South Dakota
DENTAL ASSOCIATION

A constituent society of the American Dental Association

S.D. Dental Association
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May 1, 2023

Dr. Nicholas Renemans, Chairman
South Dakota State Board of Dentistry
PO Box 1079
Pierre, SD 57501

Dear Dr. Renemans:

The South Dakota Dental Association appreciates the Board of Dentistry's work to update the administrative rules concerning specialists and specialty advertising as well as the supervision requirements for allied staff administering local anesthesia and nitrous oxide.

Over the course of the past year, the Board has solicited input and incorporated feedback from stakeholders in the various drafts of the proposed rules. We appreciate the transparent and thorough process of review undertaken by the Board. We have responded to the Board's requests for input by providing both oral and written recommendations.

The Association supports the rules as published by the Board. Once adopted, we will share the new rules with our members and will provide them with information, as needed, to assist with adherence to the new rules.

Thank you for the opportunity to provide input on the rule changes being considered by the Board.

Sincerely,

Paul Knecht
Executive Director

Specialization

The public today has an intuitive understanding of the meaning and value of specialty training and care. This legitimacy and trust come from rigorous educational standards and the notion of 'training to competence' in selective full time residency programs. Well conducted surveys have demonstrated that this trust is indeed built on the assumption that a specialist has completed a full-time residency in a particular, focused field.

We should never be done learning and growing as professionals. Continuing dental education is an expectation for all dentists. It is normal and good for dentists to develop special interests in their clinical practice and to pursue continuing education in those areas. Part time continuing education courses provide valuable avenues for licensed providers to pursue these interests and expand their clinical skills.

When a certain thresh-hold of continuing education is completed by a practitioner, coupled with passage of a written and oral examination, it is appropriate for an accredited board, such as the ABOI, to certify the diplomate status of this practitioner. Diplomate status is a meaningful achievement. Diplomate status can and should be advertised. We should not impede dentists in appropriately sharing this diplomate status achievement with the public.

The ABOI model of certification, however, does not come close to providing the same level of selective and supervised training to competence as do full-time residency programs.

Residency programs accept a select group of applicants through a competitive application process, whereas the ABOI model accepts all candidates for examination. Perhaps more importantly, the ABOI model of certification involves completing a set amount of self-directed continuing education, adding up to a fraction of the training that a two-year residency provides. As a substitute for the multi-year experience of mentored and supervised practice obtained during a residency program, the ABOI certification model relies on documentation of unsupervised cases completed in private practice, and defense of selective cases before a board of examiners, along with a written examination.

While certainly worthwhile to help a practitioner expand clinical skills, the ABOI model of certification lacks the selectivity, rigor, direct supervision and commitment of a two-year full-time residency training program. The ABOI model of certification is typically completed part time and achieved while the practitioner continues to practice general dentistry full time. As such, instructors and teachers within these part time continuing education courses do not have the same opportunity to see the practitioner's successes and failures over time, to help train in areas the practitioner is deficient in, or to witness the practitioner's interactions with peers.

Upon completion of the ABOI certification, the practitioner typically continues to practice general dentistry, perhaps with a special emphasis on implant dentistry. This is different from specialty practice, where specialists work on a referral basis within that narrower or "specialized" scope of practice, honing and expanding a specialized skill set for the rest of their professional careers.

I applaud AAID and ABOI for meaningfully raising the knowledge and skills of dentists placing implants. However, using the term specialist to characterize ABOI certification is substantially misleading and potentially harmful to the public.

Full time residency training has defined medical and dental specialization for many decades in our society, and for good reasons. When my daughter, with complex congenital heart disease needed the care of a specialist, we intuitively knew what that meant.

We rightfully assumed that the cardiac specialist who we put our trust in for her specific and complicated needs had the background and license to practice medicine in a general sense. But the real reassurance and confidence that we needed came from the correct assumption that her specialist had applied for and successfully completed a full-time residency program within that specialized sphere of practice.

After competing for a spot, practitioners completing a residency program embark on a rigorous and immersive training experience. Some of the practitioners discover for themselves that they are not prepared to complete the rigorous requirements and they are not able to complete the residency program. Others need experienced mentors and comparative experiences with other residents to perhaps help them realize that they are not in the right field of clinical practice. Ultimately, every practitioner accepted into a residency does not graduate and become certified. Those practitioners that successfully complete a specialty residency program give up general clinical practice for at least two years to gain the extensive breadth and depth of experience to earn the designation of a specialist in that particular field.

