South Dakota State Board of Dentistry

Board Meeting Agenda
Richard F. Kneip Building Conference Room #3
700 Governors Drive – Pierre, SD
10:00 a.m. Central Friday June 18, 2021

1) **Call to Order**
2) **Open Forum:** 5 minutes for the public to address the Board
3) **Approval of Minutes:** January 8, 2021
4) **Adoption of Agenda**
5) **Financial Report**
6) **Office Update**
7) **Executive Session - SDCL 1-25-2(3)**
8) **License Applications**
9) **Old Business**
    a. Whitepaper on the Effective Management of Acute Pain
    b. Administrative Rules Project Update - Draft ARSD 20:43:09
10) **New Business**
    a. Southeast Technical College Dental Assisting Program update - Fenecia Foster
    b. Western Dakota Tech Dental Assisting Program Update – Chanin Hartnett
    c. SD Dental Association Wellness Program Request – Paul Knecht
    d. Health Professionals Assistance Program Update – Maria Piacentino
    e. Anesthesia Inspections
    f. Anesthesia Course Review – Moderate Permit and Permit to Monitor
    g. Course Review - Other
    h. Policies Review
    i. Continuing Education Guidelines Review
    j. Elections
    k. Membership Approval
    l. Travel Approval
    m. Meeting Dates
11) Announcements: Next Meetings – October 22, 2021 and January 14, 2022.
12) Adjourn

SD State Board of Dentistry
Board Meeting
Drifters Event Center, Ft. Pierre, SD
Friday January 8, 2021

President Dr. Harold Doerr called the meeting to order at 10:10 am Central.

Board Members Present: Dr. Harold Doerr, Dr. Nick Renemans, Dr. Tara Schaack, Dr. Scott Van Dam, Dr. Brian Prouty, Zona Hornstra and Molly Fulton.

Board Staff Present: Brittany Novotny, Lisa Harsma, Megan Borchert, and Justin Williams.

Others Present: Paul Knecht and Dr. Michelle Hofer.

Others Present via Telephone: Dr. Jay Crossland, Mercer May, Larry Nelson, Ann Schwartz, Fenecia Foster, Melissa DeNoon, Dr. Michelle Scholtz, Kim Laudenslager, Kelly Reich, Pat Connolly-Atkins, Jessica Bui, Dr. Gerry Walker and Renea Chapman.

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

Motion to approve the meeting minutes of the October 23, 2020 meeting by Schaack. Second by Renemans. Motion carried.

Motion to adopt the agenda by Hornstra. Second by Schaack. Motion carried.

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

Novotny provided an office update.

Motion to move into Executive Session pursuant to SDCL 1-25-2 (3) consulting with legal counsel and (4) contracts by Hornstra. Second by Renemans. Motion carried. The board went into Executive Session at 10:21 am.

Motion to move out of Executive Session by Van Dam. Second by Hornstra. Motion carried. The board moved out of Executive Session at 1:07 pm.

Motion to approve the FY 2022 contracts, as presented, by Renemans. Second by Van Dam. Motion carried.

Motion to approve the dentist credential verification applications of Eric Guy Harrison, Jason Richard Leet, Kristin Kay Murphy and George Allen West IV by Schaack. Second by Renemans. Motion carried.

Motion to approve the dental hygienist credential verification application of Carla Marie Grivas, Kirsten Dawn Nelson, Jennifer Rose Sams, and Patricia Jean Shields by Hornstra. Second by Schaack. Motion carried.

Motion to approve the dental hygienist regular applications of Relissa Beth Backman, Madison Josephine Cole, Hayley Rose Durland, Tina Rae Schneider, and Lily Michelle Stinehour by Hornstra. Second by Renemans. Motion carried.

Motion to approve the collaborative agreements of Nicole Glines and Kylie Beckman by Hornstra. Second by Schaack. Motion carried.

The Board discussed the COVID-19 impact on licensing. The SDDA noted the availability of an approved CPR course at the 2021 annual session.

The Board was provided an update on the anesthesia administrative rules project (ARSD 20:43:09). The Board noted that specific information on this project, including the opportunity to provide feedback on the current draft, can be found on the Board's website. Motion to appoint a subcommittee consisting of Prouty, Van Dam and Doerr to review the informal stakeholder feedback relative to the proposed draft of ARSD 20:43:09 and provide recommendations for updates by Hornstra. Second by Fulton. Motion carried.

The Board was provided an update on the ongoing review and update of the administrative rules. The Board noted that the specialty advertising regulations (ARSD 20:43:04:01) were slated for the next review. Motion to appoint a subcommittee consisting of Schaack, Renemans and Hornsta to review the specialty advertising administrative rules and bring forward a draft to be reviewed by the Board and disseminated for informal stakeholder feedback by Hornstra. Second by Fulton. Motion carried.

Fenecia Foster provided an update on the Southeast Tech Dental Assisting Program.

Melissa DeNoon provided an update on the Prescription Drug Monitoring Program (PDMP) and dental specific information.

Representatives from the clinical competency testing agencies joined via teleconference to present information on the examination components and format. Presenting were Kelly Reich from WREB, Kim Laudenslager from CRDTS, Jessica Bui from SRTA, Renea Chapman from CITA and Pat Connolly-Atkins from CDCA.

Motion to approve the components of the patient and manikin based dental clinical competency exams administered by CRDTS, CDCA, CITA, SRTA and WREB that meet the requirements outlined in 20:43:03:02, as presented, by Schaack. Second by Fulton. Motion carried.

Motion to approve the components of the patient and manikin based dental hygiene clinical competency exams administered by CRDTS, CDCA, CITA, SRTA and WREB that meet the requirements outlined in ARSD 20:43:03:09 including the intra and extra oral assessment components, as presented, by Hornstra. Second by Van Dam. Motion carried.

Motion to approve, per 20:43:03:04(4), the patient and manikin based dental clinical competency examinations administered by CRDTS, CDCA, CITA, SRTA and WREB, as presented, by Fulton. Second by Schaack. Motion carried.

Motion to approve, per 20:43:03:10(4) the patient and manikin based dental hygiene clinical competency examinations administered by CRDTS, CDCA, CITA, SRTA and WREB, as presented, by Hornstra. Second by Schaack. Motion carried.

Dr. Michelle Scholtz discussed a telehealth initiative. The Board's legal counsel reviewed the current statutes pertaining to teledentistry.

Motion to approve the South Dakota Dental Association (SDDA) and South Dakota Dental Hygiene Association (SDDHA) 2021 speaker honorarium application for $8,500 for Dr. Michal Glick to present "Treatment of the Medically Complex Dental Patient" & "The Oral Systemic Health Connection" by Renemans. Second by Van Dam. Motion carried.

Motion to approve the SDDA 2021 speaker honorarium application for $2,000 for Dr. Don-John Summerlin to present "Things you should have been taught in Oral Pathology, but weren't" by Schaack. Second by Hornstra. Motion carried.

The Board announced the following meeting dates: June 18, 2021, October 22, 2021 and January 14, 2022.

Motion to adjourn by Fulton. Second by Hornstra. Motion carried. The meeting was adjourned at 2:16 pm.

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Zona Hornstra, Secretary

Remaining Authority by Object/Subobject

Expenditures current through 05/29/2021 03:50:49 PM
HEALTH -- Summary
FY 2021 Version -- AS -- Budgeted and Informational
FY Remaining: 9.0 %

09202 Board of Dentistry - Info

Subobject		Operating	Expenditures	Encumbrances	Commitments	Remaining	PCT AVL
EMPLOYEE SALARIES							
5101030	Board & Comm Mbrs Fees	9,293	1,200	0	0	8,093	87.1
Subtotal		**9,293**	**1,200**	**0**	**0**	**8,093**	87.1
EMPLOYEE BENEFITS							
5102010	Oasi-employer's Share	847	92	0	0	755	89.1
Subtotal		**847**	**92**	**0**	**0**	**755**	89.1
51 Personal Services							
Subtotal		**10,140**	**1,292**	**0**	**0**	**8,848**	87.3
TRAVEL							
5203030	Auto-priv (in-st.) H/rte	1,500	467	0	0	1,033	68.9
5203070	Air-charter-in State	22,000	20,132	0	0	1,868	8.5
5203100	Lodging/in-state	1,266	150	0	0	1,116	88.2
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	92	0	0	108	54.0
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**	**20,841**	**0**	**0**	**10,930**	34.4
CONTRACTUAL SERVICES							
5204010	Subscriptions	300	0	0	0	300	100.0
5204020	Dues & Membership Fees	5,000	3,310	0	0	1,690	33.8
5204050	Computer Consultant	34,400	641	31,859	0	1,900	5.5
5204060	Ed & Training Consultant	3,307	0	10,500	0	-7,193	0.0
5204080	Legal Consultant	28,616	4,638	0	0	23,978	83.8
5204090	Management Consultant	260,103	248,334	21,304	0	-9,535	0.0
5204100	Medical Consultant	40,000	19,167	156,508	0	-135,675	0.0
5204130	Other Consulting	7,000	5,460	94,040	0	-92,500	0.0
5204160	Workshop Registration Fee	2,000	0	0	0	2,000	100.0
5204181	Computer Services-state	316	118	0	0	198	62.7
5204190	Computer Services-private	500	0	0	0	500	100.0
5204200	Central Services	3,166	3,155	0	0	11	0.3
5204203	Central Services	203	13	0	0	190	93.6
5204204	Central Services	1,211	749	0	0	462	38.2
5204207	Central Services	1,016	429	0	0	587	57.8
5204360	Advertising-newspaper	400	825	0	0	-425	0.0

Remaining Authority by Object/Subobject

Expenditures current through 05/29/2021 03:50:49 PM
HEALTH -- Summary
FY 2021 Version -- AS -- Budgeted and Informational
FY Remaining: 9.0 %

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	0	0	0	725	100.0
5204530	Telecommunications Srvcs	4,000	2,918	0	0	1,082	27.1
5204550	Garbage & Sewer	0	54	0	0	-54	0.0
5204590	Ins Premiums & Surety Bds	1,500	343	0	0	1,157	77.1
5204960	Other Contractual Service	12,000	3,795	0	0	8,205	68.4
Subtotal		**406,263**	**293,949**	**314,211**	**0**	**-201,897**	0.0
	SUPPLIES & MATERIALS						
5205020	Office Supplies	1,100	389	0	0	711	64.6
5205310	Printing-state	1,000	868	0	0	132	13.2
5205320	Printing-commercial	1,600	0	0	0	1,600	100.0
5205350	Postage	4,500	2,324	0	0	2,176	48.4
5205390	Food Stuffs	500	1,446	0	0	-946	0.0
Subtotal		**8,700**	**5,027**	**0**	**0**	**3,673**	42.2
	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
	CAPITAL OUTLAY						
5207491	Telephone Equipment	0	37	0	0	-37	0.0
5207901	Computer Hardware	0	236	0	0	-236	0.0
Subtotal		**0**	**273**	**0**	**0**	**-273**	0.0
	OTHER						
5208010	Other	500	0	0	0	500	100.0
Subtotal		**500**	**0**	**0**	**0**	**500**	100.0
52 Operating Subtotal		**454,734**	**320,090**	**314,211**	**0**	**-179,567**	0.0
Total		**464,874**	**321,382**	**314,211**	**0**	**-170,719**	0.0

AGENCY: 09 HEALTH
BUDGET UNIT: 09202 BOARD OF DENTISTRY - INFO

COMPANY	CENTER	ACCOUNT	BALANCE	DR/CR	CENTER DESCRIPTION
6503	092000061807	1140000	558,376.16	DR	BOARD OF DENTISTRY
COMPANY/SOURCE TOTAL 6503 618			558,376.16	DR *	
COMP/BUDG UNIT TOTAL 6503 09202			558,376.16	DR **	
BUDGET UNIT TOTAL 09202			558,376.16	DR ***	

AGENCY 09 HEALTH
BUDGET UNIT 09202 BOARD OF DENTISTRY - INFO

CENTER	COMP	ACCOUNT	DESCRIPTION	CURRENT MONTH	YEAR-TO-DATE
COMPANY NO	6503				
COMPANY NAME	PROFESSIONAL & LICENSING BOARDS				
092020061807	6503	4293005	DENTIST CREDENTIAL	.00	7,050.00
092020061807	6503	4293015	HYGIENIST CREDENTIAL	.00	1,600.00
092020061807	6503	4293025	PROCESSING FEE	.00	750.00
092020061807	6503	4293105	DENTIST NEW LICENSE	1,350.00	3,150.00
092020061807	6503	4293110	DENTIST LICENSE RENEWAL	32,470.00	39,780.00
092020061807	6503	4293115	DENTIST JP EXAM	1,800.00	7,650.00
092020061807	6503	4293125	DENTIST REINSTATE LICENSE	.00	1,800.00
092020061807	6503	4293135	DENTIST NITROUS OXIDE	80.00	760.00
092020061807	6503	4293137	DENTIST NITROUS RENEW	4,320.00	5,080.00
092020061807	6503	4293140	DENTIST MODERATE SEDATION	.00	100.00
092020061807	6503	4293145	DENTIST MOD SEDAT RENEW	.00	100.00
092020061807	6503	4293147	DENTIST MOD SED AD RENEW	3,160.00	3,260.00
092020061807	6503	4293150	DENTIST GA/DEEP SEDATION	.00	50.00
092020061807	6503	4293152	DENTIST GA/DEEP SED RENEW	700.00	750.00
092020061807	6503	4293205	HYGIENIST NEW LICENSE	2,300.00	3,800.00
092020061807	6503	4293210	HYGIENIST RENEWAL LICENSE	18,715.00	28,975.00
092020061807	6503	4293215	HYGIENIST JP EXAM	2,645.00	5,405.00
092020061807	6503	4293220	HYGIENIST ANESTH RENEW	3,600.00	5,460.00
092020061807	6503	4293222	HYGIENIST ANESTHESIA	520.00	1,360.00
092020061807	6503	4293225	HYGIENIST REINSTATE	400.00	1,320.00
092020061807	6503	4293235	HYGIENIST NITRIOUS OXIDE	920.00	1,640.00
092020061807	6503	4293237	HYGIENIST NIT OXIDE RENEW	3,240.00	4,520.00
092020061807	6503	4293305	RADIOLOGY NEW	280.00	5,840.00
092020061807	6503	4293307	RADIOLOGY RENEWAL	1,720.00	5,540.00

AGENCY 09 HEALTH
BUDGET UNIT 09202 BOARD OF DENTISTRY - INFO

CENTER	COMP	ACCOUNT	DESCRIPTION	CURRENT MONTH	YEAR-TO-DATE	
092020061807	6503	4293315	RADIOLOGY REINSTATE	.00	1,200.00	
092020061807	6503	4293405	ADA EXPANDED FUNCTION NEW	320.00	3,840.00	
092020061807	6503	4293410	ADA EXPAND FUNCTION RENEW	3,380.00	6,227.00	
092020061807	6503	4293415	ADA EXPAND FUNCT REINSTAT	.00	800.00	
092020061807	6503	4293420	ADA EXPAND FUNC ADMIN NIT	.00	1,560.00	
092020061807	6503	4293422	ADA EXPAND FUNC NIT RENEW	1,540.00	2,960.00	
092020061807	6503	4293505	CORPORATE NEW LICENSE	200.00	1,250.00	
092020061807	6503	4293510	CORPORATE RENEWAL	25.00	1,000.00	
092020061807	6503	4293600	TEMP LICENSE	150.00	1,800.00	
092020061807	6503	4293850	COLLABORATIVE SUPERVISION	.00	125.00	
ACCT: 4293		BUSINESS & OCCUP LICENSING (NON-GOVERNMENTAL)		83,835.00	156,502.00	*
092020061807	6503	4299000	OTHER LIC., PRMTS, & FEES	42,817.07	24,836.00	
ACCT: 4299		OTHER LIC, PRMTS, & FEES (NON-GOVERNMENTAL)		42,817.07	24,836.00	*
ACCT: 42		LICENSES, PERMITS & FEES		126,652.07	181,338.00	**
092020061807	6503	4595000	VERIFICATION LETTERS	75.00	1,325.00	
092020061807	6503	4595800	LIST OF PRACTITIONERS	300.00	5,250.00	
ACCT: 4595				375.00	6,575.00	*
ACCT: 45		CHARGES FOR SALES & SERVICES		375.00	6,575.00	**
092020061807	6503	4920045	NONOPERATING REVENUES	.00	13,951.05	
ACCT: 4920		NONOPERATING REVENUE		.00	13,951.05	*
ACCT: 49		OTHER REVENUE		.00	13,951.05	**
CNTR: 092020061807				127,027.07	201,864.05	***
CNTR: 092020061				127,027.07	201,864.05	****
CNTR: 0920200				127,027.07	201,864.05	*****
COMP: 6503				127,027.07	201,864.05	******
B UNIT: 09202				127,027.07	201,864.05	*******

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: January 18, 2021

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

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

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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.

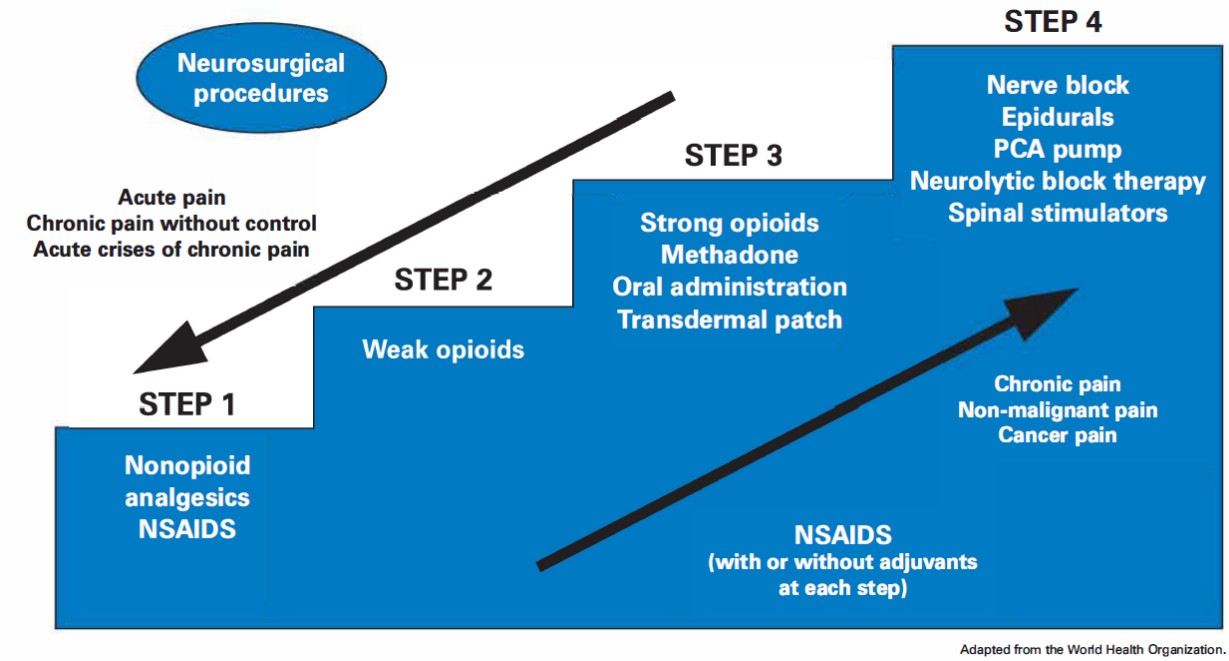
Strategies for acute pain control

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



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 guideline.

