

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Thursday, March 3, 2016

Public Board Meeting

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

1. **Pierre - Public DDN site:** CAP A, 500 E. Capitol Ave., Room B12, Pierre, SD 57105 (605-773-3333)
2. **Rapid City - Public DDN site:** TIE Dakota Room, 1925 Plaza Blvd, Rapid City, SD 57701 (605) 394-1876)
3. **Board Conference Room:** 101 N. Main Ave., **Suite 215**, Sioux Falls, SD 57104

9:00 am (central time)

Current Board Member Meeting Attendance Record¹

	KLB	DKB	WOC	MSC	LBL	BJL	DEL	JAM
3/11/15	<input checked="" type="checkbox"/>	<input type="checkbox"/>						
6/11/15	<input checked="" type="checkbox"/>							
7/21/15	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9/10/15	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	r	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9/24/15	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12/3/2015	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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

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

Meeting Agenda

1. Welcome, call to order, roll call (Jane), approval of agenda – President Walter O. Carlson, MD
2. **9:00 AM - Public Hearing on Proposed Administrative Rules**
Legislative Research Council -comments and form/style changes
 - a. Article 20:83, Chapter 20:83:04, Section 20:83:04:01;.02 – Licensed Nutritionist - Continuing Education.
 - b. Article 20:64, Chapter 20:64:02&.04 – OT/OTA - Licensure Requirements.**Request withdrawal or reschedule hearing for future date**
 - a. Article 20:52;. Chapter 20:52:01, Section 20:52:01:03:02 - Supervision of a licensed physician assistant -- Separate practice location.
 - b. Article 20:63, Chapter 20:63:01;.02;.03 – Athletic Trainers - General Provisions.
 - c. Article 20:66, Chapter 20:66:03 – PT/PTA-Continuing Education.
 - d. Article 20:47, Chapter 20:47:03, Section 20:47:03:13 – Physicians and Surgeons Licensure - Locum tenens certificate.
 - e. Article 20:83, Chapter 20:83:04, Section 20:83:04:03 – Licensed Nutritionist – Continuing Education - Waiver
3. Approval of minutes: December 3, 2015
4. Approval of new licenses, permits, certificates and registrations issued: December 1, 2015 through February 29, 2016 (available after March 1, 2016)
5. Public Hearing
 - a. PA Hearing
 - b. CNP Hearing
6. 10:30 am – Advanced life support petition
7. Financial report
8. Advisory committee business
9. Executive director report
10. Lunch (noon)
11. 1:00 pm - Confidential physician hearings (Closed sessions pursuant to SDCL 36-4-31.5 unless privilege is waived by physician)
12. Mission Statement review
13. Proposed Rule for Physician/Physician Assistant Spouses and Supervision – for review
14. Proposed Rule for Medical Record Documentation – Opioids – for review
15. Docket Review
16. Executive session: SDCL 1-25-2(3): consult with legal counsel
15. Future Meeting Dates
2016: Thurs. June 2; Thurs. September 8; Thurs. December 1
FSMB Annual Meeting: April 28 – 30 – San Diego, CA
2017: Thurs. March 9; Thurs. June 8; Thurs. September 14; Thursday, December 14
FSMB Annual Meeting: April 20-22 Ft. Worth, TX

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

¹ Meeting attendance history available upon request



January 29, 2016

Tyler Klatt
South Dakota Board of Medical and Osteopathic Examiners
101 North Main Avenue, Ste. 301
Sioux Falls, SD 57104

Dear Mr. Klatt:

The Board of Medical and Osteopathic Examiners has proposed the amendments of ARSD chapters 20:47:03:13 – Locum tenens certificate, 20:52:01:03.02 – Supervision of a licensed physician assistant -- Separate practice location, articles 20:63 – Athletic Trainers, 20:64 – Occupational Therapists and Occupational Therapy Assistants, 20:66 – Physical Therapists and Physical Therapist Assistants, and 20:83 – Nutrition and Dietetics. We have reviewed the proposed rules, scheduled for hearing on March 3, 2016, and approve them for legality, with the following exceptions.

SDCL §36-4-20.4 allows for a locum tenens certificate to be issued for a period not to exceed 60 days. However, 20:47:03:13 goes beyond the scope of authority granted by statute by allowing for a locum tenens certificate to be issued for a total of 120 days. Unless there is other statutory authority to extend the time allowed by statute, please remove it from the list.

The activities of physical therapists and physical therapist assistants that constitute unprofessional conduct are specified in SDCL §36-10-40 and the statute does not delegate authority to the Department of Health to add any activities to the list. However, 20:66:03:01 goes beyond the scope of authority by classifying failure to meet the continuing education requirements as unprofessional conduct. Unless there is other statutory authority to expand upon the activities listed in the general authority or laws implemented, please remove the last sentence from 20:66:03:01.

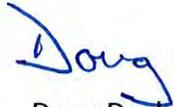
The laws being implemented under Article 20:26 do not require continued education for physical therapists and physical therapist assistants. Although requiring continued education may fall under the general authority to promulgate rules regarding licensure, this authority is weak. Unless there is

other statutory authority to allow for requiring continuing education of physical therapists and physical therapist assistants we recommend pursuing statutory changes before promulgating the rules of Chapter 20:66:03.

Finally, SDCL §36-10B-9 requires practitioners of nutrition and dietetics to have 15 hours of continuing education annually and does not allow for that requirement to be waived. However, 20:83:04:03 goes beyond the scope of authority by allowing the requirement of continuing education to be waived. Unless there is other statutory authority to waive the continuing education requirements for practitioners of nutrition and dietetics, please remove it from the list.

This letter is based on a preliminary review of your rules. Attached are your rules edited for form and style pursuant to SDCL §1-26-6.5, the Directions For Submitting the Final Draft of the Rules, and the Interim Rule Review Committee Rules Presentation Format. If you have any questions, please do not hesitate to call me or the staff member who has reviewed your rules.

Sincerely,



Doug Decker
Code Counsel

DD:jml
Enclosures

ARTICLE 20:47

PHYSICIANS AND SURGEONS

Chapter

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

CHAPTER 20:47:03

LICENSURE

Section

- 20:47:03:01 Application for license.
- 20:47:03:02 Personal appearance.
- 20:47:03:03 General application requirements.
- 20:47:03:04 Application for reciprocity.
- 20:47:03:05 Repealed.
- 20:47:03:06 Repealed.
- 20:47:03:07 Application for approval of medical or osteopathic colleges.
- 20:47:03:08 Procedure for approval of hospitals.

- 20:47:03:09 Temporary permit for state institution.
- 20:47:03:10 Repealed.
- 20:47:03:11 Repealed.
- 20:47:03:12 Report of facility suspending or revoking licensee's privilege to practice.
- 20:47:03:13 Locum tenens certificate

20:47:03:13. Locum tenens certificate

*Beyond
scope of
authority.*

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 has submitted an application for a full license as described in SDCL 36-4-11. The certificate holder shall be responsible for notifying the Board, in writing, to extend the initial certificate.

Source:

General Authority: SDCL 36-4-35

Law Implemented: SDCL 36-4-20.4

ARTICLE 20:52
PHYSICIAN ASSISTANTS

Chapter

20:52:01 Physician assistant license.

20:52:02 Ethics

CHAPTER 20:52:01

PHYSICIAN ASSISTANT LICENSE

Section

20:52:01:01 Application for physician assistant license.

20:52:01:02 Repealed.

20:52:01:03 Physician assistant practice agreement.

20:52:01:03.01 Supervision of a licensed physician assistant.

20:52:01:03.02 ~~Supervision of a licensed physician assistant — Separate practice location.~~

Repealed

20:52:01:04 Repealed.

20:52:01:05 Termination of physician assistant practice agreement.

20:52:01:06 Repealed.

20:52:01:07 Repealed.

20:52:01:08 Repealed.

20:52:01:09 Renewal of physician assistant license.

20:52:01:10 Repealed.

20:52:01:11 Fee amounts.

~~20:52:01:03.02. Supervision of a licensed physician assistant — Separate practice location.~~

~~In addition to the required two meetings per month, the supervising physician must be physically present on-site every ninety days at each physician assistant practice location. This requirement does not apply to locations where health care services are not routine to the setting, including patient homes and school health screening events. Repealed.~~

Source: 34 SDR 93, effective October 17, 2007.

General Authority: ~~SDCL 36-4A-42.~~

Law Implemented: ~~SDCL 36-4A-29.~~

ARTICLE 20:63

ATHLETIC TRAINERS

Chapter

20:63:01 General provisions.

20:63:02 Licensure requirements.

20:63:03 Continuing education.

20:63:04 Ethics

CHAPTER 20:63:01

GENERAL PROVISIONS

Section

20:63:01:01 Definitions.

20:63:01:02 Date of notice.

20:63:01:03 Filing of physician's written protocol.

20:63:01:04 Revision of physician's written protocol.

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; ^{and} instructional methods;

~~(5)~~ ^{keep} "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 ^{methods} ~~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) "Board of Certification," the Board of Certification, Inc. ~~for its successor~~

[↑]
for the Athletic Trainer

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.~~ **Repealed.**

~~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.
- 20:63:02:03 Replacement of license.

20:63:02:04 Evidence of change of name.

20:63:02:05 Fees for licensure or renewal.

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~~ ^{methods} 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~~ Board of Certification.

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 for its successor.~~

The examination approved by the board is the certification exam of the Board of Certification.

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.
- 20:63:03:02 Standards for continuing education.
- 20:63:03:03 Reporting continuing education.
- 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~~ ^{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: 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.
- 20:64:02:02 Application for licensure by reciprocity.
- 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 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

- 20:64:04:01 Continuing competency requirements.
- 20:64:04:02 Activities for continuing competency requirements.
- 20:64:04:03 Reporting continuing education.
- 20:64:04:04 Waiver of continuing competency requirements.

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.

ARTICLE 20:66

PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

Chapter

- 20:66:01 Fees
- 20:66:02 Ethics
- 20:66:03 Continuing education

CHAPTER 20:66:03

CONTINUING EDUCATION

Section

- 20:66:03:01 Continuing education requirements.
- 20:66:03:02 Activities for continuing education requirements.
- 20:66:03:03 Reporting continuing education.
- 20:66:03:04 Waiver of continuing education requirements.

Weak Statutory Authority

20:66:03:01. Continuing education requirements. To qualify for renewal of a license upon its expiration as prescribed in SDCL 36-10-33, an applicant for renewal must complete 15 continuing education hours in a one-year period in professional education activities updating competency in physical therapy and practice. Failure to meet this requirement shall constitute unprofessional conduct.

the practice of

the continuing education

In addition to SDCL 36-10-40,

Remove last sentence beyond authority

Source:

General Authority: SDCL 36-10-36

Law Implemented: SDCL 36-10-33, 36-10-35.2, 36-10-40

20:66:03:02. Activities for continuing education requirements. Activities that qualify for credit toward completion of the continuing education requirement include programs sponsored or approved by the American Physical Therapy Association or other national or state physical therapy association, activities conducted by a hospital or related institution, and programs sponsored by a college or university. The ~~educational~~ activities must have significant intellectual or practical content dealing primarily with matters directly related to the practice of physical therapy or to the professional responsibility or ethical obligations of the participants.

Source:

General Authority: SDCL 36-10-36

Law Implemented: SDCL 36-10-33, 36-10-35.2

20:66:03:03. Reporting continuing education. To demonstrate compliance with the continuing education requirements, each physical therapist and physical therapist assistant shall sign a statement to confirm completion of the required continuing education hours each year on the renewal application, and shall present proof of completion if requested by the ~~Board~~^b.

Source:

General Authority: SDCL 36-10-36

Law Implemented: SDCL 36-10-33, 36-10-35.2

20:66:03:04. Waiver of continuing education requirements. The board may excuse an applicant from the annual 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: SDCL 36-10-36

Law Implemented: SDCL 36-10-33, 36-10-35.2

ARTICLE 20:83

NUTRITION AND DIETETICS

Chapter

- 20:83:01 Definitions.
- 20:83:02 Licensure requirements.
- 20:83:03 Ethics.
- 20:83:04 Continuing education

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 chapter 36-10B-9, an applicant for renewal must complete at least fifteen hours of continuing education annually or maintain current registration by the Commission on Dietetic Registration.

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: SDCL 36-10B-3

Law Implemented: SDCL 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.

Beyond
scope
of
authority
granted.

Source:

General Authority: SDCL 36-10B-3

Law Implemented: SDCL 36-10B-9

ARTICLE 20:83

NUTRITION AND DIETETICS

Chapter

- 20:83:01 Definitions.
- 20:83:02 Licensure requirements.
- 20:83:03 Ethics.
- 20:83:04 Continuing education

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 chapter 36-10B-9, an applicant for renewal must complete at least fifteen hours of continuing education annually or maintain current registration by the Commission on Dietetic Registration.

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: SDCL 36-10B-3

Law Implemented: SDCL 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: SDCL 36-10B-3

Law Implemented: SDCL 36-10B-9

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.
- 20:64:02:02 Application for licensure by reciprocity.
- 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 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

- 20:64:04:01 Continuing competency requirements.
- 20:64:04:02 Activities for continuing competency requirements.
- 20:64:04:03 Reporting continuing education.
- 20:64:04:04 Waiver of continuing competency requirements.

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.

CHAPTER 20:52:01

PHYSICIAN ASSISTANT LICENSE

Section

- 20:52:01:01 Application for physician assistant license.
- 20:52:01:02 Repealed.
- 20:52:01:03 Physician assistant practice agreement.
- 20:52:01:03.01 Supervision of a licensed physician assistant.
- ~~20:52:01:03.02 Supervision of a licensed physician assistant — Separate practice location.~~

Repealed

- 20:52:01:04 Repealed.
- 20:52:01:05 Termination of physician assistant practice agreement.
- 20:52:01:06 Repealed.
- 20:52:01:07 Repealed.
- 20:52:01:08 Repealed.
- 20:52:01:09 Renewal of physician assistant license.
- 20:52:01:10 Repealed.
- 20:52:01:11 Fee amounts.

~~**20:52:01:03.02. Supervision of a licensed physician assistant — Separate practice location.**~~

~~In addition to the required two meetings per month, the supervising physician must be physically present on-site every ninety days at each physician assistant practice location. This requirement does not apply to locations where health care services are not routine to the setting, including patient homes and school health screening events. Repealed.~~

Source: 34 SDR 93, effective October 17, 2007.

General Authority: ~~SDCL 36-4A-42.~~

Law Implemented: ~~SDCL 36-4A-29.~~

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 20:66

PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

Chapter

- 20:66:01 Fees
- 20:66:02 Ethics
- 20:66:03 Continuing education

CHAPTER 20:66:03

CONTINUING EDUCATION

Section

- 20:66:03:01 Continuing education requirements.
- 20:66:03:02 Activities for continuing education requirements.
- 20:66:03:03 Reporting continuing education.
- 20:66:03:04 Waiver of continuing education requirements.

20:66:03:01. Continuing education requirements. To qualify for renewal of a license upon its expiration as prescribed in SDCL 36-10-33, an applicant for renewal must complete 15 continuing education hours in a one-year period in professional education activities updating competency in physical therapy and practice. Failure to meet this requirement shall constitute unprofessional conduct.

Source:

General Authority: SDCL 36-10-36

Law Implemented: SDCL 36-10-33, 36-10-35.2, 36-10-40

20:66:03:02. Activities for continuing education requirements. Activities that qualify for credit toward completion of the continuing education requirement include programs sponsored or approved by the American Physical Therapy Association or other national or state physical therapy association, activities conducted by a hospital or related institution, and programs sponsored by a college or university. The educational activities must have significant intellectual or practical content dealing primarily with matters directly related to the practice of physical therapy or to the professional responsibility or ethical obligations of the participants.