Seeing a specialist traditionally involves referral from a generalist to specialist who has deliberately narrowed their scope of practice based on the training obtained during the residency program. Practicing as a specialist does not involve practicing as a generalist and then putting on a different "specialist" hat within the same practice, however well-earned that second hat may be.

Preserving the special meaning of the designation 'specialist' by no means should limit the scope of practice of non-specialists. A general dentist with extra training and even certification in orthodontics can and should tackle many orthodontic cases, but parents trying to help their teenager manage a progressive skeletal anterior open bite deserve to know that they are being helped by a specialist that has completed a full-time residency program in which they obtained the breadth and depth of experience and knowledge to tackle such a complex case.

The term specialist has also taken on meaning in the insurance and legal realms, helping to define standards of clinical care.

So, by all means, dentists should share their education and extra credentials, but for the sake of the easily misled public, and as a courtesy to those providers who have cleared this substantially higher bar of residency training, let us not gut the meaning of this designation of "specialty" that still has so much relevance.

Accredited institutions of higher learning are free to develop residency programs based on the need for them and popular demand. Loma Linda has such an implant residency. Others have and will continue to follow suit, perhaps forging a path forward to a well-recognized and legitimate dental implant specialty. In the meantime, patients can get their dental implants wherever they feel most comfortable, either from start to finish with their general dentist, or with a periodontist or oral surgeon in collaboration with their general dentist. Preserving the term "specialist" for those that have completed the residency

training does not impact access to care or limit who can provide the service. It merely informs the public, so they can make an informed decision regarding their care.

Both periodontal and oral surgery residencies - the two well established surgical based residencies in dentistry - have incorporated significant amounts of dental implant training into their programs. I want to be clear, this does not make them implant specialists. They are specialists in periodontics and oral surgery. However, telling the public that an ABOI certified provider has obtained anything close to the level of experience and proficiency gained in surgical implant dentistry through residency training is misleading.

It should be added that specialty board certification does not make the specialist. It is the residency experience that qualifies a practitioner to be a specialist, not subsequent elective oral and written exams.

A helpful illustration of this logic is my diplomate status with the National Dental Board of Anesthesiology. The formal education that qualified me to seek diplomate status with the National Dental Board of Anesthesiology included four months of dedicated time on the anesthesia service during my hospital-based residency. During this time I ran OR anesthesia cases all day under the direct supervision of medical anesthesiologists. In addition, during countless hours of work in the outpatient oral surgery clinic from 2001 to 2007, I practiced IV sedation under the direct supervision of both oral surgeons and anesthesiologists, including pediatric general anesthesia.

In private practice I continue to expand my knowledge and skills in anesthesia with regular CE and office-based team training. I have additionally achieved certification by examination through the National Dental Board of Anesthesiology. Does this board certification and fellowship status qualify me to put myself forward to the public as a specialist in dental anesthesia? No, because I did not complete a residency program in dental anesthesia. There are dentists that have completed extensive and thorough training through a focused residency program in dental anesthesia; they are true specialists in dental anesthesia. I know when I need their specialized services in my office, or when to take my patient to the hospital to let a medical anesthesiologist help provide the specialized anesthesia care my patients may need.

The primary argument that has been used to justify opening the door wider to specialty advertising is free speech. Free speech is great, but when your health is on the line, that may not be the best argument.

State dental boards across the country are currently wrestling with this problem. Most members of these boards, the practitioners licensed by these boards, and the public at large, have an intuitive sense of what the right answer is when the facts are all laid out. That doesn't mean that deep pocketed, industry-supported special interest groups will not convince some people, and even some courts, that alternative paths to specialty recognition are justified based on free speech.

South Dakota is the next state in line to address this issue. I am hopeful that a commonsense argument for basing specialty recognition and advertising on the simple criteria of completing a minimum two-year full-time residency, will prevail. Every specialist in the state has cleared this unambiguous and rigorous bar, and patients desiring their specialized assistance should not be misled by false equivalents.

