Frye provided a recorded statement to the Des Moines Police Department Office of Professional Standards detailing her conversation with Defendant shortly after the incident occurred, and also testified at trial. *See* Tr. 374–75 (Clerk's No. 175 at 241–42). The Court finds the testimony credible and that these statements are proved by a preponderance of the evidence. The Court finds it unnecessary to resolve the dispute about a message Frye posted to Facebook post after her conversation with Defendant.

Finally, Defendant objects to PSR paragraphs 15 and 16, which summarize Defendant's testimony. The Court finds that paragraphs 15 and 16 accurately state Defendant's trial testimony. Further, Defendant does not actually claim that he did not testify to the statements reflected in the PSR. *See* Clerk's No. 179 at 3–4. Defendant's objections to paragraphs 18, 26, 27, and 30, involving the enhancement for obstruction of justice, will be discussed separately below.

III. LAW AND ANALYSIS

When imposing a sentence, this Court is not bound by the Sentencing Guidelines, but "must consult those Guidelines and take them into account." *United States v. Booker*, 543 U.S. 220, 264 (2005). "[A] district court should begin all sentencing proceedings by correctly calculating the applicable [Sentencing] Guidelines range." *Gall v. United States*, 552 U.S. 38, 50 (2007). The Court should then consider all of the factors enumerated in 18 U.S.C. § 3553(a) and "make an individualized assessment based on the facts presented." *Id*. Section 3553(a) instructs the district courts to "'impose a sentence sufficient, but not greater than necessary,' to accomplish the goals of sentencing, including 'to reflect the seriousness of the offense,' 'to promote respect for the law,' 'to provide just punishment for the offense,' 'to afford adequate deterrence to criminal conduct,' and 'to protect the public from further crimes of the defendant.'" *Kimbrough v. United States*, 552 U.S. 85, 101 (2007) (quoting 18 U.S.C. § 3553(a)). The Court should also consider '"the nature and circumstance of the offense,' 'the history and characteristics of the defendant,' 'the sentencing range established by the Guidelines,' 'any pertinent policy statement' issued by the Sentencing Commission pursuant to its statutory authority, and 'the need to avoid unwarranted sentence disparities among defendants with similar records who have been found guilty of similar conduct.'" *Id*. (quoting 18 U.S.C. § 3553(a)). The statute "requires a court to give respectful consideration to the Guidelines," but also "'permits the court to tailor the sentence in light of other statutory concerns as well.'" *Id*. (quoting *Booker*, 543 U.S. at 245–46). The Court must "adequately explain the chosen sentence to allow for meaningful appellate review and to promote the perception of fair sentencing." *Gall*, 552 U.S. at 50.

A. *Advisory Guideline Calculation*

1. *Obstruction of justice enhancement.*

Defendant objects to the Government's position that a two-level enhancement for obstruction of justice applies in this case. The enhancement applies:

> If (1) the defendant willfully obstructed or impeded, or attempted to obstruct or impede, the administration of justice with respect to the investigation, prosecution, or sentencing of the instant offense of conviction, and (2) the obstructive conduct related to (A) the defendant's offense of conviction and any relevant conduct; or (B) a closely related offense.

USSG § 3C1.1. The Government argues that the enhancement applies because Defendant committed perjury during the trial, specifically, Defendant testified that he delivered a sweep kick towards Hill's shoulder rather than a straight kick to Hill's face.[2] Clerk's No. 184 at 11.

"Committing perjury at trial constitutes an obstruction of justice within the meaning of § 3C1.1. Because a finding of obstruction results in an increase in a defendant's sentence, the government bears the burden of proving the facts necessary to support the finding by a preponderance of the evidence." *United States v. Flores*, 362 F.3d 1030, 1037 (8th Cir. 2004) (internal citations omitted). "The sentencing court cannot give the upward departure simply

[2] The PSR also cites, as a basis for the enhancement, Defendant's testimony that he first noticed Hill's facial injuries when Hill was in the ambulance, despite video of the scene showing Defendant bending over Hill right after the kick occurred. But the Government does not advance this basis for the enhancement in its Sentencing Memorandum, and the Court concludes that even if it had, Defendant's testimony does not support a finding of perjury. Defendant's testimony about when he first noticed the injuries is not entirely clear, and supports a conclusion that Defendant was confused or could not remember exactly what he saw, at least to the same extent that it supports a conclusion that he willfully lied. *See* Tr. 727 (Clerk's No. 177 at 77) ("I noticed when they rolled him over . . . that there was some blood on his face."); Tr. 728–29 (Clerk's No. 177 at 78–79) ("[I] walked down to the ambulance . . . I noticed that he had a gash or a slit on his eyebrow, and my first thought was, wow, that looks like maybe something like boot laces or the side of your boot may cause, and I knew that I had struck him up in the upper shoulder, and I started to wonder if maybe I hit him in the head, too."); Tr. 783 (Clerk's No. 177 at 133) (testifying that while Hill was on the ground after being handcuffed he "saw that [Hill] had . . . a facial laceration").

because a defendant testifies on his own behalf and the jury disbelieves him." *Id*. (internal quotation omitted). "A witness testifying under oath or affirmation [commits perjury] if []he gives false testimony concerning a material matter with the willful intent to provide false testimony, rather than as a result of confusion, mistake, or faulty memory." *United States v. Dunnigan*, 507 U.S. 87, 94 (1993) (internal quotation and citation omitted); *see also* USSG § 3.3C1.1, cmt. 2. A defendant's "testimony may be truthful, but the jury may nonetheless find the testimony insufficient to excuse criminal liability or prove lack of intent." *Dunnigan*, 507 U.S. at 94. "[I]f a defendant objects to a sentence enhancement resulting from [his] trial testimony, a district court must review the evidence and make independent findings necessary to establish a willful impediment to or obstruction of justice, or an attempt to do the same." *Id*. "[T]he trial court must make findings to support all the elements of a perjury violation." *Id*. at 97.

The Government asserts that Defendant's testimony that he delivered a sweep kick rather than a straight kick constituted perjury. As summarized above, Defendant consistently maintained that he delivered a sweep kick towards Hill's shoulder area despite the other officers' testimony that they witnessed Defendant deliver a straight kick to Hill's face. This testimony is material because it goes to willfulness. *See* 18 U.S.C. § 242 (requiring the deprivation of rights to be willful). Although the Court is persuaded that a preponderance of the evidence shows that Defendant did in fact deliver a straight kick to Hill's face, such a conclusion does not equate to a finding that Defendant willfully intended to provide false testimony. Defendant does not deny that he kicked Hill, nor does he deny that a straight kick to Hill's face would have been an unreasonable use of force. Rather, Defendant's subjective memory of what occurred that evening was different than the other officers on the scene. That makes this case different from others where the enhancement was applied to defendants who completely denied knowledge of

the crimes for which they were accused. *See Dunnigan*, 507 U.S. at 90 (defendant denied ever possessing or distributing cocaine); *United States v. Esparza*, 291 F.3d 1052, 1056 (8th Cir. 2002) (defendant testified that he did not know there were drugs in his trailer); *United States v. Pena*, 67 F.3d 153, 157 (8th Cir. 1995) (defendant denied knowledge or involvement in drug trafficking). The Court finds it equally as likely as not that Defendant truly believes he attempted to deliver a sweep kick on the night in question. Further, it is conceivable that the jury may have believed Defendant's testimony and still found that a sweep kick constituted excessive use of force under the circumstances of the case. *See Dunnigan*, 507 U.S. at 94 ("[Defendant's] testimony may be truthful, but the jury may nonetheless find the testimony insufficient to excuse criminal liability or prove lack of intent.").