Source:

General Authority: SDCL 36-10-36

Law Implemented: SDCL 36-10-33, 36-10-35.2

20:66:03:03. Reporting continuing education. To demonstrate compliance with the continuing education requirements, each physical therapist and physical therapist assistant shall sign a statement to confirm completion of the required continuing education hours each year on the renewal application, and shall present proof of completion if requested by the Board.

Source:

General Authority: SDCL 36-10-36

Law Implemented: SDCL 36-10-33, 36-10-35.2

20:66:03:04. Waiver of continuing education requirements. The board may excuse an applicant from the annual 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: SDCL 36-10-36

Law Implemented: SDCL 36-10-33, 36-10-35.2

ARTICLE 20:47

PHYSICIANS AND SURGEONS

Chapter

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

CHAPTER 20:47:03

LICENSURE

Section

- 20:47:03:01 Application for license.
- 20:47:03:02 Personal appearance.
- 20:47:03:03 General application requirements.
- 20:47:03:04 Application for reciprocity.
- 20:47:03:05 Repealed.
- 20:47:03:06 Repealed.
- 20:47:03:07 Application for approval of medical or osteopathic colleges.
- 20:47:03:08 Procedure for approval of hospitals.

20:47:03:09 Temporary permit for state institution.
20:47:03:10 Repealed.
20:47:03:11 Repealed.
20:47:03:12 Report of facility suspending or revoking licensee's privilege to practice.
20:47:03:13 Locum tenens certificate

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 has submitted an application for a full license as described in SDCL 36-4-11. The certificate holder shall be responsible for notifying the Board, in writing, to extend the initial certificate.

Source:

General Authority: SDCL 36-4-35

Law Implemented: SDCL 36-4-20.4

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

Thursday, December 3, 2015

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

To participate by:

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

Rapid City: Rapid City University Center, Room 113, 4300 Cheyenne Blvd. Rapid City, SD

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

Unapproved Draft Minutesⁱ

South Dakota Board of Medical and Osteopathic Examiners Public Meeting and Public Rules Hearing- 9:00 am (CT) Thursday, December 3, 2015

Boards Members Present: Kevin Bjordahl, MD; Ms. Deb Bowman, Laurie Landeen, MD; Brent Lindbloom, DO; Mr. David Lust; Jeffrey Murray, MD

Boards Members Absent: Walter Carlson, MD; Mary Carpenter, MD; David Erickson, MD

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

Board Counsel: Steven Blair

Staff Counsel: William Golden

Attendees: Timothy Engel, attorney, South Dakota State Medical Association (SDSMA)
Mark East, South Dakota State Medical Association (SDSMA)
Jen Porter, South Dakota Association of Healthcare Organizations (SDAHO)
John Hult, Argus Leader

1. Dr. Kevin Bjordahl, vice president of the Board, called the meeting to order at 9:00 am. Roll was called and a quorum was confirmed. A motion: to approve the agenda was ratified by roll call vote (Murray/unanimous).
2. The scheduled Public Hearing on Administrative Rule ARSD Chapter 20:78:06: Opioid Overdose Prevention was called to order at 9:00 am by Mr. Steven Blair. The proposed administrative rule was introduced by Mr. Tyler Klatt. Written comments from Dr. Timothy Ridgway, president of the SDSMA, were presented and accepted into the record. Mr. Blair called for testimony from proponents of the proposed rule, but no testimony was offered. Mr. Blair called for testimony opposing the proposed rule. Attorney Timothy Engel, on behalf of the SDSMA, and Mr. Mark East, on behalf of the SDSMA, presented testimony in opposition to the proposed rule which was accepted into the record. Mr. Engel stated that their testimony on behalf of the SDSMA was not to be characterized as opposition, but instead as a request for clarification, information, and to provide suggestions to improve the rule. Staff then presented responses and clarification for Mr. Engel and Mr. East, and this information was accepted into the record. Discussion was held resulting in the following amendments to the proposed administrative rule:
 - i. ARSD 20:78:06:01(3): amend the language as follows: "Protocols, a standardized plan for medical procedures or administration of ~~medications~~ nasal or auto-injector medication."
 - ii. ARSD 20:78:06:02: add as follows:
 1. (5) Opioid antagonist duration
 2. (6) The protocols and procedures for monitoring the suspected overdose victim and re-administration of opioid antagonist if necessary for the safety and security of the suspected overdose victim

- iii. ARSD 20:78:06:03(2): amend the language as follows: “Shall specify the method of opioid antagonist administration that is compatible with the education and training of the person administering the antagonist;”

A motion: to approve ARSD 20:78:06 as amended was ratified by roll call vote (Landeen/unanimous).
A motion: to close the public hearing on administrative rules was ratified by roll call vote (Landeen/unanimous).

3. A motion: to amend the minutes of the September 10, 2015, Board meeting to clarify that Dr. Landeen was not present at the meeting because she recused herself due to a conflict of interest, and to approve the minutes as amended was ratified by roll call vote (Bowman/unanimous).
4. A motion: to approve the new licenses, permits, certificates and registrations issued between September 1, 2015, through November 30, 2015, was ratified by roll call vote (Bowman/unanimous).
5. Discussion was held regarding the whitepaper presented by the SDSMA on Opiate Analgesics for Chronic Non-Cancer Pain, and the SDSMA draft of guidelines for documentation in the medical record when prescribing controlled substances for the treatment of chronic, non-cancer pain. A motion: to direct staff to draft a proposed administrative rule for medical record documentation when prescribing controlled substances for the treatment of pain was ratified by roll call vote (Lust/unanimous).
6. A motion: to direct staff to begin the legislative process to open Chapter 36-4 to request authority for the Board to provide education was ratified by roll call vote (Landeen/unanimous). A motion: to accept the financial report for information was ratified by roll call vote (Landeen/unanimous).
7. A motion: to amend the FY 2015 Annual Report and accept for information was ratified by roll call vote (Bowman/unanimous).
8. A motion: to approve the re-appointment of Louise Papka, PA-C to the physician assistant advisory committee was ratified by roll call vote (Bowman/unanimous).
A motion: to approve the appointment of Mariah Weber, LN, to the licensed nutritionist advisory committee was ratified by roll call vote (Landeen/unanimous).
The reports of the advisory committee meetings were presented by Mr. Klatt and were accepted for information.
9. The executive director report was accepted for information.
10. Dr. Roy Mortinsen and Paramedic Matthew Callahan from the Vermillion/Clay County Emergency Medical Service submitted a Petition requesting authorization for their Advanced EMTs to perform additional procedures after satisfactory completion of Board approved education and training provided by their physician medical director for the administration of the following:
 - a. Use intraosseous (IO) devices for adult therapy after failed intravenous attempts
 - b. Use positive pressure ventilator (CPAP)
 - c. Administration of the following medications:
 - Amended: Flumazenil (IV) for acute 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 protocolsA motion: to approve the amended petition was ratified by roll call vote (Murray/unanimous).

11. Mr. Klatt presented draft language for the following proposed administrative rules:
 - a. Chapter 20:47, Section 20:47:03:13: Locum tenens certificate:
The Board amended the language to state: *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 has submitted an application for a full license as described in SDCL 36-4-11.*

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

Thursday, December 3, 2015
9:00 am (central time)/8:00 am (mountain time)

To participate by:

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

Rapid City: Rapid City University Center, Room 113, 4300 Cheyenne Blvd. Rapid City, SD

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

The certificate holder shall be responsible for notifying the Board in writing to extend the initial certificate. A motion: to approve the amended rule was ratified by roll call vote (Bowman/unanimous).

- b. Article 20:63, Chapter 20:63:01: Athletic Trainers General Provisions: The Board amended the language of 20:63:01 to spell out BOC (Board of Certification) when it appears in the rules. A motion: to approve the amended rule was ratified by roll call vote (Bowman/unanimous).
 - c. Article 20:64, Chapter 20-64-02: Occupational Therapy Licensure Requirements. A motion: to approve the rule was ratified by roll call vote (Bowman/unanimous).
 - d. Article 20:83, Chapter 20:83:04: Nutrition and Dietetics Continuing Education. The Board amended the language of 20:83:04:01 to state: *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 ~~accumulation of a total of seventy five hours of continuing education during a five year period~~ maintain current registration by the Commission of Dietetic Registration.* A motion: to approve the amended rule was ratified by roll call vote (Bowman/unanimous).
12. A motion: to direct staff to draft language similar to the North Dakota administrative rule for physician/physician assistant supervision requirements between spouses, and present it to the Board at the next meeting was ratified by roll call vote (Bowman/unanimous).
13. Public Hearings:
- a. Colin J. Boone, applicant for paramedic student status. A motion: to adopt the Findings of Fact, Conclusions of Law and ALJ recommendation and deny the application for student status was ratified by roll call vote (Bowman/unanimous). Dr. Landeen, the Board member in this case, did not participate in the discussion or deliberation, and recused herself from the vote.
 - b. Matthew P. Gildeleon, EMT I/85. A motion: to approve the Board's findings that Mr. Gildeleon was notified that his license was placed under investigation, that he was notified of the renewal period for his license, that he was notified that if he did not renew his license it could be deemed as withdrawn under investigation, that Mr. Gildeleon failed to respond to the notifications and failed to renew his license, that his license expired due to non-renewal, and that his license is deemed withdrawn under investigation was ratified by roll call vote (Bowman/unanimous).
14. Confidential Physician Hearings (Closed session pursuant to SDCL 36-4-31.5 unless privilege is waived by physician).
- a. Bradley J. Goad, DO. A motion: to approve the Consent Agreement with Reprimand and the temporary approval order was ratified by roll call vote (Murray/unanimous). Dr. Lindbloom, the Board member in this case, did not participate in the discussion or deliberation, and recused himself from the vote.

- b. James H. Price, DO. A motion: to approve the Consent Agreement with Reprimand and the temporary approval order was ratified by roll call vote (Murray/unanimous). Dr. Bjordahl, the Board member in this case, did not participate in the discussion or deliberation, and recused himself from the vote.
 - c. Claude W.E. Zeifman, MD. The staff requested a continuance in this matter. A motion: to approve a continuance was ratified by roll call vote (Murray/unanimous).
15. A motion: to accept the complaint and investigation docket and the standards of competency docket for information was ratified by roll call vote (Bowman/unanimous).
16. A motion: to enter executive session pursuant to SDCL 1-25-2(3) to consult with legal counsel was ratified by roll call vote (Bowman/unanimous).
17. The public meeting resumed. A motion: to direct the staff to proceed with the repeal of ARSD 20:52:01:03:02 was ratified by roll call vote (Bowman/unanimous).

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

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

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

STIPULATION
AND
AGREEMENT

IN RE: Beau Douglas Braun, PA

This Stipulation and Agreement, made and entered into by the South Dakota Board of Medical and Osteopathic Examiners, hereinafter referred to as "the Board", and Beau Douglas Braun, PA, hereinafter referred to as "Mr. Braun", and the Board having been advised of the premises witnesseth:

The Board and Mr. Braun have agreed that his South Dakota physician assistant license will be issued and that total compliance with the following conditions shall be required:

- Mr. Braun shall enroll in the South Dakota Health Professionals Assistance Program (SD HPAP) and he shall maintain total compliance with his participation agreement and all its requirements for as long as he holds a physician assistant license in South Dakota.
- Mr. Braun understands and agrees that any violation of this Stipulation and Agreement may be considered an act of unprofessional conduct, and could result in further disciplinary actions including but not limited to suspension or revocation of his physician assistant license and additional mandated evaluations and treatments at Board approved facilities.
- Mr. Braun may request to be released from this Stipulation and Agreement by the Board upon recommendation from SD HPAP.
- Mr. Braun agrees that this Stipulation and Agreement is a public document of the State of South Dakota and the Board, and shall be published on the Board's website and reported to the national data banks and to any other entity deemed necessary by the Board in compliance with state and federal law.

Informal Agreement: It is the intent of the parties to this Stipulation and Agreement to provide for the informal compromise and settlement of all issues which could be raised by a formal contested hearing. The Stipulation and Agreement will be presented to the Board at a future meeting where it may accept, modify or reject the agreement.

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

Mr. Braun has unconditionally agreed to this Stipulation and Agreement by affixing his signature to this document.

By: Beau Braun Date: 18 Jan, 2012
Beau Douglas Braun, PA

By: [Signature] Date: Jan. 23, 2012
Attorney for Mr. Braun (optional)

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By: Margaret B. Hansen Date: 2/6, 2012
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: 2/9/12

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Re: Beau Douglas Braun

TEMPORARY ORDER

Beau Douglas Braun (Mr. Braun) and the South Dakota Board of Medical and Osteopathic Examiners (the Board) entered into a Stipulation and Agreement. Mr. Braun signed the agreement on January 18, 2012, and Margaret B. Hansen, executive director of the Board signed the agreement on February 6, 2012.

The Board has authorized the executive director to execute a temporary approval order pending consideration by the Board at its next regularly scheduled meeting.

For this reason, the executive director has executed this temporary order of approval pending consideration by the full Board at its meeting on March 28, 2012.

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By: Margaret B. Hansen Date: 2/6/2012
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 JHO
Date: 3/9/12

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Re: BEAU D. BRAUN, PA

FINAL ORDER

The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("Board") by the signing of a Stipulation and Agreement, and by a Temporary Order executed by the executive director of the Board, and the Board having been fully advised in the premises thereof;

NOW; THEREFORE, the Board hereby:

APPROVES the Stipulation and Agreement and the Orders, and directs that the Stipulation and Agreement and the Orders are public records of the Board and the State of South Dakota and shall be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

By:  Date: 3/30/12
Mary S. Carpenter, MD
Vice President
South Dakota Board of Medical and Osteopathic Examiners

STATE OF SOUTH DAKOTA } S.S.
MINNEHAHA COUNTY }
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.

Executive Secretary
By: RS
Date: 4-2-12

SOUTH DAKOTA

BOARD OF MEDICAL
AND OSTEOPATHIC
EXAMINERS

SDBMOE

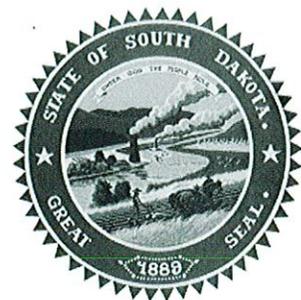
101 N MAIN AVE, SUITE 301

SIOUX FALLS, SD 57104

SDBMOE@STATE.SD.US

P 605-367-7781 F 605-367-7786

HTTP://WWW.SDBMOE.GOV



Via electronic and regular mail

February 18, 2016

Beau D. Braun
25041 Ridge Road
Chamberlain, SD 57325
beau.braun@gmail.com

Dear Mr. Braun:

Enclosed please find a Notice of Hearing in regard to your request for an unrestricted South Dakota Physician Assistant license.

Your request will be presented to the South Dakota Board of Medical and Osteopathic Examiners for consideration at the Board meeting on Thursday, March 3, 2016. The Board meeting will be held in the Board Room at 101 N. Main Ave., Suite 215, Sioux Falls, SD.

You have the right to attend the meeting, and to be represented by an attorney of your own choosing at your expense if you so desire; however, this is not a requirement.

*Please be advised that neither you nor any other party on your behalf may contact Board members about your request in any manner, including by phone, letter, in person, or by e-mail. Board members may only receive information at the meeting. See SDCL 1-26-26.

If you have any questions please contact Mr. William Golden at (605) 201-8588 prior to February 29, 2016

Sincerely,

Jane Phalen
Board Staff

Enclosure:

cc: William H. Golden
Assistant Attorney General/Civil Litigation Division
Counsel to the South Dakota Board of Medical
and Osteopathic Examiners

Maria Eining, Executive Director
Midwest Health Management Services
SD Health Professionals Assistance Program (HPAP)

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

IN THE MATTER OF THE PETITION
FOR UNRESTRICTED PHYSICIAN
ASSISTANT LICENSE:
Beau D. Braun, PA-C
License #0806

NOTICE OF HEARING

COPY

Respondent.

Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on Thursday, March 3, 2016, in the Board Room, 101 N. Main Ave., Suite 215, Sioux Falls, SD, beginning at 10:30 am (central time)

Dated this 16th day of Feb, 2016.