Scott Van Dam, DDS MD

Letter to the Board in preparation for the June 2, 2023 meeting

The discussion centers around the fact that for all intents and purposes the proposed rules and the ABDS/ABOI-AAID rules are the same and that ABDS/ABOI-AAID do not enforce the requirement for alternative trade organization paradigms to prove equivalency to their own 2 year full time implantology residency programs in order to sit for the exam. At this time no evidence has been presented that the weekend CE trade organization paradigm in any way shape or form is equivalent to a 2-year full time residency in implantology such as the one at Loma Linda University. It's hard to imagine any meaningful objection to the rules by ADBS/ABOI-AAID since you'd be objecting to oneself if you did. The trade organization paradigm has set up a 2-tiered system for advertising as a specialist where you can have weekend CE trained practitioners with an emphasis in implants or a residency trained implantology specialist (yes, they exist). Flannery/Georgalis makes a good point that "It is unrealistic to think that the ordinary consumer will know the difference between an emphasis and a specialty". It follows then that it is unrealistic that the public will be able to discern the difference between a weekend CE trained practitioner with an emphasis in implants and a residency trained implantology specialist when their ABOI advertising is the same. In this regard we agree with Flannery/Georgalis that the trade organization paradigm will mislead the public. Furthermore, surveys of the public prove Flannery/Georgalis' point that the public cannot discern the difference and feel misled when they find out the difference.

We believe it can be shown unequivocally that the trade organization weekend CE paradigm is not equivalent to a 2-year full time residency in implantology at an accredited institution. The Board does not have to prove that they are not equivalent. Rather it is the trade organizations that have to prove that they are equivalent, to the satisfaction of the Board, not to the satisfaction of a trade organization.

So, on the grounds that there is no proof of equivalency between weekend CE and full time residency training in implantology, that the ADBS/ABOI-AAID rules are the same as the proposed rules and that the public would otherwise be misled we support the proposed rules.

The Board is to be commended for its work to ensure high quality, consistent and equitable specialty training to serve the people of South Dakota.

Siouxland Oral & Maxillofacial Surgery
Drs, Miller, George and Leet

Background

We support the Board's proposed rules on specialty education and advertising because Implantology would be recognized as a specialty and all specialties would be treated equally. Enforcement of the existing ABDS/ABOI-AAID rules and proof of educational equivalency are the key issues. The focus of the proposed rules is where it should be: ensuring that specialists are trained at the specialty educational level and possess not only adequate, but complete comprehensive training and mastery of the specialty. We have not found, and no one so far has produced, evidence that any type of continuing education (CE), weekend or otherwise, is comparable to a 3,300-hour full time Implantology residency. For all practical purposes the ABDS/ABOI educational requirements are the same as the rules proposed by the Dental Board so this is a simple matter of enforcing the rules already adopted by ABDS/ABOI-AAID since the addition of a test is immaterial to the educational requirement. Practitioners must meet the educational requirement first in order to qualify to sit for the test so the issue of the test as a determinant of specialty training is irrelevant according to the ABDS/ABOI-AAID rules.

The Board is not required to accept a trade organization's say so that weekend CE is equivalent to a full-time residency. In fact, and because of certain legal proceedings in which commercial free speech was the focus, the Board is specifically prohibited from deferring to a trade organization such as ABDS/ABOI-AAID when deciding matters that concern the Board such as educational standards. In this case proof of equivalency is required but lacking. Even a cursory comparison of abbreviated weekend educational experiences to an implant residency such as the one at Loma Linda would appear to be a valid unbiased, comprehensive benchmark to determine equivalency, ... or not. There would be more residencies to choose from but according to Dr. Hilt Tatum from AAID/ABOI leadership there were 4 full time implantology residencies with 5 in development by 1983/84 that tragically were killed off by commercialization of the field. It is hard for trade organizations to complain that full time residencies aren't available when they are the ones that killed most of them off. The focus needs to return to the quality of the program and education offered. In that regard, the burden of proof to show that limited CE produces the same quality as a specialized residence program resides with the trade organizations to produce, not the Board.

CE is just that, it builds on an already learned competency. CE is not used to learn a new competency, that's why CERP (continuing education recognition program) prohibits it. Agreeing to the CERP rules as a CE participant or as a CE provider and then using that CE towards a degree or certificate is disingenuous, even if it is allowed by some organizations. Migrating generalist competencies from teeth and tissue borne prosthetics learned in Dental

School to implant and tissue borne prosthetics is a continuation of a learned competency. There is no core surgical competency as it pertains to dental implants and grafting that is learned in dental school at the specialty level. You have to attain the specialty competency first, then you can continue your education in that competency. You can't continue your education into a specialty competency. CE assumes you have the attained the competency first. There is a big difference between training to competency and then continuing an education in that competency or maintaining that competency. That is the difference between competency from completing an implantology residency and participating in weekend CE. Continuing education for generalists to maintain and build on their core dental competencies is a great thing and it should be encouraged and promoted but it is not specialty training to competence.