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/physical activity
- 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). Physical therapy and physical activity helps prevent joint stiffness, muscle tightness and improve overall physical function. Physical activities like swimming and walking have shown to be effective in decreasing pain and improving function (https://www.hhs.gov/fitness/be-active/importance-of-physical-activity/index.html). With appropriate identification of injured tissues and pain areas, along with appropriate guidance on frequency, intensity, time and type of activity, physical activity can be an effective way to manage and treat acute pain.

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. With the incorporation of mind/body or psychological therapies, cultural awareness is important – non-pharmacologic methods for addressing acute pain should both incorporate and be culturally appropriate. The South Dakota Department of Health website, Better Choices, Better Health, located at: https://goodandhealthysd.org/communities/betterchoicesbetterhealth/ has a number of resources for both providers and patients.

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.

While evidence-based research on the use of hypnosis to relieve pain is limited, a large, well-designed study conducted in 2000 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

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 noncombination 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

Prescribers may access patient MME/day information through the South Dakota PDMP at: https://southdakota.pmpaware.net/login

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. A listing of South Dakota-specific locations who take back drugs can be found at https://www.avoidopioidsd.com/take-action/take-back-sites/
- 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 – to include the utilization of non-opioid therapies – 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 - Medical	**Range of total MME in prescription (Rx)**	**Total # of pills in Rx (Example: Oxycodone 5mg)**
Thyroidectomy	0-37.5	0-5
Laparoscopic Anti0reflux (Nissen)	0-75	0-10
Appendectomy - Lap or Open	0-75	0-10
Laparoscopic Donor Nephrectomy	0-75	0-10
Hernia Repair - Minor or Major	0-75	0-10
Sleeve Gastrectomy	0-75	0-10
Laparoscopic Cholecystectomy	0-75	0-10
Open Cholecystectomy	0-112.5	0-15
Laparoscopic Colectomy	0-75	0-10
Open Colectomy	0-112.5	0-15
Illeostomy/Colostomy Creation, Re-siting, or Closure	0-112.5	0-15
Open Small Bowel Resection or Enterolysis	0-112.5	0-15
Prostatectomy	0-75	0-10
Carotid Endarterectomy	0-75	0-10
Cardiac Surgery via Median Sternotomy	0-37.5	0-25
Caesarean Section	0-30	0-20
Hysterectomy - Laparoscopic or Vaginal	0-112.5	0-15
Hysterectomy - Abdominal	0-150	0-20
Breast Biopsy or Lumpectomy	0-37.5	0-5
Lumpectomy + Sentinel Lymph Node Biopsy	0-37.5	0-5
Sentinel Lymph Node Biopsy Only	0-37.5	0-5
Wide Local Excision $\pm$ Sentinel Lymph Node Biopsy	0-150	0-20
Simple Mastectomy $\pm$ Sentinel Lymph Node Biopsy	0-150	0-20
Modified Radical Mastectomy or Axillary Lymph Node Dissection	0-225	0-30
Total Hip Arthroplasty	0-225	0-30
Total Knee Arthroplasty	0-375	0-50

Procedure - Dental	Range of total MME in prescription (Rx)	Total # of pills in Rx (Example: Oxycodone 5mg)
D7140 Dental Extraction*	0	0
D7210 Surgical Extraction*	0-75	0-10
D7220-7250 Surgical Extraction - Impacted Teeth*	0-112.5	0-15
Osseous Procedures - Include Bone Grafting and Alveoloplasty*	0-90	0-12
Dental Implant Surgery*	0-75	0-10
Soft Tissue Procedures*	0-45	0-6

*Start with Acetaminophen 1g PO 8 hours, Ibuprofen 400mg PO 8 hours unless contraindicated

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.

Opioid naïve patients

While "opioid naïve" is variably defined in the literature, for the purpose of this paper, opioid naïve patients are those who have not received opioids in the 30 days prior to the acute event or surgery.

As in all cases, opioids should be prescribed only when necessary, in the lowest effective dose, and for the duration necessary. Taking opioids for acute pain is associated with a greater likelihood of long-standing opioid use. Further, a greater amount of initial opioid exposure (i.e. higher total dose, longer duration prescription) is associated with greater risks of long-term use, misuse and overdose. Multiple studies have reported an increased risk of new, persistent opioid use after a prescription of opioids for acute pain in opioid naïve patients. Even patients who undergo relatively minor low-pain surgery are at an increased risk of long-term opioid use.

Risk factors for persistent opioid use after surgery include preoperative pain; medical comorbidities; depression; a history of drug, alcohol or tobacco use, lower socioeconomic status; and use of benzodiazepines or antidepressants.

Importantly, postsurgical opioid prescription in opioid naïve patients is also associated with an increase in overdose and misuse. In a retrospective study of 1,015,116 surgical patients who had no history of opioid misuse or ongoing opioid use, 56 percent received postoperative opioids and misuse was

identified in 0.6 percent of the patients after surgery. The duration of the opioid prescription was the strongest predictor of misuse. Each prescription refill was associated with a 44 percent increase in the rate of misuse, and each additional week of opioid use increased the risk of misuse by 20 percent.

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] When treating acute pain in a patient with opioid dependence, it is important to: 1) create a supportive, nonjudgmental environment; 2) establish whether other drugs are misused; 3) optimize nonopioid analgesia; 4) use increased doses of opioids compared with opioid-naïve patients but with careful monitoring for side effects; 5) change from parenteral to oral formulations of opioids as soon as possible; 6) continue opioid substitution therapy or replace with an appropriate opioid; 7) consider the withdrawal syndromes of other drugs taken; 8) minimize stress on the patient; and 9) allow for multidisciplinary discharge planning.

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

Pregnant, lactating or women of childbearing age

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 and review the PDMP AWARxE.

Of note, the American Academy of Pediatrics classifies morphine as compatible with breastfeeding; however, long-term effects on neurobehavior and development are unknown. Morphine is passed on to infants in breast milk in concentrations ranging from 0.8 to 12 percent of the maternal dose. Occasional doses of hydrocodone probably represent minimal risk to a nursing infant but higher and more frequent maternal doses may cause toxicity. In summary, low doses of as needed opioids used while breastfeeding are of minimal risk but infants should be observed for changes in breathing and sedation. Breastfeeding is best avoided in infants when the mother is using higher doses or chronic administration of opioids.

For reproductive age women who are not pregnant, discuss family planning and effects on pregnancy, counseled on contraception and offered pregnancy testing. Women who are not pregnant but of childbearing age and already on chronic opioids, should be counseled regularly on birth control. Pregnant women not on opioids should be urged to minimize their exposure.

Pediatrics and adolescents

To safely prescribe opioids to pediatric patients requires consultation with a pharmacist or clinician trained in age and weight-appropriate dosing. Of note, codeine has a black box warning against use in pediatric patients due to its incidence of accidental overdose. Per the Food and Drug Administration (FDA):

- Codeine should not be used to treat pain or cough and tramadol should not be used to treat pain in children younger than 12 years of age;
- Tramadol should not be used in children younger than 18 years to treat pain after surgery to remove the tonsils and/or adenoids;

- Codeine and tramadol should not be used in adolescents between 12 and 18 years who are obese or have conditions such as obstructive sleep apnea or severe lung disease, which may increase the risk of serious breathing problems; and
- Breastfeeding is not recommended when taking codeine or tramadol medicines due to the risk of serious adverse reactions in breastfed infants. These can include excess sleepiness, difficulty breastfeeding, or serious breathing problems that could result in death.

Adolescents prescribed opioids require special care.

A study by Miech et al. of 6,220 individuals found that adolescents exposed to opioids for traditional indications prior to high school graduation had a 33 percent increase in future opioid misuse. In addition, adolescents may have undiagnosed mental health issues, as well as early substance use disorder, leading to additional risk. In general, opioids should be avoided if possible in this population. If opioids are prescribed, ideally there will be close parental/caregiver supervision of opioid use whenever possible.

Patients with kidney and renal failure

Acetaminophen is an antipyretic analgesic with weak anti-inflammatory activity. It is metabolized extensively in the liver and in therapeutic doses, has no other important pharmacologic effects. Only 2-5 percent of the dose is excreted in the urine and there are no clinically significant changes observed in patients with kidney failure. Further, recent evidence suggests that lifetime cumulative doses of acetaminophen do not have an adverse effect on chronic kidney disease progression. However, liver injury can be seen with acetaminophen doses of <4,000 mg; therefore, the recommended max dose is 3,000 mg.

The American Geriatric Society recommends that the chronic use of all oral nonsteroidal anti-inflammatory drugs (NSAIDs), including high-dose aspirin, be avoided – especially in those greater than 75 years of age. Providers should be cautious about their use in patients with chronic kidney disease due to increased risks of bleeding, cardiovascular events, psychiatric events, and kidney-related complications in those with residual kidney function. NSAIDs are best reserved for specific indications of acute pain, limiting their use to the lowest effective dose and shortest duration.

Patients with chronic kidney disease are at increased risk for adverse effects of opioids due to reduced elimination and increased accumulation of the parent analgesic and/or active metabolites. Analgesics may also be removed by dialysis, leading to uncertain analgesic effects during treatment. (The risks of opioid toxicity, poor analgesic response, and drug interactions are determined largely by which enzyme system(s) metabolizes the opioid and the patient's genetics factors and medical conditions (most notably kidney or liver disease.))

Given the minimal changes in kinetics in kidney failure, hydromorphone, fentanyl, methadone, and buprenorphine may be potentially useful opioids. They appear to have stable analgesic affect during hemodialysis.

Geriatric patients

Geriatric 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 geriatric patients can be complicated by issues such as age-related physiologic changes, physical accessibility to treatment, cognitive impairment, coexisting illnesses, and polypharmacy. In general, geriatric patients are more vulnerable to the adverse effects of opioids to include: impaired drug clearance; polypharmacy; past response to opioids; increased likelihood of falls and fractures; chronic medical conditions; liver and renal malfunction; respiratory insufficiency; and cognitive impairment. Further, geriatric patients may under- or over-report their experience of pain due to functional impairment or psychological distress. Therefore, careful consideration must be given to the unique risks associated with prescribing opioids to geriatric patients to prevent harm.

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.

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.

Appendix 1. Acute Pain Workflow Guideline

Patient presents with acute pain or anticipated postoperative pain

Brief Pain Assessment:

In the emergency setting use opioids judiciously to alleviate pain when it overwhelms the patient's ability to contribute to the assessment.

Comprehensive Pain Assessment:

Inclusive of the following:

- Etiology and nature of the pain
- Appropriate diagnostics
- Medication history, including past and current opioid use
- Check PDMP (Prescription Drug Monitoring Program)

Acute Exacerbation of Chronic Pain

Treatment Options:

- Avoid prescribing increased dosage or additional opioids because of potential risks and adverse effect.
- Check prescription monitoring program (PDMP) for history of opioid prescriptions.
- Consult the patient's pain care agreement prior to prescribing any medications.
- Consider collaborating with the clinician managing the patient's chronic pain care plan, an interdisciplinary team or available resources to provide appropriate chronic pain management.
- Assess the patient's mental health status and social situation to determine if additional resources, e.g. social services, behavioral health, pain management or addiction medicine consult may be appropriate.

Non-traumatic tooth pain

Symptom Management could include:

Symptom Management could include:

- Long-acting local anesthetic.
- NSAID and/or acetaminophen.
- Topical anesthetic rinse for stomatitis or mouth ulcers.
- Antibiotics with presence of swelling or exudates in cheek or jaw.
- Chlorhexidine mouth wash for localized gum inflammation/infection.
- Stress need for dental follow up and avoid prescribing opioids without examination and diagnosis of the underlying reason for tooth pain, including appropriate tests and X-rays.

Other Acute Pain

See Page 2

Acute Pain Workflow Guideline

Other Acute Pain

Severe Pain that may require opioid:
(i.e. fracture, post operative pain, severe injury)

Determine if prescribing opioid Is appropriate.

Assess for risk:

- Personal or Family History of Substance abuse?
- Personal History of misuse of prescription controlled substance?
- Concurrent sedative, alcohol, muscle relaxant use?
- Respiratory insufficiency or sleep apnea?
- Identify risk factors such as age, delirium, dementia, and fall risk.
- Check PDMP

Is the answer yes to any of the above?

YES

High Risk Patients:

- Avoid prescribing opioid and use alternative if at all possible and refer to PCP or to pain specialist or provider experienced in case of opioid at risk patients.
- If must prescribe such as in severe injury.
  - Use lowest dose for shortest period of time.
  - Educate and document risks with patient
  - Monitor closely.
- Consider naloxone prescription
  - Particularly for total daily dosage > 50 mg Morphine Equivalents (MME).

NO

Does potential benefit of opioids outweigh potential risk?

YES

Prescription of Opioids:

- Educate patient on opioid risks/benefits to make informed decision and review side effects.
- If opioids are deemed necessary, prescribe only an amount to cover the expected pain or realistic duration of time to a follow-up appointment. (Tramadol is an atypical opioid and should be managed appropriately).
- Never prescribe long-acting/extended–release for acute pain.
- Caution using opioids in the elderly.
- Review safe driving, work, storage, and disposal.
- Follow-up with patient within 3-5 days.
- Maximize appropriate non-opioid therapies.

NO

Common pain conditions that are almost never indicated for opioids (non-inclusive):

- Fibromyalgia
- Headache
- Self-limited illness, i.e., sore throat
- Uncomplicated back and neck pain
- Uncomplicated musculoskeletal pain

Appropriate therapy and/or referral:

- Treat with other analgesics or NSAIDs, physical, psychological , interventional, or other appropriate non-opioid therapies.
- Reassure and provide patient education, include expected duration of pain episode and warning signs that would require immediate medical attention.
- Arrange appropriate follow-up.

Clinical Pearls

1. Over 5 million Americans report that they currently (within 30 days) abuse prescription opioids and 10.3 million have abused them at some point in their lifetime. It has been noted that although most of these pills originated from a licensed prescriber, only 20% of users were the legitimate recipient of the initial prescription, with 71% of users having received the drug through methods of diversion. In addition, it is reported that 55% of these people received pills for free from a family member or friends who had excess pills.[2,3,4]
2. In one study of 642 general surgery patients it was found that opioid pills are greatly over-prescribed for the treatment of acute postoperative pain in general surgery patients: over 70% of the prescribed pills were never taken. In this study, depending on the procedure, 22-82% of patients never took any opioid following surgery.[1]

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SUMMARY OF DRAFT ARSD 20:43:09 PROJECT

This is an educational summary only.
Please review the draft rules and/or current regulations for specific requirements and information.

Project History:

- The process below is not required as part of the statutorily defined rule promulgation process. However, as it has done historically, the Board incorporated the process below to ensure ample opportunity for stakeholder feedback.
- The Anesthesia Credentials Committee (ACC) presented areas in ARSD 20:43:09 identified for update at the *public* Board of Dentistry meeting held on June 26, 2020.
- A draft of proposed updates to ARSD 20:43:09 was presented, section by section, at a *public* Board of Dentistry meeting held on October 23, 2020. Following that meeting, the process to solicit stakeholder feedback began.
- The goal of the informal feedback phase is to obtain feedback, identify areas of concern or consensus, and address areas of concern where possible. As part of the stakeholder feedback process:
  - An online form to sign up to receive future notification was posted to the Board's website.
  - An online form to submit feedback was posted to the Board's website.
  - An outline of the process and all updated information was posted on the Board's website to keep stakeholders informed.
- A meeting to listen to stakeholder comments was held on December 17, 2020.
- A stakeholder meeting to outline the process moving forward was held on December 28, 2020.
- At its *public* Board of Dentistry meeting on January 8, 2021, the Board appointed a committee comprised of three Board members to further review the draft rules and work with stakeholders. The committee is comprised of a dentist that does not hold a sedation or anesthesia permit, a dentist that holds a general anesthesia and deep sedation permit, and a dentist that holds a moderate sedation permit and utilizes the services of a licensed anesthesia provider (LAP).
- The Board kept the public comment period open until January 29, 2021. After conclusion of the comment period, the Board appointed committee reviewed feedback that was received, and the draft rules were modified pursuant to that feedback.
- A second draft was released on May 7th.
- The Board solicited stakeholder feedback and kept the public comment period open until June 1st.
- The Board appointed committee reviewed feedback that was received, and the draft rules were modified pursuant to that feedback.

Future Project Considerations:

- If these anesthesia rules are promulgated, a review the inspection process, including the current patient procedure component of the inspection, will be necessary. Stakeholders will have an opportunity to review and provide feedback regarding any proposed changes in the inspection process.

20:43:09:01 Definitions.

- Updates definitions - ADA definitions.

20:43:09:02 Prohibitions.

- Incorporates authority for host dentist to advertise sedation and anesthesia.

20:43:09:03 General anesthesia and deep sedation permit requirements.

- Updates permit requirements. Requires ACLS for all and PALS if sedating patient under 12. Creates a path to obtain a permit both for those with recent anesthesia experience and those with gaps in practice.
- Specifies minimum anesthesia team when general anesthesia or deep sedation is being administered (1 provider, 2 monitors = 3). Expands anesthesia team to those with independent authority to monitor patients under anesthesia.

20:43:09:04 Moderate sedation permit requirements.

- Updates permit requirements. Requires ACLS. Creates a path to obtain a permit both for those with recent sedation experience and those with gaps in practice.
- Requires residency training, along with PALS, for those sedating pediatric patients under 12 years old.
- Requires PALS if utilizing a LAP to sedate pediatric patients under 12 years old.
- Specifies minimum anesthesia team when moderate sedation is being administered (1 provider, 1 monitor = 2). Expands anesthesia team to those with an independent scope of practice to monitor patients under anesthesia.

20:43:09:04.01 Moderate sedation course requirements.

- Specifies requirements for moderate sedation educational courses and provides for an annual review.
- The ADA does not accredit moderate sedation courses, so this rule incorporates criteria set forth in the current ADA Guidelines for Teaching Pain Control to Dentists and Dental Students.