The Government also points to inconsistencies between Defendant's testimony and the testimony of the other officers on the scene regarding statements that tend to prove or disprove the willfulness of Defendant's actions that evening. *See* Clerk's No. 184 at 11. First, the Government asserts that Defendant's testimony that Hill's arm was out and that Hill was attempting to push up was false. That assertion appears to be based on Officer Klinge's testimony at the first trial that Hill's hand was tucked underneath his chest. *See* Clerk's No. 95 at 194 (First Trial Tr.). But Officer Klinge also testified that he couldn't recall whether Hill's hand was ever on the ground, or whether Hill had ever pushed up on his hand. *Id*. at 195. Next, the Government asserts that Defendant falsely testified that he did not tell Officers Simonson and Kenkel that he was trying to "knock [Hill] out a little." But Defendant did not deny making the statement, rather Defendant testified that he didn't think he ever said that, and also testified that he didn't know, and didn't remember the conversation. Tr. 802 (Clerk's No. 177 at 152). The Government also argues that Defendant mischaracterizes his conversation with Officer Idhe by

contending that he told Officer Idhe he "may" have kicked Hill in the head, while Officer Idhe testified that Defendant told him he *did* kick Hill in the head. *See* Clerk's No. 184 at 11. Finally, the Government argues that Defendant falsely denied that he made certain statements to his then-fiancée Angela Frye. But Defendant conceded at trial that it was possible he made the statements Frye attributed to him, but that he couldn't remember saying them. Tr. 804 (Clerk's No. 177 at 154). The Court finds that none of the inconsistencies identified by the Government support a conclusion by a preponderance of the evidence that Defendant willfully lied under oath. For all the foregoing reasons, the Court declines to impose a two-level enhancement for obstruction of justice.

2. *Guideline calculation.*

The Guideline for 18 U.S.C. § 242 offenses, including those involving individual rights, is found in USSG § 2H1.1. Section 2H1.1 instructs the Court to apply the base offense level for the underlying offense, here, aggravated assault. The base offense level for aggravated assault is 14. USSG § 2A2.2(a). Because the victim sustained an injury between bodily injury and serious bodily injury, the offense level is increased by 4 levels. USSG § 2A2.2(b)(3)(D). Because Defendant committed the offense under the color of law, 6 levels are added. USSG § 2H1.1(b)(1). Since the victim was physically restrained in the course of the offense, 2 levels are added. USSG § 3A1.3. The total offense level is, therefore, 26. As discussed above, the Court declines to apply the obstruction of justice enhancement. The Defendant has no prior criminal history, resulting in a criminal history category of I. The resulting advisory sentencing range of imprisonment is 63–78 months.

B. *3553(a) Factors*

For the reasons discussed below, the Court finds that a Guideline sentence is appropriate in this case. Specifically, the Court finds that a sentence at the bottom of the Guideline range, 63 months, is "sufficient but not greater than necessary."

1. *Nature and circumstances of the offense.*

The history of 18 U.S.C. § 242 can be traced back to Reconstruction following the Civil War. *See* Hon. Paul J. Watford, *Screws v. United States and the Birth of Federal Civil Rights Enforcement*, 98 MARQ. L. REV. 465, 470 (2014). At the time, violence against African Americans in the South was ubiquitous and Congress passed a series of statutes between 1866 and 1875 aiming to enforce the rights conferred by the Thirteenth, Fourteenth, and Fifteenth Amendments to the United States Constitution. *Id*. In December 1865, just a few months after the Thirteenth Amendment was ratified, Congress enacted the Civil Rights Act of 1866 which "included § 242 in its originally narrow form." *United States v. Price*, 383 U.S. 787, 804 (1966). Shortly after the ratification of the Fifteenth Amendment, Congress enacted the Enforcement Act of 1870, which contained an early version of 18 U.S.C. § 241,[3] and a re-enactment of the 1866 Civil Rights Act's version of § 242. *Id.* at 802. The two statutes have long been recognized as "companion sections designed for the protection of great rights won after the Nation's most critical internal conflict." *United States v. Williams*, 341 U.S. 70, 87 (1951) (Douglas, J., dissenting).

Today, § 242 preserves the federal government's power to prosecute violations of citizens' civil rights that occur under color of law. *See* 18 U.S.C. § 242; Watford at 483.

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[3] 18 U.S.C. § 241 makes it a crime for "two or more persons [to] conspire to injure, oppress, threaten, or intimidate any person . . . in the free exercise or enjoyment of any right or privilege secured to him by the Constitution or laws of the United States, or because of his having so exercised the same."

Pertinent here, § 242 protects an individual's right to be free from the unreasonable or excessive use of force by law enforcement. "[I]t is plain that basic to the concept of due process of law in a criminal case is a trial—a trial in a court of law, not a trial by ordeal." *Screws v. United States*, 325 U.S. 91, 106 (1945). "A prisoner unlawfully beaten by an arresting officer is denied the right of due process of law and also the right of equal protection of the laws." *Lynch v. United States*, 189 F.2d 476, 479 (5th Cir. 1951). The seriousness of section 242 crimes simply cannot be understated, as they harm far more than individual victims; society as a whole is harmed when those entrusted to protect the public and enforce the laws turn to lawlessness themselves. *See United States v. McQueen*, 727 F.3d 1144, 1157 (11th Cir. 2013) (finding a violation of § 241 to be a "particularly serious offense," and stating that the "evils against which this civil rights statute is directed especially include correctional officers who flagrantly beat inmates (and young ones at that) placed by the law in their charge.").[4]

In addition, the specific facts of this case are troubling, particularly in that Defendant committed the act in front of his fellow officers, showing a brazen disrespect for the law. Defendant's act, although only a single kick, caused serious injury to Hill, and was potentially deadly. The Court agrees with the Government that the offense damages the reputation of police officers generally, and specifically the Des Moines Police Department and "impugns the credibility and work of the hundreds of upstanding officers who serve with the department." *See* Clerk's No. 184 at 12. A Guideline sentence accounts for the violent nature of the crime and the seriousness of civil rights violations by a law enforcement officer.

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[4] Though *McQueen* concerned a violation of § 241, the Court finds that the similar history and purpose of the two statutes makes the analysis equally applicable to violations of § 242. Moreover, while the conduct in *McQueen* was arguably more egregious than that here at issue, "the evils against which the civil rights statute is directed" undoubtedly encompass Defendant's conduct toward Orville Hill.

2. *History and characteristics of the defendant*.

Defendant is 39 years old with no history of substance abuse or mental health issues. PSR ¶ 39. He grew up in a stable, middle-class environment, and has the support of his parents and two brothers. *Id*. ¶¶ 38–45. Defendant possesses an associate of applied science degree in professional studies from Metro Community College in Omaha, and has completed additional college coursework. *Id*. ¶ 61. In 1997, Defendant first entered the field of law enforcement, training police dogs and training officers how to work with them. Def.'s Allocution Statement. Defendant later attended the police academy and spent a year working as a Capitol Police officer. *Id*. He was eventually hired by the Des Moines Police Department ("DMPD"), attended the police academy again, and commenced work as a Des Moines Police Officer in 2000. *Id*. During his approximately 14 years with the DMPD, Defendant attended a great deal of training, received several promotions, and became an expert in accident reconstruction, OWI enforcement, RADAR/LIDAR, and drug-impaired driving enforcement. *Id*. Defendant also became an instructor for several police academy courses and received various awards and commendations for his work, including a Medal of Valor for pulling accident victims from a burning car. *Id*. Since his termination from the DMPD, Defendant moved to South Dakota to be closer to his family, and has been employed as an emergency medical technician, serving a high poverty area. *Id*.; PSR ¶¶ 50, 63. Defendant also volunteers as an official for several youth sports programs, and has done an admirable job improving his own health, including losing nearly 200 pounds and participating in marathons and triathlons. Def.'s Allocution Statement.

The record also reflects by a preponderance of the evidence, however, that the use of force against Orville Hill was likely not the first time Defendant used unreasonable force against an arrestee while working as a Des Moines police officer. The evidence at trial showed that

Defendant used force on an arrestee inside a Des Moines Police Station and then attempted to cover up the incident with another officer. Tr. 291–315 (Clerk's No. 175 at 157–81) (Testimony of Officer Chris Latcham). That arrestee sued Defendant and the other officer, alleging that Defendant used excessive force against her.[5] Tr. 343 (Clerk's No. 175 at 210).