Previous discussions missed the whole point of calibrating and self-referencing weekend CE education to full time Implantology residency education as required by ABDS/ABOI-AAID. They compared everything else to weekend CE or abbreviated training but not the thing that actually mattered, that is their own full time implantology residencies. Weekend CE is at best an abbreviated and disconnected version of full-time training with the clinical experience mostly being self-directed and unsupervised. In many cases the "hands on" component is on models, by demonstration and in at least one case an egg, to "train" generalists advanced procedures that they then take back to their practices and experiment on the public. The egg "hands on" program at the MaxiCourse Harvard Club of Boston proposes to train participants to the specialty level, how to complete advanced sinus lift bone grafting. There is no training to competence during multiple surgeries under supervision. After the weekend is done the practitioner is free to complete these advanced techniques on patients in their office and claim completion of the module as part of the continuum requirement of AAID/ABOI. Then they can apply this to qualifying for the ABOI exam as specialist training. Clearly this is not training to the specialist level and to even consider it training to the generalist level is highly suspect and concerning. According to the South Dakota Scope of practice decision making tree one would have to question the integrity of a practitioner that thought egg training was sufficient, to believe that they were trained to competence, to perform that procedure unsupervised on a patient. This calls into question any claims of "rigorous training". This is where the claim of equivalency between weekend CE or abbreviated training and residency training falls apart.

Previous discussions also missed that the ABDS rules state that training must be above and beyond general dental education, meaning that generalists cannot be training generalists into becoming specialists. Specialists must train generalists into becoming specialists. This is consistent with HLC requirements that govern higher education requirements in our state and consistent with the ABDS/ABOI-AAID rules on proving equivalency of didactic and clinical training.

Previous discussions also missed the obvious problem of misleading the public when there is a two-tiered system of specialists in the trade organization paradigm. Surveys show that the

public expects a specialist to be full time residency trained and are misled if that is not so. Flannery/Georgalis makes a good point that "It is unrealistic to think that the ordinary consumer will know the difference between an emphasis and a specialty". It follows then that it is unrealistic that the public will be able to discern the difference between a weekend CE trained practitioner with an emphasis in implants and a residency trained implantology specialist when their ABOI "credentials" are the same. In this regard we agree with Flannery/Georgalis that the trade organization paradigm will mislead the public. Is it truly truthful to say that 670 hours equals 3,300 hours? Is it truly truthful to assert that every hour of weekend CE is equivalent to 5 hours of full-time residency training?

The Board already has precedent to impose educational standards on dentists by only allowing dentists that have completed a 4-year full time dental program at an accredited institution to practice dentistry in this state. Trade organizations already depend on the Board to enforce this educational threshold as a qualification for their own courses. So, it is disingenuous to require and depend on the Board to promulgate an educational standard in one sense that benefits the trade organization and then not want to abide by that same idea of an educational standard when it applies to specialty training and doesn't benefit the trade organization. You can't have it both ways.

When the focus is where it should be—ensuring that specialists are truly specialty trained, so that patients are protected—it is difficult to claim the ABDS/ABOI-AAID rules are different than those being proposed by the Dental Board. The way the ABDS rules are written, they already acknowledge that the educational standard is a 2-year full time residency in Implantology at an accredited institution. By doing so ABDS/ABOI-AAID have established that everything about weekend or abbreviated CE must be compared to the educational standard including, that the level of education of the educators is at least one degree higher than that of the student as it is in a residency. This is the didactic and clinical part of showing equivalency as per the ABDS/ABOI-AAID rules. This is consistent with the Higher Learning Commission standards (HLC - 19 states in our region) that accredit all higher learning institutions in South Dakota, specifically states the same thing. That in order to be a valid form of education the educator must hold a certificate or degree that is at a higher level than the students/residents they teach. In 2020 the DOE eliminated the distinction between regional and national accreditation agencies by creating one unified set of institutional accreditors. This is how it is throughout the whole country according to the higher education accreditation agency's "Assumed Practice B. Teaching and Learning; Quality, Resources and Support" requirements.

As the law office representing AAID, Flannery/Georgalis acknowledges, "...the board is entitled to prohibit fraudulent or misleading claims of specialization..." and ABDS/ABOI-AAID rules state that alternative education "...must demonstrate it is equivalent with didactic, clinical and completed cases to their two-year post-graduate training program". This is a

requirement in order to sit for the exam. Since alternative weekend education has failed to show equivalency, it is not in the best interest of the public to recognize non implant residency trained practitioners as specialists, completion of the exam is irrelevant. Because of this lack of proof of equivalency, we believe that claims of specialty "credentials" by weekend trained dentists are not bona fide and the credibility of the organizations that promote those "credentials" is also called into question.