20:43:09:04.02 Host permit requirements.

- Reduces barriers and increases access to care. ARSD currently in effect requires dentists to hold a moderate sedation permit to administer moderate sedation or to utilize a LAP.
- This draft rule creates and sets forth requirements for a new host permit that would be available for dentists that would like to utilize a LAP, but not administer moderate sedation themselves. Host permit also incorporates authority to monitor patients as part of the anesthesia team.
- Although a host dentist will not be administering sedation, he or she is part of the overall anesthesia team. The host dentist will most often be selecting a LAP to come into his or her office, will be involved with patient selection, and will be operating in the airway of the sedated patient. The training required for a host dentist is outlined in the next rule.

20:43:09:04.03 Host course requirements.

- Outlines requirements for host permit educational courses and provides for an annual review. Any course that meets these requirements would be eligible for review and approval on an annual basis. Two initial courses have been identified that would provide this training, each require approximately 6-8 hours of training, involve a relatively small financial investment, and are available online.

20:43:09:04.04 Anesthesia or sedation education – Other.

- Increases portability. Allows the Board to approve sedation or anesthesia training accepted in any state or jurisdiction that resulted in an equivalent permit being issued or maintained in that state or jurisdiction.

20:43:09:04.05 Employing or contracting with licensed anesthesia provider that provides general anesthesia, deep sedation, or moderate sedation in dental office.

- Helps ensure patient safety. Sets forth requirements for dentists that utilize a LAP, based on patient safety issues identified in other states. Specifies minimum anesthesia team when general anesthesia or deep sedation is being administered (1 LAP, 1 host, 1 monitor = 3). Minimum anesthesia team required for administration of moderate sedation is 1 LAP, 1 host = 2.

20:43:09:04.06 Utilizing licensed anesthesia provider for general anesthesia and deep sedation or moderate sedation in ambulatory surgery center or hospital.

- Continues exemption for utilization of LAP in licensed ambulatory surgery centers or hospitals from permit requirements.

20:43:09:05 Nitrous oxide inhalation analgesia permit requirements -- Dentists.

- Helps ensure patient safety and regulatory consistency. Updates permit requirements, incorporates scavenger system requirement, and incorporates timeline for education or training to maintain consistency in regulation. Allows the administration of nitrous oxide + MRD of one enteral drug to patients 12 years and older. If a patient is under 12 years old, nitrous oxide can be administered.

20:43:09:06 Nitrous oxide inhalation analgesia permit requirements -- Dental hygienists and registered dental assistants.

- Helps ensure patient safety and regulatory consistency. Updates permit requirements, incorporates equipment requirements to maintain consistency in regulation.

20:43:09:06.02 Minimal sedation.

- Helps ensure pediatric patient safety. Specifies that a dentist may administer, without a sedation or anesthesia permit, up to the MRD of one enteral drug to patients 12 years or older to achieve a state of minimal sedation.

20:43:09:08 Application for permits -- Renewal.

- Incorporates host permit into renewal process.
- Helps ensure patient safety. Requires a dentist that holds a general anesthesia or deep sedation permit complete at least 50 cases of general anesthesia or deep sedation annually. Requires a dentist that holds a moderate sedation permit complete at least 12 cases of moderate sedation annually. Does not have a case requirement for host permit. Requires a dentist that holds a host, moderate, or general anesthesia and deep sedation permit document completion of team training on emergency response protocols at least annually in the setting where the anesthesia or sedation is being provided.
- Data has been shared freely with stakeholders throughout the process highlighting that a small minority of states have an annual case requirement. However, other models and constructs were review and considered - including the medical model, maintenance of certification for anesthesia providers, credentialing requirements within licensed healthcare facilities, and maintenance of non-core privileges. Case requirements is a consistent component of these models and has been incorporated in this draft to help

ensure active practice and recent experience for not just the anesthesia provider, but the entire functioning anesthesia team.

- Note, the current advisory opinion recommends 25 moderate sedation cases per year. The current draft has reduced that number to 12.

20:43:09:09 Reports of adverse conditions.

- Requires reporting of adverse conditions and incorporates host permit.

20:43:09:11 Inspection.

- Incorporates criteria for anesthesia inspectors that would allow a variety of professions to act as inspectors, if they have the requisite education and experience in a dental office. Clarifies the timing of inspections currently required.

20:43:09:12 Requirements of inspection.

- Lists the components of a facility, host, moderate and general anesthesia and deep sedation inspection. Allows the flexibility to evaluate alternative inspection models and formats, as it removes the live patient procedure and monitoring requirement.

20:43:09:13 Equipment -- Moderate sedation.

- Updates equipment requirements for moderate sedation.

20:43:09:13.01 Equipment -- General anesthesia and deep sedation.

- Updates equipment requirements for general anesthesia and deep sedation.

20:43:09:14 Clinical guidelines.

- Broadens guidelines and references general standard of care.

20:43:09:17 Emergency response protocol.

- Incorporates requirement for written emergency response protocol.

20:43:03:07 Continuing education requirements -- Dentists

- Includes host permit in anesthesia continuing education requirements.

ADMINISTRATIVE RULES DRAFT PROPOSAL

Minimal - No Permit

- Training: Accredited Dental School Curriculum [*Reference: CODA Standards*]

- Dentist may administer up to MRD of one enteral drug to achieve minimal sedation for patients 12 years or older.

Nitrous Oxide - Permit

- Training: Nitrous Oxide Course [*Reference: ADA Guidelines*]

- Dentist may administer Nitrous Oxide to patients of all ages

- Dentist may administer Nitrous Oxide + up to MRD of one enteral drug to achieve minimal sedation for patients 12 years or older.

Host - Permit

- Training: Host Course [*Reference: Host Training/Online course*]

- Ongoing: Inspection (1 per 5 yr) + CE (25hrs per 5 yr) + Team training (Annually)

- Dentist may utilize licensed anesthesia provider (LAP) to administer all levels of sedation to patients of all ages, based on authority of LAP. Dentist cannot administer.

Moderate Sedation - Permit

- Training: Moderate Sedation Course [*Reference: ADA Guidelines*]

- Ongoing: Cases (12 per yr) + Inspection (1 per 5 yr) + CE (25hrs per 5 yr) + Team training (Annually)

- Dentist may administer up to Moderate Level to patients 12 years or older.

- Incorporates Host + Nitrous Oxide authority

Moderate Sedation + Pediatric - Permit

- Training: Accredited Residency with pediatric moderate sedation training [*Reference: CODA Standards & ADA Guidelines*]

- Ongoing: Cases (12 per yr) + Inspection (1 per 5 yr) + CE (25hrs per 5 yr) + Team training (Annually)

- Dentist may administer up to Moderate Level to patients of all ages.

- Incorporates Host + Nitrous Oxide authority

General Anesthesia/Deep Sedation - Permit

- Training: Accredited Residency with general anesthesia and deep sedation training [*Reference: CODA Standards*]

- Ongoing: Cases (50 per yr) + Inspection (1 per 5 yr) + CE (25hrs per 5 yr) + Team training (Annually)

- Dentist may administer up to General/Deep Level to patients of all ages.

- Incorporates Moderate + Host + Nitrous Oxide authority

This is an educational summary only.
Please review the draft rules and/or current regulations for specific requirements and information.

ADMINISTRATIVE RULES DRAFT PROPOSAL
Routine Inspections

Facility Inspection - Temporary Host, Moderate, Moderate + Pediatric, or General Anesthesia and Deep Sedation

Facility inspection required to obtain a temporary permit includes an evaluation of:
1. Facility;
2. Drugs, emergency medications, staff, equipment; and
3. Technical competency of the dentist and staff to effectively respond to emergencies.

Temporary Permit Issued (12 Months)

A temporary permit allows the dentist to administer sedation/anesthesia or host a licensed anesthesia provider for a period of up to 12 months. During the term of the temporary permit, the dentist must pass a full inspection to obtain a regular permit. To maintain the permit, the dentist must pass a full inspection once in every five year licensure cycle.

H

Full Inspection - Host Permit

Full inspection required to obtain and maintain a host permit includes an evaluation of:
1. Facility;
2. Drugs, emergency medications, staff, equipment;
3. Technical competency of the permit holder and staff to effectively respond to emergencies; and
4. Appropriate patient anesthesia records.

M

Full Inspection - Moderate Sedation Permit or Moderate Sedation + Pediatric Permit

Full inspection required to obtain and maintain a Moderate or Moderate + Pediatric permit includes an evaluation of:
1. Facility;
2. Drugs, emergency medications, staff, equipment;
3. Technical competency of the permit holder and staff to effectively respond to emergencies;
4. Appropriate patient anesthesia records; and
5. Technical competency of the permit holder to safely administer the level of anesthesia or sedation authorized by the permit.

GA

Full Inspection - General Anesthesia and Deep Sedation Permit

Full inspection required to obtain and maintain a General Anesthesia and Deep Sedation permit includes an evaluation of:
1. Facility;
2. Drugs, emergency medications, staff, equipment;
3. Technical competency of the permit holder and staff to effectively respond to emergencies;
4. Appropriate patient anesthesia records; and
5. Technical competency of the permit holder to safely administer the level of anesthesia or sedation authorized by the permit.

This is an educational summary only.
Please review the draft rules and/or current regulations for specific requirements and information.

Host Permit Courses*:

American Society of Anesthesiologists (ASA) Safe Sedation Training (SST):
This is an online course with nine modules that must be completed.

Module 1: Course Introduction
Module 2: Continuum of Sedation
Module 3: Pre-Procedure Patient Evaluation and Preparation
Module 4: Rescue
Module 5: Respiratory Complications
Module 6: Patient Safety Monitoring
Module 7: Airway Assessment and Management
Module 8: Sedation Pharmacology
Module 9: Recovery

American Dental Society of Anesthesiology (ADSA) On Demand Assistant Courses:
The six individual online courses listed below must be completed. Other courses are available in the ADSA On Demand catalog.

1. Anesthetic Drugs (1 hour)
2. Common Airway Complications (1 hour)
3. Identifying Roles in an Anesthetic Emergency (1 hour)
4. Emergencies Scenarios: An Interactive Experience (1.5 hours)
5. Intraoperative + Postoperative Patient assessment (1.5 hours)
6. Preoperative Assessment (1.5 hours)

The host course is not limited to those above. Any course that meets the criteria outlined in rule would be eligible for review and approval.

* Courses are subject to Board approval.

CHAPTER 20:43:09

ANESTHESIA AND ANALGESIA

Section

20:43:09:14 Clinical guidelines.

20:43:09:15 Intravenous line.

20:43:09:16 Anesthesia credentials committee.

20:43:09:17 Emergency response protocol.

20:43:09:01. Definitions. Terms used in this chapter mean:

(1) "Minimal sedation," a minimally depressed level of consciousness, produced by a ~~single enteral drug administered in a dose appropriate for the unsupervised treatment of anxiety, insomnia, or pain that does not exceed the maximum recommended dose Incremental dosing may be utilized. Patient retains the ability~~ pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected;

(2) "Nitrous oxide inhalation analgesia," the administration by inhalation of a combination of nitrous oxide and oxygen producing an altered level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond purposefully to physical or verbal command;

(3) "Moderate sedation," a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. ~~Reflex withdrawal from a painful stimulus is not considered a purposeful response.~~ No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained~~. Moderate sedation can be administered either orally or parenterally~~;

(4) "Deep sedation," a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function ~~independently~~ may be impaired. ~~Reflex withdrawal from a painful stimulus is not considered a purposeful response.~~ Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained;

(5) "General anesthesia," a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function ~~independently~~ is often impaired. Patients ~~frequently~~ often require assistance in

maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired;

(6) "Incremental dosing," administration of multiple doses of a drug until a desired effect is reached but not to exceed the maximum recommended dose (MRD);

(7) "Maximum recommended dose," maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use;

(8) "Accredited," a program accredited by the American Dental Association Commission on Dental Accreditation.

Source: 9 SDR 49, effective October 25, 1982; 12 SDR 151, 12 SDR 155, effective July 1, 1986; transferred from §§ 20:43:04:08 and 20:43:04:10, 19 SDR 32, effective September 6, 1992; 37 SDR 131, effective January 6, 2011.

General Authority: SDCL 36-6A-14(1).

Law Implemented: SDCL 36-6A-14.

20:43:09:02. Prohibitions. A dentist licensed in this state may not administer general anesthesia and deep sedation, moderate sedation, or nitrous oxide inhalation analgesia unless the dentist has obtained the permit required in § 20:43:09:03, 20:43:09:04, or 20:43:09:05.

Any dentist who advertises sedation using terms other than minimal sedation or nitrous oxide inhalation analgesic must have a general anesthesia and deep sedation, ~~or~~ moderate sedation permit, or host permit.

Source: 19 SDR 32, effective September 6, 1992; 37 SDR 131, effective January 6, 2011.

General Authority: SDCL 36-6A-14(1).

Law Implemented: SDCL 36-6A-14, 36-6A-16.

20:43:09:03. General anesthesia and deep sedation permit requirements. The board may issue a permit to a licensed dentist to ~~use~~ administer general anesthesia and deep sedation ~~for~~ to dental patients on an outpatient basis if the dentist ~~meets the following requirements~~:

(1) Has successfully completed an accredited advanced dental education residency program in oral and maxillofacial surgery or dental anesthesiology that provides comprehensive and appropriate training necessary to administer general anesthesia or deep sedation ~~as evidenced by:~~. If the residency was completed more than 12 months prior to application, the applicant must also:

(a) Hold a permit to administer general anesthesia and deep sedation, or an equivalent permit, in another state and have completed a minimum of 50 general anesthesia or deep sedation cases in the 12 months prior to application; or

(b) Undergo a review by the board of applicant's recent training and experience and complete supplemental training, education, evaluation, or remediation required by the board. The applicant shall pay all costs of the training, education, evaluation, remediation, and proceedings; and

~~(a) Designation as a diplomate of the American Board of Oral and Maxillofacial Surgery;~~

~~(b) Designation as a member of the American Association of Oral and Maxillofacial Surgeons;~~

~~(c) Designation as a fellow of the American Dental Society of Anesthesiology;~~

~~(d) Completion of an accredited residency in oral and maxillofacial surgery; or~~

~~(e) Completion of an accredited residency in dental anesthesiology;~~

(2) ~~Meets~~ Has fulfilled the requirements ~~of~~ outlined in §§ 20:43:09:12 and 20:43:09:13.01; and

(3) Is certified in administering ~~advanced cardiovascular life support~~ Advanced Cardiovascular Life Support by the American Heart Association or an equivalent program approved by the board and, if providing general anesthesia or deep sedation to a patient under 12 years of age, is certified in Pediatric Advanced Life Support by the American Heart Association or an equivalent program approved by the board.~~; and~~

~~(4) Employs auxiliary personnel who hold a permit to monitor patients under general anesthesia, deep sedation, or moderate sedation.~~

A dentist with a general anesthesia and deep sedation permit may not administer general anesthesia or deep sedation or monitor a patient without the presence and assistance of ~~qualified auxiliary personnel~~ at least two individuals who hold a permit to monitor patients under general anesthesia, deep sedation, or moderate sedation or who are otherwise authorized by law to monitor patients under general anesthesia, deep sedation, or moderate sedation.

A dentist administering general anesthesia or deep sedation must be proficient in airway management and advanced cardiac life support, must be capable of providing intravenous access, and ~~shall~~ must apply the current standard of care ~~to~~ including, but not limited to, continuously

~~monitor~~ monitoring and ~~evaluate~~ evaluating the patient's blood pressure, pulse, respiratory function, and cardiac activity.

A general anesthesia and deep sedation permit ~~precludes the need for~~ incorporates the authority granted by a moderate sedation permit, ~~or~~ a nitrous oxide inhalation analgesia permit, and a host permit.

Source: 9 SDR 49, effective October 25, 1982; 12 SDR 151, 12 SDR 155, effective July 1, 1986; transferred from § 20:43:04:08, 19 SDR 32, effective September 6, 1992; 26 SDR 37, effective September 20, 1999; 37 SDR 131, effective January 6, 2011; 42 SDR 83, effective December 3, 2015.

General Authority: SDCL 36-6A-14(1)(3)(13)(14).

Law Implemented: SDCL 36-6A-14(1)(3)(13)(14)(22).

20:43:09:04. Moderate sedation permit requirements. The board may issue a permit to a licensed dentist to ~~use~~ administer moderate sedation ~~for~~ to dental patients 12 years of age and older on an outpatient basis if the dentist ~~meets the following requirements~~:

(1) Has successfully completed a ~~board approved~~ moderate sedation course ~~that meets the objectives and content as described in Part 5 of the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. A board approved course must include a minimum of 60 hours of instruction plus management of at least 20 patients and clinical experience in management of the compromised airway and establishment of intravenous access;~~ approved by the board pursuant to § 20:43:04.01. If the course was completed more than 12 months prior to application, the applicant must also:

(a) Hold a permit to administer moderate sedation, or an equivalent permit, in another state and have completed a minimum of 12 moderate sedation cases in the 12 months prior to application; or

(b) Undergo a review by the board of applicant's recent training and experience and complete supplemental training, education, evaluation, or remediation required by the board. The applicant shall pay all costs of the training, education, evaluation, remediation, and proceedings; and

(2) ~~Meets~~ Has fulfilled the requirements outlined in §§ 20:43:09:12 and 20:43:09:13; and

(3) Is certified in administering ~~advanced cardiovascular life support~~ Advanced Cardiovascular Life Support by the American Heart Association or an equivalent program approved by the board~~; and~~.

~~(4) Employs auxiliary personnel who hold a permit to monitor patients under general anesthesia, deep sedation, or moderate sedation.~~

A dentist with a moderate sedation permit may not administer moderate sedation or monitor a patient without the presence and assistance of ~~qualified auxiliary personnel~~ at least one individual who holds a permit to monitor patients under general anesthesia, deep sedation, or moderate sedation or who is otherwise authorized by law to monitor patients under general anesthesia, deep sedation, or moderate sedation.

A dentist ~~using a parenteral route of administration must limit the use of pharmacological agents to those for which there are reversal agents~~ administering moderate sedation cannot use general anesthetics, must be proficient in airway management and advanced cardiac life support, must be capable of providing intravenous access, and must apply the current standard of care including, but not limited to, continuously monitoring and evaluating the patient's blood pressure, pulse, respiratory function, and cardiac activity.

A dentist ~~providing~~ that meets the requirements of this rule may be authorized by the board to administer moderate sedation to a child under 12 years of age ~~must also document appropriate training in pediatric sedation techniques, according to the Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures, and in pediatric resuscitation, including the recognition and management of pediatric airway and respiratory problems and must sign an affidavit certifying that the dentist understands the requirements of the Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures~~ only if the dentist has successfully completed an accredited advanced dental education residency program that provides comprehensive and appropriate training necessary to administer and manage pediatric moderate sedation and is certified in Pediatric Advanced Life Support by the American Heart Association or an equivalent program approved by the board. A dentist that does not meet these requirements by June 30, 2022 cannot administer moderate sedation to a child under 12 years of age.