The Court in general commends Defendant for his extensive public service and accomplishments. It also acknowledges, as Defendant points out, that this "case is about less than 15 seconds in a 14-year law enforcement career" and that it "involved a single strike." Clerk's No. 185 at 9 (Def.'s Sentencing Br.). Sadly, it is not uncommon in the criminal justice system for a few seconds of poor judgment in an otherwise productive and mostly law-abiding life to carry severe consequences. No doubt, the consequences that Defendant has experienced already, including termination from his job with the DMPD, a felony conviction, and a corresponding loss of civic rights, are severe. However, the injury that Defendant inflicted on Orville Hill was also severe, and like Defendant, Orville Hill will live with the consequences of Defendant's actions for the rest of his life. Given that Defendant's sworn duty was to protect and serve, the Court likewise cannot ignore the pall that his conduct has cast over not just himself, but law enforcement officers in general. After careful consideration, the Court concludes that Defendant's history and characteristics, while laudable in general, are not particularly unusual for a law enforcement officer and do not, when considered in conjunction with the other § 3553(a) factors, warrant a departure or variance from the advisory guideline range under the particular facts and circumstances of this case.

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[5] The Court believes this evidence bolsters the appropriateness of a sentence within the advisory guideline range, as it tends to show that the Defendant's assault against Orville Hill was not an isolated event, but rather part of a pattern of unlawful behavior directed towards arrestees. The Court notes, however, that it would still impose a sentence within the advisory guideline even without consideration of Defendant's "other bad acts."

3. *Need for the sentence to reflect the seriousness of the offense, promote respect for the law, and provide just punishment for the offense, to afford adequate deterrence to criminal conduct, to protect the public from further crimes of the defendant, and to provide the defendant with needed training or treatment.*

Defendant is not a risk to the public as he no longer serves in a law enforcement role, nor is there a need for the sentence to address training or treatment needs. But the Court believes a Guideline sentence in this case is appropriate to reflect the seriousness of the crime and to act as just punishment. Indeed, the legislative history of § 3553(a) recognizes that the purpose of the "just punishment" provision is "essentially a 'just deserts' concept . . . it is another way of saying that the sentence should reflect the gravity of the defendant's conduct." *McQueen*, 727 F.3d at 1157 (quoting S. Rep. No. 98-225, at 75–76 (1983)). "From the public's standpoint, the sentence should be of a type and length that will adequately reflect, among other things, the harm done or threatened by the offense, and the public interest in preventing a recurrence of the offense." *Id*. (quoting S. Rep. No. 98-225, at 75–76).

In addition, the Court considers deterrence, especially general deterrence, to be particularly important in this case. "General deterrence is 'one of the key purposes of sentencing,'" and careful consideration of it in fashioning a sentence is "especially compelling in the context of officials abusing their power." *United States v. Hooper*, No 13-11584, 566 Fed. Appx. 771, 2014 WL 1924437 (11th Cir. May 13, 2014) (quoting *United States v. Pugh*, 515 F.3d 1179, 1191–92 (11th Cir. 2008) and citing *McQueen*, 727 F.3d at 1157–58). As Justice Brandeis stated nearly 90 years ago:

> Decency, security, and liberty alike demand that government officials shall be subjected to the same rules of conduct that are commands to the citizen. In a government of laws, existence of the government will be imperiled if it fails to observe the law scrupulously. Our government is the potent, the omnipresent teacher. For good or for ill, it teaches the whole people by its example. Crime is contagious. If the government becomes a lawbreaker, it breeds contempt for law; it invites every man to become a law unto himself; it invites anarchy. To declare

> that in the administration of the criminal law the end justifies the means—to declare that the government may commit crimes in order to secure the conviction of a private criminal—would bring terrible retribution. Against that pernicious doctrine this court should resolutely set its face.

Olmstead v. United States, 277 U.S. 438, 468 (1928) (Brandeis, J., dissenting). A Guideline sentence in this case will make explicit that the excessive use of force by law enforcement is a serious civil rights violation that simply will not be tolerated.

4. *Remaining statutory considerations.*

The Court has also considered the need to avoid unwanted sentencing disparities among similarly situated offenders. Neither party has argued that a Guideline sentence in this case would produce such a disparity. Generally, while not mandatory, a Guideline sentence helps promote uniformity and fairness in sentencing. *See Gall*, 552 U.S. at 54 ("[A]voidance of unwarranted disparities was clearly considered by the Sentencing Commission when setting the Guidelines ranges."); *United States v. Bartlett*, 567 F.3d 901, 908 (7th Cir. 2009) ("The best way to curtail 'unwarranted' disparities is to follow the Guidelines, which are designed to treat similar offenses and offenders similarly."). Accordingly, the Court concludes that a Guideline sentence serves to avoid unwanted sentencing disparities.

IV. CONCLUSION

After considering all the statutory factors, the Court finds a sentence of 63 months, the bottom of the applicable Guideline range, to be "sufficient but not greater than necessary." Following the term of incarceration, Defendant shall be on supervised release, subject to the special conditions detailed in the judgment, for a term of one year. Defendant must also pay the required $100 to the crime victims' fund. The Court is unable to enter an order of restitution at this time. Pursuant to the agreement at the sentencing hearing, the Government shall have 30 days to provide supporting documentation for the victim's restitution request. The Defendant

shall have 14 days to enter a response. If necessary, a hearing will be set at that time in accordance with 18 U.S.C. § 3664(d)(5). The Court declines to order any additional fine or penalty.

IT IS SO ORDERED.

Dated this ___22nd___ day of June, 2015.

ROBERT W. PRATT, Judge
U.S. DISTRICT COURT

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* * * \

Re: Email sent to me regarding lapse of EMT license due to investigation of employment at Hill City Ambulance

November 3, 2015

Dear SD Medical Board Staff,

I am writing in response to your letter sent to me on September 1, 2015 that states I was terminated from Hill City Ambulance for poor job performance and unprofessional conduct. In regard to termination of employment, I was told by my supervisor I was being let go for my negative attitude towards fellow employees. I was never formally written up for an attitude problem or verbally told that there were comments from fellow employees about my having a negative attitude prior to my termination. There is nothing to my knowledge placed in my personnel file regarding this allegation.

I would also like the SD Medical Board to know that on March 12, 2015 I received a letter from Hill City Ambulance after my termination thanking me for my many years of service. Please find a copy of this letter enclosed.

Thank you for your attention to this matter.

Sincerely,

Matthew GildeLeon

Hill City Ambulance

P.O. Box 671 Hill City, SD Phone: (605) 574-2631 Fax: (605) 574-9068
E-Mail: hcas@hills.net

12 March 2015

Matt Gildeleon
PO Box 1042
Hill City, SD 57745

Hello Matt,

We want to thank you for your many years of service to Hill City Ambulance and would like to advise you as to what happens now to your employment benefits.

- You can continue on our Dakota Care health insurance for up to 18 months under COBRA but you will have to take over full payment of the premium. Your premium payment will be due to us in advance of our monthly premium due date. Scott Duncan is our Dakota Care agent. His number: (800) 553-4711
- The ambulance service will no longer make contributions to your retirement plan with South Dakota Retirement System but you will still have the benefit of the retirement plan. You or future employers can make begin contributions again. Further details can be obtained by calling SDRS directly. Their phone number: (605) 773-3731
- Your AFLAC policies can remain active but you will need to take over direct payment of the premiums. Our AFLAC agent, Heather, can give you the details. Her number: (605) 484-4193.

Some moneys for these may be withheld from your final paycheck based on whether payments are made in advance or arrears on the individual benefits.

We are holding your last check (as authorized by SDCL 60-11-10) pending the return of all clothing issued you bearing the Hill City Ambulance name or logo - i.e. coat, jacket, zip hoody, sweatshirt, polo shirt, etc. The EMT pants and boots were purchased for you and you are welcome to keep them.

Your pager and radio are here at the station and are yours to continue to use as a member of the Hill City Volunteer Fire Department. We've talked with the Fire Chief and he says you are still a member of the Fire Department and he hasn't gotten any indication from you that you want to discontinue your association with them.

We are mailing this to you certified mail as that seems to be the best way to contact you and we want to be sure you receive it.