In addition, up until 2022 it was not allowed to use CERP CE towards a degree or certification so any applicant to AAID/ABOI that relied on CERP CE to meet their requirements would have submitted CE hours that failed to meet set and accepted educational standards and in violation of the agreement with those CE providers, the CE participants and CERP. It would be interesting to review the CE of all ABOI graduates to see which relied on CERP and therefore did not meet the qualifications of ABOI to sit for the exam. It is interesting to note that many MaxiCourses are CERP certified as well.

We have much more information now than what was available in 2017 and in reading the court documents the courts didn't endorse the trade organization paradigm they just didn't receive enough information to reject it. The courts left open the possibility of different rules in the future if the Board could show that the rules were sufficiently narrow in scope and served a legitimate purpose. We believe that the information we have brought forward proves the legitimate purpose and that the rules are narrow in scope. In fact, for all practical purposes, they are the same as the rules already promulgated by ABDS/ABOI-AAID. We also believe we have shown that the trade organization paradigm misleads the public. So it really boils down to the Board enforcing the rules that ABDS/ABOI-AAID have failed to enforce themselves.

The Board is rightly concerned about educational standards since information from Device Events and iData Research (which is in the public domain) shows harm caused to patients, with a doubling of implant failures since 2018 with only a relatively small rise in implant cases. So it is appropriate that the board with its proposed rules enforces the educational standards that promote the health and safety of patients.

We need these proposed rules because there is no national educational standard for trade organizations and no governmental or independent third-party oversight as there is for educational institutions. So it falls to the Dental Board to protect the public by maintaining high quality educational standards for South Dakota.

The Board is to be commended for its work to ensure high quality, consistent and equitable specialty training to serve the people of South Dakota.

Siouxland Oral & Maxillofacial Surgery
Drs, Miller, George and Leet

FLANNERY
GEORGALIS
LLC

May 26, 2023

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

Re: *Stakeholder Feedback*
American Academy of Implant Dentistry
Draft Advertising / Specialty Advertising Administrative Rules

Dear Members of the Board:

Flannery | Georgalis represents the American Academy of Implant Dentistry ("AAID"). We write in response to the proposed amendments to Rule 20:43:04:01, which would govern the ability of dentists in South Dakota to hold themselves out as "specialists." More specifically, we write to express our objection to the proposed rule, which would prohibit dentists from advertising their *bona fide* credentials and, in so doing, infringe on the First Amendment free-speech rights of both dentists and credentialing organizations like AAID.

As you know, AAID is a national dental organization that supports a certifying board, the American Board of Oral Implantology/Implant Dentistry ("ABOI/ID").

The ABOI/ID Diplomate designation symbolizes the highest level of competence in implant dentistry. Certification by the ABOI/ID attests to the fact that a dentist has demonstrated knowledge, ability, and proficiency in implant dentistry through a rigorous examination process. To obtain that certification, a dentist must pass both written and oral examinations and either complete (1) 670 hours of verified continuing education specific to implant dentistry or (2) a residence training program in oral surgery, prosthodontics, periodontics or implant dentistry.

AAID awards membership credentials—recognizing dentists as either Fellows or Associate Fellows. To earn these credentials a dentist must earn *at least* 300 hours of postdoctoral or continuing education in implant dentistry, demonstrated experience, and passing scores on AAID's required examinations.

As proposed here, a dentist would only be permitted to advertise as a "specialist" if they completed a minimum two-year post-doctoral program that is accredited by an accreditation agency recognized by the U.S. Department of Education. Any dentist calling himself a specialist who does not meet this requirement would be guilty of "unprofessional conduct" for "false and misleading advertising" and subject to discipline. Simply stated, there is no legitimate basis to adopt such a regulatory regime, which would serve only to deny consumers factually accurate information about potential providers and unconstitutionally infringe on AAID and its South Dakota members' free speech rights.

Courts have long recognized that commercial speech is protected by the First Amendment. To regulate commercial speech, as the proposed rule would do, the government must show (1) that it has a substantial interest in regulating a commercial speaker's speech, (2) that the proposed regulation "directly advances" that interest, and (3) that the regulation is no more extensive than necessary to advance the government's interest. The proposed rule plainly cannot satisfy this test.