~~A dentist using moderate sedation must adhere to the standards of the Guidelines for the Use of Sedation and General Anesthesia by Dentists.~~

~~A dentist intending to produce a given level of sedation~~ A dentist who administers moderate sedation shall maintain a margin of safety and a level of consciousness that does not approach general anesthesia or deep sedation and must be able to rescue a patient whose level of sedation becomes deeper than initially intended. ~~A dentist using moderate sedation must be proficient in airway management and advanced life support and capable of providing intravenous access. A dentist using moderate sedation shall apply the current standard of care to continuously monitor and evaluate the patient's blood pressure, pulse, respiratory function, and cardiac activity.~~

~~——~~If moderate sedation results in a general anesthetic state, the requirements outlined in § 20:43:09:03 for general anesthesia and deep sedation apply.

A moderate sedation permit ~~precludes the need for~~ incorporates the authority granted in a nitrous oxide inhalation analgesia permit and host permit. A dentist that holds a moderate sedation permit and utilizes a licensed anesthesia provider to administer general anesthesia, deep sedation, or moderate sedation to a patient under 12 years of age must also be certified in Pediatric Advanced Life Support by the American Heart Association or an equivalent program approved by the board.

Source: 9 SDR 49, effective October 25, 1982; 12 SDR 151, 12 SDR 155, effective July 1, 1986; transferred from § 20:43:04:11, 19 SDR 32, effective September 6, 1992; 37 SDR 131, effective January 6, 2011; 42 SDR 83, effective December 3, 2015.

General Authority: SDCL 36-6A-14(1)(3)(13)(14).

Law Implemented: SDCL 36-6A-14(1)(3)(13)(14)(22).

~~**References:** "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students," 2012 Edition, American Dental Association. Copies may be obtained from the American Dental Association at www.ada.org free of charge. "Guidelines for the use of Sedation and General Anesthesia by Dentists," 2012 Edition, American Dental Association. Copies may be obtained from the American Dental Association at www.ada.org free of charge. "Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update," 2011 Edition, American Academy of Pediatrics.~~

~~Copies may be obtained from the American Academy of Pediatrics at www.aapd.org free of charge.~~

20:43:09:04.01. Moderate sedation course requirements. The board may approve a moderate sedation training course pursuant to subdivision § 20:43:09:04(1) if the course meets the following requirements:

(1) The course satisfies all objectives and content as described in Part 5 of the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students;

(2) The course includes a minimum of 60 clock hours of coursework that is provided through didactic instruction;

(3) The course includes the administration of moderate parenteral sedation via the intravenous route to at least 20 individually managed live patients of the appropriate age. The course participant must be listed on the anesthesia record, administer the medications, and document the administration and physiologic findings on the anesthesia record;

(4) The course includes clinical experience in the management of the compromised airway and establishment of intravenous access;

(5) The course is directed by a dentist or physician qualified by experience and training, including the following:

(a) The course director has not been disciplined for conduct that, in the opinion of the board, would jeopardize the safety of the public or patients;

(b) The course director holds a current permit or license to administer general anesthesia and deep sedation or moderate sedation in at least one state;

(c) The course director has at least three years of experience administering general anesthesia and deep sedation or moderate sedation, including formal postdoctoral residency training in anxiety and pain control;

(6) The course has a clinical participant-faculty ratio of not more than four-to-one;

(7) The course includes a mechanism for the course participant to evaluate the performance of individuals presenting the course material, a summary of which is maintained and available for review;

(8) The course provides additional clinical experience if the course participant has not achieved competency within the time allotted for the course; and

(9) The course director certifies the competency of a course participant in each moderate sedation technique including instruction, clinical experience, managing the airway, intravascular or intraosseous access, and reversal medications before the course participant is issued documentation verifying successful completion of the course.

Annually the board will conduct a review of moderate sedation courses that have submitted documentation necessary to verify that the course requirements outlined in this rule have been met. A course director may be required to participate in an interview as part of the course review.

Source:

General Authority: SDCL 36-6A-14(1)(3)(13).

Law Implemented: SDCL 36-6A-14(1)(3)(13)(22).

References: "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students," 2016 Edition, American Dental Association. Copies may be obtained from the American Dental Association at www.ada.org free of charge.

20:43:09:04.02. Host permit requirements. The board may issue a permit to a licensed dentist to utilize a licensed anesthesia provider to administer general anesthesia, deep sedation or moderate sedation in compliance with § 20:43:09:04.05 on an outpatient basis to a dental patient that the dentist is performing a dental procedure on, if the dentist:

(1) Has successfully completed a course approved by the board that meets the criteria outlined in § 20:43:09:04.03. If the course was completed more than 12 months prior to application, the applicant must also hold a permit equivalent to the host permit in another state;

(2) Has fulfilled the requirements outlined in § 20:43:09:12;

(3) Has fulfilled the requirements outlined in §§ 20:43:09:13 or 20:43:09:13.01, based on the highest level of sedation or anesthesia that will be provided to a patient that the dentist will be performing a dental procedure on; and

(4) Is certified in administering Advanced Cardiovascular Life Support by the American Heart Association or an equivalent program approved by the board.

A dentist that holds a host permit is authorized to monitor a patient under general anesthesia, deep sedation, or moderate sedation. A dentist that holds a host permit and utilizes a licensed anesthesia provider to provide general anesthesia, deep sedation, or moderate sedation

to a patient under 12 years of age must also be certified in Pediatric Advanced Life Support by the American Heart Association or an equivalent program approved by the board.

Source:

General Authority: SDCL 36-6A-14(1)(13)(14).

Law Implemented: SDCL 36-6A-14(1)(13)(14)(22).

20:43:09:04.03. Host course requirements. The Board may approve an educational course pursuant to subdivision § 20:43:09:04.02(1) if the course meets the following requirements:

(1) The course provides instruction and an assessment of knowledge and skill in the following areas:

(a) Preoperative patient assessment;

(b) Emergency Scenarios and Rescue;

(c) Respiratory complications;

(d) Patient safety and monitoring;

(e) Airway assessment and management;

(f) Anesthetic drugs; and

(g) Recovery; and

(2) Upon completion, the course participant is able to:

(a) Identify a high-risk patient;

(b) Differentiate between levels of sedation;

(c) Monitor a patient receiving sedation or anesthesia; and

(d) Rescue a patient from deeper-than-intended level of sedation;

Annually the board will conduct a review of each course that has provided the documentation necessary to verify the course requirements outlined in this rule have been met. A course director may be required to participate in an interview as part of the course review.

Source:

General Authority: SDCL 36-6A-14(1)(3)(13).

Law Implemented: SDCL 36-6A-14(1)(3)(13)(22).

20:43:09:04.04. Anesthesia or sedation education – Other. At its discretion, in lieu of the requirement outlined in §§ 20:43:09:03(1), 20:43:09:04(1), or 20:43:09:04.02(1), the board may consider training or experience accepted in any state or jurisdiction that resulted in an

equivalent permit being issued to the applicant by that state or jurisdiction or maintained by the applicant in that state or jurisdiction. The board may deem such training or experience substantially equivalent and issue a permit or may require that the applicant complete supplemental training, education, evaluation, or remediation before a permit will be issued. The applicant shall pay all costs of the training, education, evaluation, remediation, or proceedings.

Source:

General Authority: SDCL 36-6A-14(1)(13).

Law Implemented: SDCL 36-6A-14(1)(13)(22).

20:43:09:04.01~~5~~. Employing or contracting with licensed anesthesia provider that provides general anesthesia, deep sedation, or moderate sedation in dental office. ~~If a~~ A dentist ~~employs or contracts with a~~ that holds a general anesthesia and deep sedation, moderate sedation or host permit and utilizes a licensed anesthesia provider ~~that provides~~ to administer general anesthesia, deep sedation, or moderate sedation ~~for dental patients~~ in a dental office or facility on an outpatient basis to a dental patient that the dentist is performing a dental procedure on ~~the dentist~~ must:

(1) Have a written contract or written agreement with the licensed anesthesia provider ~~stating~~ that outlines the appropriate roles and responsibilities of the dentist, licensed anesthesia provider, and clinical staff for the administration of sedation or anesthesia, which shall include a requirement that the licensed anesthesia provider:

(a) Collaborate with the dentist on patient selection based on clearly defined patient selection criteria;

(b) ~~that the licensed anesthesia provider must~~ Be continuously ~~be~~ present during the administration of the anesthetic ~~and remain~~ ;

(c) Remain with the patient until the patient is communicating effectively;

(d) Transfer care of the patient to an individual who holds a permit to monitor patients under general anesthesia, deep sedation, or moderate sedation or who is otherwise authorized by law to monitor patients under general anesthesia, deep sedation, or moderate sedation; and

(e) Remain on the premises of the facility where the anesthesia was administered until the anesthetized patient is fully recovered and discharged from the facility to a responsible adult;

(2) Notify the board ~~that~~ of the location of any dental office or facility where general anesthesia, deep sedation, or moderate sedation services ~~are being~~ will be provided ~~and the location of the facility where such services are being provided~~;

(3) ~~Employ~~ Ensure the availability of auxiliary personnel that are certified in administering basic life support by the American Heart Association for the Healthcare Provider, the American Red Cross for the Professional Rescuer, or an equivalent program approved by the board;

(4) ~~Meet the equipment~~ Verify that the requirements for the level of anesthesia or sedation being provided, as required in § 20:43:09:13 or 20:43:09:13.01, are satisfied;

(5) Hold a general anesthesia and deep sedation, moderate sedation, or host permit and have completed the inspection, as required in § 20:43:09:12;

(6) Ensure that the licensed anesthesia provider holds a license in good standing in South Dakota; ~~and~~

(7) ~~Ensure that the licensed anesthesia provider holds anesthesia privileges at a licensed ambulatory surgery center or licensed hospital.~~ Ensure that the qualifications and competency of the licensed anesthesia provider to deliver the necessary sedation or anesthesia services have been meaningfully verified; and

(8) Ensure that the licensed anesthesia provider is not administering general anesthesia and deep sedation without the presence and assistance of at least one individual, other than the dentist completing the dental procedure, who holds a permit to monitor patients under general anesthesia, deep sedation, or moderate sedation, or is otherwise authorized by law to monitor patients under general anesthesia and deep sedation.

Source: 37 SDR 131, effective January 6, 2011; 42 SDR 83, effective December 3, 2015.

General Authority: SDCL 36-6A-14(1)(13)(14).

Law Implemented: SDCL 36-6A-14(1)(13)(14)(22).

20:43:09:04.02~~2~~6. Utilizing licensed anesthesia provider for general anesthesia and deep sedation or moderate sedation in ambulatory surgery center or hospital. No permit is required if a dentist utilizes the services of a licensed anesthesia provider for dental patients in ~~an~~ a licensed ambulatory surgery center or hospital.

Source: 37 SDR 131, effective January 6, 2011.

General Authority: SDCL 36-6A-14(1).

Law Implemented: SDCL 36-6A-14, 36-6A-16.

20:43:09:05. Nitrous oxide inhalation analgesia permit requirements -- Dentists. The board may issue a permit to a dentist to ~~use~~ administer nitrous oxide inhalation analgesia sedation ~~for~~ to dental patients on an outpatient basis if the dentist ~~meets the following requirements~~:

(1) ~~Meets one of the following educational requirements:~~ Is certified in administering basic life support by the American Heart Association for the Healthcare Provider, the American Red Cross for the Professional Rescuer, or an equivalent program approved by the board; and

~~(a)~~ (2) Has successfully completed a board approved course that meets the objectives and content as described in Part 4 of the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students~~;~~ or

~~(b) Has taken~~ a course in nitrous oxide inhalation analgesia sedation ~~while a student in an accredited school of dentistry;~~ through an accredited dental school; and

(a) Completed the course within thirteen months prior to application; or

(b) Completed the course more than thirteen months prior to application, has legally administered nitrous oxide inhalation analgesia for a period of time during the three years preceding application, and attests to his or her current clinical proficiency to administer nitrous oxide inhalation analgesia.

~~(2) Has equipment for administering nitrous oxide inhalation analgesia with fail-safe features and a 20 percent minimum oxygen flow;~~

~~(3) Is certified in administering basic life support by the American Heart Association for the Healthcare Provider, the American Red Cross for the Professional Rescuer, or an equivalent program approved by the board; and~~

~~(4) Employs auxiliary personnel who are certified in administering basic life support by the American Heart Association for the Healthcare Provider, the American Red Cross for the Professional Rescuer, or an equivalent program approved by the board~~.

A dentist that administers nitrous oxide inhalation analgesia must use equipment with fail-safe features, a 20 percent minimum oxygen flow, and a scavenger system.

~~A~~ If a patient is 12 years of age or older, a dentist may administer nitrous oxide inhalation analgesia in combination with a single enteral drug to achieve ~~a minimally depressed level of consciousness~~ minimal sedation only if the maximum recommended dose of the enteral drug is

not exceeded. Incremental dosing may be utilized. A dentist may not administer nitrous oxide inhalation analgesia used in combination with more than one enteral drug or by dosing a single enteral drug in excess of the maximum recommended dose unless the dentist holds the appropriate general anesthesia and deep sedation permit or moderate sedation permit.

Source: 9 SDR 49, effective October 25, 1982; 12 SDR 151, 12 SDR 155, effective July 1, 1986; transferred from § 20:43:04:12, 19 SDR 32, effective September 6, 1992; 37 SDR 131, effective January 6, 2011; 42 SDR 83, effective December 3, 2015.

General Authority: SDCL 36-6A-14(1)(3)(13)(14).

Law Implemented: SDCL 36-6A-14(1)(3)(13)(14)(22).

Reference: "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students," ~~2012~~ 2016 Edition, American Dental Association. Copies may be obtained from the American Dental Association at www.ada.org free of charge.

20:43:09:06. Nitrous oxide inhalation analgesia permit requirements -- Dental hygienists and registered dental assistants. The board may issue a permit to a dental hygienist or a registered dental assistant to ~~use~~ administer nitrous oxide inhalation analgesia ~~for~~ to dental patients on an outpatient basis under the direct supervision of a dentist if the dental hygienist or registered dental assistant ~~has met the following requirements~~:

(1) Is certified in administering basic life support by the American Heart Association for the Healthcare Provider, the American Red Cross for the Professional Rescuer, or an equivalent program approved by the board; and

(2) Has successfully completed a board approved educational course that substantially meets the objectives and content as described in Part 4 of the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students and either:

(a) Completed the course within thirteen months prior to application; or

(b) Completed the course more than thirteen months prior to application, has legally administered nitrous oxide inhalation analgesia for a period of time during the three years preceding application, and provides written documentation from a dentist that has employed or supervised the applicant, attesting to the current clinical proficiency of the applicant to administer nitrous oxide inhalation analgesia.

A dental hygienist or registered dental assistant that administers nitrous oxide inhalation analgesia must use equipment with fail-safe features, a 20 percent minimum oxygen flow, and a scavenger system.

Source: 19 SDR 32, effective September 6, 1992; 32 SDR 188, effective May 15, 2006; 37 SDR 131, effective January 6, 2011; 42 SDR 19, effective August 17, 2015; 42 SDR 83, effective December 3, 2015.

General Authority: SDCL 36-6A-14(1)(3)(7)(10)(13)(14).

Law Implemented: SDCL 36-6A-14(1)(3)(7)(10)(13)(14)(22), 36-6A-40.

Reference: "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students," ~~2012~~ 2016 Edition, American Dental Association. Copies may be obtained from the American Dental Association at www.ada.org free of charge.

20:43:09:06.02. Minimal sedation. ~~A~~ If a patient is 12 years of age or older, a dentist may administer oral medication to achieve a state of minimal sedation without a permit. A dentist administering minimal sedation must have appropriate access to oxygen and suction and emergency drugs and must meet the standards of the Guidelines for the Use of Sedation and General Anesthesia by Dentists. If a patient is 12 years of age or older, ~~A~~ a dentist may ~~not~~ administer to the patient or prescribe for patient self-administration ~~more than~~ up to the maximum recommended dose of a single enteral drug ~~for a patient at the same setting unless the dentist holds the appropriate~~ per visit to achieve a state of minimal sedation without a general anesthesia and deep sedation permit or moderate sedation permit.

Source: 37 SDR 131, effective January 6, 2011; 42 SDR 83, effective December 3, 2015.

General Authority: SDCL 36-6A-14(1)(3)(13)(14).

Law Implemented: SDCL 36-6A-14(1)(3)(13)(14)(22).

Reference: "Guidelines for the Use of Sedation and General Anesthesia by Dentists," ~~2012~~ 2016 Edition, American Dental Association. Copies may be obtained from the American Dental Association at www.ada.org free of charge.

20:43:09:08. Application for permits -- Renewal. The application for a ~~permit to administer~~ general anesthesia and deep sedation, ~~or~~ moderate sedation, or host permit must include a fee of $50. The application for a permit for a dentist, dental hygienist or registered dental assistant to administer nitrous oxide inhalation analgesia must include a fee of $40. The

application for a permit for a dental hygienist to administer local anesthesia must include a fee of $40.

The board may issue a temporary permit to an applicant that has met the applicable requirements of this chapter~~, but before all processing and any applicable inspection have been completed~~. The duration of this temporary permit shall be determined by the board, but may not exceed one year. The temporary permit of an applicant who fails an inspection is automatically suspended. Upon suspension, the applicant may request another inspection.

A general anesthesia and deep sedation permit ~~or~~ , moderate sedation permit, or host permit must be renewed annually. The annual fee for a general anesthesia and deep sedation permit ~~or~~ , a moderate sedation permit, or a host permit is $50. A re-evaluation of the credentials and facility of the permit holder may be conducted for permit renewal. Any ~~person~~ dentist renewing a general anesthesia and deep sedation permit or moderate sedation permit must be able to demonstrate continued competency as required by the board. A dentist that holds a general anesthesia or deep sedation permit must complete at least 50 cases of general anesthesia or deep sedation annually. A dentist that holds a moderate sedation permit must complete at least 12 cases of moderate sedation annually. A dentist that holds a general anesthesia and deep sedation, moderate sedation, or host permit must document completion of team training on emergency response protocols at least annually in the setting where the anesthesia or sedation is being provided. Documentation shall be provided to the board upon request.