William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
*Attorney for the South Dakota Board of
Medical and Osteopathic Examiners*
(605) 201-8588

CERTIFICATE OF SERVICE

I hereby certify that on February 18, 2016, I mailed, by first class mail, postage prepaid, a true and correct copy of the foregoing Notice of Hearing to Beau D. Braun, 25041 Ridge Road, Chamberlain, SD 57324, and emailed a copy to beau.braun@gmail.com.


William H. Golden

WHEREAS, it is the intent of this agreed-upon disposition to provide for a settlement of the licensing issues presented by the Licensee's conduct in a professional manner, without the necessity of further hearings and proceedings herein, and to provide for a responsible resolution;

NOW, THEREFORE, it is hereby stipulated and agreed as follows:

1. That the Boards have jurisdiction over the person of the Licensee and the subject matter of this Order.

2. The Boards assert that the Licensee, while working as a certified nurse practitioner for a health assessment review organization, did not adequately assess or document physical examinations for patients to whom she had been assigned to perform said services. Licensee neither admits nor denies the Boards' assertions.

3. The Licensee recognizes that the matters complained of are of a nature that would constitute grounds for discipline of her license to practice as a nurse practitioner in the State of South Dakota under SDCL § 36-9A-29.

4. That the Licensee understands that she has a right to a contested hearing case pursuant to SDCL Ch. 1-26 regarding the allegations in the pending complaint and that such rights under SDCL Ch. 1-26 include, but are not limited to, the right to be present at the contested case hearing, the right to be represented by legal counsel, to introduce evidence and testimony on her behalf, to call witnesses, to cross examine witnesses, and to inspect all documentary evidence submitted to the Boards and to appeal the Boards' decision to the circuit court and state Supreme Court as provided by law.

5. By entering into this agreed-upon disposition with the Boards, the Licensee hereby knowingly and voluntarily waives the above rights.

6. The Licensee has been given the opportunity to discuss this stipulation with an attorney of Licensee's choice and is aware of her rights as outlined above. Licensee hereby voluntarily waives all such rights to a hearing, notice, appearance, or other rights. Licensee is entering into this stipulation voluntarily and without duress or compulsion.

Based upon the foregoing acknowledgements, the Boards and the Licensee hereby agree that this pending complaint will be resolved as follows:

PROBATION WITH MANDATED HPAP

That from the date of this stipulation, the Licensee's license to practice as a certified nurse practitioner is placed upon a probationary status. The Licensee shall comply with the following terms during her probation:

1. Licensee is hereby mandated to the Health Professionals Assistance Program ("HPAP"). The Licensee agrees to be enrolled and demonstrating active participation within thirty (30) days. Failure to comply with any aspect of HPAP and its contract will result in further disciplinary action by the Boards. All terms and conditions, and any restrictions shall be set by HPAP and Licensee shall be fully compliant with all of the terms and conditions.

2. In addition, probationary terms and monitoring conditions shall be set by HPAP and Licensee shall fully comply with these terms and conditions. After verification from HPAP that Licensee has fully completed all monitoring terms, Licensee may petition the Boards for closure of her probation. The duration of the terms of probation will be set by HPAP. It is

recognized that the Boards may require additional probationary time or additional terms upon completion of HPAP. Additionally, Licensee shall comply with the following during her probation:

EVALUATION AND REMEDIATION

1. The Licensee is to complete a full psychological evaluation with a practitioner approved or as recommended by HPAP.
2. In addition, the Licensee shall be required to complete remediation as follows:
 - A. An ethics course as recommended by the Boards; and
 - B. A competency assessment (course or individualized assessment conducted by a consultant, who will be selected by the Board of Nursing) and remediation as determined by assessment.

CONDITIONS

1. Licensee shall at any time during the period of probation, report in person to such meetings of the Boards or to its designated representatives as directed and otherwise fully cooperate with the Boards or their representatives in the terms of this probation.
2. The Licensee shall notify the Boards, as well as HPAP, in writing, within one (1) week of any change in nursing employment, personal address, and/or telephone number.
3. Licensee shall pay for all costs and expenses in carrying out conditions of this agreed-upon disposition.
4. That within ten (10) days of the effective date/execution of this order, Licensee shall submit her current renewal certificate to the Boards to be stamped PROBATION.

Agreed Upon Disposition and Waiver of Hearing
Licensee: Leann K. Batiz

5. During the term of this order, the Licensee is to immediately inform the Boards of the outcome of any criminal charges presently or hereafter pending against the Licensee, and whether the Licensee has been convicted, pled no contest, *nolo contendere*, pled guilty to or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor or petty offense, other than minor traffic violations, that have not previously been reported to the Boards.

6. If the Licensee violates any terms of this agreed-upon disposition, the Boards may take such action against Licensee's license as the Boards deem necessary, up to and including an immediate suspension, additional terms, revocation, or other disciplinary action.

7. Licensee shall not violate any laws or regulations regarding the practice of nursing.

8. This agreed-upon disposition is subject to public reporting.

NOW, THEREFORE, the foregoing Agreed Upon Disposition and Waiver of Hearing is entered into and is respectfully submitted to the Boards with the request that the Boards adopt its terms as an Order of the Boards in the above matter.

Dated this 26th day of February 2016.



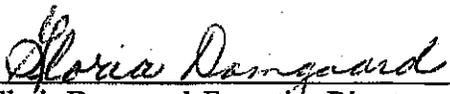
Leann K. Batiz

Agreed Upon Disposition and Waiver of Hearing
Licensee: Leann K. Batiz

The South Dakota Board of Nursing met on the 20th day of November, 2015, and approved the terms and conditions of this probationary order by a vote of 8-0 and issued its Order as follows:

IT IS HEREBY ORDERED that the above Agreed Upon Disposition and Waiver of Hearing is adopted as shown herein by the South Dakota Board of Nursing this 15th day of March, 2016.

SOUTH DAKOTA BOARD OF NURSING



Gloria Damgaard, Executive Director

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

IT IS HEREBY ORDERED that the above Agreed Upon Disposition and Waiver of Hearing is adopted as shown herein by the South Dakota Board of Medical and Osteopathic Examiners this _____ day of _____, 2016.

SOUTH DAKOTA BOARD OF MEDICAL &
OSTEOPATHIC EXAMINERS

Margaret Hansen, Executive Director

The staff recommends approval of the petition for additional tasks with following conditions:

- Develop additional protocols to meet the needs of physicians to adequately form a medical opinion based on the paramedic's assessment of a patient
- The mobile medic clinic training program, protocols, and course need to be in compliance with the rules for Board approval of advanced life support courses
- The records for the mobile medic be sent to the board staff each month to review for a year

Staff concern:

- Paramedics, hospitals and doctors may lose their immunities under 36-4B-21 through 25 because once it is a non-emergency situation immunities may not apply

The Advanced Life Support Advisory committee meeting was originally scheduled for February 2nd but due to weather had to reschedule to February 16. All members were present. The Rapid City Fire Department mobile medic proposal was the topic of discussion.

The committee heard legal opinion on the petition presented to the committee. The focus was on how this could be accomplished within the scope of practice by ALS. Advice was given that the paramedic can only communicate medical opinions from a physician. For any circumstances other than the patient being transported for emergency care, the protocols need to reflect a requirement to call the physician to receive the medical opinion to give to the patient. This requirement needs to be documented. Paramedics, by definition, provide care to patients in emergency situations. ALS may only practice ALS skills with an emergency patient so the nonemergency language needs to be changed to emergency. The petition asks to provide care in non-emergency situations which would result in a loss of immunity and may put various parties at risk.

After discussion, Dr. Kosiak made a motion and this motion was agreed upon; to not recommend approval of the petition request as it is currently written, but to provide advice for improving the petition request and provide help, in the form of a workgroup, which addresses the problem(s) that this program is attempting to alleviate. To allow a solution to move the Mobile Medic program forward, the following recommendations are suggested:

1. Dr. Kosiak would like staff to set up a conference call where he can talk to the RC Emergency Department physicians, including Dr. Long, to help explain the issues and to provide feedback and advice for improving the request and provide help to allow the Mobile Paramedical program to go forward.
2. For the long term; a workgroup will be formed to include the ALS advisory committee and interested parties to address the problem(s) that have resulted in the abuse of the ambulance/ems system which this ALS program is attempting to address as well as other ALS issues of scope.

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

STATE OF SOUTH DAKOTA

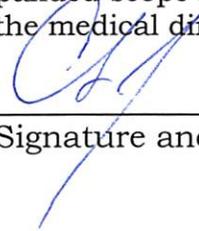
IN RE: Mobile Medic)
)
) **PETITION FOR**
) **PARAMEDIC**, AEMT, EMT I/85, EMT I/99
) *(please circle one of the above)*
) **PRACTICE SCOPE EXPANSION**

I am a South Dakota licensed Advanced Life Support provider and I am petitioning the South Dakota Board of Medical and Osteopathic Examiners (BMOE) for an expansion of my scope of practice.

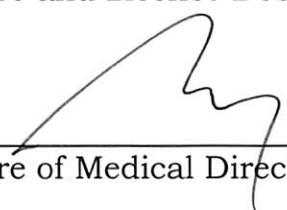
It is requested that, as a licensed Advanced Life Support Provider (*please circle one – **PARAMEDIC**, AEMT, EMT I/85 or EMT I/99*), as defined by SDCL 36-4B(1), and as defined by the medical director of this facility, that I be approved by the Board to perform the following expanded duties/procedures:

Respond as a single resource (Mobile Medic) to requests for service and provide an advanced patient assessment to formulate a field impression. Determination of disposition in consultation with the patient will be made upon the field impression to ensure the patient receives the right level of care at the right time.

I understand that Board approval of this petition will permit me to provide the above described care only after I successfully complete the appropriate training and education. I have attached an outline with the specific training and education that I will complete. It is requested that these duties and/or procedures be included within my scope and training, and I understand that I will be required to successfully complete ongoing continuing education in order to maintain and demonstrate competency and continue to provide this expansion of my scope. I understand that this expanded scope is approved only for my work at my current ambulance service under the medical direction of Nathan Long, MD.


Date: 2/9/16

Signature and License Designation (PARAMEDIC, AEMT, EMT I/85 or EMT I/99)
(please circle one of the above)


Date: 2/10/16

Signature of Medical Director

Attachment (A):

The Rapid City Fire Department (hereinafter "RCFD") is requesting the ability to respond to 911 calls for service with a single responder (Mobile Medic) in an SUV or similar vehicle. The goal of the responder is to improve the health of our medically vulnerable patients while saving healthcare dollars. The RCFD is not asking to provide a level of care or scope of care outside of what we are providing now. The patients we will be responding to are patients that have called 911; we only want to change how we respond to the call operationally. Patients will get a level of care they are accustomed to and, in my opinion, that care will be superior to what we are providing today.

Why do we want to do this?

In 2003, the Rapid City Fire Department took over the ALS transport business for the City of Rapid City and Pennington County. Call volume has increased dramatically, with an ever increasing burden on the emergency medical system, including the ambulance service and emergency department. We have taught people how to call 911 for help in an emergency. A by-product of this is citizens calling 911 for any problem, large or small. The days of being called only when a person has an "emergency" are gone. We respond to calls for stomach aches, nervous feelings, hang nails, toe pain, medication refills, inability to sleep, and law enforcement evaluations of intoxicated individuals, to name a few. The department is being forced to respond to all calls for service regardless of emergency status. The local hospital's emergency department is feeling this burden as well. We evaluated the state of our department and the trends in the nation and feel the utilization of a single responder in our community to educate and help prevent overutilization of our emergency services, is a vital piece to our success as a medical provider in our community.

Our call volume has seen a steady rise in the number of patients utilizing emergency services for non-emergent complaints. In 2004 (our first full year of service) we responded to 9,159 calls for service. In 2010 we responded to 10,034. This year, 2015, we responded to 14,000 calls for service. In fiscal year 2012, we evaluated our patient demographic, focusing on patients who accessed our service 5 or more times. There were 134 patients who generated 985 calls for service. During the same period, RCRH ED had 549 patients who met the target criteria and accounted for 3,898 ED visits. From October 1, 2014 to October 1, 2015, 20 patients accounted for 369 calls for service. That is an average of 18.45 visits per person. We have one patient that was transported twelve times in November 2015. That same patient owes the City of Rapid City \$78,090.05 in direct billable services rendered in 2014-2015. These same patients impact not only the Rapid City Fire Department; they impact other public safety agencies, health agencies, and the hospital.

In the past, more patient transports equated to increased income. That is simply not the case any longer. Governmental and private payors are becoming more stringent on what they reimburse ambulance services for. A number of our patients have complaints or reasons why they called that payors deem as not medically necessary so they simply will not pay for the service provided. This leaves us in the difficult position of providing transport knowing full well we will not be reimbursed for that particular transport.

We have embraced that our job has changed. 80% of our call volume is for patients that are not in immediate danger of life or health. We provide standby services at football games and rodeos. We provide scheduled transfers from the hospital to nursing homes or other locations such as Denver, Minneapolis, Rochester, and Billings. A large percentage of patients have more social issues that are not necessarily immediate medical issues that can receive more appropriate care by other partner health agencies such as Community Health of the Black Hills or Behavior Management Systems.



RAPID CITY REGIONAL HOSPITAL
353 Fairmont Blvd * Rapid City, SD 57701
(605) 755-1000

January 29, 2016

Members of the South Dakota State Board of Medical and Osteopathic Examiners:

Dear Sirs:

I regret that I am unable to personally attend your meeting, as I will be hosting the conference for the South Dakota chapter of the American College of Emergency Physicians.

I am the medical director for the Rapid City Fire Department. My fellow emergency medicine physicians and I provide around the clock online medical control for the fire department. We are actively engaged in the writing of policy for dispatch and medical interventions. I also provide regular education and review many case reports.

Members of my group, along with medical staff leadership at Rapid City Regional Hospital, have been actively involved in the planning of this program. We joined several other community organizations in our support. We will continue to provide oversight to ensure quality medical care is provided to the members of our community.

I believe the mobile medic program being proposed would greatly help in meeting the needs of the citizens of Rapid City and Pennington County. I thank you for your consideration of this matter and will be available by phone if you have any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read "Nathan Long".

Nathan Long, MD, FACEP

NL/lh

Attachment 2

Physician Supplement to Petition for Scope of Practice Expansion

(Please attach additional sheets if needed)

I, Nathan Long, am the physician medical director, and I request the following expansion to the scope of practice for (circle pertinent designation - **Paramedic**, AEMT, EMT I/85, EMT I/99):

The Rapid City Fire Department requests that individually identified paramedics (Mobile Medic) be allowed to respond as a single responder in a light vehicle or other quick response vehicle (not an ambulance) to low acuity, non-emergent requests for service. We request the ability to allow Mobile Medics, under the direction of the Department Medical Director, to provide an advanced patient assessment and formulate a field impression to allow the Mobile Medic to field triage the patient to ensure the patient gets the right level of care at the right time. Further, we request the Mobile Medic be allowed to work with other allied health professionals and entities to ensure that proper patient care is provided to better serve our medically vulnerable populations.

1. What is the reason for this request?

Please see attachment (A).

2. What duties, procedures, medication(s), etc are requested?

Respond as a single resource to requests for service and provide an advanced patient assessment to formulate a field impression. Determination of disposition in consultation with the patient will be made upon the field impression to ensure the patient receives the right level of care at the right time.

How do we envision the response?

