South Dakota State Board of Dentistry
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South Dakota State Board of Dentistry

10:00 a.m. Friday October 18, 2019 or immediately following the Administrative Rules Public Hearing
Kneip Building, Board Room C – 700 Governors Drive Pierre, SD
Proposed Meeting Agenda

The Public is Welcome to Attend

1) **Call to Order**
2) **Open Forum:** *5 minutes for the public to address the Board*
3) **Approval of Minutes:** *June 21, 2019 and August 27, 2019*
4) **Adoption of Agenda**
5) **Financial Report**
6) **Office Update**
7) **Executive Session - SDCL 1-25-2(3) and 1-25-2(4)**
8) **License Applications**
9) **Old Business**
    a. **Anesthesia Credentials Committee Report/ACC Member Appointments:** *Final action can be taken per SDCL 1-27-1.18.*
10) **New Business**
    a. **Health Professionals Assistance Program:** *Amanda McKnelly, MS, LAC and Maria Eining, MA, LPC-MH, LAC, QMHP with the HPAP will provide an update on the program.*
    b. **Whitepaper on the Effective Management of Acute Pain**: *The Board will review the draft Whitepaper.*
    c. **Patient Based Clinical Competency Examinations:** *The Board will review examination content.*
    d. **Administrative Rules***: The Board will discuss future administrative rule updates.*
    e. **Continuing Education – Complaint Investigators:** *The Board will review a CE request.*
    f. **Course Review – Radiography:** *The Board will review a radiography course request.*
    g. **Mobile Dental Unit Authorization:** *The Board will review a draft application and review process.*
    h. **Appointments:** *The Board will make appointment(s).*
    i. **Speaker Honorarium Application Process**: *The Board will review a draft speaker honorarium application.*
    j. **Meeting Dates:** *The Board will set future meeting date(s).*
11) **Announcements:** *Future Meetings – January 10, 2020 and June 26, 2020*
12) **Adjourn**

SD State Board of Dentistry
Board Meeting
Kneip Building Conference Room
Friday, June 21, 2019

President Dr. Tara Schaack called the meeting to order at 10.05 am Central.

Board Members Present in Person: Dr. Tara Schaack, Dr. Harold Doerr, Dr. Nick Renemans, Zona Hornstra and Molly Fulton.

Board Members Present via Telephone: Dr. Amber Determan

Board Staff Present: Matthew Templar, Shelly Munson, Brittany Novotny, and Lisa Harsma.

Others Present: Ann Schwartz, Paul Knecht, Dr. Jay Crossland, Dr. Mark Bierschbach, and Melissa DeNoon.

Others Present via Telephone: Dr. Scott Terry, Dr. Kevin Horner, Nicole Pahl, Andrew Wiltsch, Bob Hall, Cindy Washburn, Kimber Cobb, Alex Vandiver, and Dr. Stuart Blumenthal.

Schaack called for public testimony during the open forum. No public testimony was given.

Motion to approve the minutes of January 11, 2019 by Hornstra. Second by Renemans. Motion carried.

Motion to adopt the agenda by Fulton. Second by Renemans. Motion carried.

Motion to approve the financial statements by Fulton. Second by Renemans. Motion carried.

Novotny provided an office update.

Motion to move into Executive Session pursuant to SDCL 1-25-2(3) and 1-25-2(4) by Doerr. Second by Hornstra. Motion carried. The board went into Executive Session at 10:17 am.

Motion to move out of Executive Session by Renemans. Second by Hornstra. Motion carried. The board moved out of Executive Session at 11:55 am.

Motion to approve the agreed disposition for complaint 13.1819 by Hornstra. Second by Fulton. Motion carried.

Motion to approve the agreed disposition for complaint 21.1819 and to appoint Dr. Ellwein as the Board's designee for purposes of course approval by Doerr. Second by Renemans. Motion carried.

Motion to designate the use of the PFM as substantially equivalent to the use of cast gold for the purposes of determining clinical competency by Renemans. Second by Doerr. Motion carried.

Motion to approve the 1988 California State Dental Exam as substantially equivalent to the accepted patient based dental clinical competency exams per SDCL 36-6A-47 by Doerr. Second by Renemans. Motion carried.

Motion to approve the request of the St. Francis Mission Dental Clinic (SFMD) to use a mobile unit per ARSD 20:43:04:07 by Renemans. Second by Hornstra. Motion carried. The Board

noted that the mobile unit is an outreach clinic of the SFMD and must follow all regulations that apply. The Board also noted that the patients utilizing the mobile dental unit will be patients of the SFMD, can access their patient records through the SFMD, and would have access to follow up care through the SFMD.

Motion to approve the dentist credential verification applications of Page Allen Hudson, Paula Caskey, Christopher Scott Freeman, Jagdeep Singh Goraya, Joseph Randall Gregg, Jeremy Lathan Hood, Marlene Lacayo, Paola M. Lomba, Terry Leon Lowry, Cory Seth Peterson, Glenn David Thompson, Daniel Uzbelger Feldman, Sara Johanna Van Demark, and Jessica Jill Waterbury by Doerr. Second by Fulton. Motion carried.

Motion to approve the dental hygienist credential verification applications of Danielle Judith Bosch, Kari L. Hopkins, Karen Marie Husmann, Tina Sue Nelson and Krystyna Sowinksi by Hornstra. Second by Renemans. Motion carried.

Motion to approve the dentist reinstatement application of Joshua Bly Day and Nicole Renee Hartmann by Doerr. Second by Renemans. Motion carried.

Motion to approve the dental hygienist reinstatement application of Heather Ann Erickson, Jessica Ellen Johnson, Natalie Jo Williamson and Alleana Gay Schwiesow by Hornstra. Second by Fulton. Motion carried.

Motion to approve the dentist applications of Alex Wilson Broesder, Kassandra Renee Gorena, Estaban Noe Morales, Joshua Thomas Petersen, Madeline Lee Pfeiffer, Seth Thomas Schroeder, Lauren Marie Schroeder, Joan Marie Umiker, Nathan Tanner VanLaecken and Maria Bernadette Yeash by Doerr. Second by Renemans. Motion carried.

Motion to approve the dental hygienist applications of Cassiday Campbell Halls, Hali Rochelle Davis, Nicole Marie Driggs, Breana Nicole Foresman, Allyson Raye Frankenhoff, Kelsey Rae Gainor, Alyssa Lenore Gregg, Katelyn Shawn Gundvaldson, Emily Elizabeth Haar, Aislynn Chanel Hamann, Shanda Jo Hayden, Carly Jo Henning, Laura Kay Homan, Kaitlyn Reiley Johnson, Tressa Lynn Launsby, Ashley Marie Lopez, Anna Kristine Nichols, Morgan Elisa Osterloo, Heather Patricia Plueger, Paige Marie Podoll, Hannah Reed Poppens, Brittany Marie Schmit, Nichol Renae Smee, Tessiah Elisabet Sprague, Michaela Elizabeth Sterrett, Courtney Dianne Tiesler, Cecelia Thi Tran, Emily Elisabeth Ullom, Breanna Lynn Van Bochove, Atara Leah Wipf and Ashley Elizabeth Zamoa by Hornstra. Second by Fulton. Motion carried.

Motion to approve the applications of Kaylee Van Laecken and Jace Bunkers, noting the use of PFM versus cast gold as substantially equivalent on the WREB dental examination by Doerr. Second by Renemans. Motion carried.

The Board discussed the Scope of Practice request from Dr. Terry. The Board referred him to the regulations along with the Scope of Practice Decision Making Framework document.

The Board discussed the draft updates to ARSD 20:43:08. The American Association of Orthodontists (AAO) and the South Dakota Society of Orthodontists (SDSO) discussed their respective positions and recommended changes. The Board reviewed the recommendations and the litigation surrounding this issue. The Board, by consensus, adopted SDSO recommended changes to line 8 on page 3, to include “Making impressions or obtaining digital records for casts and appliances” and line 15 on page 3, to include “Removing existing and replacing lost or

missing elastic orthodontic separators". Motion to move forward with the rule promulgation process by Doerr. Second by Renemans. Motion carried.

Novotny reported on the Anesthesia Credential Committee recommendations. The Board reviewed the recommendations and noted its intent to act on the recommendations at the next scheduled board meeting per SDCL 1-27-1.18.

Motion to approve the Approved Courses Policy, as presented, by Renemans. Second by Hornstra. Motion carried.

Motion to approve the Board Policies, with the modification of adding application to the Self-Reported Activity policy, by Doerr. Second by Hornstra. Motion carried.

Motion to approve the Continuing Education Guidelines, as presented, by Renemans. Second by Hornstra. Motion carried.

Schaack and Novotny provided a report on the 2019 American Association of Dental Boards (AADB) Mid-Year meeting.

Dr. Bob Hall provided an update on SRTA and its 2020 dental and dental hygiene exams.

Cindy Washburn provided an update on CITA and its 2020 dental and dental hygiene exams.

Kimber Cobb provided an update on CRDTS and its 2020 dental and dental hygiene exams.

Alex Vandiver and Dr. Stuart Blumenthal provided an update on CDCA and its 2020 dental and dental hygiene exams, along with its anesthesia exams.

Motion to approve the 2020 dental and dental hygiene exam components, as presented, by Renemans. Second by Hornstra. Motion carried.

Melissa DeNoon from the South Dakota Board of Pharmacy presented on the Prescription Drug Monitoring Program (PDMP). Motion to authorize up to $3,000 to be paid to Albertson Consulting to facilitate integration of the PDMP with the Board's licensing database by Doerr. Second by Hornstra. Motion carried.

Novotny presented an update on the Board's new website.

Fulton nominated Dr. Tara Schaack for the position of President, Dr. Harold Doerr for the position of Vice President and Zona Hornstra for the position of Secretary/Treasurer. Motion to cease nominations and cast a unanimous ballot for Dr. Tara Schaack as President, Dr. Harold Doerr as Vice President and Zona Hornstra as Secretary/Treasurer by Fulton. Second by Renemans. Motion carried.

Motion to appoint Zona Hornstra as the Dental Hygiene CRDTS ERC representative by Renemans. Second by Doerr. Motion carried.

Motion to approve annual memberships in the American Association of Dental Boards (AADB) and the American Association of Dental Administrators (AADA) by Hornstra. Second by Renemans. Motion carried.

Motion to approval travel for two representatives to attend the AADB 2019 Annual and 2020 Mid-Year meeting and one representative to attend the AADA 2019 Annual and 2020 Mid-Year meeting by Doerr. Second by Hornstra. Motion carried.

The Board announced the following meeting dates: October 18, 2019, January 10, 2020, June 26, 2020.

Motion to adjourn by Doerr. Second by Fulton. Motion carried. The meeting was adjourned at 3:35 pm.

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Zona Hornstra, Secretary

SD State Board of Dentistry
Board Meeting-
Teleconference
Tuesday August 27, 2019 7:30pm Central

President Schaack called the meeting to order at 7:33pm Central.

Board Members Present via Telephone: Dr. Tara Schaack, Dr. Harold Doerr, Dr. Nick Renemans, Dr. Amber Determan, Dr. Scott Van Dam, Zona Hornstra and Molly Fulton.

Board Staff Present via Telephone: Shelley Munson, Brittany Novotny and Lisa Harsma.

Others Present via Telephone: None

Schaack called for public testimony during the open forum. There was no public testimony.

Motion to move forward with the rule promulgation process with the draft rules, as amended, by Doerr. Second by Hornstra. Determan, Doerr, Hornstra, Fulton, Renemans, Schaack and Van Dam vote aye. Motion carried.

Motion to approve a contract with Albertson Consulting for the proposed amounts to complete the PDMP integration project by Renemans. Second by Hornstra. Determan, Doerr, Hornstra, Fulton, Renemans, Schaack and Van Dam vote aye. Motion carried.

Motion to move into Executive Session pursuant to SDCL 1-25-2 by Hornstra. Second by Determan. Determan, Doerr, Hornstra, Fulton, Renemans, Schaack and Van Dam vote aye. Motion carried. The board went into Executive Session at 8:07pm.

Motion to move out of Executive Session by Hornstra. Second by Determan. Determan, Doerr, Hornstra, Fulton, Renemans, Schaack and Van Dam vote aye. Motion carried. The board moved out of Executive Session at 8:13 pm.

Motion to approve the 1986 and 1987 Washington State Dental Examination as equivalent to a clinical competency patient based dental examination per SDCL 36-6A-47 by Van Dam. Second by Fulton. Determan, Doerr, Hornstra, Fulton, Renemans, Schaack and Van Dam vote aye. Motion carried.

Motion to approve the licensure by credential application of Dr. Steven Nack by Doerr. Second by Renemans. Determan, Doerr, Hornstra, Fulton, Renemans, Schaack and Van Dam vote aye. Motion carried.

Motion to adjourn by Determan. Second by Fulton. Determan, Doerr, Hornstra, Fulton, Renemans, Schaack and Van Dam vote aye. Motion carried.