If you have any questions, please call us. We wish you the best moving forward.

Sincerely,

Sara Booth & Slade Swedlund
Co-Directors

CC:
Hill City Ambulance Board of Directors
Fire Chief, Hill City Volunteer Fire Department

Exhibit 1

Hill City Ambulance

P.O. Box 671 Hill City, SD Phone: (605) 574-2631 Fax: (605) 574-9068
E-Mail: hcas@hills.net

To: South Dakota Board of Medical & Osteopathic Examiners

RE: Matthew Gildeleon, ALS license 1528, SD EMT 19261

Date: March 4, 2015

Effective at 2100 hrs. on this day, Matt Gildeleon's employment with Hill City Ambulance is terminated due to poor performance of job duties.

Sara Booth & Slade Swedlund
Hill City Ambulance Service Co-Directors

Dr Lisa Brown
Hill City Ambulance Service Medical Director

CC: South Dakota State EMS Office
Hill City Ambulance Service Board of Directors
Employee file

Reply to Subpoena Duces Tecum
In Re: Matthew Gildeleon

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

STATE OF SOUTH DAKOTA)
) SS.
COUNTY OF MINNEHAHA)

REPLY TO SUBPOENA DUCES TECUM

From: Hill City Ambulance Service
Attn: Sarah Booth
359 E Main St. PO Box 671
Hill City, SD 57745

In Re: Matthew Gildeleon

The undersigned was duly served with a Subpoena Duces Tecum dated April 17, 2015 issued by the Executive Director of the above captioned Board commanding production of "Any and all documents relating to the termination of Matthew Gildeleon from Hill City Ambulance Service".

REPLY: Attached please find copies of all documents from the file held in the ordinary course of business by Hill City Ambulance Service (operating by and through Hill City Ambulance District) that the undersigned has in good faith determined to be compliant with the subpoena. This Reply with attachments is being delivered electronically in advance of the scheduled proceeding and therefore no appearance will be made at the proceedings, as allowed by said subpoena.

Dated this 30 day of April, 2015.

HILL CITY AMBULANCE DISTRICT
dba HILL CITY AMBULANCE SERVICE

BY: Sara Booth
Sara Booth
Co-Director

(Certificate of Service on following page)

Reply to Subpoena Duces Tecum
In Re: Matthew Gildeleon

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on the day below, a true and correct copy of the above referenced document was served in the following manner upon the following person(s), pursuant to the service indicated, postage prepaid as applicable, addressed as follows:

Hon. Margaret B. Hansen Executive Director SD Board of Medical & Osteopathic Examiners 101 N. Main Ave. Ste. 301 Sioux Falls, SD 57104	[ ] U.S. Mail (First Class) [ ] Hand Delivery [ ] Facsimile [ ] Overnight Delivery [ ] Electronic Case Filing [X] E-Mail

Dated this 30 day of April, 2015.

HILL CITY AMBULANCE DISTRICT
dba HILL CITY AMBULANCE SERVICE

BY: Sara Booth

Sara Booth
Co-Director
359 E Main St. PO Box 671
Hill City, SD 57745
605-574-2631

Exhibit 2

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

April 17, 2015

Hill City Ambulance Service
Attention: Sara Booth
359 E Main St
Hill City, SD 57745

Re: In the matter of Matthew Gildeleon

Dear Ms. Booth:

Attached is a Subpoena Duces Tecum which requests information in the matter of Matthew Gildeleon. Please comply with the subpoena by mailing the requested materials to this office as soon as possible.

If you have any questions, please do not hesitate to contact our office and thank you for your cooperation in this regard.

Sincerely,

Misty Rallis

Misty Rallis
Board Investigator

misty.rallis@state.sd.us

Enclosure

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

STATE OF SOUTH DAKOTA) : SS
COUNTY OF MINNEHAHA)

SUBPOENA

DUCES TECUM

TO: Hill City Ambulance Service
Attn: Sara Booth
359 E Main St
Hill City, SD 57745

In the matter of: In Re: Matthew Gildeleon

GREETINGS

YOU ARE HEREBY COMMANDED to be and appear at the office of the South Dakota Board of Medical and Osteopathic Examiners, 101 N. Main Ave., Suite 301, Sioux Falls, SD, 57104, at 10:00am on May 1, 2015, then and there to give testimony on the part of the South Dakota Board of Medical and Osteopathic Examiners, in the matter noted above which is an administrative proceeding pending before the South Dakota Board of Medical and Osteopathic Examiners.

You are further commanded to produce for examination at the time, date and place stated above, the following:

Any and all documents relating to the termination of Matthew Gildeleon
from Hill City Ambulance Service

In lieu of your appearance as above stated, you may, on or before10:00am on May 1, 2015, mail or otherwise deliver to the undersigned legible copies of the documents and items you are commanded to produce in response to this subpoena. If such documents and items are produced in advance of the date and time set for your appearance, your appearance will not be required.

WITNESS, the Hand and Seal of the South Dakota Board of Medical and Osteopathic Examiners on April 17, 2015.

SEAL

Margaret B. Hansen

Margaret B. Hansen, Executive Director
South Dakota Board of Medical & Osteopathic Examiners

Hill City Ambulance Service
Employee Annual Evaluation

Name: Matt G.	Date: 8 Nov 2013	Hire Date 3/29/2010
EMT# 19261	Certification Level: EMT-I (uncertified Paramedic)	

Remarks: current wage 11.29 hour
scheduled 40 hrs/week 11.79

Performance Elements (please rate yourself)	Overall Ranking: Exceeds		Satisfactory		unsatisfactory
Patient Care	5	(4)	3	2	1
Strengths					
Weaknesses	nervous				
Compliance with Protocols	(5)	4	3	2	1
Strengths					
Weaknesses					
Communication (written & verbal)	5	4	(3)	2	1
Strengths					
Weaknesses	doesn't seem to "like" to communicate				
Scene Management	5	4	(3)	2	1
Strengths					
Weaknesses	over bearing / lack of teamwork				
Driving Skills	(5)	4	3	2	1
Strengths					
Weaknesses					
Patient Confidentiality	(5)	4	3	2	1
Interaction with Staff/Supervisor (decision-making, cooperativeness, involvement)	5	4	3	(2)	1
	Confrontational, doesn't communicate				
Involvement (meetings, extra-curricular, social)	5	4	3	(2)	1
	doesn't				
Dependability (attendance, punctuality, attentiveness)	5	4	(3)	2	1
Knowledge (Treatments, Protocols, Scope of Practice)	5	(4)	3	2	1
Skills (IV, AED, 12-lead, Combitube, nebulizer, etc)	5	(4)	3	2	1
	lack of confidence?				
Abilities (lifting & carrying, scene management, stress management)	5	(4)	3	2	1
Attitude (motivation, cooperativeness, personal appearance/hygiene)	5	4	3	(2)	1
	unshaven, unshowered, unprof. appearance, often irritated				

Where do you see yourself in a year?
What are your goals? (career development/satisfaction, personal development, etc)

46

Sara Booth, Hill City Ambulance Co-Director Notes:

20 August 2014

1015 hrs

Had to tell Matt to report to the station. Told him staff is expected to keep "office Hours" at the station.

---

3 Sept 2014

1000 hrs

Had to ask matt to report to work again

Oct 15 2013

Matt agreed to work 0001-1600 for Sara (8 hrs tradeback, 8 hours OT). Allison reports that she was awake all night because she was concerned that he did not come in at midnight, she wasn't sure she even had a partner. When he finally came in about 8:00 am or so he was evasive and defensive saying he "was around".

When Sara came in around 9:30 for office business, she directly asked him if he'd forgotten that he had agreed to work for her at midnight, he denied forgetting. When Sara asked him where he was rather than at the station, he said he was "at a buddy's house".

December 18, 2014

Very upset with Matt after outburst at Christmas party Dec 13 where he got on stage and "thanked" Brandon for being the only Paramedic in Hill City for two years.

Sara & Slade met with Monte and Kay at 4:30 pm on Dec 16 to discuss firing Matt. Not so much for their approval but to bounce strategy off them. Was decided that it was poor timing (week before Christmas) and that we really didn't have a proper "paper trail" of attempts to correct his behavior.