As this Board knows, AAID and its members have successfully challenged similar rules enacted by licensing boards in other states across the country.[1] In an effort to avoid the cost and disruption of litigation whenever possible, AAID has also negotiated favorable resolutions with several dental boards who, like South Dakota, have either considered or enacted specialty advertising regulations that could not withstand First Amendment scrutiny. AAID stands ready to the do the same here and work with the Board to craft specialty advertising rules that are applied equally and allow truthful and full information to be disseminated to the public as they choose their provider. For these reasons, AAID urges the board to abandon the current proposed rule.

Sincerely,

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[1] *See, e.g.*, *AAID v. Parker*, 860 F.3d 300, 304 (5th Cir. 2017)

CDCA WREB CITA

One agency. One mission. One national exam.

May 16, 2023

To whom it may concern,

Our organization is pleased to fully support the recommendation of new rules crafted by the South Dakota State Board of Dentistry pertaining to clinical competency examination requirements for licensure.

This Board's decision to incorporate psychomotor performance language within its written requirements is consistent with the highest standards of public protection and licensure for oral health professionals in jurisdictions throughout the United States. The inclusion of the term "psychomotor performance" is important as it relates to the practice of Dentistry and Dental Hygiene as it requires clinicians to demonstrate sufficient competency in the clinical hand skills required to perform expected surgical and closed-surgical procedures. The absence of a psychomotor performance standard from licensure requirements has the potential to endanger the welfare of the dental care-seeking public.

CDCA-WREB-CITA began significant research and development activities to create and test technology to enable full simulated patient examinations beginning in 2017 with the objective of providing the most ethical licensure testing platform without compromising the demonstration of necessary knowledge, skills, and judgments to show clinical competency. In the last three years, we have seen widespread, long-term acceptance of this pathway in the profession of Dentistry. Substantial and consistent evidence demonstrating the comparability of ADEX simulated patient assessments to the ADEX patient-based assessments gathered through post-examination data evaluation shows overwhelming reliability. We are happy to provide this data upon request.

The ADEX Dental and Dental Hygiene Examinations administered by CDCA-WREB-CITA continue to meet the important standards outlined in South Dakota's Administrative Rules. We continue to be committed to providing South Dakota and other jurisdictions with the highest quality examinations.

Our organization applauds the South Dakota State Board of Dentistry and Ms. Brittany Novotony for its open and transparent rules development process. Please let us know if we assist you in the future and serve your mission to protect the citizens of South Dakota.

Sincerely,

Kimber Cobb, RDH
Nat'l Director of Licensure & Portability; Director of Dental Hygiene Examinations

Dr. Mark Armstrong
Chair, CDCA-WREB-CITA Board of Directors

Alexander Vandiver, MBA
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adha™ | South Dakota DENTAL HYGIENISTS' ASSOCIATION

May 9, 2023

South Dakota State Board of Dentistry
Attention:
Dr. Nicholas Renemans, Chairman
PO Box 1079
Pierre, SD 57501

Dear Dr. Renemans:

The South Dakota Dental Hygienists' Association has read and reviewed the proposed changes that the Board of Dentistry is considering in regards to the delivery of nitrous oxide and local anesthesia. The changes more closely align with a dental hygienists' capabilities and skills, while providing clinical autonomy to both dentist and dental hygienist. It will also provide more flexibility for scheduling dental hygiene services requiring pain management, increasing access to care. A written emergency plan will help support the whole dental team in a health crisis event. The SDDHA board recommends accepting the changes as written.

Thank you for considering this change and supporting all members of the dental team.

Sincerely,

Tasha Wendel
South Dakota Dental Hygienists' Association President 2022-2023

UNIVERSITY OF
SOUTH DAKOTA
SCHOOL OF HEALTH SCIENCES

May 17, 2023

Dr. Nicholas Renemans, Chairman
South Dakota State Board of Dentistry
PO Box 1079
Pierre, SD 57501

Dear Dr. Renemans:

As the Chair of the University of South Dakota Department of Dental Hygiene, I have read and reviewed the proposed changes that the Board of Dentistry is considering in regards to the delivery of nitrous oxide and local anesthesia. The changes more closely align with a dental hygienists' capabilities and skills, while providing clinical autonomy to both dentist and dental hygienist. It will also provide more flexibility for scheduling dental hygiene services requiring pain management, increasing access to care. A written emergency plan will help support the whole dental team in a health crisis event. As the Chair of the University of South Dakota Department of Dental Hygiene recommend accepting the changes as written.

Thank you for considering this change and supporting all members of the dental team.

Sincerely,

Miranda Drake MSDH, BSDH, RDH, RF, CCRP
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