There being no further business, the meeting was adjourned at 8:18 pm.

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Zona Hornstra, Secretary

Remaining Authority by Object/Subobject

Expenditures current through 09/28/2019 12:51:13 PM
HEALTH -- Summary
FY 2020 Version -- AS -- Budgeted and Informational
FY Remaining: 75.6%

09202 Board of Dentistry - Info

Subobject		Operating	Expenditures	Encumbrances	Commitments	Remaining	PCT AVL
EMPLOYEE SALARIES							
5101030	Board & Comm Mbrs Fees	7,010	360	0	0	6,650	94.9
Subtotal		**7,010**	**360**	**0**	**0**	**6,650**	94.9
EMPLOYEE BENEFITS							
5102010	Oasi-employer's Share	542	28	0	0	514	94.8
Subtotal		**542**	**28**	**0**	**0**	**514**	94.8
51 Personal Services							
Subtotal		**7,552**	**388**	**0**	**0**	**7,164**	94.9
TRAVEL							
5203030	Auto-priv (in-st.) H/rte	1,500	234	0	0	1,266	84.4
5203070	Air-charter-in State	22,000	6,351	0	0	15,649	71.1
5203100	Lodging/in-state	1,266	0	0	0	1,266	100.0
5203130	Non-employ. Travel-in St.	2,500	0	0	0	2,500	100.0
5203140	Meals/taxable/in-state	305	0	0	0	305	100.0
5203150	Non-taxable Meals/in-st	200	0	0	0	200	100.0
5203260	Air-comm-out-of-state	1,000	0	0	0	1,000	100.0
5203330	Non-employ Travel-out-st.	3,000	0	0	0	3,000	100.0
Subtotal		**31,771**	**6,585**	**0**	**0**	**25,186**	79.3
CONTRACTUAL SERVICES							
5204010	Subscriptions	300	0	0	0	300	100.0
5204020	Dues & Membership Fees	5,000	2,935	0	0	2,065	41.3
5204050	Computer Consultant	32,400	0	31,500	0	900	2.8
5204060	Ed & Training Consultant	3,307	0	0	0	3,307	100.0
5204080	Legal Consultant	30,000	3,150	10,000	0	16,850	56.2
5204090	Management Consultant	252,603	69,493	180,933	0	2,177	0.9
5204100	Medical Consultant	25,000	5,529	88,164	0	-68,693	0.0
5204130	Other Consulting	7,000	1,598	96,400	0	-90,998	0.0
5204160	Workshop Registration Fee	2,000	0	0	0	2,000	100.0
5204181	Computer Services-state	316	0	0	0	316	100.0
5204190	Computer Services-private	500	0	0	0	500	100.0
5204200	Central Services	3,115	1,383	0	0	1,732	55.6
5204203	Central Services	203	0	0	0	203	100.0
5204204	Central Services	1,211	101	0	0	1,110	91.7
5204207	Central Services	1,016	134	0	0	882	86.8
5204360	Advertising-newspaper	400	0	0	0	400	100.0

Remaining Authority by Object/Subobject

Expenditures current through 09/28/2019 12:51:13 PM
HEALTH -- Summary
FY 2020 Version -- AS -- Budgeted and Informational
FY Remaining: 75.6%

09202 Board of Dentistry - Info Subobject		Operating	Expenditures	Encumbrances	Commitments	Remaining	PCT AVL
5204480	Microfilm & Photography	500	0	0	0	500	100.0
5204510	Rents-other	725	75	0	0	650	89.7
5204530	Telecommunications Srvcs	4,000	780	0	0	3,220	80.5
5204550	Garbage & Sewer	0	7	0	0	-7	0.0
5204590	Ins Premiums & Surety Bds	1,500	0	0	0	1,500	100.0
5204960	Other Contractual Service	12,000	777	0	0	11,223	93.5
Subtotal		**383,096**	**85,962**	**406,997**	**0**	**-109,863**	0.0
	SUPPLIES & MATERIALS						
5205020	Office Supplies	1,100	74	0	0	1,026	93.3
5205310	Printing-state	1,000	119	0	0	881	88.1
5205320	Printing-commercial	1,600	320	0	0	1,280	80.0
5205350	Postage	4,500	1,487	0	0	3,013	67.0
5205390	Food Stuffs	500	0	0	0	500	100.0
Subtotal		**8,700**	**2,000**	**0**	**0**	**6,700**	77.0
	GRANTS AND SUBSIDIES						
5206070	Grants To Non-profit Org	7,500	0	0	0	7,500	100.0
Subtotal		**7,500**	**0**	**0**	**0**	**7,500**	100.0
	OTHER						
5208010	Other	500	0	0	0	500	100.0
Subtotal		**500**	**0**	**0**	**0**	**500**	100.0
52 Operating Subtotal		**431,567**	**94,547**	**406,997**	**0**	**-69,977**	0.0
Total		**439,119**	**94,935**	**406,997**	**0**	**-62,813**	0.0

AGENCY: 09 HEALTH
BUDGET UNIT: 09202 BOARD OF DENTISTRY

COMPANY	CENTER	ACCOUNT	BALANCE	DR/CR	CENTER DESCRIPTION
6503	092000061807	1140000	638,193.14	DR	BOARD OF DENTISTRY
COMPANY/SOURCE TOTAL 6503 618			638,193.14	DR *	
COMP/BUDG UNIT TOTAL 6503 09202			638,193.14	DR **	
BUDGET UNIT TOTAL 09202			638,193.14	DR ***	

AGENCY 09 HEALTH
BUDGET UNIT 09202 BOARD OF DENTISTRY

CENTER	COMP	ACCOUNT	DESCRIPTION	CURRENT MONTH	YEAR-TO-DATE
COMPANY NO	6503				
COMPANY NAME	PROFESSIONAL & LICENSING BOARDS				
092020061807	6503	4293005	DENTIST CREDENTIAL	500.00	2,000.00
092020061807	6503	4293015	HYGIENIST CREDENTIAL	.00	200.00
092020061807	6503	4293110	DENTIST LICENSE RENEWAL	.00	5,950.00
092020061807	6503	4293115	DENTIST JP EXAM	225.00	900.00
092020061807	6503	4293125	DENTIST REINSTATE LICENSE	225.00	450.00
092020061807	6503	4293135	DENTIST NITROUS OXIDE	40.00	280.00
092020061807	6503	4293137	DENTIST NITROUS RENEW	.00	600.00
092020061807	6503	4293145	DENTIST MOD SEDAT RENEW	.00	50.00
092020061807	6503	4293147	DENTIST MOD SED AD RENEW	.00	150.00
092020061807	6503	4293205	HYGIENIST NEW LICENSE	100.00	200.00
092020061807	6503	4293210	HYGIENIST RENEWAL LICENSE	.00	8,170.00
092020061807	6503	4293215	HYGIENIST JP EXAM	115.00	345.00
092020061807	6503	4293220	HYGIENIST ANESTH RENEW	80.00	1,580.00
092020061807	6503	4293222	HYGIENIST ANESTHESIA	40.00	160.00
092020061807	6503	4293225	HYGIENIST REINSTATE	805.00	1,150.00
092020061807	6503	4293235	HYGIENIST NITRIOUS OXIDE	40.00	120.00
092020061807	6503	4293237	HYGIENIST NIT OXIDE RENEW	40.00	1,200.00
092020061807	6503	4293305	RADIOLOGY NEW	680.00	1,520.00
092020061807	6503	4293307	RADIOLOGY RENEWAL	.00	2,260.00
092020061807	6503	4293315	RADIOLOGY REINSTATE	680.00	1,200.00
092020061807	6503	4293405	ADA EXPANDED FUNCTION NEW	640.00	1,360.00
092020061807	6503	4293410	ADA EXPAND FUNCTION RENEW	.00	1,440.00
092020061807	6503	4293415	ADA EXPAND FUNCT REINSTAT	600.00	840.00
092020061807	6503	4293420	ADA EXPAND FUNC ADMIN NIT	320.00	880.00

AGENCY 09 HEALTH
BUDGET UNIT 09202 BOARD OF DENTISTRY

CENTER	COMP	ACCOUNT	DESCRIPTION	CURRENT MONTH	YEAR-TO-DATE	
092020061807	6503	4293422	ADA EXPAND FUNC NIT RENEW	140.00	840.00	
092020061807	6503	4293505	CORPORATE NEW LICENSE	100.00	700.00	
092020061807	6503	4293510	CORPORATE RENEWAL	600.00	1,000.00	
092020061807	6503	4293600	TEMP LICENSE	200.00	650.00	
092020061807	6503	4293850	COLLABORATIVE SUPERVISION	20.00	80.00	
ACCT:	4293	BUSINESS & OCCUP LICENSING (NON-GOVERNMENTAL)		6,190.00	36,275.00	*
092020061807	6503	4299000	OTHER LIC., PRMTS, & FEES	3,083.44-	.00	
ACCT:	4299	OTHER LIC, PRMTS, & FEES (NON-GOVERNMENTAL)		3,083.44-	.00	*
ACCT:	42	LICENSES, PERMITS & FEES		3,106.56	36,275.00	**
092020061807	6503	4595000	VERIFICATION LETTERS	100.00	400.00	
092020061807	6503	4595800	LIST OF PRACTITIONERS	300.00	1,800.00	
ACCT:	4595			400.00	2,200.00	*
ACCT:	45	CHARGES FOR SALES & SERVICES		400.00	2,200.00	**
092020061807	6503	4920045	NONOPERATING REVENUES	.00	12,475.24	
ACCT:	4920	NONOPERATING REVENUE		.00	12,475.24	*
ACCT:	49	OTHER REVENUE		.00	12,475.24	**
CNTR:	092020061807			3,506.56	50,950.24	***
CNTR:	092020061			3,506.56	50,950.24	****
CNTR:	0920200			3,506.56	50,950.24	*****
COMP:	6503			3,506.56	50,950.24	******
B UNIT:	09202			3,506.56	50,950.24	*******

Complaints											
	Total Received	Total Investigated	Total Resolved	Total Hearings Held	Total Pending	Total Licensees Reprimanded/ Probationed	Total Licenses Suspended/ Revoked	No Action Taken Against Licensee	Total Prosecutions		
	34	34	26	0	22	1	0	22	0		
Number	Quality of Care	Competence	Substance Abuse	Fee Dispute	Inappropriate Contact with Patient	Poor Communication or Chair Side Manner	Failure to Release Copy of Patient Records	Suspect Insurance Fraud	Improper Prescribing of Medications	Patient Abandonment	Other Complaint
1											1
2	1					1				1	
3	1			1		1					
4	1	1				1					1
5	1	1		1				1			1
6	1										1
7	1			1		1		1		1	
8	1	1									
9											1
10	1	1									
11	1			1		1				1	1
12	1					1			1	1	
13	1					1					
14					1					1	
15											
16	1										
17				1							1
18					1	1					
19				1							
20	1	1		1							
21	1	1		1		1					1
22	1										1
23	1									1	
24	1			1		1				1	
25	1					1	1				
26											
27											
28											
29											
30											
31											
32											
33											
34											
Totals	**18**	**6**	**0**	**9**	**2**	**11**	**1**	**2**	**1**	**7**	**9**

SD State Board of Dentistry FY 2019	
Licenses/Registrations Renewed	3,493
Permits - Renewed	2,042
Licenses/Registrations - New	371
Permits - New	238
Temporary Registrations (exempt new graduates)	65
Collaborative Supervision Agreements	4
Anesthesia Inspections	21
Continuing Education Audits	171
Board Meetings Held	3
Practitioner Lists	40
Verification Letters	71

South Dakota State Board of Dentistry

P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079

Ph: 605-224-1282 Fax: 1-888-425-3032

E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.com

BOARD APPROVED COURSES POLICY:

It is the policy of the Board to use the Board Approved Courses Policy as guidance when determining whether to issue a license, registration or permit.

DENTISTS

General Anesthesia and Deep Sedation Permit: 20:43:09:03

1. General Anesthesia and Deep Sedation Program: 20:43:09:03 – Programs are set forth in rule. These are not Board approved.