Sara & Slade met with Matt at about 4:30 on Dec 17 to discuss with him the following:

Bad attitude
Relations with staff
Driving
Outburst at Christmas party
His general stress level
Lack of participation in AEMT class
Dropping out of AEMT class

Shaking
Drinking

We told him that it seemed as though he was miserable here. He frequently complained about other staff and there was a long list of staff that he had said he was not willing to work with. Many staff had said they didn't want to work with him.

We put him on performance probation and will reevaluate in January.
Life's too short to be miserable.

Matt expressed surprise that staff was not happy with him. He said that after a couple years of significant stress in his personal life (EMT-P school & ride-along, test, not passing test, separation & divorce) things were looking up for him (first vacation next week with new girlfriend) he thought things were definitely improving and having a better relationship with staff and better attitude would be no problem.

January 6, 2015

Matt asked me to find staff to work for him so he could be gone to celebrate Christmas. He wanted to trade time so that he could preserve his paycheck – he had no vacation or sick time left.

I worked two shifts for him and arranged "payback" dates with him before his trip.

On Thursday Jan 1 I called matt to double check that he remembered he was working for me "payback" 0001-0800 on Friday Jan 2 and also reminded him that the other "payback" shift he owed me was 0001-0800 Monday Jan 5. He verbally confirmed all of this.

Monday afternoon, jan 5 matt called me to confess that he had completely forgotten he was suppose to work for me 0001-0800 hrs that day and was, in fact, not in Hill City during that time. He offered to work for me to fulfill the payback on 0001-0800 Jan 6. He said he specifically want to tell me of his mistake in person and apologized a couple times over the course of the conversation. I agreed to let him work for me on Jan 6.

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27 Jan 2015

Texted Allison to ask about PCR 1418501 – it is still not completed despite date of service being 12/15/2014. The report is now 6 weeks old.

She said: "I was going to do it last week and refused to breathe any more of the toxic air around Matt in the meeting room. He reeks."

I was briefly in training room with matt Jan 21 or 22 and it was apparent that Matt had not showered recently. The odor in the room was very strong.

Feb 4, 2015

Went down to the station about 10 am to show Matt the new responding software. He was asleep in the chair in training room. Had to ask him at least 3 times to wake up – made some argumentative comments ("but I'm sleeping" "why do I have to wake up?" "you want to talk about Insurance?")

Feb 5, 2015

Got to the station around 8 am for my shift and immediately began truck checks. Matt came out after a little while obviously having just woke up. Commented that he'd done truck checks the day before just didn't write them down. I commented that there was no way for me to know what had been done if it wasn't written down. After I was done with H2 (primary ambulance and the time) I asked him to do checks on H1 – there was nothing written down for many days previous. He made a snarky comment about "I bet I go back there (the back of the ambulance) and the paper (daily test strip) is gone from the Lifepak" this is his "proof" that someone did truck checks. I replied that I could tear a paper off and do nothing else too. He didn't seem pleased at all that I was asking him to do his chores.

Exhibit 2

From: SS [emtfyr@gmail.com]
Sent: Monday, December 15, 2014 12:05 PM
To: Hill City Ambulance Service
Subject: just my thoughts

It's been obvious that you're not happy with the service for a long time.
We have had board members tell us that you have complained about us on more than one occasion.
When we spoke to you about it, you had your facts wrong. Example (No raises due to auto accident and financial issues. Not because we just didn't want to).

Nearly every EMT on the service has complained to us about your performance.
Examples:
Driving – Some have said they are very concerned for their own safety. That you drive erratically and way to fast.
Patient skills – many have told us that they are concerned about your patient skills, time management on calls, decision making, and IV skills.
Intoxication – we have had complaints that you have come into the fire hall while very intoxicated. And that there are times you have been somewhat aggressive with some of the on duty staff.
Several staff have commented on you shaking to the point where you have struggled to give IV's.
We had a patient also comment on you shaking and making them nervous.
You admitted that the shaking was due to over drinking when off duty.
Misrepresentation – Last christmas party you announced to the staff and the ambulance board that you are a paramedic
This past Saturday night you made it very apparent how unhappy you are with the service and our leadership.

We had a Board member suggested we let you go several months ago. We decided to try to continue to work with you.
We have personally witnessed most of these issues ourselves and we have spoken to you about these problems on many occasions.

Slade Swedlund, Co-Director Hill City Ambulance, Note:

On December 31st 2014 I received a text from Clayton stating the following.

Clayton = "Hey sorry to bother you on a holiday but I think Matt is not thinking clearly. He has been acting strange all morning and I don't know how to proceed."

I asked Clayton what Matt was specifically doing that was strange.

Clayton = "Kinda slurring his speech and talking about things no one else was talking about. Just out of the blue"

I called and spoke to Matt on the phone. I asked him how things were going and if he had a good Christmas. On the phone it sounded to me that Matt was alert and oriented, however he did slur his speech a couple times.

I drove to Hill City and he spoke with Matt in person. Matt's hands were shaking somewhat dramatically, his eyes were blood shot, and he seemed to have some trouble articulating a few of his words. For example: when Matt was trying to describe a Scale he said "the thing that measures weight". Matt was alert and oriented to person, place, time, and event. When Matt walked into the other room his walk seemed normal.

On Friday January 2nd Matt no longer appeared to be shaking, He seemed more calm, and his eyes were no longer blood shot. I asked Matt about his shaking and he said he did go to the doctor last Tuesday. Matt said the doctor switched up his medications and he thought it would help. Matt also mentioned he has a lot of anxiety and he gets a little nervous when he is around me.

LMARLIS

DURING LATE ~~SPRING~~ FALL, EARLY WINTER I RESPONDED TO A CHOKING CALL TO SLATE CREEK GRILL WITH EMT RASK AND LEMTS BONDE AND GILDEZEON. MATT DROVE WHILE BONDE AND MY SELF SAT IN THE BACK. RATHER THAN TAKING THE DIRECT ROUTE DOWN MAIN ST, MATT TOOK THE BACK ROAD OFF MAJOR LAKE DR. UPON ADDITIONAL INFORMATION FROM DISPATCH, THE PATIENT WAS NO LONGER CHOKING AND WAS ALERT JUST WANTED VITALS TAKEN. MATT DID NOT SLOW DOWN AND CONTINUED HOT. WHEN WE CAME TO THE BRIDGE, HE DID NOT SLOW DOWN AND HIT THE SPEED BUMP SO HARD THAT BONDE AND MYSELF WE TOSSED AROUND THE BACK AND HAD TO HOLD ON AS TO NOT BE THROWN AROUND. UPON ARRIVAL MATT ~~DID NOT~~ DO ANY PATIENT CARE, EMT RASK TOOK LEAD WHILE MYSELF AND BONDE TOOK ALL VITALS.

JESSE MCHARGUE - EMT

6MAR15

LATE LAST SUMMER I RAN A CALL WITH EMT CLAYTON RASK AND IEMT MATT GILDELEON. THE CALL WAS AN EIGHT YEAR OLD GIRL IN SEVERE RESPIRATORY DISTRESS. THE LOCATION OF THE CALL WAS THE HILL CITY CLINIC. UPON ARRIVAL, AUDIBLE WHEEZES WERE HEARD. BASED ON THE GENERAL IMPRESSION OF THE GIRL, IT WAS IMMEDIATELY DETERMINED THAT RAPID TRANSPORT WAS NEEDED. HIGH FLOW O^2 WAS ADMINISTERED VIA NON REBREATHING MASK AND SHE WAS PLACED ON THE STRETCHER. WE INFORMED HER GRANDMOTHER THAT WE WE TRANSPORTING HER TO RAPID. EMT RASK DROVE WHILE MYSELF AND IEMT GILDELEON TOOK PATIENT CARE. WE REQUESTED THAT A MEDIC INTERCEPT WITH US. AFTER OBTAING VITALS, AND DETERMING O^2 WAS NOT HELPING, GILDELEON SAID "SHE NEEDS A NEBULIZER TREATMENT" I TOLD HIM TO DO IT AND HE REFUSED. HE TOLD ME TO ~~DOTO~~ DO IT, I INFORMED HIM ~~THAT~~ IT WAS OUT OF MY SCOPE