A nitrous oxide inhalation analgesia permit, local anesthesia permit, and permit to monitor patients under general anesthesia, deep sedation, or moderate sedation must be renewed annually. The annual fee for a nitrous oxide inhalation analgesia permit for a dentist is $40. The annual fee for a nitrous oxide inhalation analgesia permit for a dental hygienist is $20. The annual fee for a nitrous oxide inhalation analgesia permit for a registered dental assistant is $20. The annual fee for a permit to administer local anesthesia for a dental hygienist is $20. There is no annual fee for a permit to monitor patients under general anesthesia, deep sedation, or moderate sedation.

Failure to properly renew a general anesthesia and deep sedation permit, moderate sedation permit, host permit, nitrous oxide inhalation analgesia permit, local anesthesia permit, or a permit to monitor patients under general anesthesia, deep sedation, or moderate sedation constitutes an automatic suspension of the permit.

Source: 19 SDR 32, effective September 6, 1992; 37 SDR 131, effective January 6, 2011; 38 SDR 172, effective April 25, 2012; 42 SDR 19, effective August 17, 2015; 42 SDR 83, effective December 3, 2015.

General Authority: SDCL 36-6A-14(9)(14), 36-6A-50(12).

Law Implemented: SDCL 36-6A-14(9)(14)(22).

20:43:09:09. Reports of adverse conditions. All dentists must notify the board within 72 hours after any death or any incident which results in temporary or permanent physical or mental injury requiring medical treatment of the dentist's patient during, or as a result of, the administration of general anesthesia and deep sedation, moderate sedation, or nitrous oxide inhalation analgesia. A complete written report of the incident must be submitted to the board within 30 days. The report shall be submitted on a form provided by the board.

Failure to comply with reporting requirements constitutes an automatic suspension of the ~~permit to administer~~ general anesthesia and deep sedation, moderate sedation, host, or nitrous oxide inhalation analgesia permit.

Source: 19 SDR 32, effective September 6, 1992; 37 SDR 131, effective January 6, 2011.

General Authority: SDCL 36-6A-14(1)(2).

Law Implemented: SDCL 36-6A-14.

20:43:09:11. Inspection ~~of facilities~~. ~~The board may at any time require an on-site inspection of the facility, equipment, and personnel to determine if the requirements of this chapter are being met.~~ The dentist subject to an on-site inspection is responsible for all costs associated with an inspection. The on-site inspection ~~should~~ shall be ~~performed~~ completed by ~~two board approved inspectors~~. ~~However, if utilizing two board approved inspectors presents a hardship, the board may allow the inspection to be performed by one board approved inspector.~~ inspector(s) approved by the board. Inspectors must be individuals who are legally authorized to administer anesthesia or sedation at the level of the inspection being completed, have at least three years of experience administering dental anesthesia or sedation in a dental office, have not been disciplined for conduct that, in the opinion of the board, would jeopardize the safety of the public or patients, and abide by the inspection process approved by the board.

~~Each~~ A dentist who applies for a general anesthesia and deep sedation ~~or~~ , moderate sedation, or host permit must ~~have~~ pass an on-site facility inspection conducted at ~~the primary office within twelve months of application or~~ the facility where anesthesia or sedation will be

provided before a temporary general anesthesia and deep sedation, moderate sedation, or host permit permit will be issued.

A dentist ~~prior to expiration of the~~ who holds a temporary general anesthesia and deep sedation, moderate sedation, or host permit ~~whichever is earlier. The board may require inspection of a dentist's satellite office at any time. If the dentist does not have a primary office located in South Dakota, the on-site inspection may be conducted at a satellite office located in South Dakota.~~ must pass a full on-site inspection before a general anesthesia and deep sedation, moderate sedation, or host permit will be issued.

~~Following the initial inspection, each~~ A dentist who holds a general anesthesia and deep sedation, moderate sedation, or host permit must ~~have an~~ pass a full on-site inspection ~~conducted at the primary office~~ at least once in each five year licensure cycle to maintain the permit. ~~If the dentist does not have a primary office located in South Dakota the dentist may submit, subject to board approval, a report from a successful inspection conducted at the primary office located in a different state. An on-site inspection of the satellite office may also be required by the board.~~

Failing an on-site inspection constitutes an automatic suspension of the permit and may subject the dentist to disciplinary proceedings.

Source: 9 SDR 49, effective October 25, 1982; 12 SDR 151, 12 SDR 155, effective July 1, 1986; transferred from § 20:43:04:09, 19 SDR 32, effective September 6, 1992; 37 SDR 131, effective January 6, 2011; 42 SDR 83, effective December 3, 2015.

General Authority: SDCL 36-6A-14(1)(2)(13).

Law Implemented: SDCL 36-6A-14(1)(2)(13)(22).

20:43:09:12. Requirements of inspection. ~~An~~ Each inspection shall be completed for the dentist whose permit or application is under review using an inspection form and process approved by the board and shall include ~~an evaluation of~~ the following:

(1) ~~The office facilities, records,~~ A facility inspection to obtain a temporary general anesthesia and deep sedation, moderate sedation, or host permit shall include an evaluation of:

(a) The physical facility in which anesthesia or sedation will be provided;

(b) The drugs, ~~and~~ emergency medications, ~~including~~ ~~all~~ staff, and equipment ~~and the physical facility~~ necessary for the safe administration of the level of anesthesia or sedation authorized by the permit; and

(c) The technical competency of the permit holder and clinical office staff to

effectively respond to anesthesia related emergencies.

(2) A full inspection to obtain and maintain a host permit shall include an evaluation of:

(a) The physical facility in which anesthesia or sedation will be provided;

(b) The drugs, emergency medications, staff, and equipment necessary for the safe administration of the level of anesthesia or sedation authorized by the permit;

(c) The technical competency of the permit holder and clinical office staff to effectively respond to anesthesia related emergencies; and

(d) Appropriate patient anesthesia records.

(3) A full inspection to obtain and maintain a general anesthesia and deep sedation or moderate sedation permit shall include an evaluation of :

(a) The physical facility in which anesthesia or sedation will be provided;

(b) The drugs, emergency medications, staff, and equipment necessary for the safe administration of the level of anesthesia or sedation authorized by the permit;

(c) The technical competency of the permit holder and clinical office staff to effectively respond to anesthesia related emergencies;

(d) Appropriate patient anesthesia records; and

(e) The technical competency of the permit holder to safely administer the level of anesthesia or sedation authorized by the permit.

~~(2) A live dental procedure performed by the dentist whose facility is being examined utilizing the type of anesthesia or sedation for which the dentist is applying for a permit;~~

~~(3) Any anesthesia or sedation technique that is routinely employed during the administration of anesthesia or sedation;~~

~~(4) The appropriate monitoring of a live patient during anesthesia or sedation;~~

~~(5) The observation of a patient during recovery and the time allowed for recovery; and~~

~~(6) Simulated emergencies in the surgical areas of the dental office with participation by members of the staff that are trained to handle emergencies. Emergencies shall be listed on the board approved inspection form.~~

Source: 37 SDR 131, effective January 6, 2011.

General Authority: SDCL 36-6A-14(1)(13)(14).

Law Implemented: SDCL 36-6A-~~16~~-14(1)(13)(14).

20:43:09:13. Equipment -- Moderate sedation. Any dentist who administers moderate sedation or who provides dental services to patients under moderate sedation must ensure that the office in which the work is performed:

(1) Has an operatory of the appropriate size and design to permit access of emergency equipment and personnel and to permit appropriate emergency management;

(2) Has the following equipment:

(a) An automated external defibrillator or full function defibrillator that is immediately accessible;

(b) A positive pressure oxygen delivery system and a backup system;

(c) A functional suctioning device and a backup suction device;

(d) Auxiliary lighting;

(e) A gas storage facility;

(f) A recovery area. Recovery may take place in the surgical suite. If a separate recovery area is utilized, it must be of the appropriate size for emergency access and management and must have resuscitative equipment present;

(g) Methods to monitor respiratory and cardiac function, including all of the following:

(i) Pulse oximetry; ~~and~~

(ii) Electrocardiogram display;

(iii) Precordial stethoscope;

(iv) Measurement of EtCO2, capnograpy; and

(v) Method to monitor blood pressure; and

(h) A board approved emergency cart that must be available and readily accessible and includes the necessary and appropriate drugs and appropriately sized equipment to resuscitate a non-breathing and unconscious patient and provide continuous support while the patient is transported to a medical facility. ~~There must be~~ The permit holder must provide documentation that all emergency equipment and drugs are ~~checked~~ inspected and maintained on a prudent and regularly scheduled basis, according to manufacturer specifications where applicable.

Source: 37 SDR 131, effective January 6, 2011; 41 SDR 108, effective January 6, 2015.

General Authority: SDCL 36-6A-14(1)(3)(13)(14).

Law Implemented: SDCL 36-6A-~~16~~ 14(1)(13)(14).

20:43:09:13.01. Equipment -- General anesthesia and deep sedation. Any dentist who administers general anesthesia or deep sedation or who provides dental services to patients under general anesthesia or deep sedation must ensure that the office in which the work is performed:

(1) Has an operatory of the appropriate size and design to permit access of emergency equipment and personnel and to permit appropriate emergency management;

(2) Has the following equipment:

(a) An automated external defibrillator or full function defibrillator that is immediately accessible;

(b) A positive pressure oxygen delivery system and a backup system;

(c) A functional suctioning device and a backup suction device;

(d) Auxiliary lighting;

(e) A gas storage facility;

(f) A recovery area. Recovery may take place in the surgical suite. If a separate recovery area is utilized, it must be of the appropriate size for emergency access and management and must have resuscitative equipment present;

(g) Methods to monitor respiratory and cardiac function, including all of the following:

(i) Pulse oximetry;

(ii) Electrocardiogram display;

(iii) Precordial or pretrachial stethoscope; ~~and~~

(iv) Measurement of EtCO2, capnograpy; and

(v) Method to monitor blood pressure; and

(h) A board approved emergency cart that must be available and readily accessible and includes the necessary and appropriate drugs and appropriately sized equipment to resuscitate a non-breathing and unconscious patient and provide continuous support while the patient is transported to a medical facility. ~~There must be~~ The permit holder must provide documentation that all emergency equipment and drugs are ~~checked~~ inspected and maintained on a prudent and regularly scheduled basis, according to manufacturer specifications where applicable.

Source: 41 SDR 108, effective January 6, 2015.

General Authority: SDCL 36-6A-14(1)(3)(13)(14).

Law Implemented: SDCL 36-6A-~~16~~-14(1)(3)(13)(14).

20:43:09:14. Clinical guidelines. A dentist who provides any level of sedation ~~must meet the standards of the Guidelines for the Use of Sedation and General Anesthesia by Dentists for~~ or utilizes the services of a licensed anesthesia provider shall apply the current standard of care including, but not limited to, thorough patient assessment, pre-operative preparation, recovery and discharge, and management of emergencies.

Source: 37 SDR 131, effective January 6, 2011.

General Authority: SDCL 36-6A-14(1)(3).

Law Implemented: SDCL 36-6A-~~16~~ 14(1)(3)(13)(14).

~~**Reference:** "Guidelines for the Use of Sedation and General Anesthesia by Dentists," 2007 Edition, American Dental Association. Copies may be obtained from the American Dental Association at www.ada.org free of charge.~~

20:43:09:17 Emergency response protocol. A dentist must ensure a written emergency response protocol is in place for all patients undergoing nitrous oxide inhalation analgesia, local anesthesia, minimal sedation, moderate sedation, deep sedation or general anesthesia.

Source:

General Authority: SDCL 36-6A-14(1)(13)(14).

Law Implemented: SDCL 36-6A-14(1)(13)(14).

20:43:03:07. Continuing education requirements -- Dentists. A dentist shall complete at least 100 hours of board approved continuing education in each five-year licensure cycle. One hour of continuing education may be earned for each hour of attendance at a board approved continuing education course.

Fifty hours of the required 100 hours must be academic. Academic hours must directly relate to the provision of clinical dental services and meet one of the following criteria:

(1) The course must be taken physically at a dental school accredited by the American Dental Association Commission on Dental Accreditation;

(2) The course presenter must be affiliated with a dental school accredited by the American Dental Association Commission on Dental Accreditation;

(3) The provider organization must be approved by the American Dental Association Continuing Education Recognition Program; or

(4) The provider organization must be approved by the Academy of General Dentistry Program Approval For Continuing Education.

Credit for nutrition continuing education is limited to 15 hours per five-year licensure cycle. Credit for practice management continuing education is limited to 10 hours per five-year licensure cycle. Credit for home study continuing education is limited to 30 hours per five-year licensure cycle. Credit for cardiopulmonary resuscitation continuing education is limited to 15 hours per five-year licensure cycle. Credit for clinical continuing education is unlimited per five-year licensure cycle. Up to five hours of clinical continuing education may be earned for attendance at exhibits at a state, regional, or national dental conference.

Dentists holding a general anesthesia and deep sedation ~~or~~ , moderate sedation, or host permit must complete an additional 25 hours of continuing education in anesthesia related topics per five-year licensure cycle.

The board's continuing education guidelines shall be reviewed annually.

Source: SL 1975, ch 16, § 1; 5 SDR 68, effective February 13, 1979; 6 SDR 87, effective March 2, 1980; 12 SDR 151, 12 SDR 155, effective July 1, 1986; 13 SDR 23, effective September 3, 1986; 18 SDR 132, effective February 17, 1992; 20 SDR 166, effective April 11, 1994; 26 SDR 37, effective September 20, 1999; 35 SDR 67, effective September 25, 2008; 37 SDR 131, effective January 6, 2011; 38 SDR 172, effective April 25, 2012; 45 SDR 35, effective September 19, 2018.

General Authority: SDCL 36-6A-14(1)(3)(11)(14), 36-6A-55.

Law Implemented: SDCL 36-6A-14(1)(3)(11)(13), 36-6A-55.

Southeast Technical College
Dental Assisting Program Update
June 2021

Purpose:
To provide the South Dakota Board of Dentistry an update on the dental assisting program and any developments related to the CODA application.

- Twenty-two students successfully completed both the first and second semester of coursework. The students completed the following courses during the Spring 2021 term:
    - **Dental Radiology**: This course provides the fundamental background and theory for the safe and effective use of x-radiation in dentistry. It encompasses the history of x-rays, production and uses of radiation, radiographic film, exposure factors, interpretation of radiographs and radiation hygiene. An introduction to digital radiography, occlusal radiography and several other supplemental techniques are also included.
    - **Dental Materials II and Lab**: Students will demonstrate an understanding on how to assist with the management of medical and dental emergencies, have an understanding of the drugs used in dentistry, drugs the patients are taking for a specific medical condition, the terminology and usage of prescriptions, the understanding of anesthesia and local pain control used in dentistry.
    - **Dental Practice Management:** This course provides a study of the business aspect of a dental office. It includes exposure to dental practice management software.
    - **Dental Specialties Procedures and Expanded Functions:** This course will focus on treatment procedures specific to the various dental specialty practices. Specialty areas covered are endodontics, periodontics, pediatric dentistry, oral and maxillofacial surgery and pediatric dentistry. Topics will include treatment indications, instrumentation and the selection dental materials needed for treatment, patient education, pre-operative and post- operative instruction, and the role and responsibility of the dental assistant in each specialty practice. Laboratory practice will focus on practice of competency skills including expanded functions that support and deliver patient treatment.
    - **Clinical Experiences I:** The goal of this course is to introduce students to the practices in dentistry. The student should be able to describe dental procedures including general dentistry, restorative dentistry, fixed prosthodontics, provisional coverage, removable prosthodontics, and implant dentistry.

- Students are currently participating in their externship.
    - General office placements include Dental Essence, Southwestern Dental, Great Plains Dental, Mass Dental Office in Hot Springs, Neighborhood Dental, 10 St Dental, Knutson Dental, Winner Dental Clinic, First Class Dental, Lone Oak Dental, Dell Rapids Dental, Complete Dental, Embrace Dental, Sioux Falls Dental, Pillar Dental, Wagner Family Dental, Sensational Smiles, Dakota Family Dentistry, Lifetime Dental, and Falls Community Health
    - Specialty dental placements include Dunes 4 Kids, Children's Dental, ABC Dental, Siouxland Oral Surgery, Parkway Orthodontics, Wermerson Orthodontics, Horner's Orthodontics, Crist and Wenade Orthodontics, Drake Orthodontics, Vanlaecken Orthodontics, Kaler Orthodontics, and Lavin Periodontics.

- CODA opened the electronic application submission process following their February board meeting. STC has submitted the $16,850 initial fee and has been granted access to the online portal. Our application is nearly complete and we be able to submit the application as soon as our inaugural class officially graduates at the end of July following successful completion of their externships.

- As a reminder, because we decided to move forward with our inaugural dental assisting class this Fall prior to CODA accreditation, we will be submitting the Fully Operational application rather than the Initial Accreditation application.

- The STC website has a Program Video and a Virtual Lab Tour. You can access those through this link: STC Dental Assisting Program

Proposal for a Wellness Program

The South Dakota Dental Association is proposing to create and administer a wellness program for all individuals working in dental offices in South Dakota. While the need for such a program may be self-evident, we hope that by being proactive we can help members of the dental community better deal with issues that often result in self-destructive behavior.

The SDDA will secure the services of an individual or organization with licensed-professional-counselor credentials and with previous experience in counseling healthcare professionals. This person would be advised by a "Wellbeing Committee" of approximately five individuals primarily from the target audience.

There are two components to the program. The first is to create a "culture of wellness" within the dental community in South Dakota and the other is to provide an entry point for individuals from within the dental community to seek care by providing an individual needs assessment.

Culture of Wellness - The selected counselor would lead the program and the work of the wellness committee. Each of the following functions would offer education about wellness and promote the availability of a needs assessment. A culture of wellness would be pursued through:

- Education and training of the wellbeing committee and SDDA leaders (including staff)
- A wellbeing article in each quarterly SDDA newsletter
- Two wellbeing webinars
- A presentation during the SDDA Annual Session
- Wellbeing tips in six e-news email blasts
- A wellbeing page on the SDDA and/or Board of Dentistry web site
- Brief presentations at district dental society meetings

Individual Needs Assessment - The wellness program will cover the cost of an initial assessment for someone needing help. The assessment offers the dentist or staff member the opportunity to talk with a licensed counselor about their situation. The counselor will give recommendations and determine the best level of care needed for each situation, including coaching or referrals to other resources. Referrals could include a psychiatrist, a counselor, a chemical dependency assessment, support group, or coaching. Having quick and easy access to an assessment is essential as people often don't ask for help because they don't know where to start. It is difficult to estimate the number of needs assessments that would be conducted during the first year of the program, but we are estimating at least eight (at $500 per session).

The SDDA is proposing the program for an initial period of one year, beginning on July 1, 2021. Based on proposals from two professional counseling groups we are estimating a budget of $18,000. We are requesting $9,000 from the Board of Dentistry and $9,00 from the South Dakota Dental Foundation to fund the cost of retaining the services of a licensed professional counselor first year of the program.