2. ACLS: 20:43:09:03(3) –
    a. American Heart Association Advanced Cardiac Life Support (ACLS)
    b. American Heart Association Pediatric Advanced Life Support (PALS)

Moderate Sedation Permit: 20:43:09:04

1. Moderate Sedation Courses: 20:43:09:04
    a. IV Conscious Sedation
        i. Location: Augusta, GA.
        ii. Sponsor: Medical College of Georgia Regents University (*formally known as* Georgia School of Dentistry)
        iii. Hours: At least 60. Patients: At least 20
    b. Medical Emergencies, Local Anesthesia and Moderate Sedation in Dental Practice
        i. Location: Dayton, OH.
        ii. Sponsor: Miami Valley Hospital
        iii. Hours: At least 60. Patients: At least 20
    c. Learn IV Sedation
        i. Location: Portland, OR.
        ii. Sponsor: Oregon Academy of General Dentistry
        iii. Hours: At least 60. Patients: At least 20
    d. Clinical Intravenous Sedation
        i. Location: Los Angeles, CA.
        ii. Sponsor: The Herman Ostrow School of Dentistry of USC
        iii. Hours: At least 60. Patients: At least 20
    e. IV Training for Moderate Sedation
        i. Location: Various Locations in the United States.
        ii. Sponsor: Conscious Sedation Consulting
        iii. Hours: At least 60. Patients: At least 20
    f. ADA CODA accredited General Practice Residency that meets the regulatory requirements
        i. Location: Various.
        ii. Hours: At least 60. Patients: At least 20.
    g. ADA CODA accredited Periodontal Residency that meets the regulatory requirements
        i. Location: Various.
        ii. Hours: At least 60. Patients: At least 20.
    h. IV Sedation for Dentistry at Oregon Health & Science University

        i. Location: Oregon Health and Science University School of Dentistry and various clinical facilities.
        ii. Sponsor: Oregon Health and Science University School of Dentistry and DOCS Education
        iii. Hours: At least 60. Patients: At least 20
    i. Moderate Sedation Training Course
        i. Location: Varies
        ii. Sponsor: Dentinomics
        iii. Hours: At least 60. Patients: At least 20
2. ACLS: 20:43:09:04(3)
    a. American Heart Association Advanced Cardiac Life Support (ACLS)
    b. American Heart Association Pediatric Advanced Life Support (PALS)

PERMIT TO MONITOR PATIENTS UNDER ANESTHESIA – DH, RDA & DA

DH, RDA and DA Monitoring Moderate and Deep/General: 20:43:09:10

1. Dental Anesthesia Assistant National Certification Examination (DAANCE)
    a. Sponsor: American Association of Oral and Maxillofacial Surgeons (AAOMS)
    b. Hours: 36
2. Anesthesia Assistants Review Course
    a. Sponsor: American Association of Oral and Maxillofacial Surgeons (AAOMS)
    b. Hours: 12
3. Assistant Sedation/Anesthesia Course
    a. Sponsor: American Dental Society of Anesthesiology (ADSA)
    b. Hours: 12
4. Assistant Sedation/Anesthesia Course – On Demand CE Course (Online)
    a. Sponsor: American Dental Society of Anesthesiology (ADSA)
    b. Hours: 12. Twelve individual one hour assistant courses must be completed. All twelve certificates must be submitted with the application. If ADSA offers more than 12 courses, you can choose the 12 you would like to complete.
5. Conscious Sedation Consulting Online Sedation Course.
    a. Sponsor: Conscious Sedation Consulting
    b. Hours: 8. Eight individual one hour courses must be completed: A Culture of Safety; Patient Assessment; Sedation; Pain; Patient Monitoring; Adverse Events – Airway & Respiratory; Adverse Events – Cardiac & Neurological; and Recovery and Discharge. All eight certificates must be submitted with the application.
6. Sedation and Anesthesia in the Dental Practice
    a. Sponsor: South Dakota Dental Association
    b. Hours: 8
7. Intravenous Conscious Sedation Course, GRU, College of Dental Medicine
    a. Sponsor: Georgia Regents University
    b. Hours: 40
8. Assisting on the Sedated Patient – A Certification Course for Assistants
    a. Sponsor: Dentinomics
    b. Hours: 8 Hours
9. Monitoring of Sedation/General Anesthesia Patients for Dental Procedures and intravenous catheter insertion
    a. Sponsor: Saint Louis University Center for Advanced Dental Education
    b. Hours: 24

Anesthesia Credentials Committee

	ACC Member	Location	Expiration	Recommended Replacement	Board Action
Board Member/	Dr. Scott Van Dam	Rapid City			
GA/Deep	Dr. Denis Miller	Sioux Falls	2019	Dr. Carl Kimbler (Aberdeen) - 6 year term	Appoint in October
GA/Deep	Dr. Brent Henriksen	Sioux Falls	2021		
GA/Deep	Dr. Jay Crossland	Rapid City	2023		
Moderate	Dr. Bruce Wintle	Huron	2019	Dr. John Bridges (Rapid City) - 6 year term	Appoint in October
Moderate	Dr. Ed Kusek	Sioux Falls	2023		
No Permit	Dr. Jesse Fast	Huron	2021		

Effective Management of Acute Pain

Recommendations from the Ad Hoc Committee on Pain Management and Prescription Drug Abuse

South Dakota State Medical Association

Draft date: 06/01/2019

Participants in the Ad Hoc Committee's recommendations on acute pain management:

South Dakota Board of Dentistry
South Dakota Board of Nursing
South Dakota Board of Medical & Osteopathic Examiners
South Dakota Board of Pharmacy
South Dakota Dentistry Association
South Dakota Department of Health
South Dakota Department of Social Services
South Dakota Nurse Practitioner Association
South Dakota Pharmacists Association

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Executive Summary

Although the focus of much public and professional attention in the past decade has been on the problems related to opioid analgesics for treating chronic non-cancer pain, the treatment and management of acute pain is an equally important topic because many of the same dynamics (e.g., prescribing opioids when non-opioids may be just as effective, or prescribing higher doses/durations than needed) are at work with acute pain as with chronic pain.

Properly and responsibly managing acute pain is desirable not only because it relieves patient suffering, but because it reduces the chances that acute pain will morph into chronic pain, and responsible prescribing can help stem the tide of opioid diversion, misuse, and abuse. Opioids do, of course, play an invaluable role in the management of acute pain, but they carry important risks, as well, and thus are generally viewed as second-line agents or to be used only as part of a multi-modal approach. The risks of opioids, even when used for acute pain and for relatively short durations, are amplified among older adults, patients with impaired renal or hepatic function, those with COPD, cardiopulmonary disorders, sleep apnea, or mental illness, and in anyone likely to combine opiates with other respiratory depressants such as alcohol or benzodiazepines.[3]

This white paper summarizes the current evidence for optimal management of acute pain, with the key recommendations being:

- *Assess the degree of expected or actual pain from an injury, surgery, or procedure*
- *Consider patient-related and drug-related factors related to pain and pain relief*
- *Use multimodal pain control methods, emphasizing, when appropriate, non-pharmacological methods and non-opioid pharmacotherapy*
- *If opioids are deemed necessary, prescribe only an amount to cover the expected pain or realistic duration of time to a follow-up appointment*
    - *Check PDMP AWARxE, South Dakota's prescription drug monitoring program.*
    - *Screen for risk factors such as history of substance abuse disorder or mental illness.*
    - *Prescribe only short-acting opioids.*
    - *Discuss with patients safe storage, use, and disposal of opioids.*
    - *Taper or discontinue opioids as soon as possible.*
    - *Re-evaluate patients if healing does not follow the expected course.*

Although the practices described in these guidelines are intended to apply broadly, they are not intended to establish a "standard of care." Providers – to include all prescribers - must exercise their own

best medical judgment when providing treatment, taking all relevant circumstances into account, including the potential for abuse, diversion and risk for addiction.

Introduction

As unpleasant as it is, acute pain serves an important adaptive biological purpose: it alerts us to internal or external damage or dysfunction in our bodies. Acute pain can provoke a range of protective reflexes (e.g., withdrawal of a damaged limb, muscle spasm, autonomic responses) that can help the body heal. Even brief episodes of acute pain, however, can induce suffering, neuronal remodeling, and can set the stage for chronic pain.[4] Associated behaviors (e.g., bracing, abnormal postures, excessive reclining) may further contribute to the development of chronic pain. An example of this phenomenon is persistent postsurgical pain (PPP), which is pain persisting beyond the expected healing period. Many common operations (e.g., mastectomy, thoracotomy, hernia repair, coronary artery bypass surgery) are associated with an incidence of PPP of up to 30-50 percent.[5] The intensity of perioperative and postoperative pain is estimated to contribute about 20 percent of the overall risk for transition from acute pain to PPP.[6]

In addition to the purely humanitarian value of reducing or eliminating acute pain, therefore, effectively and aggressively treating acute pain may reduce complications and progression to chronic pain states.[7]

Acute pain is a multidimensional experience that usually occurs in response to tissue trauma, and although responses to acute pain may be adaptive, they can have adverse physiologic and psychological consequences (e.g., reduced tidal volume, excessive stress response, or inability to comply with rehabilitation). Acute pain is more difficult to manage if permitted to become severe, so prompt and adequate treatment of acute pain is imperative, with the basic goals of:

- Early intervention, with prompt adjustments in the regimen for inadequately controlled pain
- Reduction of pain to acceptable levels
- Facilitation of recovery from underlying disease or injury

Although much attention has been paid in the past decade to the range of problematic issues related to opioid analgesics and chronic pain, many similar issues can be at work in the treatment of acute pain. For example, a number of studies demonstrate increased risk of new persistent opioid use in opioid-naïve patients after having been prescribed opioids for acute pain.[8-11] Although the risk of opioid misuse in patients prescribed opioids for acute post-surgical or post-procedural pain is relatively small (roughly 0.6 percent), the volume of such procedures (approximately 48 million ambulatory surgeries or procedures in 2010) translates into large numbers of patients (i.e., approximately 160,000) who may develop dependence, abuse, or overdose every year.[12]

A related issue with opioid prescription for acute pain is the risk of diversion or inappropriate use from leftover pills. Approximately 40-50 percent of those who abuse opioids initially obtain the drugs

from family members or friends with pills remaining from legitimate prescriptions.[13] Many studies have found excessive levels of routine opioid prescriptions for a range of surgical procedures or emergency department visits for painful conditions.[14,15] One study of 1,416 patients in a 6-month period found that surgeons prescribed a mean of 24 pills (standardized to 5 mg oxycodone) but that patients reported using a mean of only 8.1 pills (utilization rate 34 percent).[16]

The South Dakota State Medical Association's Committee on Pain Management and Prescription Drug Abuse has reviewed current literature and existing clinical guidelines in order to articulate the following recommendations for effective and responsible treatment of acute pain, including the use of opioid analgesics. Although the practices described in these guidelines are intended to apply broadly, they are not intended to establish a "standard of care." All prescribers must exercise their own best medical judgment when providing treatment, taking all relevant circumstances into account, including the potential for abuse, diversion, and risk for addiction associated with opioid analgesics.

Types and levels of acute pain

Acute pain is typically defined as pain concordant with the degree of tissue damage and which remits with resolution of the injury. A more holistic definition is "a complex, unpleasant experience with emotional and cognitive, as well as sensory, features that occur in response to tissue trauma."[17] This definition captures the multiple levels of effects that pain can have, as well as the fact that cognitive and emotional factors can influence how pain is perceived. The subjective experience of pain (as opposed to the purely physical phenomenon of nociceptive nerve activation) varies widely in degree (from mild to severe) and quality (dull, sharp, stinging, burning, throbbing, etc.) and is significantly modulated by such factors as:

- Type of injury or surgical procedure
- Cultural or ethic factors
- History of drug or alcohol use
- History of anxiety or depression
- Anatomic location

Injuries or procedures involving bones and joints tend to be more painful than those involving soft tissues.[16] For example, in one study of 5,703 ambulatory surgical patients, those having microdiscectomy were most likely to have severe pain, followed by laparoscopic cholecystectomy, shoulder surgery, elbow or hand surgery, ankle procedures, hernia repair, and knee surgery.[18] Variations in pain levels for different procedures can also be seen in data about the amount of opioids needed to

control pain. In one study, in which opioid doses were standardized to units of 5 mg pills of oxycodone, 5 pills were adequate for patients having partial mastectomy, 10 pills for partial mastectomy with lymph node biopsy, and 15 pills for laparoscopic cholecystectomy and inguinal hernia repair.[19] (Significantly, in this study, many patients used no opioids, ranging from 22 percent after hernia repair to 82 percent after partial mastectomy.) Another study found that in the 3 days post-surgery, patients having wrist or hand surgery used about 7 pills, those having forearm or elbows procedures used an average of 11 pills, and those having upper arm or shoulder procedures used an average of 22 pills (all pills standardized to oxycodone or hydrocodone 5 mg or codeine 30 mg).[16]

Table 1. Common types of acute pain[20]

Type	Source or Examples
Acute illness	Appendicitis, renal colic, myocardial infarction
Perioperative	• Head and neck surgery • Chest and chest wall surgery • Abdominal surgery • Orthopedic and vascular surgery (back, extremities)
Major trauma	Motor vehicle accident
Minor trauma	Sprain, laceration
Burns	Fire, chemical exposure
Procedural	Bone marrow biopsy, endoscopy, catheter placement, circumcision, chest tube placement, immunization, suturing
Obstetrical	Childbirth by vaginal delivery or Cesarean section

Assessing pain

The etiology of acute pain, as opposed to chronic pain, is typically straightforward since it is usually associated with some kind of obvious injury, disease process, surgery, or procedure. Nonetheless, it can be helpful to systematically evaluate the pain using pain scales (numerical or visual-analog) to increase the precision of a patient's self-report and provide a baseline against which to evaluate analgesia and/or healing over time. Consider the following steps in assessing acute pain:[21]

Ask the patient to describe the pain using 5 characteristics:

a. What makes the pain more or less intense?

b. What does the pain feel like? (i.e., dull, throbbing, sharp, pins-and-needles)

c. Does the pain spread anywhere?
d. How severe is the pain?
e. Is the pain constant or does it come and go?