The RCFD and its 911 communications center currently utilize the Medical Priority Dispatch System. It is a nationally recognized dispatch protocol that asks a standard set of questions to 911 callers. There are 33 standard complaint cards, e.g. card 1 is abdominal pain, card 10 is chest pain, and card 26 is sick person. The 33 cards also have increasing levels of severity (omega, alpha, bravo, charlie, delta, and the most severe echo). For example: A 911 caller who calls with a complaint of chest pain (card 10) that is having abnormal breathing and is clammy will get a code 10-delta-4 which translates to a fire engine hot and an ambulance hot. This protocol has been approved by Dr. Nathan Long, the RCFD and Pennington County 911 Medical Director. Initially, the dispatch center will send the Mobile Medic on very low acuity calls from card 26-sick person omega level calls. Card 26 omega level include calls for complaints such as boils, bumps, constipation, earache, nervousness, sore throat, toothache, infected wound, medication refill, social service complaints, and many simple non-descript complaints. These types of calls tie up valuable resources for true

emergencies. The responder will respond to calls for service in a light duty truck or SUV, leaving ambulances and fire apparatus free to respond to calls requiring their use. The light vehicle will be identified with fire department markings and lighting and will be equipped appropriately.

3. What risks are associated with the requested expansion(s)?

Risk is very low. Mobile Medics will be sent as a single responder to low acuity complaints. One risk area would be patients call 911 and state a low acuity complaint when they are having a high acuity problem. This will be revealed after the patient assessment by the Mobile Medic. This could cause a slight delay in transport.

4. What training and education will the advanced life support personnel complete?
(please attach the syllabus)

**Attachment(s): Mobile Medic Intro 2016
RCFD Mobile Medic Clinical Syllabus**

5. Who will provide the training and verify competency?

Dr. Nathan Long or current Medical Director will provide oversight and verify competency of the Mobile Medic training. Instructors will vary depending on topic covered.

6. Describe the ongoing schedule of continuing education and training that will be provided in order to ensure competency and patient safety (or attach syllabus).

Dr. Nathan Long or current Medical Director will provide continuing education and training. Training will be based upon need and identified through his evaluation and quality assurance of the Mobile Medics duties and care.

7. Who will provide the continuing education and training and verify continued competency?

Dr. Nathan Long or current Medical Director will provide oversight of the continuing education and training. Instructor will be based upon topic of training. Training will be based upon need and identified through his evaluation and quality assurance of the Mobile Medics duties and care. The Medical Director will verify competency.

8. Will documentation about the training, continuing education, and verification of competency be available for Board review in the event of an audit?

Yes, records will be kept on training and activities within our records management system as outlined by the Rapid City Fire Department.

9. Will logs documenting the times the expansion to the scope is used, and any adverse effects/results be available for Board review in the event of an audit?

Yes, all documentation of the Mobile Medic calls and procedures are documented on the approved electronic patient care report as identified by the Rapid City Fire Department.

Signature: _____

(Physician medical director)

Date: _____

2/10/16

Name and Location of Ambulance Service(s):

Rapid City Fire Department 10 Main St. Rapid City, SD 57701

ASSESSMENT - NEUROLOGIC

Management of patients with head injury or neurologic illness depends on careful assessment of neurologic function. **Changes** are particularly important. The first observations of neurologic status in the field provide the basis for monitoring sequential changes. It is therefore important that the first responder accurately observe and record neurologic assessment using measures which will be followed throughout the patient's hospital course.

- A. Vital Signs: Observe particularly for adequacy of ventilation, also depth, frequency, and regularity of respirations.
- B. Level of consciousness: Use Glasgow Come scale.

TABLE 1.B.

GLASGOW COMA SCALE – ADULT / CHILD

EYE OPENING:

<u>None</u>	<u>1</u>
<u>To pain</u>	<u>2</u>
<u>To speech</u>	<u>3</u>
<u>Spontaneously</u>	<u>4</u>

BEST VERBAL RESPONSE:

<u>None</u>	<u>1</u>
<u>Garbled sounds</u>	<u>2</u>
<u>Inappropriate words</u>	<u>3</u>
<u>Disoriented sentences</u>	<u>4</u>
<u>Oriented</u>	<u>5</u>

BEST MOTOR RESPONSES:

<u>None</u>	<u>1</u>
<u>Abnormal extension</u>	<u>2</u>
<u>Abnormal flexion</u>	<u>3</u>
<u>Withdrawal to pain</u>	<u>4</u>
<u>Localizes pain</u>	<u>5</u>
<u>Obeys commands</u>	<u>6</u>

Score = Sum of scores in 3 categories: (15 points possible)

ASSESSMENT - NEUROLOGIC (cont.)

- C. Eyes:
 - 1. Direction of gaze.
 - 2. Size and reactivity of pupils.
- D. Movement: Observe whether all four extremities move equally well.
- E. Sensation (if patient awake): Observe for absent, abnormal, or normal sensation at different levels if cord injury is suspected.

Special Notes:

- A. The Glasgow Coma Scale (GCS) used above has gained acceptance as one method of scoring and monitoring patients with head injury. It is readily learned, has little observer-to-observer variability, and accurately reflects cerebral function. Always record specific responses rather than just the score (sum of observations). **Remember that a patient who is totally without response will have score of 3, not 0.**
- B. Use a flow sheet to follow and identify changes rapidly.
- C. Sensory and motor exam must be documented before moving patient with suspected spinal injury.
- D. Note what stimulus is being used when recording responses. Applied noxious stimuli must be adequate to the task but not excessive. Initial mild stimuli can include light pinch, dull pinprick - if these are unsuccessful at eliciting a pain response, pressure with a dull object to base of nailbed, stronger pinch (particularly in axilla) may be necessary to demonstrate the patient's best motor response.
Note: The "sternal rub" shall not be used to test pain response.
- E. When responses are not symmetrical, use motor response of the best side for scoring GCS and note asymmetry as part of neurologic evaluation.
- F. Use of restraints or intubation of patient will obviously make some observations less accurate. Be sure to note on chart if circumstances do not permit full verbal or motor evaluation.

ASSESSMENT - NEUROLOGIC (cont.)

Special Notes (cont.):

- G. Glasgow Coma Scale of 13 or less-observe closely for deterioration. Glasgow Coma Scale of 8 or less will probably require airway intervention at some point.

- H. In infants and small children, the GCS may be difficult to evaluate. Children who are alert and appropriate should focus their eyes and follow your actions, respond to parents or caregivers, and use language and behavior appropriate to their age level. In addition, they should have normal muscle tone and a normal cry. Several observers should attempt to elicit a “best verbal response”, to avoid over or underestimation of level of consciousness.

TABLE 1.C.

GLASGOW COMA SCALE – INFANT / SMALL CHILD

EYE OPENING:	<u>None</u>	<u>1</u>
	<u>To pain</u>	<u>2</u>
	<u>To speech</u>	<u>3</u>
	<u>Spontaneously</u>	<u>4</u>
BEST VERBAL RESPONSE:	<u>None</u>	<u>1</u>
	<u>Moans, grunts</u>	<u>2</u>
	<u>Cries to pain</u>	<u>3</u>
	<u>Irritable cries</u>	<u>4</u>
	<u>Coos, babbles</u>	<u>5</u>
BEST MOTOR RESPONSES:	<u>None</u>	<u>1</u>
	<u>Abnormal extension</u>	<u>2</u>
	<u>Abnormal flexion</u>	<u>3</u>
	<u>Withdrawal to pain</u>	<u>4</u>
	<u>Localizes pain</u>	<u>5</u>
	<u>Spontaneous movement</u>	<u>6</u>
Score = Sum of scores in 3 categories: (15 points possible)		

ASSESSMENT - PEDIATRIC PATIENT

Children can be examined easily from head to toe, but lack of understanding by the patient, poor cooperation, and fright often limit the ability to assess completely in the field. Children often cannot verbalize what is bothering them, so it is important in trauma victims to do a systematic primary and secondary survey, which covers areas that the patient may not be able to tell you about. Any observations about spontaneous movements of the patient and areas that the child protects are very important. In the patient with a medical problem, the more limited set of observations listed below should pick up potentially serious problems.

A. General:

1. Level of alertness, eye contact, attention to surroundings.
2. Muscle tone: Normal, increased or weak and flaccid.
3. Responsiveness to parents, caregivers; is the patient playful or inconsolable?

B. Head:

1. Signs of trauma.
2. Fontanelle, if open: abnormal depression or bulging.

C. Face:

1. Pupils: size, symmetry, reaction to light.
2. Hydration: brightness of eyes, is child making tears, are the mouth and lips moist or dry?

D. Neck: note stiffness.

E. Chest:

1. Note presence of stridor, retractions (depressions between ribs on inspiration), grunting, increased respiratory effort, or rapid/overly slow respiratory rate.
2. Breath sounds: symmetrical, wet, wheezing.
3. Heart rate, obvious murmur?

F. Abdomen: distention, rigidity, bruising, tenderness.

ASSESSMENT - PEDIATRIC PATIENT (cont.)

G. Extremities:

1. Brachial pulse.
2. Signs of trauma.
3. Muscle tone, symmetry of movement.
4. Areas of tenderness, guarding or limited movement.

H. Skin:

1. Skin temperature and color, capillary refill.
2. Unusual rashes, i.e., petechia, urticaria.
3. Skin turgor.

I. See Neurologic Assessment

TABLE 1.A.

NORMAL VITAL SIGNS IN THE PEDIATRIC AGE GROUP

AGE	PULSE beats/min. (mean)	RESPIRATIONS rate/min.	BLOOD PRESSURE Systolic + or - 20
Premature	144	20-38	N/A
Newborn	140	20-38	N/A
6 months	130	20-30	80 palp
1 year	130	20-24	90 palp
3 years	100	20-24	95 palp
5 years	100	20-24	95 palp
8 years	90	12-20	100 palp

ASSESSMENT-TRAUMA PATIENT PRIMARY SURVEY

Environmental Assessment:

- A. Recognize environmental hazards to rescuers, and secure area for treatment.
- B. Recognize hazard to patient, and protect from further injury.
- C. Identify number of patients. Initiate a triage system if appropriate.
- D. Observe position of patient, mechanism of injury, surroundings.
- E. Initiate communications if hospital resources require mobilization; call for backup if needed.
- F. Identify self. Consider **TRAUMA ALERT**.

Primary Survey:

Note initial level of responsiveness (awake, verbal, pain, unresponsive).

- A. Airway:
 1. Observe the mouth and upper airway for air movement.
 2. Protect cervical spine from movement in trauma victims. Use assistant to provide continuous in-line cervical immobilization.
 3. Look for evidence of upper airway problems such as vomitus, bleeding, and facial trauma.
- B. Breathing:
 1. Look for jugular venous distention and tracheal deviation.
 2. Expose chest and observe chest wall movement.
 3. Note respiratory rate (qualitative), noise, and effort.
 4. Look for life-threatening respiratory problems and briefly stabilize:
 - a. Open or sucking chest wound - Seal.
 - b. Large flail segment - Stabilize.
 - c. Tension pneumothorax: transport rapidly and consider decompression.
 5. Auscultate for crackles (wet sounds), wheezes, or decreased breath sounds.
 6. Palpate for tenderness, wounds, fractures, crepitus, or unequal rise of chest.

ASSESSMENT-TRAUMA PATIENT PRIMARY SURVEY (cont.)

C. Circulation:

1. Palpate for radial and carotid pulses. Note pulse quality (strong, weak), and general rate (slow, fast, moderate). Where a pulse is able to be palpated can be indicative of an approximate systolic BP. The following are general guidelines, they should not be considered absolutes:
 - a. Radial pulse - systolic BP > 90
 - b. Femoral pulse - systolic BP > 80
 - c. Carotid pulse - systolic BP > 70
2. Check capillary refill time in fingertips: ≤ 2 sec is typically normal.
3. Check skin color and condition.
4. Control hemorrhage by direct pressure with clean dressing to wound.

D. Responsiveness:

1. Reassess level (awake, responsive to voice or pain, no response).
2. Briefly note body position and extremity movement.
3. Check movement and sensation in all four extremities prior to moving patient.

ASSESSMENT-TRAUMA PATIENT SECONDARY SURVEY

Secondary survey is the systematic assessment of the entire patient. The purpose of the secondary survey is to uncover problems which are not life-threatening but which could be injurious or could become life-threatening to the patient. It should be performed after:

1. Primary survey.
 2. Stabilization and initial treatment of life-threatening airway, breathing, or circulatory difficulties.
- A. Initial Vital signs.
- B. Additional History.
- C. Head and Face:
1. Observe for deformities, asymmetry, bleeding.
 2. Palpate for deformities, tenderness, or crepitus.
 3. Re-check airway for potential obstruction: dentures, bleeding, loose or avulsed teeth, vomitus, abnormal tooth position from mandibular fracture, and absent gag reflex.
 4. Eyes: pupils (equal or unequal, responsiveness to light), foreign bodies, contact lenses, periorbital ecchymosis (raccoon eyes).
 5. Nose: deformity, bleeding, discharge.
 6. Ears: bleeding, discharge, bruising behind ears. (Battles sign)
- D. Neck:
1. Re-check for deformity or tenderness if not already immobilized.
 2. Observe for penetrating wounds, neck vein distention and use of neck muscles for respiratory effort. Also note altered voice, and medical alert tags.
 3. Palpate for crepitus, tracheal shift, sub-q air.
- E. Chest:
1. Observe for wounds, symmetry of chest wall movement
 2. Have patient take deep breath: observe for pain, symmetry, air leak from wounds.

ASSESSMENT-TRAUMA PATIENT SECONDARY SURVEY (cont).

3. Re-auscultate for crackles (wet sounds), wheezes, and decreased or absent breath sounds.
4. Palpate for tenderness, wounds, fractures, crepitus, or un-equal rise of chest.

F. Abdomen:

1. Observe for wounds, bruising, distention.
2. Palpate all 4 quadrants for tenderness, rigidity.

G. Pelvis:

1. Palpate and compress lateral pelvic rims and symphysis pubis for tenderness or instability.

H. Shoulders/Upper Extremities:

1. Observe for angulation, protruding bone ends, symmetry.
2. Palpate for tenderness, crepitus.
3. Note distal pulses, color, medical alert tags.
4. Check sensation.
5. Test for weakness if no obvious fracture present (have patient squeeze your hands).
6. If no obvious fracture, gently move arms to check overall function.

I. Lower Extremities:

1. Observe for angulation, protruding bone ends, symmetry.
2. Palpate for tenderness, crepitus.
3. Note distal pulses, color.
4. Check sensation.
5. Test for weakness if no obvious fracture present (have patient push feet against your hands).
6. If no obvious fracture, gently move legs to check overall function.

J. *Back:

1. If patient is stable, logroll, observe and palpate for wounds, fractures, tenderness, bruising.
2. Recheck motor and sensory function as appropriate.

ASSESSMENT-TRAUMA PATIENT SECONDARY SURVEY (cont).

- * Examination of the back may take place after the primary survey and prior to placing patient on backboard if rapid transport is indicated (see Trauma and Hypovolemic Supportive Care Protocol).

Special Notes:

- A. Be systematic. If you jump from one obvious injury to another, the subtle injury that is most dangerous to the patient is easily missed.
- B. Obtain and record two or more sets of vital signs and neurologic observations on every patient. A patient cannot be called “Stable” without sets of vital sign’s giving similar normal readings. Serial vital signs are an important parameter of the patient’s physiologic status. Vital signs should be repeated as necessary to document changes in abnormal findings.
- C. Use your judgment. Weigh benefits vs risks to patient in considering a prolonged field evaluation vs rapid transport to medical facility.



City of Rapid City Fire-Lead Mobile Medic EMS Operations Position Description

Job Title: Lead Mobile Medic
Department: Fire
Division: EMS Operations
Reports To: Assistant Chief - EMS Operations
FLSA Status:
Classification:

Grade:
Prepared By: Jason Culberson
Prepared Date: 7/15/2014
Approved By:
Approved Date:

Summary

Under the direction of the Assistant Chief – EMS Operations the Mobile Medic directly manages the Mobile Integrated Health Care Program and supervises the Mobile Medics in performing their daily duties and emergency response actions.

Essential Duties and Responsibilities

Essential duties and responsibilities include the following. Other duties may be assigned.