OF PRACTICE. HE AGIN TOLD ME TO DO IT BECAUSE "HE WASN'T GOING TO." I GOT THE NEB TREATMENT FROM THE CABNIT AND AS I DID I ASKED GILDELEON TO ESTABLISH AN IV ACCESS. HE REFUSED SAYING, "I DON'T WANT TO SCARE HER ANYMORE THAN SHE IS." MATT SAT IN THE CAPTAINS CHAIR FACING THE WALL REFUSING TO ASSESS THE PATIENT. I ASKED MATT TO ASSEMBLE THE NEBULIZER TREATMENT FOR ME AND HAD TO EXPLAIN EACH STEP TO HIM. HIS HANDS WERE SO SHAKY THAT I TOOK THE ALBUTEROL FROM HIM AND POURED IT MYSELF OUT OF FEAR HE WOULD SPILL IT. UPON MEDIC INTERCEPT, I GAVE A FULL VERBAL REPORT ON MY PATIENT. IN MY OPINION, I SHOULD NOT HAVE TAKEN LEAD ON THAT CALL NOR SHOULD HAVE BEEN THE ONE TO ADMINISTER ALBUTEROL

JESSE MCHARGUE - EMT

Cesar Meza, EMT with Hill City Ambulance, stated the following about Matt.

"Matt has random outbursts"

"I've witnessed Matt struggling with doing IV's due to his shaking dramatically"

"There are times when Matt is not in the right frame of mind"

"Matt left his on duty partner (Noble) to respond to a motorcycle accident"

At the motorcycle accident mentioned above (patient had a seizure, then wrecked the motorcycle), "Matt was Extremely hyped up", causing people at the scene to become nervous and hyped up themselves.

On March 4, 2015 around 08:10 while doing trucks with my partner Matt Gildeleon I approached close to him and detected what I thought to be a strong smell of alcohol. He immediately moved away and tried to remain at a distance for the rest of the morning.

At approximately 11:10 we had a walk in patient who asked me to check them out. I proceeded to do so as Matt was at breakfast. After I checked vitals and gave the patient a brief assessment I told them we should take them to the emergency room. The patient denied and attempted to call their spouse. I managed to get the patient to wait with me while they tried to contact their spouse.

At this time Matt returned and I apprised him of the situation. He got in the back of the ambulance with the patient and I went to use the restroom. Upon arriving back at the ambulance I opened the door to go in and a very strong smell was immediately apparent. It smelled like alcohol and body odor. I entered the ambulance and Matt was telling the patient there was no need for us to take them to the ER if their spouse was coming as we could not fix anything that may have been wrong with their condition based on their symptoms and diagnostic equipment.

At this time I asked Matt if we should have the patient sign a refusal. He replied no and then offhandedly stated we could if we wanted to do the paperwork.

Numerous times I have smelled what I thought to be the smell of alcohol coming from Matt. It seems that Wednesday mornings when he comes in the smell is more of alcohol and he does not shake. He also tries to keep his distance from people. As the day progresses the smell starts to be more like body odor. It is at this time that he begins to shake.

I regret that I have begun to dread getting a call on Wednesday mornings. Most of the Wednesdays I am torn between letting him drive or have patient care. I do not feel safe letting him do either if he smells like alcohol as he so often does.

Sincerely

Clayton Rask
March 4, 2015 18:16

To: Hill City Ambulance Attn: Slade

On 3-4-15 while responding to a call for a structure fire, I encountered Matt Gildeleon on scene. While talking with Matt in the structure, I smelled alcohol on his breath. Matt was on duty with 29H1.

Jason Peters

Hill City Fire & Emergency Services

PO Box 308 Hill City, South Dakota. 57745

To whom it may concern;

Hill City VFD responded to a possible structure fire on Watson Parker Road on March 4th at 12:31. Hill City Ambulance Service provided stand-by for the event. When I entered the dwelling I noticed the smell of alcohol. This odor was present while Matt Gildeleon was in the building. It went away when Matt left the building. One of my Fire Officers mentioned the smell to me as well. I had a conversation with our Pennington County Deputy and he advised me he had smelled alcohol at the incident. I can not personally state that the odor was from Matt. I can state I had contact directly with all of my firemen on scene and did not notice it on them and that the odor was absent when Matt left the building.

Best Regards,

Hill City Chief

Exhibit 2

From: Allison Bonde [complete00no7@yahoo.com]
Sent: Thursday, March 05, 2015 11:33 AM
To: Hill City Ambulance Service; Sara Booth; Slade Swedlund
Subject: Incidents regarding Matt Gildeleon
Attachments: bathroom after Matt 08-06-2014.jpg; matt mess in chair.jpg; matt chew in chair.jpg; IMG_0314.MOV (1).mov; 08-18-2014 Matt Chute Rooster.m4a; 08-18-2014 Matt Ride To Slade's.m4a; 08-20-14 Matt Complaining Of Checking In.m4a

To the Hill City Ambulance Service:

I have been keeping a record of a few of my encounters with Matt Gildeleon. I am now going to share them with you. Included are descriptions, dates, pictures, and even recordings. I have always tried to help Matt, but became increasingly uncomfortable around and with him, so decided so take some precautions.

Incidents regarding Matt Gildeleon:

I have found that working with EMT-I Matt Gildeleon is very stressful for many reasons.

The first thing that strikes you is the smell. Every Wednesday morning when he comes to work, he reeks of ETOH or ETOH and body odor. Even if he *has* showered recently, he cannot control the smell of his breath. The alcohol smell takes over the entire meeting room (if he stays in there and doesn't just avoid you for hours in the bay), and this is a large room with an automatic air freshener. It eventually drives you to seek out another place to be.

At least now he *does* show up on Wednesday mornings. For an extended period of time, it wasn't unusual to go awhile without even seeing him. I always stayed as a volunteer after my shift until he did arrive. Both Clayton and I were afraid there would be a call and Clayton wouldn't have a partner.

On 08-20-2014, he still hadn't arrived by 10 AM for his 8 AM shift. Clayton became worried and texted this information to Slade. Clayton finally called Sara to share his concerns. Matt showed up around 10:30 (after receiving a call from Sara, who had his number) and Matt was on the fight. He was complaining to me from the other end of the fire hall (as I was at the refrigerator). I decided that would be a good time to record the conversation and did so. It is attached. He blamed me, even though I had nothing to do with it and had stayed to ensure coverage on my own time. Still he staunchly blamed me and kept muttering nasty things about me. I told him to say it to my face. He also complained that he was the only one who had to "check in". (Standard procedure is that the EMTs working the 8 AM to 4 PM weekday shift do so from the fire hall. Everyone else complies.)

Then there is the shaking. During AEMT class, Clayton and I would practice placing IVs on each other. Since Matt is an Intermediate, he could sign off as a witness. Even then, signing was almost more than he could do. His hands shook so badly that he could barely initial the paperwork.

Exhibit 2

Since Matt was also in the class and needed 25 successful IVs to pass, Clayton and I would offer to let him practice on us. Being an Intermediate, I could also sign as a witness, just not to my own placements. Matt always refused. In fact, he never completed a single IV, thus contributing to his inability to pass the class.

In August, Matt showed up with at least twenty little cuts to his face (blood clots and scabs were present everywhere). He asked if he could borrow some lotion from me as he had a "rash". I provided some. Clayton and I both suspected that he had cut himself shaving since he shakes so badly. The next week he confirmed that he thought he did it shaving, also recorded.

Then there is the mess in the bathroom. Clayton has to deal with it all of the time. I only have to when he uses the women's restroom. On 08-06-2014, he used the bathroom shortly after I had. It was fine when I used it. I went back in for a Q-tip and saw the reflection of drops on the stool. He had peed all over the stool and some on the floor and I had to clean it up. Picture is attached. I can only assume it was because his hands shake so violently. Clayton shares this suspicion and has to endure the filth and clean up after him.