The answers to these questions can help determine if the pain is nociceptive (i.e., the result of injury to bones and muscles) or neuropathic (i.e., the result of injury to peripheral or central nerves). Making this determination is important because neuropathic pain is not particularly responsive to non-steroidal anti-inflammatory drugs (NSAIDs) or opioids. Other medications such as antidepressants or anticonvulsants may be more appropriate first-line agents for neuropathic pain.

As will be detailed later in these guidelines, opioid analgesics should not typically be considered as first-line agents for acute pain, nonetheless, just when assessing patients in chronic pain, it is important to evaluate a patient in acute pain for risk of opioid dependence or abuse. Such assessment is not completely objective, and opinions differ about which patients should be more rigorously assessed. Some favor a "universal precautions" approach, in which all pain patients are considered to have some degree of vulnerability to abuse and addiction and, hence, all patients are given the same screenings and diagnostic procedures.[22] Some patient characteristics, however, do appear to be predictive of a potential for drug abuse, misuse, or other aberrant behaviors, particularly a personal or family history of alcohol or drug abuse.[23] Some studies also show that younger age and the presence of psychiatric conditions are associated with aberrant drug-related behaviors.[23]

Relatively brief, validated tools can help formalize assessment of a patient's risk of having a substance misuse problem (Table 2) and these should be considered for routine clinical use.[23] For more information on risk reduction strategies, a free online CME is available at www.opioidprescribing.com.

The 4Ps of Screening

- Parents – Did any of your parents have a problem with alcohol or drug use?
- Partner – Does your partner have a problem with alcohol or drug use?
- Past – In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?
- Present – In the past month, have you drunk any alcohol or used other drugs – illicit or otherwise?

Table 2. Tools for Patient Risk Assessment

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

Using state PDMP for patients with acute pain

A standard part of assessing any patient in acute pain, even if opioid analgesics are not expected to be immediately prescribed, should be accessing the South Dakota prescription drug monitoring program PDMP AWARxE. This can help identify patients at higher risk for opiate overdose or opiate use disorder, and help determine which patients may benefit from great caution and increased monitoring or interventions when risk factors are present. Research indicates that most fatal overdoses could be identified retrospectively on the basis of two pieces of information – multiple prescribers and high total daily opiate dosage – both of which are available to prescribers through the PDMP AWARxE.

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

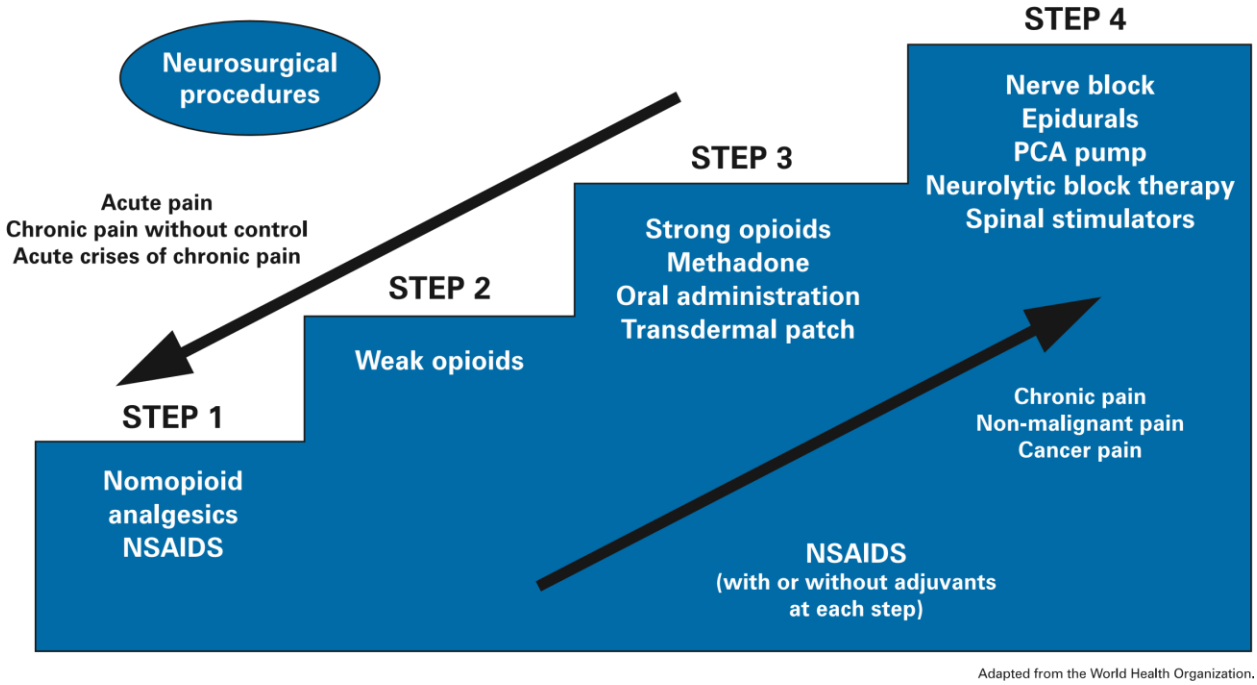
Information from PDMP AWARxE may also reveal that a patient is being prescribed medications whose combinations are contraindicated. By reviewing the PDMP each prescriber can identify other prescribers involved in the care of their patient. Pharmacies and practitioners that dispense any Schedule II, III, or IV controlled substances in South Dakota, or to an address in South Dakota, must report such dispensing to PDMP AWARxE.

Strategies for acute pain control

Ladder of pain

The World Health Organization advocates a 3-step "Pain relief ladder" model in which non-pharmacologic or non-opioid approaches are preferred as first-line pain treatment, followed by low-dose or low-potency opioids with or without adjunctive pharmacological or non-pharmacological therapies, and, for moderate to severe pain, higher doses and/or more potent opioids with or without adjunctive treatment.[24] Variations on this model include a "fast-track" approach that skips directly to step 3 for controlling intense acute pain, incorporation of "movement" on the ladder both up (when, for example, a disease process worsens) as well as down (in response to healing or remission of symptoms), and adding a 4th step that includes invasive procedures such as nerve blocks, neurolysis, epidurals, and spinal stimulators.[25]

Figure 1. 4-Step Adaptation of WHO analgesic ladder



Adapted from the World Health Organization.

Clinicians should bear in mind that the goal of pain treatment is not necessarily zero pain, but a level of pain that is tolerable and that allows the patient maximum physical and emotional functioning with the lowest risk of side effects, progression to chronic pain, or misuse or abuse. This requires an adroit balancing of many factors (both patient-related and drug-related). One way to operationalize this paradigm is with multimodal analgesia, in which several therapeutic approaches, each acting at different

sites of the pain pathway, are used, which can reduce dependence on a single medication and may reduce or eliminate the need for opioids.[26] Using both pharmacological and non-pharmacological interventions, and, if warranted, opioid and non-opioid medications can reduce overall opioid use as well as opioid-related adverse effects.

This approach involves the use of more than one method or modality of controlling pain (e.g., drugs from two or more classes, or drug plus non-drug treatment) to obtain additive beneficial effects, reduce side effects, or both. These modalities may operate through different mechanisms or at different sites (i.e., peripheral versus central actions).[26] One example of multimodal analgesia is the use of various combinations of opioids and local anesthetics to manage postoperative pain. Table 3 summarizes some specific examples of multimodal therapy; Appendix 1 provides a workflow guidline.

Some benefits of multimodal analgesia include earlier ambulation, oral intake, and hospital discharge for postoperative patients as well as higher levels of participation in activities necessary for recovery (e.g., physical therapy).[26] Some pain experts advocate revision of traditional postoperative care programs to include accelerated multimodal postoperative recovery programs.

Table 3. Examples of multimodal therapy

Combination of Agents
Systemic NSAID plus systemic opioid
Systemic NSAID plus epidural opioid and local anesthetic
Systemic NSAID plus local infiltration of anesthetic plus systemic opioid
Regional block plus systemic NSAID plus epidural opioid and local anesthetic
Ketamine plus opioid

Non-pharmacological treatments for acute pain

When possible, non-pharmacologic methods should be used, alone or combined with analgesics, to manage acute pain. The degree to which this can be done depends on the severity of pain, availability, and patient preference, but many non-pharmacological approaches can be very effective and their use avoids the potential side effects and risks associated with pharmacological interventions.

Non-pharmacologic methods for managing early-phase acute pain:[20]

- Application of cold (standard protocols are icing for 20 minutes every two hours or every 10 minutes, alternating with 10 minutes of rest)
- Compression

- Elevation
- Immobilization (although recovery from some injuries, such as ankle sprains, may be faster with graduated exercises rather than rest alone)[27]

Non-pharmacologic methods for late-phase acute pain and/or pain prophylaxis

- Physical therapy
- Yoga
- Hypnosis/guided imagery
- Massage

Physical methods of acute pain management can be helpful in all phases of care, including immediately after tissue trauma (e.g., rest, application of cold, compression, elevation) and late during the healing period (e.g., exercises to regain strength and range of motion). Mind/body or psychological therapies can encourage active patient participation in their care, address psychological or social dimensions of pain, and can support sustained improvements in pain and function with minimal risks. These therapies are not always, or fully, covered by insurance, and access and cost can be barriers, but for many patients, non-pharmacologic management can be used even with limited access to specialty care. A randomized trial comparing patients assigned to low-cost group aerobics vs. more expensive individual physiotherapy and muscle reconditioning sessions found similar reductions in low back pain intensity, frequency, or disability.[28] Low-cost options to increase physical activity include brisk walking in public spaces or use of public recreation facilities for group exercise.

Cognitive behavioral therapy (CBT) can help address psychosocial contributors to pain and has been shown to improve function.[29] Primary care clinicians can integrate elements of CBT into their practice by simply encouraging patients to take an active role in their care plan, by supporting patients in engaging in beneficial activities such as exercise, or by providing education in relaxation techniques and coping strategies. There may be free or low-cost patient support, self-help, and educational community-based programs in more populated areas of South Dakota that can provide stress reduction and other mental health benefits. Patients with more entrenched anxiety or fear related to pain, or other significant psychological distress, can be referred for formal therapy with a mental health specialist.

Multimodal therapies should be considered for patients not responding to single-modality therapy, and combinations should be tailored depending on patient needs, cost, and convenience. Additional details on some common non-pharmacological treatments shown to be effective in managing acute pain follow.

Physical therapy

Physical therapy may be useful for a range of musculoskeletal issues and can be helpful in recovering from acute pain-producing traumas initially treated with other methods. A 2018 study reported that patients with low back pain who first consulted a physical therapist were less likely to receive an opioid prescription compared to those who first saw their primary care provider.[30] Physical therapists typically create individualized exercise, stretches, and body alignment adjustments to help relax tight muscles, decrease back and joint pain, and improve range of motion. Professional guidelines have strongly recommended aerobic, aquatic, and/or resistance exercises for patients with osteoarthritis of the knee or hip[31] and maintenance of activity for patients with low back pain.[32]

Yoga

Yoga involves poses with a range of extensions and challenge, which can be tailored to an individual's level of flexibility, strength, and conditioning. Moderate evidence suggests that yoga can reduce late-stage acute pain, as well as chronic pain conditions, particularly back pain. For example, a 2017 trial randomized 131 patients (mean age 75) with lower extremity osteoarthritis to twice-weekly sessions of chair yoga vs. a health education program.[33] At 3-month follow-up, participants in the yoga group showed greater reductions in pain interferences (P=0.01) compared to control.[30] During the intervention, patients in the yoga group had reduced pain and improved gait speed compared to the control group. In addition to reducing pain, the people in the yoga group were more likely to have stopped taking pain relievers at one-year follow-up.

Massage

Massage therapy may help relieve muscular pain (acute or chronic) as well as reduce stress and anxiety. Some massage therapists specialize in working with people recovering from injuries or surgeries, or they may have focused training for treating particular conditions such as back or neck pain. A review of seven randomized trials with 352 participants suggests that massage as a stand-alone treatment may be better than no treatment for reducing pain.[34] The trials were diverse with respect to outcomes, massage techniques, and patient populations. Clinical effect sizes for pain were moderate with about a 20-point reduction in pain scores from a baseline of 50-60 points. The functional benefits were less clear; some trials showed no benefit while others showed improvement in the 50-foot walk test.