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

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

Administer Nitrous Oxide: 20:43:09:05

1. Nitrous Oxide Courses taken through American Dental Association Commission on Dental Accreditation (ADA CODA) accredited dental, dental hygiene or dental assisting schools.
2. Western Dakota Technical Institute (WDTI) Nitrous Oxide course (Approved until CODA Accreditation is completed). *Operational as of June 17, 2016.*

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
    i. Intravenous Conscious Sedation Course
        - Location: Augusta, GA
        - Sponsor: Augusta University Dental College of Georgia
        - Hours: At least 60. Patients: At least 20
    ii. Intravenous Moderate Sedation (previously titled *Medical Emergencies, Local Anesthesia and Moderate Sedation in Dental Practice*)
        - Location: Dayton, OH.
        - Sponsor: Miami Valley Hospital
        - Hours: At least 60. Patients: At least 20
    iii. Parenteral Moderate Sedation (previously titled *Learn IV Sedation)*
        - Location: Portland, OR.
        - Sponsor: Oregon Academy of General Dentistry
        - Hours: At least 60. Patients: At least 20
    iv. IV Sedation Training for Dentists
        - Location: Various Locations in the United States.
        - Sponsor: Conscious Sedation Consulting
        - Hours: At least 60. Patients: At least 20
    v. ADA CODA accredited General Practice, Periodontal or Pediatric Residency that meets the regulatory requirements
        - Location: Various.

- Hours: At least 60. Patients: At least 20.

vi. IV Sedation for Dentistry at Idaho State University and Meharry Medical College *(formerly at Oregon Health and Science University)*
- Location: Idaho State University and Dental School Satellite Campus
- Sponsor: Idaho State University and DOCS Education
- Hours: At least 60. Patients: At least 20

vii. Moderate Sedation Training Course
- Location: Varies
- Sponsor: Dentinomics
- Hours: At least 60. Patients: At least 20

ix. Puerto Rico AAID MaxiCourse Program and Clinical Residency in Implant Dentistry
- Location: Puerto Rico
- Sponsor: Advanced Dental Implant Institute
- Hours: At least 60. Patients: At least 20

x. Clinical Intravenous Sedation
- Location: Los Angeles, CA.
- Sponsor: The Herman Ostrow School of Dentistry of USC
- Hours: At least 60. Patients: At least 20
- *This course is currently not offered due to COVID-19.*

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)

Cardiopulmonary Resuscitation (CPR)
1. American Heart Association Basic Life Support (BLS) Provider
2. American Red Cross for the Professional Rescuer or the Healthcare Provider
3. Military Training Network (MTN) Healthcare Provider Course
4. American Heart Association Advanced Cardiac Life Support (ACLS)
5. American Heart Association Pediatric Advanced Life Support (PALS)

Regional Examination Equivalency
1. California State Board Dental Exam – 1988
2. Washington State Board Dental Exam – 1986 and 1987
3. Arizona State Board Dental Exam – 1972
4. Florida State Board Dental Exam - 1986

DENTAL HYGIENISTS (DH):

DH Administer Nitrous Oxide: 20:43:09:06
1. Nitrous Oxide Courses taken through ADA CODA accredited dental, dental hygiene or dental assisting schools.
2. Western Dakota Technical Institute (WDTI) Nitrous Oxide course (Approved until CODA Accreditation is completed). *Operational as of June 17, 2016.*

DH Administer Local Anesthesia: 20:43:09:06.01
1. Local Anesthesia Courses taken through ADA CODA accredited dental or dental hygiene schools.

Cardiopulmonary Resuscitation (CPR)

1. American Heart Association Basic Life Support (BLS) Provider
2. American Red Cross for the Professional Rescuer or the Healthcare Provider
3. Military Training Network (MTN) Healthcare Provider Course
4. American Heart Association Advanced Cardiac Life Support (ACLS)
5. American Heart Association Pediatric Advanced Life Support (PALS)

Regional Examination Equivalency

1. California Dental Hygiene State Board Exam—1988

REGISTERED DENTAL ASSISTANTS (RDA)

RDA: 20:43:08:03

1. ADA CODA accredited dental assisting programs.
2. Western Dakota Technical Institute (WDTI) dental assistant program (Approved until CODA Accreditation is completed). *Operational as of May 21, 2016.*
3. DANB Certified Dental Assistant (CDA) Certification (three components: Radiation Health and Safety, Infection Control and General Chairside Assisting)
4. Lake Area Technical Institute (LATI) expanded functions dental assistant continuing education course.
5. Southeast Technical College (STC) dental assistant program (pending CODA accreditation. Approval for graduates between 10/23/2020 and 10/23/2021.)
6. Western Dakota Technical Institute (WDTI) dental assistant training program (non-accredited). *Discontinued as of May 20, 2016.*
7. South East Technical Institute (SETI) dental assisting program (non-accredited). *SETI discontinued its dental assisting program effective May 12, 2011.*

RDA Administer Nitrous Oxide: 20:43:09:06

1. Nitrous Oxide courses taken through ADA CODA accredited dental, dental hygiene and dental assisting schools.
2. Western Dakota Technical Institute (WDTI) Nitrous Oxide course (Approved until CODA Accreditation is completed). *Operational as of June 17, 2016.*

Cardiopulmonary Resuscitation (CPR)

1. American Heart Association Basic Life Support (BLS) Provider
2. American Red Cross for the Professional Rescuer or the Healthcare Provider
3. Military Training Network (MTN) Healthcare Provider Course
4. American Heart Association Advanced Cardiac Life Support (ACLS)
5. American Heart Association Pediatric Advanced Life Support (PALS)

RADIOGRAPHERS

Radiographer: 20:43:07:07

1. 16 hour Radiography courses taken through ADA CODA accredited dental, dental hygiene or dental assisting programs.
2. 16 hour Radiography courses taken through Western Dakota Technical Institute (WDTI). WDTI offers a standalone 16 hour course or a course that students in the Dental Assisting program complete while completing the Dental Assisting program. WDTI provides a radiography certificate upon completion of the radiography component.

3. 16 hour Radiography courses taken through Southeast Technical College (STC) with a completion date after October 12, 2018.
4. 16 hour Radiography courses taken through Accelerated Dental Assisting Academy (ADAA) with a completion date after October 18, 2019.
5. Radiography component of Dental Assisting National Board (DANB).
6. Department of the Air Force, Ellsworth Air Force Base 16 hour radiography course taught by Ms. Luann F. Brownson, offered to personnel (active duty, reserve, guard, Red Cross or GS) working as dental technicians at the Ellsworth Air Force Base.

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)
    - Sponsor: American Association of Oral and Maxillofacial Surgeons (AAOMS)
    - Hours: 36
2. Anesthesia Assistants Review Course (AARC)
    - Sponsor: American Association of Oral and Maxillofacial Surgeons (AAOMS)
    - Hours: 12
3. Assistant Sedation/Anesthesia Course
    - Sponsor: American Dental Society of Anesthesiology (ADSA)
    - Hours: 12
4. Assistant Sedation/Anesthesia Course – On Demand CE Course (Online)
    - Sponsor: American Dental Society of Anesthesiology (ADSA)
    - 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.
    - Sponsor: Conscious Sedation Consulting
    - 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
    - Sponsor: South Dakota Dental Association
    - Hours: 8
7. Intravenous Conscious Sedation Course, GRU, College of Dental Medicine
    - Sponsor: Augusta University Dental College of Georgia
    - Hours: 40
8. Assisting on the Sedated Patient – A Certification Course for Assistants
    - Sponsor: Dentinomics
    - Hours: 8

9. Monitoring of Sedation/General Anesthesia Patients for Dental Procedures and intravenous insertion

- Sponsor: Saint Louis University Center for Advanced Dental Education
- Hours: 24

Cardiopulmonary Resuscitation (CPR)

1. American Heart Association Basic Life Support (BLS) Provider
2. American Red Cross for the Professional Rescuer or the Healthcare Provider
3. Military Training Network (MTN) Healthcare Provider Course
4. American Heart Association Advanced Cardiac Life Support (ACLS)
5. American Heart Association Pediatric Advanced Life Support (PALS)

Application Review Policy: It is the policy of the Board to use the Application Review Policy as guidance when determining whether to issue a license, registration or permit. The Board, or a member of the Board, will be consulted as appropriate for complex applications.

Regular Applications

- Dentist: License Applications – A completed application will be reviewed by a Board member to determine if an interview is necessary. The Board may approve an application on a case by case basis.
- Dental Hygienist: License Applications – A completed application will be reviewed by a Board member to determine if an interview is necessary. The Board may approve an application on a case by case basis.
- Collaborative Supervision Applications - A completed application will be reviewed and may be approved by the Board on a case by case basis.
- Radiographer Applications - A completed application will be reviewed and may be approved by the board office staff on a case by case basis.
- Registered Dental Assistant Applications - A completed application will be reviewed and may be approved by the board office staff on a case by case basis.
- Corporation Applications - A completed application, or a change in the ownership or management of a registered corporation, will be reviewed and may be approved by the board office staff on a case by case basis.
- General Anesthesia and Deep Sedation Permit or Moderate Sedation Permit Applications (temporary and regular applications) - A completed application or inspection will be reviewed and may be approved by a member of the Board or the chair of the Anesthesia Credentials Committee on a case by case basis.
- All other permit applications - A completed application will be reviewed and may be approved by the board office staff on a case by case basis.

Volunteer and Temporary Applications

- Dentist: Temporary Permit Applications - A completed application will be reviewed and may be approved by a member of the Board on a case by case basis.
- Dental Hygienist: Temporary Permit Applications - A completed application will be reviewed and may be approved by a member of the Board on a case by case basis.
- Dentist and Dental Hygienist: Volunteer Temporary Registration and Permit Applications – A completed application will be reviewed and may be approved by a member of the Board on a case by case basis.
    - Dentist – Volunteer temporary nitrous oxide, moderate sedation or general/deep sedation: To obtain a temporary permit, the applicant must verify that he or she holds a valid permit to provide this service or is otherwise allowed to provide this service under a regular dental license in his or her home state and that he or she has been regularly providing such service during the three years preceding application, or if the person has graduated less than three years preceding application, that he or she has been regularly providing such service since graduation. The Board reserves the right to inspect any facility where anesthesia is being provided.
    - Dental Hygienist – Volunteer temporary local anesthesia, nitrous oxide and monitoring patients under anesthesia: To obtain a temporary permit, the applicant must verify that he or she holds a valid permit to provide this service or is otherwise

allowed to provide this service under a regular dental hygiene license in his or her home state and that he or she has been regularly providing such service during the three years preceding application, or if the person has graduated less than three years preceding application, that he or she has been regularly providing such service since graduation. The Board reserves the right to inspect any facility where anesthesia is being provided.

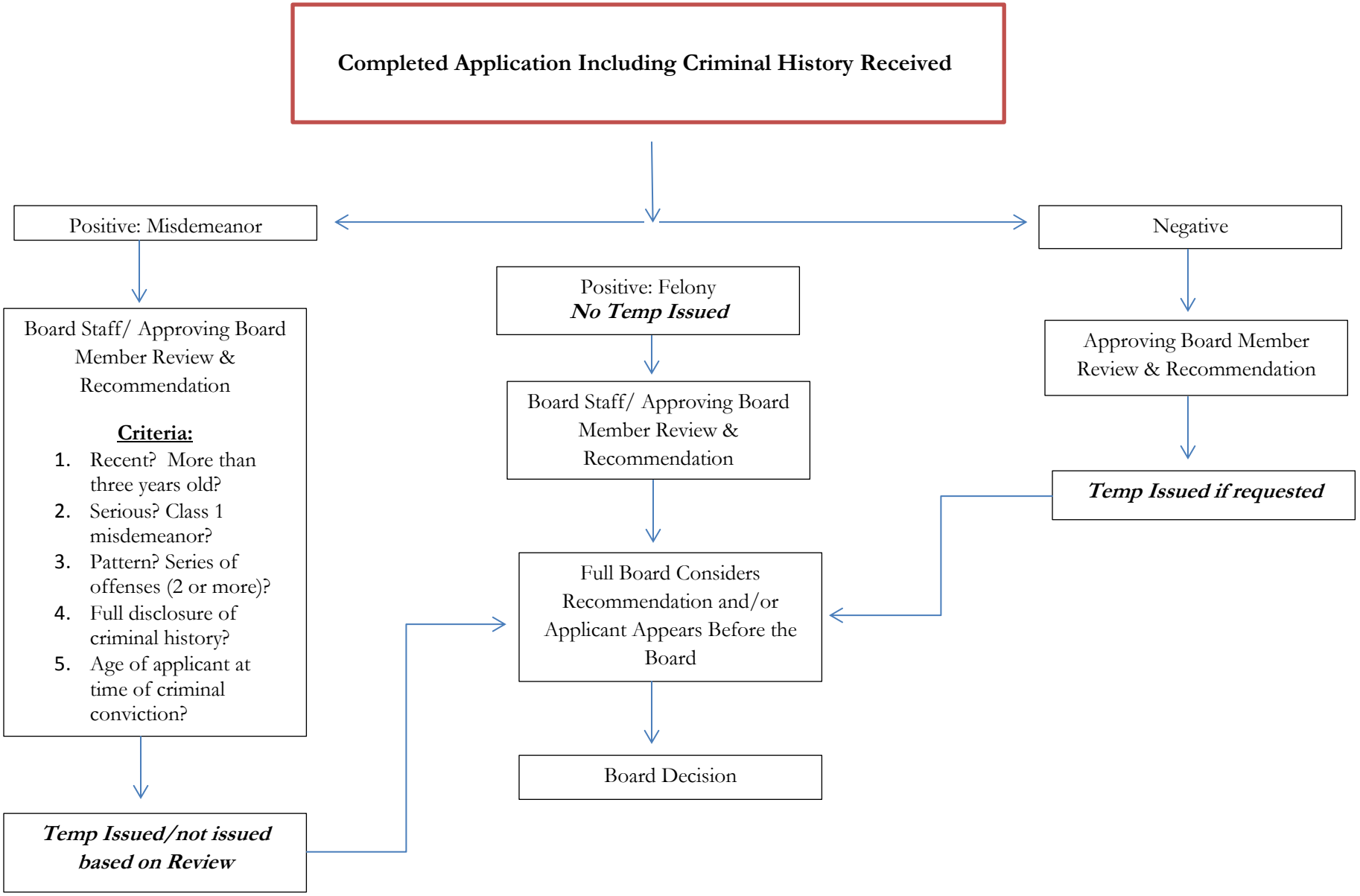
Continuing Education Audit Policy: It is the policy of the Board that a continuing education audit will be conducted annually and that it will utilize the Continuing Education Audit Policy as guidance when completing this audit.

It is important that licensees and registrants maintain a file of all the continuing education courses attended during the applicable continuing education cycle**.** The Board will randomly audit continuing education records and licensees and registrants selected for an audit will be required to provide verification of attendance for all continuing education courses claimed during the applicable continuing education cycle. Verification should include proof of attendance or a certificate of completion. A proof of attendance or a certificate of completion should include the continuing education activity, name of the course, name of the presenter, sponsor of the program, city the course was held in and the number of hours awarded. A certificate of completion must also indicate that the licensee or registrant passed a post-test with a satisfactory score or successfully completed the course.

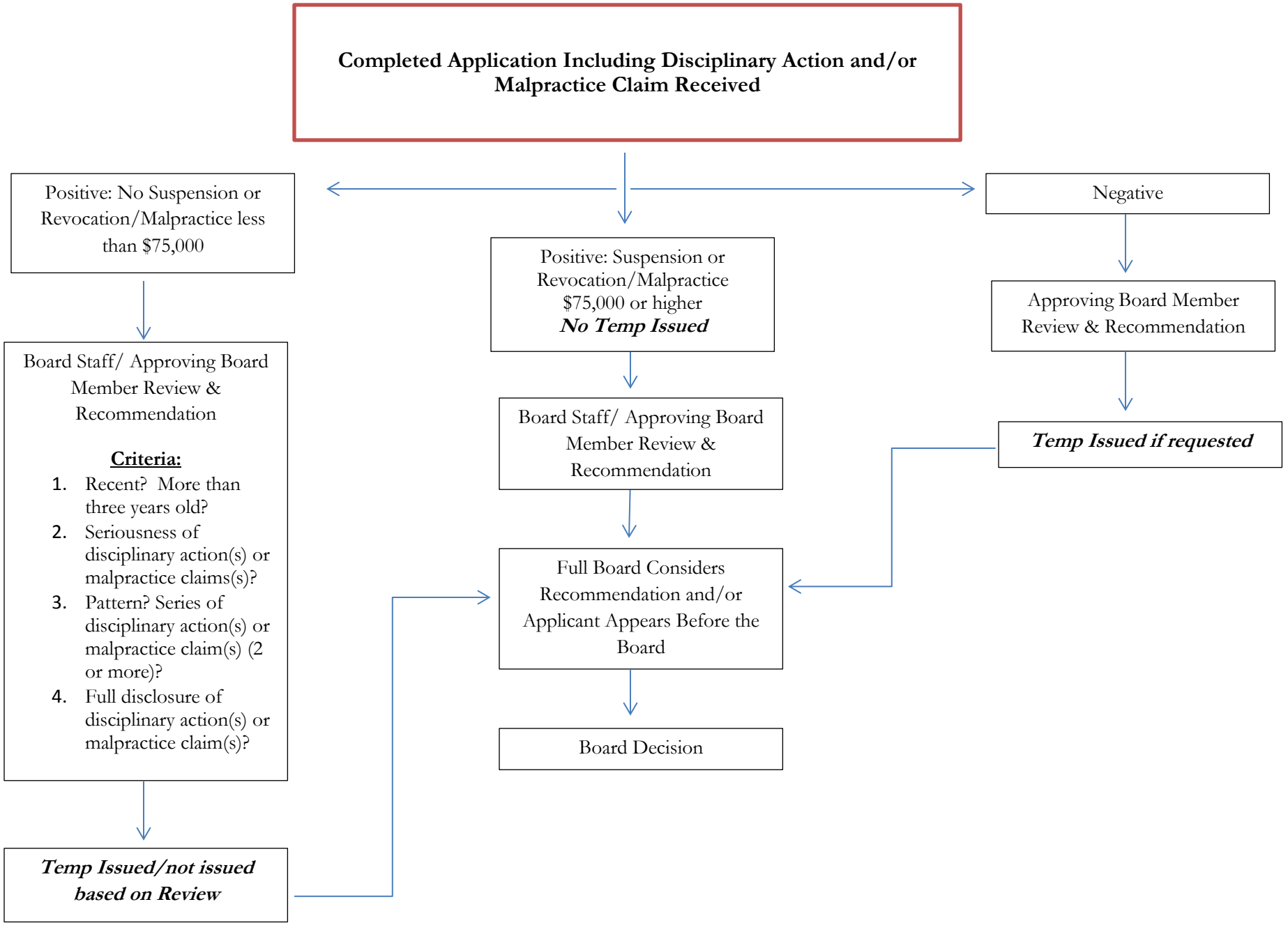
AUDIT PROCEDURE

1. A percentage of licensees and registrants required to maintain continuing education hours will be selected for audit. The percentage and other selection criteria will be determined by the Board.
2. Licensees and registrants selected will be notified by the Board. They will be provided a timeframe within which to provide verification of attendance for each continuing education course claimed on his or her continuing education report.
3. If satisfactory verification of attendance cannot be produced, the continuing education course will not be approved and the licensee or registrant will not be given credit for that continuing education course.
4. If a licensee or registrant has no continuing education courses entered or a minimal number of continuing education courses entered in his or her continuing education record and is selected for an audit, that individual will be audited the following year.
5. The Board will consider each audit individually and take action as it deems necessary.

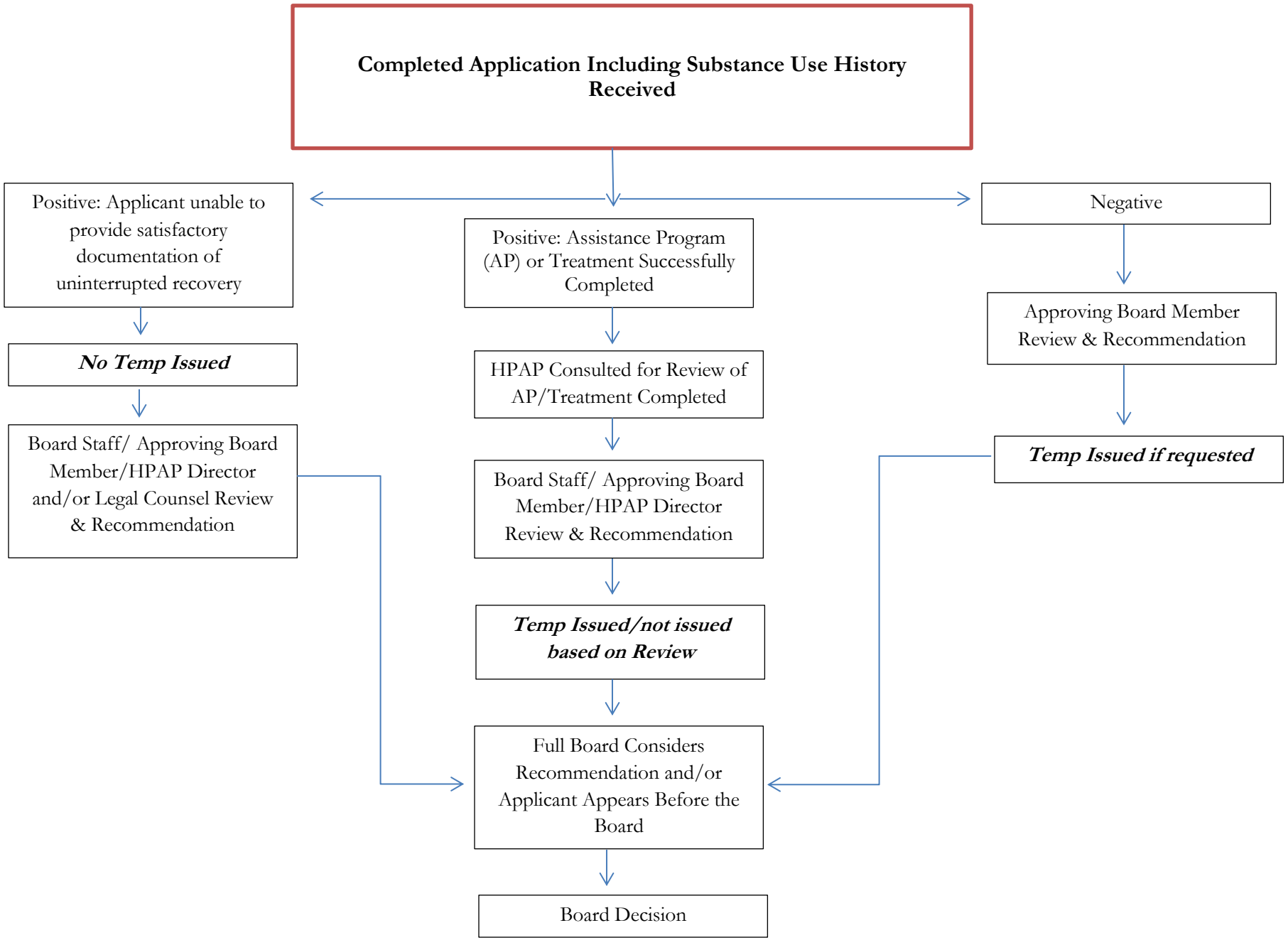
Criminal History Algorithm: It is the policy of the Board to use the Criminal History Algorithm as guidance when determining whether to issue a license, registration or permit.



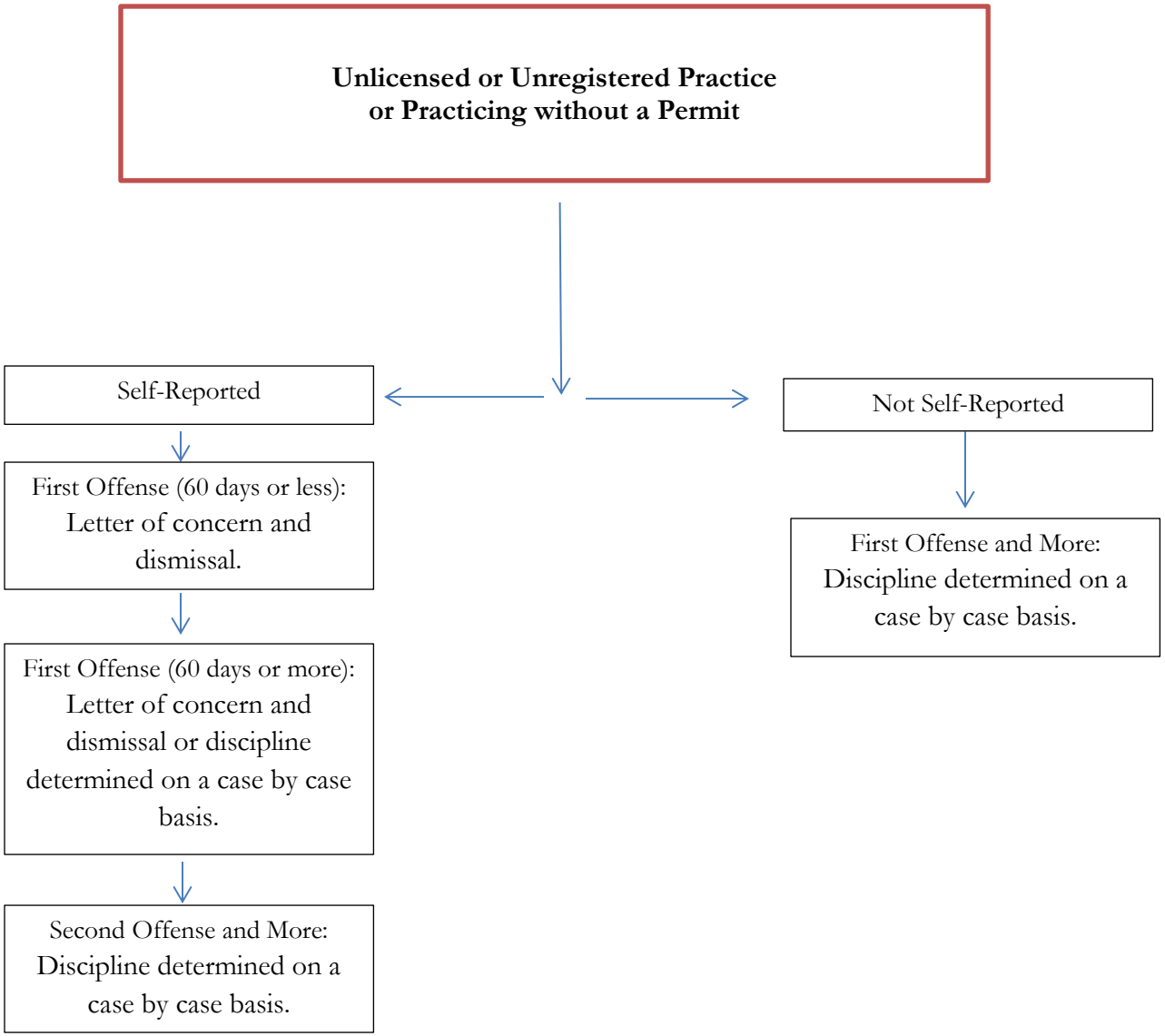
<u>Disciplinary Action & Malpractice Claim Algorithm</u>: It is the policy of the Board to use the Disciplinary Action & Malpractice Claims Algorithm as guidance when determining whether to issue a license, registration or permit.



<u>Substance Use History Algorithm</u>: It is the policy of the Board to use the Substance Use Algorithm as guidance when determining whether to issue a license, registration or permit.



<u>Unlicensed, Unregistered or Practicing without a Permit Policy</u>: It is the policy of the Board to use the Unlicensed, Unregistered or Practicing without a Permit Policy as guidance when reviewing complaints or other matters pertaining to individuals that qualify for a license, registration or permit.



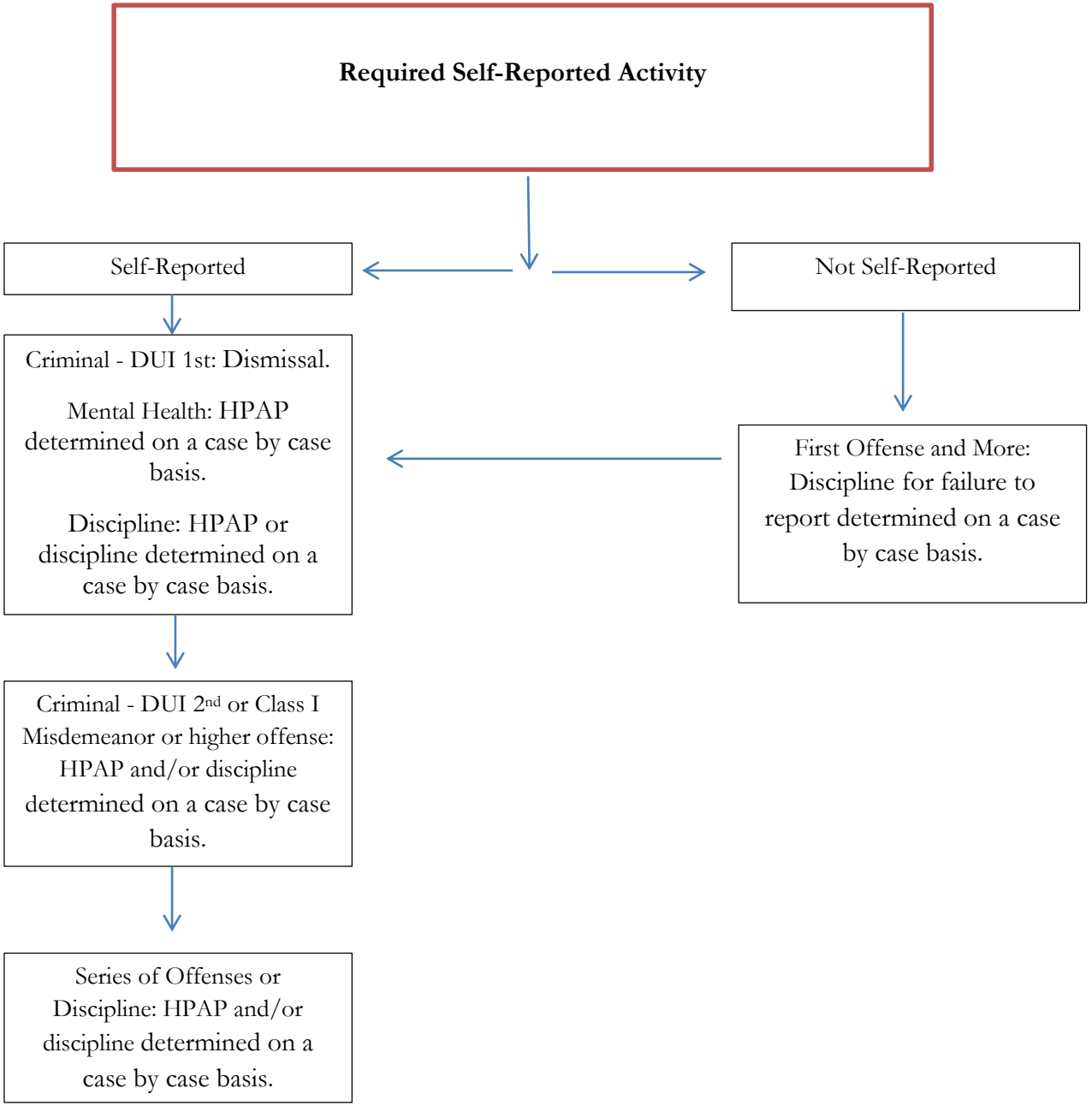
Reinstatement Following Failure to Renew: It is the policy of the Board that it will grant a reasonable period of time following July 1st to a licensee, registrant or permit holder that has failed to renew to reinstate his or her respective license, registration, or permit(s) by fulfilling all renewal criteria and paying the applicable fee(s). Facts and circumstances surrounding a failure to renew will be considered on a case by case basis.

Anesthesia Application Policy: It is the policy of the Board to use the Anesthesia Application - Policy as guidance when determining whether to issue a Moderate Sedation or General Anesthesia and Deep Sedation Permit. The Board, or a member of the Board and/or Anesthesia Credentials Committee, will be consulted as appropriate for complex applications.

An applicant for a permit to administer Moderate Sedation or General Anesthesia and Deep Sedation that is not licensed and providing Moderate Sedation or General Anesthesia and Deep Sedation in a different state will be allowed up to twelve months between completion of education and date of application. If an applicant has more than twelve months between completion of education and date of application, the applicant will be required to successfully complete a new board approved course or program and meet all other permit requirements before a permit will be issued.

An applicant for a permit to administer Moderate Sedation or General Anesthesia and Deep Sedation will be required to pass an inspection before being issued a temporary permit. This inspection will include all elements of the full on site anesthesia inspection except the sedation of a patient and completion of a dental procedure. If issued a temporary permit, the dentist will be required to pass the full on site anesthesia inspection before the expiration of the temporary permit. If issued a permit to administer Moderate Sedation or General Anesthesia and Deep Sedation, the dentist must pass the full on site anesthesia inspection as set forth in administrative rule.

Self-Reported Activity: It is the policy of the Board to use the Self-Reported Activity as guidance when reviewing information required to be reported to the Board.



Honorarium Request Policy: It is the policy of the Board to allocate resources, when available, to fund continuing education courses that further the mission of the Board. The Board will utilize the Honorarium Request Procedure as guidance:

HONORARIUM REQUEST PROCEDURE

- The Board will determine the following:
  - Fund allocation amount;
  - Information required for submission;
  - Eligibility criteria, which shall include all applicable state contractor requirements;
  - Deadline for submission of applications; and
  - Timeframe for review of applications.
- The Board will release an application at least 30 days prior to the deadline for submission.
- Any application received after the deadline for submission will not be considered unless extenuating circumstances warrant review.

Code of Conduct and Conflict of Interest Policy for Use By State Authority, Board, Commission, and Committee Members

Purpose

The purpose of this code of conduct and conflict of interest policy ("Code") is to establish a set of ethical principles and guidelines for members of state authorities, boards, commissions, or committees when acting within their official public service capacity. This Code applies to all appointed and elected members of state authorities, boards, commissions, and committees (hereinafter "Boards" and "Board member(s)").

Conflict of Interest for Board Members

Board members may be subject to statutory restrictions specific to their Boards found in state and federal laws, rules and regulations. Those restrictions are beyond the scope of this Code. Board members should contact their appointing authority or the attorney for the Board for information regarding restrictions specific to their Board.

General Restrictions on Participation in Board Actions

A conflict of interest exists when a Board member has an interest in a matter that is different from the interest of members of the general public. Examples of circumstances which may create a conflict of interest include a personal or pecuniary interest in the matter or an existing or potential employment relationship with a party involved in the proceeding.

Whether or not a conflict of interest requires a Board member to abstain from participation in an official action of the Board depends upon the type of action involved. A Board's official actions are either quasi-judicial or quasi-legislative. A quasi-judicial official action is particular and immediate in effect, such as a review of an application for a license or permit. In order to participate in a quasi-judicial official action of the Board, a Board member must be disinterested and free from actual bias or an unacceptable risk of actual bias. A Board member must abstain from participation in the discussion and vote on a quasi-judicial official action of the Board if a reasonably-minded person could conclude that there is an unacceptable risk that the Board member has prejudged the matter or that the Board member's interest or relationship creates a potential to influence the member's impartiality.

A quasi-legislative official action, also referred to as a regulatory action, is general and future in effect. An example is rule-making. If the official action involved is quasi-legislative in nature, the Board member is not required to abstain from participation in the discussion and vote on the action

unless it is clear that the member has an unalterably closed mind on matters critical to the disposition of the action.

"Official action" means a decision, recommendation, approval, disapproval or other action which involves discretionary authority. A Board member who violates any of these restrictions may be subject to removal from the Board to which the member is appointed.

Contract Restrictions

There are federal and state laws, rules and regulations that address conflict of interest for elected and appointed Board members in the area of contracts. As an initial matter, a Board member may not solicit or accept any gift, favor, reward, or promise of reward, including any promise of future employment, in exchange for recommending, influencing or attempting to influence the award of or the terms of a state contract. This prohibition is absolute and cannot be waived.

Members of certain Boards are required to comply with additional conflict of interest provisions found in SDCL Chapter 3-23 and are required to make an annual disclosure of any contract in which they have or may have an interest or from which they derive a direct benefit. The restrictions apply for one year following the end of the Board member's term. The Boards impacted by these laws are enumerated within SDCL 3-23-10. For more information on these provisions, see the State Authorities/Boards/Commissions page in the Legal Resources section of the Attorney General's website at: http://atg.sd.gov/legal/opengovernment/authorityboardcommission.aspx.

Absent a waiver, certain Board members are further prohibited from deriving a direct benefit from a contract with an outside entity if the Board member had substantial involvement in recommending, awarding, or administering the contract or if the Board member supervised another state officer or employee who approved, awarded or administered the contract. With the exception of employment contracts, the foregoing prohibition applies for one year following the end of the Board member's term. However, the foregoing prohibition does not apply to Board members who serve without compensation or who are only paid a per diem. See SDCL 5-18A-17 to 5-18A-17.6. For more information on these restrictions see the Conflict of Interest Waiver Instructions and Form on the South Dakota Bureau of Human Resources website at: http://bhr.sd.gov/forms/.

Other federal and state laws, rules and regulations may apply to specific Boards. For general questions regarding the applicability of SDCL Chapter 3-23 or other laws, a Board member may contact the attorney for the Board. However, because the attorney for the Board does not represent the Board member in his or her individual capacity, a Board member should contact a private attorney if the member has questions as to how the conflict of interest laws apply to the Board member's own interests and contracts.

Consequences of Violations of Conflict of Interest Laws

A contract entered into in violation of conflict of interest laws is voidable and any benefit received by the Board member is subject to disgorgement. In addition, a Board member who violates conflict of interest laws may be removed from the Board and may be subject to criminal prosecution. For example, a Board member may be prosecuted for theft if the member knowingly

uses funds or property entrusted to the member in violation of public trust and the use resulted in a direct financial benefit to the member. See SDCL 3-16-7, 5-18A-17.4, and 22-30-46.

Retaliation for Reporting

A Board cannot dismiss, suspend, demote, decrease the compensation of, or take any other retaliatory action against an employee because the employee reports, in good faith, a violation or suspected violation of a law or rule, an abuse of funds or abuse of authority, a substantial and specific danger to public health or safety, or a direct criminal conflict of interest, unless the report is specifically prohibited by law. SDCL 3-16-9 & 3-16-10.

Board members will not engage in retaliatory treatment of an individual because the individual reports harassment, opposes discrimination, participates in the complaint process, or provides information related to a complaint. See SDCL 20-13-26.

Anti-Harassment/Discrimination Policy

While acting within their official capacity, Board members will not engage in harassment or discriminatory or offensive behavior based on race, color, creed, religion, national origin, sex, pregnancy, age, ancestry, genetic information, disability or any other legally protected status or characteristic.

Harassment includes conduct that creates a hostile work environment for an employee or another Board member. This prohibition against harassment and discrimination also encompasses sexual harassment. Sexual harassment includes unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexually harassing nature, when: (1) submission to or rejection of the harassment is made either explicitly or implicitly the basis of or a condition of employment, appointment, or a favorable or unfavorable action by the Board member; or (2) the harassment has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Harassment or discriminatory or offensive behavior may take different forms and may be verbal, nonverbal, or physical in nature. To aid Board members in identifying inappropriate conduct, the following examples of harassment or discriminatory or offensive behavior are provided:

- Unwelcome physical contact such as kissing, fondling, hugging, or touching;
- Demands for sexual favors; sexual innuendoes, suggestive comments, jokes of a sexual nature, sexist put-downs, or sexual remarks about a person's body; sexual propositions, or persistent unwanted courting;
- Swearing, offensive gestures, or graphic language made because of a person's race, color, religion, national origin, sex, age or disability;
- Slurs, jokes, or derogatory remarks, email, or other communications relating to race, color, religion, national origin, sex, age, or disability; or
- Calendars, posters, pictures, drawings, displays, cartoons, images, lists, e-mails, or computer activity that reflects disparagingly upon race, color, religion, national origin, sex, age or disability.

The above cited examples are not intended to be all-inclusive.

A Board member who is in violation of this policy may be subject to removal from the Board.

Confidential Information

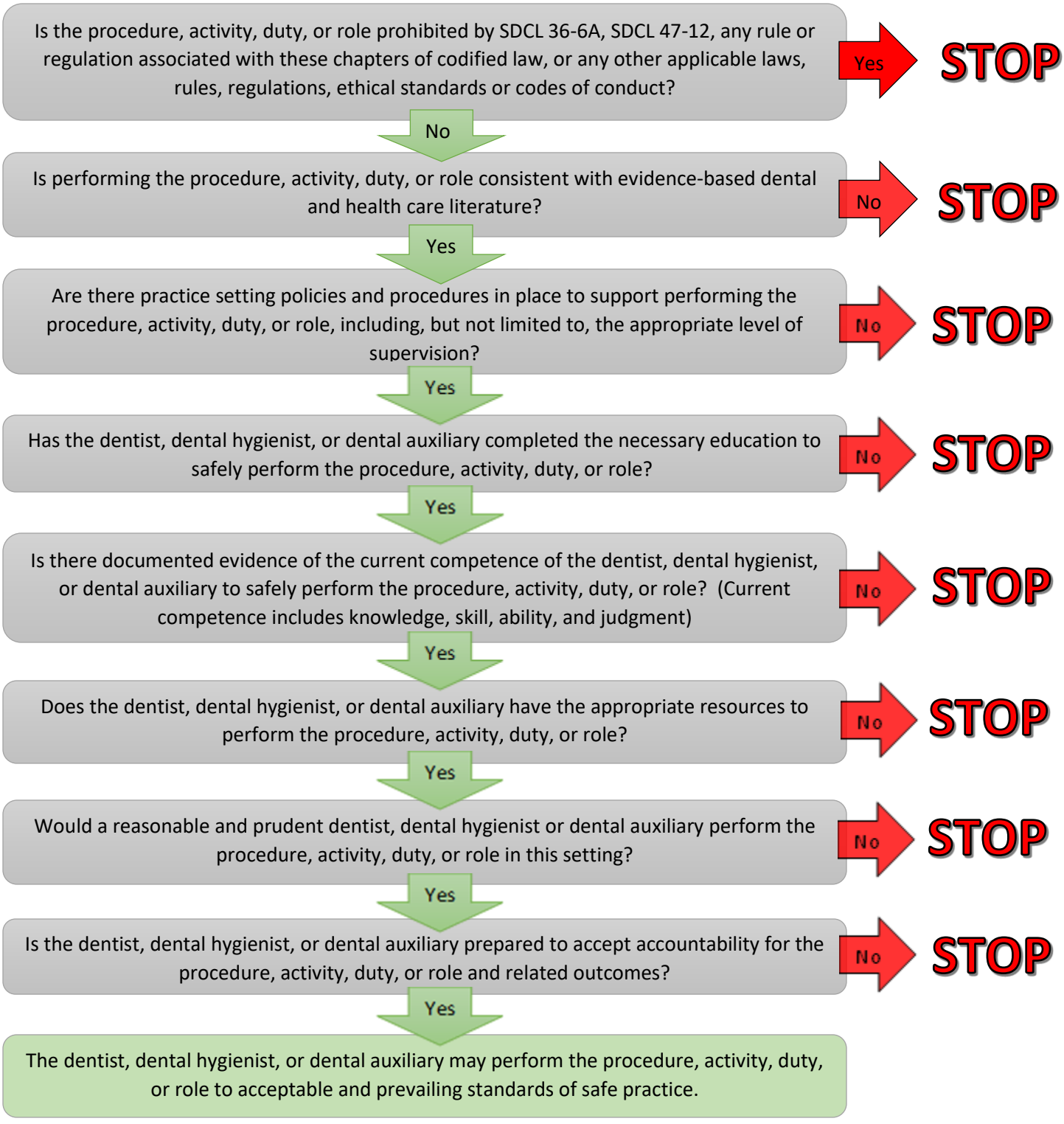
Except as otherwise required by law, Board members shall not disclose confidential information acquired during the course of their official duties. In addition, members are prohibited from the use of confidential information for personal gain.

Reporting of Violations

Any violation of this Code should be reported to the appointing authority for the Board member who is alleged to have violated the Code.

Scope of Practice Decision-making Framework

Identify, describe, or clarify the procedure, activity, or role under consideration.



These decision-making framework guidelines are for educational purposes only. The guidelines do not purport to establish a standard of care or advise a course of action for patient care in any particular situation.

Framework adopted by the South Dakota State Board of Dentistry on January 11, 2019.

South Dakota State Board of Dentistry
Continuing Education Requirements

Dentists

Dentists must earn 100 hours of continuing education in every 5-year CE cycle. Fifty (50) of those hours must be academic. Dentists must maintain a current cardiopulmonary resuscitation (CPR) card. The Board of Dentistry will only accept the American Heart Association for the Basic Life Support (BLS) Provider (*formerly known as the Healthcare Provider*), the American Red Cross for the Professional Rescuer or the American Red Cross for the Healthcare Provider cards. A Dentist holding a general anesthesia and deep sedation or moderate sedation permit must have a current Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) card from the American Heart Association. *See the CPR requirements in the CE guidelines below*. A Dentist holding a general anesthesia and deep sedation or moderate sedation permit must complete an additional 25 hours of continuing education in anesthesia related topics for each five-year licensure cycle.

Dental Hygienists

Dental Hygienists must earn 75 hours of continuing education in every 5-year CE cycle. A Dental Hygienist must have documented at least five hours of continuing education in dental radiography in a five-year period. Dental Hygienists must maintain a current cardiopulmonary resuscitation (CPR) card. The Board of Dentistry will only accept the American Heart Association for the Basic Life Support (BLS) Provider (*formerly known as the Healthcare Provider*), the American Red Cross for the Professional Rescuer or the American Red Cross for the Healthcare Providers cards. *See the CPR requirements in the CE guidelines below.*

Registered Dental Assistants (Expanded Functions)

Registered Dental Assistants must earn 60 hours of continuing education in every 5-year CE cycle. A person who is certified in dental radiography must have documented at least five hours of continuing education in dental radiography in a five-year period. Registered Dental Assistants must maintain a current cardiopulmonary resuscitation (CPR) card. The Board of Dentistry will only accept the American Heart Association for the Basic Life Support (BLS) Provider (*formerly known as the Healthcare Provider*), the American Red Cross for the Professional Rescuer or the American Red Cross for the Healthcare Providers cards. *See the CPR requirements in the CE guidelines below.*

Dental Radiographers

Dental Radiographers are required to earn 5 hours of continuing education in dental radiography in every 5-year CE cycle.

Continuing Education Categories

Academic: Dentists must complete a minimum of 50 hours in a 5-year CE cycle

Dentists are the only practitioners required to obtain academic hours. Dental hygienists and registered dental assistants who attend academic continuing education should submit those courses in the clinical category.

Academic hours must directly relate to the provision of clinical dental services and meet one of the following criteria: The course must be taken physically at a dental school accredited by the American Dental Association Commission on Dental Accreditation (CODA), the course presenter must be affiliated with a dental school accredited by the American Dental Association Commission on Dental Accreditation (CODA), the provider organization must be approved by the American Dental Association Continuing Education Recognition Program (CERP), or the provider organization must be approved by the Academy of General Dentistry Program Approval For Continuing Education (PACE).

Home Study: Limited to 30 hours maximum in a 5-year CE cycle

Online continuing education courses or webinars that include an interactive component are not considered home study and should be categorized based on course content.

Home study continuing education may include online courses or courses presented via CD that do not have an interactive component. Home study courses require that you demonstrate your participation in the course or lecture through a certificate of completion from the continuing education provider. You cannot receive credit for the same home study course more than one time during your 5-year CE cycle.

CPR: Limited to 15 hours maximum in a 5-year CE cycle

Being certified in cardiopulmonary resuscitation (CPR) is a requirement for all dentists, dental hygienists, and registered dental assistants. All such licensees/registrants must maintain a current CPR card. The Board of Dentistry will only accept the American Heart Association for the Basic Life Support (BLS) Provider (*formerly known as the Healthcare Provider*), the American Red Cross for the Professional Rescuer or the American Red Cross for the Healthcare Providers cards. You do not have to take a refresher course every year; just keep your certification current. Credit for CPR courses is hour for hour. *The Board of dentistry does not recognize on-line CPR courses.* Dentists holding a general anesthesia and deep sedation or moderate sedation permit may submit an Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) card from the American Heart Association to satisfy the CPR requirement. The Board of Dentistry will recognize hours taken for a certified paramedic, certified emergency medical technician and advanced certified life support in the CPR category with the applied 15 hour limit.

Practice Management: Limited to 10 hours maximum in a 5-year CE cycle

Practice management courses or lectures are taken to benefit oneself for personal or professional gain or enhancing the business aspects of dentistry. Courses and lectures include, but are not limited to, practice management, dental ethics, risk management, stress management, communication skills, office ergonomics, HIPAA, domestic violence, etc. Completion of a college business or college computer-business class will be accepted for 10 hours of practice management if the class included at least 10 hours of lecture or class time.

Nutrition: Limited to 15 hours maximum in a 5-year CE cycle

Nutrition courses or lectures include topics of dental nutrition. These topics included, but are not limited to, diet, exercise, dental nutrition, and health issues affecting dental health (ex. Anorexia nervosa, bulimia, etc.)

Clinical: Unlimited

Clinical courses or lectures are presented by an instructor who is not affiliated with a CODA accredited university or do not meet the criteria for Academic continuing education. These courses or lectures emphasize practitioner to patient contact. Examples include, but are not limited to latest techniques in dentistry, clinical courses, specialties, OSHA/infection control, etc. Courses presented by colleagues or other presenters providing an in-office presentation should obtain prior course approval from the Board.

Radiography: Dental Hygienist and Radiographers must have a minimum of 5 hours of radiography courses in a 5-year CE cycle. Limited to 20 hours maximum in a 5-year CE cycle.

Radiography topics can include radiation safety, equipment operation, film processing, emergency procedures, anatomy and positioning of relevant procedures, radiographic quality assurance, correcting and identifying technique and processing errors, and recognition and identification of radiographic information, such as procedures for enhancing interpretation of radiographic information including disease. Home study radiography courses are allowed. However, if you take the same home study course more than one time during your 5-year CE cycle, you will only receive credit for one course. You cannot receive credit for the same home study course more than one time during your 5-year CE cycle.

Anesthesia/Sedation: Dentists holding a general anesthesia and deep sedation or moderate sedation permit must complete an additional 25 hours of continuing education in anesthesia related topics for each five-year licensure cycle.

A Board approved anesthesia inspector is eligible for two hours of anesthesia related continuing education for each anesthesia inspection completed with a maximum of ten hours per continuing education cycle.

Dentists holding a general anesthesia and deep sedation or moderate sedation permit may claim 4 hours of anesthesia related continuing education for each ACLS or PALS certification completed and may claim a maximum of 8 hours per continuing education cycle (i.e. 2 ACLS certification courses).

Other Continuing Education Guidelines

Clinical – Exhibits (State, Regional or National Meetings/Conventions):

Hour for hour up to five (5) hours of Clinical-Exhibits CE may be earned for attendance at the exhibits and meetings at a state, regional or national meeting/convention up to twenty-five (25) hours per 5 year CE cycle.

Clinical – Course (table clinics of a state, regional or national meetings/conventions)

One (1) hour Clinical-Course CE may be earned for each attendance at the table clinics of a state, regional or national meeting/convention.

Examiners:

CRDTS and other Regional Board Examiners are allowed five (5) hours Academic CE per year in the area of the exam for which he/she calibrates. If a CRDTS examiner calibrates in all three different areas (restorative, periodontal, and clinic floor) of the exam, he/she may earn the five (5) hours for each area and therefore up to fifteen (15) hours per year.

Clinical - Volunteer Services:

Up to thirty (30) hours of Clinical-Volunteer CE may be earned per 5 year CE cycle for volunteer service with:

- Delta Dental Mobile Program
- Donated Dental Services (DDS) programs
- Sanford Children's Hospital: Cleft Lip & Palate Clinic
- Christina's Smile Care Mobile
- Examinations for troops before deployment
- St. Francis Mission Dental Clinic
- Sioux Empire Smiles

Clinical-Volunteer CE may be earned for other volunteer activities that involve direct patient care with approval from the Board.

The Board will not approve oral health or oral health career presentations given to elementary and secondary students for continuing education credit. These types of presentations are considered community service.

Teleconference or Live Webcast Courses:

Teleconference or live webcast courses may fall under the categories of Clinical, Academic, Practice Management, or Radiography depending on the instructor's credentials and the content of the course.

Class Instruction/Attendance:

Dentists, dental hygienists and registered dental assistants teaching seminar classes may have their seminar teaching hours allowed as Clinical CE after completing the CE Course Approval Form and providing a course outline and biography for Board approval. Hour for hour credit will be allowed for instruction of the course as a one-time credit per course during the 5-year cycle. An in-office presentation to dental hygienists and registered dental assistants by another dental professional may be allowed as Clinical CE. You must submit the CE Course Approval Form and provide a course outline and biography of the presenter for Board approval.

Class instruction and/or class attendance at a CODA accredited dental school may be allowed as Academic CE. You must provide an outline of teaching content and obtain Board approval. Hour for hour credit may be given for class instruction and /or class attendance up to one half of the required hours during the 5-year cycle. For example, a maximum of 50 hours for dentists, 38 hours for hygienists, and 30 hours for registered dental assistants is allowed.

Upon request, if a licensed practitioner attends an accredited dental or dental hygiene school full time or is completing a specialty or general practice residency while licensed with the Board, the required continuing education credits may be waived for the time period that the licensee is attending the accredited dental or dental hygiene school or completing a specialty or general practice residency.

In Office Instruction:

In office classes presented to staff by the in office Dentist are allowed. The Board requires prior approval by submitting the CE Course Approval Form.

Digital Software Courses: In office instruction and training of hygienists and registered dental assistants in digital x-rays by digital software professional trainers may be allowed partly as Radiography CE and partly as Practice Management CE. You must complete the CE Course Approval Form and provide a course outline and the Board will determine the number of hours to be applied in each category.

Practice Management Software Courses: In office instruction and training of dental hygienists and registered dental assistants in practice management software by the professional trainers may be allowed as Practice Management CE. You must complete the CE Course Approval Form and provide a course outline and the Board will determine the number of hours to be applied in each category.

Specialty Dental Practice/Laboratory: Instruction of a dental hygienist or registered dental assistant at another specialty dental practice or dental laboratory in order to perform new procedures and tasks, not previously performed, may be allowed as Clinical CE. You must complete the CE Course Approval Form and provide a course outline and the Board will determine the number of hours to be applied in each category. The Board recommends the specialty dental practice submit the CE Course Approval Form and course outline for prior approval.

Miscellaneous:

The Board will not approve continuing education classes on the subject of animal dentistry, as the Board issues licenses to dentists performing dental services on humans per SDCL 36-6A-32.

The Board generally recognizes continuing education providers certified through the American Dental Association Continuing Education Recognition Program (ADA CERP), the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) and the American Academy of Dental Hygiene as valid continuing education providers.

Courses that have been approved are listed on the Approved CE Calendar, which you can access in your account by logging in to your account through the Board of Dentistry web site.

The Board determines whether a continuing education course will be approved and the category each course will fall under. If you are uncertain about approval and/or what category a continuing education course will fall under, please contact the South Dakota State Board of Dentistry office.