Please ask Clayton about the shaking on duty, especially when working with a patient (including the patient asking Clayton if Matt was all right). It would also be in the best interest of the Service to interview Noble LaCroix on this subject for the same reasons, as well as Jesse McHargue, Cesareo Meza, and former employee Melissa Swedlund. These people have all shared their concerns with me.

These things pale in comparison to the incompetence and downright dangerous decision making displayed by EMT-I Gildeleon. I will expand.
Clayton and I volunteered over each other's shifts last summer in an effort to have three people on an ambulance and get him experience in the back of the rig with the patient and not just as a driver. I was therefore present on many calls with Clayton and Matt.

By far the most fear inducing was the call for a woman choking at the Slate Creek at the end of last summer. Matt was first to the truck and got in the driver's seat. Clayton was on duty and in the passenger seat. Both of them were wearing seatbelts. Jesse McHargue was present at the station and both he and I got in the back of the ambulance – me in the captain's chair facing forward and Jesse on the long bench.
Traffic was heavy. While we were still on the apron in front of the fire hall, Dispatch came back on the radio to inform us that the woman was now fine, but still wanted to be checked out, just to be safe. Matt was shaking uncontrollably. After the information was acknowledged, he turned on the lights, gunned the engine, and LURCHED headlong into traffic without checking, both throwing me backward off my feet from a complete stop and causing vehicles to slam on their brakes. He inexplicably turned right instead of left, coming to a stop in the middle turn lane just before Deegan Street. He said he was going to come from the back to avoid traffic. I reminded him that he HAD to use his sirens in town, and he was shaking so badly that he was having trouble centering in on the switch and turning it on. Upon finally succeeding, he once again shot forward in front of oncoming traffic and turned left and left again onto Museum Road. At this point he again floored the ambulance accelerator. I knew the road and the upcoming dip on the bridge. I loudly said "Matt there's a bump!" but he didn't slow. I stated

again in a louder voice "Matt, there's a huge bump!" No change. Not wanting to be knocked on the floor, I quickly sat back into the captain's chair. He saw the vicious hump at the last second and braked, but it was too late. I went flying upward in my seat, completely leaving it and then coming back down half on it. The equipment in the cabinets smacked down hard. Jesse and I just looked at each other in amazement.

Remember, this was all to get to a person who was now fine and only wanted to be checked out. There was no reason to run hot at all. There was no conceivable justification for endangering everyone on board, as well as all of the civilians in surrounding vehicles. Please, please, please talk to Clayton and Jesse as I'm sure they remember this incident. Clayton can tell you of other poor driving choices, as well.

Even doing his job seems to be more than he is willing. As I stated, when Clayton first started, I ran as a third so he could get experience with the patient and another EMT. Clayton and I initially shared 16 hours of my shift, so I couldn't help him there, but could when he was on with Matt. Slade asked that I let Matt and Clayton take patient care so as to avoid any appearance of favoritism and to broaden Clayton's experience. I readily agreed. The very next night we were paged to an elderly man having severe difficulty breathing . Matt drove, Clayton was in front, and I was in back and didn't see the driveway during arrival as I was preparing equipment. Once there, Clayton and I carried the jump bag and portable oxygen inside. The man was in dire need of assistance. We took vital signs and started him on oxygen and were ready to load and go. Matt still had not come inside.

I hated to leave Clayton alone, but had promised to let the two of them take patient care. I took the minute to check on Matt. He was outside standing by the ambulance. He told me he figured we could handle it and was getting the cot ready. The cot was still in the truck and hadn't been touched. I helped him unload and prepare it and take it to the bottom of the outside stairs. He still wouldn't go in. I asked him to take patient care with Clayton and he didn't want to. I then told him what Slade had said and he reluctantly went inside. I accompanied and we then brought out the patient and loaded him into the ambulance.

As driver, I now needed to back out of a long driveway in the dark that I hadn't seen. I did know it dropped off on the left. Matt had driven in and offered to spot me. It was then that I discovered he didn't know the basics of spotting. Not only did he constantly disappear behind the rig (if you can't see me in the mirror, I can't see you), but he almost ran me into a rock wall on the right. I saw it at the last minute. It was then I decided to ignore his instructions and do it myself. I do have a lot of practice. I went slowly so that he had plenty of time to get out of the way when I couldn't see him. He then got back in the ambulance and I drove to Rapid City.

On 12-18-2014, when Matt and I were on shift, we were called to the Hill City Clinic for a young man who had passed out after receiving a shot. Matt beat me to the driver's seat, so I rode in the passenger seat. We parked behind the clinic and firefighter Vic Alexander was already there. Matt came around the rig and passed me and went to the clinic door thirty feet away. I asked him to help me take in our equipment. He said no, we would just use theirs. I strongly disagreed with this decision and got the equipment. Matt was already inside, but Vic waited for me and held the door while I carried the jump bag and portable oxygen in myself.

Once inside, we found a young man lying on the floor with a blood pressure cuff on his arm.

Exhibit 2

Matt had already taken lead and was talking to the patient. No other diagnostic equipment was present. I took the supporting role and obtained vital signs. Matt was in a hurry to get back out of there. He didn't interview the patient long enough and the patient was no better when Matt wanted to leave. He had been assisted to a sitting position in a chair, which almost made him pass out. Yet Matt was going to leave because the man refused and he was in a clinical setting. I was not only uncomfortable with this decision; I was also not going to go along with it. I took over the interview and subsequently found out that the young man was training for an iron man marathon and hadn't eaten or been drinking fluids since the previous day. It was his birthday and he and his mother were going to The Alpine for lunch, so he was building up his appetite. She was also present and helpful with more information. Upon further questioning it was discovered that his father had passed out similarly (but at The Alpine) a few months previously and the ambulance had been called. More importantly, he had affective schizoid disorder, depression, took multiple medications, and it was finally revealed that he had a cardiac history. Jesse McHargue had arrived on foot by this time and witnessed much of this. I asked him to get the LifePak from the truck and obtained several ECG readings both to monitor the patient's health and to save us and the Service from claims of neglectful care later. During this whole time I had the patient drinking fluids and the nurse gave him chocolates. His blood sugar was fine, but he hadn't eaten. His mother then ordered take out from The Alpine and we didn't leave until he was eating and starting to feel stronger. I made him promise not to get up or walk without someone beside him for awhile. We were there close to an hour, but only because I wouldn't leave.

This was a call that could have easily gone terribly wrong. Yet Matt merely thanked the young man for not calling the ambulance until his movie was over, because people usually paged him out when he had ten or fifteen minutes left to go and he hated that. I cringed inside.

By the way, not bringing in equipment is also a common complaint among Matt's partners.

Now I come to 12-31-14. Matt arrived on time for his 8 AM Wednesday shift. Clayton and I were shortly thereafter convinced that Matt was altered in some way. He was slouched down in his recliner chewing on the ends of the cords of his hoodie, which was pulled half over his eyes. He kept making random outbursts and statements that had nothing to do with any conversation in progress or the programming on the TV. And, of course, there was the smell. Cesareo Meza arrived during this time and noticed the odd behavior, as well. Both Clayton and I texted Directors about Matt being "off" and stated he should be checked.

I would be remiss if I didn't mention the swearing. While I pepper my conversation occasionally, Matt usually has pretty strong words to use in his descriptions. Mostly the "F" word.

On 08-17-2014, Matt got kicked out of the Chute Rooster and walked to the fire hall. He slept it off in a recliner and made a mess. Picture attached. The next morning he made conversation when he awoke and then was going to walk to Slade's, where he was apparently staying. He then walked back into the hall and asked me for a ride, which I gave him. I recorded both conversations. I'm afraid I didn't know what to expect and wanted to be on the safe side. They are attached. Please notice the language. This is mostly standard for him.

Even his mother worries about him. She once called the station looking for him because he

Exhibit 2

hadn't arrived on a flight to California as scheduled. He was considered missing for awhile.

There are more incidents for which I have neither a recording, picture, or date. However, it is always something. Matt has problems, even including poor EMT skills, as demonstrated in class. Interviews with any of his partners will yield similar concerns, whether it be the proper air flow for a nebulizer treatment (with which he disagrees and doesn't use), IVs attempted while shaking uncontrollably, substandard driving, or simply poor decisions regarding patient care/refusals, etc. I urge you to canvass the other employees.

Thank you for your time.

Allison Bonde

From: SDBMOE
To: "gildeleonsd@msn.com"
Subject: South Dakota Board of Medical and Osteopathic Examiners
Date: Thursday, May 14, 2015 12:28:00 PM
Attachments: 5-14-15 Letter to Matthew Gildeleon.pdf

Mr. Gildeleon,
Please find attached a letter that was also sent by US mail.

Sincerely,
Misty Rallis
Board Investigator
SD Board of Medical & Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104
www.sdbmoe.gov

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

Exhibit 3

May 14, 2015

Matthew Gildeleon
PO Box 310
Hill City, SD 57745

Dear Mr. Gildeleon:

According to the South Dakota administrative rules for complaints[1] and investigations[2], you are receiving this letter to notify you of a complaint, that a file is being opened in this matter, and that a response from you is required. The complaint is regarding your termination from the Hill City Ambulance Service and we would appreciate receiving your response no later than May 28, 2014. 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 Misty.Rallis@state.sd.us to make other arrangements.

Sincerely,

Misty Rallis

Misty Rallis
Board Investigator

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[1] **SDCL 20:78:04:02. Complaints.** The executive secretary may initiate an investigation based on a written complaint. Any person filing a complaint shall submit the complaint in writing to the executive secretary. A complaint is not a public record. The executive secretary shall dismiss any complaint that concerns matters over which the board does not have jurisdiction, and shall notify the complainant of that action. The executive secretary may also initiate an investigation upon reasonable suspicion that a licensee is in violation of any applicable standard for professional conduct.

[2] **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.

From: Rallis, Misty
To: "gildeleonsd@msn.com"
Subject: South Dakota Board of Medical and Osteopathic Examiners
Date: Thursday, June 04, 2015 8:33:00 AM
Attachments: 6-4-15 Letter to Matthew Gildeleon.pdf
5-14-15 Letter to Matthew Gildeleon.pdf

Mr. Gildeleon,
Please find attached two letters that were also sent by US mail today.

Sincerely,
Misty Rallis
Board Investigator
SD Board of Medical & Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104
www.sdbmoe.gov

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Exhibit 4

June 4, 2015

Via email and US Mail

Matthew Gildeleon
PO Box 310
Hill City, SD 57745

Dear Mr. Gildeleon:

On May 14, 2015, I sent a letter requesting that you provide a response to a complaint submitted to the Board by May 28, 2015. Attached please find at copy of that letter.

We would appreciate receiving your response no later than June 19, 2015. 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

Misty Rallis
Board Investigator

From: SDBMOE
To: "gildeleonsd@msn.com"
Subject: South Dakota Board of Medical and Osteopathic Examiners
Date: Wednesday, July 01, 2015 10:28:00 AM
Attachments: 7-1-15 Letter to Matthew Gildeleon.pdf
6-4-15 Letter to Matthew Gildeleon.pdf
5-14-15 Letter to Matthew Gildeleon.pdf

Mr. Gildeleon,
Please find attached letters that were also sent by US mail today.

Sincerely,
Misty Rallis
Board Investigator
SD Board of Medical & Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104
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HTTP://WWW.SDBMOE.GOV

Exhibit 5

July 1, 2015

Via email and US Mail

Matthew Gildeleon
PO Box 310
Hills City, SD 57745
gildeleonsd@msn.com

Dear Mr. Gildeleon:

On May 14 and June 4, 2015, I sent letters requesting that you provide a response to a complaint submitted to the Board. At this time, we have not received your response. Please find copies of those letters attached.

Your license is due to expire on July 15, 2015. If your license expires on this date it is reportable[1] to any national database as "withdrawn while under investigation." This is according to SDCL 20:78:04:06.

Thank you for your attention to this matter and we anticipate your prompt response. If you have questions, please notify this office in writing by email to SDBMOE@state.sd.us or US mail.

Sincerely,

Misty Rallis

Misty Rallis
Board Investigator

---

1 SDCL 20:78:04:06. **Effect of failure to renew during investigation.** The holder of a license, permit, or certificate may choose not to renew the license, permit, or certificate after a complaint investigation has been initiated by the executive secretary. A failure to renew after investigation has been initiated shall be reported as "withdrawn under investigation" in the board's permanent license files and in any national databases to which the board is required to report licensure action.

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

Re: MATTHEW PIERRE GILDELEON TEMPORARY APPROVAL ORDER

****

Matthew Pierre Gildeleon, EMT I/85 Licensee failed to renew his license while it was under investigation. Pursuant to ARSD 20:78:04:06, his license is deemed "withdrawn under investigation".

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

Margaret B. Hansen

By:_____ Date: 9/1/2015

Margaret B. Hansen
Executive Director

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 9-1-15

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* * * \

STATE OF SOUTH DAKOTA
DEPARTMENT OF HEALTH

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

IN THE MATTER OF SOUTH DAKOTA EMT/I 85 LICENSE #1528 Re: MATTHEW PIERRE GILDELEON	FINAL ORDER LICENSE WITHDRAWN UNDER INVESTIGATION

****

The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("Board"), and the Board having been fully advised in the premises thereof; and Mr. Gildeleon not appearing personally or through counsel. Board staff was present and represented by Assistant Attorney General William Golden.

The Board having found that pursuant to *ARSD 20:78:03:07* Mr. Gildeleon failed to submit a renewal application or renew his EMT I/85 license while it was under investigation. It is hereby

ORDERED that Mr. Gildeleon's EMT I/85 license #1528 is deemed withdrawn under investigation. It is further

ORDERED that this is a public record of the Board and the State of South Dakota and shall be published on the Board's website and reported as required to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

Dated this 3rd day of December, 2015

BOARD OF MEDICAL AND OSTEPATHIC EXAMINERS

By:_____
Kevin L. Bjordahl, MD
Board Vice President

STATE OF SOUTH DAKOTA
DEPARTMENT OF HEALTH

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

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IN THE MATTER OF SOUTH DAKOTA EMT/I 85 LICENSE #1528 Re: MATTHEW PIERRE GILDELEON	FINAL ORDER LICENSE WITHDRAWN UNDER INVESTIGATION

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The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("Board"), and the Board having been fully advised in the premises thereof; and Mr. Gildeleon not appearing personally or through counsel. Board staff was present and represented by Assistant Attorney General William Golden.

The Board having found that pursuant to *ARSD 20:78:03:07* Mr. Gildeleon failed to submit a renewal application or renew his EMT I/85 license while it was under investigation. It is hereby

ORDERED that Mr. Gildeleon's EMT I/85 license #1528 is deemed withdrawn under investigation. It is further

ORDERED that this is a public record of the Board and the State of South Dakota and shall be published on the Board's website and reported as required to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

Dated this 3rd day of December, 2015

BOARD OF MEDICAL AND OSTEPATHIC EXAMINERS

By:_____
Kevin L. Bjordahl, MD
Board Vice President

STATE OF SOUTH DAKOTA
DEPARTMENT OF HEALTH

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

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IN THE MATTER OF: 14-189

COLIN J. BOONE FINAL ORDER

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The above captioned matter came before the Board of Medical and Osteopathic Examiners on Thursday, September 10, 2015. Mr. Boone did not appear personally or through counsel. Board staff was present and represented by Assistant Attorney General William Golden. The Board being otherwise fully informed of the facts and issues pertinent to the matter, the Board issues the following: It is therefore

ORDERED that the Findings of Fact, Conclusions of Law and ALJ Recommendation for Denial of his Application for Advanced Life Support Student Status is adopted by the Board. It is further

ORDERED that these documents are public records of the Board and the State of South Dakota and shall be published on the Board's website and reported as required to the national practitioner data bank and all other entities deemed appropriate by the Board in compliance with State and Federal law.

Dated this 3rd day of December 2015

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By:_____
Kevin L. Bjordahl, MD
Board Vice President