A 2011 study randomized 401 adults with back pain to two types of weekly massage (structural and relaxation) for 10 weeks vs. a usual care group. At the end of the study 36 percent of the adults having structural massage and 40 percent of the adults having relaxation massage reported that their pain was "much better" or "gone" vs. 4 percent of the control group.[35]

Hypnosis

Clinical hypnosis is a procedure in which a trained clinician or therapist gives a patient a series of verbal instructions with the goal of helping the patient enter a state of deep relaxation. In this relaxed state, the patient is aware of everything that is going on, but at the same time, becomes increasingly absorbed in using his or her imagination as directed by the therapist. Therapists often teach their patients self-hypnosis methods that they can employ on their own to reinforce and continue the process at home.

Evidence-based research on the use of hypnosis to relieve pain is limited, but a large, well-designed study, however a 2000 trial evaluated the effectiveness of hypnosis—termed "nonpharmacologic analgesia"—in easing pain and anxiety in people who were having minimally invasive surgical therapies such as angiograms, angioplasty, simple kidney procedures, or liver biopsies, during which they remained conscious.[36] Patients participated in a self-hypnosis relaxation session that involved deep-breathing and concentration techniques. The researchers found that these patients required less than half the amount of analgesic drugs compared to those receiving standard treatments. Procedures also took less time for the hypnosis group, and participants had lower levels of anxiety and pain at both one hour and four hours into the procedure.

Pharmacological management of acute pain

Most acute pain is nociceptive and responds to non-opioids and opioids. However, some adjuvant analgesics (e.g., local anesthetics) also are used to manage acute pain and medications for neuropathic pain are also important agents in the analgesic armamentarium. In general, mild-to-moderate acute pain responds well to oral non-opioids (e.g., acetaminophen, NSAIDs, and topical agents). Moderate to severe acute pain is more likely to require opioids, although, as mentioned earlier, lower doses and short durations may be appropriate.

NSAIDs and acetaminophen

NSAIDs, which include aspirin and other salicylic acid derivatives, and acetaminophen are used in the management of both acute and chronic pain such as that arising from injury, arthritis, dental procedures, swelling, or surgical procedures. Although they are weaker analgesics than opioids, acetaminophen and NSAIDs do not produce tolerance, physical dependence, or addiction and they do not induce respiratory depression or constipation. Acetaminophen and NSAIDs are often added to an opioid regimen for their opioid-sparing effect. Since non-opioids relieve pain via different mechanisms than opioids, combination therapy can provide improved relief with fewer side effects.

These agents are not without risk, however. Potential adverse effects of NSAIDs include gastrointestinal problems (e.g., stomach upset, ulcers, perforation, bleeding, liver dysfunction), bleeding (i.e., antiplatelet effects), kidney dysfunction, hypersensitivity reactions and cardiovascular concerns, particularly in the elderly.[37] The threshold dose for acetaminophen liver toxicity has not been established; however, the SDSMA recommends that the total adult daily dose should not exceed 3,000 mg in patients without liver disease (although the ceiling may be lower for older adults).[38]

The Food and Drug Administration (FDA) currently sets a maximum limit of 325 mg of acetaminophen in prescription combination products (e.g., hydrocodone and acetaminophen) in an attempt to limit liver damage and other potential ill effects of these products.[32]

Topical agents

Topical capsaicin and salicylates can both be effective for short term pain relief and generally have fewer side effects than oral analgesics, but their long-term efficacy is not well studied.[39,40] Topical NSAIDs and lidocaine have been reported to be effective for short-term relief of superficial pain with minimal side effects, although both are more expensive than topical capsaicin and salicylates. None of the topical agents are useful for non-superficial pain.

Anticonvulsants

Antiepileptic drugs (AEDs) are increasingly used for treating neuropathic pain because they can reduce membrane excitability and suppress abnormal discharges in pathologically altered neurons.[41] The exact mechanism of action for their analgesic effects, however, is unclear. It does not appear to be specifically related to their antiepileptic activity. Other drugs that suppress seizures (e.g., barbiturates) do not relieve pain, and some AEDs with effective antiepileptic activity do not necessarily have good analgesic activity.[42] Few trials have evaluated AEDs in acute pain conditions, so the evidence base is weak.[43] A 2017 trial, for example, randomized 209 patients with acute or chronic sciatica to pregabalin 150 mg/day vs. placebo and found no significant differences in leg pain or functional outcomes.[44]

Ketamine

Ketamine has been used as a general anesthetic since the 1960s, but its use in subanesthetic concentrations for analgesia has grown rapidly in recent years, due, in part, to efforts to reduce the risks of chronic opioid use.[45] Ketamine has been successfully used to treat such acute pain conditions as sickle cell crises, renal colic, and trauma.[45]

Opioids for acute pain in opioid-naïve patients

If an opioid is deemed necessary to treat acute pain, oxycodone, hydrocodone, or tramadol in short-acting formulations are commonly used. Guidelines from the Centers for Disease Control and other organizations strongly recommend that only short-acting opioids be prescribed for acute pain because they reach peak effect more quickly than extended-release formulations and the risk of unintentional overdose is reduced.[46] (One study looking at the prescription of opioids in about 840,000 opioid-naïve patients over 10 years found that unintentional overdose was 5 times more likely in patients prescribed extended-release opioids compared to immediate-release opioids.[47])

Research shows general equivalency of efficacy and tolerability between different opioids. Hydrocodone 5 mg, oxycodone 5 mg, and tramadol 50 mg alone or in combination with acetaminophen or ibuprofen have similar analgesic power to treat acute pain.[48-50] Oxycodone and hydromorphone are available as pure drugs, whereas hydrocodone (in the United States) is only available co-formulated with acetaminophen or ibuprofen, therefore oxycodone or hydromorphone might be preferred if a patient is already taking acetaminophen or NSAIDs, or if those drugs are prescribed simultaneously with the opioid as part of multi-modal therapy.

Legal limits on opioid prescribing

A number of states have passed laws in recent years regulating the prescription of opioids for acute pain, with allowed durations of prescriptions for opioid-naïve patients ranging from 5-10 days.[1] To date, South Dakota does not have similar regulations, although the South Dakota Department of Health has appointed a Prescription Opioid Abuse Advisory Committee (to which SDSMA has a representative) to review opioid use in the state and develop strategies for preventing opioid misuse and abuse.[2]

Dose and duration of opioid therapy

Only enough opioids should be prescribed to address the expected duration and severity of pain from an injury or procedure (or to cover pain relief until a follow-up appointment). Several guidelines about opioid prescribing for acute pain from emergency departments[51,52] and other settings[3,53] have recommended prescribing ≤ 3 days of opioids in most cases, whereas others have recommended ≤ 7 days,[54] or ≤ 14 days.[55] CDC guidelines suggest that for most painful conditions (barring major surgery or trauma) a 3-day supply should be enough, although many factors must be taken into account (for example, some patients in South Dakota might live so far away from a health care facility or pharmacy that somewhat larger supplies might be justified).[46]

Clinician discretion in choosing an opioid and deciding how much to prescribe is always necessary because so many factors influence how a patient will respond to both pain and an analgesic. These factors include:

- Age
- Hepatic or renal impairment
- Genetic polymorphisms
- Comorbid conditions
- History of substance abuse
- Potential drug-drug interaction
- Co-administration with other central nervous system depressants

Opioid-induced hyperalgesia

Basic science and clinical data suggest that patients receiving opioids can actually become more sensitive to painful stimuli.[56] This opioid-induced hyperalgesia is probably due to upregulation of pro-nociceptive pathways in the peripheral and central nervous systems.[57] Although hyperalgesia has traditionally been associated with chronic pain, it can also occur after intraoperative or postoperative administration of high-dose opioids as well as in low-dose or maintenance-dose regimens.[58] Opioid-induced hyperalgesia is different pharmacologically from the phenomenon of opioid tolerance, although both can lead to an increased need for opioids and disentangling the two, clinically, can be difficult.

Calculating morphine equivalents

Calculating a patient's total daily dose of opioids is important to appropriately and effectively prescribe, manage, and taper opioid medications use for both acute and chronic pain. This can be done with printed or online equianalgesic charts, which provide conversion factors and dose equivalents of all available opioid medications relative to a standard dose of morphine.

Care must be taken in using such charts because dose is not the only relevant variable. Clinicians must also consider the route of administration, cross tolerance, half-life, and the bioavailability of a drug. In addition, the patient's existing level of opioid tolerance must be taken into account. Printed equianalgesic charts are common, and online calculators are also freely available (a common one can be accessed at clincalc.com/Opioids). The CDC provides a helpful guide to opioid conversions available at: www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Pain medicine specialists

Integrated pain management requires coordination of medical, psychological, and social aspects of health care and includes primary care, mental health care, and specialist services when needed Consultation with an addiction medicine specialist or psychiatrist may be necessary if an episode of acute

pain involves many complicating variables (such as multiple comorbidities) or if opioids are needed but the patient is already using an opioid for chronic pain and/or opioid maintenance therapy.

Patient education

Before prescribing an opioid for acute pain, providers should discuss the known risks and benefits of such therapy. Providers should talk openly and honestly to patients in order to arrive at informed decisions about opioid therapy. Here are some suggestions:

- Be explicit and realistic about expected benefits, including the fact that complete pain relief is unlikely and not necessarily desired
- Emphasize improvement in function as a primary goal and that function can improve even when some pain in present
- Advise patients about potential serious adverse effects including respiratory depression, constipation, and development of an opioid use disorder
- Review common effects such as dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids
- Discuss effects that opioids might have on one's ability to operate a vehicle, particularly when opioids are initiated, when dosages are increased, or when other central nervous system depressants, such as benzodiazepines or alcohol are used concurrently
- Review increased risks for respiratory depression when opioids are taken with benzodiazepines, other sedatives, alcohol, illicit drugs such as heroin, or other opioids
- Discuss risks to household members and other individuals if opioids are intentionally or unintentionally shared with others from whom they are not prescribed.
- Consider whether cognitive limitations might interfere with management of opioid therapy, and if so, determine whether a caregiver can responsibly co-manage the therapy

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

Remind patients that pain medications are sought after by many people, and, thus it is best if opioids are stored in a locked cabinet or other secure storage unit. If a locked unit is not available, patients should, at least, not keep opioids in a place that is obvious to, or easily accessed by others, since theft by

friends, relatives, and guests is a known route by which opioids become diverted.[59] Storage areas should be cool, dry, and out of direct sunlight.

Proper disposal methods should be explained:

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

Specific acute pain populations

Management of acute perioperative pain

A full discussion of ways to manage perioperative pain is beyond the scope of this document because it can involve a diverse array of pharmacological and invasive measures administered by hospital-based anesthesiologists or pain specialists in order to relieve suffering, achieve early mobilization post-surgery, and reduce hospital stay. It is worth noting, however, that a multimodal approach to acute pain management is the primary model for dealing with perioperative pain as it is, more generally, for the treatment of acute pain in primary care settings. Also, just as competent and responsible treatment of acute pain in primary care can help prevent the development of chronic pain and attendant morbidities, research has shown an array of adverse outcomes associated with the under-treatment of perioperative pain, including thromboembolic and pulmonary complications, additional time spent in an intensive care unit or hospital, hospital readmission for further pain management, needless suffering, impairment of health-related quality of life, and development of chronic pain.[60]

In addition, the issue of opioid analgesic over prescription is as important an issue in the perioperative arena as it is anywhere in medicine. A 2018 cohort study of 2,392 adults having a range of surgeries found that, overall, a median of 30 pills of hydrocodone/acetaminophen (5/325 mg) were prescribed for postsurgical pain, but patients only used a median of 9 pills.[61] The study also found that the strongest association with higher use of opioids was not level of pain, but the quantity of opioids prescribed: 0.53 more pills used (95 percent CI 0.4-0.65 $p < 0.001$) for every additional pill prescribed.[62]

Table 4 summarizes a set of 2019 recommendations from the Michigan Opioid Prescribing Engagement Network.

Table 4. Opioid Dose Recommendations for Post-procedural Pain[63]

Procedure	**Number of Oxcodone 5 mg tablets (or equivalent)**
Dental extraction	0
Thyroidectomy	5
Breast biopsy or lumpectomy	5
Lumpectomy plus sentinel lymph node biopsy	5
Sentinel lymph node biopsy only	5
Laparoscopic anti-reflux (Nissen procedure)	10
Hernia repair (minor or major)	10
Sleeve gastrectomy	10
Laparoscopic cholecystectomy	10
Carotid endarterectomy	10
Prostatectomy	10
Open cholecystectomy	15
Colectomy (laparoscopic or open)	15
Cesarean delivery	15
Hysterectomy (all types)	15
Cardiac surgery via median sternotomy	15
Open small bowel resection	20
Simple mastectomy with or without sentinel lymph node biopsy	20
Total hip arthroplasty	30
Total knee arthroplasty	50

Of note, professional opinions on this topic will continue to evolve and while this paper summarizes current findings and provides South Dakota prescribers with clear, evidence-based guidance about the appropriate prescription of opiate analgesics and the treatment of acute pain, these guidelines are intended to apply broadly, they are not intended to establish a "standard of care." Providers – to

include all prescribers - must exercise their own best medical judgment when providing treatment, taking all relevant circumstances into account, including the potential for abuse, diversion and risk for addiction.