1. Maintain minimum qualifications commensurate with previous position or rank in the operations division held prior to promotion. Able to perform duties commensurate with abilities during emergency response operations and may be assigned to an Incident Command System (ICS) position consistent with abilities.
2. Assists with the implementation and administration of the Mobile Integrated Health Care Program (MIHCP).
3. Directs, coordinates, and assists Mobile Medics with daily operations of MIHCP.
4. Responds to emergency medical incidents, determines the nature and extent of the emergency, and coordinates with other emergency responders on treatment and transport.
5. Responds to non-emergency medical incidents, determines the nature and extent of the situation and makes a treatment and/or transport decision based on assessment findings, protocols, and medical direction.
6. Gathers statistical data, analyzes information, and makes recommendations on MIHCP improvements.
7. Prepares incident reports, completes other written reports and records.
8. Maintains data on high frequency users to assist with care, treatment, and transport determination.
9. Coordinates with Public Health Officials, Community Health Practitioners, and other community advocates.
10. Assists the Assistant Chief-EMS Operations in the preparation and management of the program and division budget.
11. Assigns tasks to Mobile Medics and evaluates work performance of personnel.
12. Set performance objectives for the Mobile Medics and assists the Assistant Fire Chief-EMS operations with formulating program goals and objectives.
13. Manages assigned projects and programs.
14. Mentors Mobile Medics for the position of Lead Mobile Medic.
15. Maintains license through continuing education.

Supervisory Responsibilities

Manages the Mobile Medics in the EMS Division. Is responsible for the overall direction, coordination, and evaluation of these positions. Carries out supervisory responsibilities in accordance with the organizations policies and applicable laws. Responsibilities include interviewing and training employees, planning, assigning and directing work; appraising performance; rewarding and disciplining employees; addressing complaints and resolving problems.

Minimum Qualifications

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily, the requirements listed below are representative of the knowledge, skill and or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.



City of Rapid City Fire-Lead Mobile Medic EMS Operations Position Description

Education: Bachelor's degree or equivalent in experience or training to include four years as a Journeyman Firefighter-Paramedic

Communication Skills: Able to read, analyze and interpret common scientific and technical journals, financial reports and legal documents. The ability to respond to common inquiries or complaints from customers, regulatory agencies, or members of the business community. Ability to write speeches and articles for publication that conform to prescribed style and format. Ability to effectively present information to top management, public group, and governing body.

Mathematical Skills: Ability to work with mathematical concepts such as probability and statistical inference, fundamentals of plane and solid geometry as well as trigonometry. Ability to apply concepts such as fractions, percentages, ratios, and proportions to practical situations.

Reasoning Ability: Ability to solve practical problems and deal with a variety of concrete variable in situations where only limited standardization exists. Ability to interpret a variety of instructions furnished with written, oral, diagram, or schedule form.

Computer and Administrative Skills: To perform this job successfully, an individual should have knowledge of Microsoft Office products, Dream Weaver, Publisher, and Firehouse Products.

Certificates, Licenses, Registrations: Must possess a valid South Dakota Drivers License or the ability to obtain within 30 days from date of hire. Must possess a National Registry Paramedic Certification or State of South Dakota Paramedic License.

Physical Demands: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodation may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently required to sit and talk or hear. The employee is occasionally required to stand; walk; use hands to finger; handle or feel; reach with the hands and arms; climb or balance and stoop, kneel, crouch, or crawl. The employee must occasionally lift and or move more than 100 pounds.

Work Environment: The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job the employee is occasionally exposed to an environment that is immediately dangerous to life and health, wet and/or humid conditions; moving mechanical parts; high, precarious places, fumes or airborne particulate; toxic or caustic chemicals; outside weather conditions; extreme heat and vibration. The noise level in the work environment is moderate.



City of Rapid City Mobile Medic EMS Operations Position Description

Job Title: Mobile Medic

Department: Fire

Division: EMS Operations

Reports To: Lead Mobile Medic

FLSA Status:

Classification:

Grade:

Prepared By: Jason Culberson

Prepared Date: 10/15/2014

Approved By:

Approved Date:

Summary

Under the supervision of the Lead Mobile Medic, the Mobile Medic will provide care and treatment determination to medically vulnerable patients in the community.

Essential Duties and Responsibilities

Essential duties and responsibilities include the following. Other duties may be assigned.

1. Maintain minimum qualifications commensurate with previous position or rank in the operations division held prior to promotion. Able to perform duties commensurate with abilities during emergency response operations and may be assigned to an Incident Command System (ICS) position consistent with abilities.
2. Assists with the implementation of the Mobile Integrated Health Care Program (MIHCP).
3. Performs daily operations of MIHCP.
4. Responds to emergency medical incidents, determines the nature and extent of the emergency, and coordinates with other emergency responders on treatment and transport.
5. Responds to non-emergency medical incidents, determines the nature and extent of the situation and makes a treatment and/or transport decision based on assessment findings, protocols, and medical direction.
6. Assists Lead Mobile Medic in gathering statistical data.
7. Prepares incident reports, completes other written reports and records.
8. Assists Lead Mobile Medic in maintaining data on high frequency users to assist with care, treatment, transport, and education determination.
9. Coordinates with Lead Mobile Medic, and Public Health Officials, Community Health Practitioners, and other community advocates.
10. May perform procedures and drug administrations as allowed by current Protocols signed by the Medical Director.
11. Provides high level of decision making authority commensurate of a company officer.
12. Manages assigned projects and programs.
13. Delivers MIHCP public education and prevention activities.
14. Maintains license through continuing education.

Supervisory Responsibilities

Delivers a high level of decision making authority and supervision as it pertains to the care, treatment, and transport of patient. Carries out supervisory responsibilities in accordance with the organizations policies and applicable laws. Responsibilities include interviewing and training employees, planning, assigning and directing work; appraising performance; rewarding and disciplining employees; addressing complaints and resolving problems.

Minimum Qualifications

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily, the requirements listed below are representative of the knowledge, skill and or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.



City of Rapid City Mobile Medic EMS Operations Position Description

Education: Associates degree or equivalent from a two-year college or technical school. Minimum of 5 years as a Paramedic and two years as a Journeyman Firefighter with past ACO or FTO experience.

Communication Skills: Able to read, analyze and interpret common scientific and technical journals, financial reports and legal documents. The ability to respond to common inquiries or complaints from customers, regulatory agencies, or members of the business community. Ability to write speeches and articles for publication that conform to prescribed style and format. Ability to effectively present information to top management, public group, and governing body.

Mathematical Skills: Ability to work with mathematical concepts such as probability and statistical inference, fundamentals of plane and solid geometry as well as trigonometry. Ability to apply concepts such as fractions, percentages, ratios, and proportions to practical situations.

Reasoning Ability: Ability to solve practical problems and deal with a variety of concrete variable in situations where only limited standardization exists. Ability to interpret a variety of instructions furnished with written, oral, diagram, or schedule form.

Computer and Administrative Skills: To perform this job successfully, an individual should have knowledge of Microsoft Office products, Dream Weaver, Publisher, and Firehouse Products.

Certificates, Licenses, Registrations: Must possess a valid South Dakota Drivers License or the ability to obtain within 30 days from date of hire. Must possess a National Registry Paramedic Certification or State of South Dakota Paramedic License.

Physical Demands: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodation may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently required to sit and talk or hear. The employee is occasionally required to stand; walk; use hands to finger; handle or feel; reach with the hands and arms; climb or balance and stoop, kneel, crouch, or crawl. The employee must occasionally lift and or move more than 100 pounds.

Work Environment: The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job the employee is occasionally exposed to an environment that is immediately dangerous to life and health, wet and/or humid conditions; moving mechanical parts; high, precarious places, fumes or airborne particulate; toxic or caustic chemicals; outside weather conditions; extreme heat and vibration. The noise level in the work environment is moderate.



RAPID CITY FIRE DEPARTMENT

EMS ACADEMY



Mobile Medic Care Course Syllabus (16 hours)

Course No:

Date:

Days/Time: TBD

Classroom: RCFD Classroom

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

Phone: 605-415-3373

Email: chris.jolley@rcgov.org

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

Course Description:

This course provides students with the principles of providing care outside of the ambulance in a non-emergent capacity. To provide an understanding of the role the Mobile Medic has in the community and the greater healthcare system. Focused low acuity patient assessment training will be provide as well as focused documentation and communications with outside agencies.

Prerequisite:

Rapid City Fire Department Paramedic in good standing

Student Learning Outcomes:

- Describe the characteristics of the profession of paramedicine
- Describe the characteristics, components and functions of pre-hospital medicine
- Explain the roles and responsibilities of the Mobile Medic
- Select behaviors that promote EMS workforce safety and wellness
- Map Community healthcare needs
- Apply principles of public health in your role as a Mobile Medic
- Understand community healthcare resources
- Identify the health and social needs in underserved areas
- How to access the social services system and their role
- Recognize and appropriately respond to medical/legal issues in the practice of paramedicine
- Apply the ethical principles of paramedicine to your work as a Mobile Medic
- Use technology and knowledge of EMS communications systems and skills to communicate effectively in carrying out your responsibilities as a Mobile Medic
- Create complete, well-written patient care reports

Teaching-Learning Methods:

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

Course Completion Requirements:

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

Course Attendance Policy:

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

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

Comportment:

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

Dress and Appearance:

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

Academic Dishonesty:

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

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

Course Schedule

Date	Chapter	Assignments, Tests, Quizzes
Day 1:	Course Introduction and Overview Roles and responsibilities of the Mobile Medic Social Services presentation	
Day 2:	Community Healthcare resources Focused patient assessment of the low acuity patient Documentation of your patient interaction	

PATIENT HISTORY

Medical:

- A. Chief complaint:
 - 1. When did it start? How long has it been going on? Is it changing?
 - 2. How intense is the problem? Very severe, mild?
 - 3. What caused or brought on the condition?
 - 4. Does anything make it better or worse?
 - 5. For pain: describe the location, type of pain, severity, radiation.
 - 6. What caused the patient or family to seek help at this time?
 - 7. Has the patient experienced or been treated before for this problem? When?
- B. Associated complaints: Are there any other symptom bothering the patient at this time?
- C. Pertinent past medical history.
- D. Allergies.
- E. Medications and drugs.
- F. Survey of surroundings for evidence of drug abuse, mental function, family, problems.

Trauma:

- A. Chief complaints: areas of tenderness, pain.
- B. Associated complaints.
- C. Mechanism of injury:
 - 1. What were the implements involved-weapons, autos, etc?
 - 2. How did the injury happen: cause, precipitating factors?
 - 3. What trajectories were involved. Bullets, cars, people?
 - 4. How forceful was the mechanism: speed of vehicles, force of the blow, etc.?

PATIENT HISTORY (cont.)

Trauma (cont.):

4. With a vehicle: What is the condition of windshield, steering wheel, and vehicle body? Was there significant intrusion into the passenger compartment? Were the passengers wearing seatbelts? Was the patient ejected from the vehicle? Type: rollover, head-on, rear-end, T-bone?
- D. Mental status and pertinent findings since accident according to witnesses or bystanders. Patient getting worse? Better?
- E. Treatment since accident: movement of patient by bystanders, etc. Patient ambulatory at scene?

Special Notes:

- A. Do not let the gathering of information distract from management of life-threatening problems.
- B. Appropriate questioning can provide valuable information while establishing authority, competence, and rapport with patient.
- C. In medical situations, history is commonly obtained before or during physical assessment. In trauma cases it may be simultaneous or following the primary survey. An assistant is often used for gathering information from family or bystanders.
- D. USE BYSTANDERS to confirm information obtained from the patient and to provide facts when the patient cannot. History from the scene is invaluable.
- E. Over-the counter medications (including aspirin and birth control pills) are frequently overlooked by patient and EMS, but may be important to emergency problems.

Protocol 6.11: No-Transport (Refusal, Cancel)

General Principles:

- A. Non-transport of a patient when EMS is called to a scene is one of the greatest areas of exposure to legal liability that EMS agencies and individual EMS providers face. The EMS provider is responsible for a reasonable assessment of the patient and situation to determine if there is injury or illness, or a reason to treat and/or transport. When a non-transport situation occurs, care must be taken to assure that procedures are followed correctly and the encounter is documented fully.
- B. An adult patient that has decision making capacity has the legal right to refuse treatment, evaluation and transport in spite of the fact they may be injured or ill. The minor patient does not have that same legal right to refuse, a parent or legal guardian must represent them.
- C. Non-transport situations generally fall into two primary categories: **Cancel** and **Refusal**.

Definitions:

- A. Cancels are calls where the response is discontinued prior to patient contact being made (by EMS personnel).
- B. Refusals are calls where patient contact is made by EMS personnel, but the patient(s) refuse treatment and or transport.
- C. When EMS personnel arrive on the scene of a call originally dispatched as an EMS call and after investigation find that no medical situation exists, these will also be categorized as Refusals for purposes of this protocol.
- D. A minor in SD is any patient less than 18 years of age.
- E. An emancipated minor in SD is any patient less than 18 years old that:
 - 1. Has entered into a valid marriage, whether or not such marriage was terminated by dissolution; or
 - 2. Is on active duty with any of the armed forces of the United States; or
 - 3. Has been declared an emancipated minor by the courts.

An emancipated minor is treated the same as an adult.

Protocol 6.11: No-Transport (Refusal, Cancel) (cont.)

Procedures:

Cancel:

A. A response may be cancelled enroute to a call when a first-response Fire and or EMS agency already on scene advises to cancel. These cancellations may encompass a number of different situations, to include but are not limited to:

1. MVA or other trauma call with no patients claiming injuries.
2. Medical call where patient is refusing treatment and or transportation.
3. Man down/unknown problem call where first response agency has determined patient to be public inebriate only and Law Enforcement will handle.
4. Medical or trauma call where no patient has been found or patient has left the area.

Note: Use extreme care in the “no patient found” or “patient left the area” scenarios. It is not uncommon for even a seriously ill or injured patient to wander a short distance from the area where they were initially reported to be. As much as is possible, assure that a thorough search for the patient was done before cancelling. This is particularly true in the rollover MVA and assault situation.

B. Response to a MVA shall not be cancelled only on advice from Law Enforcement or civilians when they report no injuries. An evaluation must be done by a first response Fire and or EMS agency and they must advise no injuries before cancelling. An initial hot response may however, be downgraded to cold in this scenario.

C. Response may be cancelled on advice from Law Enforcement in the following scenarios:

1. Reported MVA and LE has found no accident.
2. Reported MVA and LE has found no one around the vehicle or patient has apparently left the area.
3. Reported MVA turns out to be accident previously reported and already investigated.

Protocol 6.11: No-Transport (Refusal, Cancel)

Procedures (cont.):

Cancel (cont.):

4. "Man down" or unknown problem is determined to be a public inebriate by LE and they will handle.
- D. EMS personnel shall have the discretion to continue a response to a scene in spite of a first response Fire and or EMS agency request to cancel if the request to cancel seems inappropriate or if the information appears to be incomplete, incorrect or inaccurate. Communication is the key, if you are uncomfortable cancelling based on what you've heard, continue and try to get more information.

Refusal:

- A. In all refusal situations, EMS personnel shall perform as complete an assessment as the situation and the patient(s) will allow (see assessment /documentation guidelines below). The results of the assessment (or the patients refusal to allow one) shall be documented fully in the Patient Care Report (PCR). A refusal with no assessment and accompanying documentation is an area of extreme legal risk for EMS personnel.
- B. When EMS personnel reach the scene of a MVA or other trauma call where patients are refusing service and:
1. There are no patients claiming injuries or with any visible injuries.
 2. There are no patients requesting treatment and or transportation to a medical facility.
 3. There is no significant mechanism of injury to suggest a possible hidden injury.
 4. All affected patients at the scene are mentally competent, with decision making capacity.

If an assessment reveals no problems, EMS personnel may treat these patients as "involved not injured" and clear the scene, no Refusal of Ambulance Services form is required (this includes all minors). If an assessment reveals injuries, patient(s) shall be offered treatment and transport to a medical facility.

Protocol 6.11: No-Transport (Refusal, Cancel) (cont.)

Procedures (cont.):

Refusal (cont.):

C. When EMS personnel reach the scene of a MVA or other trauma call where patients are refusing service and:

1. There are patients claiming injuries or that have any visible injuries.
2. There is any significant mechanism of injury to suggest a possible hidden injury.
3. All affected patients at the scene are mentally competent, with decision making capacity.

EMS personnel shall fully advise the patient(s) of the results of the assessment and of the risks of refusing treatment and transport and obtain a signed Refusal of Ambulance Services form for each affected patient before clearing the scene.

If the patient(s) refuses to sign the **Refusal of Ambulance Services** form, it should be witnessed and documented fully in the Patient Care Report (PCR).

D. If a non-emancipated minor at the scene of a MVA or other trauma call is attempting to refuse service and has:

1. Any visible/discovered on assessment injury ; or
2. Claims any injury; or
3. Is involved in a situation where there is any significant mechanism of injury to suggest a possible hidden injury;

That minor may not refuse service and may not sign a **Refusal of Ambulance Services** form. The parent or a legal guardian of a minor must refuse treatment and or transport for their minor children in person and the minor left in their custody.

If a parent or legal guardian is not able to arrive in an expedient manner to handle the refusal and take custody of the minor, that minor must be transported to a medical facility. Do not wait on scene for extended periods of time waiting for a parent/legal guardian to arrive.

Protocol 6.11: No-Transport (Refusal, Cancel) (cont.)

Procedures (cont.):

Refusal (cont.):

- E. When EMS personnel reach the scene of a medical call where a mentally competent adult patient(s), with decision making capacity that had or has a chief complaint is refusing service; EMS personnel shall fully advise the patient(s) of the results of the assessment and of the risks of refusing treatment and transport and obtain a signed **Refusal of Ambulance Services** form for each affected patient before clearing the scene.

If the patient(s) refuses to sign the **Refusal of Ambulance Services** form, it should be witnessed and documented fully in the Patient Care Report (PCR).

- F. A non-emancipated minor at the scene of a medical call that had or has a chief complaint may not refuse service and may not sign a **Refusal of Ambulance Services** form. The parent or a legal guardian of a minor must refuse treatment and or transport for their minor children in person and the minor left in their custody.

If a parent or legal guardian is not able to arrive in an expedient manner to handle the refusal and take custody of the minor, that minor must be transported to a medical facility. Do not wait on scene for extended periods of time waiting for a parent/legal guardian to arrive.

- G. EMS personnel may treat and release an adult hypoglycemic diabetic patient, given that the following conditions are met:
1. The patient must be a diagnosed diabetic being treated with a form of insulin.
 2. The patient must not be taking any oral agents for the control of their blood sugar.
 3. The patient must have had an initial blood glucose <**70** before treatment, and a blood glucose >**100** after treatment.
 4. The patient must not have exhibited any focal neurologic deficits before treatment with glucose.
 5. After treatment the patient must be exhibiting completely normal neurologic signs and have a Glasgow coma scale score of 15.
 6. The patient must have access to food, or a source of food must be provided to the patient before releasing the patient from care.

Obtain a signed **Refusal of Ambulance Services** form before clearing the scene. See **Protocol 2.19: Diabetic Emergencies** for further information.

Protocol 6.11: No-Transport (Refusal, Cancel) (cont.)

Procedures (cont.):

Refusal (cont.):

- H. In circumstances where a patient, parent or legal guardians mental competency is obviously in question; or the obvious presence of alcohol or chemical intoxication is interfering with decision making capacity, contact with Medical Control to help sort out the situation is strongly suggested. Seek the assistance of Law Enforcement when necessary.
- I. When EMS personnel respond to a scene where a verified suicide gesture has taken place, the patient(s) involved may not refuse service, they must be transported to a medical facility. If there is some dispute about whether or not the suicide gesture has actually taken place, investigate carefully and seek the assistance of Law Enforcement where necessary. Remember, patients that engage in suicide gestures many times have a reason to be untruthful, so do not rely on their word alone that a suicide gesture has not taken place.
- J. When EMS personnel respond to the scene of a reported illness or injury and after an investigation and assessment find that no medical situation exists, a **Refusal of Ambulance Services** form is not appropriate.

Assessment / Documentation Guidelines:

- A. In refusal situations, particularly those with patients refusing against medical advice (AMA), EMS personnel wherever possible, shall assess and document:
 - 1. Mental status i.e., orientation to person, place and time, and patients comprehension of the nature/severity of illness/injury and comprehension of the nature of treatment.
 - 2. Vital signs (ECG also if potentially cardiac related).
 - 3. Glasgow Coma Scale score.
 - 4. Any plan for alternative care.
 - 5. Risks of refusal up to and including death (inform patient).

Protocol 6.11: No-Transport (Refusal, Cancel) (cont.)

Assessment / Documentation Guidelines (cont.):

- B. In adult patients refusing an assessment who have a chief complaint, have sustained an injury or might reasonably be suspected to have sustained an injury:
1. Evaluate the patient's mental status as to coherency/decision making capacity.
 2. Explain the significance of the mechanism of injury (if there is one).
 3. Explain the possible related complications of the illness or injury.
 4. Explain the possible consequences of the illness or injury if left untreated, up to and including death.
 5. Have patient read (or read it to them) and sign a **Refusal of Ambulance Services** form and document discussion in Patient Care Report (PCR) narrative. If patient will not sign, document the refusal to sign in the narrative as well

Additional Considerations:

- A. EMS personnel should err on the side of contacting Medical Control in Refusal situations that are unclear or are not covered by this protocol.
- B. Obtaining a signature on a **Refusal of Ambulance Services** form is always strongly encouraged when appropriate, because signing may be evidence of the patients decisional capacity and physical ability. However, remember that a signature does not relieve EMS personnel of the responsibility for a reasonable assessment and possibly treatment of the patient.
- C. For the patient who is refusing treatment/transport against medical advice (AMA), providing the patient with clear instructions and warnings is imperative (having them read or reading to them the **Refusal of Ambulance Services** form is recommended). Having this form co-signed by a witness that is not an employee of the RCFD is also recommended.
- D. For Cancel situations that are unclear or not covered by this protocol, contact the on-duty Battalion Chief or the EMS Chief.

Protocol 6.12: Patient Care Report (PCR) Requirements

General principles:

- A. The Patient Care Report (PCR) is an integral component of patient care, the quality improvement process and is a professional responsibility of the EMS provider.
- B. The Patient Care Report (PCR) is many times the sole source of information regarding the patient's condition and any pre-hospital treatment they received. It is imperative that the information is accurate, complete and provided to the receiving hospital in an expedient manner in order to provide for an efficient and safe transfer of care.
- C. The Patient Care Report (PCR) is the legal record of the EMS provider's encounter with the patient, and the treatment and transport that patient received. The PCR is discoverable in a court of law and can be (and frequently is) subpoenaed. Given that fact, the PCR must be complete and it must be accurate in all respects.
- D. The Patient Care Report (PCR) is also the primary tool used by patient billing services to collect fees for ambulance services, which are the primary funding source for the EMS system. The PCR must be complete and it must be accurate to allow the billing process to take place in an expedient manner and to satisfy federal regulations regarding ambulance billing.

Procedures:

- A. The procedures detailed herein apply to both the handwritten (paper) PCR and any electronic charting method the Department uses.
- B. The following minimum information shall be gathered and documented relative to the patient and their personal information:
 - 1. Patient name
 - 2. Patient age and birth date
 - 3. Patient sex
 - 4. Patient social security number
 - 5. Patient residential address
 - 6. Patient phone number
 - 7. Patient health insurance company(s) and numbers (to include Medicare/Medicaid)
 - 8. Patient next of kin or responsible party

Protocol 6.12: Patient Care Report (PCR) Requirements (cont.)

Procedures (cont.):

Note: It is understood that at the time of the call, some of the above information may be difficult to obtain in the event a patient is unconscious, intoxicated, etc. Every effort should be made to obtain the information in a timely manner if at all possible. Family members, friends, law enforcement and the hospital face sheet are all good potential sources for this information.

C. The following minimum information shall be gathered and documented relative to the incident itself:

1. Incident number
2. Date incident occurred
3. Run/call type and or reason for dispatch
4. Incident location
5. Response mode to the call and back to the hospital (hot/cold and any changes)
6. Location patient transported to
7. Times:
 - a. Dispatch
 - b. Enroute
 - c. On Scene
 - d. First Paramedic on scene (if applicable)
 - e. Enroute to hospital
 - f. Out at hospital
 - g. Clear of call
 - h. Cancelled (if pertinent)
8. Patient loaded mileage
9. Medic Unit number and station
10. Receiving physician
11. Crew names (signature) and skill level

D. The following minimum information shall be gathered and documented relative to the patient and the medical care they received:

1. Patient chief complaint
2. Nature of the incident and or mechanism of injury
3. Results of physical exam/assessment to include but not limited to:
 - a. Vital signs (BP, RR, HR, O2 Sat.) repeated every 10 minutes if transport > 10 min.
 - b. LOC – Mentation - GCS
 - c. Skin signs

Protocol 6.12: Patient Care Report (PCR) Requirements (cont.)

Procedures (cont.):

- d. ECG. (Where pertinent, copy of ECG shall be attached to all copies of report whenever an ECG is done)
 - e. Lung sounds (where pertinent)
 - f. End –Tidal CO₂ (where pertinent)
 - g. Glucose (where pertinent)
 - h. Motor function
 - i. Any visible trauma or abnormality
 - j. Pupil size and reactivity
 - k. Temperature (where pertinent)
4. Condition patient first found in.
 5. History of present event (brief).
 6. Known patient past medical history, medications, allergies.
 7. All treatment rendered (including treatment rendered prior to arrival). Treatment times shall be noted. Medication administrations shall include times and dose(s).
 8. Any changes in patient condition noted, and specifically those changes noted as a result of treatment (including lack of changes).
 9. Any orders requested and whether granted or denied (include physicians name).
 10. Any special circumstances (weather, facility divert, violence, prolonged extrication, etc.).
 11. Patient condition on arrival at medical facility.
- E. For specific PCR requirements in refusal cases, see **Protocol 6.11: No-Transport (Refusal, Cancel)**.
- F. Patient Care Reports for patients who have had invasive airway procedures done and or IV medications administered, shall be completed at the hospital and left there with the patient. All other ALS reports shall be printed out or copies left at the hospital within 12 hours of the call. All BLS reports shall be printed out or copies left at the hospital before the end of the shift.

Additional Considerations:

- A. In all circumstances, Patient Care Reports shall be completed in sufficient detail to allow the receiving medical facility and system Medical Director to easily determine the nature and extent of the patients injury or illness and any treatment rendered.

Protocol 6.13: Public Inebriate Disposition

General Principles:

- A. Medic Units and Engine Companies will at times receive requests from Law Enforcement to perform a medical evaluation of the public inebriate. These requests are valid due to the fact that the public inebriate population has a statistically higher incidence of serious medical problems than most other segments of society.
- B. Law Enforcement agencies and other allied agencies like the Pennington County Jail, Juvenile Services and Detox typically use an arbitrary BAC number of .400 or .500 as a limiting factor to determine whether a subject is suitable for transport to that particular facility. While these numbers may be suitable to determine if a subject is suitable for a particular facility, they are not suitable to determine if a subject requires transport to a medical facility by an ALS ambulance. The determination of whether or not one of these subjects will be transported to a medical facility by ambulance will be based on a clinical evaluation by the attending Paramedic and not on the BAC number generated by a portable breath tester.
- C. This protocol pertains only to the encounter with the public inebriate in public. When a facility (Pennington County Jail, Juvenile Services, Detox, etc.) requests transport for a subject/patient in their facility, those patients shall be transported immediately.
- D. When requests for an evaluation of the public inebriate are received, refer to the following:

Procedures:

- A. These requests will be processed through Dispatch and will receive a *cold (immediate)* response unless triaged to a higher response by Dispatch.
- B. In times of system overload, these requests will be triaged to a *delayed* response and will be handled as soon as resources become available. If at any time, Dispatch indicates a need for a higher level of response, that will place the call higher in the queue and it will be responded to as appropriate.
- C. Representatives from agencies making these requests will be treated with the same courtesy and respect you would expect from them. These requests for medical evaluation are not an unnecessary interruption of our daily operations; they are a very necessary part of the public safety net for a segment of the population that is unable or unwilling to seek mainstream medical care.

Protocol 6.13: Public Inebriate Disposition (cont.):

Procedures (cont.):

- D. On arrival at one of these incidents, the Paramedic will obtain a complete history of the requesting agencies contact with the subject (who, what, when, where, how long) **make no assumptions**.
- E. The determination of whether or not the subject will be transported by ambulance to a medical facility will be based on the following evaluation and parameters.
1. Complete history and exam finding the following:
 - a. Subject must be easy to arouse
 - b. Must have a minimum GCS of 14
 - c. Must be ambulatory with minimal assistance and have no focal motor or sensory deficits
 2. Complete set of vital signs within the following parameters:
 - a. Pulse **60-110**
 - b. SBP **90-160**
 - c. RR **12-25**
 - d. O2 Sat **> 94%**
 - e. Glucose **70-200**
 3. Subject **not** requesting transport to a medical facility.
- F. If the above parameters are **not** met, the subject will be transported to the appropriate medical facility by ambulance.
- G. If the above parameters **are** met, politely explain to the requesting agency representative that the subject does not meet our criteria for transport by ambulance. Brief them completely on your findings and your basis for declining to transport the subject. Further explain that if they still wish to have the subject transported to a medical facility after your evaluation, they will need to find alternative means to do so. All of this will be accomplished in a polite, professional, non-confrontational manner.

Protocol 6.13: Public Inebriate Disposition (cont.):

Procedures (cont.):

- H. If at any time during one of these encounters, the subject requests transport to a medical facility because of an *injury or illness*, they will be transported by ambulance immediately.
- I. If the above vitals signs assessment and evaluation are not performed (or are not able to be performed), the subject will be transported to a medical facility by ambulance immediately.
- J. Document the encounter completely with vitals signs, see **Protocol 6.11: No-Transport (Refusal, Cancel)** for additional details.

Additional Considerations:

- A. **Remember, always err on the side of caution in questionable or unclear circumstances, it is medically-legally safer to transport someone to a medical facility that doesn't need to go than to not transport someone that does need to go.**
- B. In situations where there is unresolved disagreement between a requesting agency and the attending Paramedic reference whether a subject should be transported by ambulance, contact the on-duty Battalion Chief or the EMS Chief.



RAPID CITY FIRE DEPARTMENT

EMS ACADEMY



Mobile Medic Clinical Course Syllabus

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

Instructor: Jason Reitz, BHS, NRP, CCP
Phone: 605-394-4180
Email: jason.reitz@rcgov.org
Office Hours: By appointment

Course Descriptions:

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

Prerequisite:

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

Textbook:

None.

Required Materials:

Class uniform, ID badge

Student Learning Outcomes:

- Utilize techniques taught to date
- Analyze patients with low acuity complaints
- Evaluate a patient
- Choose a treatment plan for a patient

Teaching-Learning Methods:

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

- Students must complete all the same functions as the Preceptor and perform their daily duties with them. Participation is paramount.
- At the end of shift, complete the required paper work, give to your preceptor (preferably an hour prior to leaving) so there is adequate time for them to evaluate and write it down.
- In class clinical evaluation will consist of case reviews, going over procedures used in current clinical setting and paperwork turned in to staff.

Course Completion Requirements:

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

Course Attendance Policy:

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

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

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

Comportment:

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

Dress and Appearance:

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

Academic Dishonesty:

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

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

Course Grading and Grading Scale:

This course is a Pass or Fail.

Clinical Schedule:

Clinical times vary per personal schedules.

Attachment 2

Physician Supplement to Petition for Additional Tasks
(Please attach additional sheets if needed)

I, Nathan Long, am the physician medical director, and I request the following additional tasks for the scope of practice for Christopher Jolley.

The Rapid City Fire Department requests that individually identified paramedics (Mobile Medic) be allowed to respond as a single responder in a light vehicle or other quick response vehicle (not an ambulance) to 911 requests for service. We request the ability to allow Mobile Medics, under the direction of the Department Medical Director, to provide an advanced patient assessment and field impression to then communicate the assessment and field impression to a physician. The Mobile Medic then can communicate the physician's recommendation to the patient.

1. What is the reason for this request?

Please see attachment (A).

2. What duties, procedures, medication(s), etc. are requested?

Respond as a single resource to requests for service and provide an advanced patient assessment and field impression to a physician. After consultation with the physician, the Mobile Medic then communicates the transportation recommendation to the patient.

How do we envision the response?

The RCFD and its 911 communications center currently utilize the Medical Priority Dispatch System. It is a nationally recognized dispatch protocol that asks a standard set of questions to 911 callers. There are 33 standard complaint cards, e.g. card 1 is abdominal pain, card 10 is chest pain, and card 26 is sick person. The 33 cards also have increasing levels of severity (omega, alpha, bravo, charlie, delta, and the most severe echo). For example: A 911 caller who calls with a complaint of chest pain (card 10) that is having abnormal breathing and is clammy will get a code 10-delta-4 which translates to a fire engine hot and an ambulance hot. This protocol has been approved by Dr. Nathan Long, the RCFD and Pennington County 911 Medical Director. Initially, the dispatch center will send the Mobile Medic on 911 calls from card 26-sick person omega level calls. Card 26 omega level include calls for complaints such as boils, bumps, constipation, earache, nervousness, sore throat, toothache, infected wound, medication refill, social service complaints, and many simple non-descript complaints. These types of calls tie up valuable resources for true emergencies. The responder will respond to calls for service in a light duty truck or SUV, leaving ambulances and fire apparatus free to respond to calls requiring

their use. The light vehicle will be identified with fire department markings and lighting and will be equipped appropriately.

3. What risks are associated with the requested expansion(s)?

Risk is very low. Mobile Medics will be sent as a single responder to 911 complaints. One risk area would be patients call 911 and state a low acuity complaint when they are having a high acuity problem. This will be revealed by the physician recommendation after the patient assessment and physician consultation by the Mobile Medic. This could cause a slight delay in transport.

Comment [HM1]: The risk actually is unknown at this time until the mobile medic program is up and running and data gathered has been audited and assessed.

Comment [HM2]: Much like the risk, whether this is a slight or significant delay is unknown until the mobile medic program is up and running and data gathered has been audited and assessed.

4. What training and education will the advanced life support personnel complete? (please attach the syllabus)

Attachment(s): Mobile Medic Intro 2016
RCFD Mobile Medic Clinical Syllabus

5. Who will provide the training and verify competency?

Dr. Nathan Long or current Medical Director will provide oversight and verify competency of the Board approved Mobile Medic training. Instructors will vary depending on topic covered.

6. Describe the ongoing schedule of continuing education and training that will be provided in order to ensure competency and patient safety (or attach syllabus).

Dr. Nathan Long or current Medical Director will provide Board approved continuing education and training. Training will be based upon need and identified through his evaluation and quality assurance of the Mobile Medics duties and care.

7. Who will provide the continuing education and training and verify continued competency?

Dr. Nathan Long or current Medical Director will provide oversight of the Board approved continuing education and training. Instructor will be based upon topic of training. Training will be based upon need and identified through his evaluation and quality assurance of the Mobile Medics duties and care. The Medical Director will verify competency.

8. Will documentation about the training, continuing education, and verification of competency be available for Board review in the event of an audit?

Yes, records will be kept on training and activities within our records management system as outlined by the Rapid City Fire Department.

Comment [HM3]: The Board typically asks for 1 year of regular e.g. monthly reports on petition requests. These reports would contain all documentation including but not limited to the medical records.

9. Will logs documenting the times the additional tasks for the scope are used, and any adverse effects/results be available for Board review in the event of an audit?

Comment [HM4]: See previous comment and this would be included in those monthly reports.

Yes, all documentation of the Mobile Medic calls and procedures are documented on the approved electronic patient care report as identified by the Rapid City Fire Department.

Signature: _____ Date: _____
(Physician medical director)

Name and Location of Ambulance Service(s):

Rapid City Fire Department 10 Main St. Rapid City, SD 57701

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

STATE OF SOUTH DAKOTA

IN RE: Mobile Medic) PETITION FOR
) ~~PARAMEDIC, AEMT, EMT I/85, EMT I/99~~
NAME: Christopher Jolley) Allowing additional tasks to my
) scope of practice
)

I am a South Dakota licensed Advanced Life Support provider and I am petitioning the South Dakota Board of Medical and Osteopathic Examiners (BMOE) for ~~an~~ allowing additional tasks to my scope of practice.

It is requested that, as a licensed Advanced Life Support Provider, **PARAMEDIC**, as defined by SDCL 36-4B-1 that I be approved by the Board to perform the following additional tasks:

Respond as a single resource (Mobile Medic) to requests for service and provide an advanced patient assessment to formulate a field impression. After consultation with a physician, determination of disposition will be made to ensure the patient receives the right level of care at the right time.

I understand that Board approval of this petition will permit me to provide the above described care only after I successfully complete the appropriate training and education. I have attached an outline with the specific training and education that I will complete. It is requested that these duties and/or procedures be included within my scope and training, and I understand that I will be required to successfully complete ongoing continuing education in order to maintain and demonstrate competency and continue to provide these additional tasks.

Signature) Date:

Signature of Medical Director Date:

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Protocol VI. ##.#: Mobile Medic Transport Determination

Premise:

Mobile Medics will receive requests for patient evaluations of emergency complaints from 911 callers, Law Enforcement or other allied agencies. These are valid calls for service and must have an evaluation done. Many times these requests do not need transport via ambulance to the local emergency department.

Law Enforcement agencies and other allied agencies like the Pennington County Jail, JSC and Detox or those that call 911 request an evaluation. The simple act of calling does not constitute a medical problem that means they require transport to a medical facility by an ALS ambulance. The determination of whether or not one of these subjects will be transported to a medical facility by ambulance will be based on a clinical evaluation by the attending Paramedic and consultation with a physician.

When requests for an evaluation of these subjects are received, the following procedures will be followed.

- These requests will be processed through Dispatch and will receive a *cold (immediate)* response unless triaged to a higher response by Dispatch.
- In times of system overload, these requests will be triaged to a *delayed* response and will be handled as soon as resources become available. If at any time, Dispatch indicates a need for a higher level of response, that will place the call higher in the queue and it will be responded to as appropriate.
- Representatives from agencies making these requests will be treated with the same courtesy and respect you would expect from them. These requests for medical evaluation are not an unnecessary interruption of our daily operations; they are a very necessary part of the public safety net for a segment of the population that is unable, unwilling, or have difficulty in seeking mainstream medical care.
- On arrival at one of these incidents, the Mobile Medic will obtain a complete history of the requesting party and **make no assumptions**.
- The determination of whether or not the subject will be transported by ambulance to a medical facility will be based on the following evaluation and parameters communicated to a physician for recommendation.

Comment [HM1]: This may not be sufficiently developed to communicate the situation adequately to the physician.

- 1) Complete H&P
 - a. Subject must be easy to arouse
 - b. Must have minimum GCS of 14

Protocol VI. ##. #: Mobile Medic Transport Determination(cont.)

c. Must be ambulatory with minimal assistance and have no focal motor or sensory deficits

2) Complete set of vital signs within the following parameters:

- a. Pulse 60-110
- b. SBP 90-160
- c. RR 12-25
- d. O2 Sat > 90%
- e. Glucose 70-200

3) If the above parameters are **not** met, the subject will be transported to the appropriate medical facility by ambulance.

~~4) Contact medical control for determination of transportation or disposition of the patient.~~

~~3)4) _____~~

5) If the above parameters **are** met, explain to the patient or allied agency that they may have alternatives and if it is ok with them to discuss alternatives to transport with the allied agency, the patient, and medical control.

~~6)5) Contact medical control for determination of transportation or disposition of the patient.~~

~~7)6) _____ Assist patient with final disposition.~~

Note: If at any time during one of these encounters, the subject requests transport to a medical facility, they will be transported by ambulance immediately.

If the above vital signs assessment and evaluation are not performed (or are not able to be performed), the subject will be transported to a medical facility by ambulance immediately.

Remember, always err on the side of caution in questionable or unclear circumstances, it is medically-legally safer to transport someone to a medical facility that doesn't need to go than to not transport someone that does need to go.

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Comment [HM2]: See previous comment –point 6) needs to come before point 5)

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Comment [HM3]: Physician needs to make the recommendation not the Mobile Medic.

Comment [HM4]: See previous comment –point 6) needs to come before point 5)

EXECUTIVE SUMMARY FINANCIAL REPORT

TO: THE BOARD OF MEDICAL AND OSTEOPATHIC EXMINERS
FROM: MARGARET B HANSEN
DATE: FEBRUARY 11, 2016

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

- Petty Cash
- Local Checking
- State Treasury Fund

	FY16	FY15	FY14
	01/31/16	06/30/2015	06/30/2014
Total Cash	3,006,990	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
	01/31/2016	06/30/2015	06/30/2014
Total Revenue	688,638.46	1,307,603.35	1,256,516.60

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

	FY16	FY16	FY15	FY15
	Budgeted	1/31/2016	Budgeted	06/30/2015
4-A 5203040 – Air-State Owned – Instate • Use of a state owned plane for meetings	16,000	912	16,000	7,372
4-B 5203100 - Lodging Out-Of-State • Hotel expenses for in state meetings or training attended	500	2,900	500	3,977
4-C 5204160 – Workshop Registration Fee • Registration fee for meetings or training attended	2,000	630	2,000	4,656
4-D 5204530 - Telecommunication Services • Board Member Laptop wireless • Background Reports e.g.	3,000	5,770	3,000	10,185
4-E 5205020 – Office Supplies • Supplies for daily tasks in the office	10,000	1,651	10,000	2,560
4-F 5205320 - Duplication – Private • Printed pages from leased printers • Licensure Cards ordered	300	5,146	300	6,046

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

Shows total expenses and budget comparison.

	FY16	FY16	FY15	FY15	FY14	FY14
	Budgeted	01/31/2016	Budgeted	06/30/2015	Budgeted	06/30/2014
Total Expenses	1,025,703	719,021	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	01/31/2016	Budgeted	06/30/2015	Budgeted	06/30/2014
Net Income	233,797	-30,382	174,257	315,639	210,382	332,261

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

	FY16	FY15	FY14
	01/31/2016	06/30/2015	06/30/2014
Total Other Contractual Services	23,215	36,751	60,868

SDBMOE Financial Report

02/11/2016

for
07/01/15 - 1/31/2016

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 - January 31, 2016

	FY16 01/31/2016	FY15 06/30/2015	FY14 06/30/2014	FY13 06/30/2013	FY12 06/30/2012	FY11 06/30/2011
Cash						
Petty Cash	100	100	100	100	100	100
Local Checking	3,359	2,034	3,598	2,930	4,223	4,712
State Treasury Fund	3,003,532	2,970,153	2,653,139	2,300,852	1,810,978	1,370,641
1. Total Cash	3,006,990	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 - January 31, 2016

Type	07/01/15 - 1/31/16 Amount	07/01/14 - 06/30/15 Amount	07/01/13 - 06/30/14 Amount
Licenses			
Athletic Trainer Application	\$ 2,500.00	\$ 3,400.00	\$ 3,000.00
Athletic Trainer Reinstatement	\$ -	\$ -	\$ -
Athletic Trainer Renewal	\$ 550.00	\$ 11,350.00	\$ 9,500.00
Advanced EMT for Instate Graduate	\$ 600.00	\$ 1,400.00	\$ 850.00
Advanced EMT for out of state Graduate	\$ 150.00	\$ 300.00	\$ 225.00
Advanced EMT Renewal	\$ 300.00	\$ 1,550.00	\$ 800.00
Advanced EMT Reinstatement	\$ 50.00	\$ 50.00	\$ -
ALS-I 85 Application for Instate Graduate	\$ 50.00	\$ 50.00	\$ -
ALS-I 85 Application for Out of State Graduate	\$ -	\$ 150.00	\$ 75.00
ALS-I 85 Renewal	\$ 600.00	\$ 3,850.00	\$ 3,625.00
ALS-I 99 Application for Instate Graduate	\$ -	\$ -	\$ -
ALS-I 99 Application for Out of State graduate	\$ -	\$ -	\$ -
ALS-I 99 Renewal	\$ 50.00	\$ 250.00	\$ 225.00
ALS-I 99 Reinstatement	\$ -	\$ -	\$ -
ALS-I85 Reinstatement	\$ -	\$ 100.00	\$ 450.00
ALS-Paramedic Application for Instate graduate	\$ 1,100.00	\$ 1,300.00	\$ 1,850.00
ALS-Paramedic Application for Out of State Graduate	\$ 2,550.00	\$ 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	\$ 4,600.00	\$ 3,800.00	\$ 1,600.00
Genetic Counselor Renewal	\$ 100.00	\$ 3,100.00	\$ 1,900.00
Licensed Nutritionist Application	\$ 2,450.00	\$ 1,610.00	\$ 1,750.00
Licensed Nutritionist Renewal	\$ 425.00	\$ 10,710.00	\$ 10,395.00
Temporary License Nutritionist Application	\$ 100.00	\$ 400.00	\$ 250.00
Licensed Nutritionist Reinstatement	\$ 200.00	\$ 300.00	\$ -
Locum Tenens Application	\$ 3,450.00	\$ 2,850.00	\$ 2,550.00
MD/DO Application	\$ 48,600.00	\$ 67,600.00	\$ 74,600.00
MD/DO Reinstatement	\$ 2,200.00	\$ 9,200.00	\$ 6,600.00
MD/DO-Renewals	\$ 399,000.00	\$ 746,600.00	\$ 729,400.00
Medical Assistant Application	\$ 320.00	\$ 840.00	\$ 1,000.00
Medical Assistant Renewal	\$ 2,725.00	\$ 20.00	\$ 2,720.00
Medical Assistant Reinstatement	\$ 135.00	\$ 40.00	\$ 300.00
Medical Corp Application	\$ 100.00	\$ 650.00	\$ 550.00
Medical Corp Reinstatement	\$ 950.00	\$ 700.00	\$ 1,000.00
Medical Corp Renewal	\$ 14,100.00	\$ 15,900.00	\$ 15,900.00
Occupational Therapist Application	\$ 1,450.00	\$ 1,750.00	\$ 1,950.00
Occupational Therapist Reinstatement	\$ 50.00	\$ 75.00	\$ 50.00
Occupational Therapy Assistant Application	\$ 950.00	\$ 1,050.00	\$ 850.00
Occupational Therapist Renewal	\$ 23,300.00	\$ 21,200.00	\$ 22,000.00
Occupational Therapy Assistant Reinstatement	\$ 25.00	\$ -	\$ -
Occupational Therapy Assistant Renewal	\$ 7,950.00	\$ 7,200.00	\$ 7,150.00
Occupational Therapist Limited Permit	\$ -	\$ 25.00	\$ 125.00
Occupational Therapy Assistant Limited License	\$ -	\$ 25.00	\$ 75.00
Physical Therapist Application	\$ 1,620.00	\$ 5,040.00	\$ 3,900.00
Physical Therapist Renewal	\$ 47,800.00	\$ 44,800.00	\$ 43,900.00
Physical Therapist Reinstatement	\$ 100.00	\$ 600.00	\$ 150.00
Physical Therapist Assistant Application	\$ 1,260.00	\$ 2,880.00	\$ 1,980.00
Physical Therapist Assistant Renewal	\$ 13,900.00	\$ 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	\$ 200.00
Physician Assistant Corporation Reinstatement	\$ -	\$ -	\$ -
Physician Assistant Application	\$ 2,850.00	\$ 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	\$ 2,100.00	\$ 2,175.00	\$ 3,225.00
Respiratory Care Temporary Application	\$ 720.00	\$ 520.00	\$ 520.00
Respiratory Care Practitioner Renewal	\$ 60.00	\$ 27,000.00	\$ 60.00
Respiratory Care Practitioner Reinstatement	\$ 95.00	\$ 190.00	\$ 95.00
NSF Check Board Fine	\$ -	\$ -	\$ -
USMLE Testing	\$ -	\$ -	\$ 3,150.00
Other Income	\$ -	\$ 190.00	\$ -
Total Licenses	\$ 596,135.00	\$ 1,107,190.00	\$ 1,054,695.00

SDBMOE
Revenue by Item Summary

Date Range: July 1, 2015 - January 31, 2016

		07/01/15 - 1/31/16 Amount	07/01/14 - 06/30/15 Amount	07/01/13 - 06/30/14 Amount
Other				
Interest Income	\$	12,229.46	\$ 24,236.35	\$ 30,177.73
Fines & Penalties	\$	-	\$ -	\$ -
Total Services	\$	12,229.46	\$ 24,236.35	\$ 30,177.73
Services				
Information Request	\$	-	\$ 30.00	\$ 30.00
Online Verifications	\$	53,244.00	\$ 128,857.00	\$ 118,256.00
Written Verifications	\$	26,730.00	\$ 46,620.00	\$ 47,940.00
Duplicate License Card	\$	300.00	\$ 670.00	\$ 1,020.00
Candian Service Fee (Skype Fee Charge)	\$	-	\$ -	\$ (2.13)
Mailing List			\$	\$ 4,400.00
Total Services	\$	80,274.00	\$ 176,177.00	\$ 171,643.87
Total	3.	\$ 688,638.46	\$ 1,307,603.35	\$ 1,256,516.60

SDBMOE
Income Statement

Date Range: July 1, 2015 - January 31, 2016

	FY16 Budgeted	FY16 01/31/2016	% of Budget FY16	FY15 Budgeted	FY15 06/30/2015	% of Budget FY15	FY14 Budgeted	FY14 06/30/2014
Ordinary Income/Expense								
Income								
License Fee Revenue	1,089,000	596,135	55%	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	80,274	53%	150,750	176,177	117%	152,000	171,646
Total Income	1,239,500	676,409	55%	1,160,750	1,283,557	111%	1,164,000	1,226,341
Gross Profit	1,239,500	676,409	55%	1,160,750	1,283,557	111%	1,164,000	1,226,341
5101000 - Employee Salaries	300,801	192,236	64%	288,154	326,321	113%	277,412	308,612
5101030 - Board & Community Member Fees	3,418	1,620	47%	3,275	1,620	49%	3,154	2,520
5102010 - OASI	27,812	14,073	51%	26,392	23,656	90%	24,207	22,796
5102020 - Retirement	16,133	11,530	71%	16,133	19,332	120%	16,133	18,472
5102060 - Health Insurance	60,790	32,576	54%	60,790	65,024	107%	50,963	70,193
5102080 - Worker's Compensation	889	249	28%	889	261	29%	889	216
5102090 - Unemployment Insurance	42	75	178%	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	449	22%	2,000	278	14%	2,000	1,412
4-A 5203040 - Air-State owned-Instate	16,000	912	6%	16,000	7,372	46%	16,000	8,473
5203060 - Air-Commercial Carrier Instate	0				5,565			582
5203070 - Air Travel - Charter Flights	30,000	10,325	34%	30,000		0%	30,000	3,750
5203100 - Lodging In-State	2,000	446	22%	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	190	32%	600	405	68%	600	353
5203230 - Auto -Private Out-of state - High Rate		171						
5203260 - Air-Commercial Out-of-state	1,100	3,091	281%	1,100	1,876	171%	1,100	1,795
5203280 - Other Public Out-of-state	100	183	183%	100	260	260%	100	150
4-B 5203300 - Lodging Out-Of-State	500	2,900	580%	500	3,977	795%	500	3,653
5203320 - Incidentals - Out of State		183			25			50
5203350 - Out of State Meals		818			640			436
5204010 - Subscriptions	1,000	406	41%	1,000	90	9%	1,000	270
5204020 - Membership Dues	6,000	3,900	65%	6,000	4,425	74%	6,000	4,171
5204030 - Legal Document Fees								10
5204050 - Computer Consultant		84,550			47,970			70,980
5204080 - Legal Counsel	198,000	77,625	39%	198,000	78,008	39%	198,000	37,188
5204090 - Management Consultant		126,970			173,333			22,655
5204100 - Consultant Fees--Medical	13,500	9,450	70%	13,500	1,500	11%	13,500	1,750
5204110 - PR & Advertising Consultant		4,850						
5204130 - Other Consulting	0	8,738		0	9,692		0	8,820

SDBMOE
Income Statement

Date Range: July 1, 2015 - January 31, 2016

	FY16 Budgeted	FY16 01/31/2016	% of Budget FY16	FY15 Budgeted	FY15 06/30/2015	% of Budget FY15	FY14 Budgeted	FY14 06/30/2014	
4-C									
5204160 - Workshop Registration Fees	2,000	630	32%	2,000	4,656	233%	2,000	3,280	
5204180 - State Computer Services	9,359	12,506	134%	9,359	17,810	190%	9,359	15,734	
5204181 - BIT Development Costs					155			12	
5204190 - Private Computer Services									
5204200 - Central Services	3,531	2,741	78%	3,531	5,772	163%	3,531	3,709	
5204202 - Property Management		16			307			317	
5204203 - Purchasing Central Services		28			420			488	
5204204 - Records Management		96			112			131	
5204207 - Human Resource Services		2,748			3,931			3,454	
5204220 - Equipment Maintenance		262			1,670			35,201	
5204230 - Janitorial								0	
5204250 - Cable TV (Office Internet)		545			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	292		500	1,255		500	207	
5204400 - Advertising Internet	500		0%	500	294	59%	500	0	
5204460 - Equipment Rental	2,000	624	31%	2,000	960	48%	2,000	1,040	
5204490 - Rents - Other								791	
5204510 - Rents - Lease	83,000	54,705	66%	83,000	82,058	99%	62,000	51,160	
4-D									
5204530 - Telecommunication Services	3,000	5,770	192%	3,000	10,185	339%	3,000	15,418	
5204550 - Garbage and Sewer		845			1,118			1,610	
5204580 - Truck-Drayage & Freight		2,333			2,095			857	
5204590 - Professional Liability Insurance	20,000		0%	20,000	2,394	12%	20,000	2,400	
5204620 - Taxes and License Fees		956			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	23,215	15%	151,986	43,306	28%	172,986	50,800	
4-E									
5205020 - Office Supplies	10,000	1,651	17%	10,000	2,560	26%	10,000	1,912	
5205290 - Flags					209				
5205040 - Educational & Instructional Sup								275	
5205310 - State-Printing								0	
4-F									
5205320 - Duplication - Private	300	5,146	1715%	300	6,046	2015%	300	1,142	
5205340 - Supp. Public & Ref Material		22			185				
5205350 - Postage	11,000	8,388	76%	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)		4,152			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		184			260			275	
Total Expense	5.	1,025,703	719,021	70%	1,011,493	992,155	98%	988,618	924,257
Net Ordinary Income		213,797	-42,612	-20%	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	-30,382	-13%	174,257	315,639	181%	210,382	332,261

SDBMOE

Other Contractual Services

Date Range: July 1, 2015 - January 31, 2016

Description	FY16 01/31/2016	FY15 06/30/2015	FY14 06/30/2014
Other Contractual Services			
Health Practitioners Assistance - HPAP	\$ -	\$ -	\$ 28,295
SDBON - CNP, CNM Co-regulation	\$ -	\$ -	\$ -
Investigator Contractor	\$ -	\$ -	\$ -
Investigations Expenses	\$ 5,865	\$ 4,625	\$ 1,521
Temporary Employment Services	\$ -	\$ -	\$ -
Other State Verifications	\$ -	\$ -	\$ -
Shredding	\$ -	\$ -	\$ -
Goods and Services	\$ -	\$ -	\$ -
Background Reports	\$ -	\$ -	\$ -
BD member Expenses	\$ 197	\$ 441	\$ 172
Board Meeting Audio	\$ -	\$ -	\$ -
Other	\$ 17,153	\$ 31,684	\$ 30,881
7. Total Other Contractual Services	\$ 23,215	\$ 36,751	\$ 60,868

Advanced Life Support Committee met on February 16, 2016

1. After receiving a petition to allow additional practices for paramedics, the committee reviewed the petition and agreed on recommended changes to give the petitioner.

Athletic Trainer Committee met on February 23, 2016

1. Reviewed the committee appointments expiring in 2016
2. Reviewed the proposed administrative rules

Genetic Counselor Committee met on February 4, 2016

1. Discussed HB 1069 which provides updates to the genetic counselor practice act
2. The nominee to replace Dr. Benn is Dr. Cara Hamilton. Her nomination will be considered at the March 3 board meeting
3. If HB 1069 passes, it will allow the board to establish rules for genetic counselor continuing education. The committee will be looking at preparing a recommended draft

Nutrition and Dietetics Committee met on February 11, 2016

1. Provided new member Mariah Weber with introductory training
2. Discussed the proposed administrative rules being considered on March 3

Occupational Therapy Committee met on February 22, 2016

1. Discussed the proposed administrative rules being considered on March 3
2. Reviewed the committee appointments expiring in 2016
3. Began initial planning of a continuing education audit

Physical Therapy Committee met on February 11, 2016

1. Reviewed questions from licensees
2. Reviewed comments from LRC regarding lack of authority for proposed administrative rules.
3. The possibility of statutory change will be considered

Physician Assistant Committee met on February 17, 2016

1. Member Louise Papka will be resigning from the committee as she moves into her role as President of the SDAPA
2. Discussed additional stakeholders to communicate the recommended repeal of the separate practice location supervision requirement
3. Reviewed the draft rule regarding Physician/Physician Assistant supervision as it relates to spouses

Respiratory Therapy Committee met on February 17, 2016

1. Final results of continuing education audit from fall 2015
2. Discussed the medical direction requirement and the importance of the respiratory therapist ensuring the relationship is current
3. Reviewed a question regarding medical equipment and what a non-licensed individual can do

Black Hills Pediatrics and Neonatology
2905 5th St
Rapid City, SD 57701

Work phone: 605.341.7337

1408 Enchantment Rd
Rapid City, SD 57701

Cell phone: 605.390.2650
Email: Cara.Hamilton1@gmail.com

WORK EXPERIENCE

2010—present *Black Hills Pediatrics and Neonatology—General Pediatrician*
Rapid City Regional Hospital—On-call General Pediatrician
2011—present *Child Advocacy Center of the Black Hills—Physician Examiner*
2013—present *University of South Dakota Sanford School of Medicine—Pediatric*
Clinical Assistant Professor—Rapid City, SD

EDUCATION

2007 – 2010 *University of Iowa Children’s Hospital Pediatric Residency Iowa City, IA*
Graduated in June 2010
2003 – 2007 *University of South Dakota Doctor of Medicine Vermillion & Rapid City, SD*
Graduated in May 2007
1999 – 2003 *University of South Dakota Bachelor of Science in Physics Vermillion, SD*
Graduated with honors, minors in math and chemistry in May 2003

PROFESSIONAL INTERESTS

Community pediatrics, advocacy, international and travel medicine, biomedical ethics, sports and adolescent medicine, child abuse and neglect

LICENSURE / CERTIFICATIONS

American Board of Pediatrics Board Certified 10/2010
United States Medical Licensing Examination (USMLE) Steps I, II, II CS, & III, successfully completed
South Dakota State Medical license 8/2010 number 7819
Pediatric Advanced Life Support (PALS) Certified, Expires 2/15

PROFESSIONAL MEMBERSHIPS

2007 – present *American Academy of Pediatrics*
2011 – present *American Professional Society on the Abuse of Children (APSAC)*

AWARDS AND ACCOLADES

- 2010 UICH Gilbert Cuthbertson award for overall excellence as a pediatrician (residency)
- 2009 AAP Community Access to Child Health Grant (CATCH) for “Health and Fitness for Puertas Abiertas” project in local elementary school
- 2009 UICH Sarah Riesz Award for compassion and communication with families

CLINICAL RESPONSIBILITIES

<i>Clinical Care Roles</i>	Clinical pediatric appointments ranging from minor acute illnesses to patients with complex medical issues including physical examiner of child abuse victims, arranging consultations, on-call duties from normal newborn care to pediatric inpatients and pediatric ICU patients
<i>Teaching Roles</i>	Teaching medical students, residents, patients and patient families in clinic and hospital settings
<i>Competent Procedures</i>	Conscious sedation, lumbar puncture, intubation, circumcision, suturing, bladder catheterizations, gynecologic exam, needle thoracentesis

CONFERENCE ATTENDANCE

1/2011, 13, 15	San Diego International Conference on Child and Family Maltreatment including APSAC training institute on sexual abuse—1 week conference every other year
6/2011	Court Preparation Workshop for Professionals working in Child Abuse Cases, Rapid City, SD
7/2011	Midwest Regional Core Medical Training Academy on child abuse, Minneapolis, MN

CLINICAL EXPERIENCES

4/2009	Pediatric medical rotation and medical Spanish in Riobamba, Ecuador (4 weeks)
4/2007 – 5/2007	Pediatric medical rotation in Moshi, Tanzania (6 weeks)

SERVICE AND ADVOCACY

9/2010--present	Member of Biomedical Ethics Committee Rapid City Regional Hospital
9/2009	Medical mission trip to Mazatlan, Mexico (1 week)
2/2009	American Academy of Pediatrics Advocacy trip in Washington DC
9/2008	Pediatric medical mission in Ocho Rios, Jamaica (1 week)
9/2008 – 6/2010	Member of Ethics Committee, U of IA Hospitals and Clinics, Iowa City, IA
7/2007 – 6/2010	Continuous Quality Improvement Projects, Iowa City, IA
3/2007	Presentations to middle school-aged girls about eating disorders, Rapid City, SD
9/2006 – 3/2007	Volunteer on Sexual Assault Response Team, Rapid City, SD
2/2007 – 3/2007	Remodeled playroom at Working Against Violence shelter, Rapid City, SD
8/2005 – 5/2007	Weekly health screenings at Cornerstone Rescue Mission, Rapid City, SD

SKILLS AND LANGUAGES

<i>Languages</i>	Spanish, including medical Spanish (not fluent)
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Proposed Update to BMOE Mission Statement - for Board Review

The mission of the South Dakota Board of Medical and Osteopathic Examiners is to protect the health and welfare of the state's citizens by assuring that only qualified **allopathic and osteopathic physicians**, advanced life support personnel, athletic trainers, dietitians, **genetic counselors**, **medical assistants**, occupational therapists, **occupational therapy assistants**, physician assistants, physical therapists, **physical therapist assistants**, and respiratory therapists are licensed to practice in South Dakota.

pink = added verbiage

ARTICLE 20:52
PHYSICIAN ASSISTANTS

CHAPTER 20:52:01
PHYSICIAN ASSISTANT LICENSE

Section

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

Section

20:52:01:03.03 Supervision agreement requirements.

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

Source:

General Authority: SDCL 36-4A-42

Law Implemented: SDCL 36-4A-29

ARTICLE 20:47

PHYSICIANS AND SURGEONS

Chapter

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

CHAPTER 20:47:07

MEDICAL RECORD DOCUMENTATION

Section

<u>20:47:07:01</u>	<u>Medical record documentation</u>
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20:47:07:01 Medical record documentation. Every physician who treats patients for chronic pain must maintain accurate and complete medical records.

1. Copies of the signed informed consent and treatment agreement.
2. The patient's medical history.
3. Results of the physical examination and all laboratory tests.
4. Results of the risk assessment, including results of any screening instruments used.

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

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

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

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

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