Management of acute pain in patients already using opioids or on Medication-Assisted Treatment

When caring for patients who are physically dependent on opioids—whether because of ongoing chronic pain or opioids used as part of treating opioid use disorder (OUD)—clinicians must know the type and quantity of opioid the patient is currently using so that an equivalent (equianalgesic) dose can be administered by an appropriate route to cover their baseline opioid requirement as well as the additional medication required for the acute pain.

Some clinicians mistakenly believe that the opioid agonist therapy (methadone) or partial agonist therapy (buprenorphine) used for medication-assisted therapy (MAT) provides enough analgesia to "cover" acute pain.[64] In fact, the doses of methadone and buprenorphine typically used in MAT do not provide sustained analgesic effects and are insufficient to treat acute pain.[62] Patients on opioid agonist therapy also develop cross-tolerance, which means they require higher and more frequent doses of short- or long-acting opioids to provide analgesia for episodes of acute pain. Because buprenorphine binds to mu-receptors with much higher affinity than other opioid agonists, pain management in patients using buprenorphine can be complicated. Several types of regimens using both buprenorphine and other opioids for acute pain have been described in the literature with choices of regimen guided by the specifics of a patient's existing regimen, presence of comorbid conditions, setting, and degree of acute pain.[64]

Patients Served by Multiple Providers

Ideally, patients in pain, whether acute or chronic, would receive prescriptions for analgesic prescriptions or other pain treatments from a single provider. In the real world, this is often neither possible nor feasible. Unfortunately, the risks of overdose and overdose-related death rise steeply as the number of prescribers increases. For example, the risk of overdose (from prescribed opioids or sedatives) is 3.5 times higher for patient with 4-5 prescribers compared to patients seeing a single prescriber.[65] Increasing numbers of prescribers is a potential indicator of opioid misuse or abuse, but it can also be related to non-problematic causes such as high use of emergency room services, suboptimal medical care, "nomadic" or "migrant" populations, or of populations in which providers rotate through clinics on a short-term, regular basis (as can be the case in areas serviced by the Indian Health Service). It is not always easy to determine whether a patient with multiple providers is obtaining overlapping prescriptions in an attempt to obtain more medication than a single provider would give. But the existence of multiple

providers should be a "red flag" warranting investigation, starting with conversations with the patient, but always including use of a PDMP.

Emergency department considerations

Although emergency departments prescribe only a fraction of opioid analgesics prescribed nationwide, ED prescriptions for opioids are reported to account for about 45 percent of the opioids diverted for non-medical use.[52] Guidelines from the American Academy of Emergency Medicine and other groups have attempted to reduce the variability in pain management and prescribing practices that has been evident in past decades. These guidelines mirror recommendations by the CDC and other organizations, with the following key provisions:[52]

- Give short-acting opioids as second-line treatment to other analgesics unless there is clear indication for opioid (e.g., acute abdominal pain or long bone fracture)
- Start with lowest effective dose
- Prescribe no more than a 3-day course of opioid for most acute pain conditions
- Address exacerbations of chronic pain with non-opioid analgesics, non-pharmacological therapies, or referral to pain specialists for follow-up
- Assess for opioid misuse or addiction using validated screening tools
- Access PDMPs when available
- Avoid long-acting or extended-release opioids
- Refrain from refilling chronic opioid prescriptions—refer to treating clinician who provided original prescription
- Refrain from replacing lost, stolen, or destroyed opioid prescriptions
- Understand that the federal Emergency Medical Treatment and Labor Act (EMTALA) does not state that severe pain is an emergency medical condition, and that EMTALA allows emergency medical providers to withhold opioid treatment if in their professional judgment such withholding is clinically justified

Older adults

Older patients are at increased risk of acute pain related to trauma, surgery or procedures, or degenerative conditions such as osteoarthritis. The elderly undergo surgery four times more often than other age groups, and are therefore more likely to suffer from associated pain.[66] In those 65 years and older, acute pain leads to about 4 million U.S. emergency department visits each year.[67]

Assessing and treating pain in older patients can be complicated by issues such as age-related physiologic changes, physical accessibility to treatment, cognitive impairment, coexisting illnesses, and

polypharmacy. Elderly patients may under- or over-report their experience of pain due to functional impairment or psychological distress. Doses of NSAIDs often need to be reduced to avoid hepatic or kidney damage, and opioids may induce unacceptable risks related to falls, constipation, or respiratory depression. Clinical decision-making must take into account all of these considerations, each of which can increase the risk for adverse outcomes.

Pregnancy

In general, and whenever possible, opioids should be avoided in pregnancy due to associations between opioid use and adverse fetal outcomes such as stillbirth, poor fetal growth, pre-term delivery, and neonatal opioid withdrawal syndrome.[46] If a opioid is indicated however, don't hesitate to prescribe based on concern for neonatal abstinence syndrome alone (NAS).

Before prescribing opioids in pregnancy:

- Ensure opioids are indicated
- Maximize non-opioid therapy, including exercise, physical therapy, behavioral approaches, and non-opioid medications
- Discuss the risks and benefits of opioids, including the risk of physiologic dependence and the risk of NAS
- Take a thorough history of substance use of substance use and review the PDMP AWARxE.

For reproductive age women who are not pregnant, discuss family planning and effects on pregnancy.

Conclusions

Although the focus of much public and professional attention in the past decade has been on the problems related to opioid analgesic prescribing for chronic pain, as this report had demonstrated, the treatment and management of acute pain is an equally important topic because many of the same dynamics (e.g., prescribing opioids when non-opioids may be just as effective, or prescribing higher doses/durations than needed) are at work with acute pain as with chronic pain.

Properly and responsibly managing acute pain is desirable not only because it relieves patient suffering, but because it reduces the chances that acute pain will morph into chronic pain, and it can help stem the tide of opioid diversion, misuse, and abuse. Opioids can, of course, play an invaluable role in the pain management armamentarium, but they carry important risks, as well, and thus should be generally viewed as second-line agents or as part of a multi-modal approach. The risks of opioids, even when used for acute pain and for relatively short durations, are amplified among older adults, patients with impaired renal or hepatic function, those with COPD, cardiopulmonary disorders, sleep apnea, or mental illness, and in anyone likely to combine opiates with other respiratory depressants such as alcohol or benzodiazepines.

These guidelines present evidence-based recommendations for treating acute pain with a range of pharmacological and non-pharmacological strategies to be administered usually in a step-like fashion, with opioids only used when necessary and then at the lowest dose and shortest duration deemed clinically beneficial. As with treating chronic pain, the appropriate deployment of opioids for chronic pain can be challenging, but it is not inherently different from using any other treatment option with significant risks of harm. With proper pain assessment, primary reliance on non-pharmacologic and non-opioid analgesics, and a view that includes critical emotional, psychological, and social dimensions of pain, clinicians can both relieve immediate suffering and maximize their patients' long-term health.

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CDCA (ADEX) DENTAL EXAMINATION						
20:43:03:02. Clinical competency examination -- License to practice as a dentist. The board may approve a patient-based clinical competency examination pursuant to subdivision 20:43:03:01(4) that includes, at a minimum, the following components:	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
(1) A patient-based periodontal component;	Yes	Yes	Yes	Yes	Yes	Yes
(2) A patient-based restorative component;	Yes	Yes	Yes	Yes	Yes	Yes
(3) A manikin-based prosthodontic component;	Yes	Yes	Yes	Yes	Yes	Yes
(4) A manikin-based endodontic component; and	Yes	Yes	Yes	Yes	Yes	Yes
(5) A remediation policy to address candidate deficiencies.	Yes	Yes	Yes	Yes	Yes	Yes
CDCA (ADEX) DENTAL HYGIENE EXAMINATION						
20:43:03:09. Clinical competency examination -- License to practice as a dental hygienist. The board may approve a patient based dental hygiene clinical competency examination pursuant to subdivision 20:43:03:08(4) that includes, at a minimum, the following components:	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
(1) Pocket depth detection;	Yes	Yes	Yes	Yes	Yes	Yes
(2) Calculus detection and removal;	Yes	Yes	Yes	Yes	Yes	Yes
(3) An intra oral and extra oral assessment; and	Yes	Yes	Yes	Yes	Yes	Yes
(4) A remediation policy to address candidate deficiencies.	Yes	Yes	Yes	Yes	Yes	Yes

CITA (ADEX) DENTAL EXAMINATION						
20:43:03:02. Clinical competency examination -- License to practice as a dentist. The board may approve a patient-based clinical competency examination pursuant to subdivision 20:43:03:01(4) that includes, at a minimum, the following components:	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
(1) A patient-based periodontal component;	Yes	Yes	Yes	Yes	Yes	Yes
(2) A patient-based restorative component;	Yes	Yes	Yes	Yes	Yes	Yes
(3) A manikin-based prosthodontic component;	Yes	Yes	Yes	Yes	Yes	Yes
(4) A manikin-based endodontic component; and	Yes	Yes	Yes	Yes	Yes	Yes
(5) A remediation policy to address candidate deficiencies.	Yes	Yes	Yes	Yes	Yes	Yes
CITA (ADEX) DENTAL HYGIENE EXAMINATION						
20:43:03:09. Clinical competency examination -- License to practice as a dental hygienist. The board may approve a patient based dental hygiene clinical competency examination pursuant to subdivision 20:43:03:08(4) that includes, at a minimum, the following components:	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
(1) Pocket depth detection;	Yes	Yes	Yes	Yes	Yes	Yes
(2) Calculus detection and removal;	Yes	Yes	Yes	Yes	Yes	Yes
(3) An intra oral and extra oral assessment; and	Yes	Yes	Yes	Yes	Yes	Yes
(4) A remediation policy to address candidate deficiencies.	Yes	Yes	Yes	Yes	Yes	Yes

CRDTS DENTAL EXAMINATION						
20:43:03:02. Clinical competency examination -- License to practice as a dentist. The board may approve a patient-based clinical competency examination pursuant to subdivision 20:43:03:01(4) that includes, at a minimum, the following components:	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
(1) A patient-based periodontal component;	Yes	Yes	Yes	Yes	Yes	Yes
(2) A patient-based restorative component;	Yes	Yes	Yes	Yes	Yes	Yes
(3) A manikin-based prosthodontic component;	Yes	Yes	Yes	Yes	Yes	Yes
(4) A manikin-based endodontic component; and	Yes	Yes	Yes	Yes	Yes	Yes
(5) A remediation policy to address candidate deficiencies.	Yes	Yes	Yes	Yes	Yes	Yes
CRDTS DENTAL HYGIENE EXAMINATION						
20:43:03:09. Clinical competency examination -- License to practice as a dental hygienist. The board may approve a patient based dental hygiene clinical competency examination pursuant to subdivision 20:43:03:08(4) that includes, at a minimum, the following components:	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
(1) Pocket depth detection;	Yes	Yes	Yes	Yes	Yes	Yes
(2) Calculus detection and removal;	Yes	Yes	Yes	Yes	Yes	Yes
(3) An intra oral and extra oral assessment; and	Yes	Yes	Yes	Yes	Yes	Yes
(4) A remediation policy to address candidate deficiencies.	Yes	Yes	Yes	Yes	Yes	Yes

SRTA DENTAL EXAMINATION						
20:43:03:02. Clinical competency examination -- License to practice as a dentist. The board may approve a patient-based clinical competency examination pursuant to subdivision 20:43:03:01(4) that includes, at a minimum, the following components:	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
(1) A patient-based periodontal component;	Yes	Yes	Yes	Yes	Yes	Yes
(2) A patient-based restorative component;	Yes	Yes	Yes	Yes	Yes	Yes
(3) A manikin-based prosthodontic component;	Yes	Yes	Yes	Yes	Yes	Yes
(4) A manikin-based endodontic component; and	Yes	Yes	Yes	Yes	Yes	Yes
(5) A remediation policy to address candidate deficiencies.	Yes	Yes	Yes	Yes	Yes	Yes
SRTA DENTAL HYGIENE EXAMINATION						
20:43:03:09. Clinical competency examination -- License to practice as a dental hygienist. The board may approve a patient based dental hygiene clinical competency examination pursuant to subdivision 20:43:03:08(4) that includes, at a minimum, the following components:	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
(1) Pocket depth detection;	Yes	Yes	Yes	Yes	Yes	Yes
(2) Calculus detection and removal;	Yes	Yes	Yes	Yes	Yes	Yes
(3) An intra oral and extra oral assessment; and	**No**	**No**	**No**	Yes	Yes	Yes
(4) A remediation policy to address candidate deficiencies.	Yes	Yes	Yes	Yes	Yes	Yes

WREB DENTAL EXAMINATION						
20:43:03:02. Clinical competency examination -- License to practice as a dentist. The board may approve a patient-based clinical competency examination pursuant to subdivision 20:43:03:01(4) that includes, at a minimum, the following components:	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
(1) A patient-based periodontal component;	Yes	Yes	Yes	Yes	Yes	Yes
(2) A patient-based restorative component;	Yes	Yes	Yes	Yes	Yes	Yes
(3) A manikin-based prosthodontic component;	**Grandfather Clause**	**Grandfather Clause**	**Grandfather Clause**	Yes	Yes	Yes
(4) A manikin-based endodontic component; and	Yes	Yes	Yes	Yes	Yes	Yes
(5) A remediation policy to address candidate deficiencies.	Yes	Yes	Yes	Yes	Yes	Yes
WREB DENTAL HYGIENE EXAMINATION						
20:43:03:09. Clinical competency examination -- License to practice as a dental hygienist. The board may approve a patient based dental hygiene clinical competency examination pursuant to subdivision 20:43:03:08(4) that includes, at a minimum, the following components:	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
(1) Pocket depth detection;	Yes	Yes	Yes	Yes	Yes	Yes
(2) Calculus detection and removal;	Yes	Yes	Yes	Yes	Yes	Yes
(3) An intra oral and extra oral assessment; and	**Grandfather Clause**	Yes	Yes	Yes	Yes	Yes
(4) A remediation policy to address candidate deficiencies.	Yes	Yes	Yes	Yes	Yes	Yes

Accelerated Dental Assisting Academy Radiography Course Overview

Documents included:

- Request letter from Angie LeBlanc at Accelerated Dental Assisting Academy
- SDSBOD Radiography Course Approval Request Form
- Signed Verification from ADAA that this course meets all requirements of ARSD 20:43:07:03
- Course Syllabus
- Instructor applications
- Also available is the full course curriculum including instructor guidelines, quizzes and exams

The ADAA Radiography course is integrated into ADAA's Dental Assisting course. The Radiography components do not fall into a two day, 16 hour timeframe, but are included when appropriate with other training.

> *Accelerated Dental Assisting Academy reserves Class 2 for the main portion of our Dental Radiology course. The course teaches the essential concepts of dental radiology for dental assistants. Class 2 is eight hours and consists of lecture and clinical guidance. Each student will then practice x-ray in each class from class three to class nine and will be quizzed and tested throughout the rest of the course, for a total of **20 hours** of Radiology. Students will learn the intra-oral and extra-oral techniques and safeguards of dental radiology.*

Instructors apply by completing the ADAA Instructor Application which includes school and work experience, certification in CPR and a copy of their drivers license. Included are applications for four instructors out of Dr. Ben Jensen's office in Yankton, SD. Two are Registered Dental Assistants, one is a Radiographer, and one is a Dental Hygienist.

> *The South Dakota Radiology Course will be taught by a highly skilled instructor. A person must meet minimum qualifications in order to become an instructor with Accelerated Dental Assisting Academy. An instructor must have received a high school diploma or general education diploma. He/she must a Licensed Dental Radiographer with the South Dakota State Board of Dentistry and must be CPR certified. An instructor must have a minimum of two years of work experience in dental assisting. Once hired as an instructor for Accelerated Dental Assisting Academy, the instructor will be trained to teach the course and will participate in multiple training seminars throughout the year.*

The Radiography course is currently Board approved in Louisiana, Mississippi, Georgia and North Carolina.

ADAA has an agreement with Dr. Ben Jensen in Yankton, SD to hold the course in his office.

Accelerated Dental Assisting Academy
PO Box 1120
Denham Springs, LA 70727

South Dakota State Board of Dentistry
P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079
Ph: 605-224-1282 Fax: 1-888-425-3032
E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.com

Radiography Course Approval Request Form

The following information is required for Board review of a radiography course per ARSD 20:43:07:06 and must be submitted at least 30 days prior to a scheduled board meeting to be considered.

Name of Person Requesting Approval: Angie LeBlanc

Address: PO Box 1120 Denham Springs LA 70727

Phone: 844-727-3755 Email: licensing@adaa.us

Notification regarding approval of the course will be sent to this email address.

Title of Course: Dental Radiography Course

Sponsor Organization: Accelerated Dental Assisting Academy

Course Length: 20 Hrs.

Instructor(s): Kelsey Pleiss, Desarae Heine,Courtney Hochstein, Carrie Wiepen

Location(s): 2703 Fox Run Parkway Yankton SD 57078

Date(s) of Course: Feb 2020, June 2020, Sept 2020

The following must be attached to this application or it will not be considered:

1. A resume or curriculum vitae for each course instructor; and
2. A detailed course outline that documents:
   i) 16 hours of instruction; and
   ii) Training in all areas outlined in ARSD 20:43:07:03.

For Office Use Only: Approved: y/n _____

Accelerated Dental Assisting Academy- Dental Radiography Course Review

A Board approved Radiography course must meet the following requirements. Please circle the appropriate response and initial each component. This will be attached to your course review information.

20:43:07:03. Training requirements. An applicant for registration as a dental radiographer must have successfully completed a 16-hour board approved program or course of study within six months of application in dental radiography which includes the following training:

(1) Practice in placement techniques and exposing radiographs on a training manikin;
(Yes) No Initials: MBR

(2) Fundamentals of radiation safety: characteristics of radiation, unit of radiation measurement, hazards of exposure to radiation, levels of radiation from source, and methods of controlling radiation dose; (Yes) No Initials: MBR

(3) Familiarization with equipment: identification of controls, function of each control, how each control affects the radiographic image, and the requirements for and use of a technique chart;
(Yes) No Initials: MBR

(4) Film processing: film speed as it relates to patient exposure, film processing with automatic processors, manual film processing, factors affecting film processing quality, and identification of common errors in processing;
(Yes) No Initials: MBR

(5) Anatomy and positioning relative to scope of practice to include patient preparation and correct method for performing procedures and identification of common technique errors; and
(Yes) No Initials: MBR

(6) Familiarization with federal and state regulations pertaining to services offered.
(Yes) No Initials: MBR

Name: Mishaux Ramirez Title: CEO

Signature: [signature] Date: 9-30-19

ACCELERATED
DENTAL ASSISTING
ACADEMY

Dental Radiology

Course Syllabus

Textbooks

Modern Dental Assisting – Elsevier 11th Edition by D. L. Bird and D.S. Robinson

Dental Assisting Online for Modern Dental Assisting – Elsevier 11th Edition by D. L. Bird and D.S. Robinson (http://evolve.elsevier.com/Bird/modern)

Accelerated Dental Assisting Academy Student Handbook

Accelerated Dental Assisting Academy Student Workbook

Course Objectives

1	Introduction to dental radiographs.
2	Defining the mechanics and operations of a dental radiograph machine.
3	Explain and discuss the hazards of primary, secondary, and scatter radiation.
4	Discuss the hazards and biological effects of exposure to radiation.
5	Describe the need for and methods used to protect the operator and patient from radiation exposure.
6	Define conventional and digital methods of dental radiography including the similarity and differences of both.
7	Describe the characteristics and uses of periapical, bite-wing, occlusal, and panoramic dental radiographs.
8	Discuss variations of films and sensors and how they function.
9	List, discuss, and label the essential landmarks as applied to intraoral dental radiographs.
10	Demonstrate seating and preparing a patient for dental radiography, including observing the universal precaution infection control steps.
11	Discuss and demonstrate the methods for assembling an extension-cone paralleling instrument (XCP).
12	Define the types of x-ray machines, the intent of use, proper techniques and methods of use.
13	Demonstrate, on a dental radiography manikin, taking a complete series of dental radiographs using the paralleling techniques.
14	Discuss the methods for developing and mounting conventional x-rays (FMX and bitewings).
15	Identify the causes for errors when exposing and processing dental x-rays and discuss the methods to prevent such errors.
16	Describe the maxillary and mandibular anatomic landmarks that are evident in radiographs.
17	Discuss strategic methods for identifying radiographs.
18	Practice mounting dental radiographs on a manikin.
19	Operate a dental x-ray machine. Process a full mouth series on a manikin.
20	Use radiation precautions.
21	The student will complete dental radiography worksheets.

Teaching Methods

The class will primarily be taught by the lecture and demonstration method. There will be question and answer sessions over material covered in lecture. Supervised lab time is provided for students to complete hands-on training.

Grading System

X-RAY PRACTICE TEST:	Students are given an x-ray quiz to evaluate their ability to identify x-rays and understand the precautionary methods used for exposure to radiation.
X-RAY QUIZ:	Students are given an x-ray practice test to evaluate their ability to identify x-rays by their anatomic and intraoral landmarks.
X-RAY EXAM:	38-question exam including practical testing. Students will be evaluated on their ability to identify x-rays by their anatomic and intraoral landmarks, types of x-ray units and their functions, and their understanding of the precautionary methods used for exposure to radiation.

MINIMUM PASSING SCORE: 70%

Description of Classroom, Laboratories, and Equipment

All Accelerated Dental Assisting Academy campuses are owned and operated by Accelerated Dental Assisting Academy. The Dental Assisting program provides students the opportunity to work with professionally certified instructors in modern, well-equipped facilities.

Available Certifications

The student will receive a certificate documenting completion of a structured course of training in Radiology. This will allow the student to apply for radiology licensure with the South Dakota Board of Dentistry.

South Dakota Handbook Table of Contents		Hours of X-Ray
Class 1	Introduction to Dental Assisting and Sterilization	
Class 2	Dental Radiology	4
Class 3	Impressions	0.5
Class 4	X-RAY EXAM Instrument Transfer and Fillings: Amalgam and Composite	0.5
Class 5	MIDTERM and Charting	0.5
Class 6	Crown and Bridge	
Class 7	Endodontics, Orthodontics, Pedodontics, Periodontics	
Class 8	Oral Surgery, Implants, Partials and Dentures	
Class 9	Office Management, OSHA and Final Review	
Class 10	FINAL and CPR	

Workbook Table of Contents		Hours of X-Ray
Class 1	Clinic Guide Handouts Clinic Worksheets	
Class 2	Clinic Guide Handouts Clinic Worksheets	4
Class 3	Clinic Guide Handouts Clinic Worksheets	1
Class 4	Clinic Guide Handouts Clinic Worksheets	1
Class 5	Clinic Guide Handouts Clinic Worksheets	1
Class 6	Clinic Guide Handouts Clinic Worksheets	1
Class 7	Clinic Guide Handouts Clinic Worksheets	1
Class 8	Clinic Guide Handouts Clinic Worksheets	1
Class 9	Clinic Guide Handouts Clinic Worksheets	0.5
Participation Day		4
Total Hours of X-Ray		20

5/3/2019

° ° °

Angie LeBlanc
Accelerated Dental Assisting Academy
P.O. Box 1120
Denham Springs, LA 70727

South Dakota State Board of Dentistry
P.O. Box 1079
Pierre, SD 57501

To Whom It May Concern:

On behalf of Accelerated Dental Assisting Academy, I am requesting the review and approval of our Dental Radiology course. The Dental Radiology program is part of our 10-week dental assisting program.

Though we are not nationally accredited due to the length of our course, Accelerated Dental Assisting Academy takes great pride in our program and we strive daily to offer the best education for our students. We are currently licensed to operate as a private proprietary school by the Louisiana Board of Regents, the Arkansas State Board of Career Education, the Mississippi Commission on Proprietary Schools and College Registration, the Alabama Community College System, Georgia Nonpublic Postsecondary Education Commission, Missouri Department of Higher Education, Michigan Licensing and Regulatory Affairs, Texas Workforce Commission, and the North Carolina Community College System. At this time, we have thirty-eight licensed schools and are in agreement with Dr. Jensen in Yankton, South Dakota to hold a course in his office.

We are honored to have our Dental Radiography course approved in multiple states. In Louisiana, we are the first proprietary school ever to have been approved by the Louisiana Board of Dentistry. Upon completion of our course, Louisiana students will receive a certificate of completion. This certificate is accepted by the Louisiana State Board of Dentistry and allows a dental assistant to legally operate dental x-ray equipment. It also meets the criteria for advancement into the status of Expanded Duty Dental Assistant.

Our course has also been approved by the Mississippi Board of Dental Examiners. A Mississippi Board-approved radiology seminar is needed by dental assistants upon applying to the Mississippi State Board of Dental Examiners for a radiology permit. We are only one of two proprietary schools in the state that has received approval from the board.

Our course has also been approved by the Georgia Department of Human Services. In order to legally operate dental x-ray equipment and perform dental radiographic procedures under the direct supervision of a licensed dentist in Georgia, a dental assistant must complete a minimum of six hours of instruction in dental radiography. We are proud to be able to offer this instruction to our students and have them prepared to legally operate x-ray equipment upon completion of our course.

In North Carolina, our course has been approved by the North Carolina Board of Dentistry as all dental assistants are required to attend a board-approved course before they can expose radiographs.

Accelerated Dental Assisting Academy reserves Class 2 for the main portion of our Dental Radiology course. The course teaches the essential concepts of dental radiology for dental assistants. Class 2 is eight hours and consists of lecture and clinical guidance. Each student will then practice x-ray in each class from class three to class nine and will be quizzed and tested throughout the rest of the course, for a total of 20 hours of Radiology. Students will learn the intra-oral and extra-oral techniques and safeguards of dental radiology.

The South Dakota Radiology Course will be taught by a highly skilled instructor. A person must meet minimum qualifications in order to become an instructor with Accelerated Dental Assisting Academy. An instructor must have received a high school diploma or general education diploma. He/she must a Licensed Dental Radiographer with the South Dakota State Board of Dentistry and must be CPR certified. An instructor must have a minimum of two years of work experience in dental assisting. Once hired as an instructor for Accelerated Dental Assisting Academy, the instructor will be trained to teach the course and will participate in multiple training seminars throughout the year.

For your review, I am including a copy of the Course Syllabus and Hours of Instruction in Radiology, the Instructor's Workbook, the Instructor's lecture PowerPoint, x-ray practice quiz, x-ray quiz and the x-ray exam. Our desire is for all graduate students to become extraordinary future employees and be completely trained and ready to become an asset to a dental office upon completion of the course. With your board approval, our school will be able to produce top-quality dental assistants who will be able to meet South Dakota's radiography requirements.

If you have any questions or concerns, you can reach me by phone at 844-727-3755 or by email at angie@adaa.us. Thank you in advance for your consideration.

Sincerely,

Angie LeBlanc
Licensing Technician
Accelerated Dental Assisting Academy

SOUTH DAKOTA INSTRUCTOR CHECKLIST

INSTRUCTOR'S NAME: Kelsey Pleiss

DOCTOR'S NAME: Ben Jensen

CONTACT NUMBER: 605-660-7479

EMAIL: odensk24@gmail.com

STREET ADDRESS: 2703 Fox Run Parkway

CITY/STATE/ZIP: Yankton, SD 57078

DOCUMENTS NEEDED TO BECOME A LICENSED INSTRUCTOR

- ☑ Completed ADAA Instructor Application (work history must show a minimum of 2 years of clinical experience as a dental assistant)
- ☑ Copies of any Dental Training Certificates (including BLS Certification and Radiology)
- ☑ Copy of Driver's License

ACCELERATED DENTAL ASSISTING ACADEMY

ACCELERATED DENTAL ASSISTING ACADEMY

Instructor Application-ADAA

First Name: Kelsey Last Name: Pleiss

Email: odensk24@gmail.com

Phone Number: 605-660-2035 Date of Birth: 02/24/1990 Job Title: Instructor

Education

High School Name & Address: Yankton High School
1801 Summit St. Yankton, SD 57078

From: 2004 to 2008 Diploma Equivalent Received: Yes or No (circle one)

Must include transcript or photocopy of diploma*

College Name & Address: Northeast Community College,
801 E Benjamin Ave Norfolk, NE 68701

From: 2008 to 2012 Degree Received: (yes) of no (circle one) Major: AAS in Physical Therapist Assistant

Must include transcript or photocopy of diploma*

Graduate School Name & Address: _____

From: _____ to _____ Degree Received: yes or no (circle one) Major: _____

Must include transcript or photocopy of diploma*

Other School Name & Address: _____

From: _____ to _____ Degree Received: yes or no (circle one) Major: _____

Must include transcript or photocopy of diploma*

Employment Experience

List most recent positions first. Each Instructor ***must*** have a ***minimum of 2 years*** of practical experience as a dental assistant. Also, instructors are ***required*** to submit the Verification of Work Experience for Personnel Licensure in the Non-Degree Granting Proprietary Schools of New York State Form. Use only one form for each employer. ***Must*** be notarized.

From 6/2017 to present Position: DA Hours Per Week: 34
Employer Name & Address: Ben Jensen Dental 2703 Fox Run Parkway Yankton, SD 57078
Duties: prepare tx rooms, take x-rays, educate pt's, assist w/ procedures, sterilization

From_____ to _____ Position: _____ Hours Per Week: _____
Employer Name & Address: _____
Duties: _____

From_____ to_____ Position:_____ Hours Per Week: _____
Employer Name & Address: _____
Duties: _____

From_____ to_____ Position:_____ Hours Per Week: _____
Employer Name & Address: _____
Duties: _____

Other Disclosures

1. Have you resigned from a position rather than face disciplinary charges? YES or (NO)
   If yes, please explain:
2. Have you ever been discharged from an employment as a result of disciplinary action? YES or (NO)
   If yes, please explain:

3. Have you ever been convicted of any crime (felony or misdemeanor)? YES or (NO)
   If yes, submit official copies of court reporting including disposition of the case.

4. Have you ever had a professional credential revoked, suspended, or annulled? YES or (NO)
   If yes, please explain:

   _____

   _____

5. Are you currently under charges for any crime (felony or misdemeanor)? YES or (NO)
   If yes, please explain:

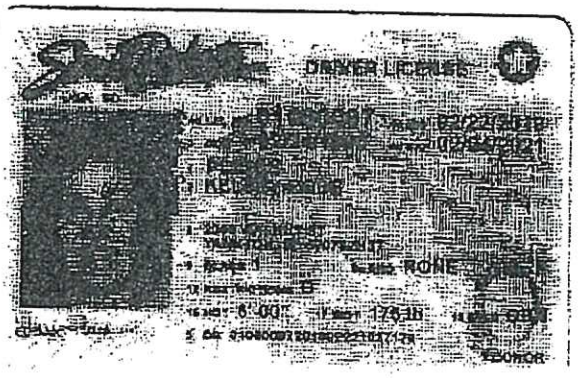
   _____

   _____

Certification

I certify that all of the data and information in this application are true, complete and correct to the best of my knowledge and belief.

Instructor Signature: Kelsey Reiss Date: 5/7/19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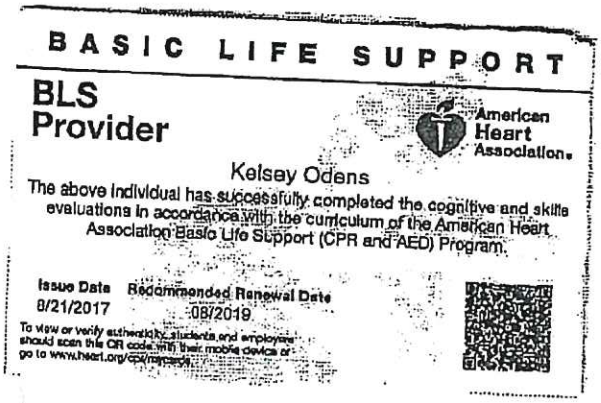
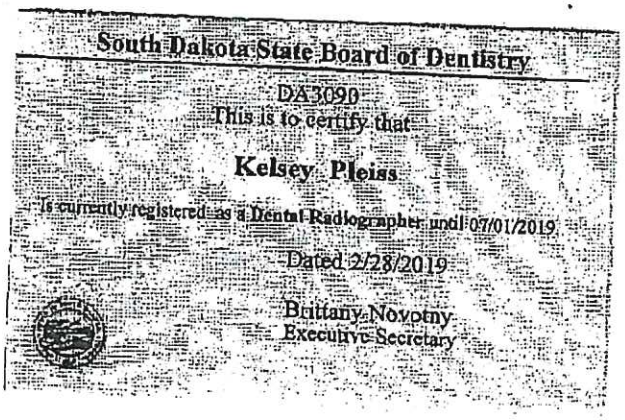
NONE


BASIC LIFE SUPPORT
BLS
Provider
American Heart Association.
Kelsey Odens
The above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program.
Issue Date
8/21/2017
Recommended Renewal Date
08/2019


South Dakota State Board of Dentistry
DA3090
This is to certify that
Kelsey Pleiss
is currently registered as a Dental Radiographer until 07/01/2019
Dated 2/28/2019
Brittany Novotny
Executive Secretary

Yankton High School

Yankton South Dakota

This Certifies That

Kelsey Rose Odens

Has satisfactorily completed the Course of Study prescribed for Graduation and is therefore entitled to this

Diploma

Given this month of May, 2008.

Joseph P. Petersmeyer
SUPERINTENDENT

Douglas A. Kindle
PRINCIPAL

C. L. Specht
PRESIDENT, BOARD OF EDUCATION

Richard A. Hunsaker
BUSINESS MANAGER

This diploma recognizes that the student has completed an approved program. Content of the program completed may be determined only with reference to the student's transcript.

Northeast Community College

Certifies That

Kelsey R. Odens

has satisfactorily completed all the requirements prescribed by the
Board of Governors of Northeast Community College
for the

Associate of Applied Science Degree
in
Physical Therapist Assistant

Conferred on this seventh day of August, two thousand twelve.

PRESIDENT OF NORTHEAST COMMUNITY COLLEGE

CHAIRPERSON OF BOARD OF GOVERNORS

South Dakota State Board of Dentistry
P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079
Ph: 605-224-1282 Fax: 1-888-425-3032
E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.org

MOBILE DENTAL FACILITY AUTHORIZATION APPLICATION

Please attach the following to this application:

1. Written description of the mobile dental facility, including make/model/description/equipment;
2. Written procedure for emergency and follow-up care; and
3. Written procedure for creating, maintaining, and accessing patient dental records.

Name of Entity Operating Mobile Dental Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____Email: _____

This email will be used to correspond with you regarding the application. Please be sure the email is current.

Date(s) that mobile dental facility will be operating in South Dakota:

From: _____ To: _____

From: _____ To: _____

From: _____ To: _____

Mobile dental facility is registered in the following state(s):

STATE_____REGISTRATION #_____DATE RECEIVED_____STATUS_____

STATE_____REGISTRATION #_____DATE RECEIVED_____STATUS_____

Yes No. An inspection has been completed on this mobile dental facility. *If yes, please attach most recent inspection documentation.*

Yes No. The mobile dental facility and all dental equipment has been maintained per the manufacturer's specifications.

I declare and affirm under the penalties of perjury that this application has been examined by me and to the best of my knowledge and belief is in all things true and correct.

Signature: _____ Date: _____

Printed Name: _____

Version 19.0903

South Dakota State Board of Dentistry
P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079
Ph: 605-224-1282 Fax: 1-888-425-3032

E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.com

Application for Continuing Education Course Honorarium

Background

It is the policy of the Board to allocate resources, when available, to fund continuing education courses that further the mission of the Board.

Procedure

Application Deadline:	December 9, 2019. *Applications received after this deadline will not be considered.*
Submit Applications to:	South Dakota State Board of Dentistry PO Box 1079 Pierre, SD 57501 Or electronically to contactus@sdboardofdentistry.com
Fund Amount:	The Board will fund up to $7,500 in total during this request cycle.

Criteria for Consideration

- ✓ The sponsor organization must meet the applicable state contractor requirements.
- ✓ The course must further the mission of the Board.
- ✓ Preference will be given to courses that impact a large number of licensees or registrants and courses provided in partnership with other professional associations.
- ✓ Any funded course must be open to all dental professionals free of charge.

If an application is approved:

- ✓ The sponsor organization must be prepared to complete the state contract process.
- ✓ The sponsor organization must note in its promotional materials the following: *"The honorarium for this speaker is being funded by the South Dakota State Board of Dentistry. This course is open to all dental professionals free of charge. The content and opinions expressed during this course do not necessarily reflect the views of nor are they endorsed by the South Dakota State Board of Dentistry."*
- ✓ Following the course date, the sponsor organization must submit a brief report, including how many South Dakota licensees and/or registrants attended.

Course Information

Title of Course: *Detailed course outline must be attached:*

_____

Speaker(s): *Curriculum Vitae or Resume must be attached:*

_____

Date(s) of Course: _____

Course Location: _____

Honorarium Amount requested: $_____

Applicant Information

Sponsor Organization Name:

_____

Sponsor Organization Contact:

Name: _____

Address: _____

Phone: _____

Email: _____

Partner Organization Name (if applicable):

_____

Application Questions

Please type or print clearly; use additional paper if necessary.

1. Does the sponsor organization meet the requirements to serve as a state contractor?

   ☐ Yes

   ☐ No

2. Please list the course objectives:

3. What is the target population?

4. What is the anticipated number of *South Dakota* licensees and/or registrants that will attend this course?
   a. Dentists:_____
   b. Dental Hygienists: _____
   c. Registered Dental Assistants: _____
   d. Radiographers: _____
   e. Other Dental Office Staff: _____

5. List other possible sources of financial support for this course: