# STATE OF NEW HAMPSHIRE
## BOARD OF DENTAL EXAMINERS
## OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

## PERFORMANCE AUDIT REPORT
## November 2022

MICHAEL W. KANE, MPA
Legislative Budget Assistant
(603) 271-3161

CHRISTOPHER M. SHEA, MPA
Deputy Legislative Budget Assistant
(603) 271-3161

State of New Hampshire

OFFICE OF LEGISLATIVE BUDGET ASSISTANT
State House, Room 102
Concord, New Hampshire 03301

STEPHEN C. SMITH, CPA
Director, Audit Division
(603) 271-2785

*To The Fiscal Committee Of The General Court*:

We conducted a performance audit to assess the efficiency and effectiveness of the New Hampshire Board of Dental Examiners (Board), and Office of Professional Licensure and Certification (OPLC) controls affecting Board operations, during State fiscal years 2019 and 2020. The audit was to address the recommendation made to you by the joint Legislative Performance Audit and Oversight Committee. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. However, absent or broadly defective controls, incomplete understanding of relevant processes and practices by responsible officials, and incomplete agency records compel us to qualify our conclusions.

Given the length of this report and complexity of the audit's scope, we provide some insights into the report's structure.

- The report is assembled to be useful to several sets of potential readers with different needs. This includes the public, the General Court, policy committees, the Board, and the OPLC.

- An executive summary, starting on page 1, captures main themes and the most significant concerns arising from our work. A recommendation summary, starting on page 5, distils key recommendations into a table.

- Chapter 1 contains observations addressing Board and OPLC management controls that broadly affect the Board's operations.

- Chapter 2 addresses the Board's regulatory program which structures each of the Board's main functions.

- Chapter 3 addresses the Board's credentialing function.

- Chapter 4 addresses the Board's monitoring of applicant and regulatee compliance.

- Chapter 5 addresses the Board's enforcement function.

- Observations in each chapter address one or more system or process. Observations generally include, in their first paragraph or two, a summary of the defects we identified. This summary is intended for general readers.

- The remainder of each observation contains detailed information intended to inform the Board and OPLC management about specific deficiencies. This information may also be useful to members of the General Court examining observations that include legislative suggestions. Some observations contain extensive details, and often similar facts, when describing deficiencies and their causes or likely causes. This repetition is partly because of the interrelationship between management control systems and Board functions or processes. It is necessary to allow each observation to be understood independently from the rest. This information is not intended for general readers unless they have a specific interest in an observation's subject matter.

Office Of Legislative Budget Assistant

November 2022

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## ABBREVIATIONS

| | |
|---|---|
| AADB | American Association Of Dental Boards |
| APU | Administrative Prosecutions Unit, Department Of Justice |
| ASEC | Anesthesia and Sedation Evaluation Committee |
| ASEC-AS | ASEC Advisory Subcommittee |
| Board | Board Of Dental Examiners |
| BoMIRT | Board Of Medical Imaging And Radiation Therapy |
| BoRMT | Board Of Registration Of Medical Technicians |
| CPHDH | Certified Public Health Dental Hygienist |
| CY | Calendar Year |
| DEA | U.S. Drug Enforcement Administration |
| DHC | Dental Hygienists Committee |
| DoIT | Department Of Information Technology |
| DOJ | Department Of Justice |
| EFDA | Expanded Function Dental Auxiliary |
| GA/DS | General Anesthesia/Deep Sedation |
| LBA | Legislative Budget Assistant |
| MS-R | Moderate Sedation-Restricted |
| MS-U | Moderate Sedation-Unrestricted |
| NPDB | National Practitioner Data Bank |
| OPLC | Office Of Professional Licensure And Certification |
| PDMP | Prescription Drug Monitoring Program, also known as the Controlled Drug Prescription Health And Safety Program |
| SFY | State Fiscal Year |

## DEFINITIONS

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|---|---|
| Abuse | Behavior that is deficient or improper when compared with behavior that a prudent person would consider a reasonable and necessary business practice, given the facts and circumstances. |
| *Access To Governmental Records And Meetings* | RSA Chapter 91-A, also known as the Right-to-Know law. |

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|---|---|
| Ad Hoc Rule | Uncodified and unenforceable clarification or interpretation of an insufficiently detailed adopted rule. |
| *Administrative Procedure Act* | RSA Chapter 541-A. |
| Certificant | Someone holding a State-issued certificate. |
| Credential | A State-issued permission, such as a license, permit, or certificate, allowing the holder to engage in a regulated occupation or expanded scope of practice. |
| Credential Holder | Someone holding a State-issued credential. |
| Deep Sedation | An induced state of depressed consciousness, accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and to respond purposefully to verbal command, produced by a pharmacologic or nonpharmacologic method, or combination thereof. |
| Dental Auxiliary | Someone who assists a dentist in the care and treatment of dental patients. Responsibilities vary according to the dentist's needs, the auxiliary's training and ability, and regulations. Auxiliaries can include administrative staff, dental assistants, hygienists, dental laboratory technicians, and Expanded Function Dental Auxiliaries. |
| *Dentists And Dentistry* | RSA Chapter 317-A, also known as the Practice Act for dentists and hygienists. |
| Extra-jurisdictional | Actions taken outside the jurisdiction of an agency's delegated authority, and which instead were under an authority delegated to another agency. For example, regulation of an occupation regulated by another agency, without delegated authority, is extra-jurisdictional. |
| Extra-legal | Actions taken outside the authority delegated to any agency, truncating the separation of powers, and encroaching on the General Court's prerogative to set State policy. For example, ad hoc rulemaking is prohibited across agencies. |
| General Anesthesia | A controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including inability to maintain an airway independently and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or nonpharmacologic method, or combination thereof. |
| Hygienist | A dental auxiliary who administers oral hygiene care to patients, assesses patient oral hygiene problems or needs, and advises patients on oral health maintenance and disease prevention. Hygienists may also provide advanced care, such as fluoride treatment or topical anesthesia. |

| | |
|---|---|
| Licensee | Someone holding a State-issued license. |
| Local Anesthesia | A drug-induced loss of sensation in a limited and usually superficial area. |
| Minimal Sedation | A drug induced state during which the patient can respond normally to verbal commands. Although cognitive function and coordination might be impaired, ventilatory and cardiovascular functions are unaffected. |
| Moderate Sedation | A minimally depressed level of consciousness where the patient retains the ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command, produced by a pharmacologic or nonpharmacologic method, or combination thereof. |
| Permittee | Someone holding a State-issued permit. |
| Regulatee | Someone regulated by the Board, including credential holders, as well as those not holding a credential but nonetheless subject to Board regulation. |
| Waste | Using or expending resources carelessly, extravagantly, or to no purpose, primarily due to mismanagement, inappropriate actions, or inadequate oversight. |

## EXECUTIVE SUMMARY

The Board of Dental Examiners (Board) lacked adequate controls to ensure it consistently achieved expected outcomes. The Legislature created the Board to protect the public's health, safety, and welfare from unqualified, unscrupulous, or impaired dentists and hygienists. However, the Board, composed of volunteer members, lacked a discernible management control framework. It did not fully understand the complex interagency, intergovernmental environment within which it operated; its authorities and limitations; operations carried out on its behalf; or its performance or effectiveness. As a result, the Board did not establish, monitor, and enforce a rule-based regulatory program that consistently assured adequate public protection. While the Board was assigned to the Office of Professional Licensure and Certification (OPLC) for administrative support, the OPLC's support of Board operations was problematic. Leadership and staff turnover, inadequate controls, and an inadequately structured relationship between the two agencies further limited effectiveness.

### Credentialing, Monitoring, And Enforcement Functions Lacked Oversight

Before approving a credential application, the whole Board was required to find applicants possessed the necessary professional qualifications and no circumstances existed that would be grounds for discipline. However, 459 of 504 initial credentials issued during the two-year audit period (91.1 percent) were issued without preceding Board action. This included 262 applications (57.1 percent) accepted after a credential had already been issued and 197 applications (42.9 percent) that were never presented to the Board. Credentials were issued to some applicants who did not meet requirements.

The Board primarily relied on credential holder attestations to monitor compliance with ongoing character, conduct, and competency requirements. The Board rarely verified these claims. All 430 regular licenses issued between August 2018 and June 2021 lacked required criminal history record checks. During the audit period, 3,086 of 3,089 credentials (99.9 percent) were renewed without Board action. The Board also relied on reactively monitoring complaints, but we could not determine whether all 109 compliant-like matters submitted during the audit period were even addressed.

The Board developed the fewest controls over its enforcement function. It could not consistently ensure cases progressed and were effectively resolved. Inadequate external support prevented at least three investigations and six adjudicative proceedings from being conducted timely, or at all. Additionally, seven of nine initial license applications with potential conduct issues (77.8 percent) never had a hearing. We also found three cases where the Board imposed extra-legal sanctions.

### Risks Inadequately Managed And Effectiveness Unmonitored

Unaddressed regulatory capture risks, failure to fully implement State policy, and imposition of extra-legal requirements at times exposed the Board to potential federal antitrust scrutiny. The Board lacked a means to objectively establish what threats to public safety, health, and welfare existed. It did not establish the severity of threats, determine whether Board regulations could effectively and efficiently control threats; and whether Board regulation was the only way to

control threats. Instead, the Board regulated based on perceived risks and typically imposed credentialing requirements upon occupations or expanded scopes of practice, often without authority. Requirements it created, such as credential renewals, were perfunctory at times, lacking any means to assess regulatee compliance. The Board inadequately coordinated regulations with other agencies having concurrent or overlapping jurisdictions.

The Board did not monitor its effectiveness. It could not demonstrate its requirements achieved expected outcomes or what it cost to obtain the results it did achieve. The Board could not objectively demonstrate its requirements operated in the public's interest, and *not* in the interest of the industry it was intended to regulate on the public's behalf. The Board relied primarily on limited and haphazard performance reporting based on incomplete and inaccurate records and anecdotes. This led to overly positive, impressionistic views of its performance.

**Compliance Inadequately Controlled**

In developing and operating its regulatory program, the Board was obligated to comply with laws, rules, and other requirements to help protect due process, provide transparency, and ensure its regulations were confined to its statutory authority. However, the Board lacked compliance controls, and:

- exceeded its authority, including by regulating practitioners under the purview of other regulatory agencies;
- inconsistently implemented State policy, including certain permit requirements;
- often relied upon ad hoc rules, imposing some knowingly, resulting in abuse;
- imposed fees that at times lacked statutory and rule basis, and waived statutory requirements, including some fees, without authority;
- inappropriately delegated its joint discretionary decision-making authority to subordinate entities, individual Board and subordinate entity members, and staff;
- created and relied on extra-legal entities to develop and impose regulations, but without effective oversight, eliminating public control over certain regulations; and
- allowed members of some subordinate entities to improperly collect honorarium from the individuals they were responsible for regulating.

**Support Relationship Poorly Structured**

The Board relied upon the OPLC for its business processing, recordkeeping, and other administrative and clerical operations. However, the relationship between the two agencies was largely uncontrolled.

- The Board did not oversee operations carried out on its behalf. There was no accountability framework to address inadequate support or wasteful practices. Board processes were not inventoried to ensure comprehensive support was provided. There were no controls to ensure support processes did not limit regulatory effectiveness.

- The OPLC lacked adequate management controls to ensure it achieved expected outcomes, complied with requirements, and consistently remained within the

boundaries of its authority. There was no overarching risk-based strategy to establish performance goals, objectives, and targets. There were no plans to resource, structure, and control statutory, regulatory, and procedural change. There were no quality measures, such as efficiency or timeliness, to understand the adequacy of OPLC support. Neither was there a performance measurement system to establish baseline process performance and measure the effect OPLC-initiated changes had on performance over time.

- Some OPLC control deficiencies were identified in earlier audits. However, management lacked a system to ensure defects leading to audit findings were remediated timely, and that processes remained under control. Some legacy control deficiencies affected Board operations.

- Systemic defects with records management made some controls, processes, practices, and transactions unauditable. Combined with responsible officials' inadequate understanding of operating procedures and practices, we were compelled to qualify our use of – and every conclusion resting on – the records and information we were provided during the audit. Some essential Board records could not be located, due in part to: 1) a lack of written procedures, 2) Board member and staff turnover, 3) inadequate information technology, and 4) not being held by the State.

**Remedial Actions Required**

Board noncompliance with statutory, regulatory, and other requirements may in part be attributable to insufficient support and organizational turbulence. Current Board members and OPLC managers did not create many of the defective controls we identified. While some defects were known, members and managers were either unaware of, or were unaware of the extent of, other defects. Regardless, current members and managers were responsible for effective and efficient control, and achieving expected outcomes. The Board was ultimately responsible for actions members, subordinate entities, or staff took on its behalf. The Board had to do more than assume everything that had to be done was done, and was done correctly.

Developing and implementing a well-controlled, efficiently supported regulatory program objectively shown to effectively achieve expected outcomes appears to be a multi-year undertaking. OPLC management reported reviewing its internal practices. Integration of Board and OPLC controls to help ensure defects are fully remediated and remain well controlled has reportedly begun. However, some Board responses to recommendations were inconsistent and many lacked enough detail to make clear whether, how, and when the Board will remediate defects. Some Board responses and our rejoinders show the Board inconsistently recognized limitations on its authority and it disagreed with the need to follow some fundamental State policy requirements. Consequently, we suggest the General Court consider how expanded oversight of the Board could help ensure it effectively carries out State policy and complies with limitations imposed upon it.

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## RECOMMENDATION SUMMARY

| Observation Number | Page | Legislative Action May Be Required | Recommendations | Agency Response |
|---|---|---|---|---|
| 1 | 14 | No | The Board of Dental Examiners (Board) improve its operating environment and organizational culture, design controls to efficiently and effectively achieve outcomes, and adequately control processes. | Board: Concur |
| 2 | 19 | Yes | The Legislature consider exerting additional oversight of Board audit remediation.<br><br>The Board develop and execute a risk-based, data-informed strategy and supporting plans. | Board: Concur In Part |
| 3 | 21 | Yes | The Legislature consider how to structure regulatory agency controls to ensure agencies' actions conform to State policy and receive active State supervision.<br><br>The Board develop objective, data-informed risk management processes tied to strategy and plans, regularly review risks, and establish mitigating controls. | Board: Concur |
| 4 | 28 | Yes | The Board control, simplify, monitor, and refine its statutory, regulatory, and procedural framework. | Board: Concur |
| 5 | 33 | No | The Board comply with statutory and regulatory requirements. | Board: Concur |
| 6 | 38 | No | The Board discontinue enforcement of extra-legal and extra-jurisdictional rules, comply with the *Administrative Procedure Act*, and ensure its rules help control risks and structure Office of Professional Licensure and Certification (OPLC) procedural rules. | Board: Concur |
| 7 | 46 | Yes | The Legislature consider increasing the number of public Board members.<br><br>The Board discontinue forming and operating subordinate entities without authority, effectively control authorized subordinate entity operations, and seek legislation to: add a member well-versed in dental anesthesia and sedation, reconstitute the Dental Hygienists Committee, and increase the number of public members. | Board: Concur In Part |

| Observation Number | Page | Legislative Action May Be Required | Recommendations | Agency Response |
|---|---|---|---|---|
| 8 | 52 | Yes | The Board discontinue operating the unauthorized agencies regulating dentist anesthesia and sedation, discontinue allowing receipt of honorarium by its agents, and request legislative authority for an advisory body on dentist anesthesia and sedation.<br><br>If authority is granted to create subordinate entities, oversee their operation to ensure compliance with requirements and expected outcomes are produced. | Board: Concur |
| 9 | 58 | Yes | The Legislature consider: 1) requiring the Board and OPLC to adopt rules formalizing the terms and conditions of their relationship or 2) directly establishing the detailed terms and conditions of the relationship through statute.<br><br>The Board and the OPLC formalize the terms and conditions of their relationship through rules.<br><br>The Board discontinue delegating substantive, discretionary authority; discontinue delegating authority when allowed to, but where no effective controls exist; adopt oversight and accountability rules; and actively monitor delegations. | Board: Concur<br><br>OPLC: Concur |
| 10 | 63 | No | The Board develop, implement, and refine a performance management system, and regularly assess and incorporate performance data into decision making. | Board: Concur |
| 11 | 70 | No | The Board ensure reliable and accurate records are retained, establish information requirements, migrate towards data-informed decision making, and ensure reporting is timely, reliable, and relevant. | Board: Concur |
| 12 | 77 | No | OPLC management maintain an operating environment and organizational culture supportive of effective management control; manage strategy, plans, and risk; and develop, monitor, and refine comprehensive controls. | OPLC: Concur |
| 13 | 84 | Yes | The Legislature consider clarifying OPLC roles and responsibilities and whether changes to the | OPLC: Concur |

| Observation Number | Page | Legislative Action May Be Required | Recommendations | Agency Response |
|---|---|---|---|---|
| 13 (Continued) | 84 | Yes | State's approach to regulating occupations and related industries are needed.<br><br>OPLC management stabilize, control, and optimize its organization, delegations, and accountabilities; adopt rules on the terms and conditions of support it provides; and preserve assigned agency independence and discretionary decision-making authority. | |
| 14 | 91 | Yes | OPLC management identify its customers; inventory support requirements; develop a customer-centric strategy and plan; develop a performance management system; assist assigned agencies with operations, compliance, rulemaking, and knowledge management; ensure data reliability; migrate towards data-driven decision making; and routinely report on performance.<br><br>The Board formalize performance expectations, communicate unsatisfactory performance and require remediation, and consider requesting statutory authority to oversee support quality. | OPLC: Concur<br><br>Board: Concur |
| 15 | 100 | Yes | The Board seek statutory authority to require necessary fees, monitor OPLC fee setting, and levy fees to recover enforcement case costs.<br><br>OPLC management develop a cost allocation system reflecting actual costs, avoid potential taxation, inventory and clarify fee requirements, seek necessary statutory changes, discontinue charging unauthorized fees, set fee values, and provide assigned agencies cost data to enable enforcement case cost recovery. | Board: Concur<br><br>OPLC: Concur |
| 16 | 108 | No | The Board adopt rules on waiving late fees and ensure late fee waivers are consistent.<br><br>OPLC management ensure fee-related procedures conform to rules, adopt comprehensive fee administration rules, develop procedures, and discontinue unauthorized refunds. | Board: Concur<br><br>OPLC: Concur |

| Observation Number | Page | Legislative Action May Be Required | Recommendations | Agency Response |
|---|---|---|---|---|
| 17 | 114 | Yes | The Legislature consider increasing oversight of the OPLC's audit remediation efforts.<br><br>OPLC management timely and fully remediate the conditions identified in audits and develop and publish required plans and reports. | OPLC: Concur |
| 18 | 119 | Yes | The Board develop a regulatory strategy; objectively establish public protection threats, assess regulatory costs and benefits, demonstrate each regulation is necessary, and identify the minimum level of regulation necessary; adhere to State policy; review license-specific practices and reciprocity requirements; seek necessary changes to statutory authority; ensure credentialing provides substantive public protection; eliminate perfunctory, wasteful, and gratuitous requirements; monitor the regulatory program; ensure the program operates as intended; and routinely report on program performance. | Board: Concur |
| 19 | 143 | No | The Board fully implement State initial licensing policy, ensure requirements are necessary and used to assess qualifications, oversee initial licensing; substantively review applications, and approve applications before issuing licenses. | Board: Concur |
| 20 | 153 | Yes | The Board ensure issued licenses comply with State policy, correct defective licenses, and seek statutory changes to implement staggered renewals.<br><br>OPLC management discontinue noncompliant renewal practices and identify defective licenses it issued. | Board: Concur<br><br>OPLC: Concur |
| 21 | 158 | Yes | The Board improve controls over temporary licenses, seek legislative changes to allow for temporary credentials for all credentials, oversee temporary credentialing, and approve applications before issuing credentials. | Board: Concur In Part |
| 22 | 162 | Yes | The Board examine the costs and benefits of the Expanded Function Dental Auxiliary permit and if the permit does not provide substantive public protection, eliminate it; otherwise, seek legislative changes to fully incorporate permits in | Board: Concur |

| Observation Number | Page | Legislative Action May Be Required | Recommendations | Agency Response |
|---|---|---|---|---|
| 22 (Continued) | 162 | Yes | statute, oversee permitting, and approve applications before issuing permits. | |
| 23 | 167 | Yes | The Board approve reactivation and reinstatement applications before issuing licenses, seek statutory changes to ensure consistent requirements, oversee reactivations and reinstatements, and monitor lapsed and inactive credentials. | Board: Concur |
| 24 | 175 | Yes | The Board examine the costs and benefits of the dentist anesthesia and sedation permit renewal process and if the current process provides substantive public protection, seek statutory authority for permit renewal fees; otherwise, eliminate renewal requirements or make the process valuable; fully implement State policy; review permit applications; ensure all substantive requirements precede permit issuance; approve applications before issuing permits; and oversee permitting, inspections, and evaluations. | Board: Concur |
| 25 | 188 | Yes | The Board examine the costs and benefits of hygienist local anesthesia and nitrous oxide minimal sedation permits and if permitting does not ensure substantive public protection, eliminate it; otherwise, seek statutory authority for permits, require competency maintenance, approve applications before issuing permits, and oversee permitting. | Board: Concur |
| 26 | 192 | Yes | The Board establish the costs and benefits of the Certified Public Health Dental Hygienist certificate and if certification does not provide substantive public protection, eliminate it; otherwise, seek necessary statutory authority, approve applications before issuing certificates, and oversee certification. | Board: Concur |
| 27 | 196 | No | The Board ensure dental assistant regulation does not exceed its authority; discontinue extra-legal, informal, and improvised regulations; and harmonize dental assistant regulations with agencies with concurrent jurisdiction. | Board: Concur In Part |
| 28 | 203 | No | The Board review monitoring strategy and requirements, develop minimum necessary and cost-effective monitoring controls, ensure | Board: Concur In Part |

| Observation Number | Page | Legislative Action May Be Required | Recommendations | Agency Response |
|---|---|---|---|---|
| 28 (Continued) | 203 | No | requirements are clear and consistently applied, and coordinate regulation with agencies with concurrent jurisdiction. | |
| 29 | 210 | Yes | The Board discontinue relying on attestations, verify regulatee compliance with character and conduct requirements, remedy defective licenses issued without criminal history records checks, and seek legislative changes to require criminal history records checks for all primary credentials. | Board: Concur In Part |
| 30 | 216 | No | The Board ensure licensees timely register with the Prescription Drug Monitoring Program, implement statutory requirements, and sanction noncompliance. | Board: Concur In Part |
| 31 | 225 | Yes | The Board examine the costs and benefits of the license renewal process, revise requirements to ensure they provide substantive public protection, implement proactive monitoring, fully implement State policy, oversee renewal licensing, and approve applications before licenses are renewed. | Board: Concur In Part |
| 32 | 234 | No | The Board evaluate continuing education requirements to ensure they provide substantive public protection, formalize review processes, and conduct hearings for noncompliance. | Board: Concur In Part |
| 33 | 243 | No | The Board monitor complaint processing and patterns of potential noncompliance, and discontinue dismissing adverse event reports. | Board: Concur |
| 34 | 252 | No | The Board and OPLC management review statutory changes to investigations-related authority, and the Board discontinue informal investigation referrals, create investigative plans, and monitor investigation progress. | Board: Concur<br>OPLC: Concur |
| 35 | 262 | No | The Board and OPLC management review statutory changes to hearings-related authority, members attend necessary training, and the Board hold required hearings and monitor disciplinary case progress. | Board: Concur In Part<br>OPLC: Concur |
| 36 | 269 | Yes | The Board identify gaps and refine the statutory disciplinary framework, discontinue imposing sanctions beyond its authority, and consistently address noncompliance. | Board: Concur In Part |

## CHAPTER ONE
## MANAGEMENT CONTROL

In calendar year (CY) 1891, the Legislature created the Board of Registration in Dentistry to regulate dentists through examinations and issuing certificates to practice. Subsequent legislative changes replaced the Board of Registration with the Board of Dental Examiners (Board). The Board was an independent regulatory agency created to implement and administer State policy regulating dentists and hygienists. Dental care was regulated due to the potential harm to the public from unqualified, unscrupulous, or impaired practitioners. Potential harm could include injury to patients or transmission of infectious diseases. Inadequate care could contribute to serious health problems for certain patients. To protect the public's health, safety, and welfare, the Board was required to develop an efficient and effective regulatory program.

The Board was to credential qualified applicants, monitor their compliance, and enforce regulatory requirements by:

- establishing initial and renewal credentialing requirements,
- determining applicant qualifications and approving or denying credential applications,
- regulating the practices of dentistry and hygiene,
- monitoring regulatees to ensure they remained qualified to practice,
- investigating potential misconduct,
- conducting adjudicatory proceedings and other hearings, and
- sanctioning noncompliance.

The Board regulated dental occupations by licensing dentists and hygienists, and permitting Expanded Function Dental Auxiliaries (EFDA). Hygienists and EFDAs worked under the supervision of a licensed dentist. Supplemental credentials were required for licensed dentists and hygienists to expand their scopes of practice. Dentists administering general anesthesia, deep sedation, moderate sedation, and pediatric minimal sedation were required to be permitted. Hygienists practicing as Certified Public Health Dental Hygienist (CPHDH) were required to be certified. Hygienists were also allowed to administer local anesthesia or nitrous oxide minimal sedation, but no credential was required.

To aid the Board with industry regulation, the Legislature created the Dental Hygienists Committee (DHC) to develop rules related to hygienist licensure and CPHDH certification. The Board created the Anesthesia and Sedation Evaluation Committee (ASEC) and the ASEC Advisory Subcommittee (ASEC-AS) to assist with dentist anesthesia and sedation permitting regulations, develop relevant rules, and exert substantive permitting control.

The Board was administratively assigned to the Office of Professional Licensure and Certification (OPLC) for business processing, recordkeeping, and other administrative and clerical support. The OPLC was an independent, executive agency created in CY 2015. Its scope was narrowly concerned with the specific administrative function of promoting efficiency and economy of its assigned regulatory agencies. The OPLC was to:

- improve administrative efficiency and customer service;
- issue credentials to applicants who met credentialing requirements;
- deny credentials to applicants who did not meet credentialing requirements;
- maintain the official record for all applicants and credential holders;
- provide rulemaking supervision, coordination, and assistance to its assigned agencies;
- report on its own performance and that of its assigned agencies annually;
- adopt in rules the value of fees authorized by statute; and
- establish organizational and procedural rules necessary to administer assigned agencies' business processes.

**Board Management Control Systems**

A well-controlled regulatory program could have helped ensure adequate public protection and the full implementation of State policy. Designing, implementing, monitoring, and refining an efficient and effective system of complimentary, cooperating controls could have helped the Board achieve expected outcomes. Controls should have been monitored and measured for effectiveness, and refined when deficiencies were identified or changes occurred. Supporting management control systems were interrelated and interconnected, underpinning all operations, as shown in Figure 1. Control systems included:

- the **operating environment and organizational culture**, effectively setting the tone for Board operations;
- **strategic management**, the process of developing, implementing, monitoring, and refining strategies, plans, goals, objectives, and targets to guide operations, and establishing relationships with strategic partners to achieve expected outcomes;
- **risk management**, the process of identifying, assessing, and mitigating risks that could potentially interfere with achieving expected outcomes;
- **compliance management**, the process of ensuring compliance with statutory, regulatory, and other requirements;
- **organization and delegation**, the process of creating an organization, delegating duties, overseeing, and ensuring accountability;
- **performance management**, the process of managing organizational performance to objectively demonstrate operations achieved expected outcomes;
- **knowledge management**, the process of managing information to enable objective, data-informed decision making and ensure transparency; and
- **relationships with support agencies**, the process of managing staff performance to ensure service delivery expectations were met and expected outcomes were achieved.

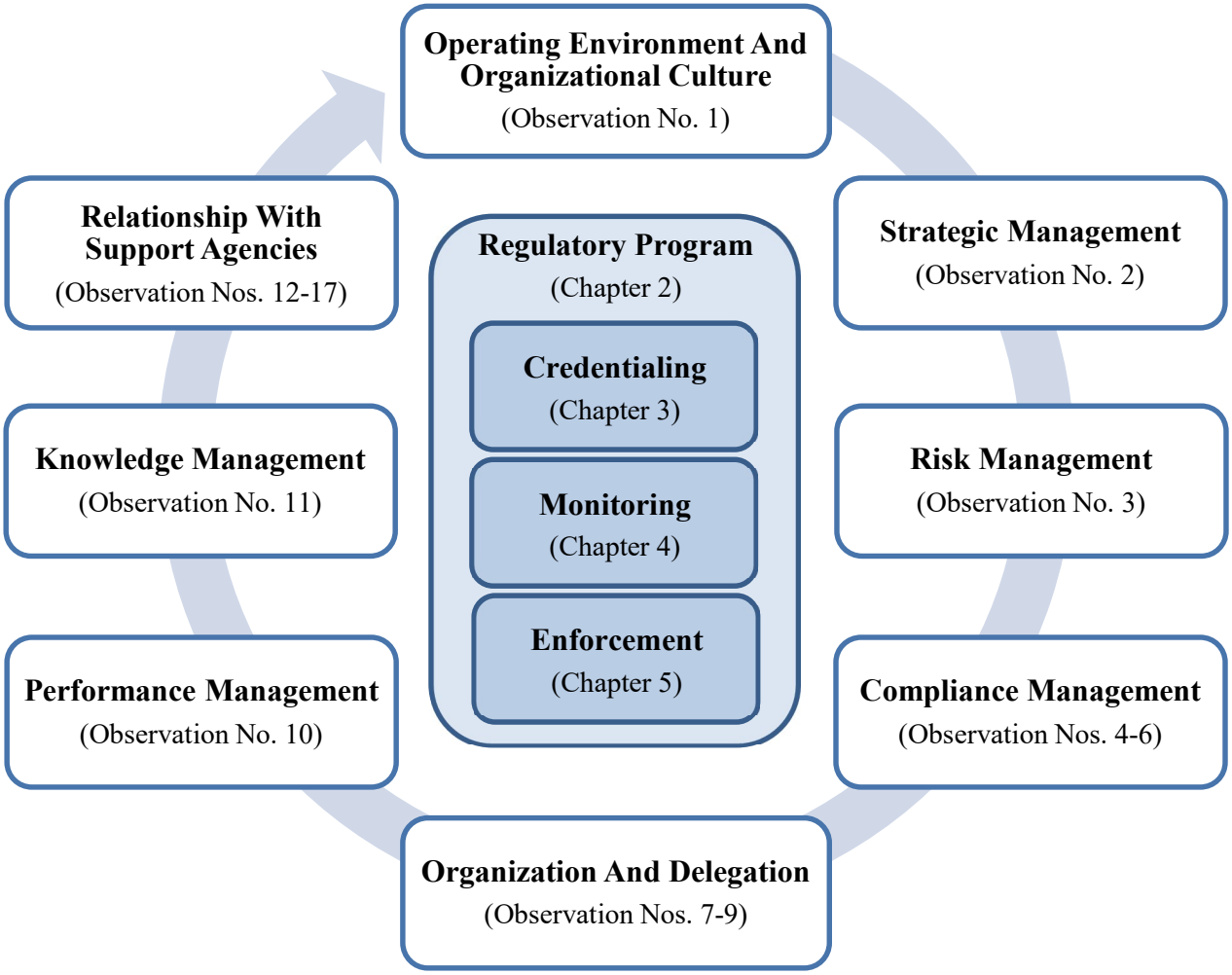
The Board's regulatory program consisted of three primary functions:

- **credentialing**, to help ensure regulatees met entry requirements, were qualified to practice, and were properly credentialed;
- **monitoring**, to help ensure regulatees maintained competency and eligibility to practice; and

- **enforcement**, to investigate potential noncompliance, adjudicate contested cases, and sanction those found noncompliant.

**Figure 1**

**Management Control Systems Integral To Effective Board Operations**




Note: Depicts an optimized system of management control. Board management controls did not fit this model during the audit period. Observations discussing deficiencies with each control system are noted. Chapters describing the effects management control deficiencies had on the Board's regulatory program and functions are also noted.

Source: LBA analysis of management controls.

To ensure expected outcomes were achieved, the Board was responsible for its operation and performance, the operation and performance of its subordinate entities, and the performance of staff. While the Board developed various elements of control systems, like rules, most were affected, or in many cases wholly controlled, by other agencies, particularly the OPLC.

## Managing The Board's Operating Environment And Organizational Culture

By demonstrating a commitment to ethical behavior, efficiency, effectiveness, and compliance with State policy, and establishing controls to achieve these objectives, the Board could have established an environment and culture that facilitated achievement of expected outcomes. The Board managed its operations and those of its subordinate entities within a complex and evolving interagency, intergovernmental environment, while seeking to regulate a changeable industry. High turnover among members and staff exacerbated complexity and volatility. Effective management controls could have helped create predictability and stability in operations and expectations over time.

### Observation No. 1

### Improve The Board's Operating Environment And Organizational Culture

The Board lacked an effective management control system to help ensure it protected the public health, safety, and welfare from unqualified, unscrupulous, or impaired practitioners. Its operating environment and organizational culture accommodated deficient and absent control systems. The Board lacked formal controls to monitor, evaluate, and refine control efficiency and effectiveness. There was no apparent design to control systems. The Board did not fully understand its operating environment; relevant operations, processes, practices, or performance; or how well it fulfilled existing statutory duties. Inadequacies inhibited the Board's ability to achieve, or demonstrate achievement of, outcomes. The Board engaged in extra-legal and extra-jurisdictional activities. It also discussed expanding its jurisdiction, with no clear nexus to expected outcomes, even though the existing statutory and regulatory framework was not fully or accurately implemented. Deficiencies resulted in abuse and waste.

Some controls, processes, practices, and transactions were unauditable due to inadequate records. Responsible officials lacked a complete understanding of relevant processes and practices. Inadequate records and knowledge management compelled us to qualify our use of, and our conclusions resting on, agency records and information reported by responsible officials.

### Inadequate Operating Environment And Organizational Culture

Board controls inadequately ensured its operations and those of its subordinate entities, and the operating environment and organizational culture of each, were effective. The Board lacked an adequate understanding of its operating environment. This included applicable administrative and regulatory requirements, as well as its operations, processes, practices, and performance. Volunteer members were expected to independently obtain an understanding of, and comply with, numerous and complex responsibilities as public officials. They often lacked sufficient support or adequate orientation to their role as regulators of occupations and an industry. Issues with the OPLC's operating environment and organizational culture, accountability framework, and level of support provided, discussed in Observation Nos. 12–17, meant the OPLC was largely operating in its own interests and often not in the Board's interests. The Board conducted little to no oversight or follow-up on the performance of its subordinate entities or staff. Passive Board control resulted in:

- instances of inadequate and potentially inadequate public protection;
- abusive and potentially abusive practices;
- inconsistent results among similarly situated applicants and regulatees;
- potential conflicts of interest and regulatory capture, extra-legal and extra-jurisdictional actions, and an increased risk exposure to federal antitrust scrutiny;
- known inefficiencies, gratuitous fees, perfunctory requirements, and waste and potential waste of public resources;
- noncompliance with ethical and administrative requirements; and
- uncontrolled and inconsistent processes and practices.

The Board was responsible for setting the ethical standards, values, and expectations for Board and subordinate entity operations. Ethical guidelines were integral to good management control, should have been comprehensive and formal, and should have addressed conflicts of interest. Members were required to avoid conflicts of interest. This included any situation, circumstance, or financial interest that might cause a private interest to interfere with the proper exercise of a public duty. However, the Board lacked a comprehensive understanding of ethical requirements and did not develop supplemental ethical guidance specific to its operating environment. Conflicts of interest, and other potential ethical issues, were inherent in the composition of both the Board and its subordinate entities. Of 34 total members, as of February 2021, only one (2.9 percent) was not credentialed by the Board. Each credentialed member had one or more industry interest group affiliation.

The Board deferred member orientation to the OPLC. Orientation lacked information on relevant ethics requirements and was inconsistently provided to subordinate entity members. The Board lacked a system to objectively demonstrate its control over member ethics was effective, and members held overly positive impressionistic views of the control environment. Current and former Board members who responded to our CY 2021 survey generally reported ethical controls were effective or mostly effective. DHC and ASEC member views were inconsistent. However, without an adequate understanding of ethical requirements or Board-specific guidelines:

- ASEC members inappropriately accepted honorarium from applicants and permittees they inspected and evaluated, and did not file required statements of financial interest;
- two members reviewed and approved license and permit applications for an applicant with whom they were affiliated outside their membership, one of whom had even requested assignment of the review;
- a former Board member reportedly served as an expert reviewer despite a potential conflict of interest other members were unaware of until after expert reviewer duties were completed; and
- a former Board member affiliated with one educational institution reported informally investigating another educational institution without Board instruction to do so.

These and other potential conflicts created risks for the Board and its subordinate entities. In August 2021, after we informed the Board of ASEC-related risks, it passed an emergency rule intended to stop ASEC members from accepting honorarium.

**Inadequate Management Control Systems**

Board control systems were absent or deficient and lacked discernible design.

- **Strategic management control systems** were absent. The Board lacked a strategy and plans. There were no goals, objectives, and targets to focus Board, subordinate entity, or supporting agency operations on expected outcomes. The Board also lacked plans to improve operations, resulting in inefficiency, ineffectiveness, and waste.

- **Risk management control systems** were absent. The Board lacked processes to identify, assess, and manage risks. This unnecessarily increased risk exposures to potential conflicts of interest, regulatory capture, and federal antitrust scrutiny. Deficiencies also contributed to potentially abusive acts, noncompliance, waste, inefficiency, ineffectiveness, and inconsistency within and across functions.

- **Compliance management control systems** lacked discernible design. The Board lacked processes to ensure operations complied with statutory, regulatory, and administrative requirements. Statute and rules were not evaluated routinely, resulting in an overly complex framework that did not always implement State policy. The framework frequently relied upon ad hoc rules.

- **Organization and delegation control systems** lacked discernible design. The Board lacked a formal organizational construct and cohesive control over its organization, and the organization and operation of its subordinate entities. Some subordinate entities lacked authority in statute or rules. Deficiencies contributed to insufficient representation of the public interest and an inability to effectively regulate aspects of a dynamic and technical industry. The Board lacked authority to delegate substantive authority, but nonetheless did so. Roles, responsibilities, and accountability were inconsistently formalized.

- **Performance management control systems** were limited and lacked discernible design or connections to outcomes. The Board could not demonstrate the effect of its regulatory program. It lacked determinations as to whether requirements and processes were necessary and adequately protected the public. The Board also lacked basic data on credentialing, monitoring, and enforcement processes. Without accurate and reliable performance information, inefficient, ineffective, and wasteful processes, and perfunctory requirements persisted.

- **Knowledge management control systems** lacked discernible design. The Board was aware of the risks posed by member and staff turnover. However, the Board lacked formal controls to ensure information was collected, recorded, synthesized, and analyzed to produce and use knowledge effectively. Responsible officials lacked complete understanding of relevant processes and practices. Both internal and external communication were inadequate. Deficiencies made processes and transactions unauditable, limiting Board oversight of operations and transparency.

- **Support control systems** were absent. The terms and conditions of the Board's relationship with support agencies were never formalized. Staff operated without Board direction or oversight at times, and inconsistently fulfilled statutory responsibilities, compromising Board effectiveness. Deficient recordkeeping contributed to the unauditability of some controls, processes, practices, and transactions.

**Adverse Effect On Board Functions**

Inadequate control systems adversely affected the Board's regulation of the dental care industry, and each function we examined. Without structured, evidence- and risk-based regulations, the Board could not demonstrate it efficiently and effectively protected the public. Some control deficiencies compromised public protection and limited accountability. Some requirements were perfunctory or extra-legal, some processes were wasteful, and some fees were gratuitous.

- Regulatory Program – Without discernible design, the Board failed to fully implement State policy, and potentially exposed itself to federal antitrust scrutiny. At times, regulation was subjective, lacked a clear nexus to expected outcomes, was more restrictive than demonstrated to be necessary, and infringed on the fundamental rights of some individuals to pursue an occupation. Regulation was internally uncoordinated, contributing to siloed processes and a disproportionate focus on credentialing at the expense of monitoring and enforcement. Regulation was not coordinated with other agencies with overlapping jurisdictions, contributing to extra-jurisdictional regulation of non-dental health care providers.

- Credentialing – Deficient controls over credentialing prevented the Board from consistently demonstrating the individuals it credentialed met all requirements. Deficient controls contributed to extra-legal limitations on applicants, abusive imposition of ad hoc rules, and questionable validity of most initial credentials. Deficient controls also contributed to the extra-legal regulation of EFDAs, hygienist administration of anesthesia and sedation, and dental assistants.

- Monitoring – Deficient controls over monitoring prevented the Board from consistently demonstrating regulatees complied with requirements and remained qualified to practice. Deficient controls contributed to abusive imposition of ad hoc rules, inequitable treatment of licensees, and questionable validity of most renewed credentials.

- Enforcement – Deficient controls over enforcement prevented the Board from demonstrating it effectively remediated regulatee noncompliance. Deficient controls contributed to potential misconduct not being investigated, adjudicative hearings being delayed or not conducted, inconsistent sanctions, and abusive imposition of ad hoc rules.

**Recommendations:**

**We recommend the Board improve its operating environment and organizational culture, and:**

1. **develop and maintain an operating environment and organizational culture supportive of effective management control;**
2. **ensure its members and those of its subordinate entities demonstrate the importance of controls through adherence to controls and by timely addressing deviations;**
3. **develop, implement, monitor, and refine controls designed to efficiently and effectively protect the public health, safety, and welfare from unqualified, unscrupulous, or impaired practitioners;**
4. **ensure uncontrolled processes and practices upon which the Board and its subordinate entities depend are adequately controlled through rules and procedures;**
5. **develop formal ethical standards for Board and subordinate entity operations, including provisions related to conflicts of interest and recusals; and**
6. **include ethical standards in rule and ensure members are aware of the standards through orientation and periodic review.**

Board Response:

*We concur with the recommendations.*

*The Board desires an improved operating environment with the OPLC. The Board intends to address the operating environment through developing a plan for reevaluation of the rules, policies, and Board orientation process. The Board agrees that formal ethical standards should be developed in a clear manner and reviewed frequently. These issues will be addressed in a comprehensive strategic plan.*

*The Board also recognizes that the recommendation that it strategically manage all aspects of the Board's functions is unrealistic without the ability to delegate certain tasks to: 1) committees with specialized expertise; and 2) the OPLC, which provides administrative, rulemaking, enforcement, and other support. The Board will ensure it complies with statute while doing so, and seek legislative changes to create advisory bodies and make structural changes to the Board. The Board plans to seek structural changes. Issues will be addressed in a complete strategy and plan that: 1) formalizes ethical standards, 2) addresses conflicts of interest, 3) develops Board orientation materials and guidelines, 4) clarifies rules and procedures, and 5) schedules routine reviews of the comprehensive plan.*

**Strategic Management**

Strategy and planning were integral to effective management control. Effective strategy development and planning could have helped the Board and its subordinate entities understand

their operating environment, proactively respond to change, and plan for the future. Well-designed controls could have helped increase effectiveness and efficiency. Strategic management should have included development of a strategy that identified the Board's mission, goals, objectives, and targets focused on expected outcomes. Resourced, time-phased supporting plans should have described how the Board, its subordinate entities, and staff would accomplish goals and objectives and meet targets. Plans should have been implemented timely, efficiently, and effectively. Plans should have been routinely monitored and updated to remain relevant. The Board should have also developed controls to efficiently implement plans and achieve goals, objectives, and targets.

**Observation No. 2**

**Develop Strategic Management Controls**

The Board operated without a strategy or plans, which adversely affected achievement of expected outcomes. The Board lacked goals, objectives, and targets focused on public protection and lacked plans to improve operations. Consequently, the Board's approach to operations was haphazard. It failed to fully implement State policy or an effective regulatory program, and lacked connection to expected outcomes. The Board depended on meetings, its subordinate entities, and staff to guide operations. However, it did so without adequate oversight and accountability mechanisms. The Board never articulated its support and performance expectations, and neither staff nor subordinate entities had a framework structuring their responsibilities.

**Lack Of Strategy And Plans**

With no strategy or plans, members and staff had inadequate understanding, and at times conflicting views, of the Board's dynamic and complex internal and external operating environments. The Board's operations were not informed by assessments of its operating environment, lacking systematic monitoring or understanding of, for example:

- dental care industry changes affecting public protection or its regulatory program;
- numerous statutory, regulatory, and administrative requirements;
- proposed legislation affecting its operations;
- federal antitrust laws and related U.S. Supreme Court rulings;
- stakeholder perspectives on its regulatory program or customer service quality;
- statewide oral health objectives;
- its own operations, those of its subordinate entities, or support services provided; and
- areas of overlapping regulation or agencies with concurrent jurisdiction.

**Reactive Management And Inadequate Accountability And Transparency**

Board management was reactive, and members held overly positive impressionistic views of the effectiveness of controls. Current and former Board and subordinate entity members who responded to our CY 2021 survey generally reported the Board's mission and goals were clear or mostly clear. However, there was no single understanding of what the Board and its subordinate entities should do and how they should do it. Members and staff identified various and, at times, competing priorities. A clear understanding of mission, goals, objectives, and targets was essential

to help ensure operations consistently focused on achieving expected outcomes. This was particularly important given the lack of an effective management control system and substantial staff discretion in making decisions affecting the public across Board functions.

Consequently, no member could demonstrate how the Board achieved expected outcomes. Instead, the Board at times pursued extra-legal and extra-jurisdictional activities at the expense of implementing State policy requirements. The Board also failed to address, or adequately address, some higher risk exposures while overfocusing on lower risk exposures. The Board lacked effective monitoring of credential holder practice and compliance with requirements, notably for high-risk scope of practice areas such as in-office dentist administration of anesthesia and sedation. It also did not prioritize implementation of its own priorities and State policy, including criminal history record checks, credential reciprocity, and pediatric minimal sedation permits for dentists. However, it simultaneously expended resources on extra-legal regulation of dental assistants. This, despite a lower risk scope of practice and no quantified public protection risk.

Board control systems and operations were heavily – and at times negatively – influenced by administrative support. The Board was dependent upon staff to implement any plans and carry out processes. Members expressed substantial concerns with adequacy of support, resulting in inadequate follow through and operational limitations. However, the Board never sought to establish the terms and conditions of this relationship, leaving it largely unable to adequately manage its own operations.

**Audit Remediation Plans**

Following an LBA audit, the Board is required to develop a remedial action plan within 30 days of the release of an audit, provide semi-annual progress reports until all findings are resolved, and provide plans and reports to be published on the State's transparency website. Having a time-phased strategy and implementing plans could help ensure compliance with accountability and transparency requirements, given the broad scope of control deficiencies identified by this audit.

**Recommendations:**

**We suggest the Legislature consider exerting additional oversight of the Board's audit remediation efforts due to the extensive number of audit findings; the lack of a detailed, resourced, time-phased remedial action plan in response to this audit that makes it clear what the Board intends to do and when it intends to do it; and the Board's reluctance to acknowledge its responsibility for certain key obligations.**

**We recommend the Board improve strategy and planning, and:**

1. **develop a risk-based, data-informed strategy and plans in concert with strategic partners and key stakeholders, and incorporate relevant statewide objectives, to help ensure expected outcomes are achieved and related efforts are harmonized statewide;**

2. **incorporate measurable goals, objectives, targets, and timelines for completion, assigning accountability to the Board, its subordinate entities, or supporting agencies for implementation;**
3. **ensure the Board, subordinate entities, and supporting agencies execute the portion of Board strategy and plans for which they have responsibility;**
4. **incorporate remediation of current audit findings, and develop, implement, monitor, and refine a resourced, time-phased plan to timely remediate findings;**
5. **develop performance measures, regularly and formally monitor performance, and refine the strategy and plans as warranted; and**
6. **periodically report publicly on performance and attainment of expected outcomes, goals, objectives, and targets.**

Board Response:

*We concur in part with the recommendations.*

**The Board's lengthy, detailed response and associated rejoinders are in Appendix B.**

**Risk Management**

Strategy and plans should be risk-informed and systematically manage risks that could adversely affect achievement of expected outcomes. The Board's complex and dynamic internal and external operating environments presented a growing number of risk exposures. While management controls could not absolutely ensure effectiveness, effective risk management was a core element of effective management control. Controls included:

- establishing measurable goals, objectives, and targets defining what was to be achieved, by whom, how, and by when;
- identifying risks that could have hindered the achievement of results;
- analyzing risks to determine potential risk exposure frequency and effect;
- defining measurable risk tolerances, or acceptable performance variations;
- implementing controls to mitigate, avoid, or accept risks;
- communicating risk-related responsibilities to those implementing controls; and
- monitoring control effectiveness and performance, refining controls to ensure continued effectiveness.

**Observation No. 3**

**Develop Risk Management Controls**

The Board lacked a formal, systematic approach to managing risk, decreasing the likelihood strategic and operational objectives would be achieved. The Board operated in a complex and dynamic inter-agency, inter-governmental environment. Its operations occurred without consideration of the changing risks to which it and its subordinate entities were exposed. The Board did not conduct formal risk assessments, define risk tolerances, or develop and implement controls

to manage identified risks. Consequently, the Board faced a growing number of risk exposures that it either failed to address, or address adequately, including potential exposure to federal antitrust scrutiny. At times, uncontrolled risks led to noncompliance, extra-legal and extra-jurisdictional activities, abuse, waste, inefficiency, and ineffectiveness.

We identified numerous risks during our audit. However, our scope did not include development of a comprehensive inventory of strategic and operational risks, which was a proper role for the Board.

**No Controls Over Risk Management**

The Board operated without a sufficient understanding of whether relevant risks, including risks inherent in the Board's operating environment, were identified and knowingly accepted or effectively mitigated. The Board experienced ongoing organizational and operational changes. However, it did not periodically and formally review its operating environment or operations to assess where and how achievement of goals and objectives could be hindered. Neither did the Board evaluate the likelihood of those occurrences or establish reasonable responses to potential risks.

Board members were aware risk quantification did not occur. Without a risk assessment and integration of risks into strategic management, the Board's identification and response to risk was reactive. Uncontrolled risks adversely affected each control system and function we examined, as well as the Board's ability to efficiently achieve its objectives.

- Credentialing – Uncontrolled risks contributed to unimplemented State policy, imposition of extra-legal and perfunctory regulations, limitations on individuals' rights to pursue an occupation, and extra-jurisdictional regulation of professions regulated by other agencies. Inadequately controlled risks led to deficiencies with application approval decision making, and undermined the validity of most credentials issued. There were no controls to ensure due process protection for conditional approvals or denials.

- Monitoring – Uncontrolled risks contributed to reactive monitoring of regulatee compliance with entry, practice, and eligibility maintenance requirements. The Board also imposed extra-legal requirements, including renewal requirements, affecting supplemental credential holders. Requirements were inconsistently monitored, and some could not be monitored. Competency maintenance requirements were largely perfunctory, as were renewal processes and practices, resulting in gratuitous fees and waste. Practice requirements were also largely perfunctory, as there were no controls to consistently and proactively monitor many licensee practice requirements.

- Enforcement – Uncontrolled risks contributed to ineffective public protection. A lack of support and resources reportedly prevented some investigations from being conducted and some required adjudicative proceedings from occurring timely, or at all. Inadequate support also contributed to difficulties following up on prior decisions or adequately monitoring sanctions to ensure compliance.

**Unaddressed Risk Of Regulatory Capture And Federal Antitrust Scrutiny**

The organization and operations of the Board and its subordinate entities created inherent risks of conflict of interest, regulatory capture, and federal antitrust scrutiny. None were adequately controlled. The Board was responsible for adopting and enforcing regulatory requirements, as well as credentialing qualified dentists, hygienists, and EFDAs – in effect deciding who could participate in the dental care industry and on what terms. However, key officials reported having a limited understanding or being unaware of federal antitrust laws and related U.S. Supreme Court rulings. No official could describe controls either developed or under consideration to help mitigate these risks and provide reasonable assurances antitrust issues were avoided. No changes were made to the Board's control framework to help ensure anticompetitive actions did not inappropriately occur following a significant CY 2015 federal court ruling.

Federal antitrust laws were intended to protect competition for consumer benefit. They did not restrict State anticompetitive actions when the State acted in its sovereign capacity. The Legislature could restrict occupations, confer rights to dominate a market, and otherwise limit competition to achieve public objectives. However, the Board was not so empowered and was not necessarily exempt from federal antitrust liability. Its actions could have been subjected to federal antitrust scrutiny, if: 1) active market participants controlled the Board, 2) there was no clear articulation and affirmative expression of State policy underpinning Board actions, and 3) there was no active State supervision of potentially anticompetitive Board actions.

***Active Market Participant Control***

The Board inadequately controlled the risk that its members could pursue self-interests, other private interests, or industry interests, which would lead to regulatory capture. As of February 2021, 33 of 34 members (97.1 percent) were active market participants – dentists and hygienists credentialed and regulated by the Board. One member (2.9 percent) was not. All members were to avoid conflicts of interest and not participate in any matter in which they had a private interest potentially directly or indirectly affecting their decision making. Board regulation should have protected the public from the unqualified practice of a regulated occupation, and not protected those who were regulated by the Board. However, risks were ineffectively controlled.

- Self-serving Behavior – For example, no regulatory action was taken after some ASEC members raised concerns about imposing competency maintenance monitoring requirements due to the potential liability purportedly incurred by permittees. The DHC also pursued extra-jurisdictional activities, such as advancing the expansion of hygienists' scope of practice, without objective assessments.

- Potential Conflicts Of Interest – For example, ASEC members improperly received honorarium from the applicants or permittees they were inspecting or evaluating. This occurred even though each ASEC member was a permittee and potentially was in economic competition with new permit applicants and other permittees.

- Exclusion Of Key Stakeholders – For example, two special interest groups had standing agenda items during Board meetings. Employees of one educational institution

frequently participated in Board and DHC meetings. Other stakeholders were not afforded similar accommodations.

- Inappropriate Special Interest Group Participation – For example, an employee of one educational institution recommended changes to hygienist permit forms completed by educational institutions. These changes were approved by the DHC, without authority or evidence of public notice of rulemaking.

- Inappropriate Promotion Of Special Interest Groups – For example, the Board restricted certain applications and practices to individuals holding commercial, third-party credentials. Members also suggested training courses be held at one specific educational institution, with which some members were affiliated, and advertised the availability of courses at that institution during meetings. At the same time, a member informally investigated another institution's program for accreditation status and advertising practices. No member had an affiliation with the investigated institution.

- Inadequate Transparency Of Potential Conflicts – For example, ASEC members did not file required statements of financial interest, while Board members inconsistently reported expense reimbursements.

- Regulation Of Economic Competitors Pursued Without Demonstrated Risk – For example, members engaged in efforts to regulate dental assistants. These efforts were based on subjective impressions of risk without the participation of relevant stakeholders or objective establishment a risk existed and it that could be successfully regulated.

***Articulated State Policy Inconsistently Implemented And Followed***

The Board lacked controls to ensure it consistently implemented State policy or limited itself to delegated authority. Without clear State policy underpinning specific actions – such as when the Board or its subordinate entities impermissibly acted outside their statutory authority – those actions could be subject to federal antitrust scrutiny. Also, while State policy might have been clearly stated, it might have been so general as to require clarification on how or to what extent regulation should occur. Such clarification should have occurred through rulemaking. However, there was risk that the authority and discretionary judgment delegated to the Board could result in anticompetitive behavior and be used to pursue private or industry interests, rather than the public interest. This form of regulatory capture could have resulted in less strict or non-existent enforcement of requirements. Alternatively, it could have resulted in high barriers to entry. The Board and its subordinate entities exceeded their delegated statutory authority or operated inconsistently with State policy. This included:

- the creation and use of extra-legal entities to formulate and impose regulations, as the ASEC and ASEC-AS developed and implemented regulation over dentist anesthesia and sedation permits without statutory authority;
- extra-jurisdictional regulation of some non-dentist anesthesia providers in dental offices;

- extra-legal regulation of dental assistants, EFDAs, hygienist administration of local anesthesia and nitrous oxide minimal sedation, dental specialties, and certain programs and credential holders;
- limitation of eligible applicants, including for hygienist licenses and EFDA permits;
- imposition of ad hoc rules across Board functions, including their known and abusive imposition;
- potentially unduly high barriers to entry for credential holders and dental assistants, due to perfunctory requirements with no demonstrated connection to expected outcomes;
- failure to implement State policy, including processes to improve credential portability and implementation of pediatric minimal sedation permit requirements;
- potentially anticompetitive actions, such as the restriction on certain dental assistant duties through adoption of commercial, third-party standards, as well as use of cease-and-desist letters without statutory authority and use of letters of concern beyond what statute allowed; and
- failure to enforce or consistently enforce regulatory requirements, affecting each of the Board's three primary functions.

***No Active State Supervision***

The Board and its subordinate entities did not receive active State supervision. Without active supervision, the State might have been unaware of anticompetitive Board or subordinate entity actions that exceeded the Board's delegated authority. Active supervision could have provided assurances that anticompetitive actions promoted State policy, and not member self-interest or industry interests. Active supervision should have been conducted by someone who was not an active market participant. Active supervision should have included: 1) a review of the substance of a decision, not only for compliance with rulemaking or other processes used to produce the decision; and 2) the ability to veto or modify a decision to ensure it aligned with State policy. However, the Board:

- lacked cohesive control over subordinate entity operations, which inconsistently complied with State policy requirements underpinning transparency and supervision;
- delegated substantive discretionary decision making without authority to do so, and without adequate oversight and accountability, meaning the Board could not even supervise operations occurring on its behalf;
- along with the ASEC and staff, imposed ad hoc rules circumventing legislative and public supervision; and
- did not ensure its members and those of its subordinate entities received training on federal antitrust risks.

**<u>Recommendations</u>:**

**We suggest the Legislature consider how to structure controls over regulatory agencies to ensure agencies' actions conform to articulated State policy and receive active State supervision to, in part, help mitigate potential federal antitrust scrutiny risk.**

**We recommend the Board improve controls over risk, and:**

1. **establish, document, implement, monitor, and refine formal risk management processes tied to strategy and plans to help ensure the Board recognizes, evaluates, and effectively responds to risks that could adversely affect its ability to achieve expected outcomes;**
2. **develop appropriate, clear, and measurable risk tolerances;**
3. **holistically review operations and the operating environment on a regular basis for indicators of new and changed risks, and establish and monitor controls to manage those risks;**
4. **ensure the Board and subordinate entities implement the Board's risk management processes to help ensure operations are risk informed and expected outcomes are achieved; and**
5. **discontinue relying upon informal and qualitative risk assessments and migrate to holistic, formal, data-informed, objective, and quantitative risk management practices.**

Board Response:

*We concur with the recommendations.*

*The Board is committed to examining its current risk management processes, identifying potential risks, and monitoring the controls that are in place to address those risks.*

*The Board will continue to communicate and collaborate with OPLC management and staff to establish processes and procedures to decrease and manage risks surrounding licensure and enforcement.*

*The Board will review operations on a regular basis to identify any indications of increased risk and will develop controls to monitor those risks.*

*The Board's risk management policy should be clearly stated and available to necessary groups and subordinate entities.*

*The Board acknowledges it could have provided more Board oversight of the committees it created. The Board is in the process of, and intends to continue, the process of providing increased oversight to these committees during their monthly meetings. The Board created the committees to decrease the risk of injury and protect the safety of the public and the Board remains committed to supporting that work.*

*To the extent the auditors are continuing to address issues arising from the ASEC and ASEC subcommittee in this section, the Board responded following Observation Nos. 7 and 8 in other sections of the audit. However, the Board has already initiated significant changes and will continue to initiate further changes in processes and procedures, including increased oversight, in order to decrease risk and protect public safety.*

*With help from the State and OPLC the Board will seek statutory authority to create a subordinate entity such as the ASEC committee in order to protect the public and ensure public accountability as soon as feasibly possible when meeting as a Board in monthly Board meetings. The Board cannot ensure that the supporting agency will execute the Board's strategy and plan without statutory changes. The Board would like to seek legislative changes to make the supporting agency accountable.*

## Managing Compliance

The proper functioning of State government rested on delegated and enumerated powers. The Board could exercise only the executive, quasi-legislative, and quasi-judicial authority the Legislature delegated to it. Such authority allowed the Board to regulate the dental care industry and credential qualified applicants, monitor regulatee compliance, and enforce duly adopted requirements within its jurisdiction. While affecting the separation of powers, these limited delegations were necessary for efficiency. The Legislature also imposed numerous limitations upon the Board, to avoid the accumulation of too much power, limit overreach, and maintain popular control. Board obligations and limitations were included throughout State law and administrative rules, as well as federal laws and regulations. Compliance with State and federal requirements was a basic expectation. However, conforming to these complex requirements without adequate staff support was a long-standing challenge for regulatory agencies, like the Board, composed of members who were essentially part-time volunteers.

### *Controlling The Statutory, Regulatory, And Procedural Framework*

Effective compliance management controls relied upon a Board-coordinated framework of statutes, rules, and procedures. The framework should have been designed, implemented, monitored, and refined to efficiently and effectively achieve expected outcomes. However, in practice, the framework developed piecemeal over decades and was affected by changes to regulatory and administrative requirements, the dental care industry, and its operating environment generally. Additionally, over time the Board gained shared regulatory responsibilities with other regulatory agencies as the Legislature established overlapping jurisdictions.

Effective compliance controls also depended upon comprehensive and consistently followed internal procedures that operationalized requirements in statute and rule. Board rules had to establish clear requirements to allow for Board procedure development. Procedures were necessary to define how the Board would control its own operations, consistently implement strategies and plans, comply with statute and rule, and achieve outcomes. Board rules should have also provided a starting point for corresponding OPLC rules and procedures. Integrated procedures should have provided members and staff with a clear understanding of their obligations and constraints.

**Observation No. 4**

## Control The Board's Statutory, Regulatory, And Procedural Framework

The Board did not actively control its statutory, regulatory, and procedural framework. The Board lacked controls to optimize the framework and help ensure efficient achievement of expected outcomes. Without effective controls, the Board did not always fully implement State policy, and framework inadequacies remained unidentified or unaddressed. The Board, its subordinate entities, staff, and regulatees inadequately and inconsistently understood the framework. Despite substantial framework defects, current and former members of the Board and its subordinate entities who responded to our survey generally reported the Board's statute, rules, procedures, and practices were clear or mostly clear. However, members did not attempt to assess the validity of their overly positive impressionistic views, lacking a means to objectively assess framework effectiveness. Consequently, members' views of effectiveness were likely subjected to confirmation bias.

We did not review every provision in *Dentists and Dentistry*, other statutes, or Board rules. Our work was focused on controls and not designed to find every inadequacy with the framework, inconsistent interpretation, or inconsistent result. However, we did find instances demonstrating how inadequate controls, at times, contributed to noncompliance, exacerbated extra-legal and extra-jurisdictional activities, negatively affected consistency and predictability, and likely added inefficiency, uncertainty, and complexity. Deficient controls also contributed to abuse, the imposition of perfunctory requirements, and waste. They negatively affected the Board's ability to protect the public. The Board did not implement certain statutory changes designed to improve public protection, operations, and customer service. Statute and rules were at times outdated and did not keep pace with changes to the Board's operating environment. Formal procedures were often absent and, when present, were at times contrary to statute or rules, incomplete, or inconsistently implemented. The Board, its subordinate entities, and staff often relied upon informal practices to operationalize statute and rules, exacerbating ad hoc rulemaking. Inadequate control exposed Board actions to potential federal antitrust scrutiny.

### Inconsistently Implemented And Outdated Statutory Framework

The statutory framework did not consistently reflect the Board's operating environment, was not fully implemented, and did not cohesively establish requirements. The dental care industry was dynamic, and some industry changes had a potential effect on the public's health, safety, or welfare, or otherwise fell under the Board's regulatory authority. Some provisions of *Dentists and Dentistry* dated to at least CY 1971, and statute did not always underpin changing credentialing, monitoring, and enforcement practices. Other statutory provisions were sporadically augmented, resulting in inconsistencies, and the Board lacked controls to ensure the overall design of its framework was coherent.

#### *Improperly Waived, Unimplemented, And Circumvented State Policy Requirements*

The Board waived, failed to fully implement, or actively circumvented State policy. *Dentists and Dentistry* authorized the Board only to waive one State policy requirement: late fee payments for regular license renewal. However, the Board and staff inappropriately waived other requirements,

both formally and informally. Unqualified applicants and licensees were nonetheless issued initial and renewal licenses. For example, an applicant who had not passed Board-accepted didactic or clinical examinations was issued an initial license, and an out-of-state licensee not actively practicing in New Hampshire was issued an active renewal license.

The Board did not implement certain State policy requirements, including some public protection measures, making credentialing for some applicants easier. Other deficient controls made it more difficult for certain applicants to obtain a credential and exacerbated the imposition of ad hoc rules. At times, the Board knowingly allowed risks to remain uncontrolled. While the Board implemented some requirements untimely, other requirements remained unimplemented for more than three to nearly 30 years. Unimplemented requirements included:

- applicant criminal history record checks,
- entry eligibility requirements for military personnel and their spouses,
- credential portability information for credential holders in other states,
- anesthesia and sedation regulations,
- opioid prescribing competency rules,
- reciprocal discipline procedures, and
- administrative fines.

Some endorsement applicants who did not meet at least one requirement were nonetheless licensed. Most dentist and hygienist applicants were issued credentials without the Board finding applicants possessed the necessary qualifications and that no circumstances existed which would be grounds for disciplinary action. Criminal history record checks were not completed. Some applicants were issued an initial regular license shortly before the statutory expiration date, but were not required to renew until the next biennial renewal period more than two years later.

Some Board actions went beyond its delegated authority. The Board was not allowed to take such actions, which truncated the separation of powers and encroached on legislative prerogative to set State policy. The Board had no discernible controls in place to help prevent overreach, and the Board effectively made State policy. For example, the Board:

- created its own subordinate agencies,
- established its own credentials,
- imposed unauthorized fees,
- imposed ad hoc rules on members of the public, and
- inconsistently enforced regulatee compliance with statutory requirements.

***Outdated And Inconsistent Statutory Framework***

Inadequate controls over the statutory framework at times compromised achievement of the Board's regulatory responsibilities. Increased interaction with other agencies created unaddressed gaps. The Board lacked controls to identify and request necessary updates to *Dentists and Dentistry* to help ensure the framework was coherent.

- Changed Responsibilities – Board responsibilities were not updated to reflect the OPLC's creation in CY 2015 and subsequent changes to Board and OPLC duties. For example, CY 2021 legislation proposed by the OPLC, reportedly without Board knowledge or input, altered several Board responsibilities. The ambiguous division of responsibilities contributed to erosion of Board independence, as the Board inappropriately delegated substantive, discretionary duties to staff. Staff also undertook other duties without specific delegation.

- Overlapping Regulation – Statute was not updated to address overlapping regulation, including shared monitoring and enforcement responsibilities with other agencies. These included the Pharmacy Board, the Prescription Drug Monitoring Program, the Board of Registration of Medical Technicians, and the Board of Medical Imaging and Radiation Therapy. The Board did not coordinate overlapping regulatory responsibilities, address gaps in statutory authority, or establish a cohesive framework to structure its own responsibilities.

- Inconsistencies – Entry and eligibility maintenance requirements, administrative processes, and sanctions varied across credential types, without an objective basis. For example, criminal history record checks were required only for initial regular licensure or license reinstatement, omitting all other primary credentials. Consequently, applicants could obtain a credential and begin practicing without ever being required to undergo a criminal history record check.

- Illogical Requirements – The Board lacked controls to ensure statutory changes did not create illogical requirements. For example, the Board inappropriately allowed dental students and dental residents to practice dentistry without obtaining a license. Statute had previously allowed such practice in narrowly defined settings. However, subsequent changes specified dental students and residents could only practice with a license, but prevented dental students from qualifying for licensure because they had not yet graduated from dental school. The Board did not attempt to clarify the discrepancy, even after an inquiry as to how dental residents should become licensed.

- Unaddressed Gaps – Changes to the statutory framework, Board and OPLC operations, and industry conditions created other unaddressed gaps. This at times led to the imposition of ad hoc rules. For example, statute did not accommodate non-disciplinary relinquishment of a credential. License inactivation requirements omitted licensees renewing for the first time, but who had never worked in New Hampshire. Statute did not accommodate regulation of dentists performing only non-clinical duties. Legacy features also persisted, including reference to the Board's former role directly examining applicant competency. Additionally, hygienists, licensed since CY 1997, were still referred to as "registered" hygienists.

- Ambiguity – Statute contained ambiguous terms that were either undefined or not clearly defined by rules. For example, the Board could deny credential applications for any criminal conviction involving "moral turpitude." Moral turpitude was not defined in statute and only vaguely defined in rules. This ambiguity could have led to denials

unrelated to an individual's ability to practice that were instead based on improvised Board member interpretations. Additionally, the Board could issue a license to individuals licensed in another state when requirements were at least "substantially equivalent" to New Hampshire's. The Board never defined substantially equivalent. Lacking a definition, each Board member had to subjectively interpret when other jurisdictions' requirements met the ambiguous threshold on a case-by-case basis.

**Incomplete And Complex Regulatory Framework**

The Board was aware aspects of its regulatory framework were inadequate, but lacked controls to ensure its rules were coherent. Inadequate controls adversely affected the ability of the Board to ensure State policy was reflected in rules or rules reflected its current operating environment.

- When interpretations were proposed for adoption as rules, the Board lacked a system to ensure approved changes proceeded through the rulemaking process. For example, the Board voted to amend rules related to didactic and clinical examinations. Only one of the six approved changes was reflected in updates to Board rules. The Board subsequently requested an update on the status of four of the desired rules changes, but there was no indication staff provided an update.

- The Board lacked controls to routinely update rules to reflect industry changes. For example, in August 2018, the Board concluded that rulemaking changes would be necessary to reflect forthcoming changes to didactic examinations. However, no apparent rulemaking efforts were undertaken through at least October 2021, when we concluded audit work on this topic.

- Rules did not reflect the Board's migration from an entirely independent regulatory agency to one supported by the OPLC, which began in CY 2015. While rules could establish Board requirements of staff and establish performance expectations, there was no formalization of responsibilities. Board rules did not provide the OPLC with a comprehensive starting point to begin developing its own procedural framework.

Furthermore, there were no controls to ensure the Board limited its regulatory framework to its statutory authority. Rules should have been the Board's definitive interpretation of statute, but as a matter of practice, the Board regularly interpreted, explained, and clarified its rules. Rules and declaratory rulings at times amplified statutory complexity or created their own complexities. While rules should have included all requirements binding on the public and other agencies, rules did not fully implement statutory requirements or reflect numerous Board, subordinate entity, or staff practices. Neither were rules shown to ensure expected outcomes were achieved efficiently and effectively. Many of the systemic inadequacies in Board functions we identified sourced back to inadequacies in rules.

**Procedural Framework Inadequately Controlled Practice**

The Board's controls over internal practices, forms, and procedural guides were inadequate. The Board lacked procedures controlling practices and certain processes. For example, no procedures

addressed strategic and risk management, compliance with ethical and transparency requirements, subordinate entities' actions and internal communications, or the review and approval of credential applications and renewals. When present, procedures were incomplete, unmonitored for compliance with statute and rule, and inconsistent. Some internal forms and guidance also had the effect of imposing ad hoc rules upon the public. This included credential applications and renewals, as well as the ASEC's entire procedural framework that was developed, implemented, and operated without Board oversight.

Elements of a procedural framework were formalized before the Board was assigned to the OPLC, some parts of which survived the organizational change. However, these controls were later abandoned and never incorporated into separate Board or OPLC procedural guides. Furthermore, these legacy controls were inadequate, containing numerous ad hoc rules imposed on the public and improvised requirements structuring internal practices. The Board informally delegated development and implementation of additional procedural requirements to the OPLC. The OPLC's procedural framework relied upon improvised practices and informal guidance, which were not always consistent with the Board's statutory authority or rules. This further compromised the Board's regulatory responsibilities.

**Recommendations:**

**We recommend the Board improve controls over the statutory, regulatory, and procedural framework, and:**

1. **exert control over its statutory, regulatory, and procedural framework;**
2. **ensure uncontrolled processes and practices are adequately controlled through comprehensive and clear rules and procedures;**
3. **discontinue improvised regulation, including overreach and ad hoc rules;**
4. **include elements in its strategy and plans to continually ensure statutes reflect the current operating environment, rules interpret and implement statutes, and Board and OPLC procedures operationalize all internal practices, without affecting the public;**
5. **seek to simplify the statutory, regulatory, and procedural framework; and**
6. **monitor and refine statute, rules, and procedures to ensure relevance and accuracy.**

Board Response:

*We concur with the recommendations.*

**The Board's lengthy, detailed response and associated rejoinders are in Appendix B.**

### *Compliance With Regulatory And Administrative Requirements*

The Board was not allowed to act beyond its delegated authority, as such actions encroached on legislative prerogative to set State policy. The Board was subject to numerous federal and State

laws, rules, and regulations establishing either substantive regulatory requirements or administrative requirements generally applicable to State regulatory agencies. The Board had to conform to administrative statutes affecting its organization, transparency, recordkeeping, member ethics, among others. These statutes included the *Administrative Procedure Act* and the Right-to-Know law. They were intended to provide transparency through public and Legislative oversight and help ensure due process. When the Board did not fully comply with requirements, an imbalance in the separation of powers and a loss of public accountability could occur.

**Observation No. 5**

## Develop Compliance Management Controls

The Board lacked a system of control to ensure its operations and those of its subordinate entities consistently complied with statute, rules, and other requirements. The Board also lacked a means to ensure the duties performed by members of subordinate entities and staff on its behalf complied with requirements. Paradoxically, the Board enforced requirements upon the dental care industry and credential holders. While our audit was not designed to comprehensively review Board or subordinate entity compliance with every requirement, we identified many instances of noncompliance. Noncompliance adversely affected the Board's credentialing, monitoring, and enforcement functions and its ability to achieve expected outcomes. Noncompliance resulted in extra-jurisdictional and extra-legal regulations, led to abusive imposition of ad hoc rules, compromised the separation of powers, adversely affected accountability, and promoted undue regulatory complexity. Noncompliance undermined accountability, limited transparency, and unnecessarily increased risk exposures to potential conflicts of interest, regulatory capture, and federal antitrust scrutiny. Absent controls compromised effectiveness and contributed to inefficiency and waste.

### Inconsistently Fulfilled Requirements Regulating The Dental Care Industry

The Board lacked controls to ensure it and its subordinate entities were aware of, fully implemented, and consistently followed statutory requirements. The Board also lacked controls to ensure it limited its regulatory reach to its delegated authority.

- *Dentists And Dentistry* – The Board issued credentials to applicants who did not meet statutory requirements. This included 3,168 of 3,179 initial and renewal regular licenses (99.7 percent) issued in SFY 2019 and SFY 2020 without first finding the applicant had necessary qualifications and there were no grounds for disciplinary action. Neither did the Board consistently undertake disciplinary proceedings, pursue disciplinary action when warranted, or impose sanctions as required. The Board waived statutory requirements without authority and did not adopt all required rules, including some specifying public protection measures, allowing risks to remain knowingly uncontrolled. The Board did not control subordinate entities or staff, who inconsistently followed statutory requirements.

- *General Administration Of Regulatory Boards And Commissions* – The Board inappropriately expanded scopes of practice. It did not adopt entry eligibility

requirements for members of the military or their spouses or publish reciprocity information. Additionally, the Board adopted rules allowing for consideration of potential noncompliance outside the statute of limitations.

- *Controlled Drug Prescription Health And Safety Program* – Board procedures, adopted rules, and ad hoc rules were inconsistent with statutory requirements. The Board did not adopt competency requirements for prescribers applying for initial licensure. Prescriber compliance with requirements was inadequately monitored, and noncompliance potentially went unsanctioned by the Board.

- *Disclosure Of Ownership Interests By Health Care Practitioners* – The Board did not establish reporting procedures for initial credential applications. Board procedures did not conform to statutory requirements. Credential holder noncompliance was unmonitored and any that might have occurred was not sanctioned by the Board.

- *Administrative Procedure Act* – Certain Board rules exceeded its statutory authority. Without authority, the Board: 1) required credentialing, 2) imposed fees, 3) limited the scope of who could practice certain occupations, and 4) regulated certain occupations, professions regulated by other agencies, and businesses and other entities. The Board did not adopt all required rules or forms, and the Board and its subordinate entities engaged in broad ad hoc rulemaking. Staff extended the application of ad hoc rules by implementing improvised requirements. Additionally, rules were not designed to ensure Board processes complied with statutory processing time limits and did not address the Board's failure to timely act.

**Inconsistently Fulfilled Requirements Regulating Board Organization And Operation**

The Board lacked controls to ensure it and its subordinate entities understood, fully implemented, and followed statutory organizational and operational requirements.

- *Statutory Construction* – The Board inappropriately delegated its joint statutory authority to individual Board members, subordinate entity members, and staff.

- *Organization Of The Executive Branch* – The Board established two standing committees and other advisory committees without authority.

- *Orientation Information For Board And Commission Members* – Board and ASEC members did not receive comprehensive orientation information on their roles and responsibilities as public officials. Nothing demonstrated DHC members received any orientation.

- *Administrative Procedure Act* – The Board did not establish staff expectations or control subordinate entities through rules. Neither did the Board develop complete and accurate organizational rules.

**Inconsistently Fulfilled Transparency Obligations**

The Board lacked controls to ensure its members, members of subordinate entities, and staff understood, fully implemented, and followed statutory transparency requirements.

- Right-to-Know Law – Noncompliance may have unnecessarily exposed Board or subordinate entity actions to invalidation. Not all meetings were open to the public. The DHC and the ASEC at times lacked a physical location for public access. Some ASEC meetings were held in private facilities. DHC and ASEC meetings were inconsistently noticed. The Board, the DHC, and the ASEC engaged in discussion of matters under their purview without a quorum present. The Board and its subordinate entities inconsistently followed formal meeting procedures, inconsistently making motions to move business and taking votes on decisions.

  The Board improperly cited authority, claimed another agency's authority, claimed "executive and deliberative privileges," or altogether omitted reasons to enter nonpublic session. The Board improperly used nonpublic sessions and non-meetings to discuss items more appropriate for public sessions, including credential and waiver applications, Board financial statements, and subordinate entity membership applications. The Board also discussed changes to jurisprudence examination questions in public session, even though statute allowed such discussion to take place in nonpublic session.

  Minutes inconsistently provided accurate and sufficient information on matters discussed or final decisions. Public session minutes were not always publicly available within five business days of a meeting. Although final minutes had been approved for up to 18 months, at times, only draft minutes were available. Nonpublic session minutes were to be disclosed within 72 hours of the meeting, unless sealed by a public session vote, but the Board inconsistently complied. The ASEC-AS inconsistently complied with the requirement that all votes during meetings with remote participation were to be by roll call, affecting both substantive and procedural decisions. Some ASEC and ASEC-AS votes occurred electronically, outside meetings.

- *Administrative Procedure Act* – The Board, its subordinate entities, and staff engaged in broad ad hoc rule application. This negated statutory rulemaking controls designed to afford public and legislative oversight of the requirements the Board imposed upon others.

- *Archives And Records Management* – True records were not made and preserved of all official acts of the Board or its subordinate entities. Some records were not held by the State. Some records were unrecoverable, and true records of many transactions and decisions may never be recovered. Consequently, some controls, processes, practices, and transactions were unauditable.

- *Distribution Of Publications By Licensing Commissions And Boards* – During the audit period, the Board was to provide new credential holders with a copy of the rules

regulating their occupation. This did not occur. The requirement was later repealed, without reallocation to the OPLC or establishment of another mechanism to ensure new credential holders received a copy of rules regulating their credential.

**Inconsistently Controlled Ethical Requirements**

The Board lacked controls over inherent conflicts to ensure it and its subordinate entities fully understood, implemented, and followed statutory ethical requirements. State policy set the minimum standard to help members avoid these risks and increase transparency, but the Board never developed supplemental guidance.

- *Code Of Ethics* – Members of the Board and its subordinate entities participated in matters in which they had conflicting interests. Members engaged in behavior not designed to achieve public protection outcomes by pursuing regulation of economic competitors without demonstrated risks to the public. Individual members inconsistently took part in – and recused themselves from – decision making on a single disciplinary case. Two members – including one who requested the assignment – reviewed and approved a license and permit application for an applicant with whom they were affiliated outside their membership.

- *Financial Disclosure* – Rules regulated only Board members' filing statements of financial interest. Rules did not include DHC, ASEC, or ASEC-AS members. There were no other procedures in place to ensure statements were filed. While Board and DHC members timely filed financial disclosure statements in CY 2020, members of the ASEC and ASEC-AS did not file statements at all. Failure to file made members ineligible to serve. Additionally, the Board did not file with the Secretary of State the required organizational chart delineating members who should file.

- *Gifts, Honorariums, And Expense Reimbursements* – ASEC members improperly accepted honorarium from applicants and permittees they inspected and evaluated. Board members inconsistently reported honorarium and expense reimbursements. An honorarium was any payment for services as a consultant or advisor. Public officials were prohibited from receiving honorarium from anyone subject to, likely to become subject to, or interested in any matter or action pending before them. As early as August 2017, Board members were notified of the requirement to report such transactions related to their position as a Board member. Failure to report receipt of certain gifts and honorariums was a misdemeanor.

**Uncontrolled Federal Requirements**

The Board lacked a system of control to ensure it and its subordinate entities complied with federal requirements.

- Federal Antitrust Laws – The Board and its subordinate entities could not act in the State's sovereign capacity, unless delegated specific authority. However, the Board and its subordinate entities impermissibly acted outside their statutory authority or without

clear underpinning State policy. They did not receive active State supervision, potentially exposing Board actions to federal antitrust scrutiny.

- National Practitioner Data Bank Reporting Requirements – The Board was required to report final disciplinary actions against its credential holders. However, it lacked procedures to ensure reporting requirements were met and could not demonstrate compliance.

**Recommendations:**

**We recommend the Board develop a system to ensure consistent compliance with applicable statutes, rules, and other requirements that includes:**

1. **identifying all requirements and implementing relevant controls,**
2. **synchronizing Board and OPLC controls, and**
3. **monitoring compliance, and subsequently refining operations as needed.**

Board Response:

*We concur with the recommendations.*

*The Board generally concurs with this recommendation, but notes that it does not agree with every LBA observation. The Board has initiated and continues to work on necessary changes to the structure and function of the ASEC to improve compliance with statutes and rules. The Board is also committed to working with the OPLC and the Department of Justice (DOJ) to review, revise and update the rules and seek legislative changes when necessary. The Board acknowledges that improved communication between it, the OPLC, and the DOJ is important. The Board will work with the OPLC to synchronize Board and OPLC controls.*

### *Operationalizing The Framework For the Public*

An effective regulatory framework was essential to implement the Board's credentialing, monitoring, and enforcement responsibilities. The Legislature delegated significant rulemaking authority and latitude to the Board. The Legislature established the DHC to develop and propose certain rules for the Board's consideration. The OPLC was to provide rulemaking assistance. The Board, in turn, was expected to comply with rulemaking obligations and limitations in the *Administrative Procedure Act*. To operationalize and clarify statute, the Board developed five chapters of rules. Rules dated to CY 1971 and were last readopted in CY 2017, with minor changes during the audit period occurring in CY 2020. The Board also issued declaratory rulings and developed other guidance for the public and regulatees.

- Administrative Rules – Rules were the sole means by which the Board could require a non-member, including OPLC staff, to do anything not specifically required of them by statute, provided the rule was within the scope of the Board's statutory authority. Board rules should have implemented, interpreted, or made specific statute, or

prescribed or interpreted other binding requirements. Rules could not have added to, detracted from, or modified statute. Rules that did so exceeded the Board's authority and constituted overreach. Rules had to be clear and coherent. Insufficiently detailed or incomplete rules could have required clarifications or interpretations to be understood, which was ad hoc rulemaking and unenforceable.

- Declaratory Rulings – Declaratory rulings were Board rulings on the specific applicability of a statutory provision, or Board rule or order, to an individual in a limited, specific set of circumstances. Declaratory rulings could not substitute for rulemaking.

- Guidance – Guidance, such as instructions for Board forms, supported – and were required to conform to – rules. The Board could provide guidance to the public and regulatees but could not impose requirements not already established in statute or rules when doing so.

**Observation No. 6**

**Comply With The *Administrative Procedure Act***

The Board lacked controls to consistently ensure compliance with the *Administrative Procedure Act*. The Board lacked controls to ensure its members and members of its subordinate entities knew how to comply with statute, avoid extra-legal acts, monitor compliance and address noncompliance, and monitor proposed rule changes and ensure timely adoption. Neither did the Board have controls to ensure it and its subordinate entities consistently had sufficient support to help ensure compliance. While staff purported the Board reviewed its entire regulatory framework in CY 2017, members reported being unaware of the requirement. The results of the review were never located. Consequently, there was no record to assess whether and how the Board concluded:

- its regulations did not impose unnecessary burdens and costs on the public,
- its requirements were essential,
- the benefits of its regulations exceeded costs,
- its regulations were the least restrictive or intrusive necessary,
- its regulations did not have an unreasonably adverse effect on the State's competitive business environment,
- the effectiveness of regulations could be reasonably and periodically measured, and
- there was a process in place to measure effectiveness.

Our audit was not designed to identify each instance of Board and subordinate entity noncompliance. We nonetheless identified broad noncompliance during the audit period adversely affecting each Board function and process we examined. Inconsistent compliance contributed to:

- inconsistent public protection, including allowing unlicensed individuals to practice and inadequately regulating aspects of dental care with elevated risks, such as dentists' administration of anesthesia and sedation;

- failure to fully implement State policy and encroachment on the Legislature's prerogative to set State policy, creating irreconcilable situations, such as the failure to adopt required pediatric minimal sedation permit rules, while adopting rules creating other credentials without authority;
- the abuse of individual due process rights through the known application of ad hoc rules;
- disenfranchisement of members of unregulated occupations, professions regulated by other agencies, credential applicants, and others;
- compromised transparency and circumvention of oversight controls intended to facilitate public and legislative monitoring of the Board's regulatory framework;
- unnecessary risk exposures, including potential federal antitrust scrutiny;
- inconsistent, and at times unduly burdensome, regulation of the dental care industry;
- amplified complexity of the Board's statutory framework;
- inadequately controlled subordinate entities and staff, by providing insufficient bases for developing supporting procedure, practices, and OPLC rules; and
- untimely actions, while also imparting inefficiency upon some processes.

**Inadequate Control Of Rules**

Rules lacked cohesive design and inconsistently reflected the Board's operating environment, conformed to statute, or addressed observable risks. During the audit period, Board rulemaking requirements included credential application procedures, forms, applicant qualifications, ethical standards for dentists and hygienists, investigations, hearings, and fines and other sanctions.

***Extra-legal Rulemaking***

The Board engaged in extra-legal rulemaking by adopting rules without underlying statutory authority and engaging in extensive ad hoc rulemaking. Some extra-legal rules likely infringed on the fundamental rights of individuals to pursue an occupation. Rules without underlying statutory authority:

- created subordinate entities that engaged in substantive industry regulation;
- regulated members of professions regulated by other agencies as though they were Board-regulated occupations;
- imposed unauthorized fees, although the OPLC obtained fee setting responsibility after the audit period;
- regulated dental assistants as though they were a Board-regulated occupation;
- allowed hygienists to supervise dental assistants;
- created hygienist anesthesia and sedation permits;
- created the EFDA permit, authority for which the Board later sought and obtained;
- limited eligibility for certain credentials;
- redefined the age at which patients were considered pediatric or adult;
- allowed use of letters of concern beyond what was authorized, although statutory changes effective in January 2022 modified applicability to match Board overreach;
- regulated public health, dental residency, and dental student programs; and

- inappropriately required social security numbers, and incompletely disclosed how they were used.

Ad hoc rules improperly modified the terms and conditions of the Board's relationship with the public and regulatees. Ad hoc rulemaking circumvented statutory transparency controls and exposed Board actions to potential federal antitrust scrutiny. Ad hoc rules were developed during Board public and nonpublic meetings, during subordinate entity meetings, and by staff. We identified 123 sources of ad hoc rules, including forms, external guidance, and internal guides. Some sources contained more than one ad hoc rule. For example, one form contained 13 individual ad hoc rule requirements. The Board knew it was enforcing some ad hoc rules, constituting abuse. In some cases, entire processes were underpinned by ad hoc rules, including dentist anesthesia and sedation permitting. In other cases, ad hoc rules amplified overreach. For example, ad hoc rules imposed a nitrous oxide minimal sedation permit application fee, for a permit the Board established using extra-legal rules. Ad hoc rules led to:

- the creation of extra-legal entities, and inappropriate delegations of collective Board duties to those entities, as well as to individual members and staff;
- the creation and issuance of non-clinical dental licenses and moderate sedation-unrestricted permits with limitations;
- regulation of professions and occupations over which the Board had no authority;
- requirements that hygienists obtain extra-legal permits to administer local anesthesia or nitrous oxide minimal sedation;
- further definition of the hygienist scope of practice;
- the imposition of fees upon certain classes of credential holders and indirect costs upon unregulated occupations;
- limitations on acceptable licensure examinations;
- the substitution of ad hoc rules for duly adopted rules;
- awarding of continuing education credits; and
- conflicting and inconsistent notarization and attestation requirements.

While some ad hoc rules were eventually formalized through the rulemaking process, proper adoption took more than two years in one case we identified.

***Unadopted Rules***

The Board inconsistently adopted statutorily-required rules. In several instances, the Board nonetheless enforced related requirements without necessary rules, constituting ad hoc rulemaking. Unadopted rules included minimal sedation safety margins and auxiliaries' roles in monitoring patients undergoing general anesthesia, deep sedation, or moderate sedation and their recovery. Neither did the Board adopt rules defining the roles of staff or members of subordinate entities. Additionally, the Board was aware it had not adopted certain required rules, including:

- requirements and procedures for criminal background checks, for which the Board requested authority in CY 2017;
- pediatric minimal sedation permit requirements;

- reporting adverse events resulting from the use of general anesthesia, deep sedation, or moderate sedation, as well as the analysis of root causes and the implementation of corrective actions plans;
- requiring renewing licensees complete a Department of Health and Human Services-developed survey, or opt-out form, which were partially adopted in CY 2020; and
- entry eligibility requirements for military-service members and their spouses.

***State Policy Not Fully, Completely, Or Accurately Implemented***

Without a cohesive design, certain Board rules were inconsistent with State policy, incomplete, or inaccurate, which contributed to ambiguity and ad hoc rulemaking. For example, rules did not:

- include permittees and certificants in most regulatory processes, instead focusing on licenses;
- fully control credential expiration dates consistent with statute, for those credentials with statutorily-authorized renewals;
- comprehensively describe which duties could be delegated to a dental assistant;
- address penalties, injunctions, and temporary suspensions;
- address petitions for the review of a potential applicant's criminal record;
- accommodate key elements broadly affecting regulation and credentialing of EFDAs;
- contain all continuing education requirements specified by statute for dentist anesthesia and sedation permit issuance or renewals; or
- limit moderate sedation permit renewals to only those dentists who met continuing education requirements.

Additionally, Board rules did not:

- completely describe credential application, renewal, withdrawal, and denial procedures;
- completely describe license lapse, reinstatement, inactivation, or reinstatement procedures, or accurately reflect the statutory framework;
- describe investigative or expert reviewer procedures; or
- completely describe adjudicative and sanctions-related procedures.

The OPLC was allocated authority to adopt procedural rules in July 2018. Following the audit period, the Board's authority to adopt rules on application, renewal, complaint, and investigative procedures was rescinded. However, the Board retained rulemaking authority to establish substantive regulatory requirements.

***Improperly Controlled Incorporated Materials***

The Board inadequately controlled rules adopting third-party standards and external forms. The 39 improperly adopted third-party standards and forms we identified led to ad hoc rulemaking and created ambiguity. They also expanded, and added complexity to, the regulatory framework. Other standards contained ambiguity, requiring ad hoc clarifications in practice. Inadequately controlled third-party standards affected: 1) licensee ethical standards, 2) opioid prescribing risk assessments,

3) dentist anesthesia and sedation permitting, 4) infection control standards, 5) dentist specialties; and 6) certain standards and terms integral to defining professional misconduct. Additionally, third-party standards had to be available for public inspection. However, dentist anesthesia and sedation permitting standards were purportedly lost and unavailable, making their implementation unauditable.

Forms were rules when they affected a non-member. Without controls over forms, the Board, its subordinate entities, and staff used 27 forms or form-like publications not adopted in rule. At times, they also actively circumvented requirements to adopt and modify forms in rules, incorporated third-party publications using only forms, improperly incorporated forms into rules, contradicted or did not reflect rules in forms, and created inconsistencies between similar processes. Following the audit period, the Board's authority to develop forms was rescinded and allocated to the OPLC. However, the Board retained rulemaking authority to establish substantive regulatory requirements.

***Inconsistencies***

Certain rules created inconsistencies, and the lack of rules operationalizing aspects of statute left implementation to improvised practices. Remedying inconsistency could lead to ad hoc rulemaking. The more than 70 inconsistencies we identified affected credentialing, continuing education, hygienist duties and supervision, dental assistant duties and supervision, time limits for licensees to respond to complaints, certain fees, and notarization or attestation requirements.

***Outdated And Expired Rules***

Certain rules were outdated and did not reflect current statutory requirements, or were expired. Outdated or expired rules could lead to unclarity and require ad hoc rulemaking to clarify. Expired rules could not be enforced. For example, outdated and expired rules affected the regulation of dental assistants generally, as rules were apparently based on CY 1971 statutory language no longer in the Board's statute. Rules relied on specific dental assistant qualifications that were expired. Rules also regulated dental assistants performing dental radiology, which became the Board of Medical Imaging Radiation Therapy's responsibility in CY 2016. Additionally, ethical codes underpinning professional conduct and potential noncompliance were up to two editions, or four years, out-of-date. Substantive regulatory guidance for dentist anesthesia and sedation was also known to be one edition, or six years, out-of-date.

***Ambiguities In Rules***

Several rules contained ambiguities. Ambiguous rules were impermissible, as they required explanation, clarifications, or interpretations to be understood, potentially resulting in ad hoc rulemaking. The nearly 80 ambiguities we identified affected, for example, credentials, dentists' use of anesthesia and sedation, continuing education waivers, the age at which patients were considered pediatric or adult, acceptable qualifying examinations, and time limits and related sanctions for licensees to respond to complaint allegations. Additionally, licensee character

requirements were affected, including the legacy phrase "moral turpitude," which was explained in rules using terms vague to the point of being meaningless.

**Inadequate Control Over Declaratory Rulings And Rule Interpretations, Explanations, And Waivers**

The Board's controls over declaratory rulings and interpretations, explanations, and waivers of rules were inadequate and contributed to ad hoc rulemaking. The Board lacked procedures to monitor changes it made to ensure consistency over time. The Board did not monitor changes to identify frequently interpreted, explained, or waived provisions that might indicate a need to change rules. Precedent-setting interpretations were inconsistently memorialized in rules. This left broadly-applicable requirements affecting the public distributed throughout public and nonpublic meeting minutes, declaratory rulings, and other records. Circumvention of rulemaking procedures using these methods was impermissible. Furthermore, rules themselves were to be the Board's definitive interpretation of statute, not a starting point for additional Board interpretations. Rules that required clarifications or interpretations to be understood were impermissibly vague.

- Clarifying or interpreting rules using declaratory rulings was a misuse of the process. Declaratory rulings were limited to rulings on the applicability of a statutory provision, rule, or order, to an individual in a specific set of circumstances. However, declaratory rulings issued before the audit period contained broad, rule-like conclusions. The Board inconsistently adopted rules reflecting these conclusions. For example, in CY 2015, a declaratory ruling defined the active practice of dentistry and hygiene, which applied to every licensee under the Board's jurisdiction. Through October 2021, the Board had not adopted relevant rules. The Board did not issue declaratory rulings after CY 2016, but the application of earlier rulings extended into the audit period and resulted in ad hoc rulemaking.

- The Board created an extra-legal rule authorizing it to explain its rules. The process was limited to 30 days following the adoption of a rule. Unlike declaratory rulings, this process was not a mechanism to clarify the application of rules to individuals in specific cases. Due to inadequate records, we could not determine whether rule explanations, interpretations, or clarifications, occurred under this process.

- The Board used extra-legal procedures in public and nonpublic meetings, and outside meetings, to interpret and clarify its rules and their application in specific cases. Formal declaratory ruling or other procedures were not followed. These interpretations and clarifications also contained generally-applicable provisions, but were not memorialized in rules.

- Waivers of substantive Board rules were accommodated by statute and rule, provided procedural controls were observed. However, while the Board formally waived some rules, it also informally waived rules without adherence to rule-based procedures. In one case, rule waiver procedures circumvented rulemaking requirements.

**Inadequate Control Over Timeliness**

The Board was insufficiently attentive to the timeliness of its actions. There was no measurement or monitoring of timeliness. Without controls, the Board could not demonstrate it consistently complied with statutory time limits. The Board was required to examine applications, petitions, and requests, and request additional information, if necessary. This was to occur within 60 days of receipt before January 1, 2019, and within 30 days thereafter. The Board then had to approve or deny the application, petition, or request, or commence an adjudicative proceeding. Before January 1, 2019, the Board had 120 days to act after a complete application, petition, or request was obtained, and within 60 days thereafter. Beginning January 1, 2019, applications, petitions, or requests were deemed approved if the Board failed to meet these time limits. However, Board rules had only one rule-based time limit governing one Board process. The procedures within that process did not conform to statute. Rules also lacked procedures to deem approved applications, petitions, or request the Board did not respond to timely.

**Recommendations:**

**We recommend the Board improve *Administrative Procedure Act* compliance in the near-term, and:**

1. **identify, discontinue enforcement of, and repeal extra-legal and extra-jurisdictional rules;**
2. **identify and discontinue enforcement of ad hoc rules across all functions and processes;**
3. **develop a strategy and plan component to ensure a) future compliance with all aspects of the *Administrative Procedure Act*, b) rules reflect and are limited by statute, c) rules impose only necessary burdens and costs on the public, d) requirements are essential, e) regulatory benefits exceeds costs, f) rules are the least restrictive or intrusive necessary, g) rules do not have an unreasonably adverse effect on the State's competitive business environment, and h) there is a process to periodically measure effectiveness;**
4. **ensure rules reflect the current dental care industry and help control risks, and rules form the basis for developing Board procedures; and**
5. **formally establish expectations of staff.**

**We recommend the Board in the mid- and long-term:**

6. **recodify and amend rules to reflect the statutory framework and incorporate all requirements binding on the public that are underpinned by statutory authority;**
7. **ensure rules structure processes compliant with statutory time limits;**
8. **ensure rules help structure OPLC rules and procedures that will regulate Board administrative processes; and**
9. **monitor operations to ensure compliance with laws and rules and ensure strategy and plans are effectively implemented.**

Board Response:

*We concur with the recommendations.*

1. *We concur that we should identify, discontinue enforcement, and repeal extra-legal and extra-jurisdictional rules.*

2. *We concur with the recommendation to identify and discontinue enforcement of ad hoc rules across all functions and processes.*

   *Please see our response to Observation No. 4.*

3. *We concur with developing a strategy and plan to address all eight elements of the recommendation, above.*

   *The Board believes that public safety is paramount, and the requirements should be appropriate to achieve that goal.*

4. *We concur with the recommendation to ensure rules reflect the current dental care industry and help control risks, and rules form the basis for developing Board and OPLC procedures.*

5. *We concur with the recommendation to formally establish expectations of staff.*

   *The Board cannot ensure that the supporting agency will execute the Board's strategy and plan without statutory changes. The Board would like to seek legislative changes to make the supporting agency accountable.*

6. *We concur with the recommendation to recodify and amend rules to reflect the statutory framework and current industry environment and incorporate all generally applicable requirements binding on the public that are underpinned by statutory authority.*

   *This will be a long process. The Board will prioritize the rules that directly ensure public safety.*

7. *We concur with the recommendation to ensure that rules structure processes to help ensure compliance with statutory time limits.*

   *The Board has endured high turnover in both the Board membership and OPLC administration over the past three years. We believe that consistency is the key to the dissemination of institutional knowledge. This consistency will help ensure that rules, policies, and procedures will facilitate compliance with statutory time limits.*

8. *We concur with the recommendation to ensure rules help structure OPLC rules and procedures that will regulate Board administrative processes.*

9. *We concur with the recommendation to monitor operations to ensure compliance with laws and rules and ensure strategy and plans are effectively implemented.*

**Board Organization**

The Board had delegated and enumerated authority, and a statutorily-defined structure. The Board's structure was integral to its operating environment, and efficient and effective operation. An effectively designed organizational structure – formalized in rule and properly implemented – could have helped the Board achieve expected outcomes. Effective design could have provided a broad perspective and necessary expertise to form an appropriate regulatory approach, develop rules, monitor the industry, and evaluate credentialing, monitoring, and enforcement actions. Effective design could also have helped control anticompetitive behavior. The Board's control of its organization included its subordinate entities, the authority it delegated, its operational processes, oversight, and monitoring of results.

**Observation No. 7**

**Improve Board Organization Controls**

The Board lacked cohesive control over its organization, and the organization and operation of its subordinate entities. The Board lacked a formal organizational construct. It was supported by subordinate entities, some without underpinnings in statute or rules, and it lacked accountability and performance controls over its subordinate entities. Responsible for actions taken on its behalf, the addition of subordinate entities broadened the Board's span of control, expanding oversight requirements for its volunteer members. The Board's organizational rules and rules of practice did not address subordinate entity organization, their course and method of operations, or all formal and informal procedures. The Board's subordinate entities struggled, at times, to comply with various statutes and created risk exposures for which the Board lacked adequate controls. The organization of the Board itself did not adequately address changing risk exposures.

Subordinate entities also expanded the OPLC's span of responsibilities, risk exposures, and operational costs. The scope of the Board's operations was inconsistently understood by staff, and subordinate entities were inconsistently supported. The details of the interrelationship between the Board and the OPLC were left to the agencies to formalize. However, the terms and conditions of their relationship had not been formalized since the OPLC became responsible for Board administrative support in CY 2015.

**Inadequate Board Organization**

The Board's organization and composition did not adequately support achievement of expected outcomes or mitigate evolving risk exposures. The Board's structure should promote the public's interest, provide needed industry expertise, and mitigate risk exposures as they changed over time.

Since CY 1989, the Board consisted of nine members: six dentists, two hygienists, and one public member. Sufficient numbers of public members were required to help balance industry perspectives against the public interest purpose the Board was created to fulfill. However, the

Board's composition did not keep pace with changes in the dental care industry or the Board's operating environment, such as increased risk of exposure to federal antitrust scrutiny. Additionally, standing Board meeting agenda items always included two non-governmental entities – both dental care industry special interest groups. The Board's single public member was the only balance against industry interests, and the 33 dentist and hygienist members on the Board and its subordinate entities.

The Board intermittently needed specialized advice to address complexity on:

- dental anesthesia and sedation, the practice of which was changeable and evolving;
- hygienists, whose scope of practice progressively expanded;
- EFDAs, who were credentialed by, but unrepresented on, the Board;
- dental assistants, who were neither credentialed by nor represented on the Board, but were regulated by it;
- professional examinations, the approach nationwide being highly variable; and
- insurance claims and legal judgments for medical injury.

The Board addressed most perceived needs by forming subordinate entities, typically without statutory authority to do so. Broadening the Board's span of control, it became the members' duty to oversee administrative controls for these entities, such as orientation, ethics, statutory compliance, recordkeeping, and performance reporting. Each entity also created demand for staff support, which, along with the overhead to support each entity's activities, was a cost to the dental care industry and the public.

Instead of forming improvised entities or formalizing those entities and incurring related costs, qualifications for current Board positions could have been revised to include requisite expertise. Alternatively, members with requisite qualifications and expertise could have been added to the Board with some additional cost. If demonstrated to be necessary and cost effective, properly structured advisory committees could have intermittently provided necessary advice. Standing committees could have provided necessary advice if individual members were unable to do so effectively, and if advisory committees were unable to do so efficiently. Each option required statutory authorization.

**Statutory DHC Insufficiently Structured And Controlled**

The Board inadequately controlled the statutory DHC, and the DHC's structure inadequately controlled risks. The DHC outlived the purpose for which it was created. It lacked public members, at times engaged in activities outside its statutory scope, and wasted public resources. The DHC chair reported on DHC activities during Board meetings, the Board reviewed and approved DHC meeting minutes, and memoranda were passed between the two entities. However, Board rules lacked description of the DHC's organization, its operation, and its practices. The DHC struggled at times to comply with administrative laws, such as the Right-to-Know law, the *Administrative Procedure Act*, and those related to ethics.

Additionally, while the DHC's statutory role was rule development, it did not have rulemaking authority. Consequently, its deliberations occurred before statute required formal rulemaking

procedures be applied, including public notice, notification of affected credential holders, and public hearings. This potentially further limited public, credential holder, and other stakeholder involvement in the rule development process.

***Insufficient Organization***

The DHC's organization was insufficient to help ensure the public's interest was balanced against industry interests. The DHC institutionalized special interest group input. This potentially consolidated regulatory direction in favor of the industry.

- There were no public members on the DHC to balance public and industry interests.

- No CPHDH member was required. The DHC did not include a CPHDH until April 2021, and inconsistently had one thereafter. While CPHDHs were few in number, their scope of practice was broader than that of a non-certified hygienist, and the DHC was responsible for developing CPHDH rules.

- The five DHC members included one dentist and one hygienist member of the Board. The Governor and Council appointed the three additional hygienist members. The additional non-Board hygienist members were nominated by special interest groups, unlike Board members. Statute did not provide for Board member nominations from special interest groups.

- One non-Board hygienist member was to be nominated by the dental hygiene education community, but there was no limitation on the number of other members who could also be educators. In contrast, statute prohibited the Board from having more than one member who was a full-time faculty member.

***Outlived Purpose***

The DHC as structured outlived its purpose and engaged in activities outside its statutory scope. During CYs 2018 through 2020, the DHC held 33 meetings. At:

- 17 (51.5 percent), it addressed statutory DHC duties;
- 13 (39.4 percent), it addressed topics only generally related to hygienists, but lacked connection to statutory DHC duties; and
- three (9.1 percent), the topics addressed lacked a connection to statutory DHC duties or hygienists generally.

The DHC was established in CY 2011 to develop and propose rules on hygienists' licensure, practice, and discipline for the Board's consideration. The DHC reportedly reviewed hygienist rules annually. Relevant rules predated the creation of the DHC and were updated before and after the DHC's creation, through CY 2020. In CY 2018, statute tasked the DHC with developing and proposing application, certification, education, and other regulations related to CPHDHs. However, relevant rules were adopted in CY 2015 and not amended through June 2021, when we

concluded audit work on this topic. Additionally, the DHC was informally assigned the role of regulating hygienists' use of anesthesia and sedation, outside its statutory purpose.

The creation of the DHC did not affect or change hygienists' scope of practice or authorize independent hygienist practice. The DHC had no independent regulatory or disciplinary authority or duties other than advising the Board on specific hygienist-related rules. No rule specified DHC duties, and the Board lacked authority to expand the DHC's statutory scope or delegate Board duties to it. However, on its own initiative or at Board direction, the DHC engaged in activities outside its statutory scope, including:

- advancing the expansion of hygienists' scope of practice;
- developing publications designed to manage hygienist practice;
- engaging in regulatory duties, such as reviewing so-called "audits" of hygienists' continuing education conducted by members, and members reviewing hygienist and EFDA credential applications;
- assisting the Board with addressing inquiries and waiver requests;
- reviewing education institutions' forms, which rules required institutions provide to students upon course completion, and was outside the Board's authority;
- reviewing and recommending modification of hygienist and EFDA permit application forms not adopted in Board rules;
- attending hearings and taking positions on proposed legislation; and
- engaging in discussions on the regulation of dental assistants and EFDAs.

***Costs Incurred And Meetings Cancelled***

DHC meetings resulted in wasted resources. The DHC met monthly as a matter of routine. During the audit period, non-Board DHC members were eligible for $50 each day they engaged in official duties, plus expenses. During CYs 2018 through 2020, an estimated $1,800 was paid to non-Board DHC members for the 16 meetings where statutory duties were not carried out. It was not clear this was worth the costs incurred. Furthermore, one staff member attended 18 meetings (54.5 percent) and two staff members attended two meetings (6.1 percent). Staff did not attend the 13 remaining meetings (39.4 percent). Although the OPLC lacked a cost allocation plan to allow quantification of costs incurred supporting the DHC, some costs were likely incurred. The DHC's small size also increased sensitivity to absences. Obtaining a quorum was at times an issue, leading to cancelled or delayed meetings, potentially wasting additional resources.

**Extra-legal Subordinate Entities**

The Board created two standing committees via rules without relevant statutory authority and four entities without basis in either statute or rule. The Board lacked authority to create agencies or standing, ad hoc, or advisory committees, or direct their creation. Creation of State agencies rested with the Legislature. Similar, non-statutory entities throughout State government, not reinstated by an Executive Order, were dissolved effective in June 2011. Nevertheless, Board rules claimed it could establish standing and ad hoc committees to discharge its duties. No Executive Order created any subordinate Board entity. Rules did not detail any entity's duties, obligations, composition, authority, oversight mechanisms, or performance metrics or expectations. Neither

did the Board adequately oversee subordinate entity performance, or ensure they complied with State policy. The six extra-legal entities we identified included:

1. the ASEC, which was intended to ensure dentists with a permit to administer anesthesia and sedation complied with relevant rules;
2. the ASEC-AS, which was intended to provide the Board timely advice on anesthesia and sedation matters between ASEC annual meetings;
3. the malpractice committee, which was reportedly inoperative during the audit period and was intended to review insurance claims and legal judgments against licensees and refer them to the full Board for adjudication;
4. a steering committee, which was dissolved and for which no records existed, purportedly intended to assess licensing examinations and make recommendations to the Board;
5. a subcommittee, which was dissolved and for which no records existed, reportedly evaluated dental office medical emergency procedures; and
6. a task force, which was dissolved and for which no records existed, was purportedly formed to review and propose changes to dentist anesthesia and sedation rules.

**Recommendations:**

**We suggest the Legislature consider increasing the number of public Board members, while holding steady or decreasing the number of credential holder Board members. Considering the numerous instances of overreach and potential federal antitrust scrutiny risks we identified, this may help offset control of the Board by active market participants. Additionally, should the Legislature authorize committees or advisory bodies for the Board, we also suggest there be an adequate number of public members to offset control of those entities by active market participants.**

**We recommend the Board:**

1. **discontinue formation and operation of subordinate entities without statutory authority;**
2. **either seek legislation to add another hygienist member to the Board or have the DHC reconstituted as an advisory committee that meets at the call of the Board;**
3. **seek legislation requiring either an existing or new dentist member be experienced in dental anesthesia and sedation, and, if this Board member cannot alone provide sufficient advice, seek legislation authorizing an advisory committee that meets at the call of the Board to provide needed advice;**
4. **seek legislation to increase the relative number of public Board members, and include sufficient numbers of public members on any committees it is allowed to form;**
5. **should advisory committees be authorized, revise rules to reflect statutory authority and comprehensively control committee operations, and repeal rules without statutory basis;**
6. **formalize metrics to demonstrate its organizational construct is effective and that authorized committees efficiently and effectively accomplish their purposes; and**

**7. clarify the terms and conditions of its relationship to the OPLC via rules.**

Board Response:

*We concur in part with the recommendations.*

1. *We concur with the recommendation to discontinue formation and operation of subordinate entities without statutory authority.*

   *Please see our response to Observation No. 4.*

2. *We concur with the recommendation to seek reconstitution of the DHC as an advisory committee.*

   *The Board would like the DHC to be continuously working on updating rules pertaining to the practice of dental hygiene in the State.*

   *The need for advice about hygienists' practice exceeds the capacity of the Board's hygienist members, and we concur with the recommendation to have the DHC reconstituted as an advisory committee that meets at the call of the Board when needed to provide advice on hygienist rules. The Board agrees this would be a more efficient way of using the DHC to improve the practice of hygiene in the State of New Hampshire.*

3. *We concur with the recommendation to seek legislation requiring an existing dentist member who is well versed in dental anesthesia and sedation, and seek legislation authorizing an advisory committee that meets at the call of the Board when needed to provide advice on dental anesthesia and sedation rules if the anesthesia expert Board member cannot alone provide sufficient advice.*

   *The Board always makes a request to have an individual with general anesthesia knowledge on the Board who would be able to help with dentist anesthesia and sedation related issues.*

   *The Board does not believe that there should be another member added to the Board. The Board agrees that seeking legislation to require one member of the Board be an anesthesia and sedation provider and having an advisory committee that meets at the call of the Board would ensure that the Board always has the expertise to deal with anesthesia and sedation related issues.*

4. *We do not concur with the recommendation to seek legislative changes to increase the number of public Board members not involved in the dental care industry, and include sufficient numbers of public members uninvolved in the dental care industry on any committees it is allowed formed.*

   *The Board disagrees that the number of public members on the Board should be increased. In order to prevent a stalemate, there has to be an odd number of members on the Board. Adding*

*more public members would mean adding more hygienist and dentist Board members, which in turn would mean a larger Board, which could hinder the functioning of the Board.*

**LBA Rejoinder: We do not recommend adding additional members of the regulated industry when increasing the number of public members on the Board. There should be more public members without increasing the number of dentists or hygienists.**

5. *Should advisory committees be authorized, we concur with the recommendation to revise rules to reflect statutory authority and to comprehensively control their operations, and repeal rules without statutory basis.*

   *The Board is beginning the process of changing the rules pertaining to the ASEC.*

6. *We concur with the recommendation to formalize metrics to demonstrate our organizational construct is effective and that authorized committees efficiently and effectively accomplish their purposes.*

   *The Board will work with the OPLC to formalize metrics.*

7. *We concur with the recommendation to clarify the terms and conditions of our relationship to the OPLC via rules.*

   *The Board receives support from the OPLC and is committed to working with the OPLC to establish processes that support the Board's powers and duties.*

**Observation No. 8**

**Improve Anesthesia And Sedation Evaluation Committee And Anesthesia And Sedation Evaluation Committee-Advisory Subcommittee Controls**

The ASEC and the ASEC-AS lacked a statutory basis to exist and were inadequately controlled. The Board lacked a dedicated member with anesthesia and sedation expertise and credentialing. The ASEC, created by rule, and the ASEC-AS, created at the Board's direction without rule, were intended to operate as substitutes. The Board essentially outsourced substantive regulation of dentist anesthesia and sedation permits and practices to these entities. ASEC members inspected dentist anesthesia and sedation permit applicants and evaluated permit holders, and were paid honorarium by the very applicants and permittees they inspected and evaluated, contrary to State policy. The ASEC-AS acted as an intermediary between the Board and the ASEC and exerted regulatory control, in addition to providing the Board advice. There was no discernible design to the controls that existed over these entities, and the Board's control framework was not comprehensive. The creation and use of the ASEC and ASEC-AS without effective oversight truncated transparency, ethics, and accountability requirements. It also created a risk of federal antitrust scrutiny.

The scope and nature of the ASEC and ASEC-AS and their activities were not fully known to OPLC staff and management, and support was inconsistently provided. Much of the cost of

administrative support was reportedly transferred to an ASEC member and one of their private employees. After our discussions with staff in early CY 2021, they noted a greater role for staff was likely necessary and reported expectations to increase future support. We observed support increasing through January 2022, when we concluded audit work on this topic.

**Uncontrolled Structure And Membership**

Neither entity had a Board-set structure. Key members instead set their structure. ASEC membership ranged from 20 to 22 members between CY 2017 and CY 2021. ASEC-AS membership was five or six members during the same period, but was initially intended to be composed of five members and include each type of dentist permit. The entities selected their own chairperson. There was no set term for membership or tenure for the chairs, and there was only one ASEC-AS Chair since its creation. The same member chaired the ASEC and the ASEC-AS during the audit period. Additionally, a task force, which was dissolved and for which no records existed, was purportedly formed from members to review and propose changes to dentist anesthesia and sedation rules.

The Board did not control membership. There were no relevant rules establishing membership standards. Orientation was not controlled by the Board or provided by the OPLC. Orientation was handled by the ASEC Chair. Appointments were made by the Board. However, the ASEC solicited its own members from existing permittees. The ASEC-AS selected its members from the ASEC's membership, based on personal relationships. The Chair vetted applicants for recommendation to the Board, and Board approval was then requested. No vacancy announcements were published to broadly solicit membership even though membership was purportedly insufficient to meet workload demands. No members were appointed by the Governor and Council or another external entity. Neither entity's membership included a public member or a member of the Board. Combined with the lack of general Board oversight, this compromised accountability, and created undue opportunity for self-serving behavior and the introduction of bias or anticompetitive behavior.

Once appointed, ASEC members signed agreements with the Board, although the Board President, Vice President, and the Chair were reportedly unfamiliar with the agreements. The agreement purported to make members agents of the Board. Members were to conduct facility inspections of licensees applying for a dentist anesthesia and sedation permit and comprehensive evaluations of permittees. In addition to receiving continuing education units for their involvement, members improperly received honorarium from the applicants and permittees they inspected and evaluated. While the Board's agreement accommodated these payments, neither statute nor rules did, making the validity of the agreement's fee suspect.

**Uncontrolled Procedures And Practices**

The Board lacked rules detailing either entity's duties and obligations, procedures and practices, authority, oversight, performance metrics, or expectations. The Board did not oversee the performance of either entity to assess whether expected outcomes were achieved. Procedures they

implemented inadequately assured outcomes were achieved or demonstrated, despite the purported essential nature of the services provided.

- The ASEC – The ASEC had no formal, externally-reviewed procedures: controls were informal and internal. The ASEC was to help the Board ensure permittees conformed to relevant rules. However, rules creating the ASEC miscited the rules it was to enforce. The Board essentially outsourced management of facility inspections and comprehensive evaluations, but there were no training or other requirements to provide for consistency. In practice, permits were issued before applicant competency was determined, procedures were changeable, timeliness was a persistent deficiency, and fees were largely without basis in statute or rule. Requirements inappropriately regulated other regulatory agencies' credential holders. Additionally, the Chair assigned facility inspections and comprehensive evaluations and communicated with applicants. The Chair also oversaw timeliness, purportedly vetted results to ensure quality control, notified unresponsive applicants of potential permit termination should they remain unresponsive, and developed substantive inspection and evaluation criteria. In August 2021, the Board reported it planned to make additional changes to the ASEC's organization and practices.

- The ASEC-AS – The ASEC created the ASEC-AS in CY 2017 at the Board's direction. In addition to its advisory role, the ASEC-AS actively participated in the regulation of applicants and permittees. It actively developed rules and forms and engaged in ad hoc rulemaking by devising and implementing changes to regulations. The Board dissolved the ASEC-AS after the audit period, migrating its duties to the ASEC.

**Noncompliance With Administrative Requirements**

The ASEC and ASEC-AS were essentially outside the control framework applicable to regulatory agencies. The Board lacked oversight mechanisms to provide assurances they complied with general administrative laws. Neither entity had provisions to ensure compliance. Both entities and their members were noncompliant with several key requirements.

- Right-to-Know Law – The ASEC met annually and the ASEC-AS quarterly, but both entities struggled to conform to transparency requirements. Meetings were inconsistently noticed publicly, were at times held in private facilities, and included nonpublic sessions. Meetings were improperly initiated and, at times, business was moved without votes. There was no assurance a quorum actually voted to move business. Votes also occurred electronically outside meetings. The Chair drafted minutes and held some outside State control. Additionally, some members were appointed during nonpublic Board sessions, with minutes sealed.

- *Financial Disclosure* – Members were agents of the Board and covered by requirements to file statements of financial interest to avoid conflicts of interest. However, no statements were filed by any member for CYs 2020 or 2021. Not filing statements made members ineligible to serve.

- *Code Of Ethics* – The Board lacked a formal, supplemental code of ethics; controls over conflicts of interest and recusals; and oversight of potential ethical issues created by the ASEC and ASEC-AS. Members were required to avoid conflicts of interest by not participating in any matter in which they had a private interest. Each member had a personal stake in dental anesthesia and sedation services, and was in economic competition with other permittees. Reportedly, conflicts were infrequent but occurred with some regularity.

- *Administrative Procedure Act* – Ad hoc rulemaking proliferated. Forms used to evaluate applicants and standards for permittee operations were routinely changed without Board involvement, as were honorarium amounts. The Board also allowed for procedural changes to be put into effect before implementing rules were adopted, approved modified applications, and waived requirements. Additionally, there were no controls to assess whether, or to assure, permitting complied with statutory lime limits.

- *Archives And Records Management* – Some records were held by members and not the State. In November 2021, OPLC management reported it believed it had recovered all records in possession of the ASEC Chair. Permittee transaction lifecycles were unauditable, and it was not clear a true record of the entities' official acts, or acts taken in the name of the Board, were made and preserved. The legal and financial rights of the State and persons directly affected by the entities' activities were insufficiently protected.

**Recommendations:**

**We recommend the Board:**

1. **discontinue operating agencies without statutory authority;**
2. **treat ASEC members like other Board consultants, discontinuing the practice of allowing members to receive honorarium for services rendered on behalf of the Board;**
3. **determine the scope and nature of the support it requires to ensure it can adequately regulate dentist anesthesia and sedation, and seek legislation requiring either an existing or new dentist member be experienced in dental anesthesia and sedation, and, if this Board member cannot alone provide sufficient advice, seek legislation authorizing an advisory committee that meets at the call of the Board to provide needed advice, and a sufficient number of public members to help ensure its advice is in the public's interest;**
4. **revise rules to reflect statutory authority and, should an advisory committee be authorized, to comprehensively control the operation of the committee;**
5. **ensure all members comply with State ethics laws, and discontinue ad hoc rulemaking;**
6. **ensure practices conform to transparency, timeliness, and recordkeeping requirements, and an auditable record is created for each transaction;**
7. **actively oversee permitting processes and ensure practices conform to statute and rules;**

8. **establish performance goals, objectives, and targets to demonstrate how dentist anesthesia and sedation permitting contributes to achieving expected outcomes;**
9. **clarify the terms and conditions of its relationship to the OPLC; and**
10. **establish information requirements of the OPLC that will allow the Board to monitor and report on compliance and efficiency.**

Board Response:

*We concur with the recommendations.*

1. *We concur with the recommendation to discontinue operating agencies without statutory authority.*

   *Please see our response to Observation No. 4.*

2. *We concur with the recommendation to treat ASEC members like other Board consultants, discontinuing the practice of allowing members to receive honorarium for services rendered on behalf of the Board.*

   *The Board, in collaboration with the OPLC, is working to address this issue.*

3. *We concur with the recommendation to determine the scope and nature of the support we require to ensure we can adequately regulate dentist anesthesia and sedation, and request legislative changes to provide for a Board member with requisite expertise.*

   *The Board has requested and would welcome a Board member with the requisite expertise in anesthesia and sedation and is committed to working with OPLC and Governor and Council to facilitate that appointment.*

4. *We concur with the recommendation to revise rules to reflect statutory authority and, should an advisory committee be authorized, to comprehensively control the operation of the committee.*

   *The Board acknowledges that the ASEC would benefit from greater oversight from the Board, and the Board has taken immediate steps to address this. The Board is also taking steps to consolidate ASEC and ASEC-SC into one entity, which will improve the Board's ability to provide essential oversight to ASEC.*

5. *We concur with the recommendation to ensure all members comply with State ethics laws, and discontinue ad hoc rulemaking.*

6. *We concur with the recommendation to ensure practices conform to transparency, timeliness and recordkeeping requirement, and an auditable record is created for each transaction.*

   *The Board will seek legislative changes and promulgate rules. The Board has already started the process of addressing many of these issues. In order to streamline the process and increase*

*transparency, the Board will seek legislative changes and write rules regarding the duties and make-up of the ASEC, appointment of ASEC members, the Chair election process, set term limits for the Chair and ASEC members and collaborate with the OPLC regarding orientation, the process for setting and collecting fees, and other administrative functions.*

7. *We concur with the recommendation to actively oversee permitting processes and ensure practices conform to statute and rules.*

   *The Board is actively engaging in the process to establish updated permitting processes and ensure practices conform to statute and rules.*

8. *We concur with the recommendation to establish performance goals, objectives, and targets to demonstrate how dentist anesthesia and sedation permitting contributes to achieving expected outcomes.*

   *As previously stated, the Board is beginning the process of restructuring the ASEC and providing active oversight to the ASEC. The Board intends to establish consistent processes and procedures regarding the ASEC permitting process to ensure evaluation consistency and safety of the patients receiving outpatient services involving general anesthesia and deep or moderate sedation.*

9. *We concur with the recommendation to clarify the terms and conditions of our relationship to the OPLC.*

10. *We concur with the recommendation to establish information requirements of the OPLC that will allow the Board to monitor and report on compliance and efficiency.*

**Delegations Of Authority**

Regulatory authority was assigned to the Board as a body, and a majority of members was required for the Board to act. The Board existed to apply collective expertise to rulemaking, credentialing, disciplinary, and other discretionary regulatory matters. These duties could not be delegated. During the audit period, the Board could obtain legal counsel, investigators, and other required assistance; contract or arrange for the performance of administrative and similar services; and establish compensation rates. Non-discretionary administrative duties could be delegated, and the OPLC was created to perform such duties. The OPLC was required to adopt organizational and procedural rules necessary to administer the Board's business processes. Roles and responsibilities should have been clearly defined and understood, providing accountability and facilitating compliance with law. The DOJ was responsible for investigative and prosecutorial tasks at Board direction, as well as providing advice and legal representation. During the audit period, the Board was reliant upon OPLC and DOJ staff for support.

**Observation No. 9**

## Improve Delegation Of Authority Controls

The Board lacked adequate controls over its delegations of authority. The Board delegated substantive discretionary decision making without authority to do so. It also delegated administrative duties without adequate controls to ensure those delegations achieved expected results. Historically, the Board relied on informal delegations to its own staff, when it had staff accountable to the Board for performance. However, the practice continued after the OPLC was created, and staff were subsequently consolidated under OPLC supervision, control, and accountability. Subsequently, standing orders and other means were used to convey certain administrative and substantive discretionary duties to subordinate entities and individual members, as well as staff.

The more duties the Board delegated, the more oversight controls were required to ensure Board responsibilities were properly discharged and risks mitigated. No comprehensive control framework was ever formalized. The delegations the Board made – both proper and improper – lacked oversight constructs, performance standards, and accountability mechanisms. There were no formal procedures. Staff created informal guides, disused during the audit period, encompassing improvised staff practices, the details of which were not reviewed or approved by the Board. There was no formalization of the Board's relationship with the DOJ. Other delegations were similarly uncontrolled, effectively eroding the Board's status as an independent regulatory agency. The Board was inconsistently aware of relevant details about operations carried out on its behalf.

Consequently, the Board was inconsistently satisfied with the support it received. While our audit focused on the Board's controls over delegations and was not designed to identify every delegated task, we nonetheless found some discretionary decisions were made without the Board, undermining the basic purpose of its creation. Reorganization and reengineering of OPLC business processes were undertaken without either relevant Board expectations being established, or existing processes and procedures being fully understood. This resulted in the development of a one-size-fits-all support delivery model without required rule promulgation, and without the procedural transparency controls embedded within the rulemaking process being followed. Clear lines of authority, responsibility, and accountability for program implementation were eroded, and achievement of expected outcomes was compromised.

### Improper Delegations To Subordinate Entities

The Board delegated responsibilities to its subordinate entities without authority to do so, or adequate oversight and performance controls. The statutory DHC had no independent regulatory or disciplinary authority, but its role in practice was broader than that provided for in statute. It took on both administrative and discretionary tasks. Dentist anesthesia and sedation permitting requirements and regulation of permittees was largely delegated to the extra-legal ASEC and ASEC-AS. Both operated with significant independence from the Board, taking on administrative and discretionary tasks, such as independently changing regulatory requirements. Some of these delegations were reportedly due to inadequate administrative support.

**Improper Delegation To Individual Members**

The Board lacked a formal system of internal delegations and improperly delegated its collective authority to individual members. Deficient controls affected each Board function and contributed to risk exposures, such as regulatory capture and potential federal antitrust scrutiny. Some delegations contradicted rules or constituted ad hoc rules. Other delegations were made despite Board knowledge that collective Board decisions were required. Some of these delegations were reportedly due to inadequate administrative support.

Members reviewed license application forms before recommending a decision to the Board, but in May 2020, individual members started approving complete application forms without subsequent Board approval. DHC or Board members reviewed EFDA permit applications, DHC members reviewed CPHDH applications, and individual Board members made decisions on permit and certificate approval or denial. DHC or Board members made hygienist permit approval or denial decisions. The Board President, Board members, or staff made lapsed license reinstatement decisions. Individual Board and DHC members completed continuing education reviews. The Board President could approve extensions to comply with subpoena and complaint response time limits and could cancel adjudicatory hearings.

**Inadequately Controlled Delegation To Third Parties**

The Board delegated investigative duties to expert reviewers in some disciplinary cases, and contracted with an investigator for other cases, but without formalized procedures and practices.

**Improper Delegation To Staff**

In addition to non-discretionary administrative duties, the Board inappropriately delegated discretionary duties to staff. In prior audits, we recommended the OPLC formalize the terms and conditions of its relationship with assigned agencies, but there was no action on an OPLC-wide basis to do so. No memorandum of agreement or other broad-based agreement existed between the OPLC and the Board. No Board rules established what administrative, non-discretionary tasks were to be performed by staff. No OPLC rules established how administrative, non-discretionary tasks were to be performed on behalf of the Board. No OPLC inventory of Board functions, processes, and practices was conducted. Instead, staff drafted and sought Board approval of standing orders delegating to the OPLC responsibility for tasks it had selected. Other duties were formally or informally delegated and memorialized in staff manuals or relegated to an annotation in meeting minutes. Accountability controls were not included in delegations, and delegations were often made at the request of the OPLC or the Administrative Prosecutions Unit (APU) within the DOJ.

Each uncontrolled or inadequately controlled delegation eroded Board independence and control over its operation. The Board was an independent regulatory agency, but was at times dissatisfied with the changing degree of its independence. The OPLC was created without an oversight body composed of members from assigned agencies, or other control or accountability framework such as a legislative committee. The Board and the OPLC operated without a strategy or plan to structure and integrate operations. During the audit period, the OPLC did not adopt required

organizational and procedural rules structuring the support provided to the Board. Instead, management relied on standing orders and other delegations. Consequently, substantive, discretionary tasks were also delegated to staff without a disciplining structure and accountability framework using modes contrary to those provided for in statute. This adversely affected each Board function.

- Credentialing – Staff did not provide all initial credential applications to the Board. Some were provided after the credential had been issued by staff. For example, staff approved 488 of 504 issued initial credentials (96.8 percent), without Board acceptance or approval of the complete application. Staff also renewed temporary licenses and reactivated inactive licenses.

- Monitoring – Staff approved 3,086 of 3,089 renewal credentials (99.9 percent) issued during the audit period. Staff inconsistently provided the Board with information on identified noncompliance. They were generally responsible for administratively processing complaints, but also acted on some without Board control.

- Enforcement – Staff could conduct investigations with or without a Board order, issue subpoenas, and hold pre-hearing conferences. Staff also closed some cases without a record of Board direction.

**Recommendations:**

**We recommend the Board and OPLC formalize the terms and conditions of their relationship through rules, with specificity, objective performance metrics, and accountabilities to ensure only administrative, non-discretionary duties are delegated and services provided meet expectations. If the Board and OPLC cannot or will not timely establish the details of their interrelationship, we suggest the Legislature consider either: 1) requiring the Board and OPLC adopt and implement integrated rules by a specific date or 2) directly establish the detailed terms and conditions of the relationship in statute.**

**We recommend the Board:**

1. **discontinue delegating substantive, discretionary authority allocated to the Board;**
2. **discontinue delegating its authority where it is allowed to, but where there is no effective system of control to ensure delegates are: a) responsive to Board requirements, b) trained and effectively overseen, c) reporting performance periodically to ensure the Board is achieving expected outcomes, and d) accountable for failure to meet the terms and conditions of the relationship;**
3. **include in rules an oversight and accountability structure to ensure delegated tasks are accomplished properly, timely, and consistent with authority delegated; and**
4. **monitor delegated duties to ensure delegates achieve expected results.**

Board Response:

*We concur with the recommendations.*

*The Board concurs with the recommendation that the Board and OPLC formalize the terms and conditions of their relationship through legislation and rules, with specificity, objective performance metrics, and accountabilities to ensure only administrative, non-discretionary duties are delegated and services provided meet expectations.*

1. *We concur with the recommendation to discontinue delegating substantive, discretionary authority allocated to the Board.*

   *The Board does not agree with the analysis that it has been delegating its substantive and discretionary authority to administrative staff and other entities. However, the Board acknowledges that some of its practices can be improved and/or require changes to the existing rules. The Board is requesting to have a legal advisor from the DOJ attend the whole session of both the public and non-public meetings to assist and advise the Board regarding delegating its authority. The timeframe to implement this recommendation is immediate.*

2. *We concur with the recommendation to discontinue delegating administrative, non-discretionary tasks without an oversight and accountability structure to ensure tasks are accomplished properly, timely, and consistent with authority delegated.*

   *The Board acknowledges that the relationship between the Board and OPLC is developing and both entities are and/or will be engaged in rulemaking to address this issue. The Board is committed to working with OPLC to improve the communication and working relationship between them.*

3. *We concur with the recommendation to ensure delegated tasks have an oversight and accountability structure to ensure tasks are accomplished properly, timely, and consistent with authority delegated.*

   *The Board recognizes the need to establish a comprehensive and formalized control framework so that it is able to oversee the delegated tasks.*

4. *We concur with the recommendation to monitor delegated duties to ensure delegates achieve expected results.*

   *The Board recognizes the need to implement a more formalized comprehensive control framework. The Board has a responsibility to ensure that delegated duties should achieve the expectations.*

*OPLC Response:*

*The OPLC concurs with the recommendation that the parties' "formalize the terms and conditions of their relationship through rules, with specificity, objective performance metrics, and*

*accountabilities to ensure that only administrative, non-discretionary duties are delegated, and services provided meet expectations."*

*As discussed in greater detail in subsequent responses, the OPLC is focused on establishing internal controls throughout the agency. It is presently conducting an inventory of all statutory and regulatory requirements, drafting necessary agency rules and assisting boards with drafting necessary rules, and working on developing a memorandum of understanding between the parties, which will outline the scope of the duties that each will perform. The OPLC anticipates objective performance metrics will be included in a memorandum of understanding established between the parties, and that such duties and metrics will be reviewed on a regular basis to ensure that services provided meet expectations.*

**Managing Performance And Demonstrating Outcomes**

Managing performance and demonstrating outcomes could have helped establish the Board's value and that the cost of its operations efficiently and effectively accomplished its mission. Performance management could also have provided a basis for making transparent and data-informed, objective, strategic decisions. Performance management included ongoing, systematic:

- establishment of quantifiable goals, objectives, and targets;
- assignment of accountability for achieving expected outcomes and compliance;
- assurance of reliable, transparent, and timely monitoring, measurement, evaluation, and reporting; and
- evidence-based decision making resulting in revision of expectations and processes.

Performance measurement rested upon quantifying Board inputs, process performance, outputs, and outcomes.

- **Inputs** were resources needed for Board operations, such as credential applications or complaints submitted, or the staff allocated.

- **Process performance** included: 1) consistency, the extent to which a process produced the same result; 2) effectiveness, the extent to which goals, objectives, and targets were achieved; 3) efficiency, the extent to which processes minimized waste of resources; 4) timeliness, how quickly processes were completed; and 5) compliance, assurances processes conformed to statutory and regulatory requirements. Measures included the time taken to process applications or complaints.

- **Outputs** were measures of services provided, such as the number of credential applications approved or denied, or the number of investigations conducted.

- **Outcomes** were the results achieved from outputs and measured the degree to which the Board achieved results. Intermediate outcomes were directly supported by outputs and included making consistent credentialing decisions compliant with statutory and regulatory requirements. Expected programmatic outcomes were underpinned by

intermediate outcomes and demonstrated a connection to the Board's statutory mission – public protection.

**Observation No. 10**

**Improve Performance Management Controls**

The Board lacked a holistic performance measurement system informed by strategy and risks, and only monitored a limited subset of process outputs. The Board could not evaluate its performance or the efficiency and effectiveness of its operations, or demonstrate achievement of outcomes. It lacked a system designed to do so, sufficient evaluation of available data, and adequate reporting. The Board could not demonstrate resources allocated to Board processes would or did produce expected outcomes. The Board never demonstrated any association, correlation, or causation existed between processes for which it collected performance data and its expected outcomes. Concurrently, abusive practices, waste, inconsistency, ineffectiveness, and noncompliance persisted, largely unidentified by the few controls in place. Public accountability and effective stewardship of resources was compromised.

**Inadequate Control Design**

The Board lacked systems to objectively:

- demonstrate the effect of its regulation of the dental care industry;
- comprehensively measure, monitor, and analyze process performance;
- refine regulatory requirements and administrative processes; and
- communicate performance internally and externally.

Control deficiencies contributed to incomplete and inadequate data collection and inconsistent data quality. Inadequate records and data management adversely affected the comprehensiveness and accuracy of collected input and output data. The Board did not specify what data to collect or how often to collect it. Limitations with knowledge management adversely affecting recordkeeping and the credentialing database management system compelled us to qualify our use of, and our conclusions resting on, Board records and information. Limitations rendered compliance, consistency, and timeliness unauditable for many requirements and processes. There was a significant risk posed by defective data, causing the Board to rely upon – and invite reliance upon – information that likely did not accurately establish Board performance.

Performance measurement efforts also lacked systematic connection to outcomes. Monitoring inputs and outputs was necessary to allow the Board to assess its regulatory requirements, processes, and external communications, and then make improvements to its regulatory framework. However, neither inputs nor outputs alone demonstrated performance or effectiveness. Board output measurement centered on quantifying how often a task was completed, not whether the right task was accomplished, how well it was accomplished, or whether outcomes were achieved. Neither was organizational and staff performance tied to achieving expected outcomes, nor was staff performance tied to the Board's organizational performance.

The Board did not establish performance reporting requirements, and the OPLC did not routinely report on performance to the Board. Instead, staff and the ASEC provided incomplete information on a limited number of outputs, such as the number of approved initial license applications and completed facility inspections and comprehensive evaluations. However, more data was uncollected or unmonitored, than was collected or monitored, on key intermediate outcomes and outputs.

**Performance Management Not Informed By Strategy Or Risks**

The Board relied primarily on inconsistent and haphazard reporting and anecdotal information on inputs and outputs. Board strategy and plans should have identified what data to collect to assess performance. Systematic performance management tied to strategy and informed by risk assessments could have helped ensure objectives were met and performance was within established risk tolerances. However, the Board:

- lacked a strategy, plans, and formalized goals, objectives, and targets, making performance measurement problematic were it to occur;
- did not formally assign or clearly communicate performance monitoring, measurement, evaluation, or reporting responsibilities to subordinate entities or staff, resulting in a lack of accountability;
- lacked risk tolerances or acceptable performance variations, making it impossible to understand whether reported performance was within acceptable limits; and
- did not evaluate how effectively or efficiently responsibilities were performed.

Consequently, the Board was unable to determine whether regulatees were conforming to requirements or to make risk-based adjustments to regulatory requirements or credentialing, monitoring, and enforcement processes.

**Processes Not Connected To Outcomes**

No member could demonstrate how processes, and the requirements underpinning them, efficiently produced expected outputs, or achieved intermediate and programmatic outcomes. Credentialing, monitoring, and enforcement requirements were neither designed to achieve expected outcomes nor objectively established to be the minimum level necessary for adequate public protection. Aspects of credentialing were perfunctory. Monitoring of regulatee compliance with requirements was reactive. Enforcement, the most complex function, was the least controlled, and inadequate records management prevented performance measurement of investigations, adjudicative hearings, or sanctions.

Additionally, Board and subordinate entity members' understanding of the Board's mission was more expansive than established by statute. The Board reported its role was "to protect the public." However, its authority was limited to protecting public health, safety, and welfare from unqualified, unscrupulous, or impaired dentists and hygienists. Consequently, the Board took actions and imposed regulations beyond those allowed by statute, purportedly to protect the public.

**Impressionistic Views Of Performance**

Despite lacking adequate data, Board and subordinate entity members generally held overly positive impressionistic views of performance. The Board intermittently obtained performance-related data, but only on a select subset of readily counted inputs and outputs. Data lacked assurances it objectively demonstrated actual performance. Data only quantified aspects of some processes and were derived from unreliable records. Members relied on qualitative assessments and positive anecdotes for much of the remainder of the Board's performance management. For example, the Board relied on staff impressions, and one member relied on self-reported information from two employees, to "assess" the timeliness and effectiveness of initial license application or renewal license processes.

***No Monitoring Of Compliance And Consistency***

There was no monitoring of the extent to which the credentialing, monitoring, and enforcement functions complied with statutory and other requirements. Neither was the extent to which regulatees complied with requirements measured. The Board did not always take reasonable steps to ensure applicants or credential holders were qualified to practice.

- Without Board action, staff issued 3,545 of 3,593 applications (98.7 percent) for initial and renewal credentials issued in SFY 2019 and SFY 2020. The Board accepted or approved only 48 applications (1.3 percent).

- From August 2018 through June 2020, all 245 initial licenses were issued without required criminal history records checks.

- In one renewal case, the Board approved a license renewal after staff identified the licensee made deceptive or false statements, contrary to statute and rule.

- In a second renewal case, a licensee reported a criminal conviction and monitoring of their license in another jurisdiction. There was no record staff or the Board reviewed this application before a renewal was issued.

- The Board waived facility inspections at 12 of 37 office locations (32.4 percent) from SFYs 2018 through SFY 2021. Inspections were to be conducted before permit issuance to ensure office locations had the proper equipment, drugs, and emergency plans for dentists to safely administer anesthesia or sedation.

- Of 26 complaint cases, 21 (80.8 percent) were missing basic documentation, notably the complaint or a licensee's response to a complaint. We could not verify whether the Board addressed all complaints, much less whether complaints were adequately addressed.

- In one of the 26 complaint cases, the licensee's complaint history included 20 complaints spanning 26 years. The complaints were managed on a case-by-case basis,

even though more than half were professional misconduct allegations that should have prompted further action.

- In a second of the 26 complaint cases, the Board voted to take no further action against a licensee more than one year after they were disciplined by another jurisdiction, contrary to rule.

***No Monitoring Of Timeliness***

There was no timeliness measurement, and compliance with statutory time limits was generally unauditable. Board records were inadequate to systematically determine timeliness. Nonetheless, we identified noncompliance with statutory time limits and other untimely actions.

- In one case, the Board delayed action on a hygienist application form by one month, reportedly due to a busy meeting schedule.

- In another case, a facility inspection required to make an application complete had not been conducted at least 204 days after permit application form approval, well after the 30-day statutory time limit.

- In a third case, the Board approved a regular license application 161 days after receipt, well after the 60-day statutory time limit.

- Purportedly, it could take up to a year to complete a facility inspection, delaying permit issuance and when dentists could start administering anesthesia or sedation. From CY 2017 through CY 2019, the Board accepted or approved ten inspections between four and seven months after permit application form approval.

- Initial comprehensive evaluations, intended to establish permittee competency, were conducted up to 55 months late. Subsequent comprehensive re-evaluations, intended to ensure ongoing permittee competency, were conducted up to 23 months late.

Of 21 licensee enforcement case records we reviewed, only five (23.8 percent) included the date of referral for investigation and the date the Board received investigative information, which allowed for timeliness calculations. Those five investigations lasted from 22 to 575 days.

Neither did the Board ensure it identified illogical durations of its actions or results that were noncompliant with statutory time limits. Among the 273 initial regular licenses issued from SFY 2019 through SFY 2020, 265 (97.1 percent) were issued before any Board action. Consequently, most application decisions would have had a negative duration. Additionally, other illogical results occurred among the eight applications receiving some Board action before license issuance. For example, we found the Board approved one partial application, resulting in license issuance, 294 days before the complete application was received.

***No Monitoring Of Efficiency***

There was no measurement or monitoring of efficiency. Wasteful and inefficient practices persisted, to the detriment of Board effectiveness and at an indeterminate cost. For example, certain requirements were perfunctory.

- Completion of a partial registration form was required after completion of an initial application form. Registration forms collected only one new piece of substantive applicant data but unnecessarily added costs and delayed initial licensure and when applicants could begin practicing.

- There was essentially no verification of compliance with competency maintenance, character, and conduct requirements for most renewals, making renewal perfunctory.

- Although credential renewal processes transitioned to online renewals, the Board lacked processes to assess whether there were resulting efficiency improvements or cost savings. Neither were related fees reduced to reflect the purported increase in efficiency.

- Enforcement actions were not always used to establish a pattern of misbehavior resulting in disciplinary action and were not always effective at deterring noncompliance. One licensee received three non-disciplinary letters of concern, intended to modify behavior, over the course of one year for the same type of noncompliance, without effect.

***Limited Monitoring Of Other Basic Inputs And Outputs***

There was no routine management of other performance information.

- Credentialing Activities – The Board did not monitor, for example: 1) the number of credential applications received, incomplete, approved, or denied; 2) the pass and fail rates of jurisprudence examinations; or 3) the number of satisfactory or unsatisfactory dentist permit facility inspections and comprehensive evaluations.

- Monitoring Activities – The Board did not monitor, for example: 1) the number of complaints received, 2) the compliance status of credential holders issued "limited" credentials, 3) dentists required to register with the Prescription Drug Monitoring Program, 4) the pass and fail rates of continuing education reviews, 5) licensees reporting patient mortality, or 6) licensees reporting sanctions imposed by other jurisdictions.

- Enforcement Activities – The Board did not monitor, for example: 1) the number of complaints resulting in sanctions, 2) historical complaint information, 3) patterns of noncompliance, or 4) the number of formal and informal investigations.

Additionally, the Board did not routinely receive performance reports from other regulatory agencies – such as the Prescription Drug Monitoring Program – necessary to monitor credential holder compliance with statutory and regulatory requirements.

**Recommendations:**

**We recommend the Board improve controls over performance management, and:**

1. **develop, implement, and refine a performance management system with quantifiable performance measures tied to strategy, risk tolerances, and demonstrating achievement of expected outcomes;**
2. **formally assign performance management responsibilities and ensure those responsible are held accountable;**
3. **address deficiencies with records management and data quality control to help ensure performance measurement is based upon reliable data;**
4. **ensure collection of data is comprehensive and sufficiently frequent to ensure the Board obtains relevant input to allow for timely refinement of processes;**
5. **collect and process data timely, regularly assess performance measurement data, and publicly report results periodically; and**
6. **incorporate performance data into decision making, and revise performance expectations and processes as necessary.**

Board Response:

*We concur with the recommendations.*

1. *We concur with the recommendation to develop, implement, and refine a performance management system with quantifiable performance measures tied to strategy, risk tolerances, and demonstrating achievement of expected outcomes.*

   *Current policies will be examined and refined to develop a system that addresses the audit findings.*

2. *We concur with the recommendation to formally assign performance management responsibilities and ensure accountability with expectations.*

   *The OPLC and Board can work together to divide responsibilities.*

3. *We concur with the recommendation to address deficiencies with records management and data quality control to help ensure performance measurement is based upon holistic, reliable data.*

   *The current records management system will be examined, reviewed, and modified as needed. The Board is aware that the OPLC is currently in the process of procuring a new software package, which will allow for improved access to data and records.*

4. *We concur with the recommendation to ensure collection of data is comprehensive and sufficiently frequent to ensure the Board obtains relevant input to allow for timely refinement of practices.*

   *The Board is in the process of collaborating with OPLC administrative staff to improve communication.*

5. *We concur with the recommendation to collect and process data timely, regularly assess performance measurement data, and publicly report results periodically.*

   *Accurate data collection, assessment, and accurate public reporting are required.*

6. *We concur with the recommendation to incorporate performance data into decision making, and revise performance expectations and processes, as necessary.*

   *Periodic monitoring and analysis will be necessary to review the effectiveness of these management practices and initiate change when appropriate.*

**Managing Knowledge To Help Achieve Outcomes**

Knowledge was performance-related information identified by the Board as important to its understanding of effectiveness and efficiency and analyzed to give it meaning. Effective knowledge management should have involved data-informed decision making, underpinned transparency, and could have helped manage performance. Effective knowledge management depended upon developing, implementing, monitoring, and refining controls over:

- data, to ensure availability and reliability of necessary information;
- records, to ensure completeness, integration, and easy access;
- internal communications, to ensure necessary data was collected, recorded, analyzed, and used to produce knowledge; and
- external communications, to ensure transparency and demonstrate compliance.

Before CY 2015, State policy required the Board to establish and maintain an efficient records management system. Records were to contain adequate and proper documentation of Board organization, functions, decisions, procedures, and essential transactions. A true record had to be made and preserved of all official acts, including transactions and related decision making. In CY 2015, the OPLC was created in part to promote efficiency and economy in Board recordkeeping. This included maintaining official applicant and credential holder records and submitting performance reports on behalf of the Board. Effective and efficient records management could have helped protect the legal and financial rights of the State and the public.

**Observation No. 11**

## Improve Knowledge Management Controls

The Board's controls over knowledge management lacked discernible design. Not only were transparency, customer service, and public accountability compromised, but this also contributed to inefficiency, ineffectiveness, inconsistency, and statutory noncompliance. Transparency and accountability were limited by noncompliance, the lack of performance management, inadequate external reporting, and deficiencies with communications and records management. The Board's regulatory framework was dynamic and complex, some requirements were ad hoc, and decision making was subjective at times. Inadequate controls also inhibited the consistent achievement of expected outcomes. Similarly situated applicants were treated differently and the lack of formal monitoring and enforcement processes contributed to inconsistent regulatee compliance with requirements.

Some controls, processes, practices, and transactions were unauditable due to inadequate records. Responsible officials lacked a complete understanding of relevant processes and practices. Inadequate records and knowledge management compelled us to qualify our use of, and our conclusions resting on, agency records and information reported by responsible officials.

### Knowledge Management Not Informed By Strategy Or Risks

The Board lacked a system to:

- identify its information requirements,
- determine who was responsible for collecting needed information,
- establish how information was to be collected and analyzed, or
- establish reporting cycles to ensure it timely received required information.

Neither did it synthesize and analyze reliable information to produce, disseminate, and use knowledge to inform decision making and demonstrate it achieved expected outcomes. Effective knowledge management is guided by strategy, plans, goals, objectives, and targets. However, the Board lacked these controls or any framework to manage knowledge, despite known deficiencies with external and internal communications. Instead, the Board primarily relied on the knowledge and recollections of individual members and staff, but without adequate supervision.

### Disjointed External Communications

Despite fragmented and inconsistent Board controls over external communications, members generally held overly positive impressionistic views of performance. Communicating with and obtaining feedback from stakeholders was essential to Board operation. However, operations were neither informed by formal, data-based assessments of the Board's operating environment nor by routine communication with key stakeholders. The Board did not systematically identify stakeholder needs and determine whether needs were met, and no formal means to collect stakeholder input existed. Nonetheless, the 20 current and former Board and subordinate entity

members responding to our CY 2021 survey generally perceived stakeholder outreach to be effective or mostly effective.

- External Performance Reporting – Performance was inadequately communicated. The Board was required to report publicly on its operations, but since July 2018, the OPLC was responsible for relevant reports. OPLC reports inadequately addressed Board operations, at times providing inaccurate information on a limited subset of Board outputs. The Board had no other mechanism to publicly report on its performance.

- Staff – The Board did not establish the terms and conditions of its relationship with supporting agencies and their staff. Members reported having little to no input into establishing performance expectations. Consequently, some Board operations conducted by staff were inefficient, noncompliant, and wasteful, and some duties were not performed. Customer service was inadequate and results inconsistent.

- Other Regulatory Agencies – The Board did not engage other agencies with concurrent jurisdictions to coordinate areas of overlapping regulation or interest. Consequently, the Board engaged in extra-jurisdictional regulation and lacked processes to ensure licensees complied with requirements under the purview of other agencies.

- Applicants And Regulatees – To submit complete applications and remain qualified to practice, applicants and regulatees had to navigate and understand the Board's regulatory framework. However, extensive, inconsistent, and complex requirements created opportunities for varied interpretations, subjectivity, and uncertainty. The Board, the ASEC, the ASEC-AS, and the OPLC imposed ad hoc requirements, circumventing public and legislative input and oversight. Some requirements or interpretations were memorialized only in Board meeting minutes, adversely affecting transparency and adding complexity. Other practices were undocumented, which, for example, limited the availability of some licensing options to only those applicants who happened to be made aware of them by staff.

- Credential Holders – Upon issuing an initial credential, the Board was to provide the new credential holder with a copy of the rules regulating their occupation. However, this did not occur. Furthermore, Board distribution requirements were limited, excluding non-credentialed regulatees and requirements imposed on Board regulatees by other regulatory agencies. Board regulatees were not made aware of these requirements through other means, such as jurisprudence examinations.

- The Public – Some information was publicly available through the Board's website, which the OPLC maintained. However, there was no indication the OPLC consistently obtained or sought Board input on content. Consequently, webpages were inadequate, incompletely and inconsistently provided needed information, and contained ad hoc rule requirements. Some disciplinary information on licensees and information on limitations imposed by the Board on credentials was not publicly available. Inconsistent compliance with Right-to-Know law requirements and financial disclosure requirements further limited transparency.

**Internal Communications Overly Reliant On Individual Memory**

The Board did not deliberately manage internal knowledge. Deficient knowledge management extended to basic Board operations and supporting OPLC processes. There was no formal structure to the Board's relationship with its subordinate entities or the OPLC, and there were no internal reporting requirements.

***Memorializing Practice And Precedence-setting Decisions***

Without effective controls, the Board at times wasted effort and risked inconsistent decision making. The Board often relied heavily on staff to manage internal Board knowledge, despite known issues with frequent staff turnover. However, the Board never specified what information it needed from its subordinate entities or staff, and when or how often information was needed. The Board spent meetings re-addressing issues previously raised. It did not consistently monitor prior agenda items and decisions needing subsequent action or setting precedence. The Board inconsistently memorialized precedence into rules, perpetuating ad hoc rulemaking. It conducted little to no follow-up on subordinate entity and staff performance.

Board, subordinate entity, and OPLC practices controlling many processes were improvised and informal. Decision making was inconsistent and not reliably memorialized. The Board relied on the recollection of former members to describe aspects of statute and rule development and credentialing requirements. The Board also deferred to staff on details of certain operations and practices. Some Board members reported being unaware, for example:

- whether staff practices conformed to statute or rules;
- that staff approved initial, renewal, and reinstatement license applications;
- the Board contracted with ASEC members;
- of the purpose of the ASEC-AS, created at the Board's request;
- whether DHC or ASEC members received orientation;
- prescribing was within dentists' scope of practice and regulated, in part, by the Board;
- of the status of implementing criminal history record checks for applicants;
- of its statutory responsibility to investigate patterns of noncompliance; and
- how staff monitored complaints or licensee compliance with sanctions.

***Member Orientation***

Orientation inadequately prepared members for their roles and responsibilities as public officials, including how to avoid federal antitrust risks and conflicts of interest. There was substantial noncompliance with basic requirements, including ethics, transparency, and rulemaking. Orientation could include procedures, practices, and other information, such as statutes with which the Board and its subordinate entities were required to comply. Board orientation was deferred to the OPLC without oversight controls. Reportedly, only new members received orientation, which provided general information on member and staff responsibilities and a limited number of statutes. New ASEC members reportedly received an informational packet developed by the ASEC Chair, focusing on permit evaluation processes but lacking general information on responsibilities and ethics. Nothing indicated new DHC members received orientation.

Additionally, the DOJ annually provided administrative law training and published the *Attorney General's Memorandum on New Hampshire's Right-to-Know Law, RSA Chapter 91-A*, which provided instructions designed to facilitate compliance. However, members were not required to attend training or provided the memorandum.

***Subordinate Entity Communication And Reporting***

There was no discernible design to controls over subordinate entity communication, contributing to inadequate oversight of entities intended to help the Board achieve expected outcomes. Reporting primarily relied upon insufficiently detailed or inconsistently available meeting minutes that were typically accepted as informational by the Board. The ASEC also provided a limited subset of performance-related information, which demonstrated evaluations were inconsistently timely. However, the Board did not take corrective action.

**Inadequate Records Management Resulted In Unauditable Transactions**

The Board lacked a records management program. Although the Board remained responsible for ensuring true records were made and preserved, this did not always happen. In practice, the Board was fully reliant upon the OPLC, but never established relevant expectations or exercised oversight. The OPLC did not consistently achieve statutory expectations. Furthermore, some records were held by ASEC members – not the State, and some records were altered or destroyed by staff. Board decisions were based on information of unknown, and at times insufficient, quality.

**Recommendations:**

**We recommend the Board improve knowledge management, and:**

1. **incorporate into strategy and plans elements to ensure reliable operational information is regularly reported internally and externally, communications are optimized, and records are retained;**
2. **develop, implement, monitor, and refine controls to ensure data collection requirements are comprehensive and focused on informing strategy, plans, and outcome achievement;**
3. **establish information requirements of the OPLC that will allow the Board to monitor and report on compliance and efficiency;**
4. **ensure Board and subordinate entity members, as well as staff, are aware of and understand their knowledge management responsibilities;**
5. **migrate away from intuitive and towards data-based decision making using reliable and objective analyses;**
6. **ensure internal and external performance reporting is timely, reliable, and relevant, and helps assess achievement of outcomes and control efficiency and effectiveness; and**
7. **monitor, report on, and refine the efficiency and effectiveness of knowledge management practices.**

Board Response:

*We concur with the recommendations.*

1. *We concur with incorporating into strategy and plans elements to ensure reliable operational information is regularly reported internally and externally, communications are optimized, and public records are retained.*

   *The Board did not have control over the information contained within the OPLC and how the information was delivered to the Board. The Board meets on a monthly basis on which discussion on implementation of these matters will occur. The data was stored and maintained by OPLC, and the Board had no control over OPLC's data collection and management system.*

   *The Board will work with the OPLC to implement strategies to improve communication with other regulatory agencies on issues involving concurrent jurisdiction such as anesthesia/sedation and dental hygienist regulation.*

2. *We concur with the need to develop, implement, monitor, and refining controls to ensure data collection requirements are comprehensive and focused on informing strategy, plans, and outcome achievement.*

   *The Board concurs and will implement strategies for communication with OPLC staff and oversee the development of monitoring systems and control of data collection to properly retain public records. It is difficult to create a timeline for how long it will take to complete these changes.*

3. *We concur with establishing information requirements of the OPLC that will allow the Board to monitor and report on compliance and efficiency.*

4. *We concur with the recommendation to ensure Board and subordinate entity members, as well as staff, are aware of and understand their knowledge management responsibilities.*

   *They will implement training for current Board members and new Board members for the duties that are required of each Board member. Since the Board only meets once per month it is difficult to develop a timeline to create the steps that are necessary to remediate deficiencies.*

5. *We concur with migrating away from intuitive and towards data-based decision making using reliable and objective analyses.*

   *The Board will review data that will help with objective decision making and rulemaking.*

6. *We concur with the recommendation of ensuring internal and external performance reporting is timely, reliable, and relevant, and helps assess achievement of outcomes and control efficiency and effectiveness.*

   *The Board will coordinate with OPLC staff in the development of knowledge management practices.*

7. *We concur with the recommendation of monitoring, reporting on, and refining the efficiency and effectiveness of knowledge management practices.*

   *The Board will coordinate with OPLC staff to create a timeline in the development of performance reporting, that is timely, reliable and helps to control efficiency and effectiveness as well as knowledge management practices.*

**OPLC Business Processing, Administrative, And Clerical Support To The Board**

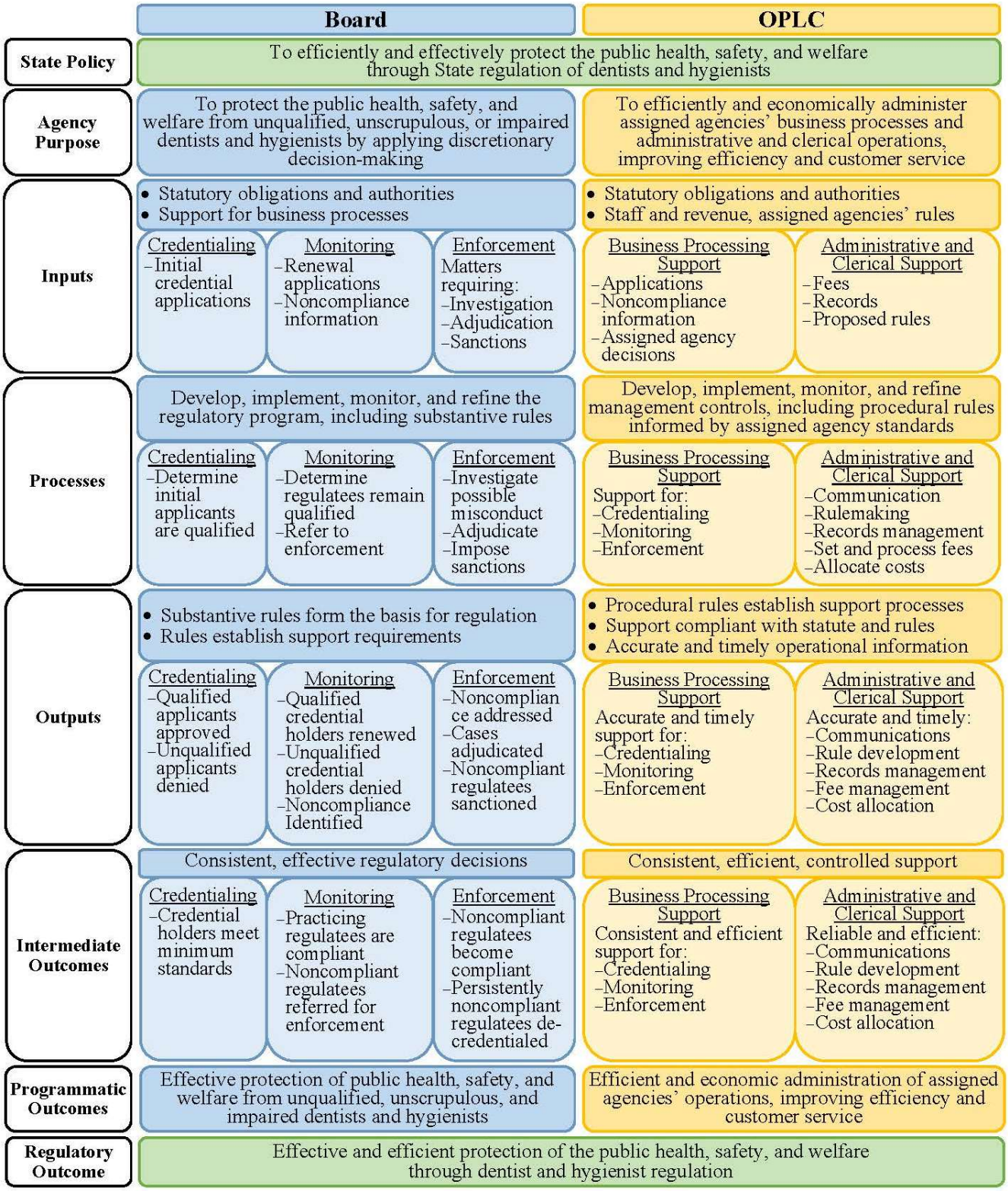
The OPLC was created in CY 2015 to be an executive agency with a scope narrowly focused on providing assigned agencies with business processing, administrative, and clerical support. Centralized support was intended to address a history of inefficient, ineffective, and noncompliant operation by some regulatory agencies that reduced transparency and accountability. OPLC management reported as of July 2021, the OPLC was assigned 52 of the State's councils, commissions, and boards regulating occupations and industries. During the audit period, agencies were assigned to one of two OPLC divisions, the Division of Technical Professions or the Division of Health Professions. The Board was assigned to the latter. Assigned agencies maintained their regulatory powers, duties, functions, and responsibilities. For the Board, this included regulating and overseeing the practices of dentistry and dental hygiene.

To fulfill its statutory responsibilities and achieve expected outcomes, OPLC management needed to design, implement, monitor, and refine efficient and effective management controls over its operations. To optimize regulation of the dental care industry, it was necessary to integrate OPLC procedural and Board regulatory functions, processes, and practices, as well as controls to help ensure efficient and effective cooperation. Board noncompliance with statutory, regulatory, and general management control standards, to some degree, might have been attributable to insufficient OPLC control over support.

A high-level control model is depicted in Figure 2. While no similar model was designed and implemented during the audit period, it is provided as an example of how integration could have been framed.

**Figure 2**

**Interface Between Board And Office Of Professional Licensure And Certification Control Systems**




Source: LBA analysis of State policy and the Board's regulatory program.

**Observation No. 12**

## Improve Office Of Professional Licensure And Certification Control Framework

The OPLC lacked adequate controls to consistently deliver on its statutory obligation to support the Board, compromising both OPLC and Board effectiveness. Controls were not systematically and consistently implemented, operated, monitored, integrated, and refined. Nothing demonstrated the OPLC attempted to design a cohesive system of controls to effectively manage its operating environment, risks, operations, information, and monitoring processes. While various elements of some control systems were developed, the OPLC remained in transition since its creation in CY 2015. Management control systems were either undeveloped, unintegrated, or lacked a discernible design. OPLC management could not demonstrate its support to the Board achieved expected outcomes, and did not understand whether or how well it accomplished existing statutory duties. While management lacked comprehensive controls to obtain performance feedback, the eight current and former Board members responding to our CY 2021 survey generally perceived OPLC support to be inadequate. We identified substantial deficiencies that aligned with Board member perceptions.

There was no indication management tried to operationalize the OPLC's statutory responsibilities as originally structured in CY 2015. Prior audits identified deficiencies that persisted after the OPLC's creation, but many deficiencies remained unremediated. At the same time, external influences, and often OPLC management decisions, drove persistent turbulence in the operating environment. The OPLC engaged in extra-legal and extra-jurisdictional activities not tied to expected outcomes. Management actively sought to expand the OPLC's mission, purportedly to improve efficiency. Changes were intended to accomplish OPLC objectives, and some eroded the independent nature of assigned agencies. However, there was no apparent design to existing control systems, increasing the risk neither the OPLC nor the Board would achieve expected outcomes. Management lacked controls to measure results to demonstrate changes actually improved outcomes. Deficient controls hindered OPLC accountability to the public and the Board.

While this audit was not designed to audit OPLC controls directly, we examined those controls impeding Board operations. Inadequate OPLC controls adversely affected each Board control system and function we examined. Deficiencies at times compromised the Board's ability to effectively protect the public. Deficiencies also resulted in wasted resources, inadequate customer service, noncompliance, ineffectiveness, inconsistency, and potentially abusive acts. Some controls, processes, practices, and transactions were unauditable due to inadequate records. Responsible officials lacked a complete understanding of relevant processes and practices. Inadequate records and knowledge management compelled us to qualify our use of, and conclusions resting on, agency records and information provided by responsible officials.

OPLC management reported improvements to its organizational culture and controls after the audit period.

**Undeveloped Controls Accommodated**

The OPLC's operating environment was unstable, and its culture did not support an organizational commitment to effective management controls. At times, operations were reactive. The culture accommodated:

- waste of public resources and known and persistent control deficiencies, by not resolving deficiencies common among assigned agencies identified in prior audits;
- potentially abusive practices, because accomplishment of statutory duties relied upon the broad application of ad hoc rules and some records were improperly modified;
- inadequate ethical controls, as the OPLC lacked a supplemental ethics code to address potential conflicts of interest unique to its operating environment;
- extra-jurisdictional and extra-legal activities, including overreach, as limitations on authority were exceeded by management initiative; and
- support for extra-jurisdictional, extra-legal, and potentially unethical Board activities, as management's position the OPLC would not support these activities was unwritten, and staff provided support, at times knowingly.

At the same time, management requested additional, expanded statutory authority and resources, perpetuating a turbulent operating environment impeding operational consistency, continuity, and performance of basic statutory duties. Some expanded authorities fundamentally changed the OPLC's role by providing it with substantive decision-making authority at the expense of assigned agencies' regulatory independence. Some changes were purportedly needed to make OPLC operations more efficient. However, at times, simple timeliness was confused for efficiency, and OPLC process efficiency was elevated over Board effectiveness. This shift occurred without:

- deliberate implementation of the statutory construct as it was originally created,
- objective demonstration of the effectiveness and efficiency of existing OPLC support,
- objective demonstration of the need for changes,
- disciplining strategy or implementing plans to guide changes,
- performance measurement to demonstrate changes actually improved support, and
- Board input.

**Lack Of Focus On Expected Outcomes**

Management lacked a disciplining strategy and plans establishing goals, objectives, performance measures, and targets focused on OPLC's statutory responsibilities. The OPLC had not inventoried Board functions, processes, or practices since its creation in CY 2015. Neither management nor staff understood the full scope and nature of required Board support. Management lacked a consistent system to routinely obtain Board input or to ensure OPLC objectives did not displace Board objectives. Management reported conducting strategic planning beginning in CY 2021, with strategy implementation expected by June 2021. Initial efforts to inventory Board functions, processes, and practices reportedly also began in CY 2021.

The OPLC's internally-created mission statement was at odds with its primary statutory purpose and largely appropriated its assigned agencies' purpose of public protection. By SFY 2021, the

OPLC's direct regulatory responsibilities included five industries with 1.6 percent of credential holders based on SFY 2020 data. This was relatively minor when compared to its administrative responsibilities for 47 other agencies regulating the remaining 98.4 percent of credential holders. In CY 2017, we recommended management re-evaluate its overly broad mission statement and ensure consistency with statute. No action was taken until CY 2021, when management reported the mission statement would be "revisited." Without a focused mission, the limited goals, measures, and targets included in OPLC's biennial budget submissions were inconsistent from one biennium to the next, and did not comprehensively address statutory duties. Neither did management monitor progress towards attaining those goals, measures, and targets.

**Longstanding, Unaddressed Risk Management Control Deficiencies**

Although the OPLC operated in a complex and turbulent environment, management lacked a systematic approach to identify, assess, and manage internal and external risks. These risks included risk of fraud, waste, abuse, noncompliance, and federal antitrust scrutiny. Operations occurred, and changes to statutory authority were sought, without due consideration of changing risks to which the OPLC and its assigned agencies were exposed. There were no formal risk assessments or defined risk tolerances. Identification of, and response to, risk was reactive. There were no controls to comprehensively identify and mitigate common control deficiencies affecting assigned agencies. Many were longstanding, and some were identified in numerous LBA audits of regulatory agencies dating back more than 20 years. Centralized support was intended to correct many of these deficiencies while preserving regulatory agencies' independence. However, all observations in our current audit include elements of previously identified control deficiencies. For example:

- relationships between agencies and their administratively-attached boards were not well-defined historically, resulting in inefficient and ineffective administration;
- regulatory agency members, essentially part-time volunteers, were required to conform to numerous complex requirements without adequate understanding and staff support;
- unreliable data adversely affected performance monitoring, and some basic process inputs and outputs could not be quantified, limiting public accountability;
- fee setting and cost accounting controls were under development; and
- inadequate communication hindered customer service and transparency.

While we identified numerous risks in prior audits and during this audit, our scope did not include development of a comprehensive inventory of OPLC risks, a proper role for management.

**Absent Controls Over Compliance Management Led To Ineffectiveness**

Compliance with law was a basic expectation, but inadequate compliance management controls compromised OPLC and assigned agency effectiveness. Management lacked formal controls to help ensure OPLC operations consistently complied with statute, assigned agency rules, and other requirements. Compliance reportedly differed across staff, but monitoring staff compliance was a future goal during the audit period. While this audit was not designed to comprehensively review OPLC compliance with every requirement, we identified instances of noncompliance.

Noncompliance adversely affected the OPLC's ability to achieve expected outcomes and support assigned agency functions necessary to protect the public.

Management also lacked controls to help the Board comply with requirements, reporting that while the OPLC provided support, the Board was responsible for ensuring its own compliance. However, assigned agencies were comprised of part-time volunteer members unfamiliar with their responsibilities as public officials. The OPLC's controls inadequately prepared members to understand these responsibilities.

**Recommendations:**

**We recommend OPLC management develop a well-designed system of controls to help ensure expected outcomes are achieved, and:**

1. **develop, implement, monitor, refine, and maintain an operating environment and organizational culture supportive of effective management control;**
2. **develop a risk-based, data-informed strategy and operating plans in concert with key stakeholders to fully implement statutory responsibilities and ensure effective control;**
3. **incorporate into the strategy and plans measurable goals, objectives, targets, and timelines for completion and monitoring of implementation;**
4. **establish, document, implement, monitor, and refine formal risk management processes tied to risk tolerances, strategy, and plans to help ensure management recognizes, evaluates, and effectively responds to risks;**
5. **discontinue relying upon informal and qualitative risk assessments and migrate to holistic, formal, data-informed, objective, and quantitative risk management practices;**
6. **develop, implement, monitor, and refine formal, comprehensive controls that are compliant with statute and rules, are effectively designed, operate as intended, are not circumvented, and are modified as required;**
8. **ensure OPLC managers and supervisors demonstrate the importance of controls through their own development of, and adherence to, controls and by timely addressing deviations;**
8. **develop, implement, and monitor training for new and existing staff to ensure they understand and can perform required control responsibilities; and**
9. **integrate assigned agencies into control redesign processes throughout development, such as when legislative changes affect assigned agencies' regulatory programs.**

OPLC Response:

*We concur with the recommendations.*

*The OPLC's plans to address the recommendations are as follows:*

1. *Develop, implement, monitor, refine, and maintain an operating environment and organizational culture supportive of effective management control.*

   *The OPLC recognizes the need to establish internal controls and has included that as a priority in its strategic plan for SFYs 2023–2025.*

2. *Develop a risk-based, data-informed strategy and operating plans in concert with key stakeholders to fully implement statutory responsibilities and ensure effective control.*

   *The OPLC agrees that it must develop a risk-based, data-informed strategy and operating plans. As this audit has found, the OPLC has not had ready access to reliable data to inform decision making due, in part, to an ineffective and insufficient licensing database management system. The OPLC recognizes the need to ensure data integrity and the availability of data to inform decision making and is in the process of procuring a case management solution for enforcement and a new licensing database management system. As early as CY 2019, the OPLC requested that the Department of Information Technology (DoIT) pursue procurement of a new enterprise solution as soon as possible. DoIT issued a request for information in late CY 2021. In early CY 2022, the OPLC requested that DoIT pursue funding through the American Rescue Plan Act and prepared a justification for DoIT's request. DoIT requested funding and, in July 2022, was awarded funding. The OPLC is now working with DoIT to procure a new solution; however, such solution will not be fully implemented until at least SFY 2025 (partially implemented in SFY 2024). The OPLC appreciates the policy reasons surrounding state enterprise solutions but, in this case, the OPLC's lack of control over the existing solution, as well as the decision to procure a new, effective solution, has prevented it from ensuring data integrity and the availability of data to inform decision making.*

   *Once DoIT procures a new solution and the data is effectively migrated and deemed reliable, the OPLC will work to develop a risk-based, data-informed strategy and operating plans with key stakeholders to ensure it has fully implemented its statutory responsibilities and that it has effective control over operations to achieve expected outcomes. The OPLC anticipates being able to complete this recommendation by the end of SFY 2026.*

3. *Incorporate into the strategy and plans measurable goals, objectives, targets, and timelines for completion and monitoring implementation.*

   *The OPLC recognizes the need to establish internal controls and has included that as the agency's main priority in its strategic plan for SFYs 2023–2025. The OPLC has included measurable goals, objectives, and targets in its strategic plan, as well as timelines for completion and monitoring implementation to ensure expected outcomes are achieved.*

4. *Establish, document, implement, monitor, and refine formal risk management policy and processes tied to risk tolerances, strategy, and plans to help ensure management recognizes, evaluates, and effectively responds to risk.*

   *Implementing this recommendation will be crucial to ensuring adequate internal controls are in place, which is a key component of the OPLC's strategic plan for SFYs 2023–2025. The OPLC recently created a temporary position of Internal Controls Administrator to assist the*

*agency in establishing internal controls. The OPLC hired a person to fill that position in June 2022. At present, the OPLC Internal Controls team members meet weekly to identify risks across the agency. As risks are identified, the team evaluates and assesses the risk and develops and implements process changes to reduce the impact of such risks, which are incorporated into policies and procedures. The OPLC is currently working to establish an overall, formal risk management policy that outlines how the agency will monitor the progress of the risk management plan and communicate to key stakeholders.*

5. *Discontinue relying upon informal and qualitative risk assessments and migrate to holistic, formal, data-informed, objective, and qualitative risk management practices.*

   *As noted in prior responses, the OPLC is working to establish a risk-based, data-informed strategy based on reliable data. Once established, it will discontinue informal and qualitative risk assessments.*

6. *Develop, implement, monitor, and refine formal, comprehensive controls that are compliant with statute and rules, reviewed to ensure they are effectively designed, operating as intended, not circumvented, and modified as required.*

   *As noted, the OPLC recognizes the need to establish internal controls and has included that as the agency's main priority in its strategic plan for SFYs 2023–2025. The OPLC is presently inventorying all board statutory and regulatory requirements ("OPLC's Profiling Project") to ensure that processes are compliant with statutory and regulatory requirements. As part of its overall effort to establish internal controls across the agency, the OPLC is creating and implementing policies and procedures consistent with statute and rules.*

7. *Ensure OPLC managers and supervisors demonstrate the importance of controls through their own development of, and adherence to, controls and by timely addressing deviations.*

   *OPLC leadership has stressed the importance of establishing internal controls, through its rollout of its strategic plan, as well as staff involvement in its Profiling Project. As policies and procedures are adopted, OPLC managers and supervisors will be expected to demonstrate adherence to controls. Additionally, OPLC managers and supervisors have been directed to develop their own controls within their business units.*

8. *Develop, implement, and monitor training for new and existing staff to ensure they understand and are able to perform required control responsibilities.*

   *The OPLC has created training in conjunction with the Department of Justice concerning administrative law for certain staff members and assigned agency members. The training can be completed at the assigned agency (or staff) members' convenience. When training opportunities or meetings have been held with assigned agency members in the past, only a small fraction of assigned agency members have chosen to attend. The OPLC does not have legal authority to require assigned agency members to complete training and is concerned that some assigned agency members will not avail themselves of this training opportunity. One assigned agency (not the Board of Dental Examiners) has already stated it will not complete*

*the administrative law training. The OPLC will be monitoring the use of these training modules by assigned agency members.*

*The OPLC is working to develop and implement training modules for staff. Once implemented, training will be required at least annually and monitored to ensure staff understand and are able to perform required responsibilities.*

9. *Integrate assigned agencies into control redesign processes throughout development, such as when legislative changes affect assigned agencies' regulatory programs.*

   *The OPLC will continue to collaborate and work with stakeholders regarding ongoing legislative changes. In Summer 2022, the OPLC provided a legislative overview for all board chairs choosing to attend the monthly Board Chair meeting. During this meeting, the OPLC provided an overview of the 2021 Legislative Session. The OPLC is drafting memoranda to the boards with information on legislation that was enacted that impacts the boards.*

   *For the next session, the OPLC has repeatedly requested that the Boards provide their legislative drafting requests by September 2022. The OPLC has received a request from the Board of Dental Examiners and has drafted legislation for their review. For legislation that the OPLC is interested in pursuing, the OPLC plans to use the Board Chair meeting to discuss and receive board feedback, as well as provide information in the quarterly update to all boards.*

***Organizational Controls***

An effectively designed organizational structure could have helped manage risk, control operations, ensure compliance, and achieve expected outcomes. To achieve expected outcomes, the OPLC was required to employ staff necessary for the proper performance of its support duties. Its basic structure was established by statute, and management was responsible for implementing the rules and procedures needed to control OPLC operations and achieve expected outcomes.

An Executive Director supervised the OPLC and was responsible for its performance. Its two main divisions were overseen by directors and supported by assigned staff. Before SFY 2021, the Board was supported by a part-time administrator, an administrative assistant, and a licensing clerk. However, significant turnover occurred. From July 2015 through March 2021, there were five Executive Directors; four Division of Health Professions Directors; and at least four part-time, interim, or full-time Board administrators.

In SFY 2020, the OPLC devised an internal reorganization plan, having determined its existing structure of two "primary divisions based on [regulatory] subject matter, was a barrier to... efficiency…." Reorganization was expected to streamline credentialing and enforcement processes, and be based on the type of service the OPLC provided. Two new divisions – a Licensing and Board Administration Division and an Enforcement Division – were created. The Enforcement Division would provide many services historically provided by the DOJ, including investigative and prosecutorial support. The OPLC began providing certain services as early as

SFY 2020 and began operating under the new organizational structure in early SFY 2021. Enabling statutes became effective at the start of SFY 2022.

**Observation No. 13**

**Improve Office Of Professional Licensure And Certification Organization, Delegation, And Accountability Controls**

The OPLC lacked adequate controls over its organization; relationships with assigned agencies, including the Board; and the authorities it was formally and informally delegated. Control design was structurally inadequate. Numerous defects identified in our current audit pre-dated the audit period and adversely affected assigned agencies generally. Many were identified in prior audits. The OPLC lacked a stable, formal organizational structure. The OPLC reorganized itself without a controlling risk-based strategy and formal plans, stakeholder engagement, metrics to measure performance, or accountabilities to ensure services rendered met assigned agencies' expectations and risks were managed. At times, reorganization occurred without statutory basis.

The details of the interrelationship between assigned agencies and the OPLC were left to them to formalize. In prior audits of OPLC-assigned agencies, we have recommended formalization of these interrelationships. However, no relevant OPLC-wide effort was undertaken, leaving the relationship between the OPLC and the Board based solely on statute and pre-existing rules. However, rules were inconsistently updated and integrated, leading to a lack of control and accountability. The support the OPLC provided assigned agencies was inconsistently sufficient. Ineffective management controls compromised Board credentialing, monitoring, and enforcement functions, as well as achievement of expected outcomes.

The Board was in an untenable position because it lacked its own staff, an adequate control framework to oversee operations carried out on its behalf, and an accountability framework to address inadequate support. Nonetheless, the Board, like other assigned agencies, retained responsibility for the results of processes wholly or in part assigned to the OPLC. Without a clearly defined relationship, whether and how well the OPLC was accomplishing its statutory mission or serving assigned agencies' needs could not be objectively assessed. Assigned agency independence and effectiveness were also compromised at times.

In SFY 2021, OPLC management reported resuming an interrupted effort to reorganize internally and develop certain controls to better serve assigned agencies. The completion of initial tasks was expected to start in SFY 2022. However, no formal risk-based strategy to set goals, objectives, and targets, or plans to resource, structure, and control change efforts, existed. Neither was there a performance measurement system that established baseline process performance and measured the effect statutory, regulatory, and procedural changes had on performance over time.

**Organizational Turbulence**

We have previously found organizational change within the OPLC and among assigned agencies may have contributed to OPLC-assigned agency noncompliance. Internal and external changes kept the OPLC's organization in flux since inception. While effective management control can help control the potentially negative effects of turbulence, the OPLC never developed adequate

controls. Over time, the OPLC's internal structure migrated from a decentralized construct focused on assigned agency-regulated industries and their unique, legacy processes, to a centralized construct focused on a few generalized functions with processes increasingly standardized by the OPLC. Internal reorganization of staff and the structure of component units, and alteration of processes occurred without the OPLC fully inventorying and understanding the scope of the support assigned agencies required. Additionally, major structural changes occurred before the OPLC had relevant statutory authority, and several changes altered the boundaries of the OPLC's authority. Certain OPLC procedures and practices also altered this boundary and altered the amount and type of support provided.

Statutory changes were, at times, made at the request of OPLC management. Changes occurred without a structured system to ensure stakeholders, including assigned agencies, were included in decision making that preceded requests for statutory changes. There was no system to routinely collect input on organizational performance or the performance of the staff tasked to support the Board, or to ensure OPLC organizational objectives did not displace Board objectives. Consequently, changes were improvised and often intended to accomplish OPLC objectives. This produced unclear and changeable boundaries between the OPLC and the Board. For example, the OPLC sought legislative changes to complaint and adjudicatory processes and to control all fee setting for assigned agencies, but had not adopted relevant rules through December 2021, when we concluded audit work on this topic. The Board reportedly was unaware of these changes. Changes also altered the OPLC's nature by expanding its direct regulatory duties, in addition to expanding the number of its assigned agencies. Expanded OPLC administrative duties increased the breadth and the scope of management control requirements, and added staffing.

**Delegation Controls And Accountability Framework**

Responsibilities were distributed between the Board and OPLC without accountability precisely assigned. The OPLC was responsible for assigned agencies' administrative, business processing, and clerical processes. Discretionary and regulatory duties were left with assigned agencies. This segregation created the need for a clearly defined relationship between the OPLC and its assigned agencies, so both could effectively fulfill their statutory responsibilities and be held accountable for results. The details were left to the agencies to formalize. Assigned agency rules could have established a starting point for OPLC procedural controls. However, no relationships were formally or completely defined through CY 2021. Nothing demonstrated OPLC management attempted to implement the existing statutory and regulatory framework or inventoried required services.

Instead, the OPLC sought to standardize processes, citing the purported impracticality of implementing controls based on 52 assigned agencies' control frameworks. However, there was a difference between processes the OPLC *could* standardize and processes the OPLC *must* standardize to achieve expected efficiency outcomes. The OPLC lacked a system or relevant effort to discriminate between the two. Nothing demonstrated:

- the areas where the OPLC sought changes to standardize had to be standardized,
- what benefits standardization would provide,
- what costs standardization would incur,

- benchmark performance of processes before standardization, or
- performance measurement of changed processes, illustrating improvement.

Additionally, preserving individual agencies' independent, discretionary decision making in regulating the industries under their purview was not an objective. The OPLC did not establish whether administering assigned agencies' functions using standardized OPLC processes was practicable. For example, discrepancies between the scope and nature of credential types were not reconciled. Credentialing complexity increased by type: from registration with the State before practicing; through permitting, which required individuals meet minimum qualifications to engage in a certain scope of practice; to licensing, which involved broad regulation of a profession's training, education, and practice. How one application process could control all credential types was not established.

Moreover, there was no process to adjudicate the potentially competing demands that: 1) the OPLC achieve process efficiency and 2) assigned agencies effectively regulate the industries under their purview. Consequently, assigned agency effectiveness did not underpin some OPLC change efforts, and the boundary between assigned agencies and the OPLC was modified, formally and informally. For example, the OPLC's drive for timeliness led to migrating manual credential renewals to an online, automated system. In doing so, the integrity of licensing records was compromised. Timeliness was unauditable. Additionally, focusing on credentialing timeliness left credentialing accuracy and the broader inventory of applications, petitions, and requests assigned agencies received, which also had to conform to statutory time limits, inadequately controlled.

The division of responsibilities left assigned agencies unable to exercise regulatory duties without proper operation of OPLC administrative duties. However, the OPLC never fully controlled its support. Organizational turbulence imparted instability in procedural controls, adversely affecting delegations and accountability. In prior audits, we found significant gaps in both the administration of assigned agencies' operations and the administrative support provided. Gaps also hinged upon the voluntary nature of assigned agencies' members, limiting, among other things, their ability to oversee and supervise their own administration. The OPLC was intended to remedy these issues. Centralization of administrative support did not come with, however, enhanced oversight or other controls to ensure accountability and improve efficiency, while preserving assigned agencies' independence.

***Formal And Informal Delegations Inadequately Controlled***

At times, assigned agencies delegated substantive, discretionary authority to the OPLC, even though they lacked authority to do so. Management was aware the Board could not delegate statutory decision-making responsibilities. This exacerbated the lack of adequate control over the boundary between assigned agency discretionary regulatory duties and OPLC non-discretionary administrative duties. Rules were the mechanism to delineate the boundary between assigned agencies and the OPLC. However, requirements and responsibilities were inconsistently formalized in rules. Delegations were instead made via other modes, often relegated to staff manuals or an annotation in meeting minutes. Accountability controls were not included in delegations, and delegations were often made at the request of the OPLC or APU.

Starting in January 2022, assigned agencies were authorized to delegate non-discretionary tasks to OPLC staff through standing orders, something which had been occurring for years. However, there was no accountability framework behind the newly permissible mode of delineating interagency boundaries. There was no overall design to help ensure effective control of delegations. Delegations lacked: 1) monitoring, 2) way to ensure delegations were effective and did not circumscribe assigned agencies' discretionary authority, 3) accountability for improper implementation, and 4) transparency controls. There were no requirements delegations be updated following membership changes in assigned agencies or staffing changes, or training to ensure competency. Furthermore, standing orders had no clear relationship to rulemaking, which had previously been the mode by which interagency boundaries were established. Lastly, standing orders appeared to be a means to delegate to the OPLC duties it already held.

***Accountability Uncontrolled***

When the OPLC was created, there was no accountability mechanism structured to help ensure expected outcomes were achieved. Nothing demonstrated assigned agencies were viewed to be an OPLC customer. No oversight body composed of assigned agencies, or a substitute control framework such as a legislative committee, was created. Neither were Board rules updated to reflect OPLC's creation and clearly establish a boundary between Board requirements and OPLC procedures or establish accountability for performance. Assigned agencies' rules were not consistently followed by staff. OPLC organizational rules were not adopted until September 2019. In November 2021, the OPLC adopted organizational rules reflecting only its new statutory structure, but not addressing other organizational changes. Procedural rules, also initially adopted in September 2019, only addressed five industries over which the OPLC had direct regulatory authority, and excluding, for example, Board specific procedures. The OPLC adopted no additional procedural rules through December 2021, when we concluded audit work on this topic.

Board controls had to be operationalized by staff, who were controlled by the OPLC. The OPLC shifted once-dedicated assigned agency staff towards pooled staff organized by function. There was no role for the Board in assessing organizational or staff performance. Neither were there controls to ensure the OPLC understood the scope of services assigned agencies needed or ensure assigned agencies knew what staff did on their behalf. Also, staff had discretion to act on the Board's behalf and effectuate a decision, or not act thereby nullifying a decision and compromising effectiveness. Staff could, and did, act without Board direction as well. There was no control to identify and remedy these gaps. Additionally, some administrative Board duties were carried out by private citizens and individual Board and subordinate entity members instead of staff.

Expected outcomes were inconsistently achieved, and in some cases public protection was compromised. Consistency, timeliness, compliance, efficiency, and effectiveness were ineffectively monitored. Staff reported this lack of monitoring had not negatively affected oversight. However, management control deficiencies and inadequate support for the Board's regulatory program adversely affected each Board function.

- Credentialing – Board credentialing rested on: 1) ad hoc rules, some instituted by staff; 2) improvised entities, some of which were not supported by staff; 3) incomplete records maintained by OPLC; 4) administrative tasks being carried out by Board and

subordinate entities' members; 5) defective credentials being issued, with staff approving and issuing most; and 6) improperly imposed fees.

- Monitoring – Credential renewals migrated from manual to online processing, purportedly to improve efficiency, but: 1) without a substantive evaluation, 2) without pre- and post-implementation metrics, and 3) using a problematic automated system. Staff not only issued renewal credentials, but also approved most. Staff processed complaints, including triaging complaints and judging their severity, which dictated the priority a complaint would receive. Some complaints were acted upon without Board control, while some noncompliant or potentially noncompliant actions requiring discipline went unaddressed.

- Enforcement – There was no formal agreement for non-OPLC enforcement-related services provided by other agencies. The Board was inconsistently able to investigate and adjudicate matters as it saw fit, in part due to unavailable or uncooperative staff. This led to inconsistent sanctioning of noncompliant credential holders. Without Board control, some matters were, and were not, investigated. When staff could not, or would not, support Board direction on cases, the Board had to conduct adjudicative proceedings on its own or terminate its efforts.

**Recommendations:**

**We suggest the Legislature clarify the OPLC's roles and responsibilities to better support the Board and its other assigned agencies, including clarifying by what means interagency accountability should be structured. This might include a board of directors composed of members of assigned agencies to oversee OPLC service delivery, help foster accountability, and help preserve the boundaries between assigned agency discretionary decision making and OPLC non-discretionary administrative support. This might also include clarifying the use of standing orders, which appear unnecessary as they serve to delegate administrative duties to the OPLC – duties it already possesses.**

**The Legislature may also wish to consider whether the State will: 1) continue to substantively regulate occupations and related industries using bodies composed largely of members of the regulated industry, or 2) migrate to a framework where an administrative agency carries out the substantive regulation of occupations and industries, perhaps with advice provided by bodies composed of regulatees. Should a larger role for the OPLC be envisioned, further reorganization and expansion might be required. The OPLC's current role, organization, and authorities are not on par with those of a department.**

**We recommend OPLC management:**

1. **stabilize its current organizational construct, delegations, and accountabilities;**
2. **devise a strategy and develop plans to control, and ultimately optimize, its organizational construct, delegations, and accountabilities;**
3. **develop, implement, monitor, and refine monitoring controls as part of its strategy to help ensure current operations accomplish statutory duties;**

4. **formalize the terms and conditions of the support provided to assigned agencies through rules;**
5. **discontinue the use of standing orders or other modes of delegation and instead adopt required organizational and procedural rules;**
6. **facilitate removal of procedural requirements from supported agencies' rules and ensure OPLC rules contain all necessary requirements;**
7. **ensure practices do not have the effect of rules;**
8. **ensure rules, standing orders, and procedures do not erode assigned agency independence and discretionary decision-making authority; and**
9. **ensure authorities it is delegated are limited to non-discretionary administrative, clerical, and business processing responsibilities.**

OPLC Response:

*We concur with the recommendations.*

*The OPLC's plans to address the recommendations are as follows:*

1. *Stabilize its current organizational construct, delegations, and accountabilities.*

   *The OPLC does not anticipate significant legislative changes related to its organizational structure or relationship with the Board this legislative session. The OPLC will be working to establish internal controls over the next three SFYs and to stabilize its current organizational construct, delegations, and accountabilities, as reflected in the OPLC's responses to other observations.*

2. *Devise a strategy and develop plans to control, and ultimately optimize, its organizational construct, delegations, and accountabilities.*

   *As noted, the OPLC has finalized a strategic plan centered upon establishing internal controls over the next three State fiscal years. This effort will ensure the agency is optimizing and fully implementing its statutory mandates. Among other things, the OPLC anticipates completing memoranda of understanding with each board by the end of SFY 2023. Additionally, the OPLC anticipates inventorying all statutory and regulatory requirements by the end of SFY 2023.*

3. *Develop, implement, monitor, and refine monitoring controls as part of its strategy to help ensure current operations accomplish statutory duties.*

   *After inventorying all statutory and regulatory requirements, the OPLC will develop policies and procedures consistent with statute and rules. Thereafter, it will implement, monitor, and refine monitoring controls to ensure its operations achieve statutory duties.*

4. *Formalize the terms and conditions the support provided to assigned agencies through rules.*

   *The OPLC is finalizing a draft memorandum of understanding to propose to the Board to clarify the relationship between the parties. The OPLC hopes to have this memorandum of*

*understanding in place by SFY 2023. The OPLC is presently conducting its own rulemaking to ensure it has all rules in place that are required by statute. The OPLC anticipates completing all such rulemaking by the end of CY 2022. The OPLC is ready, willing, and able to assist the Board with rulemaking once the Board requests support, after making policy decisions regarding rulemaking additions and changes. The OPLC is also working on a policy and procedure to detail how boards may request assistance, and to provide greater transparency over the rulemaking process, including the OPLC's assistance in rulemaking.*

5. *Discontinue the use of standing orders or other modes of delegation and instead adopt required organizational and procedural rules.*

   *As noted, the OPLC is working to draft memoranda of understanding between the OPLC and the boards to outline and clarify the relationship between the parties. Once memoranda of understanding are in place, the OPLC anticipates discontinuing the use of standing orders. The OPLC is working to promulgate necessary rules to administer assigned agencies' procedures. Since January 2021, the OPLC has filed over 15 rulemaking proposals. Most recently, the OPLC adopted Chapter Plc 200 rules, relative to procedural rules for investigations. The OPLC is planning to file Chapter Plc 300 rules, relative to licensing procedures, in Fall 2022.*

6. *Facilitate removal of procedural requirements from supported agencies' rules and ensure OPLC rules contain all necessary requirements.*

   *Once the OPLC ensures that it has all necessary rulemaking in place for itself, it will work with the assigned agencies to facilitate removal of procedural requirements from assigned agency rules. The OPLC anticipates starting to work with its assigned agencies on this initiative beginning in January 2023. Given the length of time it takes for assigned agencies to conduct rulemaking, the OPLC anticipates this initiative will be complete by CY 2024.*

7. *Ensure practices do not have the effect of rules.*

   *The OPLC is working to ensure that all necessary rules are in place for the OPLC by the end of CY 2022. The OPLC is drafting policies and procedures to be consistent with rules.*

8. *Ensure rules, standing orders, and policies and procedures do not erode assigned agency independence and discretionary decision-making authority.*

   *As part of establishing internal controls, the OPLC will ensure that all its actions are taken pursuant to valid legal authority. The OPLC will be working with boards to eliminate standing orders by the end of CY 2023.*

9. *Ensure authorities it is delegated are limited to non-discretionary administrative, clerical, and business processing responsibilities.*

   *As noted, the OPLC is conducting an inventory of all OPLC tasks to ensure that it is only performing non-discretionary administrative, clerical, and business processing tasks.*

### *Management Of Performance And Customer Service*

The OPLC was created to improve administrative efficiency and customer service. Management should have designed controls to ensure the effective and efficient provision of customer service. Customers included the public, the Legislature, assigned agencies, applicants, and credential holders. To measure performance and demonstrate value, the OPLC had to quantify inputs, process performance, outputs, and outcomes. Customer service should have been effective – services should have produced intended results and met customer expectations. Customer service should also have been efficient – minimizing waste of resources – and should have been provided timely.

**Observation No. 14**

**Improve Office Of Professional Licensure And Certification Performance And Customer Service Controls**

The OPLC lacked a system of deliberately designed and integrated controls to manage performance and customer service. Management could not demonstrate assigned agencies received service comparable to that provided before the OPLC's creation, let alone improved, efficient, or effective customer service. The OPLC's value could not be quantified. Using or expending resources without demonstrable outcome constituted waste. Lacking an objective and reliable performance management system, managers and staff had overly positive impressionistic views of performance unsupported by the actual quality of services delivered.

- Since the OPLC's creation, several LBA audits have demonstrated defective controls compromised assigned agency effectiveness and public accountability. This may have compromised public safety, exposed assigned agencies to potential federal antitrust scrutiny, and compromised due process. Management incompletely identified customers and their service needs. It did not define the support it would provide, objectively manage staff, or comprehensively monitor and report on performance. At times, the OPLC did not fulfill its statutory responsibilities, engaged in extra-legal activities, effectively nullified assigned agency requirements, and provided perfunctory services. In other cases, transactions, including compliance with statutory time limits, were unauditable and record integrity compromised.

- Defective controls also compromised the OPLC's efficiency and stewardship of public resources. While our audit was not designed to comprehensively identify OPLC inefficiencies, we identified many indicators of inefficiency during our current and prior audits. Management never developed a means to measure efficiency, conflated timeliness for efficiency, and at times elevated efficiency over effectiveness. In some cases, the OPLC did not meet statutory or internal time limits, charged and collected gratuitous fees, and engaged in wasteful activities.

Assigned agencies, like the Board, were often the public face of defective or absent OPLC business processing, administrative, and clerical support controls. Volunteer members had to navigate complex requirements; understand frequent changes to the OPLC's organization, support framework, and staffing; and understand numerous responsibilities as public officials, essentially on their own. Numerous observations in this and prior audit reports illustrate significant gaps in

the administration of assigned agency operations and the processes supporting assigned agency functions. Each was underpinned by an OPLC duty or hinged upon members' voluntary nature, limiting, among other things, assigned agencies' ability to oversee administration and increasing their dependency on staff. At the same time, OPLC management sought more authority and resources to expand the scope and change the nature of OPLC operations, while claiming, but never demonstrating, that efficiency improvements occurred. There was no accountability framework through which assigned agencies could affect OPLC performance to improve results.

**Performance Unmanaged**

Management lacked a comprehensive, integrated system to manage performance, document controls, ensure accountability, and obtain customer feedback. Management could neither demonstrate allocated resources produced expected outcomes nor assess whether and how well the OPLC was serving assigned agencies' needs. Additionally, it was focused on certain inputs and outputs, not outcomes, making performance measurement problematic were it to occur.

***Identification Of Customers And Service Needs Incomplete***

Nothing demonstrated OPLC management viewed assigned agencies as OPLC customers. Assigned agency and subordinate entity processes or support requirements were not inventoried to ensure effective support. Consequently, some Board processes remained outside the OPLC's support framework, including, for example, all ASEC operations. Neither did management consistently tailor its support to individual assigned agency requirements. Management purported variation in support processes was inefficient. Instead, management sought to provide support broadly applicable to all assigned agencies, regardless of whether this level of support ensured compliance with unique requirements of individual assigned agencies.

***Support Expectations Not Established***

The relationship assigned agencies and their subordinate entities had with the OPLC remained unstructured beyond the broad statutory framework establishing the OPLC's general obligations. Management did not systematically document which support services were available, or the service quality assigned agencies should expect to receive. Management did not develop a cost accounting system to establish the true cost of services, preventing assigned agencies from understanding how much services would cost them. Then-serving management agreed to our CY 2017 recommendation to formalize the relationship between assigned agencies and the OPLC, but never did. At times, assigned agencies did not receive statutorily-required services, while services that were provided were noncompliant, perfunctory, or wasteful, and fees were gratuitous. However, assigned agencies had no control over service quality. In practice, they simply had a right to receive statutorily-required services.

***Management Of Staff Lacked Objective Basis***

The OPLC lacked comprehensive controls to communicate responsibilities, delegate authority, and supervise staff performance, resulting in an improvised approach to managing staff. Staff implemented and operated management controls. The OPLC was required to employ necessary

staff to properly perform its duties. It also gained responsibility for assigned agencies' staff when it was created in CY 2015. Individual staff performance should have contributed to overall OPLC and assigned agency performance. However, creating an effective accountability framework was impossible without a complete inventory of services required by assigned agencies, formal procedures compliant with assigned agency rules, performance monitoring and feedback from assigned agencies, and accurate cost and performance data.

Members relied almost solely on staff to effectively carry out operations on the Board's behalf, but without Board involvement, oversight, or an accountability framework. Staff reported providing adequate support, but this impression was not informed by Board input or objective assessment. Board members reported support was, at times, insufficient and not provided timely. Management did not have an objective basis for workload assignment. Some staff were at times believed to lack full workloads, purportedly resulting in inefficiency. Reallocation of staff during the OPLC's reorganization similarly was without objective basis, lacking data on staff performance, workload, or the level of support required by service type.

***Poor Monitoring Control Design***

Management lacked reliable performance information to assess whether changes to service provision improved efficiency or effectiveness. Management did not monitor the extent to which operations complied with statute and individual assigned agencies' rules, controls were operating as intended, or whether services met customer needs. The OPLC did not formalize process performance metrics, such as timeliness or consistency, or monitor results. Routine reports were not provided to the Board. Neither did management specify what performance information it needed from other agencies, such as investigative information from the APU, and when or how often it was needed. While the OPLC did not exclusively control each step of each process, those it did control should have been well understood to help optimize processes.

Instead, management reported relying on assigned agency administrators to correctly and timely identify issues for management's consideration. The effective operation of other controls was similarly dependent upon administrators' intuition. Reorganization was to include an additional middle management layer, purportedly to help improve customer service, develop controls, and monitor compliance on behalf of management. However, without a sufficient control framework, staff themselves could not have effectively developed controls or monitored performance to consistently ensure expected outcomes were achieved over time. Furthermore, inadequate controls over performance and knowledge management compromised operations. Without first addressing those deficiencies, additional managers would still have been unable to objectively identify deficiencies or effectively operationalize improvements.

***Lack Of Public Accountability***

Public reports never described OPLC performance. Instead, reports simply totaled some input data, such as the number of complaints received, and output data, such as the number of credentials issued. Management lacked risk tolerances and did not define acceptable variations in performance, making it impossible to understand whether reported outputs were within acceptable limits. Neither was management able to assess and report on expected or actual benefits of

organizational and operational changes. For example, management intended the Enforcement Division to improve efficiency and customer service, given concerns with APU support. However, management lacked a system to identify whether directly providing support for investigations and enforcement actions actually improved efficiency or effectiveness, due in part to the lack of any baseline performance measurement.

**Business Processing Support Effectiveness Uncontrolled**

Without adequate controls, management could not demonstrate business processing support was efficient and effective. The OPLC lacked controls to ensure it operated within the limits of its statutory authority and that staff did not inappropriately act without direction or properly delegated authority from assigned agencies. The OPLC developed standing orders for assigned agency approval. Some orders inappropriately delegated discretionary responsibilities to staff, while a draft credentialing procedure contradicted statute by accommodating staff exercising assigned agency authority.

***Noncompliant Credentialing Support***

Management acknowledged application processing was, at times, noncompliant. OPLC-wide procedures provided broad guidance only on certain administrative aspects of application processing. These procedures were not clearly or consistently in effect, monitored, and tailored to assigned agencies' rules, requirements, and processes. Staff improvised Board-specific practice guidance. Some was disused during the audit period, was incomplete, or rested on ad hoc rules. At times, staff:

- inappropriately waived credentialing requirements,
- required applicants to submit information and forms without basis in rule,
- deemed incomplete applications to nonetheless be administratively complete,
- presented applications for approval that were not compliant with requirements and for which a credential had already been issued,
- approved initial credential applications without authority, and
- inappropriately modified license expiration dates, which management reported discontinuing after the audit period.

***Ineffective Monitoring Support***

Staff verified compliance with character, conduct, and competence requirements, and administered complaints. OPLC-wide procedures provided broad guidance on administrative aspects of complaint processing, but were not clearly in effect or monitored. The OPLC lacked formal procedures or processes for triaging and referring complaints requiring immediate Board action. Procedures addressing other monitoring responsibilities were absent. At times, staff:

- relied upon incomplete sources to verify character and past conduct,
- inappropriately imposed ad hoc rule requirements on renewal applicants,
- approved renewal applications without authority,
- initiated continuing education reviews before they were required,

- did not bring public safety matters to the Board's immediate attention,
- acted on complaints without Board control, and
- informed the Board it could use letters of concern for reasons not allowed by statute.

***Inadequate Enforcement Support***

Staff were responsible for referring complaints to investigators and for completing required reporting of disciplinary actions and sanctions to national databases. However, procedures did not address monitoring of: 1) investigations or expert reviews, 2) licensees subject to malpractice claims or legal judgments, and 3) noncompliance cases and resulting disciplinary actions and sanctions. At times, staff were unavailable or uncooperative, and some investigations were not pursued, and some adjudicatory hearings were not held or were delayed. Staff also investigated some matters without Board control, closed cases without a record of Board direction, and did not publish sanctions as required by statute.

**Administrative And Clerical Support Effectiveness Uncontrolled**

Management could not demonstrate administrative and clerical support was efficient and effective. Administrative and clerical support affected each assigned agency's control systems and functions. Assigned agencies shared some common administrative and clerical processes likely amenable to procedural standardization, including monitoring rule statuses, orienting members to their duties, and managing records. However, inadequate support left members to independently understand their roles as public officials and regulators of occupations and industries, and comply with the spectrum of administrative and legal requirements.

***Poorly Designed Controls Over Rulemaking Support***

The OPLC was statutorily responsible for providing supervision, coordination, and assistance in rulemaking. However, deficient Board rules contributed to inconsistent public protection, encroached on the Legislature's prerogative to set State policy, abused individual rights, disenfranchised unregulated individuals, and potentially exposed the Board to federal antitrust scrutiny. Although then-serving management reported in CY 2017 that it planned to review assigned agencies' rules for statutory compliance, such a review did not occur. OPLC-wide procedures provided broad guidance only on certain administrative aspects of rulemaking support. Procedures did not address statutory compliance reviews, identification and remediation of ad hoc rules, or other substantive aspects of rulemaking. Staff:

- were aware the Board lacked certain required rules, but inconsistently informed the Board it should engage in rulemaking to achieve compliance;
- inconsistently provided the Board guidance on the use of interim rules, contributing to noncompliance and continued imposition of ad hoc rules; and
- inconsistently followed through on Board rulemaking initiatives, with several changes dating to CY 2018 remaining undrafted through December 2021, when we concluded audit work on this topic.

***Ineffective And Inefficient Knowledge Management***

Records management was a core OPLC responsibility. Assigned agencies were wholly dependent upon the OPLC for records management and underlying information technology. However, OPLC knowledge management practices were haphazard, impeded OPLC and assigned agency operations, compromised optimization, wasted resources, and inconsistently achieved statutory expectations. Analysis to transform data into useable knowledge generally did not occur. Knowledge management was inefficient, requiring the use of multiple automated systems and improvised and standard databases, in addition to hardcopy records, with data being transferred manually.

- Records Management – Known and unknown control deficiencies impaired accountability and transparency. True records of many transactions and decisions will likely never be recovered. Management did not comprehensively inventory records management requirements, or ensure it properly managed records. Records for numerous assigned agency transactions were unauditable. Multiple data sources were required to create a complete credential holder record, if one could be created at all. At times, Board records contained false or altered information. Some were improperly destroyed, incomplete, or unavailable, while others were inconsistently provided to the Board for review and action. Some records were not held by the State.

- Information Technology Management – To improve efficiency and allow for more accurate measurement of process timeliness, the OPLC increasingly relied upon the statewide credentialing database management system it was required to use. However, management was unaware the system overwrote data and no auditable record was created. Staff also relied on other, improvised database management systems. Databases were inadequately controlled and understood, and did not provide reliable, timely information, preventing assessments of compliance or efficiency. The OPLC relied upon – and invited reliance upon – information that likely did not accurately establish its or its assigned agencies' performance.

- External Communications – To: 1) allow assigned agencies to efficiently and effectively operate, 2) the public and Legislature to exercise oversight, 3) consumers to make informed decisions, and 4) applicants and credential holders to comply with requirements, the OPLC needed to timely communicate relevant quality information. However, the OPLC did not routinely or timely provide assigned agencies with data or analyses. Staff did not consistently or timely publish meeting notifications or minutes. The Board's website and external guidance documents inconsistently contained necessary information. Staff inconsistently published conditions placed on licenses, limitations on licensees' scope of practice, and disciplinary actions. While most inquiries from credential holders and applicants were reportedly process oriented, there was no formal process to monitor customer inquiries or complaints until management reportedly established a "customer service unit" in SFY 2021.

- Internal Communications – Gaps in staff knowledge negatively affected the consistency, timeliness, efficiency, effectiveness, and continuity of operations. In CY

2017, then-serving management concurred with our recommendation to standardize procedures. In March 2021, current management reported adoption of standardized procedures and practices was still ongoing. High turnover and reorganization efforts contributed to turbulence and compromised institutional knowledge. Management lacked controls to ensure staff complied with assigned agency requirements. Staff engaged in improvised practices, contributing to inconsistent results. At times, staff knowledge of basic requirements was limited. Consequently, staff were unable to provide information to credential holders and provided inaccurate advice to the Board. Without adequate internal reporting, management was reportedly unaware of the level of support provided to the Board and of extra-legal activities, such as ASEC members receiving honorarium for services provided as agents of the Board.

***Untimely And Incomplete Adoption Of Procedural Rules And Processes***

Since July 2018, the OPLC had authority to adopt procedural rules necessary to administer assigned agencies' application procedures, complaints and investigations, and payment processing. Relevant rules were not adopted for most assigned agencies through December 2021, when we concluded audit work on this topic. Other procedural rules were not timely adopted. At the same time, management requested additional rulemaking authority, as well as authority to implement additional business and administrative processes on behalf of assigned agencies. However, relevant processes also remained unimplemented.

**Recommendations:**

**We recommend OPLC management improve customer service and accountability, by:**

1. **identifying all customers and what they require;**
2. **inventorying assigned agency and subordinate entity processes and support requirements;**
3. **developing, implementing, monitoring, and refining a customer-centric strategy and plan, including developing goals, objectives, and targets, to help ensure business processing, administrative, and clerical support is effective and efficient;**
4. **developing, implementing, monitoring, and refining agreements between assigned agencies and other support agencies, for services the OPLC does not directly provide;**
5. **supporting contracting for assigned agency-specific services not accommodated in OPLC rules detailing assigned agency support procedures;**
6. **developing, implementing, monitoring, and refining compliant and comprehensive procedures addressing all support functions, codifying performance benchmarks and expectations, and formally and routinely communicating minimum service expectations;**
7. **developing, implementing, monitoring, and refining a performance management system, including a system to routinely measure and monitor all support services provided, collect customer feedback, and help ensure accountability;**
8. **developing, implementing, monitoring, and refining a data-based, objective model for workload and staffing allocations based in part on levels of service required**

**and true costs of services, and ensure resources are allocated efficiently and effectively and achieve expected outcomes; and**

9. **routinely reporting to assigned agencies, the Legislature, and the public on the performance of all support functions and attainment of expected outcomes, goals, objectives, and targets, including consistency, timeliness, and compliance.**

**We further recommend OPLC management improve the effectiveness and efficiency of business processing, administrative, and clerical support by:**

10. **ensuring business process support complies with statute, OPLC and assigned agencies' rules, and other requirements;**
11. **ensuring the public has convenient access to all conditions and limitations on credentials and all actions taken to regulate the industry;**
12. **standardizing practice and procedure for similar administrative and clerical functions across assigned agencies, where practicable;**
13. **assisting assigned agencies in complying with statute, rules, and other requirements by synchronizing its administrative, clerical, and business processing control framework with those of assigned agencies, improving member orientation to help ensure new members adequately understand their roles and responsibilities, and monitoring compliance;**
14. **facilitating assigned agency rulemaking through necessary supervision, coordination, and assistance, and determining how rulemaking support can help mitigate the potential for federal antitrust risk scrutiny;**
15. **improving support for assigned agency knowledge management;**
16. **ensuring assigned agencies are made aware of statutory changes which affect their duties, and develop an integrated strategy to implement new requirements;**
17. **ensuring assigned agencies receive information needed to carry out regulatory duties;**
18. **complying with all statutory records management requirements, including creation and retention, and ensuring records for all applicants and credential holders are auditable and accurately and completely document transactions, decisions, and actions;**
19. **definitively establishing administrative completeness dates for credential applications, timely notifying applicants of receipt of a complete or incomplete application, clearly documenting notifications and receipt of additional information or materials, and timely providing administratively complete applications to assigned agencies for substantive review;**
20. **implementing controls to assess current data reliability and ensure future data reliability, and once revised controls consistently produce reliable records, establishing and publicizing a date after which data can be relied upon for decision making;**
21. **migrating decision making away from intuitive practices towards data-driven decision making based on reliable data and objective analyses to guide employment of resources to support assigned agencies; and**
22. **adopting and implementing all statutorily-required administrative rules, including rules on interim temporary licenses for reciprocal licensure applicants,**

**supporting assigned agencies' Prescription Drug Monitoring Program requirements, and on complaint administration.**

**We recommend the Board improve controls over the support it receives, and:**

23. **formalize performance expectations through its rules, to include consistency, compliance, and timeliness standards for business processing, administrative, clerical, and other support;**
24. **clearly communicate to support agencies when performance is unsatisfactory, and require and oversee remediation; and**
25. **consider requesting statutory authority to oversee and control support quality.**

OPLC Response:

*We concur with the recommendations.*

**The OPLC's lengthy, detailed response is in Appendix C.**

Board Response:

*We concur with the recommendations.*

23. *We concur with the recommendation to formalize performance expectations through our rules, to include consistency, compliance, and timeliness standards for business processing, administrative, clerical, and other support.*

    *Improved collaboration with the OPLC through written agreements and regular communication may be the most effective way to achieve this goal. This is especially true since the Board has no enforceable leverage over the OPLC and administrative staff, unless legislative changes are made.*

24. *We concur with the recommendation to clearly communicate to support agencies when performance is unsatisfactory, and require and oversee remediation.*

    *The Board concurs that it should clearly communicate to the OPLC when performance is unsatisfactory. The Board has done this in the past, but the Board does not have the authority to require remediation. The Board is not in a practical position to oversee any such remediation as the Board again has no statutory authority to enforce or penalize the OPLC. Again, a constantly evolving collaboration with OPLC management and staff may be the most effective way to achieve this goal.*

25. *We concur with the recommendation to consider requesting statutory authority to oversee support quality.*

***Setting And Managing Fees***

Effective controls could have helped provide reasonable assurance financial operations were effective and efficient, reporting was reliable, and laws and regulations were followed. The framework surrounding fee setting for OPLC-assigned agencies changed often since the OPLC was created in SFY 2015.

1. Through SFY 2018, fees typically were to be established in assigned agency rules. Fees had to produce revenue equal to either full costs or 125 percent of direct costs. The OPLC administered assigned agency fiscal activities, processing revenue and charging shared services costs based on a percentage of each agency's revenue.

2. By the start of SFY 2019, the OPLC was to have a fee setting method established. Changes to statute the OPLC requested in SFY 2018, and obtained in SFY 2019, transferred assigned agency rulemaking authority for setting fees to the OPLC. However, the OPLC did not operationalize that authority because the authority requested was purportedly defective. The OPLC sought to clarify the fee setting authority it had previously requested, leaving assigned agencies' fee-related rules in effect by default. Shared services costs were still charged to assigned agencies based on a percentage of agency revenue.

3. In SFY 2021, the OPLC secured additional statutory changes that became effective in SFY 2022. The OPLC also changed its allocation method for shared costs, charging assigned agencies for shared services costs based on the number of credential holders under the purview of each agency. This essentially created a per capita fee for most OPLC services. The fee was based on the potential use of services without regard for actual service utilization by assigned agencies, with an option to charge individual agencies additional fees for unique services.

Properly developed cost allocation plans could have helped ensure fees consistently and accurately reflected the actual cost of services provided. Plans should have been transparent to help establish legitimacy and been written, equitable, and reflected current operations.

Agencies could only set fees by rules when statute first authorized the fee. The amount of any fee had to approximate the expense of the service provided. Fees grossly exceeding expenses were unreasonable and considered taxation. The long-standing upper boundary for appropriate fees was set at 125 percent of direct costs. Also, high fees could have imposed an unnecessary barrier to pursuing an occupation.

**Observation No. 15**

**Improve Fee Setting And Administration Controls**

Controls over fee setting were ineffective. Since at least CY 2004, we have found regulatory agencies did not meet the requirement to collect revenue equal to 125 percent their direct costs. Similar deficiencies were also noted in three CY 2017 performance audits of OPLC-assigned agencies. There were no formal, operating controls to ensure levied fees were authorized by statute

and all authorized fees were levied. Neither were there controls to ensure fee setting was objectively based on actual costs, or fees produced revenue totaling 125 percent of direct costs. The Board poorly controlled its fee-related rules, imposed certain fees without statutory authority, and did not adopt fees for other services.

The OPLC lacked a method to accurately allocate costs and facilitate compliance with the requirement revenue equaled 125 percent of direct costs. Management never established an inventory of needed services or determined the true costs of services provided that corresponded to the utilization of services. There was no accountability structure developed to help ensure proper fees were charged or to address potentially dissenting views of assigned agencies on OPLC established fees. Consequently, some fees may have resulted in taxation either by exceeding the 125-percent-of-direct-cost threshold or by being altogether gratuitous. Some fees charged to credential holders were not authorized by statute. Other authorized fees were not charged, inappropriately transferring service costs from the service recipient to others.

**Board Fee Setting Noncompliance**

The Board's approach to – and control over – fees was inconsistent. The Board:

- used rules to set fees for which there was no statutory authority,
- used ad hoc rules to set fees for which there was no statutory or rule basis,
- lacked rules requiring certain fees actually be paid,
- referenced inapplicable statutory authority in rules to set fees,
- knew it did not comply with the requirement to collect 125 percent of costs,
- set fees without objective basis,
- did not charge all fees,
- did not update fees timely, and
- inadequately controlled fee waivers.

Consequently, Board revenues were inconsistent, as shown in Table 1.

**Table 1**

**Board Fiscal Activity, State Fiscal Years 2016–2021**

| | SFYs 2016–2017 Biennium | | | SFYs 2018–2019 Biennium | | | SFYs 2020–2021 Biennium | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2016[1] | 2017[2] | Total | 2018[1] | 2019[2] | Total | 2020[1] | 2021[2] | Total |
| **Revenue** | | | | | | | | | |
| **Total** | **$507,485** | **$337,892** | **$845,377** | **$520,454** | **$350,688** | **$871,142** | **$505,560** | **$353,073** | **$858,633** |
| **Expenditures** | | | | | | | | | |
| Board-attributed Subtotal | 280,042 | 271,428 | 551,470 | 250,262 | 270,857 | 521,119 | 253,371 | 556,640[3] | 810,011 |
| Shared Services Subtotal[4] | n/a | n/a | n/a | n/a | 66,727 | 66,727 | 106,332 | n/a | 106,332 |
| **Total** | **280,042** | **271,428** | **551,470** | **250,262** | **337,584** | **587,846** | **359,703** | **556,640** | **916,343** |
| **Revenue-Expenditures Gap** | | | | | | | | | |
| **Total** | 227,443 | 66,464 | 293,907 | 270,192 | 13,104 | 283,296 | 145,857 | (203,567) | (57,710) |
| **Revenue As Percent Of Expenditures** | | | | | | | | | |
| **Total** | 181.2% | 124.5% | 153.3% | 208.0% | 103.9% | 148.2% | 140.5% | 63.4% | 93.7% |

Notes:
1. Dentists renewed credentials in even-numbered years.
2. Hygienists and EFDAs renewed credentials in odd-numbered years.
3. Shared services costs were included in the Board-attributed subtotal and allocated by the OPLC based on credential holder count.
4. Shared services costs were allocated by the OPLC as a percentage of assigned agency revenue.

Source: Unaudited OPLC data.

Charging unauthorized fees was extra-legal. Baseless and gratuitous fees may have been an illegal tax.

- Unauthorized Fees – We identified 18 fees the Board required without statutory authority. Unauthorized fees included certain application, on-time and late renewal, and reinstatement fees.

- Baseless And Gratuitous Fees – The OPLC did not complete an inventory of Board-required services. Consequently, it could not develop a comprehensive system of cost accounting to establish true costs of the services it provided the Board. Consequently, the Board lacked an objective basis for its fee setting. The Board relied upon arbitrary methods to establish fees. Through June 2021, Board fees were to produce revenue of 125 percent of the direct cost of services provided. Deficiencies resulted in inconsistent fees being levied. As shown in Table 1, Board revenue ranged from a high of 208.0 percent of costs in SFY 2018 to a low of 63.4 percent in SFY 2021.

We also found, dentists and hygienists were required by statute and rule to submit a fee to renew their credentials, while EFDAs were not. Dentist and hygienist renewal processes were perfunctory, lacking any substantive review, making fees gratuitous. Dentists paid disproportionately high fees when compared to hygienists for perfunctory renewals. A dentist or hygienist paid the same renewal fees whether they used legacy, manual procedures or the purportedly more efficient online procedures. As shown in Table 1, revenue was significantly disproportionate year-to-year. Dentists subsidized the regulation of all occupations under the purview of the Board, and likely other occupations regulated by other agencies as well, given that no fees were reduced due to purportedly improved efficiency.

- Unrecovered Costs – The Board inconsistently recovered costs, transferring the costs of services to nonrecipients, potentially constituting a tax. We identified eight fees required in statute but not adopted in Board rules. The Board also inconsistently recovered costs of investigations and prosecutions from credential holders found to have warranted sanctions during enforcement cases. Additionally, while hygienists could access the Professionals Health Program, they were not required to pay related fees. Dentists could be charged up to $30 for each license application and renewal for program costs.

After the audit period, rulemaking authority for establishing the value of fees and other cost recovery authorities were transferred to the OPLC. However, the Board retained rulemaking authority for requiring fees as a condition of receiving a service, such as credentialing, and requiring payment for enforcement-related costs.

**OPLC Fee Setting Noncompliance**

The OPLC did not develop effective fiscal controls, including those related to fees. The OPLC never developed a cost accounting system to objectively establish the true cost of required services provided to individual assigned agencies. This could have allowed assigned agencies, when they had such authority, and later the OPLC, to in turn objectively set fees. Objective establishment of true costs underpins demonstration of efficiency improvements, which did not occur. Additionally, as we discuss in Observation No. 16, the OPLC inconsistently controlled payments and ensured payment accuracy.

Since its creation, the OPLC had an increasing number of finance staff assigned, in part to help ensure revenue complied with the 125 percent of direct costs requirement. However, the OPLC was inconsistently effective in executing fiscal control and ensuring compliance with the 125 percent threshold, as shown in Table 1. Instead of developing a system to establish service requirements and objectively establish true costs for each required service, management reported exploring various approaches to financing OPLC operations, including taxation relying on tiered fees based on credential holders' earning potential.

During the audit period, the OPLC reduced Board staffing levels, but fees were not adjusted, and OPLC charges increased. Purported savings from processing credential renewals electronically were never quantified and relevant fees were never reduced. During the three biennia shown in

Table 1, Board biennial revenues increased 1.6 percent from SFY 2016 to SFY 2021, while biennial expenditures increased 66.2 percent. Annual expenditures in SFY 2021 increased 98.8 percent from SFY 2016.

Following the audit period, the OPLC was statutorily authorized to set fees to produce revenues not to exceed 125 percent of its direct costs. Management reported efforts were underway to ensure individual fees did not constitute unlawful taxes and to refine its per-capita cost allocation method to ensure revenue was 125 percent of expenditures. The OPLC also began the rulemaking process to establish certain fees. The OPLC also sought statutory changes to some assigned agency licensing cycles, which we had recommended in CY 2017, in part to minimize the year-to-year variability in revenue.

**Recommendations:**

**We recommend the Board improve controls over fees, and:**

1. **seek statutory authority to require fees for each service it provides;**
2. **reframe rules to require submission of only fees authorized by statute, ensuring rules specify when fees are required, making service provision contingent upon fee receipt, and providing a basis for the OPLC to commence its efforts to adopt rules establishing the value of fees;**
3. **repeal rules related to setting the value of fees;**
4. **monitor OPLC fee setting; and**
5. **ensure fees for the costs of enforcement cases are consistently levied.**

**We recommend OPLC management improve controls over fees, and:**

6. **create, implement, monitor, and refine a cost allocation system that avoids potential taxation and accurately reflects the actual costs of discrete services provided to assigned agencies based on a complete inventory of required services;**
7. **ensure revenues do not exceed 125 percent of direct costs;**
8. **publish the details of the system and how fees are derived to facilitate transparency and provide assurances fees paid by credential holders reflect the value of the services they receive;**
9. **establish and maintain rules setting the value of fees for all services provided;**
10. **adopt rules establishing only statutorily-required assigned agency fees;**
11. **inventory and clarify assigned agency fee requirements and seek necessary statutory changes to ensure fee setting authority is complete;**
12. **discontinue charging fees without a statutory basis and charge only statutorily-authorized fees;**
13. **ensure assigned agencies have cost data to order recovery of enforcement-related costs from credential holders found to have engaged in misconduct; and**
14. **create, implement, monitor, and refine efficiency metrics to demonstrate the value of the OPLC and to allow for fee reductions.**

Board Response:

*We concur with the recommendations.*

1. *We concur with the recommendation to seek statutory authority to require fees for each service provided by the Board.*

   *This activity should be undertaken in concert with the OPLC as fiscal agent and administrator on behalf of the Board.*

2. *We concur with the recommendation to reframe the rules to require submission of only fees authorized by statute, specify when fees are required, and make service provision based on receipt of fees.*

   *The Board notes that implementation of these actions is contingent on the timely notification by the OPLC as fiduciary agent on behalf of the Board. These actions would also provide the OPLC with a basis to put forth rules establishing the value of each fee.*

3. *We concur with the recommendation to repeal rules whereby the Board sets the value of fees.*

   *That function now resides with the OPLC.*

4. *We concur with the recommendation to monitor OPLC fee setting.*

   *Monitoring will be contingent on the OPLC providing timely written reports to the Board.*

5. *We concur with the recommendation to ensure that fees for the costs of enforcement cases are consistently levied.*

   *The Board is dependent on the OPLC providing the Board with accurate and timely data related to enforcement costs.*

OPLC Response:

*We concur with the recommendations.*

*OPLC's plans to address the recommendations are as follows:*

6. *Create, implement, monitor, and refine a cost allocation system that avoids potential taxation and accurately reflects the actual costs of discrete services provided to assigned agencies based on a complete inventory of required services.*

   *The OPLC understands that the legislative study committee contemplated by Senate Bill 330 (2022), as amended, has been established. The OPLC is hopeful that such committee will assist the OPLC and stakeholders to reach a consensus as to how costs should be allocated. The*

*OPLC is committed to ensuring that revenues do not exceed 125 percent of direct costs. Senate Bill 313 (2022), as amended, will eliminate statutory fees that prevent the OPLC or its assigned agencies from adjusting fees to avoid potential taxation. The OPLC plans to release a request for proposal in Fall 2022 to advise and recommend a cost allocation system that is consistent with the audit recommendations.*

7. *Ensure revenues do not exceed 125 percent of direct costs.*

   *See the OPLC's response to #6, above.*

8. *Publish the details of the system and how fees are derived to facilitate transparency and provide assurances fees paid by credential holders reflect the value of the services they receive.*

   *See the OPLC's response to #6, above. Once the OPLC finalizes a new cost allocation system based on input from stakeholders, it will publish the details of the system and how fees are derived.*

9. *Establish and maintain rules establishing the value of fees for all services provided.*

   *See the OPLC's response to #6, above. The OPLC has promulgated rules, Part Plc 1002, to establish certain fees. Once the OPLC finalizes a new cost allocation system and determines appropriate fees, it will establish and maintain rules implementing such fees.*

   *Notably, in September 2021, the OPLC provided all boards with a proposed fee schedule, which it intended to adopt after receiving Board feedback. Several stakeholders become concerned that OPLC had authority to establish fees. Those stakeholders voiced their concerns at a legislative hearing. Due to these concerns, the OPLC agreed to place most fee rulemaking on hold, pending the outcome of the Senate Bill 330 study committee's report. The OPLC does plan to move all current board fees into one set of rules, Part Plc 1002, to promote greater transparency.*

10. *Adopt rules establishing only statutorily-required assigned agency fees.*

    *See the OPLC's responses to #6 and #9, above. The OPLC presented a proposal to all assigned agencies in September 2021, which would have established fees; however, due to significant stakeholder concerns, the OPLC decided to withhold filing its rulemaking petition until a consensus on fees may be achieved. The OPLC is hopeful that the legislative study committee established by Senate Bill 330 (2022) will help stakeholders to achieve consensus on that issue.*

    *The OPLC has promulgated rules with limited fees, including fees pertaining to the Board of Dental Examiners. See Part Plc 1002 (effective August 8, 2022).*

11. *Inventory and clarify assigned agency fee requirements and seek necessary statutory changes to ensure fee setting authority is complete.*

    *See the OPLC's response to #12, below.*

12. *Discontinue charging fees without a statutory basis and charge only statutorily-authorized fees.*

    *The report notes several issues surrounding dentist permit fees: 1) ASEC members improperly receiving honorarium and imposing [facility inspection and comprehensive evaluation] cancellation fees; 2) the OPLC charging a permit renewal fee; and 3) the $35 permit application fee itself, which was established by the Board.*

    *When the OPLC was granted fee-setting authority, the Legislature did not amend the practice acts to eliminate any statutorily created fees, nor did the Legislature amend the practice acts to remove fee-setting authority from all the assigned agencies. This created confusion as to the OPLC's ability to set rules regarding fees. In 2021, Senate Bill 58 removed from the Board's practice act the Board's ability to promulgate rules regarding fees, clarifying that the OPLC has fee-setting authority.*

    *OPLC has promulgated rules to establish fees concerning the Board.*

    *The OPLC offers the following comments regarding the three specific issues identified above.*

    Honorarium. *The OPLC agrees that the honorarium charged by ASEC members for inspections was without legal authority or basis. OPLC management was completely unaware of this process, which the OPLC concedes is due, in part, to the OPLC's lack of sufficient internal controls. The OPLC is working to establish internal controls to ensure compliance with statutes and rules as part of its strategic plan for SFYs 2023–2025.*

    *The OPLC recommended to the Board that the OPLC to issue a request for proposal, to obtain a contractor to conduct inspections in lieu of using ASEC members. This would mitigate potential claims of anticompetitive behavior. The Board did not agree with this approach until early CY 2022. To preserve a working relationship with the Board, and based on advice of legal counsel, the OPLC released a request for proposal once the Board agreed to utilize contracted inspectors. The OPLC is finalizing its procurement and expected to have contracts in place in October 2022.*

    Renewal Fee. *The OPLC has present authority to establish a renewal fee for permits. As the report notes, rules promulgated by the Board establish an expiration date for such permits. RSA 310-A requires the executive director to "assess annual or biennial... renewal fees...." To the extent the report is suggesting that the rules establishing expiration dates lack statutory authority, the OPLC proposes to work with the Board to propose legislation.*

    $35 Permit Fee. *OPLC has proposed to modify rules regarding fee changes. The OPLC understands the need to objectively quantify actual processing costs. The OPLC is hopeful that it can explore potential solutions with the legislative study committee established by Senate Bill 330.*

13. *Ensure assigned agencies have cost data to order recovery of enforcement-related costs from credential holders found to have engaged in misconduct.*

*The OPLC's new case management system will have the ability to track costs to facilitate the recovery of enforcement-related costs from licensees in a disciplinary action.*

14. *Create, implement, monitor, and refine efficiency metrics to demonstrate the value of the OPLC and to allow for fee reductions.*

    *Once the OPLC has established internal controls and accounted for all services that it must provide to its assigned agencies, the OPLC will establish efficiency metrics to demonstrate the value of the OPLC and to potentially allow for fee reductions.*

### *Collecting, Processing, And Waiving Fees*

Payment of fees was required for some applications, registration, late registration, reinstatement, and other Board services. Agencies were required to return and not deposit any payment in several situations. Associated applications could also be returned and a processing fee applied.

**Observation No. 16**

**Improve Fee Collection, Processing, And Waiver Controls**

The Board lacked adequate rules and procedures for collecting, returning, and waiving fees. OPLC's fee collection practices did not align with Board rules. Since SFY 2019, the OPLC was authorized to establish payment processing procedures. However, it had not adopted relevant rules through November 2021, when we concluded audit work on this topic. The OPLC lacked comprehensive procedures for collecting, returning, processing, and waiving fees, and its refunding of fees did not comply with statute. Forms of accepted payment were inconsistent. Additionally, the OPLC lacked adequate controls to ensure it consistently treated renewing licensees who were affected by credentialing database management system errors, or system errors, resulting in inconsistent late fee charges.

While our audit work was not designed to identify every instance of improper fee handling, inadequate controls over fee handling processes resulted in:

- processing and depositing fees for incomplete applications, which led to refunds and created an unnecessary administrative burden;
- inconsistent approval of late fee waiver requests;
- inadequate identification of credential holders who may have been inappropriately required to pay late fees due to system errors; and
- payment methods that were inconsistent with Board rules.

**Noncompliance With Statute**

There were no controls to ensure the Board or the OPLC complied with statute requiring fees be returned under certain conditions or providing that accompanying applications to also be returned. Neither were fees charged for defective applications or payments submitted.

- Fees were to be returned when: 1) the amount paid was incorrect, 2) an application was not submitted with the fee, 3) an associated application was improperly or incorrectly submitted, or 4) the applicant did not meet statutory eligibility requirements. However, incomplete applications and associated payments, and incorrect payments, were accepted and processed. Staff inconsistently contacted applicants to try to correct defective applications and payments. We identified one case where staff remedied, and did not return, a defective check. Incomplete applications were not monitored. However, among the 24 accepted or approved initial license application forms we reviewed, 22 (91.7 percent) were incomplete, and therefore defective.

- An informal OPLC practice provided refunds would be issued to applicants who did not qualify for an initial or renewed credential. Statute provided no authority for issuing refunds after applications had been processed. We found one case where an applicant was refunded a fee paid after OPLC processed the associated application.

**Inconsistent Rules, Procedures, And Guidance On Payment Methods**

Board rules and OPLC procedures and guidance inconsistently detailed acceptable payment methods. Inconsistencies affected dentist and hygienist license renewals, temporary licenses, registrations, reinstatements, CPHDH certificates, and EFDA, nitrous oxide minimal sedation, moderate sedation, and general anesthesia and deep sedation permits.

OPLC fee collection practices were inconsistent with Board rules. Board rules made checks, certified checks, money orders, and cash acceptable forms of payment. In practice, the OPLC accepted only credit card payments for online renewal applications, which was not provided for in Board rules. OPLC practice further limited payment by credit cards to two companies, which was also inconsistent with OPLC procedures. Informal OPLC procedures and guidance also specified personal checks would not be accepted for initial applications and would be returned, again without basis in rules.

**No Procedures To Process Late Renewal Fee Waiver Requests**

The Board lacked adequate procedures for waiving late renewal fees, and fees were inconsistently waived. To renew their license, licensees had to submit a complete registration form and fee before April 1 of their renewal year. Late renewals could be submitted from April 1 through April 30, with payment of a late fee that was waivable for "good cause." Board rules outlined additional requirements for considering a waiver, but never defined "good cause." Board requirements were not included in formal or informal OPLC procedures to ensure waiver applications addressed all Board requirements. There was no public information on submitting waivers or a standard form for waiver requests. Informal OPLC procedures and improvised instructions on fee waivers were

inconsistent. Improvised instructions notified licensees there was "no process to remove late fees," but also provided waiver information. One licensee reported being told there was no process before being told later there was a process. Consequently, licensees did not follow all waiver request submission or content requirements.

In CY 2020, nine dentists requested a waiver, and one requested a deferral of the renewal fee, which was not permissible. The ten requests were handled inconsistently.

- Six, including the deferral, were approved. This included one where the late renewal was not caused by a credentialing database management system error but instead because the licensee failed to notify the Board of an address change, a sanctionable offense.

- One waiver was not provided to the Board for action because the license had lapsed.

- Three waivers were denied. This included one where the failure to timely renew was purportedly not caused by a credentialing database management system error.

**Inconsistent Management Of Late Fees Induced By System Errors**

The Board did not ensure all licensees who may have been affected by system errors during renewal were aware late fee waivers could have been requested. Inequitable treatment of licensees may have resulted. The OPLC was aware credentialing database management system errors affected on-time submission of renewal applications. During the CY 2020 and CY 2021 renewals, an unknown number of licensees were affected by credentialing database management system errors when they attempted to renew online. This led to late renewal of licenses and charging of late renewal fees. Some applicants requested waivers of late fees. As a result, staff were tasked with investigating whether those individual applicants submitting waiver requests had been affected by system errors. Those applicants found to be affected by the system errors were reportedly granted a late fee waiver.

However, the total number of licenses affected by system errors was unknown and not investigated. The OPLC did not issue notices to renewing licensees to inform them of possible system errors, suggest they determine whether their renewal was potentially affected, and suggest applicants renewing during the late renewal period submit a late fee waiver request. Additionally, despite OPLC awareness of system errors affecting two renewal cycles, no plan was devised to identify or address the error's root cause, identify all affected credential holders, or address the error's potential impact on future renewals.

**Recommendations:**

**We recommend the Board improve controls over fee waivers, and:**

1. **repeal fee setting-related rules once relevant OPLC rules are adopted,**
2. **adopt clear rules on waiving late fees, and**
3. **ensure late fee waivers are consistently approved.**

**We recommend OPLC management improve fee collection, return, and waiver controls, and:**

4. **ensure fee-related procedures and practices conform to Board rules until Board rules are replaced with OPLC rules;**
5. **adopt comprehensive procedural rules controlling administration of fees, including acceptable methods of payment, returning defective payments and payments accompanying defective applications and those from ineligible applicants, and charging a fee for processing defective applications and payments;**
6. **develop, implement, monitor, and refine formal fee handling procedures compliant with rules;**
7. **determine when to return applications improperly or incorrectly submitted, and those from ineligible applicants;**
8. **discontinue refunding fees for services provided;**
9. **ensure all applicants and credential holders are aware systems errors preventing timely renewal of applications may occur, and that waivers can be requested; and**
10. **ensure system errors are rectified.**

Board Response:

*We concur with the recommendations.*

1. *We concur with the recommendation to remove fee setting-related elements from rules once relevant OPLC rules are adopted.*

   *As stated in the observations, the OPLC collects the fees and has been authorized to establish fee-setting rules and payment processing procedures. The Board agrees there need to be consistent and comprehensive rules and procedures however, this appears to fall under the purview of the OPLC.*

   *With respect to refunds, the observations and inconsistencies identified by the auditors fall under the OPLC. The volunteer Board that meets one time a month does not and should not have access to all the financial accounts of the OPLC to make these observations.*

   *However, the Board agrees there needs to be consistent and comprehensive rules and procedures for the OPLC to follow, with a component that can be reviewed by the Board if questions arise.*

   *With respect to methods of payment, the Board concurs in part with the recommendations. As the observations noted the Board has a list of acceptable forms of payments. To the extent that the OPLC is inconsistently following the rules, it is not the Board's responsibility.*

   *The Board will consider whether to update the list to include credit cards.*

   *However, again the Board respects that the OPLC should have a more streamlined approach that is more consistent with the Board guidelines.*

2. *We concur with the recommendation to promulgate clear rules on waiving late fees.*

   *The Board has the discretion to determine whether "good cause" exists on a case-by-case basis and agrees it needs to promulgate rules to clearly define what constitutes "good cause." The Board agrees that a more consistent approach needs to be applied by the Board when making this determination.*

3. *We concur with the recommendation to ensure late fee waivers are consistently approved.*

   *With respect to charging late fees to licensees affected by system errors, the OPLC recently addressed this issue by removing late fees from rules.*

OPLC Response:

*We concur with the recommendations.*

*The OPLC's plans to address the recommendations are as follows:*

4. *Ensure fee-related procedures and practices conform to Board rules until they are replaced with OPLC rules.*

   *The OPLC is currently conducting an inventory of assigned agency requirements, which includes an inventory of necessary procedures and practices implementing assigned agency rules. The OPLC is also working to establish internal controls, which necessarily includes ensuring that procedures and practices conform to rules.*

   *The OPLC promulgated rules, Part Plc 1002, establishing fees pertaining to the Board of Dental Examiners. See Part Plc 1002 (effective August 8, 2022). The OPLC is working to draft policies and procedures implementing such rules.*

5. *Promulgate comprehensive rules controlling administration of fees, including accepting all methods of payment, returning defective payments and payments accompanying defective applications and those from ineligible applicants, and charging a fee for processing defective applications and payments.*

   *As noted, there has been substantial delay in moving forward with promulgating all requisite fees, due to stakeholder concern over the OPLC's authority to establish fees. The OPLC is hopeful that, in working with the legislative committee established by Senate Bill 330, it can clarify its authority to establish fees. The OPLC plans to incorporate feedback from that committee into a set of comprehensive rules concerning administration of fees once the legislative committee report is released in Fall 2022.*

6. *Develop, implement, monitor, and refine formal fee handling procedures compliant with rules.*

*Once the OPLC promulgates rules regarding fee handling procedures it will establish and maintain procedures compliant with such rules.*

7. *Return applications improperly or incorrectly submitted, and those from ineligible applicants.*

   *The OPLC recognizes that it is required to return fees and applications improperly or incorrectly submitted, and those from ineligible applicants. The OPLC receives a large volume of checks per day and has over 2,000 fee types to process. The OPLC is working to develop a system to ensure appropriate controls are in place to comply with the statute. See the OPLC's response to #5, above.*

8. *Discontinue refunding fees for services rendered.*

   *The OPLC has discontinued refunding fees for services rendered. Current refund eligibility is limited to individuals who overpaid or incorrectly paid for services, are not eligible, have submitted a duplicate payment, or the payment was incorrectly applied.*

9. *Ensure all applicants and licensees are aware of system errors preventing timely renewal of applications may occur, and that waivers can be requested.*

   *As part of its strategic plan for SFYs 2023–2025, one of the OPLC's primary goals is to develop and implement a communications strategy by creating and implementing crisis, internal, and external stakeholders' communications plans. Such plans will necessarily include the requirement that applicants and licensees be made aware of system errors preventing timely renewal of applications and the ability to seek waivers, among other things.*

10. *Ensure that system errors are rectified.*

    *The OPLC does not have control over the credentialing database management system. Rather, the system is an enterprise solution managed by the DoIT. The OPLC currently works with the DoIT to resolve system errors when they occur. The OPLC is challenged by the lack of resources at the DoIT to resolve the current credentialing database management system errors. The OPLC worked with the DoIT to procure funds to purchase a new credentialing database management system that can be managed and maintained in-house.*

***Remediating Control Deficiencies Identified By External Evaluations***

External evaluations, such as audits, could have helped management identify risks, including inefficiency, ineffectiveness, and noncompliance risks. While the Board was not previously audited, several agencies assigned to the OPLC were. Management should have implemented a system to ensure timely resolution of deficiencies, assigned responsibility for resolving deficiencies, and taken appropriate follow-up action. Management should have also investigated underlying causes to prevent or address additional, related deficiencies. Since CY 2014, agencies were required to develop a remedial action plan within 30 days of an LBA audit. They were to identify planned remedial actions and those actions requiring approval from the Legislature,

Governor and Council, or others. Semiannual progress report for audits issued since January 2013 were also required. Plans and progress reports were to be published on the State's transparency website.

**Observation No. 17**

**Develop Controls To Ensure Remediation Of Audit Findings**

There were no formalized OPLC controls designed to remediate conditions leading to audit findings and monitor them to ensure processes remained controlled. Lack of remediation of prior audit findings and timely reporting unnecessarily exposed operations to risk, inhibited the achievement of expected outcomes, allowed inefficiency and statutory noncompliance to persist, and compromised transparency. Unremediated audit findings also contributed to waste. Unresolved and untimely resolved audit findings contributed to ongoing management control deficiencies affecting the Board. Some of the current audit's observations might have been unnecessary if a control system had been in place to effectively remediate prior findings and ensure processes remained controlled.

The OPLC did not ensure management control deficiencies for which it became responsible after its creation, and which were identified in prior LBA audits, had been remediated and processes remained controlled. Several deficiencies identified during our current audit of the Board were previously identified and brought to the attention of OPLC management in three LBA audits issued in CY 2017. In CY 2021, OPLC management reported having resolved, or being in the process of resolving, these prior audit findings. However, there were inconsistencies between the OPLC's reported resolution status and actual resolution.

The OPLC lacked a strategy, plans, or other controls to address deficiencies identified in audits. The OPLC did not support development and publication of required remediation plans and progress reports. Since CY 2004, nine agencies assigned to the OPLC after its CY 2015 creation have been audited by the LBA, resulting in 11 financial and performance audits containing 68 observations related to OPLC duties.

- Audits Issued Before CY 2013 – Six audit reports were issued during or after CY 2004 and before CY 2013. Although these audits predated the OPLC's creation, accounting for the systematic deficiencies related to OPLC duties these audits identified could have helped the OPLC better control its operations.

- Audits Issued From CY 2013 Through May 2015 – Two audit reports were issued between CY 2013, and May 2015, before the OPLC became an agency in July 2015. Although these audits predated the OPLC's creation, accounting for the identified systematic deficiencies related to OPLC duties could have helped the OPLC better control its operations. Additionally, agencies were required to create plans and report semi-annually on progress in remediating audit findings. After the OPLC's CY 2015 creation, administrative support for drafting and publishing these plans and reports would have been an OPLC duty. The OPLC was also responsible for remediating deficiencies under its purview.

- Audits Issued In CY 2017 – Three audit reports were issued in CY 2017. The OPLC should have helped audited agencies develop remediation plans, ensure remediation plans were published, and ensure progress reports were developed and published semi-annually. The OPLC was also responsible for remediating deficiencies under its purview.

From January 2013 through June 2021, one remedial action plan was published. Many prior findings and recommendations relevant to the current audit, and core OPLC functions, were not fully resolved. This included recommendations related to:

- the OPLC's mission statement, which remained at odds with its statutory purpose;
- administrative, clerical, and business processing services;
- the OPLC's organizational structure, as well as its relationship with assigned agencies;
- performance standards governing services provided to assigned agencies;
- assigned agency compliance with statute, rules, and other requirements;
- performance measurement and demonstrating outcomes were achieved;
- effective records management; and
- rulemaking assistance.

**Recommendations:**

**We suggest the Legislature consider increasing oversight of the OPLC's efforts to address the conditions leading to audit findings.**

**We recommend OPLC management:**

1. **develop, implement, monitor, and refine a control system to ensure audit findings are timely and fully remediated;**
2. **incorporate audit resolution processes into strategies and plans;**
3. **ensure required remedial action plans and progress reports are developed and submitted for publication; and**
4. **develop, implement, monitor, and refine procedures to ensure responsibility for resolving audit findings is clearly assigned and monitored.**

OPLC Response:

*We concur with the recommendations.*

*The OPLC's plans to address the recommendations are as follows:*

1. *Develop, implement, monitor, and refine a control system to ensure audit findings are timely and fully remediated.*

   *The OPLC recognizes the need to ensure audit findings are timely and fully remediated and is working to fulfill this recommendation. The OPLC has established an Internal Controls*

*Administrator position, which was filled in June 2022, which will assist the OPLC in establishing internal controls and to develop a control system to remediate prior audit findings.*

2. *Incorporate audit resolution processes into strategies and plans.*

   *The OPLC's current strategic plan for SFYs 2023–2025 incorporates audit recommendations.*

3. *Ensure required plans and reports are developed and submitted for publication.*

   *See the OPLC's response to #1, above. As part of addressing audit findings, the OPLC is working to ensure required plans and reports are developed and submitted for posting, as required.*

4. *Develop, implement, monitor, and refine policy and procedures to ensure responsibility for resolving audit findings is clearly assigned and monitored.*

   *See the OPLC's response to #1, above.*

## CHAPTER TWO
## REGULATORY PROGRAM

To protect the public's health, safety, and welfare from unqualified, unscrupulous, or impaired credential holders, the Legislature created the Board of Dental Examiners (Board). The Board was to implement and administer State policy regulating aspects of the dental care industry. This relied upon the Board exercising its substantive, discretionary decision-making authority to establish a supporting regulatory program. The regulatory program rested upon three functions: credentialing, monitoring, and enforcement. Board duties included:

- regulating the practice of dentistry and dental hygiene;
- developing and monitoring substantive requirements to obtain and renew a credential;
- specifying the duties a dentist could delegate to auxiliaries;
- monitoring regulatee compliance, and receiving complaints of alleged noncompliance;
- conducting investigations of alleged noncompliance;
- holding adjudicative proceedings, while ensuring due process and transparency; and
- developing and imposing sanctions on regulatees engaged in misconduct.

Development and refinement of specific requirements and processes were delegated to the Board via its rulemaking authority and its ongoing monitoring obligation. The Dental Hygienists Committee (DHC) was to assist the Board with hygienist- and Certified Public Health Dental Hygienist (CPHDH)-related rules. The Anesthesia and Sedation Evaluation Committee (ASEC) and the ASEC Advisory Subcommittee (ASEC-AS) were to develop dentist anesthesia and sedation rules and regulate permittee practice. The Office of Professional Licensure and Certification (OPLC) was responsible for developing specific components of the Board's program. Other components of the Board's program were regulated along with or by other agencies.

A well-designed regulatory program could have helped achieve expected outcomes, increasing the likelihood the public would be adequately protected, and included nine identifiable features.

1. Develop A Regulatory Strategy – The Board's regulations should have been informed by an evidence- and risk-based strategy. Data should have helped objectively establish threats to public protection and demonstrated which threats were serious enough to warrant regulation, after assessing potential costs and benefits.

2. Identify Minimum Level Of Regulation Necessary – An evidence- and risk-based strategy could have helped the Board design regulations to address threats at the minimum level necessary for public protection, without imposing unnecessary burdens and costs. The total cost of regulation included the direct and indirect costs of entry, eligibility maintenance, and practice requirements. Regulating at the minimum level necessary could have helped limit costs while providing adequate oversight and controlling identified risks. Approaches to regulation, from least to most restrictive, included no regulation, voluntary certification, inspections, and State credentialing. Credentialing included, from least to most restrictive, **registration** before engaging in the regulated occupation; **permitting** or **certification**,

requiring individuals meet minimum qualifications to engage in a certain scope of practice; and **licensing**, involving broad-based regulation of an occupation.

3. Develop Regulatory Requirements – The Board should have developed requirements for entering an occupation, practicing within an occupation, and maintaining competence to practice. Requirements should have helped ensure regulatees had acceptable character, past conduct, and competency to practice. Requirements should have been clear, been designed to achieve expected outcomes at the minimum level necessary, and not been arbitrarily burdensome or created unreasonable barriers.

4. Develop Systematic Credentialing Processes – The Board should have developed systematic and equitable processes to issue new credentials to qualified applicants. Reasonable steps should have been taken to ensure applicants met entry requirements. This included reviewing and verifying submitted information, conducting criminal background checks, or establishing competency, such as by conducting inspections and comprehensive evaluations. Credentials should have been issued timely and for a specified period.

5. Develop Systematic Monitoring Processes – The Board should have developed systematic processes to proactively monitor applicant and regulatee compliance with entry, eligibility maintenance, and practice requirements. Reasonable steps should have been taken to verify regulatees remained qualified to practice, including credential renewal processes. The Board should have also integrated reactive monitoring controls, such as complaint management, as supporting processes. Finally, the Board should have monitored regulatees who were sanctioned to ensure they timely came into – and remained in – compliance with requirements.

6. Develop Systematic Enforcement Processes – The Board should have developed systematic and equitable processes to investigate potential noncompliance, adjudicate contested cases, and sanction noncompliant credential holders. Investigations should have determined whether there was reasonable basis to conduct disciplinary proceedings. Adjudicatory proceedings should have protected due process by determining culpability and considering potential disciplinary action for noncompliance, as well as ensuring decisions were publicly transparent. Sanctions should have been graduated and commensurate with the severity of the violation, and helped timely remediate noncompliance.

7. Clearly Communicate Requirements And Processes – Effectively communicating requirements to the regulated industry and the public could have helped achieve expected outcomes. Clearly identifying individuals subject to Board regulation and conveying the substance of requirements could have helped ensure compliance. Effective communication could have also helped the public understand expectations and performance.

8. Collect, Monitor, And Analyze Regulatory Program Information – The Board should have designed systematic monitoring and program analysis processes to report accurate, timely, and relevant information to the public and the Legislature. Reporting on program efficiency and effectiveness could have facilitated transparency, demonstrated achievement of outcomes, and informed performance management efforts.

9. Refine Regulatory Program – Board regulation occurred in a complex and dynamic inter-agency, inter-governmental environment, and the dental care industry was dynamic. The Board should have monitored environmental changes for potential effect on the public's health, safety, or welfare. A systematic process should have been designed to periodically refine strategy and continuously refine the regulatory program to meet strategic goals and improve effectiveness and efficiency. The Board should have proposed or adopted needed changes to help ensure its regulatory program operated as intended and achieved expected outcomes.

State policy did not provide for unconstrained regulation of every aspect of the dental care industry. State policy had to clearly underpin the Board's regulatory program. Board development of its regulatory program had to conform to statutory procedures and established limitations on its authority. Overreach by the Board – regulation beyond that authorized by State policy – exposed it to potential federal antitrust scrutiny.

**Observation No. 18**

**Improve Dental Care Industry Regulation**

The Board lacked a structured, evidence- and risk-based approach to rationalizing, implementing, and administering State policy and its supporting regulatory program. Regulation of the dental industry was complex and dynamic. The Board's regulatory program lacked a discernible design to effectively protect the public, and potentially exposed the Board to federal antitrust scrutiny. Regulation was largely subjective, often more restrictive than demonstrated to be necessary, and involved extra-legal and extra-jurisdictional requirements. Nothing demonstrated regulations achieved expected outcomes.

The Board focused primarily on credentialing, to the detriment of monitoring – which was largely reactive – and enforcement – which was the least controlled Board function. Nonetheless, credentialing processes were often perfunctory, and fees gratuitous. Some entry requirements likely infringed on the fundamental rights of some individuals to pursue an occupation. The lack of cohesive regulation adversely affected industry participants and prospective participants.

The Board did not develop comprehensive processes to systematically monitor or analyze its regulatory program, report program results, or routinely refine its strategy and program. The Board did not systematically monitor the dental care industry for changes that could affect public health, safety, or welfare, or that could otherwise affect its regulatory program. Neither did the Board monitor the effect of its regulatory program on the dental care industry. Without accurate and reliable performance information, inefficient, ineffective, and wasteful processes and perfunctory requirements persisted. The Board could not determine whether regulatees consistently complied with requirements or demonstrate the effect of its regulations. Neither could it refine its regulatory program by making risk-based adjustments to requirements or processes.

Our audit work focused on controls and was not designed to audit every aspect of the Board's regulatory program. However, deficiencies underpinned the issues identified with its credentialing, monitoring and enforcement functions. It was the Board's purview to comprehensively review and rationalize its regulatory program with State policy.

**Lack Of Strategy And Oversight Of The Regulatory Program**

The Board did not strategically plan and manage its regulatory program. Consequently, regulation was not designed to achieve outcomes. No controls were in place to ensure the Board's regulatory responsibilities were fully and appropriately integrated into the program. The Board did not utilize data to objectively establish threats to the public, assess the potential costs and benefits of regulation, or demonstrate benefits outweighed costs. It diffused its regulatory responsibilities and inappropriately assigned certain responsibilities to the DHC, the ASEC, the ASEC-AS, the OPLC, and the Department of Justice (DOJ). The Board also inappropriately delegated development and implementation of some aspects of State policy to the OPLC, while aspects of State policy for which the OPLC was responsible remained unimplemented.

Additionally, the Board did not engage other agencies with concurrent jurisdiction to discuss areas of overlapping regulation. This included the Board of Medicine and the Board of Nursing, to coordinate regulation of anesthesia providers. Neither were the Board of Registration of Medical Technicians and the Board of Medical Imaging and Radiation Therapy, engaged to coordinate dental assistant regulations. The Board also did not routinely engage the Pharmacy Board, to coordinate regulation of controlled substances, or the Prescription Drug Monitoring Program, to coordinate controls over controlled substances.

Furthermore, components of the Board's regulatory program lacked oversight or active supervision, and inappropriate regulatory requirements and ad hoc rules were imposed on regulatees and the public. For example, the Board:

- engaged in extra-jurisdictional overreach, regulating individuals or entities over which it had no authority;
- failed to fully implement State policy, leaving potentially risky practices unregulated;
- did not ensure its regulatees were aware of relevant requirements; and
- provided inaccurate or incomplete information to regulatees, the public, and other agencies.

Finally, the Board focused primarily on establishing regulations and developing credentialing processes. However, it was unclear whether requirements were necessary for public protection, and some were perfunctory or counter to State policy. Despite the importance of ensuring ongoing credential holder qualification, the Board established only perfunctory renewal requirements and processes. Some requirements were without basis in State policy, and relied heavily on reactive compliance monitoring, primarily through complaints submitted by the public. When it did identify potential credential holder misconduct, the Board lacked controls to ensure enforcement processes effectively addressed current noncompliance or deterred future noncompliance.

**Levels Of Regulation And Scopes Of Practice Lacked Design**

The Board lacked a control designed to ensure the level of regulation and scope of practice requirements were appropriate. Regulations were not objectively established to be the minimum level necessary for public protection. In some cases, regulations were imposed on individuals or entities outside the Board's authority. Inappropriate regulation, certain expanded scopes of

practice, and overregulation imposed undue costs and an unnecessary regulatory burden. Regulation unsupported by State policy exposed the Board to potential federal antitrust scrutiny. Regulation was a barrier to entry, although the extent to which was not well understood by the Board due to the lack of monitoring and analysis. Resulting inconsistencies are shown in Table 2.

Regulatory decisions were largely subjective. Regulation was discussed and imposed without an assessment as to what potential threats existed, whether threats were serious enough to warrant regulation, and what level of regulation was the minimum level necessary for public protection. At times, members equated addressing purported safety risks to simply knowing who was providing care and ensuring regulatees met what were often third-party qualifications. Rather than imposing higher levels of regulation, such as credentialing, the Board could have opted for lower levels of regulation, such as regulating delegable practices by rule or registering individuals engaged in specific, riskier practices.

Regulation was also sometimes at odds with State policy or rules, as the Board inappropriately expanded regulation through extra-legal actions. The Board could not regulate the industry, require credentialing, or expand a scope of practice without authority. Additionally, while statute authorized credentialing in some areas, it did not require it. This left the Board with discretion to impose credentialing requirements, which it did in all cases, without demonstrating this level of regulation was necessary or monitoring it for effectiveness. Additional credentialing requirements – both with and without underlying authority – were seemingly the Board's solution-of-choice to address expanded hygienist duties. Conversely, dentists, with higher risk practices, had fewer credentialing requirements to address specialization, and the Board knowingly failed to implement statutorily-required permits for administering pediatric minimal sedation.

The Board inappropriately extended regulation through extra-legal rules and practices to public health programs and supervision, dental student programs, and dental residency programs. Programs were required to submit annual reports. However, reports were treated merely as informational, lacked substantive review, and were not used to monitor compliance. Regulation appeared perfunctory.

- Public Health Programs And Public Health Supervision – Statute required health care charitable trusts to notify the Board in writing of the dental clinicals they operated and the supervising dentist. Rules did not clearly implement this requirement. Instead, rules required all programs under public health supervision to notify and have their operation approved by the Board. To the extent health care charitable trusts operated clinics that met the Board's definition of a program under public health supervision, statute authorized notification but not approval of program operations. Additionally, without statutory authority, the Board required notification and approval of hygienists practicing under public health supervision, but not dentists exercising it.

- Dental Student And Dental Residency Programs – Without statutory authority or relevant rules, the Board required notification and acceptance or approval of: 1) dental student programs and dental student interns and externs, but not hygiene student programs or hygiene student interns and externs; and 2) dental residency programs and dental residents.

**Table 2**

**Overview Of The Board's Regulation Of The Dental Care Industry**

| | Level Of Regulation In Practice | Regulation | | | Risk Objectively Established | Regulation Minimum Necessary |
|---|---|---|---|---|---|---|
| | | Authorized By Statute | Required By Statute | Allowed By Rules | | |
| **Primary Credentials** | | | | | | |
| **Dentist, Hygienist** | License | Yes | Yes | Yes | Yes | Yes |
| **Research, Education** | Temporary license | Yes | No | Yes | No | Not established |
| **Volunteer** | Temporary license | Yes | No | Yes | No | Not established |
| **EFDA**[1] | Permit | Yes | No | Yes | No | No |
| **Supplemental Credentials** | | | | | | |
| **General Anesthesia/ Deep Sedation (GA/DS)** | Permit | Yes | Yes | Yes | Partial[2] | Not established |
| **Moderate Sedation (MS)** | Permit | Yes | Yes | Yes | Partial[2] | Not established |
| **Pediatric Minimal Sedation**[3] | None | Yes | Yes | No | Partial[2] | No |
| **Local Anesthesia**[4] | Permit | No | No | Yes | No | Not established |
| **Nitrous Oxide Minimal Sedation**[4] | Permit | No | No | Yes | No | Not established |
| **CPHDH**[5] | Certificate | Yes | No | Yes | No | Not established |
| **Other Regulations** | | | | | | |
| **Dental Assistants**[6] | Occupation generally[7] | No | No | Yes | No | Not established |
| **Dental Specialties** | Notification[7] | No | No | No | No | Not established |
| **Public Health Programs** | Notification and approval[8] | No | No | Yes | No | Not established |
| **Public Health Supervision** | Notification and approval[8] | No | No | Yes | No | Not established |
| **Dental Residency Programs, Residents** | Notification and approval[8] | No | No | No | No | Not established |
| **Dental Student Programs, Students** | Notification and approval[8] | No | No | No | No | Not established |
| **Use Of Botulinum Toxin, Dermal Filler** | Notification and acceptance | No | No | No[9] | No | Not established |

Notes:
1. The Board regulated Expanded Function Dental Auxiliaries (EFDA) solely by rule starting in October 2013, until obtaining statutory authority in August 2018. Regulation appeared to result from economic considerations.
2. The regulatory decision was informed by potential risks identified in other jurisdictions.
3. Statute required a dentist pediatric minimal sedation permit, but the Board implemented none.
4. Rules established qualifications for hygienists to administer local anesthesia or nitrous oxide minimal sedation. Permitting was not a condition of qualification, but permits were required in practice.
5. Hygienists without a CPHDH credential were also able to practice under public health supervision, but with fewer duties.
6. Rules broadly regulated dental assistant practice and qualifications and exceeded statutory authority.
7. Board regulation included specific third-party certification requirements.
8. Board action included acceptance or approval of notifications.
9. Rules required dentists to provide training records if they wished to administer these drugs.

Source: LBA analysis of the Board's regulatory program.

The Board also imposed extra-legal regulation on certain scopes of practice and dental care industry participants.

- Use Of Botulinum Toxin Or Dermal Filler – Rules required dentists to provide documentation of relevant training before administering botulinum toxin or dermal filler. However, without statutory authority or rules, the Board also at times accepted notifications. There were no practice standards, eligibility maintenance requirements, or monitoring of practice, making this extra-legal regulation perfunctory.

- Businesses And Training Providers – The Board inappropriately voted on whether some dental businesses could operate in the State. The Board also inappropriately regulated some dental assistant training, education, and examination providers through rules.

Furthermore, the Board extended its regulatory scope through extra-jurisdictional regulation of professions under the sole jurisdiction of other agencies. The Board could not adopt rules under another agency's authority and no requirement was valid or enforceable unless it had been properly adopted as a rule. However, the Board inappropriately regulated anesthesiologists licensed by the Board of Medicine and nurse anesthetists licensed by the Board of Nursing.

**Regulatory Requirements Lacked Design**

There was no discernible design to Board requirements for entry, practice, and eligibility maintenance. The Board was to review all regulatory requirements in calendar year (CY) 2017. For each requirement, the Board was to evaluate whether it was required by law or was essential to public protection. The Board reported being unaware of the requirement, and there was no record such a review was conducted. Failure to implement State policy contributed to ongoing deficiencies with the Board's regulatory requirements and exposed it to potential federal antitrust

scrutiny. Some requirements were inconsistent and seemingly arbitrary. Other requirements relied in whole or in part upon third-party standards. In any case, the Board did not clearly consider potential barriers to entry or other effects when establishing requirements. Furthermore, the Board outsourced development of dentist permit requirements to the ASEC. To address gaps in rules, the Board, the ASEC, and staff imposed ad hoc requirements on applicants and credential holders. These actions also exposed the Board to potential federal antitrust scrutiny.

***Inappropriate Limitation Of Eligible Applicants And Regulatees***

The Board could not expand or limit statutory definitions affecting the scope of who could pursue an occupation, but did so nonetheless. These extra-legal actions likely infringed on the fundamental rights of individuals to pursue an occupation.

- Hygienist Licensure – Statute allowed hygienists to be dental hygiene or dentistry school graduates. However, rules and external instructions limited hygienists to dental hygiene school graduates. The Board additionally prohibited dentists from converting a dentist license to a hygienist license without completing hygienist-specific requirements. This despite dentists supervising and delegating duties to hygienists in order for hygienists to practice. We found this effectively denied one long-practicing dentist a hygienist license.

- EFDA Permits – Statute provided any dental assistant could become an EFDA. However, rules limited eligible dental assistant applicants for an EFDA permit to certified and graduate dental assistants.

- Local Anesthesia Permits – Statute did not provide for hygienist local anesthesia permits, and rules merely allowed permits to be issued to qualified hygienists who requested one. However, in practice, the Board required hygienists obtain permits to administer local anesthesia.

- Nitrous Oxide Minimal Sedation Permits – Statute did not provide for hygienist nitrous oxide minimal sedation permits, merely requiring qualification to allow administration. Rules specified permits were to be issued only to hygienists who qualified after January 2018. However, in practice, the Board required any hygienist obtain a permit to administer nitrous oxide.

- Dental Assistants – Certain rules exceeded the Board's statutory authority, effectively creating a highly regulated occupation, albeit without a State-issued credential.

***Incoherent Approach To Entry Requirements***

The Board lacked a cohesive approach to establishing entry requirements. Inconsistencies are shown in Table 3. Entry requirements were a barrier to practice and should have ensured applicants had a minimum level of competency to practice. Requirements were created by statute or the Board, but many were perfunctory, unimplemented, or unenforceable.

**Table 3**

**Overview Of Inconsistencies In Statutory And Rule-based Entry Requirements**

| | Education | Experience | Training | Examinations | | | Continuing Education | Character, Conduct | Inspections |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Didactic | Clinical | Jurisprudence | | | |
| **Primary Credentials** | | | | | | | | | |
| **Dentist, Hygienist** | Yes | Yes[1] | Yes[1] | Yes | Yes | Yes[2] | Yes[2] | Yes[2] | No |
| **Research, Education** | Yes | Yes | Yes | Yes | Yes | Yes[3] | Yes[3] | Yes[2] | No |
| **Volunteer**[4] | No | Yes | No | No | No | No | Yes[3] | Yes[2] | No |
| **EFDA** | Yes | Yes[1] | Yes | No | No | No | Yes[3] | Yes[2] | No |
| **Supplemental Credentials** | | | | | | | | | |
| **GA/DS**[5] | Yes[2] | No | No | No | No | No | Yes[3,6] | No | Yes |
| **MS**[5] | Yes[2] | No | No | No | No | No | Yes[3] | No | Yes |
| **Pediatric Minimal Sedation** | Yes[7] | No | No | No | No | No | Yes[3] | No | No |
| **Local Anesthesia** | No | Yes[1] | Yes | Yes[2] | No | No | No | No | No |
| **Nitrous Oxide Minimal Sedation** | No | Yes[1] | Yes | Yes[2] | Yes | No | No | No | No |
| **CPHDH** | Yes[2] | Yes[2] | Yes | No | No | No | No | No | No |
| **Other Regulations** | | | | | | | | | |
| **Dental Assistants** | Yes[2] | Yes[2] | Yes[2] | Yes[2] | No | No | Yes[2] | No | No |
| **Dental Specialties** | No | No | No | No | No | No | No | No | No |
| **Public Health Programs** | No | No | No | No | No | No | No | No | No |
| **Public Health Supervision** | No | No | No | No | No | No | No | No | No |
| **Dental Residency Programs, Residents**[8] | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| **Dental Student Programs, Students**[8] | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| **Use Of Botulinum Toxin, Dermal Filler** | No | No | Yes[2] | No | No | No | No | No | No |

Notes:
[1.] Requirement was only applicable for application by endorsement.
[2.] Requirement was perfunctory.
[3.] Requirement was in statute or rules, but not implemented in practice.
[4.] Temporary volunteer license applicants met reduced requirements compared to regular license applicants, although both licensees actively practiced without limitations or restrictions.
[5.] Permitted dentists could administer GA/DS or MS before completing a comprehensive evaluation.
[6.] Statute allowed the Board to consider requiring residency training as an entry requirement for GA/DS permits. No requirement was imposed, but there was no indication such a requirement had been assessed and determined to be unnecessary.
[7.] Rules referred to third-party guidelines, which contained ambiguous requirements for educational programs teaching the administration of minimal sedation. Standards were not specific to pediatric minimal sedation.
[8.] Statute required dental students and residents to practice with a regular license and meet corresponding entry requirements. Requirements were unimplemented.

Source: LBA analysis of entry requirements.

*Unimplemented Military And Incomplete Federal Service Requirements*

State policy required licensing be facilitated for current and former members of the military. However, the Board and staff were aware required rules and enabling processes were not implemented. Since August 2014, the Board was required to accept military education, training, or service toward qualifications required for credentialing, upon presentation of satisfactory evidence. The Board was required to, but did not, develop rules regarding acceptable military education, training, or service, and the types of evidence to be provided.

Additionally, licensees serving on active military duty were exempt from the requirement to actively practice in the State to maintain an active license. However, similar accommodations were not made for licensees serving with the U.S. Public Health Service Commissioned Corps or other federal agencies, who were also required to maintain an active license but practiced out-of-state. Such a license in New Hampshire required active, in-state practice.

*Inconsistent Didactic And Clinical Examination Requirements*

Didactic and clinical examination requirements were a potential barrier to entry for new applicants and practitioners from other jurisdictions. Requirements did not clearly address public protection risks. Instead of systematically assessing examinations, the Board episodically relied on an improvised committee or discussions in meetings to decide whether an examination not specified in rules was acceptable. This often occurred seemingly without investigating the comparability of examinations.

*Inadequate Jurisprudence Examination Requirements*

Jurisprudence examinations did not clearly address risks to public protection. Jurisprudence examinations should have tested applicants' knowledge of State laws and Board rules. Examinations should have provided assurance credential holders were familiar with laws and rules regulating their occupation. However, the Board required only applicants for regular licensure or reinstatement pass a jurisprudence examination. Examinations were not required for other credentials or expanded scopes of practice despite the higher risks. Neither were examinations required for renewals or reactivations, despite regular changes to statute and rules.

The Board lacked oversight of jurisprudence examination effectiveness. The Board did not determine whether the examination adequately ensured licensees were familiar with and understood their obligations. Examinations were "open book" and could be taken as many times as necessary for an applicant to pass. However, the Board did not monitor pass or fail rates, scores, or the number of times applicants had to take the examination to pass. Neither did the Board demonstrate jurisprudence examinations accomplished their intended outcome, or refine questions based on requirements that were unclear or unknown to credential holders. Dentist and hygienist applicants completed the same examination with the same questions, regardless of relevance. Questions did not address the requirements of other regulatory entities with which licensees were to comply. This included Pharmacy Board, Board of Registration of Medical Technicians, Board of Medical Imaging and Radiation Therapy, and Prescription Drug Monitoring Program requirements. Furthermore, the Board lacked controls to use noncompliance information to improve jurisprudence examinations and ensure questions comprehensively addressed higher risks identified through its monitoring and enforcement processes.

*Inadequately Controlled Dental Specialty Requirements*

Dental specialties were incompletely controlled and were without objective demonstration of an underpinning threat to public protection warranting the few controls implemented. Since July 2000, qualified dentists could advertise their area of specialization. In February 2019, the Board approved another state's list of nine specialties and allowed for other specialties if the awarding post-doctoral programs were accredited. The Board later approved a tenth specialty. Board policy on approved specialties was memorialized only in public meeting minutes.

Rules required applicants for an initial regular dentist license to provide evidence of specialty education. However, there were no requirements specifying who was to verify evidence was sufficient for a dentist to be considered "qualified." The Board did not establish minimum requirements for qualifying as a specialist, and rules lacked criteria for accepting specialty training certificates. In practice, staff inconsistently required proof of specialty training be provided during initial license application, prior to assigning dentist specialties. Neither did the Board use dentist specialty information to proactively monitor compliance with statutory advertising requirements. Members rationalized the collection of information as being necessary in case there was a complaint. However, the information collected was incomplete. The Board never established requirements or processes for dentists to submit specialty certification evidence outside the initial license application process.

Conversely, hygienist expanded duties were specified in statute or rules. Expanded duties were regulated through the imposition of additional credentials for EFDA or CPHDH practice and extra-legal credentials for administration of local anesthesia or nitrous oxide minimal sedation. However, all similarly lacked demonstration of a threat to public protection warranting regulation, and demonstration regulations effectively mitigated purported risks.

***Barriers To Credential Portability And Expedited Processing***

The Board lacked a comprehensive approach to credential portability and expedited application processing, resulting in noncompliance and barriers to entry for practitioners from other jurisdictions. Entry requirements could vary widely across jurisdictions. However, inconsistencies affected the ability of some individuals deemed competent in other jurisdictions to transfer their qualifications to, and to practice in, New Hampshire, or made doing so more costly. State policy broadly required portability, and the Board's regulatory framework should have comprehensively integrated approaches to improve portability.

- **Portability** was the ability of individuals who were qualified to practice in one jurisdiction to transfer their qualifications to another jurisdiction. Portability could facilitate workforce mobility and reduce the time qualified individuals needed to obtain a credential. Approaches to increase portability included reciprocity agreements between jurisdictions, temporary credentials allowing individuals to work while their regular credential applications were being processed, and endorsement.

- **Endorsement** was expedited credentialing for applicants practicing in other jurisdictions where the Board determined credentialing requirements were substantially equivalent to or higher than New Hampshire's.

Since January 2018, State policy required the Board to publish information to facilitate portability, including a list of states with requirements equal to, or greater than, Board requirements. Published information was to clearly identify how individuals credentialed elsewhere could obtain a Board credential. However, required information was not published. There was no indication the Board reviewed other states' requirements or determined whether requirements were at least substantially equivalent. The Board did not enter into reciprocity agreements, formalize agreements specifying how credentials were to be recognized by multiple jurisdictions, or consider pursuing such agreements.

The Board inconsistently implemented endorsement processes, as shown in Table 4. Neither the Board nor management monitored the actual number of endorsement or examination applications submitted. While staff informally estimated one percent of regular license applications were submitted for endorsement, we found at least 4.9 percent of the applications during SFYs 2019 and 2020 were endorsement applications.

**Table 4**

**Overview Of Inconsistencies In Endorsement Requirements And Processes**

| | Authorized By Statute | Allowed By Rule | Processes Implemented | Requirements Reduced | Qualification Expedited |
|---|---|---|---|---|---|
| **Primary Credentials** | | | | | |
| **Dentist, Hygienist** | Yes | Yes | Yes[1] | No | No |
| **Research, Education** | Yes | Yes | Yes | No | No |
| **Volunteer** | Yes | No | No | n/a | n/a |
| **EFDA** | No | Yes | No | n/a | n/a |
| **Supplemental Credentials** | | | | | |
| **GA/DS** | Yes | No | No | n/a | n/a |
| **MS** | Yes | No | No | n/a | n/a |
| **Local Anesthesia** | No | Yes | Yes[2] | No | No |
| **Nitrous Oxide Minimal Sedation** | No | Yes | Yes[2] | No | No |
| **CPHDH** | No | No | No | n/a | n/a |
| **Other Regulations** | | | | | |
| **Dental Assistants** | No | Yes | No[3] | n/a | n/a |
| **Dental Specialties** | No | No | No | n/a | n/a |
| **Public Health Programs** | No | No | No | n/a | n/a |
| **Public Health Supervision** | No | No | No | n/a | n/a |
| **Dental Residency Programs, Residents** | No | No | No | n/a | n/a |
| **Dental Student Programs, Students** | No | No | No | n/a | n/a |
| **Use Of Botulinum Toxin, Dermal Filler** | No | No | No | n/a | n/a |

Notes:
1. The Board implemented general endorsement requirements but did not implement requirements specific to members of the military or their spouses.
2. Permitting by endorsement requirements were improvised in practice.
3. Dental assistants did not apply to the Board for approval of qualifications.

Source: LBA analysis of endorsement requirements and processes.

In practice, there was no meaningful distinction between regular licensure by endorsement or by examination. Applicants for licensure were required to submit the same application and registration forms, provide the same supplemental materials, and undergo the same review process regardless of how they applied. There were no indications practitioners from other jurisdictions applying by endorsement were issued a license at less cost or sooner than they otherwise would have been. The Board did not monitor for such results, and available data could not be used to determine the differences in application or processing cost or time. Additionally, endorsement qualifications were inconsistent.

- Practitioners From Other Jurisdictions – Applicants from other jurisdictions faced additional barriers. Unimplemented statutory portability requirements affected individuals qualified in U.S. territories. The Board had not established specific licensure by endorsement criteria for applicants from U.S. territories or Canada. Neither could endorsement applicants with clinical experience in foreign jurisdictions substitute experience for requirements. Conversely, Canadian licensees could be issued temporary volunteer licenses to serve a public health program, and Canadian dentists could consult with New Hampshire dentists without needing a New Hampshire license.

- Active Military Service – Active military service could be substituted for qualifications by dentists. Service as a hygienist or dental assistant could not.

- Military Spouses – The Board and staff were aware required rules and processes to facilitate portability for military spouses were unimplemented. Since August 2014, the Board was required to facilitate licensure for applicants licensed in another state whose spouse was a member of the military. This process was to include licensure if requirements were substantially equivalent. The Board was to develop rules on procedures and the type of evidence to be provided. The Board did not adopt required rules, establish what constituted satisfactory evidence, establish how substantially equivalent was to be determined, or otherwise structure this process

***Inadequate And Perfunctory Eligibility Maintenance Requirements***

The Board similarly lacked an approach to demonstrate eligibility maintenance requirements were at the level necessary for public protection. Some appeared substantial for certain credentials and scopes of practice but minimal or nonexistent for others, without a clear rationale, as shown in Table 5. Furthermore, verification of eligibility maintenance requirements was limited, making renewal largely perfunctory.

**Table 5**

**Overview Of Inconsistencies In Statutory And Rule-based Eligibility Maintenance Requirements**

| | Refresher Training | Refresher Examination | Continuing Education | Character, Conduct | Other |
|---|---|---|---|---|---|
| **Primary Credentials** | | | | | |
| **Dentist, Hygienist** | Yes[1] | Yes[1] | Yes[1,2,3,4] | Yes[1,2,3,4] | No |
| **Research, Education** | No | No | No | No | No |
| **Volunteer**[5] | No | No | Yes | No | No |
| **EFDA** | No | No | Yes[6] | No | No |
| **Supplemental Credentials** | | | | | |
| **GA/DS** | No | No | Yes[6] | No | Yes[7] |
| **MS** | No | No | Yes[4] | No | Yes[7] |
| **Local Anesthesia** | No | No | No | No | No |
| **Nitrous Oxide Minimal Sedation** | No | No | No | No | No |
| **CPHDH** | No | No | Yes[6] | No | Yes[4,8] |
| **Other Regulations** | | | | | |
| **Dental Assistants** | No | No | No | No | No |
| **Dental Specialties** | No | No | No | No | No |
| **Public Health Programs** | No | No | No | No | No |
| **Public Health Supervision** | No | No | No | No | No |
| **Dental Residency Programs, Residents** | No | No | No | No | No |
| **Dental Student Programs, Students** | No | No | No | No | No |
| **Use Of Botulinum Toxin, Dermal Filler** | No | No | No | No | No |

Notes:
1. Requirement only for reactivation of an inactive license.
2. Requirement for reinstatement of a lapsed license.
3. Requirement for renewal.
4. Requirement was perfunctory.

[5.] Temporary volunteer licensees lacked competency requirements similar to regular licensees, even though both actively practiced without limitations or restrictions on their license.
[6.] Requirement was authorized by statute or adopted in rules, but not implemented in practice.
[7.] Permittees had to complete comprehensive evaluations within eight months of permit issuance and at least once every five years thereafter. Comprehensive evaluations were the only time an agent of the Board directly observed the competency of any credential holder.
[8.] CPHDHs could practice without a dentist present if an agreement with the supervising dentist was in place and the dentist reviewed records annually.

Source: LBA analysis of eligibility maintenance requirements.

***Incoherent Controls Over Dentists Performing Only Non-clinical Duties***

The Board lacked a clear and cohesive approach to regulating dentists performing non-clinical duties. Some State regulatory agencies issued non-clinical licenses to practitioners not providing direct patient care, but the Board had not developed similar provisions. Consequently, the Board inconsistently handled licensure of these dentists.

- Unclear Framework – Statute did not clearly provide for a non-clinical license for dentists performing only non-clinical duties. Neither did statute or rules address "restricted" or "limited" licenses except in a disciplinary context. The statutory scope of practice included clinical and non-clinical duties. Statute also specified licensees who did not actively practice between renewals had to hold an inactive license but did not clearly define "active practice." In CY 2015, the Board defined active practice inappropriately by using a declaratory ruling, without adopting relevant rules.

- Inconsistent Treatment Of Applicants – The Board considered a proposal for restricted regular licenses for non-clinical duties in October 2017, but no further action was taken. The Board issued a limited license to one dentist performing only non-clinical duties in March 2018. However, in April 2020, the Board issued a regular license by endorsement to a second dentist performing only non-clinical duties, despite being ineligible for licensure by endorsement.

- Unclear Application Of Active And Inactive License Requirements – In practice, licensees performing only non-clinical duties remotely out-of-state could renew as active for their first renewal, resulting in an active regular license for up to four years. However, these licensees had to renew as inactive in second and subsequent renewals. Licensees performing only non-clinical duties in-state, including through telemedicine after July 2020, could potentially hold an active license indefinitely.

- No Controls Over Competency – The Board did not establish a means to ensure active licensees performing only non-clinical duties were competent should they return to providing direct patient care. In contrast, licensees seeking to reactivate or reinstate a license had to submit evidence of competency to return to active status.

**Inadequate Control Over Regulatory Processes And Practices**

The Board did not adequately develop or monitor regulatory processes, resulting in noncompliance and inconsistency in practice. Neither did the Board clearly consider complexity or administrative efficiency when developing requirements.

***Inadequate Control Over Credentialing Processes***

Initial credential application processes were largely perfunctory, lacking demonstrated value and required Board action, as shown in Table 6. Consequently, the Board undermined the validity of most issued credentials. Review processes inconsistently ensured applicants were qualified to practice. Staff were informally delegated responsibility to ensure required application questions were answered and documents submitted. Substantive evaluation followed to ensure applicants met credentialing requirements. However, the Board inconsistently conducted substantive evaluations and rarely made credentialing decisions. It improperly delegated its collective, discretionary authority to individual Board or subordinate entity members or staff. Applications for 459 of 504 initial credentials issued during the audit period (91.1 percent) were issued without Board action. This included 197 (42.9 percent) that were never reviewed by the Board.

***Inadequate Control Over Monitoring Processes***

The Board focused on credentialing, to the detriment of monitoring. Monitoring processes did not ensure regulatees maintained competency and eligibility to practice. Processes were inconsistent across credentials without demonstrated rationale. The Board relied primarily on perfunctory renewal processes and complaint submissions, leaving monitoring largely reactive and at odds with State policy. Implemented renewal processes lacked demonstrated value, statutory basis, or required Board action, as shown in Table 7.

Staff were informally delegated responsibility for monitoring regulatee compliance through credential renewals and complaints processing. However, staff did not always provide the Board with information on regulatee noncompliance. Applicants and credential holders who did not meet entry or eligibility maintenance requirements were issued an initial or renewal credential. The Board rarely conducted substantive evaluations or made renewal decisions, generally inappropriately delegating its decision-making authority to staff. The Board reviewed only three of 3,089 renewal applications (0.1 percent) for credentials issued during the audit period before the credential was renewed. Practice requirements were also largely perfunctory. There were no controls to consistently and proactively monitor many licensee practice requirements, and some could not be monitored.

**Table 6**

**Overview Of Initial Application Review And Decision Practices**

| | Responsible For Application Review | Aspects Were Perfunctory | Responsible For Regulatory Decision |
|---|---|---|---|
| **Primary Credentials** | | | |
| **Dentist, Hygienist** | Staff and Board member | Yes | Staff |
| **Research, Education** | Staff | Yes | Staff |
| **Volunteer** | Staff | Yes | Staff |
| **EFDA** | Staff or DHC or Board member | Yes | Board member |
| **Supplemental Credentials** | | | |
| **GA/DS** | Staff and ASEC member[1] | Yes | Board[2] |
| **MS** | Staff and ASEC member[1] | Yes | Board[2] |
| **Local Anesthesia** | Staff or DHC or Board member | Yes | Staff and DHC or Board member |
| **Nitrous Oxide Minimal Sedation** | Staff or DHC or Board member | Yes | Staff and DHC or Board member |
| **CPHDH** | DHC member | Yes | Board member |
| **Other Regulations** | | | |
| **Dental Assistants[3]** | n/a | n/a | n/a |
| **Dental Specialties** | Staff | Yes | Staff |
| **Public Health Programs** | Staff | Yes | Board |
| **Public Health Supervision** | Staff | Yes | Board |
| **Dental Residency Programs, Residents** | Staff | Yes | Board |
| **Dental Student Programs, Students** | Staff | Yes | Board |
| **Use Of Botulinum Toxin, Dermal Filler** | Board or Board member[4] | Yes | Board or Board member[4] |

Notes:
1. Staff evaluated application forms, while ASEC members conducted facility inspections.
2. Board action was based on ASEC Chair recommendations.
3. The Board lacked any controls to ensure dental assistants met rule-based entry requirements.
4. Board acceptance inconsistently occurred in practice, and individual members reviewed training documents.

Source: LBA analysis of initial application review and decision practices.

**Table 7**

**Overview Of Renewal Processes And Practices**

| | Renewal Frequency, In Practice | Renewal | | Responsible For Application Review | Aspects Were Perfunctory | Responsible For Regulatory Decision |
|---|---|---|---|---|---|---|
| | | Authorized By Statute | Allowed By Rule | | | |
| **Primary Credentials** | | | | | | |
| **Dentist, Hygienist** | Two years | Yes | Yes | Staff or automated[1] | Yes | Staff or automated[1] |
| **Research, Education** | One year or program end[2] | No[2] | Yes | Staff | Yes | Staff |
| **Volunteer** | One year[2] | No[2] | Yes | Staff | Yes | Staff |
| **EFDA** | Two years[3] | No[3] | Yes | Staff and DHC member | Yes | Staff |
| **Supplemental Credentials** | | | | | | |
| **GA/DS** | Two years[4] | No | Yes | Automated | Yes | Automated |
| **MS** | Two years[4] | No | Yes | Automated | Yes | Automated |
| **Local Anesthesia** | Two years[4] | No | No | Unclear[5] | Yes | Automated[5] |
| **Nitrous Oxide Minimal Sedation** | Two years[4] | No | No | Unclear[5] | Yes | Automated[5] |
| **CPHDH** | Two years[4] | Yes | Yes | Automated[6] | Yes | Automated[6] |
| **Other Regulations** | | | | | | |
| **Dental Assistants** | None | n/a | n/a | n/a | n/a | n/a |
| **Dental Specialties** | None | n/a | n/a | n/a | n/a | n/a |
| **Public Health Programs** | None[7] | n/a | n/a | n/a | n/a | n/a |
| **Public Health Supervision** | None[7] | n/a | n/a | n/a | n/a | n/a |
| **Dental Residency Programs, Residents** | None[7] | n/a | n/a | n/a | n/a | n/a |
| **Dental Student Programs, Students** | None[7] | n/a | n/a | n/a | n/a | n/a |
| **Use Of Botulinum Toxin, Dermal Filler** | None | n/a | n/a | n/a | n/a | n/a |

Notes:
1. Certain defective licenses renewed online were identified by the credentialing database management system for staff to review.
2. Temporary licensees were not required to obtain a regular license. In practice, they could maintain their temporary license indefinitely by renewing annually.
3. Rules required renewal before May 1 in odd-numbered years but did not establish a renewal process.
4. Credentials should have been, but inconsistently were, coterminous with an individual's license.
5. The renewal process was not clear. In practice, if the license was renewed, the permit was also typically renewed.
6. Renewal was concurrent with the renewal of the hygienist's license. Renewal required reporting updated contact information and payment of an additional CPHDH-specific renewal fee. If the license was renewed and the additional fee paid, the permit was also renewed.
7. Had only an annual reporting requirement.

Source: LBA analysis renewal processes and practices.

***Inadequate Control Over Enforcement Processes***

The Board focused on credentialing, to the detriment of enforcement, which was the Board's least controlled function. Poor design around enforcement controls – and deficiencies with monitoring processes to identify potential noncompliance – compromised the Board's ability to effectively protect the public. Enforcement processes inconsistently ensured potential noncompliance was investigated, contested cases were adjudicated, and regulatees found noncompliant were sanctioned and subsequently monitored for compliance. Staff were formally and informally delegated some enforcement responsibilities. However, a lack of support and resources reportedly prevented some investigations from being conducted and some required adjudicative proceedings from occurring in a timely manner, or at all. This also produced difficulties with following up on prior decisions and adequately monitoring sanctions to ensure compliance.

The regulatory framework focused primarily on specific acts of licensee misconduct, not on regulatee compliance more generally. State policy required investigations of certain licensees and dentist permittees, allowed for investigations of all licensees, and established numerous ways in which a licensee could be sanctioned for misconduct. Sanctions for other regulatees were limited to a temporary suspension of their credential or other privilege in cases involving imminent danger to life or health. However, this applied only to regulations authorized by *Dentists and Dentistry*, leaving other regulatees, such as dental assistants, outside the enforcement framework altogether.

**Recommendations:**

**We recommend the Board improve controls over its regulatory program, and:**

1. **develop a cohesive, evidence- and risk-based regulatory strategy and supporting plans with input from relevant regulatory entities and stakeholders;**
2. **objectively demonstrate threats to public protection exist and are serious enough to warrant regulation, assess potential costs and benefits of regulation, and**

**identify the minimum level of regulation necessary to address threats without imposing an undue burden;**

3. **adhere to statutory requirements when establishing regulations and scopes of practice, ensure all statutory requirements are implemented, discontinue regulation without statutory authority, and seek necessary statutory authority to impose regulations or expand scopes of practice only after the necessity for doing so has been objectively demonstrated;**
4. **ensure entry, practice, and eligibility maintenance requirements are clear, consistently applied, necessary for public protection, and at the minimum level necessary without creating undue burden;**
5. **ensure existing and proposed regulatory processes are effective, efficient, and include reasonable steps to verify credential holders meet regulatory requirements, and address or discontinue perfunctory, wasteful, and gratuitous processes or requirements;**
6. **establish routine processes to monitor and evaluate the regulatory program, identify the information necessary for monitoring, and ensure collection of timely and reliable information;**
7. **routinely report accurate, timely, and relevant program information on performance and attainment of expected outcomes to the public; and**
8. **routinely review strategy and the regulatory program to identify changes needed to ensure the regulatory program is operating as intended and achieving expected outcomes.**

**We additionally recommend the Board:**

9. **consider establishing a process for dentists to obtain a hygienist license;**
10. **consider seeking statutory authority to expand active practice exemptions to include licensees serving with the U.S. Public Health Service Commissioned Corps or for other government service;**
11. **improve controls over examinations, systematically assess didactic and clinical examinations for comparability with existing requirements, and ensure jurisprudence examinations address relevant regulatory requirements and are tailored for specific credentials;**
12. **discontinue requirements applicants provide dental specialty-related records;**
13. **seek statutory authority to establish a non-clinical license for individuals practicing only non-clinical dentistry, and develop and implement policy, procedure, and rules addressing non-clinical dentistry, to include establishing how many non-clinical credential holders are licensed in the State and mechanisms to ensure competency should they return to clinical practice;**
14. **seek statutory changes to improve licensure by endorsement requirements, such as by allowing individuals with active military service as a hygienist to qualify;**
15. **address licensure by endorsement application requirements and processes to ensure there is a meaningful distinction from licensure by examination, and that it actually facilitates expedient State licensure for individuals licensed in other jurisdictions; and**
16. **ensure credentialing by endorsement accomplishes intended outcomes.**

Board Response:

*We concur with the recommendations.*

1. *We concur with the recommendation to develop a cohesive, evidence- and risk-based regulatory strategy and supporting plans with input from other relevant regulatory entities and stakeholders.*

   *The Board has always made an effort to work with other regulatory agencies as needed. For instance, when the Prescription Drug Monitoring Program was developed, the Board worked with the Board of Medicine and Pharmacy Board. Similarly, when the hygiene prescription writing rules were developed, the Board worked with the Pharmacy Board.*

2. *We concur with the recommendation to objectively demonstrate threats to public safety, assess potential costs and benefits of regulation, demonstrate threats are serious enough to warrant regulation, and identify the minimum level of regulation necessary to address threats without imposing an undue harsh burden.*

   *The Board concurs with the recommendation that threats to public safety and costs and benefits of regulation should be established prior to implementing any regulatory policy and the minimum level of regulation necessary should be identified. The Board will continue to follow this recommendation as future regulations are proposed.*

3. *We concur with the recommendation to adhere to statutory requirements when establishing regulations and scopes of practice and ensure all statutory requirements are implemented, discontinue regulation without statutory authority, and seek necessary statutory authority to impose regulations or expand scopes of practice only after the necessity for doing so has been objectively demonstrated.*

   *The Board will work with the OPLC to make sure that all rules are in compliance with statute and all requirements are implemented.*

4. *We concur with the recommendation to ensure entry, practice, and competency maintenance requirements are clear, consistently applied, necessary for public protection, and at the minimum level necessary without creating undue burden.*

   *The Board will collaborate with the OPLC and begin the rulemaking process to make these requirements clear and uniform.*

5. *We concur with the recommendation to ensure existing and proposed credentialing processes are effective, efficient, and take reasonable steps to verify practitioners meet regulatory requirements, and address or discontinue perfunctory, wasteful, and gratuitous processes or requirements.*

6. *We concur with the recommendation to establish routine processes to monitor and evaluate the regulatory program, identify data and information necessary for monitoring, and ensure collection of timely and reliable data and information.*

7. *We concur with the recommendation to routinely report accurate, timely, and relevant program information on performance and attainment of expected outcomes to the public.*

8. *We concur with the recommendation to routinely review strategy and the regulatory program to identify changes needed to ensure the regulatory program is operating as intended and achieving expected outcomes.*

   *The Board anticipates initiating the rulemaking process to address issues identified in the audit.*

9. *We concur with the recommendation to consider establishing a process for dentists to obtain a hygienist license.*

10. *We concur with the recommendation to consider seeking statutory authority to expand active practice exemptions to include licensees serving with the U.S. Public Health Service Commissioned Corps or for other government service.*

    *The Board will have to deliberate which other government service should be included.*

11. *We concur with the recommendation to improve controls over examinations, systematically assess didactic and clinical examinations for comparability with existing requirements, and ensure jurisprudence examinations address relevant regulatory requirements and are tailored for specific credentials.*

12. *We concur with the recommendation to discontinue requirements applicants provide dental specialty-related records.*

    *The Board will consider the recommendation to discontinue requiring the applicants to provide dental specialty-related records. If after deliberation the Board finds that specialty information is not needed then it will cease to collect that information, but if the Board feels that specialty information is needed for any reason then it will seek statutory changes to make it possible for the Board to collect the information needed.*

13. *We concur with the recommendation to seek statutory authority to establish a non-clinical licensure process for individuals practicing non-clinical dentistry, and develop and implement policy, procedure, and administrative rules addressing non-clinical dentistry, to include establishing how many non-clinical practitioners are licensed in the State and mechanisms to ensure competency should they return to regular practice.*

    *Currently rule addresses the restricted license.*

**<u>LBA Rejoinder</u>: The Board's rules inappropriately extended its statutory authority. Statute allowed the Board to take disciplinary action, including by limiting or restricting a license. The Board had no other statutory authority to restrict licenses, such as limiting practice to non-clinical dentistry for an otherwise qualified licensee.**

14. *We concur with the recommendation to seek statutory changes to improve licensure by endorsement requirements, such as by allowing individuals with active military service as a hygienist to qualify.*

15. *We concur with the recommendation to address licensure by endorsement application requirements and processes to ensure there is a meaningful distinction from licensure by examination, and that it actually facilitates expedient State licensure for individuals licensed in other jurisdictions.*

16. *We concur with the recommendation to ensure credentialing by endorsement accomplishes intended outcomes.*

## CHAPTER THREE
## CREDENTIALING

Credentialing was intended to ensure individuals seeking permission to practice in the State were qualified. The State required primary credentials for certain dental care industry participants to enter practice. It further regulated certain scopes of practice by requiring either supplemental credentials, or delegation and supervision of specific duties by a licensed dentist. Individuals had to meet competency, character, and acceptable past conduct requirements to help protect the public health, safety, and welfare from unqualified, unscrupulous, or impaired practitioners. Requirements were a proactive control over credential holders and were intended to help ensure applicant competency before the public health, safety, and welfare was adversely affected.

A primary Board of Dental Examiners' (Board) responsibility was to make decisions on credential applications to determine whether applicants were qualified to practice. The Office of Professional Licensure and Certification (OPLC) was responsible for efficient administration of credential processes and related duties. For example, staff were to establish application completeness according to Board standards. The Board was then to consistently review applicants' substantive qualifications to determine whether they met entry requirements. As of June 14, 2021, there were 2,630 active primary credentials and 1,188 active supplemental credentials.

### Primary Credentials

Licenses were required for dentists and hygienists. This included regular dentist and hygienist licenses and temporary dentist and hygienist licenses for: 1) clinical education, 2) research, and 3) public health programs. Permits were also required to allow hygienists or dental assistants to work as Expanded Function Dental Auxiliaries (EFDA). Table 8 summarizes the total number of primary credentials by status. Table 9 summarizes the initial primary credentials issued from State fiscal year (SFY) 2018 through SFY 2021.

**Table 8**

**Total Primary Credentials And Statuses, As Of June 14, 2021**

| | Credential Status | | | | | |
|---|---|---|---|---|---|---|
| | Active | Inactive | Lapsed | Suspended | Other[1] | **Total[2,3]** |
| **Regular Dentist** | 1,178 | 194 | 1,550 | 1 | 143 | **3,066** |
| **Regular Hygienist** | 1,430 | 200 | 960 | 1 | 102 | **2,693** |
| **Temporary Research, Education[4]** | 0 | 0 | 1 | 0 | 0 | **1** |
| **Temporary Volunteer[4]** | 1 | 0 | 10 | 0 | 1 | **12** |
| **EFDA** | 21 | 0 | 4 | 0 | 1 | **26** |
| **Total** | **2,630** | **394** | **2,525** | **2** | **247** | **5,798** |

Notes:
1. Other statuses included: 102 deleted, 75 pending, 38 retired, 16 withdrawn, five deceased, five voluntary surrender, two denied, two active-pending renewal, one revoked, and one null-and-void.
2. Totals do not represent the unique number of credential holders. Totals represent the number of credentials documented in the credentialing database management system. The number of unique licensees issued primary credentials was not readily available, and licensees may have held multiple primary credentials.
3. Included 82 licenses without a license number: 37 with pending status, 32 with deleted status, and 13 with withdrawn status.
4. Included only temporary dentist licenses.

Source: Unaudited OPLC credentialing data.

**Table 9**

**Initial Primary Credentials Issued, State Fiscal Years 2018–2021**

| | State Fiscal Year | | | |
|---|---|---|---|---|
| | 2018 | 2019 | 2020 | 2021 |
| **Regular Dentist** | 102 | 71 | 71 | 88 |
| **Regular Hygienist** | 81 | 72 | 59 | 97 |
| **Temporary Research, Education[1]** | 0 | 0 | 0 | 0 |
| **Temporary Volunteer[1]** | 1 | 1 | 1 | 1 |
| **EFDA** | 6 | 7 | 1 | 1 |
| **Total[2]** | **190** | **151** | **132** | **187** |

Note:
1. Included only temporary dentist licenses.
2. Totals do not represent the unique number of credential holders. Totals represent the number of credentials documented in the credentialing database management system. The number of unique licensees issued primary credentials was not readily available, and licensees may have held multiple primary credentials.

Source: Unaudited OPLC credentialing data, as of May 27, 2021, and July 21, 2021.

***Initial Regular Licenses For Dentists And Hygienists***

To practice dentistry, State policy required certification since calendar year (CY) 1891, and licensure since at least CY 1971. To practice hygiene under a licensed dentist, the State required registration since at least CY 1971, and licensure since CY 1997. During the audit period, the Board was required to adopt rules on: 1) initial license application procedures and forms and 2) applicant qualifications in addition to requirements set by statute. To obtain a license, applicants had to pass didactic, clinical, and jurisprudence examinations; meet educational requirements; complete and submit an application form; and submit an application fee. Applicants also had to provide supplemental documentation on competence, character, and past conduct. Applicants with

a current, unrestricted license in another jurisdiction who met certain criteria could apply for licensure by endorsement. All other applicants could apply for licensure by examination.

The Board was to license only qualified applicants. Since August 24, 2018, no application was to be granted unless the Board made a finding:

1. the applicant possessed the necessary educational, character, and other professional qualifications; and
2. no circumstances existed which would be grounds for disciplinary action against a licensed dentist or hygienist.

**Observation No. 19**

## Improve Initial Regular Dentist And Hygienist License Controls

Controls over initial dentist and hygienist licensing were inadequate, compromising the Board's effectiveness as the State's regulator of the practice of dentistry and hygiene. For example, 265 of 273 initial regular licenses (97.1 percent) were issued by staff either before any Board review or action, or without Board action altogether. State policy was incompletely and improperly implemented. Rules were complex and incomplete. Failure to verify or enforce certain requirements may have placed the public at risk or, alternatively, indicated the requirements were unnecessary. In some cases, staff or the Board requested information not required by statute or rules, indicating some formal requirements were incomplete. Related OPLC procedures and practices were inconsistent with statutory and rule requirements, informal, and incomplete. Limitations with the control framework surrounding application receipt and completeness determinations made Board compliance with statutory time limits unauditable. Inadequate controls adversely affected the compliance, timeliness, consistency, and efficiency of initial licensing. The Board never established the efficiency or effectiveness of initial licensure application processing.

Our audit work focused on controls and was not designed to identify all instances of noncompliance. However, we did find cases demonstrating how inadequate controls adversely affected the timeliness and consistency of licensing decisions and, consequently, applicants. Nothing demonstrated licensing of dentists and hygienists consistently and efficiently achieved expected outcomes.

### Inadequate Controls Over Initial Licensing Requirements

The Board lacked adequate oversight and control over the statutory, regulatory, and procedural framework governing initial licensing. This contributed to a complex and dynamic licensing environment. To become licensed, applicants needed to follow formal and informal requirements. Applicants and the public had to navigate complex, inconsistent, and unclear licensing requirements, including extra-legal, ad hoc rules. Certain State policy requirements were unimplemented. Statute was internally inconsistent. Rules did not always clarify statute, contributing to the development of improvised external instructions. Some requirements were established during public or nonpublic Board meetings and memorialized only in meeting minutes,

adversely affecting transparency and adding to complexity. The OPLC lacked formal procedures, and its improvised guidance was inconsistent.

***Statutory Requirements Not Fully Implemented***

The Board knew it did not implement certain State policy requirements related to initial licensing. Criminal history record checks were statutorily required since August 24, 2018, but not performed through at least December 2021, potentially placing the public at risk. From August 24, 2018, to June 30, 2020, unaudited licensing data showed 245 applicants were issued licenses. None of the applicants received a criminal history record check.

Additionally, the Board neither adopted required rules nor structured processes to facilitate licensure of members of the military or their spouses. The Board did not monitor eligible military-related applications, nor could these applicants be identified in licensing data. However, we identified two cases where the lack of rules contributed to noncompliance and inconsistent treatment of military-related applicants.

***Imposition Of Ad Hoc Rules***

The Board lacked controls over rulemaking, contributing to the imposition of ad hoc rules and inconsistency. Rules were incomplete. Improperly adopted application forms, external instructions, requirements established during public or nonpublic Board meetings, formal OPLC procedures, and informal OPLC guidance contributed to ad hoc rules. For example, rules did not:

- establish how to obtain and submit a complete application,
- require submission of statements explaining issues with practice or conduct,
- establish the content of signed certifications of good professional character,
- specify the content of the certification statement signed by the applicant,
- specify certain continuing education requirements,
- specify how to make didactic and clinical examination scores available for review,
- set the format of the jurisprudence examination and score needed to pass, and
- require completion and submission of a partial, hardcopy-only registration form.

***Inconsistent And Unclear Requirements***

Inadequate controls contributed to inconsistent and unclear licensing requirements. Multiple documents contained licensing requirements, some of which were never published. Some requirements or interpretations of requirements were recorded only in Board meeting minutes and not published elsewhere or incorporated into rules. Rules should have clarified requirements. However:

- rules required dentists and hygienists to answer different character and conduct questions, and some application form questions were inconsistent with rule, limiting or expanding information collected;

- rules required all applicants to pass a clinical examination, while external instructions clarified dentist applicants by examination had to pass the written portion of a specific examination, without similar clarification for hygienist or endorsement applicants;
- informal OPLC guidance documented several acceptable examinations and five required components, only one of which was reflected in rules;
- statute contained conflicting requirements for commercial, third-party dental and dental hygiene school accreditation or recognition, neither of which was fully or consistently reflected in rules and external instructions; and
- didactic examination requirements were not clearly specified in rules, application forms, or external instructions, and neither forms nor instructions reflected recent changes to dentist examinations.

***Inconsistent And Noncompliant Waiver Of Examination Requirements***

The Board circumvented controls over waivers of licensing examination requirements, contributing to inconsistency. Board rules established a process to waive substantive rules. Applicants were to be informed of the reason for waiver denials. Waiver requests and Board actions were to be documented in applicants' records. However, staff did not require applicants to follow the waiver process, and the Board did not correct the noncompliance. No license was to be granted to an applicant who had not passed either a Board examination or a Board-accepted national or regional examination. The Board inconsistently enforced these requirements.

- The Board inconsistently waived clinical examination requirements. It waived the written portion of the clinical examination twice in January 2018, accepting applicant training and experience instead. It later claimed to be unable to waive the periodontal component of the clinical examination in July 2018. Although the Board could not waive statutory requirements, the periodontal component was a waivable rules-based requirement. There was no documentation in the applicant's file containing notification of the waiver denial or reason for it.

- While Board rules specifically addressed United States didactic examinations, neither rules nor external instructions, procedures, or informal OPLC guidance addressed Canadian didactic examinations. Certain Board members concluded Canadian examinations were not acceptable, which carried forward as Board policy. This decision was made without a formal vote, addressing why the rule could not be waived, addressing the issue in public session, or clarifying relevant rules.

**Inadequate Controls Over Application Processing**

The Board lacked adequate oversight and control over processing initial license applications, resulting in noncompliance and inconsistency. The Board's review of applications was largely perfunctory. Among 273 application forms, for licenses issued during SFY 2019 and SFY 2020:

- 262 (96.0 percent) underwent Board review or action after a license was issued,
- eight (2.9 percent) underwent Board review or action before a license was issued, and
- three (1.1 percent) did not undergo any Board review.

It was unclear whether this occurred with or without Board knowledge. Additionally, some required information was not clearly used to assess competence, character, or conduct; not all requirements were verified; and compliance with some requirements was inconsistently enforced.

In practice, the initial license application process included three steps, each with multiple sub-steps:

1. submitting a statutorily-required application form and application fee,
2. completing and passing a rules-based jurisprudence examination, and
3. submitting a partial, ad hoc registration form and rules-based registration fee.

To be approved for licensure, State policy required applicants to submit a complete application, which included all documents, forms, and fees required for each of the three steps. In practice, staff should have determined administrative completeness by ensuring all required questions were answered and all required documents were submitted. Staff or a Board member should have verified substantive requirements by ensuring applications demonstrated applicants met statutory and rules-based licensing requirements. However, there was no comprehensive guidance on which requirements should be verified by staff or Board members. Applications could have been referred to the full Board during any step when an applicant did not clearly meet requirements. Military-related applicants purportedly received "priority" processing. However, there were no rules or procedures structuring this process. It was unclear what priority processing entailed. No means was ever devised to quantify or monitor any aspect of application processing timeliness.

Without all required documents, forms, and fees from each step, an application was incomplete. However, the Board did not monitor incomplete applications. Applicants were not informed when their application and fees were received. Applicants may have needed to contact the OPLC to confirm receipt. The OPLC was to notify applicants of errors or omissions with their application and request missing information. There was no standard template to notify applicants of errors or omissions through May 2021, when staff purportedly began developing a standardized email template. Additionally, some notifications' compliance with statute was unauditable due to lack of documentation. A lack of comprehensive procedures resulted in inconsistent handling of incomplete application forms and partial registration forms. Handling of fees for incomplete applications was noncompliant with statute.

### ***Step One: Application Form Review***

Inadequate controls over application form reviews produced inconsistent results. Substantive evaluation of application forms was to occur after completeness determinations were made. However, completeness determinations were not consistently made or were inaccurate. At times, determinations co-occurred with substantive evaluation of application forms and supplemental materials.

#### *Inconsistent Administrative Completeness Determinations*

Staff followed internal checklists to assess application form and supplemental material completeness. However, checklists did not include all requirements in statute or rules, and there

was no comprehensive guidance on determining completeness. Consequently, determinations lacked accuracy, and some applicants who did not answer required questions or provide required documents were issued a license. Among the 24 accepted or approved forms we reviewed, 22 (91.7 percent) had uncorrected completeness defects, missing, for example:

- letters of good standing from all states in which an applicant was licensed,
- the required number of statements of professional character,
- documentation the didactic examination had been passed,
- documentation supporting a reported dental specialty, and
- proof of current basic life support for healthcare providers certification.

Additionally, some forms were determined complete only after endorsement applicants provided proof they met an ad hoc continuing education requirement.

*Inadequate Substantive Evaluations*

The Board was to take reasonable steps to ensure applicants complied with statute and rules. Substantive evaluations included third-party verification of didactic and clinical examination scores, and meeting education and certain character and conduct requirements. Individual Board members and staff reportedly relied upon the same checklists to verify a subset of requirements. Staff alone could not verify application forms met all requirements without Board member assistance. Certain requirements, such as education, examinations, and conduct, were reportedly more subjective than others, for example. All conduct issues were purportedly left for Board decision. However, there were no formal processes for identifying or addressing verification issues, and staff reported using different practices. Staff also included substantive clarifications in some notifications of incomplete application forms. This made statutory time limits on completeness determinations unauditable because applications lacked a definitive "completeness" date.

Not all licensing requirements were verified or enforced. All 24 forms we reviewed had substantive content issues, but applicants were nonetheless issued licenses.

- Neither staff nor the Board explicitly verified competency requirements were met. For example, 13 of the 24 applicants were issued a license by endorsement, but one (7.7 percent) did not meet statutory requirements. The other 12 (92.3 percent) did not clearly meet requirements. Without clear determinations, it was impossible to assess whether the Board found applicants possessed the qualifications to practice. The remaining 11 applicants were issued a license by examination, and three (27.3 percent) of these also clearly did not meet rule-based requirements.

- Compliance with character and conduct requirements was inconsistently verified. Among the 24 forms, 20 (83.3 percent) had substantive issues related to character and conduct verification. For example, 11 of 20 forms (55.0 percent) lacked a documented American Association of Dental Boards' Clearinghouse query. Queries were intended to verify certain attestations made by applicants using current or prior legal names.

Additionally, 16 of 20 forms (80.0 percent) contained certified statements from other jurisdictions' dental regulatory agencies that lacked required information.

- Compliance with continuing education requirements was perfunctory. Continuing education information was not used during decision making, other than to preliminarily verify ad hoc licensure by endorsement requirements were met. Application forms referred new license applicants to continuing education requirements for renewing an existing active New Hampshire license. In one case, approval of an application was delayed two months while the Board resolved whether a new license applicant satisfied inapplicable renewal continuing education requirements for current licensees.

***Step Two: Jurisprudence Examinations***

Jurisprudence examinations were uncontrolled and perfunctory. An applicant was required to pass an "open book" jurisprudence examination, which included questions on *Dentists and Dentistry*, Board rules, and professional codes of conduct. In practice, the examination was administered electronically through a third-party vendor's website. The vendor scored the examination and provided the score to staff. There was no contract with the vendor during the audit period.

Applicants who failed the jurisprudence examination on their first attempt could purportedly re-take the open book examination as many times as needed to pass. This process was uncontrolled. There were no rules, formal procedures, external instructions, or informal guidance related to applicants who required more than one attempt to pass the examination. There was no monitoring or Board review of either scores or the number of attempts applicants needed to pass. Informal OPLC guidance and staff reports differed as to what score was needed to pass. We identified two applicants who earned a score that did not meet the stricter requirement. Examination results were not maintained in licensees' records.

***Step Three: Partial Registration Form***

Requiring completion of an ad hoc rule-based partial, hardcopy registration form, and its review, were perfunctory. The process unnecessarily delayed licensure and when applicants could begin practicing. There was no Board review of registration forms, and completeness determinations were unauditable.

The process also appeared wasteful, was inefficient, and contributed to additional applicant and OPLC costs. Staff time spent processing the registration form could have been spent completing other tasks. Thirty-five of 36 questions (97.2 percent) on the registration form were either already asked on the application form or inapplicable to unlicensed applicants. There was no clear reason why the one question unique to the registration form could not have been included on the application form. The use of registration forms could have then been discontinued. Furthermore, registration forms were to be notarized, an additional cost to applicants.

Staff purportedly reviewed registration forms to ensure completeness. However, there was no formal review process, or process to identify missing information or information conflicting with information previously provided on application forms. We found two of 20 registration forms (10.0

percent) where applicants reported obtaining a license in another state since they had initially submitted their New Hampshire application form. However, there was no follow-up to ensure compliance with related requirements, such as providing letters of good standing from regulatory agencies in those states where they were newly licensed.

**Inadequate Controls Over Board Approvals**

Inadequate controls over Board approval of applications resulted in deficiencies with decision making, and undermined the validity of the majority of licenses issued. The Board was required to make a finding applicants were qualified based on a complete application. However, the Board reviewed and acted on only application forms, even though to obtain a license, applicants also had to take and pass a jurisprudence examination and submit a partial registration form.

- The Board inconsistently followed statutory requirements. If circumstances existed that would be statutory grounds for disciplinary action, the Board was to undertake adjudicatory proceedings to determine qualifications. This included providing notice and an opportunity for a hearing. Nine of the 24 applications (37.5 percent) we reviewed had potential conduct issues. However, only two of the nine applications (22.2 percent), which were initially denied, had a formal finding, notice, and a hearing.

- The Board did not make a finding most applicants made no knowing deceptive or false statements; possessed the necessary qualifications; and no discipline-like grounds existed. From July 2018 through February 2020, the Board voted on 22 of 331 application forms (6.6 percent) but votes on 19 forms (86.4 percent) occurred after license issuance. The Board generally treated application form acceptance or approval as informational. In March 2020, the Board inappropriately delegated authority to approve dentist application forms to individual members. In practice, the delegation was further extended to include hygienist application forms. Delegations were purportedly intended to improve efficiency. Yet, from March 2020 to June 2020, the Board voted on a greater proportion of application forms than without the delegation (23 of 25 application forms, 92.0 percent). However, votes on 21 of the 23 forms (91.3 percent) occurred after license issuance.

- The March 2020 delegation also inappropriately delegated Board authority to approve dentist application forms not only to dentist members, but also to hygienist members and the public member. This allowed hygienists and the public member to apply discretionary decision making to dentists' competency and qualification.

- The Board approved two application forms where staff identified the applicant knowingly made deceptive or false statements, contrary to statute and rule. One application was approved outright, while the second was initially denied but later approved.

**Inadequate Controls Over Denials And Contested Decisions**

Inadequate controls over denials could have resulted in the inconsistent treatment of applicants. The Board could deny applications in whole or in part. Statute required the Board to take certain actions to protect denied applicants' due process rights. This included making a finding an applicant was not qualified, providing notice to the applicant, and holding a hearing. However, no rules, external instructions, formal procedures, or informal OPLC guidance structured either a partial or full denial process. Neither were there processes defining or structuring conditional approvals or denials, including how to resolve or contest such an action. There was no apparent monitoring of denied applications. Applicants who had been denied a license were supposed to be sent an order informing them that they may appear before the Board. Four of 26 initial application files (15.4 percent) we reviewed contained some form of denial.

- One denial had no recorded Board vote.
- Two denials were communicated by an OPLC-issued letter, not a Board order.
- One denial letter cited only the four broad statutory criteria the Board *could* use as a reason for denial and not the grounds for denial. The letter informed the applicant to contact the OPLC with any questions.
- One conditional denial was pending further review for five months. The applicant was not apparently notified for the denial despite a Board vote to do so. The denial was overturned and approved after a hearing but without any record to indicate why the Board overturned the denial.
- One denied application was later approved after a hearing, but without any record to indicate why the Board overturned the denial.

**Recommendations:**

**We recommend the Board improve controls over initial dentist and hygienist licensing, and:**

1. **fully implement all statutory requirements related to initial licensing;**
2. **discontinue imposition of ad hoc rule requirements;**
3. **ensure rules comprehensively, clearly, and consistently reflect all initial licensing requirements and application procedures binding on the public, including denial processes;**
4. **ensure licensing requirements are necessary to assess applicants' competence, character, and conduct and are used for that purpose, and revise requirements as needed to conform with statute and rules;**
5. **discontinue the use of partial registration forms for initial licensing and incorporate pertinent information from partial registration forms into relevant rules and application forms;**
6. **actively oversee initial licensing processes and ensure OPLC practices conform to statute and rules;**

7. **ensure delegations of initial license processing responsibilities conform to statute;**
8. **conduct substantive review of applications;**
9. **ensure approval of complete applications from qualified applicants occurs before license issuance;**
10. **develop, implement, monitor, and refine goals, objectives, and targets tied to expected licensing outcomes; and**
11. **establish data requirements and reporting frequencies on performance metrics.**

Board Response:

*We concur with the recommendations.*

1. *We concur that all statutory requirements should be fully implemented related to initial licensing.*

   *The Board is in favor of criminal background checks and when that statute was passed the OPLC was supposed to coordinate with the concerned authorities to set up a system. Frequent changes in OPLC support, Board administrators and legal counsel has prevented this from being implemented. The Board is not aware if OPLC conducts an exit interview of the staff so the Board has no way of knowing if all pending items are turned over to the new staff coming in. Rules are in place for active military personnel.*

2. *We concur with the recommendation to discontinue imposition of ad hoc rule requirements.*

   *We agree that ad hoc imposition of rules should be eliminated.*

   *Many rules have been changed or are in the process of being changed and have not appeared in the current rules package. Due to the inordinate amount of time it takes to change a rule through the rule making process and with the speed that technology and educational modalities change the Board is continuously looking to change rules. The Board—with the assistance and support of the OPLC—intends to make the necessary rule changes to make the entire process more streamlined, concise, and transparent. Since CY 2019, more than half the Board has changed and the Board has had three different administrators and different legal counsels. The lack of institutional continuity has been a serious challenge.*

3. *We concur with the recommendation to ensure rules comprehensively, clearly, and consistently reflect all initial licensing requirements and application procedures binding on the public, including denial processes.*

4. *We concur with the recommendation to ensure licensing requirements are necessary to assess applicants' competence, character, and conduct and are used for that purpose during application processing, and revise requirements as needed to conform with statute and rules.*

5. *We concur with the recommendation to discontinue the use of partial registration forms for initial licensing and incorporate pertinent information from partial registration forms into relevant rules and application forms.*

*The Board will look into the recommendation regarding the partial registration form.*

6. *We concur with the recommendation to actively oversee initial licensing processes and ensure OPLC practices conform to statute and rules*

   *The Board does oversee the initial licensing process through its Board members. OPLC staff collects the initial licensing application forms, those applications are forwarded to the Board only once they are complete or if the staff notices issues regarding missing items. The Board has no control over incomplete applications. The Board has a standing order in place for Board members to review the initial licensing applications and then approve the applications to be accepted by the Board. This was done to make sure that applications are processed in a timely manner. For some time, the American Association of Dental Boards' Clearinghouse was down so the OPLC staff could only verify the applicants' previous licenses in other states over the phone and not have a query printed like it was required.*

   **LBA Rejoinder: Oversight of the three-step initial licensing process was more than ratifying individual member decisions on application *form* acceptability in step one *after* licenses had been issued. The Board lacked comprehensive oversight of the three-step initial licensing process. It also lacked controls over individual member application reviews or subjective decision making on application acceptability. It lacked any oversight of steps two and three or of license issuance. Not only did the Board inappropriately delegate its collective, discretionary authority, it did so without accountability controls.**

7. *We concur with the recommendation to ensure delegations of initial license processing responsibilities conform to statute and are clearly made and in writing.*

   *The Board will look into the recommendation regarding streamlining the initial licensing process by having the licensing responsibilities in writing to conform to statute.*

8. *We concur with the recommendation to conduct substantive review of applications.*

9. *We concur with the recommendation to ensure approval of complete applications from qualified applicants occurs before license issuance.*

10. *We concur with the recommendation to develop, implement, monitor, and refine goals, objectives, and targets tied to expected licensing outcomes.*

11. *We concur with the recommendation to establish data requirements and reporting frequencies on performance metrics.*

***Initial Dentist And Hygienist License Duration***

Initial regular licenses were valid until April 30 of a licensee's renewal year – even-numbered years for dentists and odd-numbered years for hygienists – regardless of the date the license was

issued or its duration. As a result, initial licenses could be valid for as little as one day or as long as two years, or more in practice. Statute and rules generally established four distinguishable renewal periods during each year.

1. February Through March: The On-time Renewal Period – The Board was to notify licensees of an upcoming renewal by February 15. To renew a license on time, licensees had to submit a complete renewal application and a fee before April 1.

2. April: The Late Renewal Period – Late renewals were permissible if a licensee submitted a complete application between April 1 and April 30, with payment of a late fee.

3. May And Later: The Lapsed Or Inactive License Period – A license lapsed when a licensee did not submit a complete renewal application, or did not meet renewal requirements, by April 30. A license became inactive if a renewing licensee was not actively practicing, or if a license had been lapsed for two years.

4. May To November: The Reinstatement Period – Lapsed licenses could be reinstated if a licensee submitted a reinstatement form and paid required fees before November 1.

**Observation No. 20**

**Develop Regular Dentist And Hygienist License Duration Controls**

Controls over license duration were largely absent, resulting in inconsistent treatment of applicants and licensees, noncompliance with law, and potential abuse. The Board did not oversee license durations, and the Board was unaware of related improvised OPLC practices. Additionally, the OPLC did not keep the Board apprised of related stakeholder concerns, which remained unaddressed.

**Extra-legal, Ad Hoc, And Noncompliant Requirements**

The Board's lack of controls over rulemaking contributed to the inconsistent imposition of statutorily-noncompliant practices. The Board was required to adopt rules on license renewal and other procedures. OPLC procedures and practices were to conform to statute and rules. However:

- while statute established on-time and late renewal deadlines, rules lacked any deadlines;
- external instructions broadly established February to April as the renewal period, typically without distinguishing between on-time and late renewal;
- rules and procedures did not address license expiration dates; and
- statute, rules, and procedures did not address renewal notification for applicants initially licensed after February 15 but before April 1 of their renewal year.

Within this loose framework, staff reportedly provided instructions to all applicants applying for initial licensure before the on-time renewal period, in December or January. According to these informal, statutorily-noncompliant instructions, applicants had two options.

1. Applicants could delay initial application completion until February 1. This would avoid the statutorily-required renewal application process and renewal fee, but also delay the date they would become licensed and could begin working.

2. Alternatively, applicants could proceed with their initial application before February 1 and pay initial application fees. They could begin working upon receipt of their initial license but they would also have to submit a renewal application and renewal fee before May.

Statute did not provide for the exception this informal practice allowed. Neither the Board nor the OPLC could waive statutory requirements without authority. Additionally, this practice was not publicized, compromising transparency as not all applicants would be aware of these options.

**Inconsistent And Noncompliant Practices**

Staff inconsistently handled renewals of initial licenses issued immediately before and during the on-time renewal period. We reviewed records for 60 applicants issued an initial license between December and March of their renewal years, during CY 2017 through CY 2020. The inconsistencies we found indicated Board noncompliance with statutory requirements and potential abuse.

- Unauthorized Modification Of Public Records – We found staff manually made extra-legal modifications extending license expiration dates for four of five hygienists issued an initial license in January 2019. Inadequate procedures and records made these renewal transactions unauditable. It was unclear why the expiration dates were modified for some, but not all licenses, or who had authorized them. The Board was purportedly unaware of this practice.

- Inequitable Treatment Of Licensees – Not only were waivers of statute impermissible, they were also applied inconsistently. None of the five hygienists issued initial licenses in January 2019 renewed during CY 2019, resulting in initial licenses valid for 27 to 28 months. Additionally, one of two hygienists issued an initial license in January 2017 did not renew during CY 2017, while the other did. Conversely, all four dentists issued initial licenses in either January 2018 or January 2020 were required to renew during the renewal period that immediately followed, one to three months later.

- Inconsistent License Duration – Ten dentists initially licensed in February or March of CYs 2018 or 2020, and 20 hygienists initially licensed in January through March of CYs 2018, 2019, and 2020 were issued licenses valid for more than two years. Conversely, four dentist licenses initially issued in January of their renewal year were valid for fewer than four months.

- Inadequate Renewal Notification – Staff reported generating renewal notifications through the credentialing database management system annually, around February 1. As a result, an applicant issued an initial license during the on-time renewal period generally would not receive a renewal notification. Inconsistent licensee records limited the auditability of staff compliance with statutory renewal notification requirements. Of the 60 records we examined, 25 dentists and hygienists (41.7 percent) were initially licensed during the on-time renewal period in CYs 2018 through 2020. However, notification records existed for only one licensee (4.0 percent).

- Inconsistent, Noncompliant Applicant Instructions – Due to inconsistent records, the auditability of staff compliance with the requirement to provide all initial license applicants with informal extra-legal instructions before February 1 of their renewal year was limited. Of the 60 records we examined, 12 dentists and hygienists (20.0 percent) applied for licensure in December 2018 or 2019 or January 2019 or 2020. However, records of the provision of instructions did not exist for nine applicants (75.0 percent).

**Unaddressed Stakeholder Concerns With Requirements**

In February 2019, staff received stakeholder concerns about why applicants issued an initial license during the on-time renewal period were required to renew within a matter of weeks and pay renewal fees. Although concerns were elevated by staff to OPLC management and counsel, there was no documented resolution. The Board was not explicitly notified of these concerns for its own consideration. These unaddressed concerns directly resulted in the current audit.

Stakeholders and staff pointed to proration of fees or issuing licenses valid past April of the renewal year as potential solutions. However, both approaches were problematic.

- Proration – Statute did not accommodate proration. Fees had to cover 125 percent of direct operating costs and approximate the expense of processing an application and issuing a license. The cost to process an application was not affected by the duration of the resulting license. Proration of fees would have compromised cost recovery for services provided. Prorating renewal fees for a subset of licensees would necessarily have shifted the unpaid-for costs to other licensees.

- Extended License Duration – Statute did not accommodate extended license durations. Licenses lapsed after April 30 if licensees had not submitted a complete renewal application.

Credential expiration set to one date, like those for dentist and hygienist licenses, can create an unnecessary administrative burden by consolidating renewal activity into three months each year. The OPLC never devised a means to quantify processing time. However, staff purported spending at least 15 to 30 minutes to process each renewal application. Staggered biennial renewals based on the initial licensure date can spread out processing and reduce the risk that applications received closest to renewal deadlines could receive inadequate review. Staggered renewals can also simplify the control framework by avoiding the need to not only prorate fees, but also issue credentials of unreasonably short or long durations. We have previously suggested staggered renewals to address

concerns of equity and promote efficient administration. Purportedly, the Board considered implementing staggered credential renewals due to a reduction in OPLC support. However, limited progress was made and members were unclear how to enact changes. Beginning in June 2021, statutory changes to the duration of licenses issued by some OPLC assigned agencies became effective, although Board credentials were not included.

**Recommendations:**

**We recommend the Board:**

1. **exert control over the issuance of initial and renewal licenses to ensure licenses issued on its behalf comply with statute;**
2. **correct defective licenses it issued or that were issued under its authority;**
3. **seek statutory changes to implement staggered credential renewals;**
4. **develop rules to address license duration; and**
5. **establish information requirements of the OPLC that will allow the Board to monitor and report on compliance and efficiency.**

**We recommend OPLC management:**

6. **discontinue noncompliant renewal practices, and**
7. **identify defective licenses it issued on behalf of the Board.**

Board Response:

*We concur with the recommendations.*

1. *We concur with the recommendation to exert control over the issuance of initial and renewal licenses to ensure licenses we issue comply with statute.*

2. *We concur that any defective licenses issued under our authority should be corrected, and we note this is dependent on coordination and notification by the OPLC of such defective licenses in order to make those corrections.*

3. *We concur that staggered license renewals for dentists and hygienists may lessen that administrative burden for the OPLC; however, we note that an equitable framework must be formulated that does not inadvertently penalize some licensees over others. We also note that promulgation of the change must be clearly communicated to all parties.*

4. *We concur that there should be clear rules delineating license duration and also note that in CY 2020 and CY 2021 there were licenses impacted by emergency orders related to COVID-19 that were outside the normal regulatory cycle.*

5. *We concur that we should establish information requirements of the OPLC that will allow us to monitor and report on compliance and efficiency.*

OPLC Response:

*We concur with the recommendations.*

*The OPLC's plans to address the recommendations are as follows:*

6. *Discontinue noncompliant renewal practices.*

   *This practice has been discontinued. The OPLC established a supervisor position to oversee licensing under the Board to ensure compliance with statutes and rules. In addition, and as noted, the OPLC is working to adopt policy and procedure directives to ensure that all statutes and rules are complied with.*

7. *Identify defective licenses it issued on behalf of the Board.*

   *The OPLC agrees wholeheartedly with the comments that "[s]taggered biennial renewals...can spread out processing and reduce the risk that applications received closest to renewal deadlines could receive inadequate review." The OPLC is presently working to move all assigned agencies to biennium schedules based on date of birth. The OPLC may seek legislation in the future.*

   *Staff have been directed not to modify license duration. Additionally, as noted, the OPLC is conducting an inventory of all statutory and regulatory requirements, promulgating necessary rules and assisting boards in promulgating rules that are statutorily required, and drafting and implementing policies and procedures consistent with statutes and rules. Once completed, internal controls should be sufficient to ensure that licenses are not improperly modified.*

***Temporary And Interim Licenses***

Since CY 1997, the Board could issue three types of **temporary** licenses to qualified applicants:

1. a professional clinical education license, for participation in educational programs using clinical dental procedures;
2. a clinical research license, for participation in research projects having a clinical dental component; and
3. a volunteer services license, for working at, or providing services without pay or compensation to, a specific public health program.

Individuals seeking temporary licensure for educational programs or research projects had to apply to the Board and meet the minimum requirements for regular licensure by examination or endorsement. Statute limited temporary volunteer licenses to an active, inactive, or formerly licensed dentist or hygienist from New Hampshire, another state, or a Canadian province. Retired licensees were required to have a license in good standing at the time of retirement to apply.

Additionally, the OPLC was authorized to issue **interim** licenses on a temporary basis to individuals licensed in good standing in another jurisdiction, unless the Board had relevant temporary licensure procedures. These licenses were valid while the Board considered the licensee's application for a regular license. Interim licenses were designed to increase interstate mobility. They allowed dentists and hygienists licensed elsewhere to obtain temporary permission to practice in New Hampshire during the period their full, regular license application was under Board review.

Furthermore, during the State of Emergency, practitioners could apply for an **emergency** license through the OPLC. The OPLC was to issue such licenses if the applicant provided evidence they were licensed in good standing in another jurisdiction. Emergency licenses remained in effect only for the duration of the State of Emergency. We did not audit emergency licenses since none were issued for a Board credential, and no control framework had been developed, during the audit period.

**Observation No. 21**

**Improve Temporary License Controls**

Controls over temporary licenses were uncoordinated, incomplete, and inadequate when present. Board rules were inconsistent with statute and incomplete in scope. In practice, temporary licenses were renewable indefinitely, like regular licenses. Requirements among temporary license types were inconsistent, and inconsistent with other regular licensing provisions. Key public protection controls were absent or inconsistently implemented. EFDAs and all supplemental credentials were entirely excluded from temporary credentialing processes. Neither the Board nor the OPLC developed a means to measure outcomes or demonstrate processes effectively and efficiently controlled temporary licenses. There was no routine monitoring of licensing process timeliness, and data were unavailable to enable assessment of timeliness or efficiency. The efficiency or effectiveness of temporary licensing was never established.

The OPLC control framework relied upon improvised practices and informal guidance, which were not always consistent with Board rules. Informal guidance contained substantive requirements not reflected in rule, and was incomplete and inconsistent. Opportunities to obtain temporary licenses were not published along with other licensing opportunities. Ad hoc rulemaking resulted. There was no fee charged for temporary volunteer licenses, even though statute required applications be accompanied by a fee to be considered complete, and fees were required to recover 125 percent of direct costs.

**Temporary Research And Education Licenses Inadequately Controlled**

Inadequate Board controls over temporary research and education licenses led to inconsistencies. Rules provided these temporary license types were valid for one year, or concluded at the end of the educational program or research project, whichever occurred first. No rules allowed for renewal of either type. However, internal guidance required staff to contact licensees annually to determine whether they wanted to renew the license and process any renewals. Unaudited OPLC data listed two temporary licenses in April 2021 – one license was held for less than one year, the

other for nearly four years. Statute, rules, and practice contained other ambiguities and inconsistencies. For example:

- there was no form to use or format to follow when applying;
- the rule-based license duration was inconsistent with the statutory requirement licenses lapse on April 30;
- there was no requirement for a criminal history record check;
- rules lacked provisions for verifying applicant character and conduct through third parties;
- jurisprudence examination requirements, even if the applicant had never practiced in New Hampshire or had not practiced in New Hampshire for years; and
- license applications and renewals were not approved by the Board.

**Temporary Volunteer Licenses Inadequately Controlled**

Inadequate Board controls over temporary volunteer licenses led to inconsistencies. Under rule, temporary volunteer licenses were renewable, but valid for one year, not the two years provided for by statute. There were no:

- continuing education requirements except for basic life support for health care providers certification and infection control each biennium, even though they were nominally annual licenses;
- refresher course requirements or requirements to pass a competency examination if the applicant had not practiced for years;
- jurisprudence examination requirements, even if the applicant had never practiced in New Hampshire or had not practiced in New Hampshire for years;
- criminal history record check requirements; and
- provisions for verifying character and conduct through third parties.

Furthermore, practice introduced ambiguities, inconsistencies, and ad hoc rule requirements, such as:

- not developing or publishing the rule-required initial application form;
- making volunteer licenses available to new regular dentist license applicants and to inactive licensees, who could then hold two licenses;
- allowing temporary licensees to obtain a federal Drug Enforcement Agency registration to prescribe scheduled drugs, but without a relevant continuing education requirement or clear verification of Prescription Drug Monitoring Program registration;
- requiring submission of letters of good standing, with no corresponding requirement in rule; and
- failing to obtain Board approval for license applications and renewals.

Additionally, in practice renewing licensees were required to submit a standard renewal registration form. However, rules required renewing licensees to re-submit an initial license application form when the information they originally provided was no longer complete or

accurate. Rules did not describe how a renewal license could be obtained if no changes to originally-submitted information had occurred.

Lastly, statute limited temporary volunteer licenses to individuals providing voluntary services at specific public health programs and locations. However, in one instance, the Board approved a request for a temporary volunteer license from a former licensee – without an application – to provide on-call services at a private practice.

**Controls Over Interim Temporary Licenses Absent**

The authority for interim temporary licenses was initially effective on January 1, 2019. However, it was not clearly operationalized by the OPLC, and the Board lacked interim temporary licensing provisions. In July 2020, the OPLC became solely responsible for issuing interim temporary licenses. However, the OPLC had not adopted required rules through April 2021, when we concluded audit work on this topic. The sole criteria for an interim temporary license beginning in July 2020 was active licensure in good standing in another jurisdiction. Individuals operating with an interim temporary license were to be under the Board's jurisdiction during the interim period while their application for a regular license was under the Board's review.

**Recommendations:**

**We recommend the Board improve controls over temporary licenses, and:**

1. **discontinue imposition of ad hoc rule requirements;**
2. **seek legislative changes to allow for temporary credentials for all types of primary credentials, and consider whether temporary credentials should be extended to supplemental credentials, and require criminal history record checks for all primary credential applicants;**
3. **recodify rules to reflect statute, fully accommodate all credential types regulated by the Board, and contain all procedures affecting the public, including required forms;**
4. **ensure rule-based requirements for all credentials, such as jurisprudence examinations, refresher training, and continuing education requirements, are consistent;**
5. **ensure fees are objectively established and collect 125 percent of direct costs;**
6. **actively oversee temporary credentialing processes and ensure OPLC practices conform to statute and rules;**
7. **approve initial applications and renewals, should these be allowed in the future, before licenses are issued;**
8. **establish performance goals, objectives, and targets to demonstrate how temporary credentialing contributes to achieving expected outcomes;**
9. **establish data requirements and reporting frequencies on performance metrics; and**
10. **clarify the terms and conditions of its relationship to the OPLC through rules.**

Board Response:

*We concur in part with the recommendations.*

1. *We concur with the recommendation to discontinue imposition of ad hoc rule requirements.*

   *Please see our response to Observation No. 4.*

2. *We concur in part with the recommendation to seek legislative changes to allow for temporary credentials for all types of primary credentials and consider whether temporary credentials should be extended to supplemental credentials, and require criminal history record checks for all primary credential applicants.*

   *The Board agrees that the criminal history record check should be required for temporary research and education licenses but does not agree that it is required for temporary volunteer licenses too. The volunteer licenses are issued only to practitioners who already held a license in good standing so they would have already had a criminal history record check in the past.*

   **LBA Rejoinder: Volunteer licensees were *no different* than applicants for temporary research and education licenses or regular licensure by endorsement – all held a permanent license. Excluding volunteers from criminal history record check requirements cannot be reconciled based on holding a credential in another jurisdiction. The Board did not review other state and Canadian province licensure requirements to ensure licensees from those jurisdictions underwent a suitable criminal history record check. Furthermore, misconduct can occur *after* a criminal history record check has been conducted, making it necessary to redetermine an applicant's character and conduct meets requirements.**

3. *We concur with the recommendation to recodify rules to reflect statute, fully accommodate all credential types regulated by the Board, and contain all procedures affecting the public, including required forms.*

4. *We concur with the recommendation to ensure rule-based requirements for all credentials, such as jurisprudence examinations, refresher training, and continuing education requirements, are consistent.*

   *The Board agrees that the jurisprudence requirement should be clearly stated for the temporary licenses. The continuing education requirements for the volunteer licenses is already stated in rule and the Board agrees that the continuing education requirement for other types of temporary licenses should be made consistent.*

5. *We concur with the recommendation to ensure fees are objectively established and collect 125 percent of direct Board costs.*

6. *We concur with the recommendation to actively oversee temporary credentialing processes and ensure OPLC practices conform to statute and rules.*

7. *We concur with the recommendation to approve initial applications and renewals, should these be allowed in the future, before licenses are issued.*

8. *We concur with the recommendation to establish performance goals, objectives, and targets to demonstrate how temporary credentialing contributes to achieving expected outcomes.*

9. *We concur with the recommendation to establish data requirements and reporting frequencies on performance metrics*

   *The Board agrees that there should be a periodic report on all types of temporary licenses issued and their impact on the practice of dentistry in the State.*

10. *We concur with the recommendation to clarify the terms and conditions of its relationship to the OPLC through rules.*

    *The Board intends to work with OPLC going forward to establish processes and procedures, seek statutory changes, and engage in rulemaking to support the recommendations.*

### *Expanded Function Dental Auxiliaries*

Beginning in August 2018, a hygienist or dental assistant with training and experience meeting Board-established standards could obtain an EFDA permit. EFDAs were qualified to place, contour, and adjust restorative materials. This allowed EFDAs to perform traditional dentist duties under a dentist's direct supervision. EFDAs were an alternative provider model originating in other jurisdictions. Creation of the permit was intended to increase the number of credential holders in the State to minimize or eliminate perceived barriers in the dental care service delivery model. The Board was required to adopt rules on application, permit, education, supervision, and scope of practice requirements. To obtain a permit, applicants had to meet rule-based educational, training, and experience requirements, and apply to the Board. Twenty-six EFDA permits were issued in total between the credential's introduction in CY 2013 and June 2021. Among the 26 issued permits, 21 (80.8 percent) were active. Licensed hygienists held two active permits (9.5 percent). Dental assistants held the remaining 19 active permits (90.5 percent).

**Observation No. 22**

**Revise Expanded Function Dental Auxiliary Permit Controls Or Dissolve The Credential**

Board controls over EFDA permits were inadequate. Regulation of EFDAs initially relied solely upon Board rules – there was no statutory underpinning. Rules also inappropriately limited eligible applicants for an EFDA permit. Such extra-legal rulemaking was prohibited, likely infringed on the fundamental rights of individuals to pursue an occupation, and exposed the Board to potential federal antitrust scrutiny. Economic factors primarily drove the development of the credential, not a clearly established risk to the public's health, safety, or welfare. Given the improvised nature of EFDA regulation, statute incompletely regulated EFDAs, and Board rules were similarly incomplete. Some OPLC controls relied upon ad hoc rules, and were informal and incomplete. The efficiency or effectiveness of EFDA permitting was never established. There were no performance

metrics or routine monitoring of permitting process timeliness. No data were available to permit assessment of timeliness or efficiency during the audit period. Nothing demonstrated regulation of EFDAs efficiently achieved expected outcomes.

**Public Protection Need For A Permit Requirement Not Clearly Established**

There was no apparent public protection need to create the EFDA credential. To achieve expected public protection outcomes, dentists and hygienists had to be qualified and licensed by the Board. EFDA permits were not explicitly tied to a similar expected outcome. Instead, EFDA regulation was purportedly driven primarily by economic considerations, not a need to protect the public from unqualified practitioners because only dentists could perform these duties. EFDA duties were supplemental to those of hygienists and dental assistants. The Board could define the scope of practice for hygiene, as well as specify the procedures a dentist could assign to a dental assistant. Both had to practice under the supervision of a dentist, and EFDA duties could have been delegated to them if Board rules allowed. Additionally, EFDA competency was established by third parties, and was not contingent upon a Board-issued credential.

Nonetheless, an EFDA permitting framework was created by rules that became effective in October 2013, without an underpinning statute. A statutory basis for EFDA rules followed nearly five years later, when the Board requested it be added to *Dentists and Dentistry* to authorize its then-baseless EFDA rules. Statute authorizing regulation of the new occupation became effective in August 2018. The requested statutory changes were characterized as housekeeping. They were not explicitly framed as an expansion of the Board's regulatory scope and the addition of another regulated occupation to the dental care industry.

**Incomplete Statute**

The statute underpinning EFDA regulation was requested by the Board but EFDAs were poorly integrated into *Dentists and Dentistry*. Board rules, to a limited extent, and ad hoc rulemaking more extensively, were relied upon to address statutory gaps. Key public protection controls were absent. For example, there were no:

- criminal history record check requirements,
- requirements the Board adopt rules on relevant ethical standards and potential credential revocation for noncompliance,
- fee requirements,
- endorsement credentialing provisions,
- penalties for unpermitted practice or noncompliance with *Dentists and Dentistry* other than temporary suspension for matters involving imminent danger to life or health,
- renewal and temporary credentialing processes, and
- inactive and lapsed credential provisions, or reactivation and reinstatement options.

**Inadequate Rules**

EFDA-related rules lacked underpinning statutory authority – and were therefore extra-legal – for part of the audit period. Rules improperly limited eligibility for the permit and incompletely

integrated EFDAs into numerous requirements. Key public protection controls were absent. Rules inappropriately required an initial application fee. Renewal fees were not required by statute or rule, but instead were imposed by ad hoc rules. Certain continuing education requirements were also imposed by ad hoc rule. Other Board-developed requirements were little more than adoption of commercial, third-party training or other standards.

***Rules Inappropriately Limited Applicants Eligible For A Permit***

Rules limited eligible dental assistant applicants for an EFDA permit to certified dental assistants and graduate dental assistants. However, State policy specified any dental assistant was eligible to become an EFDA. The Board was prohibited from expanding or limiting a statutory definition affecting the scope of who may pursue an occupation. The statute enabling the Board to permit EFDAs followed adoption of relevant Board rules, and the statute differed from the content of the rules. As a result, the rules were likely nullified, and enforcing rule-based requirements was likely improper.

***Incomplete Rules***

Rules incompletely incorporated EFDAs, leading to ad hoc rulemaking. Rules did fill in some statutory gaps. For example, rules provided for permitting by endorsement for properly credentialed individuals from other jurisdictions, specified qualification course criteria, clarified curriculum approval, and required supervised post-course completion training. However, ad hoc rulemaking affected initial and continuing education and renewal requirements and fees. Rules:

- required registration, but no application or registration form was formalized;
- required an initial permit application fee, without statutory authority;
- lacked a renewal form and renewal procedures and requirements, other than requiring EFDAs renew biennially along with hygienists and complete ten continuing education units each biennium;
- excluded EFDAs from inactivating an active permit, reactivating an inactive permit, lapsing and reinstating a permit, restricting or suspending permit, and renewing a permit as active if on active military duty;
- excluded EFDAs from requirements to notify the Board of a change in address and the corresponding sanction for failure to do so;
- did not require applicants provide their social security number, but in practice social security numbers were obtained;
- excluded EFDAs from temporary credentialing;
- excluded EFDAs from continuing education verification procedures and waiver of continuing education requirements for the first renewal; and
- lacked requirements EFDA applicants take a jurisprudence examination.

Additionally, rules were insufficiently clear, requiring clarifications that at times resulted in additional ad hoc rulemaking.

**Uncontrolled Permit Processing**

OPLC management formalized no specific controls for administrative, business processing, and recordkeeping processes related to EFDAs. Informal guidance incompletely addressed EFDA-related administrative requirements. EFDAs were treated like hygienists for the purpose of application timeliness and renewals. Internal guidance contained processing practices and ad hoc rule requirements, such as:

- proving current basic life support for health care providers;
- documenting supervision by a licensed dentist;
- submission of a passport photograph when initially applying;
- clarifying applicants without active EFDA employment could apply for and obtain a permit;
- requiring applicants provide the Board with a "supervision form" before working, but without an adopted "supervision form;" and
- providing for approval of complete applications by a single Board member.

EFDA provisions were not well represented on the OPLC's website during the audit period. For example, the application form was not on the website during or after the audit period. Some published guidance also contained ambiguities.

**Recommendations:**

**We recommend the Board examine the costs and benefits of the EFDA permit. If it cannot be objectively demonstrated to efficiently produce expected outcomes and provide substantive public protection, eliminate the credential. If the Board objectively determines the credential efficiently provides substantive public protection and should continue, we recommend the Board improve the EFDA control framework, and:**

1. **discontinue imposition of ad hoc rule requirements;**
2. **seek legislative changes to fully incorporate EFDAs throughout statute, including key public protection provisions;**
3. **revise rules to fully incorporate EFDAs, including key public protection provisions;**
4. **actively oversee EFDA credentialing processes and ensure OPLC practices conform to statute and rules;**
5. **approve applications and renewals;**
6. **establish performance goals, objectives, and targets to demonstrate how EFDA permitting contributes to achieving expected outcomes;**
7. **establish data requirements and reporting frequencies on performance metrics; and**
8. **adopt rules detailing the terms and conditions of the relationship between the Board and OPLC.**

Board Response:

*We concur with the recommendations.*

1. *We concur with discontinuing imposition of ad hoc rule requirements.*

   *As a professional board we are called upon to make sound decisions based on rules and statutes.*

2. *We concur with seeking legislative changes to fully incorporate EFDAs throughout statute, including key public safety provisions.*

3. *We concur with revising rules to fully incorporate EFDAs, including key public safety provisions.*

4. *We concur with actively overseeing EFDA credentialing processes and ensure OPLC practices conform to statutes and rules.*

   *As for processes, the Board has the dental and healthcare background to understand the education requirements needed to conform to best dental practices. Along with OPLC licensing staff, the Board is best equipped to oversee credentialing of dental providers that are safe and well qualified. We acknowledge that because of constantly changing OPLC administrative staff since its inception, some processes have been lost in transference or not as consistent as originally intended. Going forward we hope that with the collaboration of staff and Board, new training can be implemented so that we can be more consistent with statutes and rules. We intend to work on this goal as a continuous evaluation of our practices.*

5. *We concur with approving applications and renewals.*

   *The Board and the OPLC needs to clarify, in statute, the role of Board members in approving applications and renewals. Hopefully, this will be done in the next year, but is dependent on opening statute and procuring a legislative sponsor.*

6. *We concur with establishing performance goals, objectives, and targets to demonstrate how EFDA permitting contributes to achieving expected outcomes.*

   *In the next year, the Board and the OPLC will take time to formally devise goals, objectives, and targets for Board regulation of EFDAs.*

7. *We concur with establishing data requirements and reporting frequencies on performance metrics of EFDAs.*

   *Within the next year, we will develop forms and monitoring systems to collect data on the utilization of EFDAs in private practice and public health facilities to better ascertain the effectiveness of Board service to the public.*

8. *We concur with formalizing the terms and conditions of the relationship between the Board and the OPLC.*

   *Within the next year, we will formalize responsibilities of the Board and the OPLC to clarify duties of OPLC administration to the Board.*

### *Lapsed-Reinstated And Inactivated-Reactivated Primary Credentials*

Licensees no longer authorized to practice, or no longer actively practicing, could return to active practice through reinstatement of a lapsed license or reactivation of an inactive license. A license lapsed when a licensee did not submit a complete renewal application by April 30 of their renewal year, or if the licensee submitted an application but did not meet renewal requirements. A licensee with a lapsed license was not authorized to practice until their license was reinstated. Lapsed licenses could be reinstated if the licensee met renewal and reinstatement requirements, and paid applicable fees.

Lapsed licensees who did not actively practice in the State within two years of their previous renewal, with the exception of licensees on active military duty, were considered to be inactive. The Board was to place these licensees on the inactive list. Inactive licensees were required to renew biennially and pay an inactive registration fee. A licensee could return to active status by filing a written request; providing evidence of continuing good professional character, competence, and continuing education; and paying the full registration fee. Failure to maintain a license was a sanctionable offense. Nothing specified how lapse and inactive credential requirements applied to EFDA permits, but some were nonetheless categorized as lapsed and inactive. As of June 14, 2021, 1,744 dentists; 1,160 hygienists; and four EFDAs had a lapsed or inactive credential.

Reportedly, approximately 150 dentist licenses lapsed during CY 2020, and 200 hygienist licenses lapsed during CY 2021. No data on lapsed hygienist licenses from CY 2019 was readily available. Neither was the inactive list available.

**Observation No. 23**

**Improve Lapsed And Inactive Credential Controls**

Board controls over lapsed and inactive credentials were inadequate. Rules and practice did not allow for progression from lapsed to inactive status, then to termination of a license when it was not reinstated or reactivated. Key public protection controls were absent. The Board did not approve reinstatement or reactivation applications. Approvals instead relied on extra-legal delegations of authority to individual members and staff. Rules were inconsistent with statute. Some statutory and rule-based requirements between processes were inconsistent. EFDAs and all supplemental credentials were entirely excluded from lapse-reinstatement and inactivation-reactivation processes. However, rules provided for a reinstatement fee for Certified Public Health Dental Hygienists (CPHDH), but without underlying procedures.

OPLC administration of relevant business processing, recordkeeping, and other administrative and clerical operations were incomplete. There was no formal procedural manual, and staff created informal guides encompassing improvised practices. Practices relied upon extra-legal, ad hoc rules. Requirements between processes were inconsistent, and procedures within processes were internally inconsistent. Practices were inefficient. Neither the Board nor the OPLC developed a means to measure outcomes or performance. There was no routine monitoring of timeliness, and data to permit assessment of timeliness or efficiency were not published during the audit period. The efficiency or effectiveness of lapse-reinstatement and inactivation-reactivation processes was never established.

**Inconsistent Requirements Between Processes To Regain Active Licensure**

The process to reinstate a lapsed license was inconsistent with the process to reactivate an inactive license. Statute created a connection between the two processes that was not found in rule and practice. Licenses lapsed if they were not renewed. After two years of lapsed status, licensees were to be placed on the inactive list, and register as inactive. Failure to register was misconduct and grounds for disciplinary action, which could have resulted in license revocation or suspension. However, the Board did not pursue sanctions. Neither statute nor rule provided for non-disciplinary relinquishment of a license. Informal OPLC guidance accommodated a licensee choosing to lapse a license at any time. This conflated a "voluntary" lapse with the choice to inactivate or surrender a license. While individual lapse, reinstatement, inactivation, and reactivation processes were intended to achieve separate results, several elements should have been similar or the same. They were not. Some elements also varied from other credentialing processes without rationale.

- Individual Board members or staff inappropriately approved reinstatement of lapsed licenses. Staff alone inappropriately approved reactivation of inactive licenses.

- Statute required a criminal history record check for reinstatement of a license lapsed one or more days, but not for reactivation of a license inactive for an unlimited period. However, there were no relevant rules for either procedure. Internal guidance contained inconsistent, ad hoc requirements on reactivations only. Regardless, the requirement was unimplemented.

- Rules required reinstatement applicants to retake the jurisprudence examination for a lapse of one to 180 days. There was no jurisprudence examination requirement for a reactivation of a license that had been inactive for an unlimited period.

- Internal guidance provided for screening applicants using the American Association of Dental Boards' Clearinghouse, instead of the more comprehensive National Practitioner Data Bank.

- Reactivation processes controlled for Prescription Drug Monitoring Program registration through ad hoc rules, but reinstatement processes had no procedural controls over registration.

- Internal guidance lacked controls over infection control, pain management, or addiction disorder continuing education requirements.

- Neither statute nor rule for reinstatement required letters of good standing be submitted. Instead, ad hoc rules required them. Statute, rule, and internal guidance for reactivation consistently required them.

- Reactivation applicants out of practice for five years or more were required to pass one specific clinical examination. However, applicants for regular licensure by examination or endorsement were allowed to take that specific examination, or any similar national or regional examination.

- Processing procedures, availability of instructions and forms, and notarization requirements also differed.

**Lapsed Licenses Inadequately Controlled**

Controls over lapsed licenses were inconsistent with statute, internally inconsistent, incomplete, and relied upon ad hoc rules and improvised practices. Informal OPLC guidance allowed licensees to choose to lapse a license at any time. Statute provided a lapsed license became inactive after two years. In practice, the holder of a lapsed license could apply for reinstatement at any time. However, rule limited reinstatement to a six-month period immediately following April 30 of the year in which the license was not renewed. Rules were silent on the status of a lapsed license after the six-month period ended. In practice, lapsed licenses remained in the credentialing database with no expungement procedures. Some licenses that lapsed in the 1990s remained listed through May 2021. OPLC practice required former licensees to apply for licensure as a new applicant after the six-month reinstatement window, without underpinning statute or rule.

Rules framed a process for applicants to follow if they failed to timely submit a completed renewal application. However, there were no specific rules to ensure lapsed licenses were timely identified or properly categorized in the credentialing database. Neither were there rules to ensure licensees were notified of their ineligibility to practice or right to appeal. Informal OPLC guidance and practices only notified renewing licensees that their license would lapse after April 30 if it was not renewed.

The Board could reinstate a lapsed license if the applicant met eligibility requirements for renewal, met additional reinstatement requirements, and paid registration, reinstatement, and late renewal fees. However:

- there were no specific reinstatement procedures if a license lapsed because the licensee failed to qualify for renewal;
- rules and informal guides referenced a reinstatement form for applicants to use that was not available and was improperly referenced in rules;
- informal guides contained numerous ad hoc rules, such as requiring submission of information and materials beyond what rules required and conducting American

Association of Dental Boards' Clearinghouse checks, and conflicted on whether an applicant had to retake a jurisprudence examination;
- rules were silent on verifying character and conduct of applicants through third-party databases or criminal history record checks; and
- OPLC procedures provided the Board President would approve reinstatements, reflecting improperly delegated Board authority to a single member.

Additionally, rules provided for a late renewal and reinstatement fee for lapsed CPHDH certification, and the hygienist hardcopy renewal form inappropriately required lapsed certificate holders also pay an on-time renewal fee. However, there were no relevant statutes, rules, form, guides, or procedures controlling CPHDH reinstatement processes.

**Inactive Licenses Inadequately Controlled**

The framework controlling inactive licenses was inadequate. No rules described the procedures for transferring licenses from active to inactive status. The Board did not adopt required rules for administering the inactive list. If a list was requested, staff had to manually create one from the data contained in the credentialing database. Improvised practices allowed active licensees to renew as inactive during the license renewal process. These licensees were informally exempted from reporting continuing education and the use of anesthesia or sedation, which appeared appropriate. However, they were also exempted from reporting ownership interests, which appeared inconsistent with statute. In practice, staff informally waived statutory requirements for licensees to renew as inactive if they were renewing for the first time but had never worked in New Hampshire. Staff also informally waived rule requirements for these licensees to report their continuing education. Otherwise, inactive license renewal processes reportedly followed those for active renewals.

To reactivate an inactive license, licensees were to file a written request with the Board, provide documentation of continuing professional character and competence, and pay the full registration fee. Applicants had to meet competency requirements that were increasingly rigorous the longer their license was inactive. The most rigorous requirement was passing a specific clinical examination no more than six months before reactivation if the license had been inactive for five years or more. Rules incompletely defined the information required for reactivation. External instructions and internal guidance contributed to the imposition of ad hoc rules on applicants.

There was no process in rules to request Board approval of the rule-required refresher course. Informal instructions specified only that the licensee needed to complete a refresher course. Staff requested clarification in October 2017 and concluded rule changes were needed to set refresher course criteria. However, no additional guidance or criteria were provided on the parameters of the refresher course. Decisions instead rested upon subjective Board decisions with no means to memorialize criteria to add consistency to approvals over time. In one case, the Board waived the requirement altogether because it was not possible to comply with the rule-based refresher course requirement. The Board instead required additional continuing education to reactivate a license. The license was reactivated during a nonpublic meeting more than two-and-a-half years after the initial reactivation request.

Additionally, while both statute and rules required a licensee to pay the full registration fee to reactivate an inactive license, guidance specified licensees were to pay the difference between inactive and active registration fees.

**Recommendations:**

**We recommend the Board:**

1. **discontinue imposition of ad hoc rule requirements;**
2. **approve all reinstatement and reactivation applications before license issuance;**
3. **seek statutory changes to ensure consistency between reinstatement and reactivation requirements, and across credential types, including key public protection provisions, and accommodate non-disciplinary relinquishment of a license;**
4. **revise rules to reflect statute, accommodate all credential types regulated by the Board, include key public protection provisions, and contain all procedures affecting the public;**
5. **ensure rules provide for a credential's status to follow a stepwise progression from lapsed to inactive, then to revoked or non-disciplinary relinquishment;**
6. **ensure rule-based requirements for all credentials, such as jurisprudence examinations, refresher training, and continuing education requirements, are consistent;**
7. **actively oversee lapse-reinstatement and inactivation-reactivation processes and ensure OPLC practices conform to statute and rules;**
8. **establish metrics to monitor lapsed and inactive credentials, establish reporting frequencies on performance metrics, and ensure the OPLC provides relevant data; and**
9. **clarify the terms and conditions of its relationship to the OPLC.**

Board Response:

*We concur with the recommendations.*

1. *We concur with discontinuing imposition of ad hoc rule requirements.*

   *Please see our response to Observation No. 4.*

2. *We concur with approving or denying all applications, based on the statutes and the rules.*

   *The Board will review current statues and rules and seek necessary changes.*

3. *We concur with seeking statutory changes to ensure consistency between reinstatement and reactivation requirements and across credential types, including key public safety provisions, and accommodate non-disciplinary relinquishment of a license.*

*The Board intends to engage in the rulemaking process to establish applications for reinstatement and reactivation. The Board recommends that the applications be reviewed by the OPLC, and then presented to two Board members to make the final determination regarding acceptance or denial. The Board will begin the process of revising the necessary statutes and rules to support this recommended procedure.*

4. *We concur with revising rules to reflect statute, accommodate all credential types regulated by the Board, include key public safety provisions, and contain all procedures affecting the public, including required forms.*

   *As we mentioned, the consistency between the statute and the rules is a major key to accommodate all credential types including key public safety provisions. The timeframe of revising the rules is immediate.*

5. *We concur with ensuring rules provide for a credential's status to follow a stepwise progression from lapsed to inactive to revoked or non-disciplinary relinquishment.*

   *The Board is in favor of establishing a clear process to transfer the lapsed licensees to inactive status and then to revoked status if appropriate. The Board intends to immediately begin collaborating with the OPLC to mutually agree upon this process. To the extent that statutory and/or rule changes are indicated, the Board intends to immediately initiate this process.*

6. *We concur with ensuring rule-based requirements for all credentials, such as jurisprudence examinations, refresher training, and continuing education requirements, are consistent.*

   *The Board is in favor of following the statute and the rules when it comes to the jurisprudence examination, continuing education requirements, and all other credentials. Collaborating with the OPLC is key to ensuring consistency. The timeframe is immediate.*

7. *We concur with actively overseeing the credentialing processes and ensuring OPLC practices conform to statute and rules.*

   *The Board is responsible for overseeing the credentialing processes. The Board will collaborate with the OPLC since the OPLC has all licensees' data, and should update the software to implement the rules especially when it comes to reinstatement and reactivation requirements.*

8. *We concur with establishing metrics to monitor lapsed and inactive credentials, establish reporting frequencies on performance metrics, and ensure the OPLC provides relevant data.*

9. *We strongly concur with clarifying the terms and conditions of our relationship with the OPLC via formal agreement.*

   *Establishing a formal agreement with the OPLC is a major key for a healthier relationship with OPLC and a major key to implementing applicable statutes and rules. The Board is willing to immediately begin collaborating with the OPLC to reach a formal agreement and meet this goal.*

**Supplemental Credentials**

Supplemental credentials were available to qualified licensees to expand their scope of practice. Supplemental credentials available to licensees qualified to administer and monitor anesthesia and sedation included:

- dentist permits for general anesthesia and deep sedation (GA/DS),
- dentist permits for moderate sedation-unrestricted (MS-U),
- dentist permits for moderate sedation-restricted (MS-R),
- hygienist permits for nitrous oxide minimal sedation, and
- hygienist permits for local anesthesia.

Hygienists could also qualify as a CPHDH, which allowed them to perform additional duties not otherwise within the scope of a hygienist's license. Table 10 summarizes the total number of supplemental credentials by status. Table 11 summarizes supplemental credentials initially issued in SFYs 2018 through 2021.

**Table 10**

**Total Supplemental Credentials And Statuses, As Of June 14, 2021**

| | Credential Status | | | | | |
|---|---|---|---|---|---|---|
| | Active | Inactive | Lapsed | Suspended | Other[1] | **Total[2,3]** |
| **GA/DS** | 110 | 0 | 100 | 0 | 60 | **270** |
| **MS-Restricted** | 9 | 0 | 17 | 0 | 6 | **32** |
| **MS-Unrestricted** | 11 | 0 | 21 | 0 | 7 | **39** |
| **Local Anesthesia** | 889 | 117 | 118 | 0 | 27 | **1,151** |
| **Nitrous Oxide Minimal Sedation** | 122 | 6 | 1 | 0 | 6 | **135** |
| **CPHDH** | 47 | 1 | 5 | 3 | 7 | **63** |
| **Total** | **1,188** | **124** | **262** | **3** | **113** | **1,690** |

Notes:

1. Other statuses included: 69 deleted, 26 pending, seven withdrawn, six active-late renewal status, four retired, and one active-pending renewal.
2. Does not represent the unique number of credential holders, but the total number of supplemental credentials recorded in the credentialing database management system. Licensees may have held multiple supplemental credentials.
3. Included 42 not associated with a license number: 26 pending, eight deleted, seven withdrawn, and one active.

Source: Unaudited OPLC credentialing data.

**Table 11**

**Initial Supplemental Credentials Issued, State Fiscal Years 2018–2021**

| | State Fiscal Year | | | |
|---|---|---|---|---|
| | 2018 | 2019 | 2020 | 2021 |
| **GA/DS** | 22 | 18 | 12 | 24 |
| **MS-Restricted** | 1 | 1 | 0 | 1 |
| **MS-Unrestricted** | 1 | 5 | 0 | 0 |
| **Local Anesthesia** | 75 | 54 | 49 | 69 |
| **Nitrous Oxide Minimal Sedation** | 30 | 48 | 24 | 29 |
| **CPHDH** | 11 | 6 | 4 | 5 |
| **Total** | **140** | **132** | **89** | **128** |

Note: The number of unique licensees issued supplemental credentials was not readily available. Licensees may have held multiple supplemental credentials.

Source: Unaudited OPLC credentialing data, as of May 27, 2021, and July 21, 2021.

***Anesthesia And Sedation Permits For Dentists***

Five levels of anesthesia and sedation could be used in dentistry: 1) general anesthesia, 2) deep sedation, 3) moderate sedation, 4) minimal sedation, and 5) local anesthesia. Beginning in CY 1996, qualified dentists could administer general anesthesia, deep sedation, or moderate sedation on an outpatient basis after applying for and obtaining a permit from the Board. Rules provided for three types of permits for dentists with different competency requirements and practice restrictions.

- GA/DS Permit – Applicants were required to have advanced training in anesthesiology and have a properly staffed and equipped facility. GA/DS permittees could administer general anesthesia and deep sedation, or moderate sedation.

- MS Permits – Applicants were required to meet certain competency requirements and have a properly staffed and equipped facility. MS-R permittees could only administer moderate sedation to post-pubertal patients. MS-U permittees could administer moderate sedation to patients of any age.

Dentists could administer lower levels of anesthesia or sedation without a permit. In practice, this included pediatric minimal sedation, despite statutory requirements since August 2018 for the Board to require a permit and adopt practice rules.

Applicants were to document competence and undergo inspections and – once permitted – undergo comprehensive evaluations. Individual dentists could hold multiple permits, each corresponding to a different location. Permits could be issued and renewed every two years when the dentist's license was renewed, provided competency requirements were met. Unaudited OPLC data, as of

June 14, 2021, indicated 145 dentists held 329 anesthesia and sedation permits. An additional 12 GA/DS permits were not associated with a dentist's license number.

**Observation No. 24**

**Improve Dentist Anesthesia And Sedation Permit Controls**

Board controls over dentist anesthesia and sedation permits were inadequate, compromising the public protection value of the control framework. Permitting requirements and regulation of permittees was largely delegated to the improvised Anesthesia and Sedation Evaluation Committee (ASEC) and ASEC Advisory Committee (ASEC-AS), for which oversight controls were largely absent. This exposed the Board to potential federal antitrust scrutiny. Licensees of other regulatory agencies who provided anesthesia in dental offices were inappropriately regulated by the Board using extra-jurisdictional requirements. Inadequate controls over the statutory, regulatory, and procedural framework resulted in unimplemented or ambiguous and complex requirements. Improperly adopted requirements were not valid or enforceable. Known overreach, failure to implement State policy, and imposition of ad hoc rules were abusive. Application and extra-legal renewal processes provided questionable public protection, and appeared perfunctory and wasteful. There was no monitoring of permitting processes or process timeliness. The Board did not ensure dentists who needed a permit were identified and became permitted. Requirements were improperly sequenced, and inspections and evaluations were delayed and waived. Nothing demonstrated dentist anesthesia and sedation permitting efficiently achieved expected outcomes.

Our audit work focused on controls and was not designed to identify all instances of noncompliance. However, we did find cases demonstrating how inadequate controls inconsistently affected applicants, permittees, and permitting decisions. Records were inconsistently available and reliable to a degree that we qualify every conclusion resting on them. Lack of comprehensive, accurate records limited the auditability of permit application, facility inspection, comprehensive evaluation, and permit renewal transactions and decision making, as well as assessments of timeliness and consistency.

**Inadequate Controls Over Permit And Practice Requirements**

Inadequate controls over dentist permit and practice requirements were known to pose a potential risk to public safety. Requirements were often not compliant with statutory requirements. Many key statutory requirements were unimplemented. Rules outsourced the setting of regulatory standards to third-party publications that were either unavailable or contained ambiguous requirements. Some permit-related fees lacked a statutory basis.

***Extra-jurisdictional Regulation Of Other Agencies' Licensees***

Non-dental anesthesia providers licensed by other regulatory agencies were inappropriately regulated, with Board and ASEC knowledge. The Board was prohibited from adopting rules under another agency's authority. There was no indication either the Board or the ASEC consulted with the Board of Medicine or the Board of Nursing to coordinate regulation of their licensees working in dental offices.

Since August 2018, the Board was required to adopt rules requiring the physical presence of a dedicated anesthesia provider to monitor the procedure and recovery when: 1) GA/DS or MS was in effect and 2) GA/DS was administered to patients under the age of 13. The provider could be a dentist permitted for the level of anesthesia being administered or a non-dental anesthesia provider. However, the Board was aware required rules had not been adopted. Instead, Board rules addressing anesthesia or sedation administration by non-dental anesthesia providers pre-dated the August 2018 statutory requirements. Rules, internal guidance, and practice inappropriately imposed certain permitting requirements on non-dental anesthesia providers. Non-dental anesthesia providers were:

- purportedly required to submit a request to provide anesthesia in a dental office,
- reportedly required to submit emergency plans for each dental office in which they administered sedation,
- required to pass an initial facility inspection conducted by agents of the Board before being approved to administer anesthesia or sedation in a dental office,
- required to subsequently pass a comprehensive re-evaluation conducted by agents of the Board every five years,
- purportedly required to pay honorarium for inspections and evaluations, and
- reportedly required to submit to the Board for approval, requests that ad hoc requirements be waived.

Also, requirements were inconsistently applied. Unaudited OPLC data indicated, as of February 2021, of 58 offices hosting non-dental providers, 11 (19.0 percent) had facility inspections, 45 (77.6 percent) were not inspected, and two (3.4 percent) had inspections waived. Additionally, facility inspection requirements reportedly varied based on ad hoc determinations by Board agents as to whether non-dental anesthesia providers were "self-contained." A provider was not considered self-contained if a dental office provided any required equipment or drugs.

***Statutory Requirements Not Implemented***

The Board did not implement aspects of State policy related to a dentist's use of anesthesia and sedation. The Board knew it neither adopted required rules on the use of minimal anesthesia nor structured permitting processes for required pediatric minimal sedation permits. Knowingly failing to adopt required rules was abusive. Instead, rules contradicted State policy and stated dentists administering minimal sedation were not required to have a permit. Implementing a regulatory framework over minimal sedation was viewed to be a potentially "crushing" administrative burden. Furthermore, the ASEC-AS reported to the Board that dentists administering pediatric minimal sedation were required to have an MS-U permit. However, there were no corresponding requirements in rules or external instructions, and no indication an MS-U permit for pediatric minimal sedation was required in practice. Other unadopted requirements included the margin of safety for administering minimal sedation, training, equipment and drugs, and minimum staffing for administering pediatric minimal sedation.

Additionally, rules:

- adopted ambiguous credentialing requirements, including education, for GA/DS permits;
- lacked credential requirements, including education, for MS permits;
- incompletely established permit application requirements;
- lacked facility inspection and comprehensive evaluation procedures;
- lacked inspection and evaluation fees;
- did not establish all requirements for administering GA/DS to patients under the age of 13, including informed consent and the need for a dedicated anesthesia provider;
- lacked an exemption for dentists who were board-eligible or board-certified in dental anesthesiology or oral and maxillofacial surgery from the requirement to have a second dedicated anesthesia provider;
- did not define board-eligible or board-certified;
- lacked minimum requirements for monitoring patients undergoing or recovering from GA/DS or MS;
  did not establish minimum requirements for a physical evaluation and medical history prior to administering GA/DS or MS;
- lacked provisions on continuing education for renewing GA/DS permits; and
- lacked provisions on adverse events involving GA/DS or MS, including reporting, root cause analysis, and corrective action plan implementation.

Rules also lacked elements on permit suspension or revocation under conditions other than unsatisfactory facility inspection or comprehensive evaluation results. For example, the process to revoke a permit after an inspection had occurred, but an evaluation had not been conducted within the required eight-month time limit, was unstructured.

***Inadequate Control Of Non-Statutory Requirements***

The Board lacked adequate oversight and control over the regulatory and procedural framework governing permits. Inadequate control contributed to the known and unknown imposition of ad hoc rules, unclear requirements, and inconsistent practices. Rules did not always clarify statute or completely describe procedures affecting permittees or the standards permittees were required to follow.

- Reliance On Third-party Publications And Standards – The Board outsourced permitting and practice standard-setting to four separate third-party publications. Rules referenced an outdated version of one publication. Neither the current nor outdated version of this publication were available as required by statute, adversely affecting transparency. The other three publications were guidelines. They did not include all permitting or practice requirements, and included additional requirements not reflected on informal ASEC inspection and evaluation forms. As third-party publications were revised, updated requirements were imposed, but without new rules being adopted.

- Inspection And Evaluation Requirements – The Board lacked adequate oversight of facility inspection and comprehensive evaluation requirements and processes. The

Board did not adopt required rules to establish the nature and requirement of all formal and informal inspection and evaluation procedures. Instead, the ASEC imposed inspection requirements through ad hoc rules contained in unadopted and improperly modified forms.

- Fee Requirements – ASEC members improperly received honorarium from the applicants and permittees they were inspecting or evaluating. The ASEC also imposed a fee on applicants and permittees who cancelled a scheduled inspection or evaluation with 72 or fewer hours' notice. This was without statutory or rule basis. Additionally, permittees were charged a renewal fee by the OPLC, without statutory or rule basis.

**Inconsistent Public Protection**

Rules and practices did not ensure public protection consistent with established standards. The Board had a duty to ensure only properly trained and competent dentists administered anesthesia and sedation. Permit applications and renewals, inspections, evaluations, and re-evaluations could have helped provide assurance that dentists met acceptable standards for the safe and appropriate use of anesthesia and sedation. However, untimely regulatory activity, perfunctory and waived requirements, and improvised practices compromised the control framework.

In practice, obtaining and maintaining a dentist anesthesia and sedation permit included five steps:

1. submitting an initial application form and fee;
2. undergoing a facility inspection, paying honorarium, and receiving an initial permit;
3. within eight months, undergoing a comprehensive evaluation and paying honorarium;
4. during license renewals, submitting a permit renewal application form and fee; and
5. at least every five years, undergoing a comprehensive re-evaluation and paying honorarium.

Inspections were to be conducted for each office location where applicants would be administering sedation, and for each host dentist location in which mobile dentists or non-dental anesthesia providers would be working. Inspections were intended to ensure dentists had the proper equipment and drugs to safely administer anesthesia and sedation.

Comprehensive evaluations and re-evaluations were intended to ensure dentists had the proper support personnel, records, and procedures on patient treatment. In practice, the evaluation also involved: 1) a clinical review of anesthesia or sedation administration for two patients, and 2) simulated emergency scenarios intended to assess the ability of personnel to respond appropriately. However, unlike other Board-issued credentials, permits were issued before comprehensive evaluations were completed, allowing for practice before the permittee's qualifications were fully established.

***Step One: Permit Application***

The Board lacked adequate oversight and control over permit application processing, resulting in noncompliance. Staff were informally responsible for determining administrative completeness,

but did not verify applicant compliance with requirements. The process appeared perfunctory and largely wasteful without substantive review of permit applications.

*Inconsistent Controls Over Submission Of Applications And Payment Of Fees*

Requirements were inconsistently applied in practice.

- In one case, an unlicensed applicant improperly submitted a permit application. Permit applicants were to be licensed dentists. Application fees were to be returned if applicants had not complied with one or more statutory application requirement. There was no record the permit application fee was returned.

- Dentists applying to administer GA/DS or MS in their own office were required to submit a permit application form and fee. In one case, the Board accepted a "modified" application, with no record on how the application was modified, or whether the applicant submitted a waiver. The application was approved without a record the application fee was paid.

- Mobile dentists administering GA/DS or MS in a host dentist's office were reportedly required by ad hoc rule to provide certain information. Statute required any dentist seeking to administer GA/DS or MS to submit a permit application and pay an application fee. Due to inadequate records, it was unclear whether mobile dentists submitted statutorily-required permit application forms or consistently paid application fees.

- Rules required dentists hosting a mobile dentist, anesthesiologist, or nurse anesthetist to provide information on the provider. Ad hoc rules required submission of records during a facility inspection. Host dentists did not apparently pay an application fee.

Furthermore, dentists were charged a $35 application fee for each office location in which they sought to administer anesthesia and sedation. This appeared gratuitous. Permittees held up to eight permits, resulting in potential application fees totaling up to $280. However, application processing was not substantially affected by the number of office locations to be permitted. The OPLC did not conduct substantive evaluations or verify application information with dentists or third parties. For example, advanced training in anesthesia and sedation was not verified through third-party sources the way general dental education was verified for initial license applicants. Consequently, the OPLC did not incur additional processing costs for multiple office locations.

*Review Of Application Forms Unauditable*

Substantive evaluations of application forms were generally unauditable due to lack of records. The Board had statutory time limits within which it had to review applications and to identify errors or omissions before determining administrative completeness. However, the Board did not establish processes to assess compliance with application requirements or clarify known ambiguities. The Board also lacked a denial process and a process to withdraw permit applications. Board actions on permit application forms were inconsistent. The Board imposed ad hoc rules

requiring supplemental documentation. The Board used ad hoc rules to find the applicant ineligible for a permit, but later accepted a facility inspection and issued a permit without any record demonstrating how the grounds for denial were resolved. The Board sought clarification from the ASEC Chair on whether the applicant's employees had to conform to ad hoc rules, delaying action by one month. The Board delayed action by one month to obtain the Chair's recommendation. An application form was purportedly withdrawn after Board approval.

***Step Two: Facility Inspections***

The Board lacked adequate oversight and control over inspections. Inspection requirements were largely ad hoc. Applicants were improperly required to pay honorarium to ASEC members, who were also the inspectors. Some inspections occurred after statutory time limits to review and act on applications had passed. Inspections, decisions, and timeliness were generally unauditable.

*Inconsistent Controls Over Incomplete Inspections*

Inspection requirements were inconsistently applied. From SFY 2018 through SFY 2020, the Board voted facility inspections were not required for eight of 32 accepted and approved permit applications (25.0 percent). This included one application where one office location was subjected to inspection, but four other locations were apparently waived, and one application where the inspection was waived at the request of the ASEC Chair. Additionally, we identified a ninth application for which the Board apparently waived four of five inspections in SFY 2021. It was unclear whether formal waiver procedures were followed for any of the nine applications. Waiver reasons were inconsistently documented. We did find three applications where reportedly there was a comprehensive evaluation at the office location within the previous five years, which led to a waiver. However, this exception was not rule-based.

*Ad Hoc Inspection Standards*

Rules required dentists to have a properly equipped facility, as established by either one of two third-party publications. Rules did not define "properly equipped" or establish specific equipment or drug requirements to be inspected. In practice, the ASEC imposed inspection requirements through ad hoc rules within unadopted and improperly modified forms. Inspections assessed not only equipment and drugs but also included a review of staff credentials and office procedures. The ASEC also required ad hoc submission of templates for anesthesia records, emergency records, emergency plans, and post-operative instructions.

*Unmonitored Timeliness*

Board accepted and approved permit application forms were referred to the ASEC Chair, with a request to conduct an inspection. The Chair then assigned inspections to individual ASEC members. Since inspections were required before a permit was issued, and inspections followed Board acceptance of completed application forms, the statutory processing time limit for permit decisions applied. However, there were no inspections scheduling processes, internal time limits, or Board monitoring of inspection timeliness. The ASEC Chair monitored completion of inspections; however, it was unclear how frequent and over what period monitoring occurred. An

improvised OPLC permit database listed facility inspection dates. However, records were inaccurate. There were no controls over the improvised database and the database was dynamic, with data overwritten or modified without control.

In July 2020, the ASEC Chair requested, and the Board approved, an extension of the time to complete inspections. However, statutory time limits could not be extended without written agreement of the applicant. There were no records indicating affected applicants were either notified or provided a written agreement. Purportedly, it could take up to a year to complete a facility inspection under normal conditions, well outside the statutory time limit. This delayed permit issuance and when applicants could start administering anesthesia or sedation. After January 1, 2019, a permit application was to be considered approved if the Board did not approve or deny an application, or commence adjudicative proceedings, within the 60-day statutory processing time limit. It was unclear how many applicants had been affected by untimely Board action, and there was no process to issue permits when the 60-day time limit was exceeded. We found from July 2017 to April 2019, the Board accepted or approved ten inspections for three applicants between 126 and 217 days after it had accepted or approved their permit application forms.

*Inconsistent Monitoring Of Inspection Results*

Reportedly, applicants could fail an inspection for expired drugs or lack of required equipment, among other reasons. Rules allowed applicants failing an inspection to request a re-inspection be conducted by a different inspector, and required an additional fee. However, in practice, applicants were purportedly allowed one to two weeks to informally address deficiencies and still have the original inspection results be recommended to the Board as satisfactory. Uncorrected deficiencies after that time purportedly resulted in formalization of the original failed inspection.

ASEC members submitted their formal recommendations to the ASEC Chair, who in turn submitted recommendations to the Board. The Board reportedly reviewed inspection summaries to make permitting decisions. If inspection results were unsatisfactory, rules required the Board to: 1) limit or restrict a permit, without any underlying statutory authority; 2) impose remedial education; or 3) impose both requirements. No relevant procedures were established. Reportedly, staff provided information on inspections that were satisfactory to the Board. It was not clear, however, whether the Board received information on inspections that were unsatisfactory. Without this information, the Board could not take required remedial actions. No monitoring of unsatisfactory inspections was evident. We found one applicant who purportedly failed an inspection in December 2017, but Board records did not identify the failure and instead recorded an approval in March 2018. Staff issued permits once the Board accepted or approved an inspection or waiver, allowing dentists to begin administering GA/DS or MS.

***Step Three: Initial Comprehensive Evaluations***

The Board lacked adequate oversight and control over initial comprehensive evaluations. Evaluation requirements were largely ad hoc, and applicants were improperly required to pay honorarium to evaluators who were also ASEC members. Board controls allowed permitted dentists to administer anesthesia and sedation without a comprehensive evaluation demonstrating

competency, in some cases for more than four years. Since at least November 2017, the ASEC-AS expressed concerns to the Board, proposing applicants undergo a competency evaluation prior to permit issuance. Although the Board voted to accept the recommendation and adopt relevant rules, none were adopted through June 2021, when we concluded audit work on this topic.

*Ad Hoc Comprehensive Evaluation Standards*

Rules limited evaluations to only one office location, regardless of the number of locations for which a dentist submitted an application. Dentists had to have a properly staffed facility, as established by one of two third-party publications. However, neither was "properly staffed" defined nor were specific assessment requirements for an evaluation established. Evaluations also repeated the facility inspection without any clear value.

The ASEC Chair managed assignment of comprehensive evaluations to ASEC members. Members conducted evaluations in teams of two due to the subjective nature of the standards. Rules required evaluations for all permits be conducted by dentists meeting the advanced training requirements for GA/DS permits. Compliance with this requirement was unauditable. Further contributing to potential complexity and inconsistency, ASEC members reportedly did not always use current evaluation forms and standards, or ensure all ad hoc requirements were met. Although comprehensive evaluations were understood to be more subjective than facility inspections, it was purportedly unusual for permittees to fail a comprehensive evaluation. Rules established the same process for permittees to follow if they failed a comprehensive evaluation as for a failed facility inspection.

*Unmonitored Timeliness*

Permittees were required to undergo an initial comprehensive evaluation within eight months of being issued an initial permit. There were no formal, controlled processes on how evaluations were to be scheduled and by whom, although ASEC members were informed they had to ensure evaluations were timely. Nothing established what actions could be taken if evaluations occurred after the eight-month time limit because of permittee inaction. Evaluations were not always timely, and unevaluated permittees were nonetheless allowed to continue administering anesthesia and sedation. Reasons for delays included mutual scheduling conflicts, an inability to schedule patients requiring anesthesia or sedation, and lack of permittee responsiveness. The ASEC Chair purportedly received requests for extensions. However, there was no monitoring of these waiver requests or records indicating any were elevated to the Board for consideration.

Reportedly, noncompliance with the eight-month time limit was a "very significant" issue to be addressed by the ASEC Chair and elevated to the Board as soon as it occurred. However, there was no record the Board was timely provided noncompliance information. The improvised OPLC permit database only tracked the most recent and upcoming evaluation dates for each permittee. Using a separate database, the ASEC Chair monitored completion of evaluations and whether evaluations were on time or overdue. This database did not distinguish between initial evaluations and subsequent re-evaluations. It was unclear how often and over what time period monitoring occurred. Unaudited ASEC records demonstrated evaluations were inconsistently timely.

- During reporting year 2017–2018, 22 evaluations were completed, including seven that were overdue. Four were incomplete.

- During reporting year 2018–2019, 13 evaluations were completed, including three that were overdue. Two were incomplete.

- During reporting year 2019–2020, seven evaluations were completed, including one that was overdue.

Certain cases demonstrated some evaluations were significantly late or never completed. Initial comprehensive evaluations, when conducted, could be conducted up to 55 months after the eight-month window.

- One GA/DS permit was issued in May 2014. In May 2017, the Board was informed the evaluation had not been conducted. The Board then informed the permittee they were considering suspending the permit unless the evaluation is done "in the near future." The initial comprehensive evaluation was completed in November 2017, more than 34 months late.

- One MS-R permit was issued in November 2017, after a facility inspection was waived. In March 2019, the ASEC Chair reported a comprehensive evaluation had been completed, but the evaluator had not provided paperwork. There was no record of a Board vote to approve an evaluation. The improvised OPLC database showed an evaluation was still incomplete as of February 2021, more than 31 months late.

- Two MS-U permits had overdue initial comprehensive evaluations. The permittees could administer moderate sedation, including to pediatric patients. Both evaluations were to have been completed in CY 2019. As of February 2021, these evaluations were more than 17 and 22 months late.

Additionally, in July 2020, the ASEC Chair requested, and the Board approved, a one-year extension to complete outstanding comprehensive evaluations. This included some evaluations that were already overdue. During reporting year 2020–2021, 11 evaluation extensions were granted. There was no indication the ASEC Chair followed formal waiver processes, or that the Board discussed the implication waivers had on public protection.

*Inconsistent Action On Evaluation Results*

ASEC members submitted their recommendations to the ASEC Chair, who reviewed results and submitted recommendations to the Board. The Board reviewed evaluation summaries and ASEC Chair recommendations to make decisions. If comprehensive evaluation results were unsatisfactory, rules required the Board to: 1) revoke or suspend the permit, 2) limit or restrict the permit, 3) impose remedial education, or 4) impose a combination of requirements. However, rules defined no controls for any of these actions. Reportedly, staff provided the Board information on satisfactory comprehensive evaluations. It was unclear whether the Board received information on unsatisfactory evaluations and could take required remediation actions. ASEC records identified

one case where a permittee was "not prepared" at the initial evaluation, and an overdue evaluation was completed eight months late. However, there was no record the Board took required action against the permittee.

***Step Four: Permit Renewals***

The Board lacked adequate oversight and control of renewal application processing. Renewal application records and renewal decisions were unauditable. The renewal process was perfunctory, inefficient, and largely wasteful, and payment of a renewal fee was gratuitous.

Rules required permits to be renewed biennially when a dentist renewed their license. Rules required submission of a license renewal application, to include a partial registration form. All dentists were to report on the application whether they used GA/DS or MS. If they were an MS permittee, they had to also report whether they met competency maintenance requirements. MS permittees, with a narrower scope of practice and lower risk, were to document 12 cases or four hours of continuing education in sedation training per biennium. However, GA/DS permittees, with a broader scope of practice that included the MS scope of practice and higher risk, lacked competency maintenance requirements, even though they were required by statute.

Hardcopy license registration forms additionally included ad hoc rule requirements. Dentists using GA/DS or MS had to report which level of anesthesia or sedation they were using and whether they had a permit. MS permittees were required to submit competency maintenance documentation. However, online license registration forms required for renewal lacked any questions related to anesthesia and sedation. The Board was aware of concerns that not all dentists understood the need to obtain a permit. Requiring dentists to report whether they used GA/DS or MS on an outpatient basis, which had been done using hardcopy forms – and then periodically auditing a sample for compliance with permit requirements, which the Board did not do – was one way in which the Board could have identified dentists practicing without a permit. Removing the control found on hardcopy forms from the online license renewal application limited the Board's ability to identify potential risks to public protection. Furthermore, there was no process to check the names of dentists reporting they used GA/DS or MS against the names of permittees, further limiting the utility of the requirement.

Permittees were required to navigate an ad hoc, OPLC-developed supplemental process to renew their anesthesia and sedation permits. Reportedly, GA/DS permittees renewed fully online, while MS permittees renewed partially online and partially through a manual process to report competency maintenance information. However:

- there were no published instructions;
- process documentation was not readily available;
- there was no documentation demonstrating when the ad hoc process was first imposed;
- online transactions were unauditable; and
- ad hoc online processes were inconsistent with rules, reportedly resulting in "many" dentists not renewing their permits, and MS permittees "often" failing to submit required competency maintenance documentation, requiring staff follow-up.

The Board had to take reasonable steps to ensure permittees were qualified to continue practicing. However, other than requesting MS permittees' competency maintenance information, there were no substantive questions assessing dentists' qualifications to continue administering anesthesia and sedation. The Board informally delegated review of renewal applications to the OPLC, and review occurred without substantive evaluation. There was no verification of MS permittees' competency maintenance through either staff review or active licensee continuing education reviews. There was no indication the completion status of subsequent comprehensive re-evaluations was considered. Some permits were even renewed while permittees reportedly had not yet completed required subsequent comprehensive re-evaluations.

Without Board involvement, staff apparently made the only renewal decisions for permittees. There was no monitoring of denied permit renewals. For approved permit renewals, staff mailed updated permits with new expiration dates, although rules and procedures did not address permit expiration dates.

Neither statute nor rules established a permit renewal fee. However, in practice, the OPLC charged a $35 renewal fee for each individual permit renewal using ad hoc rules. Permittees held up to eight permits, resulting in fees totaling up to $280, in addition to license renewal fees. Requiring a fee without specific statutory authority was prohibited. Additionally, renewal processing was not affected by the number of office locations, making the renewal fee gratuitous.

***Step Five: Subsequent Comprehensive Re-evaluations***

The Board lacked adequate oversight and control over subsequent comprehensive re-evaluations. Re-evaluation requirements were primarily ad hoc rules, and applicants were required to improperly pay honorarium to evaluators who were also ASEC members. The need for, and timing of, re-evaluations was monitored through the improvised OPLC permit database. Re-evaluations, evaluator decisions, and compliance with rule-based time limits were generally unauditable due to lack of comprehensive and accurate records.

Re-evaluations were to be completed at least once every five years, in the same manner as the initial evaluation. However, in practice, re-evaluations occurred no more frequently than once every five years.

- One GA/DS permit, issued in March 2014, should have already had an inspection, and was required to have an initial evaluation by November 2014. However, by May 2019, the evaluation was reported to be only "16 months overdue," even though the evaluation was nearly 55 months late. The inspection was not recorded until July 2019 and approved by the Board in August 2019, nearly 66 months after the permit was issued. The evaluation was recorded in January 2020 and approved by the Board in April 2020, also nearly 66 months late.

- Ten permittees – including four ASEC members – had overdue re-evaluations. Re-evaluations for three permittees – including two ASEC members – should have been completed in CY 2019, but as of February 2021, were between 14 and 23 months late.

Nothing established what disciplinary actions could be taken if re-evaluations occurred outside the five-year time limit, and no follow up was evident.

**Recommendations:**

**We recommend the Board examine the costs and benefits of the biennial permit renewal process and, if it determines the current process provides substantive public protection, request the OPLC seek statutory authority for permit renewal fees commensurate with the processing effort required. If the Board determines the current process does not provide substantive public protection, we recommend the Board consider eliminating the biennial renewal requirement or making the process valuable, such as by incorporating competency maintenance requirements into active licensee continuing education reviews.**

**Additionally, we recommend the Board:**

1. **discontinue imposition of ad hoc rules;**
2. **fully implement all statutory requirements related to dentist anesthesia and sedation permits;**
3. **ensure rules comprehensively, clearly, and consistently reflect all permitting requirements and procedures binding on the public;**
4. **re-sequence permitting steps to ensure all substantive requirements, including comprehensive evaluations, precede permitting and permission to administer regulated anesthesia and sedation;**
5. **ensure delegations of permit application and renewal permit processing responsibilities conform to statute;**
6. **conduct substantive review of permit applications;**
7. **actively oversee permit application and renewal processes and ensure OPLC practices conform to statute and rules;**
8. **ensure approval of complete renewal applications from qualified applicants occurs prior to renewal permit issuance;**
9. **actively oversee facility inspection and comprehensive evaluation processes and ensure inspector and evaluator practices conform to statute and rules, and are consistent;**
10. **ensure a complete, auditable record of all permit-related transactions is created and maintained;**
11. **develop, implement, monitor, and refine goals, objectives, and targets tied to expected permitting outcomes; and**
12. **establish data requirements and reporting frequencies on performance metrics.**

Board Response:

*We concur with the recommendations.*

1. *We concur with the recommendation to discontinue imposition of ad hoc rule requirements and regulations outside the scope of our authority.*

*Please see our response to Observation No. 4.*

2. *We concur with the recommendation to fully implement all statutory requirements related to dentist anesthesia and sedation permits.*

3. *We concur with the recommendation to ensure rules comprehensively, clearly, and consistently reflect all permitting requirements and procedures binding on the public.*

   *Please see our response to observation No. 4.*

4. *We concur with the recommendation to resequence permitting steps to ensure all substantive requirements, including comprehensive evaluations, precede permitting and permission to administer regulated sedation and anesthesia.*

   *The Board recognizes the need to re-examine the current process and consider other options, including requiring the completion of the comprehensive evaluations before issuing a dentist anesthesia and sedation permit. The Board is currently in the initial stages of this process.*

5. *We concur with the recommendation to ensure delegations of initial permit application and renewal permit processing responsibilities conform with statute, are clearly made, and are in writing.*

   *The Board is in the process of providing increased direct oversight to the ASEC and the OPLC regarding this process.*

6. *We concur with the recommendation to conduct substantive review of permit applications.*

7. *We concur with the recommendation to actively oversee permit application and renewal processes and ensure OPLC practices conform to statute and rules.*

   *The Board concurs that increased direct Board oversight of the ASEC and OPLC administration is needed. The Board has taken steps to establish more direct Board oversight to the ASEC, and will continue to provide additional oversight as needed. The Board will continue to collaborate with the OPLC to ensure that administrative practices conform to statutes and rules.*

8. *We concur with the recommendation to ensure approval of complete renewal applications from qualified applicants occurs prior to permit issuance.*

   *The Board will continue to take necessary steps in collaboration with OPLC, to ensure that all requirements are met before either a renewal or initial permit is issued to applicants.*

9. *We concur with the recommendation to actively oversee facility inspection and comprehensive evaluation processes and ensure inspector and evaluator practices conform to statute and rules, and are consistent.*

*The Board will have more direct oversight on the ASEC and the entire dentist anesthesia and sedation permit process going forward. The Board is committed to engaging in rulemaking to revise the process as needed.*

10. *We concur with the recommendation to ensure a complete, auditable record of all permit-related transactions is created and maintained.*

    *The Board has initiated a new process whereby all administrative records related to the dentist anesthesia and sedation permitting process will be created and maintained by the OPLC administrator.*

11. *We concur with the recommendation to develop, implement, monitor, and refine goals, objectives, and targets tied to expected permitting outcomes.*

    *The Board is reconsidering and re-evaluating the current dentist anesthesia and sedation permit process and will collaborate with the OPLC in the rulemaking process to revise the current rules.*

12. *We concur with the recommendation to establish data requirements and reporting frequencies on performance metrics.*

    *The Board will collaborate with the OPLC to retain the necessary record of all permit applications issued and renewed to support this process.*

### *Anesthesia And Sedation Permits For Hygienists*

Of the five levels of anesthesia and sedation that could be used in dentistry, hygienists could administer two: minimal sedation and local anesthesia. Hygienists meeting education and training standards set in Board rules were allowed to administer local anesthesia beginning in CY 2002 and nitrous oxide minimal sedation beginning in CY 2007. Hygienists could administer local anesthesia or nitrous oxide minimal sedation only under the direct supervision of a dentist. No credential was required or authorized by State policy. If a qualified hygienist wanted a permit, applicants had to submit a written request to the Board. Hygienists from other jurisdictions could qualify for a permit by endorsement by submitting documentation of equivalent training and a letter from a supervising dentist attesting to their experience.

As of June 14, 2021, 1,134 hygienists held 1,256 anesthesia or sedation permits. An additional 30 permits were not associated with a hygienist's license number, one of which was an active local anesthesia permit.

**Observation No. 25**

**Improve Hygienist Anesthesia And Sedation Permit Controls**

Board controls over local anesthesia and nitrous oxide minimal sedation permits were inadequate. Statute incompletely regulated hygienist anesthesia and sedation, and did not provide for permits.

Creation of these permits was instead based upon extra-legal rules. However, rules also did not require qualified hygienists to be permitted. The Board imposed permitting and other requirements without corresponding rules. Such rulemaking was prohibited, and exposed the Board to potential federal antitrust scrutiny.

Some OPLC controls also relied upon extra-legal and ad hoc rules, and were informal and incomplete. There were no performance metrics or routine monitoring of permitting process timeliness or other consistency metrics. Data to allow assessment of timeliness or efficiency were not available during the audit period. Neither the efficiency nor effectiveness of local anesthesia and nitrous oxide permitting was ever established. Nothing demonstrated requiring hygienists obtain permits as part of their qualification to administer local anesthesia or nitrous oxide minimal sedation efficiently achieved expected outcomes.

**Board Lacked Authority For Permits**

Statute did not authorize permitting of hygienists for the administration of local anesthesia or nitrous oxide minimal sedation. Both administration of local anesthesia and nitrous oxide minimal sedation were within the hygienist scope of practice under statute. There was no reference to permits. Statute provided a hygienist would become qualified to administer nitrous oxide minimal sedation by the Board after completing Board-approved training and an examination. Statute did not specify additional qualifications to administer local anesthesia. Nonetheless, extra-legal rules specified procedures for hygienists to obtain permits. Hygienists wanting to obtain a permit were subjected to numerous requirements, including paying permit fees that were similarly established in rule without underpinning statute.

**Need For A Permit Not Clearly Established**

The Board did not establish a clear need to require a permit for administering local anesthesia or nitrous oxide minimal sedation. Neither permit was tied to an expected outcome. Rules outlined requirements for a hygienist to become qualified. While nothing prohibited a qualified hygienist from administering local anesthesia or nitrous oxide minimal sedation without a permit, the Board required permits in practice. To obtain either permit, a hygienist had to submit a written request to the Board with proof of qualifying course completion and payment of a fee.

- Local Anesthesia Permit – To obtain a local anesthesia permit, hygienists also had to submit examination scores. Rule specified a permit would be issued for hygienists who submitted a written request with certain information, but did not actually require a permit for a hygienist to be qualified in local anesthesia administration.

- Nitrous Oxide Minimal Sedation Permit – Qualification to administer nitrous oxide minimal sedation also did not depend upon obtaining a permit, initially. However, Board rules provided permits would be issued to hygienists who qualified to administer nitrous oxide minimal sedation after January 2018. This was nearly 12 years after nitrous oxide minimal sedation administration was added by statute to the hygienist scope of practice.

Both permits were issued without expiration dates. Internal instructions stated permits were in good standing as long as the hygienist's license remained active. The Board did not monitor permits after it was issued or establish and evaluate permitting outcomes. Neither were there renewal or competency maintenance requirements for permittees to maintain permits.

**Inadequate Rules And Inconsistent Processes**

Rules did not fully incorporate requirements imposed on the public. Rules did establish how hygienists, including those in other jurisdictions, could become qualified to provide these services. However, certain Board-developed requirements were little more than adoption of commercial, third-party training or standards. Inadequate rules resulted in ad hoc rulemaking, and some Board practices were inconsistent with rules.

- Rules merely allowed permits to be issued to qualified hygienists who requested one. Permitting was not a condition of qualification. However, in practice, the Board required permits for all qualified hygienists to administer local anesthesia. The Board and the OPLC lacked comprehensive controls for qualifying hygienists in the absence of a permit request.

- Rules specified nitrous oxide minimal sedation permits were to be issued only to hygienists who qualified after January 2018. In practice, the Board required all hygienists to obtain a permit to be qualified to administer nitrous oxide minimal sedation. The Board did not exempt hygienists who qualified before January 2018, as rules provided. The decision was based on a recommendation from the Dental Hygienists Committee (DHC).

- Rules required evidence of successful qualifying course completion for hygienists to be considered qualified. However, the Board relied on ad hoc permit application forms to gather information. It also allowed applicants to instead submit a course syllabus with evidence of successful course completion and course provider's signature. Both the forms and informal practices for substituting other records for the form imposed additional ad hoc requirements.

- The Board informally delegated approval of permit applications to staff and individual DHC members. Approvals were inconsistently documented. We reviewed records for 14 permits issued from July 2017 through February 2020 and found four (28.6 percent) with approval documented.

- Permits were reportedly renewed by staff during the hygienist licensing cycle, but without substance, renewals were perfunctory. Rules did not provide for renewals. Internal instructions were inconsistent: one provision stated permits were in good standing as long as the license was "current," while another provision referenced permit expiration dates. Informal practices resulted in one case we identified where the permit was inactive while the license was active, and another case where the license was inactive but the permit was active.

- Rule specified a hygienist qualified to administer local anesthesia in another jurisdiction could qualify for endorsement. The hygienist was to submit documentation of equivalent training and a letter from a supervising dentist attesting the hygienist had administered local anesthesia within the past two years. However, we found in one case the Board required a hygienist applying for a permit by endorsement, who had not administered local anesthesia in several years, to take a refresher course. Rules did not accommodate additional training requirements.

- Rules allowed local anesthesia permit applicants by endorsement to substitute training in lieu of passing an examination. However, we found one case in which staff erroneously informed an applicant who had not taken a qualifying examination that they only needed to submit a letter from the supervising dentist attesting to their experience. Staff did not also require the applicant to submit rule-required training documentation.

**Recommendations:**

**We recommend the Board examine the costs and benefits of the local anesthesia and nitrous oxide minimal sedation permit control framework and eliminate the permit requirements if they cannot be objectively demonstrated to contribute to achieving expected outcomes. Should continued permitting be objectively determined to be beneficial to the State, we recommend the Board:**

1. **seek legislative changes to obtain statutory authority for requiring the permits;**
2. **discontinue imposition of ad hoc rule requirements;**
3. **follow rules and discontinue requiring permits for hygienists who were determined qualified to administer nitrous oxide minimal sedation prior to January 2018, or change rules;**
4. **revise rules to require permitting for hygienists qualified in local anesthesia;**
5. **actively oversee local anesthesia and nitrous oxide minimal sedation credentialing processes and ensure OPLC practices conform to statute and rules;**
6. **approve applications and ensure an auditable record is created;**
7. **implement requirements for licensees to maintain qualifications and permits, including continuing education standards;**
8. **establish monitoring practices to ensure compliance with requirements, including through continuing education reviews;**
9. **establish performance goals, objectives, and targets to demonstrate how permitting contributes to achieving expected outcomes; and**
10. **establish data requirements and reporting frequencies on performance metrics.**

Board Response:

*We concur with the recommendations.*

**The Board's lengthy, detailed response and associated rejoinders are in Appendix B.**

*Certified Public Health Dental Hygienist*

Beginning in CY 2012, any hygienist could become a CPHDH with expanded duties, provided they completed additional education and training. CPHDHs worked under the public health supervision of a dentist, as could noncertified hygienists. However, a CPHDH had a broader scope of practice than a noncertified hygienist working under public health supervision. Both could work in a school, hospital, other institution, or the home of a homebound patient. A dentist had to authorize the procedures:

- certified or noncertified hygienists could perform without the dentist present, provided the dentist reviewed patient records once in a 12-month period; or
- a dental assistant could perform when supervised by a CPHDH.

**Observation No. 26**

## Improve Certified Public Health Dental Hygienist Controls

Board controls over the CPHDH certificate were inadequate and lacked a discernible, cohesive design. Nothing demonstrated the credential was necessary. Some rules exceeded the Board's statutory authority, while other rules required by statute were never adopted. Some processes and practices relied upon ad hoc rules, while others were contrary to statute. Some key public protection controls were absent, and credential holder practice and supervision requirements were unmonitored. Neither the Board nor the OPLC developed a method to monitor processes and assess consistency, including timeliness.

OPLC controls were informal and incomplete, and some were inconsistent with statute or rules. Neither the Board nor the OPLC developed means to monitor the CPHDH certificate to establish whether it efficiently achieved expected outcomes, or to ensure certificants conformed to laws and rules. Application processing was inefficient as well.

### Inadequate Entry, Competency Maintenance, And Practice Requirements

Practices were inconsistent with statute. The substantive review of CPHDH applications was informally delegated to individual DHC members. However, the DHC was responsible for developing CPHDH application, education, certification, and other requirements, and proposing them to the Board for review and approval. Statute did not authorize DHC members to conduct substantive evaluations of applications. Credentialing decisions were delegated to individual Board members. However, a quorum of the Board was required to make credentialing decisions.

Statute incompletely accommodated the CPHDH certificate. Key public protection controls, such as a criminal history record check, were not applied to applicants. Unlike licenses, statute did not allow for inactive status or accommodate reactivation. However, in practice, certificants could remain inactive indefinitely and resume active practice without refresher training. This was unlike licensees who were required to obtain refresher training before returning to active practice after lengthy periods of non-practice. Six of the 63 certificates (9.5 percent) listed in unaudited OPLC data on June 14, 2021, were categorized as either inactive or lapsed.

Rules exceeded the Board's statutory authority by requiring CPHDHs to pay initial application, renewal, late renewal, and reinstatement fees, and by allowing a CPHDH to supervise dental assistants. Rules also created ambiguity by not defining under what form of supervision a dental assistant could perform specific duties when supervised by a CPHDH.

Rules were incomplete, and rules and forms contained inconsistencies. Staff created informal guidance to add structure to some, but not all, processes. Some guidance resulted in ad hoc rules.

- Staff conducted administrative completeness reviews and obtained missing records needed for a complete application. Applications were referred to the DHC Chair for review then to a Board member for approval. Staff then issued the certificate. There were no rules for this process.

- As a condition of certification, applicants were required to submit a letter confirming the existence of a written collaborative agreement. Agreements between the applicant and the dentist providing public health supervision were required to practice. However, applications with and without a letter of confirmation would be accepted and processed, and certificates issued.

- Before practicing, certificants were required to have a collaborative agreement with a supervising dentist. Purportedly, staff created a list of CPHDHs with their collaborative agreement status, but no lists were available. The practice was apparently discontinued at some point during the audit period. No monitoring or enforcement of the collaborative agreement requirement was recorded.

- The application form was updated after it was adopted in rules, without readoption of rules. The form also contained outdated elements, miscited the rules applicable to CPHDH applicants, and contained ad hoc rules.

- Statute established April 1 as the deadline for renewing a hygienist license on time. Certificates did not expire under statute or rule. However, rules established May 1 as the on-time certificate renewal deadline. In practice, the CPHDH certificate renewal process supplemented the hygienist renewal process, with an additional $25 fee, and was managed by staff without Board oversight. As shown in Table 10, 16 of the 63 certificates (25.4 percent) listed in unaudited OPLC data were categorized as something other than active, even though there was no basis or related process in rule.

- Rules did not require any continuing education even though statute required it. This, despite the broader scope of practice and increased independence afforded CPHDHs.

- There was no means to withdraw or suspend a certificate.

Staff management of certificant records in the credentialing database management system was inconsistent. We also identified discrepant statuses between individuals' various credentials. For example, one hygienist with an inactive license had an active-late renewal CPHDH certificate. Another hygienist had an active license and an active-late renewal CPHDH certificate, even though

they reported not practicing as a CPHDH more than three years earlier. Also, two of the three suspended CPHDH certificates had inactive licenses, while the third license was lapsed.

**No Monitoring, Enforcement, Or Demonstrated Outcomes**

The Board never developed a method to demonstrate CPHDH certification contributed to achieving expected outcomes, or that certification was the level of regulation needed to achieve expected outcomes. There were no competency maintenance requirements, or monitoring of collaborative agreement or other practice requirements. Renewal of the credential was perfunctory, and paying the renewal fee was gratuitous. The credential was decreasingly sought from SFY 2018 through SFY 2021. Four certificates were issued in SFY 2020 and five were issued in SFY 2021. This was down from 11 certificates issued in SFY 2018 alone. Using its rulemaking authority, the Board could have provided for CPHDH-like practice without requiring a credential. The Board could have allowed dentists to delegate expanded duties to qualified hygienists, as was already allowed for noncertified hygienists. Alternatively, instead of requiring certification, the Board could have sought statutory authority to simply register qualified CPHDHs one time.

**Recommendations:**

**We recommend the Board examine the costs and benefits of the CPHDH certificate. If it cannot be objectively demonstrated to efficiently produce expected outcomes and provide substantive public protection, we recommend the Board eliminate the credential. If the Board objectively determines the credential efficiently provides substantive public protection and should continue, we recommend the Board improve the CPHDH control framework and:**

1. **actively oversee the initial and renewal certification process, monitor certificant practice, and ensure OPLC practices conform to statute and rules;**
2. **discontinue imposition of ad hoc rule requirements;**
3. **seek statutory changes to accommodate procedures created by rules or practice that are objectively determined to produce benefits and result in sufficiently controlled practice;**
4. **ensure delegations of renewal processing responsibilities conform to statute;**
5. **conduct substantive review of, and approve, applications;**
6. **revise rules to reflect statutory authority and requirements, structure the complete lifecycle of the credential, require continuing education, and comprehensively, clearly, and consistently reflect all requirements and procedures binding on the public;**
7. **determine which CPHDHs are practicing with or without a collaborative agreement, and ensure they comply with laws and rules;**
8. **ensure maintenance of a complete record of all decisions and actions on each application and certificate;**
9. **develop, implement, monitor, and refine goals, objectives, and targets tied to expected outcomes;**
10. **establish information requirements and reporting frequencies to facilitate oversight;**

**11. demonstrate the credential contributes to achieving expected outcomes; and**
**12. formalize the terms and conditions of its relationship with the OPLC.**

Board Response:

*We concur with the recommendations.*

**The Board's lengthy, detailed response is in Appendix B.**

**Dental Assistants**

Dental assistants were auxiliaries integral to the dental care industry. In practice, dental assisting was an extensively regulated occupation. State policy established a tiered framework to regulate dental assistants. State credentialing was required only when they performed certain, specified higher-risk duties.

- Since January 2016, dental assistants with access to controlled substances and contact with patients were to be registered by the Board of Registration of Medical Technicians (BoRMT), unless they were credentialed by another State agency.

- Since July 2018, dental assistants performing medical imaging or administering radiation therapy were to be licensed by the Board of Medical Imaging and Radiation Therapy (BoMIRT), unless they were credentialed by another State agency.

State policy did not otherwise provide for dental assistants not under either the BoRMT's or BoMIRT's jurisdiction to be credentialed. State policy limited the Board's authority to regulate dental assistants to adopting rules on:

- the procedures dentists could assign to dental assistants, including requirements for monitoring patients undergoing and recovering from general anesthesia, deep sedation, and moderate sedation;
- dental assistants performing coronal polishing, but not authorizing them to perform a complete oral prophylaxis; and
- requirements for dental assistants to qualify for an EFDA permit.

Board rules allowed dental assistants to perform clinical duties authorized and supervised by an actively-licensed dentist. Duties could include equipment preparation, preparing patients for treatment, assisting a dentist during treatment, radiology, patient education, monitoring nitrous oxide administration, scheduling appointments, and maintaining records. Rules also allowed a more limited subset of duties to be assigned to dental assistants under the supervision of a hygienist. Some duties overlapped with those of hygienists. Duties were not discretionary in nature, and the supervising dentist was liable for dental assistant actions.

Reportedly, some dentists employed only dental assistants; others employed a mix of auxiliaries. There was no readily available data on the number of BoRMT- or BoMIRT-registered dental

assistants or the total number of dental assistants working in the State. An estimated 1,350 dental assistants were employed in New Hampshire as of May 2019, according to federal data.

**Observation No. 27**

**Rationalize Regulation Of Dental Assistants**

The Board lacked a risk-based, data-informed approach to the regulation of dental assistants. Aspects of the Board's regulation of dental assistants were extra-legal or extra-jurisdictional. This made dental assisting a tightly controlled occupation, regulated by the Board on par with a credentialed profession. This overreach imposed costs on dental assistants and the public, and limited who could work as a dental assistant. Other aspects of the Board's rules were incomplete, lacking statutorily-authorized duties. Board rules also inappropriately extended supervision of dental assistants to hygienists. The efficacy of dental assistant regulation was unmonitored, and nothing demonstrated regulation of dental assistants efficiently achieved expected outcomes.

The distributed regulation of dental assistants was uncoordinated. Agencies should have coordinated regulatory activities when responsibilities or interests overlap. However, there was no agreement or other formalization of the relationship between the Board and other agencies responsible for regulating dental assistants. Interaction between the agencies to regularly coordinate their regulatory effort was not evident. Based on the Board's overly-broad interpretation of its regulation of dental assistants, the BoMIRT did not regulate dental assistants conducting dental radiology as required. The Board lacked sufficient interactions with the BoRMT to help ensure utilization of regulated dental assistants by dentists conformed to requirements.

**Board Regulation Lacked Design**

The Board's lack of a cohesive regulatory program extended to the regulation of dental assistants. The Board's approach to regulating dental assistants lacked a discernible design and clear nexus between risks, requirements, and expected outcomes. Certain rules exceeded the Board's statutory authority. Rules effectively imposed entry and practice requirements on the occupation on a scale similar to licensing requirements, albeit without a Board-issued credential. This limited the fundamental right of individuals to pursue an occupation and imposed costs upon dental assistants and the public. The Board also took actions affecting the practice of dental assistants during public and nonpublic meetings, limiting the transparency of certain requirements or the Board's interpretations of requirements. Other rules:

- incompletely described what duties could be delegated to a dental assistant, and which were expressly provided for by statute;
- effectively regulated training, education, and examination providers, and
- adopted commercial, third-party standards as the State's entry requirements for certain types of dental assistants.

***No Cohesive Control Framework***

The Board lacked monitoring, risk, strategy, and planning controls to help ensure dental assistant regulation achieved expected outcomes. Credentialing was often the Board's regulatory solution

of choice to address perceived dental care industry change and purported risks. Some officials associated with the Board and some stakeholders suggested dental assistants were a potential public health, safety, or welfare risk. Some suggested dental assistant regulation should be expanded to require credentialing of all dental assistants by the Board. Credentialing of dental assistants by the Board was discussed not only by the Board, but also by the DHC and ASEC-AS, since at least CY 2016 and through at least March 2021, when we concluded audit work on this topic. However, the Board never objectively established:

- its regulation of dental assistants to-date achieved expected outcomes,
- there was a need to change its regulation of dental assistants,
- there was a need for additional regulation for dental assistants, or
- the nature of additional regulation, such as credentialing, that might be needed.

Nothing demonstrated the existing regulatory framework was adjusted to achieve the Board's control objectives with lesser forms of regulation. Neither was the recognized effect regulation had on occupations, forming a barrier to entry, juxtaposed against the purported shortage of dental assistants in New Hampshire.

***No Quantified Risk***

Dental assistant-related rules had no explicit nexus to risks. Perceived risks were based on qualitative assessments, theoretical or speculative conditions, or a belief other jurisdictions were considering or beginning to regulate dental assistants. Consequently, whether dental assistant-related rules either mitigated risk, or created additional risks, was not assessed. Assessed risk could not factor into the Board's regulation of dental assistants.

- The Board controlled risk exposures for dental assistants through its rulemaking authority. The Board was required to adopt rules specifying: 1) the duties a dentist could delegate to a dental assistant and 2) the required levels of supervision. The Board should not have provided for the delegation of unacceptably risky tasks to dental assistants. If dental assistants posed a risk, it was because, at least in part, Board rules accommodated the delegation of risky tasks to dental assistants.

- Jurisprudence examinations insufficiently assured basic licensee knowledge of dental assistant duties and responsibilities. The Board controlled jurisprudence examination requirements and examination content. Jurisprudence examinations could have helped assess licensee understanding of the role dental assistants played in delivering dental care. The Board could have helped control risk by adjusting examination content. However, the Board lacked oversight of examination results.

- The Board controlled the scope of practice for hygienists and EFDAs and could have allowed for delegation of higher-risk tasks to those credential holders. Instead, rules allowed tasks that encroached upon hygienist or EFDA scopes of practice to be delegated to dental assistants.

- Rules inappropriately extended supervision of dental assistants to hygienists, thereby extending the potential risk exposure dental assistants created. Rules did not clarify under which licensee a dental assistant supervised by a hygienist operated, and which licensee would be liable for dental assistant actions.

The Board did not collect performance data or monitor dental assistants. We identified one dismissed complaint against a dental assistant during the audit period, but which was not directly related to dental services rendered. Staff also received monthly reports from the American Association of Dental Boards' Clearinghouse on actions taken by other states' regulatory agencies against dental practitioners. However, in practice, staff removed dental assistants from the reports, and reports were not retained.

***Overreach***

Board rules, declaratory rulings, and decisions in public and nonpublic meetings governed the conduct and qualifications of dental assistants. The Board lacked controls to ensure its rules remained current. Its dental assistant-related rules appeared to be based, in part, on the CY 1971 recodification of *Dentists and Dentistry*. However, the relevant authorities were since repealed. Board rules exceeded delegated authority by directly regulating: 1) dental assistants to a degree on par with credentialing and 2) dental assistant training, education, and examination providers. Furthermore, members informally investigated certain educational institutions' advertising and programs for "compliance" with Board requirements.

The Board was responsible for adopting rules in three narrow areas related to dental assistants. However, rules improperly claimed the Board was also responsible for the administration of the practice of all dental auxiliaries, and for rules governing the conduct and qualifications of dental assistants. Rules distinguished four types of dental assistants:

- dental assistants – anyone who generally assisted a dentist with clinical duties at a dental office;
- traditional dental assistants – dental assistants who were neither a certified dental assistant nor a graduate dental assistant;
- certified dental assistants – dental assistants who held a current commercial, third-party dental assistant certification; and
- graduate dental assistants – dental assistants who graduated from a dental assisting program accredited by a commercial third-party.

Rules improperly established different requirements for the different types of dental assistants, including:

- training, examination, and qualification requirements, some of which had to be met before working as a dental assistant;
- the hours of experience required before taking an introductory dental assisting course, a prerequisite to taking other training courses and performing basic and advanced dental assistant duties;
- the hours of experience required before taking specialty courses; and

- the duration and content of basic and specialty courses.

Rules on supervision extended dental assistant supervision beyond what statute provided by allowing for hygienist supervision. This also created inconsistencies. One rule allowed public health supervision for certain tasks, while other rules required direct supervision by a licensed dentist. This inconsistency was exacerbated by a Board decision that dental assistants could not treat patients without a dentist present. Rules additionally:

- limited certain duties to certain types of dental assistants, limiting the duties other types of dental assistants could perform;
- waived certain examination requirements for some dental assistants, allowing them to work without an examination;
- required dental assistants to retain records and provide them to the Board upon request;
- required dental assistants to seek Board approval of certain qualifying courses before taking them; and
- did not recognize dental assistant credentials issued in other jurisdictions, instead predicating most qualifications on a single in-State institution's educational program by specifying course length, content, and records institutions had to provide dental assistants.

### *Framework Insufficiently Clear*

Overreach, insufficient jurisprudence examination controls, poorly controlled rules, and insufficient outreach made the Board's regulatory framework insufficiently clear. Dental assisting was an entry-level occupation. Without sufficient outreach, dental assistants were less likely to be aware of the Board's rules regulating their practice. Dental assistants were likely unfamiliar with navigating the Board's rules, particularly when they were not actually credentialed, or supposed to be directly regulated, by the Board. Staff purportedly received many questions about dental assistants and had to publicize relevant information on requirements. Board clarifications in public and nonpublic sessions exacerbated unclarity by limiting or prohibiting, respectively, transparency of requirements. Even the ASEC-AS made a clarification on the dental assistant scope of practice during a public meeting. Additionally, educational institutions found the regulatory framework unclear to the point of submitting to the Board requests for permission to start dental assistant programs, programs the Board had no authority to regulate.

## Regulation Not Coordinated With Other Agencies

Regulation of dental assistants by other agencies did not appear effective and was inconsistent with legislative intent. There was no interagency coordination. Dental assistants who should likely have been credentialed by the BoRMT or the BoMIRT, or both, were not credentialed at all. This was due, in part, to the Board's overly broad rules that led to a conclusion the Board directly credentialed dental assistants. Additionally, BoMIRT and BoRMT requirements were exclusive. Dental assistants credentialed by one agency would preclude credentialing by the other, even though neither regulated the other agency's scope of practice.

- None of the three agencies monitored, or had means to monitor, the number of dental assistants or the instances of their malperformance. The BoRMT monitored noncompliance by its registrants but did not differentiate by type of registrant. The BoRMT could have provided other regulatory agencies the data it had. However, the Board never requested, or received, any data. Neither was there a clear mechanism to do so. Consequently, the Board lacked relevant input from the BoRMT.

- Upon issuing an initial credential, regulatory agencies were required to provide a copy of the rules regulating credential holders. Since dental assistants were not credentialed by the Board, no distribution of relevant Board rules to dental assistants would have occurred. Furthermore, since the BoRMT credentialed a subset of dental assistants, and not their supervising dentist or hygienist, no distribution to supervisors would occur. This even though supervisors had to comply with the BoRMT's statute and rules. Neither did the Board convey to its licensees their obligations under the BoRMT's or the BoMIRT's statutes and rules. However, the distribution requirement was repealed after the audit period. It was repealed without a replacement control to help ensure credential holders were aware of their obligations under all relevant agencies' jurisdictions.

- Dentist and hygienist jurisprudence examinations lacked questions on compliance with the BoRMT's or the BoMIRT's statutes and rules. CPHDHs, inappropriately allowed to supervise dental assistants, had no unique jurisprudence examination addressing their expanded scope of practice, including requirements on dental assistant supervision.

***Regulation By The BoMIRT Incomplete***

Dental assistants conducting dental radiology should have been, but were not, credentialed by the BoMIRT. Dental assistants were required to be licensed by the BoMIRT if they performed medical imaging unless they were: 1) issued a license or certificate by the State and 2) supervised by a dentist. The Board asserted its rules sufficiently addressed exemption requirements. However, the Board lacked statutory authority to credential dental assistants, and its rules did not provide for a State-issued credential. Furthermore, not only could certified dental assistants—dental assistants holding a specific third-party certification—perform dental radiology under Board rules, but so too could traditional and graduate dental assistants, neither of whom were certified. Additionally, dental assistants supervised by a hygienist, also accommodated by extra-legal Board rules, would not be exempt from BoMIRT licensure.

***Regulation By The BoRMT Inconsistent***

The regulation of dental assistants by the BoRMT was convoluted. Dental assistants with access to controlled substances and patient contact should have been, but were inconsistently, credentialed by the BoRMT. Dental assistants not meeting these requirements were exempt from BoRMT registration. Reportedly, the BoRMT also exempted from registration and monitoring certified dental assistants who held a third-party, not a State-issued, credential, even if they otherwise met the criteria for BoRMT regulation.

Medical establishments, including dental offices, were required to ensure the regulated medical technicians they employed were registered and to report noncompliance. Since some dental assistants were regulated by BoRMT, their employing medical establishment was subject to BoRMT oversight and reporting requirements. It was not clear the BoRMT's role in regulating dental assistants and dentists employing registered dental assistants was understood by the Board.

**Recommendations:**

**We recommend the Board:**

1. **ensure its regulation of dental assistants conforms to the limits of its statutory authority, and discontinue extra-legal, informal, and improvised regulation of dental assistants and dental assisting education and training programs;**
2. **revise rules to limit their scope to what is authorized by statute;**
3. **objectively establish the risks posed by dental assistants and revise rules to mitigate risks, changing supervision or other requirements to ensure risks are sufficiently controlled, and attenuate jurisprudence examination requirements and outreach efforts to ensure the dental care industry is aware of the regulatory requirements governing dental assistants;**
4. **harmonize regulation of dental assistants with the BoRMT and BoMIRT, clarifying that third-party certified dental assistants are not credentialed by the Board and those dental assistants are not exempt from BoRMT or BoMIRT regulation, and formalize interagency relationships via a written agreement to ensure proper monitoring;**
5. **ensure all licensees are aware of their obligations to employ only BoRMT-registered dental assistants if they meet the criteria for credentialing by that board, are aware of BoMIRT licensing requirements if the dental assistants they employ meet the criteria for licensing by that board, and develop oversight controls to ensure Board licensees comply with all statutory and rule-based requirements; and**
6. **develop, implement, monitor, and refine goals, objectives, and targets to help demonstrate how its regulation of dental assistants contributes to achieving expected outcomes.**

Board Response:

*We concur in part with the recommendations.*

**The Board's lengthy, detailed response and associated rejoinders are in Appendix B.**

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## CHAPTER FOUR
## MONITORING APPLICANTS AND REGULATEES

Systematically monitoring regulatees to ensure they remained qualified to practice was essential to provide reasonable assurance the Board fulfilled its purpose to protect the public from unqualified, unscrupulous, or impaired dentists and hygienists. State policy required applicants and credential holders to meet certain character, conduct, and competence requirements. The Board also had discretion to impose other requirements objectively established to be necessary to determine qualifications. The Board was to proactively monitor compliance and integrate reactive monitoring controls to provide reasonable assurance it efficiently and effectively achieved expected outcomes.

- Proactive monitoring—designed as a preventative measure—should have helped ensure applicants and regulatees met requirements before the public health, safety, and welfare was adversely affected. State policy required the Board to routinely monitor competency and compliance through the renewal of certain credentials. State policy also provided authority for certain investigations and inspections. The Board imposed continuing education requirements and verification during regular license renewal cycles. It also required routine comprehensive evaluations of dentist permittees administering anesthesia and sedation to assess ongoing competency and compliance.

- Reactive monitoring—acting after the public health, safety, and welfare was reportedly adversely affected—should have helped remediate regulatee noncompliance. State policy required the Board to accept and prioritize complaints from the public alleging misconduct, and required dentist permittees to submit adverse event reports. The Board imposed additional reactive monitoring requirements, such as mortality reporting.

Verifying regulatee compliance was essential to ensure both proactive and reactive monitoring controls effectively identified noncompliance. The Board should have integrated monitoring controls with enforcement controls to help ensure monitoring achieved expected outcomes. When regulatees were found noncompliant with requirements, and did not voluntarily come into compliance, the Board was obligated to take action to compel them to comply, or to stop practicing. The Board should have also monitored sanctioned regulatees to ensure they timely came into – and remained in – compliance with requirements.

The Office of Professional Licensure and Certification (OPLC) was responsible for efficiently administering underpinning verification and monitoring processes.

### Observation No. 28

### Improve Applicant And Regulatee Monitoring Controls

Board controls over monitoring applicant and regulatee compliance with requirements were insufficient, disjointed, and did not demonstrate expected outcomes were achieved. The Board's controls lacked discernible design, integration of risk identification, and performance

measurement. Although it undertook intermittent efforts to develop monitoring controls, the Board was aware certain gaps between statute and rules hindered its ability to fulfill monitoring responsibilities. Also, the requirements the Board created and imposed upon regulatees – some of which were extra-legal – were susceptible to change and inconsistently monitored. Some requirements could not be monitored. Numerous requirements and processes were perfunctory and without clear value in helping achieve expected outcomes. Rules were complex and incomplete.

Monitoring responsibilities were improperly delegated and processes, procedures, and responsibilities were not formalized. Incomplete, inadequate, or absent monitoring controls resulted in inconsistent and reactive Board actions to remedy noncompliance. Some noncompliant or potentially noncompliant actions requiring discipline went unaddressed. Credentials were issued to some applicants that did not comply with requirements. Deficient controls were due, in part, to inadequate Board oversight, inadequate OPLC support, an inadequate monitoring framework, and gaps between statute, rules, and OPLC practice.

Our audit was not designed to identify all cases where inadequate monitoring controls and a lack of proactive monitoring led to an increased risk to public protection. However, we did identify areas that were inadequately monitored. Some complaint and enforcement cases demonstrated persistent structural defects in Board management and oversight. Inadequate knowledge management limited the Board's ability to develop controls to identify, monitor, and address patterns of noncompliance, and noncompliance generally. Some controls, processes, and transactions were unauditable due to inadequate records. Responsible officials lacked a complete understanding of relevant processes and practices. Inadequate records and knowledge management compelled us to qualify our use of – and every conclusion resting on – agency records and information reported by responsible officials.

**Lack Of Comprehensive Monitoring Controls**

The Board lacked comprehensive monitoring controls over entry, practice, and eligibility maintenance requirements. Various monitoring responsibilities were inconsistently implemented, and those controls that did exist were unintegrated. For example, the Board:

- inadequately communicated requirements to the public, regulatees, and other stakeholders;
- inconsistently verified applicants and regulatees met or continued to meet requirements;
- imposed perfunctory initial or renewal application requirements;
- failed to review and act on most initial or renewal applications before credential issuance; and
- did not manage complaint processes to ensure cases progressed timely, or that case results helped ensure the public was adequately protected.

Additionally, the Board insufficiently communicated with other regulatory agencies or programs with which it held concurrent jurisdiction. These agencies, including the Prescription Drug Monitoring Program (PDMP), Pharmacy Board, Board of Registration of Medical Technicians, Board of Medicine, Board of Nursing, and Board of Medical Imaging and Radiation Therapy

shared monitoring responsibilities. Relationships with these agencies and programs were never formally established. Board regulatee compliance with the requirements of these other agencies was both inconsistent, and inconsistently monitored.

Furthermore, the Board improperly delegated some monitoring duties. The OPLC, Dental Hygienists Committee (DHC), the Anesthesia and Sedation Evaluation Committee (ASEC) and ASEC Advisory Subcommittee (ASEC-AS), and the Department of Justice's (DOJ) Administrative Prosecutions Unit (APU) all had some role in monitoring. The Board never formalized the terms and conditions of its relationship with the OPLC or other delegates, or established expected service levels. Neither did the OPLC examine the scope and nature of Board monitoring operations to understand required service levels.

***Inadequate Monitoring Of Compliance With Primary Credential Requirements***

Primary credentials were inadequately monitored. The Board did not systematically evaluate regulatees' substantiative compliance with requirements. Consequently, the Board could not have verified credential holders possessed the necessary educational, character, and other professional qualifications, and that no circumstances existed that would be grounds for disciplinary action. Applicants and credential holders who did not meet requirements were nonetheless issued credentials.

- Of the 283 initial primary credentials issued during the audit period, 275 (97.2 percent) were issued without preceding Board action and criminal history records checks were not conducted.

- Jurisprudence examinations were not required for all initial credentials or any renewals. The Board did not monitor pass and fail results. Neither did the Board compare licensee noncompliance trends to results, to determine whether the examination adequately ensured licensees understood their obligations.

- Of the 2,922 renewal credentials issued during the audit period, 2,919 (99.9 percent) were issued without Board action.

***Inadequate Monitoring Of Compliance With Supplemental Credential Requirements***

Supplemental credentials were inadequately monitored. Renewals were perfunctory. Statutorily noncompliant approvals of initial and renewal applications were made and credentials were issued to applicants who did not meet requirements.

- Certified Public Health Dental Hygienist (CPHDH) – The Board required collaborative agreements, but had no procedures to monitor and enforce agreement requirements.

- Hygienist Anesthesia And Sedation Permits – The Board did not require relevant, permit-specific continuing education for permitted hygienists.

- Dentist Anesthesia And Sedation Permits – The Board did not monitor facility inspections and comprehensive evaluation timeliness, unsatisfactory inspections and evaluations, or "limited" permits. Initial comprehensive evaluations were conducted up to 55 months late. Subsequent re-evaluations were conducted up to 23 months late.

- Administration Of Pediatric Minimal Sedation – The Board never established the required pediatric minimal sedation permit for dentists. The Board did create a hygienist nitrous oxide minimal sedation permit that allowed pediatric administration. However, there was no monitoring of either dentists or hygienists administering pediatric sedation.

***No Monitoring Of Other Regulatees And Regulated Scopes Of Practice***

The Board inappropriately regulated some occupations, individuals, and programs, which State policy did not authorize. The imposition of extra-legal and extra-jurisdictional requirements was exacerbated by a lack of monitoring of regulatee compliance with Board-imposed requirements

- Dental Assistants – Dental assistants were regulated, but not credentialed, by the Board. The Board lacked procedures to ensure dental assistants met Board-established entry and practice requirements. There were no processes to obtain compliance information, agreements with other agencies to coordinate monitoring, or processes to monitor delegation of duties to dental assistants made by dentists or hygienists.

- Dental Specialties – Board requirements related to dental specialties were perfunctory. Board rules addressed dental specialties only during initial licensure and lacked monitoring of either specialists or compliance with related requirements.

- Public Health, Dental Residency, And Dental Student Programs – Annual program reporting requirements were perfunctory. We found one case in which an annual report identified a hygienist supervising dental students – which was impermissible – but the Board took no action.

- Public Health Supervision – There was no consistent monitoring of dentists or hygienists practicing in a public health setting. Hygienists could perform certain expanded duties authorized by a dentist under public health supervision, provided the dentist reviewed patient records annually. However, the Board lacked controls to monitor annual record reviews and duties delegated to hygienists, including its inappropriate delegation of dental assistant supervision to hygienists.

- Administration Of Botulinum Toxin And Dermal Filler – Board requirements related to dentist administration of botulinum toxin and dermal filler were perfunctory. The Board lacked monitoring of dentists who administered these controlled substances or their compliance with related requirements.

### *No Ongoing Monitoring Of Practice Requirements*

There was no monitoring of most practice requirements, nor were there controls designed to monitor compliance consistently and proactively. State policy imposed certain requirements on regulatees, and Board rules, both properly adopted and ad hoc, added additional requirements. Formal processes, such as periodic compliance auditing, could have helped the Board ensure regulatees complied with practice requirements on a continued basis. However, compliance with most practice requirements was altogether unmonitored unless a complaint was made. This included aspects of dentists' administration of anesthesia and sedation; aspects of CPHDH practice, such as supervising dental assistants; hygienist anesthesia and sedation permittee practice or compliance; and the propriety of procedures delegated to auxiliaries. Additionally, the Board relied on reactive monitoring requirements that lacked controls to ensure follow-up occurred, such as:

- requiring licensees to inform the Board in writing within 20 days of patient mortality associated with dental treatment;
- third-party reporting of dentist noncompliance with controlled substances laws, rules, and regulations when prescribing opioids;
- requiring licensees to inform the Board in writing within 30 days of any sanction imposed by another jurisdiction; and
- self- or third-party reporting of noncompliance with ethical or practice requirements that did not directly relate to public health or safety risks.

### *No Monitoring For Patterns Of Potential Noncompliance*

The Board lacked controls to monitor regulatee behavior for patterns that may have indicated noncompliance, and had monitoring options available that it did not use. For example, the Board collected information and could access other regulatory agencies' information it could then have used to assess whether regulatees followed some requirements. However, the Board inconsistently recorded, requested, obtained, or used available information to help monitor compliance.

- Character And Conduct Requirements – The Board was required to, but did not, conduct criminal history record checks on applicants for initial licensure or reinstatement. Staff inconsistently used the American Association of Dental Boards' (AADB) Clearinghouse during initial credentialing. Monthly AADB reports were purportedly reviewed routinely during part of the audit period but not retained. The AADB contained disciplinary actions voluntarily reported by some dental regulatory agencies in other states. The Board also had access to the more comprehensive National Practitioner Data Bank (NPDB). The NPDB contained a wider range of mandatorily reported character and conduct information. However, the Board lacked controls to obtain NPDB information. Consequently, the NPDB was not used during credentialing and the few NPDB reports that were obtained and reviewed had been provided by other jurisdictions during enforcement proceedings. Renewal license application forms required licensees to report whether they complied with certain requirements. This self-reported compliance was not verified.

- U.S. Drug Enforcement Administration (DEA) And PDMP Requirements – Dentists applying for initial and renewal licenses were required to report whether they had a federal DEA registration number. Initial license application forms, lists of dentists with specialties, and the list of dentist anesthesia and sedation permittees also showed which dentists practiced specialties potentially requiring the use of controlled substances. Analyzing these records with PDMP data could have indicated which dentists may have needed to register with the PDMP and meet relevant competency maintenance requirements. However, the Board lacked controls to analyze application and registration-related records, or routinely obtain PDMP reports.

- Competency Maintenance Requirements – Renewal application forms required licensees and certain permittees to report whether they complied with continuing education requirements. Continuing education reviews of a small sample of renewing licensees purportedly determined licensee compliance. However, identified noncompliance was not remedied, and review results were not retained. Not all credentials were subject to renewal continuing education requirements or compliance verification. Additionally, dentist permittees were subject to comprehensive re-evaluations, but re-evaluations were inconsistently timely.

- Potential Noncompliance – Complaints submitted by the public made allegations of misconduct against licensees. Letters of concern issued by the Board contained actions previously taken to address some allegations. However, the Board lacked controls to routinely obtain summaries of past complaints, letters of concern, and discipline to inform decisions or to establish patterns of noncompliance. Furthermore, complaints and letters of concern were inconsistently retained.

- Remediation Of Noncompliance – Board orders and settlement agreements established regulatee remediation requirements and imposed sanctions. Compliance information was available to the Board through required periodic monitoring reports. However, the Board lacked controls to ensure ongoing compliance with remediation monitoring and remediation requirements. The Board received Professionals Health Program reports. However, these reports were not used for monitoring remediation, as they reportedly did not provide useful information about individual licensees.

**No Monitoring Of Complaints Or Regulatee Compliance With Remediation Requirements Arising From Enforcement Cases**

Lack of monitoring controls contributed to inconsistent complaint resolution and did not ensure regulatees complied with remediation requirements arising from enforcement cases. This left noncompliance potentially unremedied. There was no control over timeliness and no monitoring of complaint triage practices. Monitoring of staff actions performed on the Board's behalf was insufficient. Monitoring of regulatees under conditional agreements or subject to sanctions with monitoring requirements was inadequate. We reviewed complaints against 21 licensees subject to Board action from State fiscal years (SFY) 2018 through 2020. Nine (42.9 percent) had a complaint or disciplinary history ranging from three to 20 complaints.

- In one case, a licensee with a pattern of alleged noncompliance was not monitored or further investigated. During calendar years (CY) 2019 and 2020, the Board acted on three complaints alleging similar noncompliance against the licensee. One was referred to the APU, but there was no record of an investigation. The second went unaddressed for nearly 20 months after it was referred to the APU. The third was provided to the Board two-and-a-half months after it was received, at which time the Board referred it for investigation. All three complaints were dismissed, between three and 20 months after receipt. The licensee failed an anesthesia and sedation permit comprehensive re-evaluation in CY 2021, but the issue was not immediately referred to the Board. When the Board reviewed the failed re-evaluation results one month later, it did not discuss the licensee's complaint history.

- In a second case, a licensee subject to adjudicatory proceedings was allowed to nonetheless expand their scope of practice. Staff did not inform the Board of multiple complaints or that the licensee was under Professionals Health Program monitoring. The licensee, with a complaint history dating back to the mid-2000s, was the subject of a series of additional complaints beginning CY 2017. Several investigations led to adjudicatory proceedings and proposed settlement agreements. Nonetheless, the licensee practiced with an active license for over three years with no additional oversight by the Board. Despite multiple continued hearings and pending discipline, the licensee was also issued an anesthesia and sedation permit. This expanded the licensee's ability to provide certain high-risk dental services without additional Board oversight. A May 2021 Board order dismissed a then-pending case on technical grounds, but the case was under appeal as of September 2021, when we concluded audit work on this topic.

Furthermore, incomplete records adversely affected the Board's ability to make well-informed decisions. Complaints in four of the 21 cases (19.0 percent) were dismissed and unauditable. None of the available records contained the complaint, licensee response, or other records supporting the Board's decision. One case record contained evidence the licensee was subject to seven prior complaints from CYs 2009 through 2018, and one disciplinary sanction in CY 2014. However, the complaint summary was incomplete. Furthermore, the CY 2014 disciplinary sanction was not publicly available as statutorily required until August 2021, after we inquired about the missing information.

**Recommendations:**

**We recommend the Board improve monitoring of regulatee compliance with requirements, and:**

1. **develop a cohesive, evidence- and risk-based monitoring strategy and supporting plans, compliant with statute and rules, and incorporating input from other regulatory agencies and stakeholders;**
2. **review entry, practice, and eligibility maintenance requirements to determine the minimum level and frequency of monitoring necessary to achieve expected outcomes, and develop and implement cost-effective monitoring controls;**

3. **ensure all available information is used to inform monitoring efforts and identify patterns of noncompliance;**
4. **ensure monitoring requirements are clearly specified and consistently applied;**
5. **identify information necessary to inform monitoring, establish information requirements for the OPLC, and ensure reliable information is timely collected and reported;**
6. **routinely review and refine strategy, plans, and controls to identify changes needed to ensure monitoring is effective and helps achieve expected outcomes;**
7. **delegate non-discretionary, administrative duties to the OPLC via rules, and discontinue delegation of discretionary Board duties; and**
8. **coordinate monitoring of regulatee compliance with other agencies and programs with concurrent jurisdiction.**

Board Response:

*We concur in part with the recommendations.*

**The Board's lengthy, detailed response and associated rejoinders are in Appendix B.**

## Verifying Character And Conduct

The Board was responsible for establishing character and conduct requirements designed to help ensure public protection, in addition to those required by State policy. Verifying compliance with these requirements for the entire time an individual was regulated by the Board could have helped ensure the public was adequately protected. Verification of requirements should have relied on proactive and reactive monitoring controls. This included one-time verification of compliance with entry requirements during initial credentialing; ongoing verification of compliance through renewals and other processes, such as complaints or self-reporting; and verification of compliance with remediation requirements arising from enforcement cases.

**Observation No. 29**

### Improve Verification Of Compliance With Character And Conduct Requirements

The Board's control framework for verifying compliance with character and conduct requirements was inadequate. The Board's effectiveness in ensuring the public health, safety, and welfare was compromised. There was no discernible design to character and conduct requirements or the Board's monitoring of primary credential holder compliance. Nothing demonstrated requirements and processes to ensure compliance achieved expected outcomes. Other regulatees were largely excluded from Board controls. Certain key public protection requirements were not applied to some credentials, and some were cursorily verified and others were altogether unverified. The Board did not oversee verification processes or utilize available means and information to help ensure requirements were met. This led to a gap in its ability to assess the risk applicants and credential holders may have posed. Extra-legal, ad hoc rules underpinned processes. Improvised

practices rested upon reactive Board member or staff action – typically only reviewing applicant or licensee attestations. Third-party verification of compliance was infrequent.

**Inadequate Rules**

Board rules did not provide an adequate framework to determine whether primary credential holders complied with conduct and character requirements. For example, rules:

- did not require criminal history records checks, despite statutory requirements;
- did not impose any character and conduct requirements on Expanded Function Dental Auxiliary (EFDA) permittees, unlike other primary credential holders;
- only partially addressed DEA and PDMP related-requirements; and
- lacked a requirement to verify with other jurisdictions whether applicants' non-dental credentials were subject to investigation, sanction, or other disciplinary action.

Rules also established a malpractice committee that was not used in practice. This left the Board no formalized and systematic way to manage insurance claim and legal judgement data. Staff informally handled such matters without process controls.

**Inadequate Processes**

Processes to verify whether applicants met character and conduct requirements were deficient. Staff were informally delegated responsibility for making administrative completeness determinations on applications. This included ensuring all required questions on application forms were answered and all required documents were submitted. Staff or individual Board members were to conduct substantive evaluation of applications. This should have included verifying the substance of materials submitted to demonstrate compliance with requirements. Purportedly, determining compliance with certain requirements, such as conduct requirements, was more subjective than for other requirements. However, checklists and informal guides were insufficiently comprehensive to help staff verify applicants met all requirements. For example, application checklists:

- for dentists' regular and temporary volunteer licenses excluded some character and conduct requirements, and lacked checks on PDMP-related requirements;
- for hygienists' regular licenses excluded some character and conduct requirements;
- for EFDA permits did not require verification a dentist recommended the applicant for the qualification course; and
- did not exist for temporary research and education licenses.

Checklists for incomplete regular dentist and hygienist licenses required staff to check for the submission of supplemental ad hoc explanatory information on potential noncompliance with requirements. However, they were not used.

### *Inadequate Review And Verification Of Initial Primary Credential Requirements*

Board controls did not ensure character and conduct requirements applied to all primary credentials or were consistently reviewed during initial credentialing. Only a limited subset of information was independently verified, making other requirements perfunctory. As shown in Table 12, applicants for different credentials usually had to provide similar character and conduct information. However, some requirements differed, and some credentials were excluded altogether. Applicants for regular and temporary volunteer licenses were required to attest to meeting rule-based character and conduct requirements. Ad hoc rules required regular license applicants to provide supplemental explanatory information if potential character and conduct issues existed. Ad hoc rules also required additional information be provided by third parties on an applicant's behalf.

The Board lacked oversight of initial credentialing. It did not make a positive finding applicants possessed the necessary educational, character, and other professional qualifications to practice, and that no circumstances exist which would be grounds for disciplinary action. Applications for 459 of 504 initial credentials issued during the audit period (91.1 percent) were issued without preceding Board action. This included 262 applications (57.1 percent) accepted after a credential had already been issued, and 197 (42.9 percent) that were never presented to or reviewed by the Board. Deficiencies with staff review also contributed to inadequate public protection. For example, 21 of 26 (80.8 percent) regular license applications we reviewed contained substantive documentation deficiencies related to character and conduct. Applicants licensed in other jurisdictions were required to submit certified statements from those jurisdictions on whether their license was subjected to disciplinary action, had disciplinary action pending, or was under investigation. Among the 26 applications, 18 (69.2 percent) required certified statements. However, 17 of the 18 (94.4 percent) either did not contain all required statements, or statements were missing required information.

### *Perfunctory Verification Of Primary Credential Renewal Requirements*

The Board's approach to verifying compliance with character and conduct requirements at renewal was perfunctory. The Board relied on rule-based renewal applicant attestations and ad hoc self-reporting requirements to explain potential regular and voluntary temporary licensee noncompliance. Procedures to verify attestations on character and conduct requirements did not exist. The only requirement the Board routinely verified was competency maintenance, by reviewing continuing education for a small sample of renewing regular licensees. Competency maintenance requirements were a subset of eligibility maintenance requirements. Additionally, there were no character and conduct requirements for renewing EFDA permittees or temporary research and education licensees.

Renewal applications were approved without substantive evaluation. For example, of 2,922 renewal credentials issued during SFY 2019 and SFY 2020, 2,919 (99.9 percent) were issued without Board action. Without substantive evaluation of renewal applications, the Board could not have known, or made a positive finding, renewing credential holders continued to meet eligibility requirements.

**Table 12**

**Initial Primary Credential Character And Conduct Requirements And Verification Practices**

| Summary Requirements | Applicable To: | | | | Ad Hoc Rule[3] | Third Party Verification |
|---|---|---|---|---|---|---|
| | Dentist | Hygienist | Temporary[1] | EFDA[2] | | |
| Criminal history record check | Yes | Yes | No | No | n/a | No |
| Report criminal convictions that were not annulled | Yes | Yes | Yes | No | Yes | No |
| Report convictions for illegal dental or hygiene practice | Yes | Yes | Yes | No | Yes | Yes[4,5] |
| Report malpractice or professional liability claims or lawsuits | Yes | Yes | Yes | No | Yes | No[5] |
| Report initial dentist or hygienist license denials | Yes | Yes | Yes | No | Yes | Yes[4,5] |
| Report dentist licenses under investigation, sanctioned, not renewed, relinquished, or pending disciplinary actions | Yes | No | Yes | No | Yes | Yes[4,5] |
| Report any occupational license held investigated, sanctioned, disciplined, denied renewal, relinquished, subjected to corrective action, or under review | Yes | Yes | Yes | No | Yes | Yes[4,5] |
| Report a DEA registration sanctioned, denied, not renewed, or under investigation | Yes | n/a | Yes | n/a | Yes | No[5] |
| Register with the PDMP if holding a DEA registration | Yes | n/a | Yes | n/a | Yes | No[6] |
| Report any hospital privileges revoked, suspended, restricted, denied, or not renewed | Yes | n/a | Yes | n/a | Yes | No |
| Report any physical or mental impairment affecting one's ability to practice dentistry or hygiene | Yes | Yes | Yes | No | Yes | No |
| Submit a statement from other jurisdictions on whether a dentist or hygienist license was subject to or pending disciplinary action, or was under investigation | Yes | Yes | Yes | No | No | Yes[4,5] |
| Provide certificates of good professional character | Yes | Yes | Yes | No | No | No[7] |

Notes:
1. Includes research and education program and volunteer temporary licenses.
2. An active licensed dentist was required to recommend an EFDA candidate to an educational institution as a precondition of attending the qualification course.
3. There were underpinning ad hoc rule requirements.
4. Dentist and hygienist applicants had to submit certified statements from other jurisdictions only on their dentist or hygienist license. Similar certification was not required for other occupational credentials.
5. The limited AADB Clearinghouse was used to verify certain attestations. The more comprehensive NPDB was not used.
6. Processes to ensure applicants were registered with the PDMP and met initial continuing education requirements were deficient. There was no requirement to verify applicants from other jurisdictions complied with that jurisdiction's prescribing requirements.
7. There was no clear process to determine whether attestations of character were valid, or the attesting dentist was in good standing.

Source: LBA analysis of character and conduct requirements.

***Criminal History Record Checks Not Conducted***

Unaudited credentialing data showed, from August 24, 2018, through June 30, 2020, all 245 applicants issued initial regular licenses lacked a required criminal history record check. Criminal history record checks could have helped determine whether applicants' character and past conduct was acceptable. In CY 2017 the Board requested authority to conduct criminal history record checks after finding some applicants with a criminal history had been issued licenses. The requested authority became effective in August 2018. Since then, the Board was required to review the results of criminal history record checks before making licensing decisions. Through October 2021, when we concluded audit work on this topic, the Board never implemented the requirement, adopted relevant rules, or structured implementing processes. The Board had no plan or definite timeline for adopting relevant rules and initiating criminal history record checks of applicants. Additionally, the enabling authority the Board requested was incomplete—required criminal history record checks were limited to initial regular licenses and applicants for reinstatement. Authority excluded applicants for other primary credentials, including EFDA permits, temporary licenses, license reactivations, and all renewals.

***Third-party Sources Used To Verify Attestations Insufficient***

Board reliance on voluntarily-reported information from participating jurisdictions' dental regulatory agencies obtained through the AADB Clearinghouse was insufficient. The AADB Clearinghouse collected some, but not all, relevant character and conduct information, and was reportedly inconsistently available.

- Staff were to query the AADB Clearinghouse during initial regular licensure. They were to verify applicants' attestations on compliance with certain character and conduct requirements. However, six of 26 initial regular license applications (23.1 percent) we reviewed lacked an AADB Clearinghouse report.

- The OPLC lacked processes to identify potentially conflicting or missing information needed to fully query the AADB Clearinghouse. For example, AADB Clearinghouse results were useful only when all biographical information on the applicant was correct. However, seven of nine applicants (77.8 percent) who reported a name change lacked a report on their prior legal name.

- Staff received and reviewed monthly AADB Clearinghouse reports for actions taken by participating jurisdictions against current New Hampshire credential holders. Staff were supposed to follow up on other jurisdictions' actions against New Hampshire credential holders and provide the Board with relevant records. However, these informal procedures were not in place during the entire audit period, AADB reports were not retained, and the results of staff reviews were unauditable.

The Board lacked requirements and procedures to query the more comprehensive NPDB to verify applicant compliance with character and conduct requirements. This compromised the quality and quantity of information available to inform Board decision making. Reporting to the NPDB was mandatory for federal and state agencies, health care organizations, insurance companies, peer review organizations, private accreditation entities, and state licensing and certification authorities. The NPDB contained information on many of the same topics as Board-required attestations, unlike the AADB Clearinghouse. For example, the NPDB contained:

- medical malpractice payments;
- adverse actions related to licensure and clinical privileges;
- DEA registration actions;
- certain adverse actions taken by other states' regulatory agencies, state law enforcement agencies, state agencies administering state health care programs, and private accreditation organizations;
- consent orders in other states; and
- certain final adverse actions taken by federal agencies and health plans.

We did find evidence the Board received NPDB reports during the audit period. However, all seven reports appeared to have been sent to the Board on a case-by-case basis by other jurisdictions' regulatory agencies in conjunction with Board enforcement actions.

**Recommendations:**

**We recommend the Board improve controls over verifying compliance with character and conduct requirements, and:**

1. **discontinue relying solely on attestations and independently verify applicant and credential holder compliance with conduct and character requirements;**
2. **remedy defective licenses approved without required criminal history record checks;**
3. **seek legislative changes to ensure all primary credential applicants are required to undergo criminal history record checks;**
4. **adopt rules on criminal history records checks;**

5. **ensure rules contain all character and conduct requirements;**
6. **establish procedures to ensure all conduct and character requirements are verified, such as by periodically auditing credential holders' compliance;**
7. **delegate nondiscretionary tasks to the OPLC, and reserve all discretionary tasks for Board action;**
8. **establish information requirements for staff to enable Board monitoring of performance; and**
9. **broaden third-party verifications of attestations, such as by regular use of NPDB queries.**

Board Response:

*We concur in part with the recommendations.*

**The Board's lengthy, detailed response and associated rejoinders are in Appendix B.**

## Verifying PDMP Compliance

Dentists prescribing or dispensing controlled drugs had to register with the federal DEA. Dentists with a New Hampshire-associated DEA registration were also required to register with the PDMP. The PDMP was intended to monitor indicators of potential substance abuse and misuse, help identify fraudulent prescribing, and modify prescribing practices. As condition of initial and renewal licensure, PDMP-registered dentists had to verify they completed three hours of Board-approved continuing education or passed an examination in pain management, addiction disorder, or a combination of the two.

The Board held primary enforcement authority for dentist noncompliance with PDMP requirements. Noncompliance with relevant laws, rules, or related standards identified by the PDMP was to be sent to the Board for further investigation. Noncompliance included failure to register, provide accurate information, or adhere to prescribing requirements, as well as prescribing or dispensing controlled substances without registering.

**Observation No. 30**

### Improve Prescription Drug Monitoring Program Compliance Controls

Board controls to ensure dentists who prescribed or dispensed controlled drugs obtained a DEA registration number, registered with the PDMP, completed necessary continuing education, and complied with related requirements lacked a discernible design. The Board did not adopt comprehensive rules. It did not institute consistent, formalized procedures to ensure compliance with PDMP requirements and the *Controlled Drug Act*, systematically monitor licensee compliance, and consistently communicate with the PDMP. Staff procedures were improvised and focused only on registration requirements during initial licensing. Current and former Board members who responded to our survey generally reported Board controls effectively or mostly effectively ensured licensees prescribing controlled drugs were registered with the PDMP and complied with requirements. However, the Board did not monitor PDMP registration to establish

whether controls efficiently achieved expected outcomes, or to ensure dentists conformed to relevant requirements. While our audit work focused on the Board's controls and was not designed to identify all instances of potential applicant or licensee noncompliance, we did find instances of noncompliance with PDMP registration requirements.

**Defective Licensing Requirements**

Board requirements were inconsistent with State policy, unclear, and incomplete; relied on ad hoc rules; and did not ensure evidence was submitted to demonstrate compliance with requirements. Board requirements affected: 1) dentists applying for initial regular licensure who already possessed a DEA registration number, 2) licensees who obtained DEA registration after becoming licensed, and 3) temporary licenses, reinstatements, and reactivations.

***Defective Requirements For Regular License Applicants With DEA Registration Numbers***

Controls inadequately addressed requirements imposed on license applicants with existing DEA registrations. Applicants may have had one or more DEA registration numbers associated with other jurisdictions when applying for a New Hampshire dentist license. The *Controlled Drug Act* and PDMP rules required PDMP registration only for applicants who had a DEA registration number associated with New Hampshire. Board rules, the license application form, and an OPLC notification letter referenced this requirement. However, Board rules:

- were overly broad, requiring applicants provide every DEA registration number, regardless of the jurisdiction with which they were associated;
- lacked a requirement applicants provide information on required continuing education, a statutory requirement for initial licensure; and
- provided a 90-day period after receiving an initial license to register with the PDMP, without statutory basis.

The improvised, rule-based 90-day period applied only to initial license applicants who already possessed a DEA registration number associated with another jurisdiction. However, the application form and instructions misapplied the 90-day period to any licensee who obtained a DEA registration number after licensure. Furthermore, the application form required DEA-registered applicants to provide their registration numbers. However, it did not require these applicants to submit evidence of DEA registration, provide evidence they completed required continuing education, or attest to having also registered with PDMP. Neither did the OPLC notification letter require applicants to submit evidence of DEA registration or provide evidence required continuing education had been completed.

Additionally, there were no procedures to obtain and examine an applicant's prescribing history when they possessed a DEA registration number. Consequently, the Board could not ensure past prescribing practices conformed to requirements of an applicant's previous jurisdiction. When reviewing initial license applications, State policy required the Board find no circumstances existed that would be grounds for disciplinary action. This included knowingly or willfully violating any controlled drug law. Verification of compliance relied primarily on self-reported compliance information during initial application. There was limited third-party verification of

self-reported information, and no verification with other jurisdictions' prescription drug monitoring programs.

***Defective Requirements For Regular License Applicants Without DEA Registration Numbers***

Board rules inadequately addressed requirements imposed on applicants who were not registered with the DEA before they obtained a New Hampshire dentist license. Applicants did not need a DEA registration number to obtain a dentist license. Those who wanted to prescribe or dispense scheduled substances could apply for a DEA registration number any time after being issued a license. However, Board requirements were not structured to ensure dentists obtaining DEA registration after licensure timely notified the Board. Consequently, the Board could not ensure licensees timely registered with the PDMP. Only ad hoc rules required licensees to notify the Board after they registered. There were no requirements to provide evidence of registration.

Board rules did not apply to applicants who obtained DEA registration after being licensed. Rules required initial regular license applicants to notify the Board only of their DEA registration when applying. However, the application form required individuals obtaining DEA registration after being licensed, and subsequently having to register with the PDMP, to provide the Board with their DEA registration number. Application form instructions also required DEA and PDMP registration information be provided within 90 days of registering. However, there was no verification process. The OPLC's notification letter also contained the ad hoc 90-day requirement. The OPLC letter additionally informed newly licensed dentists of their registration obligation, asserting that failure to notify the Board would result in a $500 administrative fine. While the Board had statutory authority to impose fines for violating PDMP requirements, the OPLC did not. The $500 fine for failure to register was not in Board, PDMP, or OPLC rules, and there was no evidence the Board imposed administrative fines for noncompliance. While rules required regular license renewal applicants to notify the Board of any DEA and PDMP registrations during renewal, there was no process for dentists to provide registration information outside the initial and renewal license application process. Neither was there a process to provide notification of PDMP registration outside the biennial license renewal application process.

***Defective Requirements For Temporary Licensure, Reinstatements, And Reactivations***

Registration controls over temporary volunteer licensees were inadequate. Controls over licensees holding other types of temporary licenses, was well as those seeking reinstatement of a lapsed license or reactivation of an inactive license, were absent. Since August 2017, the Board informally allowed temporary volunteer licensees to obtain a New Hampshire-associated DEA registration number. Board rules required applicants for temporary volunteer licensure provide their DEA and PDMP registration numbers. Temporary volunteer licensees were exempt from PDMP continuing education requirements, however. Also, the application form did not require temporary volunteer renewal applicants to demonstrate they were registered with the PDMP or provide verification of completion of PDMP-related continuing education requirements.

**Unstructured Monitoring Of DEA And PDMP Registration**

DEA and PDMP registration compliance was inconsistently monitored, and noncompliance inconsistently sanctioned. Available data were not integrated to identify licensees needing, or potentially needing, to register. Rules did not require licensees obtaining DEA and PDMP registration after becoming licensed to provide their registration information until their next biennial renewal. Consequently, some licensees were not identified as noncompliant with requirements until they renewed their licenses.

Informal OPLC practices required staff to verify newly licensed, DEA-registered dentists were also registered with the PDMP before renewal. Staff could obtain PDMP-generated lists of dentists potentially noncompliant with registration requirements. Purportedly, however, this informal practice requirement was inconsistently followed, and lists were inconsistently provided. The Board also did not review other available information, including:

- licensees' self-reported DEA and PDMP registration data from the credentialing database management system before renewal;
- General anesthesia or deep sedation (GA/DS) or moderate sedation (MS) permit data and facility inspection and comprehensive evaluation results to help identify licensees who had or might have needed, but did not report, DEA and PDMP registration;
- lists of staff working at facilities covered by GA/DS and MS permits to help identify Board of Registration of Medical Technician-registered staff, an indicator that controlled drugs may have been used at a particular facility; and
- dental specialty data, such as oral and maxillofacial surgery specialization, to identify licensees who had or might have needed, but did not report, DEA and PDMP registration.

The credentialing database management system indicated when a licensee renewing online provided discrepant DEA and PDMP registration information. We found cases demonstrating inadequate Board controls.

- Among nine dentist renewal applications we examined, three (33.3 percent) contained conflicting answers regarding DEA and PDMP registration. There was no follow up on one of the three cases.

- We identified two additional cases where licensees failed to register with the PDMP.

- We found a third case where the Board was unaware that a licensee obtained a DEA registration after being licensed and then subsequently registered with the PDMP. Inadequate Board reporting requirements resulted in the registration going unreported for over 600 days.

There was no evidence any of these licensees were sanctioned for noncompliance.

**Defective Board And PDMP Communication**

Communication between the Board and the PDMP was insufficient to ensure adequate monitoring of licensee compliance. The Board inconsistently filled its position on the PDMP Advisory Council. Consequently, Board input on, and oversight of, PDMP operation was limited. Routine reports were supposed to pass between the Board and the PDMP. For example, the Board was obligated to monthly provide the PDMP with lists of newly licensed prescribers and dispensers, renewed licensees, and revoked, suspended, restricted, and unrenewed licenses. However, their delivery was not monitored and reports were reportedly not exchanged.

To facilitate compliance monitoring, the PDMP was obligated to provide the Board with quarterly reports on licensees when: 1) there was reason to believe noncompliance with law or other standards had occurred, or 2) a failure to report the dispensing of a scheduled controlled substance concealed a potential pattern of diversion to illegal use. The PDMP was also to provide an annual report on PDMP effectiveness and copies of any judgment on a licensee convicted of violating the *Controlled Drug Act*. The Board could then suspend, limit, or revoke their license. However, the Board lacked controls to ensure these reports were provided. The Board reported not receiving, but also did not request, information to enable monitoring of potential misconduct. Consequently, the Board could not identify potentially noncompliant licensees whose prescribing activities indicated possible fraudulent conduct and request information for further investigation.

**Recommendations:**

**We recommend the Board improve controls over PDMP-related requirements, and:**

1. **redesign rules to ensure the Board achieves all DEA and PDMP registration compliance objectives;**
2. **ensure rules encompass all statutory requirements and apply to all applicants who obtain a DEA registration number and register with the PDMP;**
3. **ensure licensees timely report registration data, and discontinue the 90-day timeframe to register with the PDMP;**
4. **utilize available license and permit data to help identify and monitor dentists who have registered or may need to register with the DEA and PDMP;**
5. **ensure relevant licensee information is routinely, accurately, and timely reported to the PDMP;**
6. **maintain communication with the PDMP to ensure receipt of information necessary for monitoring licensee DEA and PDMP registration, applicable requirements, and potential areas of misconduct;**
7. **establish information requirements of the OPLC that will allow the Board to monitor and report on compliance and efficiency;**
8. **ensure vacancies on the PDMP Advisory Council are timely filled;**
9. **ensure fines related to PDMP registration noncompliance are established in rule and are levied only by the Board after adjudicative proceedings; and**
10. **ensure sanctions are appropriately and timely applied for noncompliance.**

Board Response:

*We concur in part with the recommendations.*

1. *We concur with the recommendation to redesign rules to ensure we achieve DEA and PDMP registration compliance objectives.*

   *The Board already has rules in place to achieve PDMP registration:*

   *Rules require applicants for initial licensure, who possess a DEA number, to:*

   a. *provide the number to the Board;*
   b. *register with the NH PDMP pursuant to* Controlled Drug Prescription Health and Safety Program *and PDMP rules.*

   *If the applicant fails to register that number with the Board within 90 days of initial licensure, it constitutes professional misconduct. This rule also prohibits a licensee from prescribing or dispensing controlled substances without having registered with the NH PDMP.*

   *Board rules pertaining to dental license registration and renewal also provides that an applicant must provide information regarding whether he/she has ever had a DEA license revoked, suspended, denied, placed on probation, restricted or otherwise sanctioned by a state or federal licensing/regulatory board, or if he/she is currently involved in a disciplinary process.*

   *Board rule requires that the applicant provide information regarding whether he/she is registered with the PDMP, possess a DEA number, which must be provided to the board. Board rule provides (again) that failure to register with the PDMP constitutes disciplinable misconduct and reiterates that the applicant cannot prescribe controlled substances without having registered with the PDMP.*

   *The Board will initiate further rulemaking to achieve PDMP registration compliance.*

2. *We concur with the recommendation to ensure rules encompass all statutory requirements and apply to all dental applicants who obtain a DEA registration number and register with the PDMP.*

   *As stated in response above the Board already has rules in place and will initiate further rulemaking to ensure that statutory requirements are met for all licensees with NH DEA numbers to register with the PDMP.*

3. *We concur with the recommendation to ensure licensees timely report registration data and discontinue the 90-day timeframe to register with the PDMP.*

   *The Board will seek statutory changes to impose the 90-day time limit.*

*An applicant needs a dental license prior to applying for a DEA registration so all initial licensees will need time to get a DEA number after getting their dental license.*

4. *We concur in part with the recommendation to utilize available license and permit data to help identify and monitor dentists who have or may have to register with the DEA and PDMP.*

   *If the Board is made aware that a licensee has a NH DEA number, then the Board does require the licensee to register with the PDMP. The Board does not have access to data to know which licensee gets a DEA registration number after getting his/her dental license. The Board only finds out about new DEA registration numbers at time of license renewal. The only data the Board has available about licensees needing a DEA number are the ones that are administering in office sedation.*

   **LBA Rejoinder: Board rules should implement controls designed to ensure licensees comply with registration requirements, rather than relying on happenstance. The Board's response describes the exact gap in its controls that we recommend it address.**

5. *We concur with the recommendation to ensure relevant dental licensee information is routinely reported to the PDMP accurately and timely, to help ensure all applicable dentists have registered.*

   *Pursuant to PDMP rules, on a monthly basis, the Board is supposed to notify the manager of prescribers/dispensers who have been issued a new license, license renewal, or who have had their license revoked or suspended. The Board will collaborate with OPLC to ensure that the information is timely provided to the PDMP.*

6. *We concur with the recommendation to maintain communication with the PDMP to ensure receipt of information necessary for monitoring licensee DEA and PDMP registration, applicable requirements and potential areas for misconduct.*

7. *We concur with the recommendation to establish information requirements of the OPLC that will allow the Board to monitor and report on compliance and efficiency.*

8. *We concur with the recommendation to ensure vacancies on the PDMP Advisory Council are timely filled.*

9. *We concur with the recommendation to ensure fines related to PDMP registration non-compliance are established in rule and are levied only by the Board after adjudicative proceedings.*

   *The Board will initiate rule making process to establish fines and procedures relating to noncompliance of PDMP registration.*

10. *We concur with the recommendation to ensure sanctions are appropriately and timely applied for noncompliance.*

**Renewing Credentials**

State policy required certain credentials be renewed to enable monitoring of credential holder compliance. Renewal processes were intended to ensure credential holders continued to possess the competency, character, and acceptable past conduct to help protect the public. Renewal was required for credential holders to maintain their credentials and continue to practice. Accepting, reviewing, and approving or denying applications for credential renewal was a fundamental Board duty. Staff were to determine the administrative completeness of applications according to Board standards, and the Board was to review applicants' substantive qualifications. Table 13 summarizes the number of primary credentials renewed during SFYs 2018 through 2021.

**Table 13**

**Renewed Primary Credentials, State Fiscal Years 2018–2021**

| | State Fiscal Year | | | |
|---|---|---|---|---|
| | 2018 | 2019 | 2020 | 2021 |
| **Regular Dentist**[1] | 1,256 | 1[2] | 1,250 | 0 |
| **Regular Hygienist**[1] | 0 | 1,655 | 0 | 1,601 |
| **Temporary Research, Education**[3] | 0 | 0 | 0 | 0 |
| **Temporary Volunteer**[3] | 2 | 2 | 0 | 0 |
| **EFDA**[4] | 0 | 14 | 0 | 12 |
| **Total**[5] | **1,258** | **1,672** | **1,250** | **1,613** |

Notes:
1. Renewal processes are discussed in Observation No. 31.
2. A non-practicing dentist returned to practice, and their license was restored to active status.
3. Renewal processes are discussed in Observation No. 21.
4. Renewal processes are discussed in Observation No. 22. Renewals were dentist licenses only.
5. The number of unique individuals with renewed primary credentials was not readily available. Individuals may have held multiple primary credentials. Renewal data included active, inactive, lapsed, and other credential statuses, which could not be readily excluded from the data. The numbers of on-time and late renewals, lapses, reinstatements, and reactivations were not readily available. There were no readily available data on credential holder losses, such as through a failure to renew a credential. Available data do not necessarily represent a net change in active credential holders year-to-year.

Source: Unaudited OPLC credentialing data, as of May 28, 2021, and July 21, 2021.

Table 14 summarizes the number of supplemental credentials renewed during SFYs 2018 through 2021.

**Table 14**

**Renewed Supplemental Credentials, State Fiscal Years 2018-2021**

| | State Fiscal Year | | | |
|---|---|---|---|---|
| | 2018 | 2019 | 2020 | 2021 |
| **GA/DS[1]** | 80 | 0 | 94 | 0 |
| **MS-Restricted[1]** | 8 | 0 | 9 | 0 |
| **MS-Unrestricted[1]** | 13 | 0 | 15 | 0 |
| **Local Anesthesia[2]** | n/a | n/a | n/a | n/a |
| **Nitrous Oxide Minimal Sedation[2]** | n/a | n/a | n/a | n/a |
| **CPHDH[3]** | 0 | 49 | 0 | 44 |
| **Total[4]** | **101** | **49** | **118** | **44** |

Notes:
1. Renewal processes are described in Observation No. 24.
2. Permits were reportedly renewed by staff during the hygienist license renewal. No data was available to quantify renewals that may have occurred. Renewal processes are described in Observation No. 25.
3. Renewal processes are described in Observation No. 26.
4. There were no readily available data on credential holder losses, such as through a failure to renew a credential. Available data do not necessarily represent a net change in credential holders year-to-year. Additionally, the number of unique licensees with renewed supplemental credentials was not readily available. Licensees may have held multiple supplemental credentials.

Source: Unaudited OPLC credentialing data, as of May 28, 2021, and July 21, 2021.

***Renewing Dentist And Hygienist Licenses***

License renewals occurred biennially, in even-numbered years for dentists and odd-numbered years for hygienists. The Board was required to adopt rules on license renewal procedures; forms; applicant qualifications, in addition to statutory requirements; and continuing education requirements. Licensees had to meet conduct, character, and continuing education requirements to be eligible for renewal. A license could be renewed as either active or inactive, depending on whether a licensee had practiced in the State since their prior renewal. The Board was required to send renewal notifications to licensees by February 15. To renew a license on time, licensees had to complete and submit a registration form and fee before April 1 of their renewal year. Late renewals were allowed if licensees completed and submitted a registration form on April 1 through April 30, with payment of a late fee. No application was to be granted unless the Board found the

applicant possessed the necessary educational, character, and other professional qualifications, and no circumstances existed which would be grounds for disciplinary action.

**Observation No. 31**

**Improve Regular Dentist And Hygienist License Renewal Controls**

Controls over license renewals were inadequate, adversely affecting compliance, timeliness, consistency, and efficiency. Deficiencies compromised the Board's effectiveness. Instead of serving as a means to monitor ongoing licensee compliance, the renewal process was perfunctory for most, and largely wasteful. Nothing demonstrated license renewals achieved expected outcomes. Extra-legal requirements exposed the Board to potential federal anti-trust scrutiny and public protection was compromised.

There was no discernible design to renewal controls. There was no substantive review of renewal applications. Statute and rules incompletely accommodated the transition to online renewals. Related OPLC procedures and practices were informal, incomplete, and inconsistent with statutory and rule-based requirements. Neither the Board nor staff proactively verified compliance with requirements with third-party sources.

There was no routine monitoring of process consistency, including timeliness, and the efficiency or effectiveness of renewal application processing was never established. Data to permit assessment of timeliness or efficiency were not published during the audit period. There was no readily available data of the number of on-time renewals, late renewals, and non-renewals. Renewal application records were generally unauditable.

Although our audit work focused on controls and was not designed to identify all instances of noncompliance, we did find cases demonstrating how inadequate controls inconsistently affected licensees and renewal decisions.

**Inadequate Public Protection**

The Board lacked adequate oversight and control over renewal application processing. The lack of substantive review made the renewal process perfunctory and largely wasteful. License renewal involved multiple steps. While all applicants submitted a registration form, some were additionally required to submit an attestation form and supplemental materials. Applicants also had to submit applicable fees. Since August 24, 2018, no application was to be granted unless the Board found the applicant possessed the necessary educational, character, and other professional qualifications, and no circumstances existed which would be grounds for disciplinary action. However, there was essentially no verification of compliance with requirements, and few applications underwent substantive evaluation. We found only six of 2,905 renewal applications (0.2 percent) were even reviewed by the Board from SFY 2019 through SFY 2020. This included three (0.1 percent) reviewed after the renewal license had been issued by the OPLC. Staff apparently approved all renewal applications.

***Compliance With Renewal Requirements Not Verified***

Renewal processes were perfunctory. Compliance with requirements was not substantially verified, was unverified, or was inconsistently enforced. Requirements not clearly used to assess competence, character, or past conduct lacked clear connection to public protection. The Board informally delegated review of renewal applications to staff but established no requirements or processes to comprehensively verify licensee compliance with character and conduct requirements. Staff relied on an automated review by the electronic credentialing database management system of most renewal applications. There were no formal OPLC procedures on processing renewal applications until March 2020. These procedures focused on administrative aspects of renewal, such as notifications and processing time. Neither procedures nor informal guidance addressed how staff were to make administrative completeness determinations or established their role in substantive evaluations. Consequently, there were no formal processes:

- to identify missing information on hardcopy registration forms,
- to verify information applicants entered into the credentialing database management system,
- on whether or how to verify renewal requirements were met, or
- on whom – staff, Board members, or the Board itself – should verify requirements were met.

Consequently, some self-reported information, such as the hospitals where dentists held staff privileges or information on applicants' employers, was not clearly used to assess competence, character, or conduct. Not all self-reported information, such as information related to criminal or unprofessional conduct, was verified. Additionally, compliance with some requirements, such as failure to report a change of address or knowingly reporting deceptive or false information, was inconsistently verified. Noncompliance was inconsistently subject to enforcement action. For example, one licensee responded "yes" to questions on criminal conviction and monitoring of a professional license in another state when submitting a renewal application. There was no record this application was reviewed by either staff or the Board.

The Board required reviews of compliance with continuing education requirements for at least three percent of renewing active licensees each biennium. A similar approach could have been used to proactively verify self-reported character and conduct information for a subset of active licensees, such as by:

- requiring criminal history record checks to verify there had been no criminal conduct reported,
- using the NPDB to verify no disciplinary actions had been taken by another jurisdiction,
- using PDMP and related data to verify all prescribing or dispensing dentists were properly registered with the PDMP, and
- requiring letters of good standing from regulatory agencies to verify no investigations had been initiated.

Additionally, on-time renewal fees were gratuitous. Fees ranged from $65 for inactive hygienist licensees to $365 for active dentists. However, applications were processed internally, largely by automated means and essentially the same way, and without any added expense of third-party verifications.

***Controls Over Supplemental Ad Hoc Attestation Forms Inadequate***

No rule, procedure, or other formal controls over supplemental attestation forms existed. Nothing demonstrated the Board used information from attestation forms to ensure licensees were eligible for renewal. Attestation forms required licensees to either attest to the accuracy of their initial responses or provide corrected responses and supporting documentation. Hardcopy and online registration forms already included certification or attestation statements to which licensees had to agree. By doing so, licensees confirmed that the self-reported information they provided was accurate and they understood providing false information could result in penalties. However:

- staff inconsistently required completion of ad hoc attestation forms when they identified responses on registration forms that were potentially inconsistent;
- requiring attestation forms appeared wasteful when information provided on the attestation form did not substantively differ from that provided on the registration form;
- when staff did confirm licensees' initial responses were inaccurate, they inconsistently updated licensees' records in the credentialing database management system with the corrected information; and
- staff did not generally provide corrected responses to the Board, including one case in which a licensee provided incorrect responses to the same questions in two consecutive renewals.

**Inadequate Controls Over Board Decisions**

The Board generally did not make a finding licensees met renewal requirements or made no knowing deceptive or false statements on their renewal applications. The Board had statutory authority to register and license individuals, after it found them qualified to continue practice. No renewal was to be granted if the licensee knowingly made deceptive or false statements. Board authority could have only been exercised through a quorum. However, inadequate controls over approvals resulted in deficient decision making. This called into question the validity of 99.9 percent of renewed licenses from SFY 2019 through SFY 2020—the Board approved only one-tenth of one percent of renewal applications before a renewed license was issued.

The Board inappropriately and informally delegated renewal authority to staff. OPLC procedure provided, "[n]o employee shall renew a license *without express authority* from a statute, administrative rule, or a written, standing order of a board delegating authority to staff to issue licenses." [emphasis added] There were no relevant standing orders or rules, although any such delegation would have been counter to statute. Nonetheless, the OPLC relied on automated approval by the credentialing database management system for certain renewal applications. Once a renewal application was determined to have met requirements by staff or the credentialing database management system, the OPLC would issue a renewal license.

Additionally, the Board lacked controls over denials, conditional denials, or contested decisions. There were no processes in place to monitor denied renewal applications. Although the Board could deny applications in whole or in part, no rules, external instructions, formal procedures, or informal guidance structured a denial process. While we could not identify any denials or conditional denials of renewal applications in unaudited OPLC data, inadequate controls could result in inconsistent treatment of licensees.

**Inadequate Controls Over Renewal Requirements**

The Board lacked adequate oversight of, and control over, the statutory, regulatory, and procedural framework governing renewals. Licensees had to navigate complex, inconsistent, and unclear requirements. Rules did not always clarify statute, contributing to improvised external instructions and informal OPLC guidance. The OPLC lacked comprehensive formal procedures, and improvised guidance was inconsistent internally and with rules. Ad hoc rules underpinned many requirements.

***Statutory Requirements Not Timely Implemented***

The Board did not timely implement certain statutory obligations. Since July 2019, the Board had to adopt rules requiring completion of a Department of Health and Human Services workforce survey or opt-out form as a condition of renewal. While the Board discussed rule adoption in July 2018, a filing deadline was purportedly missed. Relevant – but incomplete – rules were adopted in October 2020. However, the CY 2020 dentist renewal occurred before relevant rules were adopted. Dentists were nonetheless subjected to ad hoc rules requiring them to participate in the survey or opt-out. External instructions inconsistently contained related requirements before and after the adoption of rules.

***Statute And Rules Incompletely Updated To Accommodate Online Renewals***

Statute and rules were incompletely updated to accommodate the transition from manual, hardcopy renewals to online renewals which began in CY 2017. Online renewal processes were not clearly designed to ensure licensee compliance with requirements. Incomplete updates to statute and rules contributed to ad hoc rules and inconsistent and unclear requirements. Since August 2018, statute accommodated online submission of initial license applications, but not renewal applications. Statutory time limits applied to all renewals. However, controls were inconsistent, and timeliness was unmeasured. While rules allowed for online renewals since at least December 2017, they did not specify how timely receipt of online applications was to be determined. In contrast, statute specified timeliness procedures for receipt of mailed or hand delivered hardcopy applications. The OPLC did not implement formal procedures to ensure fidelity with statutory recordkeeping requirements, compromising the auditability of online renewal transactions, including their timeliness.

***Inadequately Defined Renewal Process***

Rules incompletely defined the renewal process and the information applicants were required to submit. Rules inconsistently contained non-statutory requirements binding on the public, making

these requirements unenforceable. Improperly adopted forms, external instructions, OPLC procedures, and informal OPLC guidance contributed to ad hoc rules. For example, rules did not:

- properly adopt hardcopy or online registration forms,
- specify a process to follow if licensees did not receive a renewal notification,
- establish a method of application submission for hardcopy forms,
- require submission of statements explaining issues indicating potential noncompliance related to practice or conduct,
- require dentists to report on dental licenses held in Canada,
- specify content of certification and attestation statements to be agreed to by licensees,
- require notarization of hardcopy registration forms, or
- require completion and submission of a supplemental attestation form that staff used to clarify potentially inconsistent or noncompliant responses on registration forms.

***Noncompliant And Inconsistent Waivers Of Licensee Practice Requirements And Fees***

The Board inappropriately waived statutory licensee practice requirements, inconsistently waived late fees, and circumvented controls over waivers. This contributed to noncompliance and inconsistent applicant treatment. While Board rules established a process to waive substantive rules, statutory requirements could not be waived. Furthermore, the waiver process was not followed, at the direction or with the knowledge of staff, and without correction by the Board. Statute specified licensees who had not actively practiced in the State within two years of their previous biennial registration were to be transferred to the inactive list and registered as inactive. Statute exempted only licensees serving on active military duty from this requirement. However, without a documented waiver request, the Board voted to waive the requirement. It allowed a non-military licensee not practicing in the State to be issued an active license.

***Inconsistent And Unclear Requirements***

Inadequate controls contributed to inconsistent and unclear renewal requirements. Statute and rules indicated renewal involved separate acts of registration and renewal, which was not reflected in practice. Multiple documents contained renewal requirements, some of which imposed ad hoc rules. Others were unpublished. Rules:

- along with hardcopy registration forms specified licensees consented to a criminal background check by signing the registration form, but no checks were conducted, and the Board lacked relevant statutory authority;
- required dentists, but not hygienists, to report whether they had been sanctioned or had pending disciplinary actions in any jurisdiction;
- established failure to register was misconduct that would result in disciplinary action for dentists, but not hygienists;
- required one licensee signature on the registration form, while the hardcopy registration form required three signatures and the online registration form required none;
- required dentists to indicate whether they practiced as a specialist, while the hardcopy form additionally required dentists to report which specialty and the online form did not contain any relevant questions;

- required only licensees requesting an extension of time to complete continuing education requirements to pay the on-time renewal fee, and failed to clarify whether licensees submitting a late renewal application should also pay the on-time renewal fee;
- along with registration forms did not include the statutory requirement allowing licensees serving on active military duty to register as active, contributing to processing delays; and
- did not address processing renewal applications submitted by licensees on active military duty.

Rules also specified registration forms were available on the Board's website. However, forms were not available in this manner since at least November 2020, although staff reported forms were available through January 2021. Unavailability of hardcopy forms was caused by the OPLC's decision to no longer accept hardcopy forms if online forms were in use, notwithstanding the requirements of its assigned agencies' rules.

**Unauditable Renewal Notifications And Application Processing**

A focus on achieving efficiency undermined effectiveness. The OPLC was created, in part, to promote efficiency and economy in Board business processing and recordkeeping. Purportedly, to improve efficiency and timeliness, the OPLC migrated from manual, hardcopy credential renewals to electronic, online renewals. Online renewals began in CY 2017 for hygienists and in CY 2018 for dentists. The credential database management system was used. However, there was no assessment of the purported efficiency improvements or cost savings resulting from the migration. Associated fees were not reduced.

Additionally, the integrity of licensing records was compromised. Renewal transactions and timeliness were generally unauditable. Records did not reliably demonstrate processing occurred consistently or in compliance with requirements in statute and rules. The credentialing database management system lacked a reliable and comprehensive audit function easily accessible to staff. Furthermore, there were no internal audit requirements, procedures, or practices. Consequently, the OPLC failed in one of its primary missions: to maintain the official record for licensees. The Board also failed to provide adequate oversight. It did not ensure: 1) a true record of all of its official acts was made and preserved, and 2) records contained adequate and proper documentation of renewal applications and decisions.

- Dynamic Database – Records rested in a dynamic database. Data could be overwritten without preservation of individual transactions or edits. For example, one licensee had a status of "active – pending renewal" for almost ten years. Another had that status for more than six years, even though the licensee had an inactive license. The dynamic nature of the database also subjected records to alteration without management control or auditable record.

- Renewal Notifications – Renewal notifications were not retained. The dates notifications were purportedly printed and emailed were recorded electronically. However, there were no reliable supporting records verifying notifications were actually sent, or when. Some licensees reported not receiving notifications, some of

whom had also failed to timely report an address change to the Board. It was unclear why others did not receive notifications.

- Renewal Applications – Completed online registration forms were not readily available.

- Completeness Determinations – A subset of renewal questions and licensee responses were inconsistently documented. For one licensee, two consecutive renewals were unauditable, as no questions or responses were documented. Also, automatically generated checklists reportedly used to ensure administrative completeness of online forms were not readily available.

- Substantive Evaluation – Compliance with substantive renewal requirements was inconsistently and incompletely recorded through attestation forms and staff emails. Forms and emails were inconsistently included in credentialing database management system records.

- Timeliness – Compliance with statutory notification and processing time limits was unverifiable. There was no record of completeness determinations or documentation to support recorded dates, and some recorded dates conflicted.

**Recommendations:**

**We recommend the Board examine the costs and benefits of the license renewal process.**

**Unless the Board determines the renewal process can efficiently and effectively provide substantive public protection, we recommend the Board eliminate renewal requirements and design and implement an efficient and effective alternative.**

**If it determines it can make the current renewal process efficient and effective, we recommend the Board first, revise existing or develop new renewal requirements at the minimum level necessary to ensure public protection, and second, implement proactive monitoring controls, such as an audit of applicant compliance with substantive character and conduct requirements.**

**Furthermore, we recommend the Board:**

1. **fully implement all statutory and rules requirements related to license renewals;**
2. **discontinue imposition of ad hoc rule requirements;**
3. **ensure rules comprehensively, clearly, and consistently reflect all renewal requirements and procedures binding on the public;**
4. **actively oversee renewal license processes and ensure OPLC practices conform to statute and rules;**
5. **ensure delegations of renewal license processing responsibilities conform with statute, are clearly made, and are in writing;**
6. **conduct substantive review of renewal applications;**

7. **ensure approval of complete applications from qualified applicants occurs prior to license issuance;**
8. **ensure maintenance of a complete record of all renewal transactions;**
9. **develop, implement, monitor, and refine goals, objectives, and targets tied to expected licensing outcomes; and**
10. **establish data requirements and reporting frequencies on performance metrics.**

Board Response:

*We concur in part with the recommendations.*

**LBA Rejoinder: The Board did not respond to our primary recommendation – that it examine the costs and benefits of the license renewal process and, if it determines the current process does not provide substantive public protection, revise renewal requirements. The Board states only that it will "review" character requirements. It is unclear how the Board will add substance to what is currently a perfunctory process, and improve renewal processes to help ensure the public is adequately protected.**

1. *We concur with fully implementing all statutory and rules requirements related to license renewals.*

   *The Board is interpreting the rules that are in place and agrees that all statutory requirements and applicable administrative rules relative to license renewals should be fully implemented.*

2. *We concur with discontinuing imposition of ad hoc rule requirements.*

   *To the extent that the rules need to be revised, the Board is initiating that process.*

   *Please see our response to Observation No. 4.*

3. *We concur with ensuring rules comprehensively, clearly, and consistently reflect all renewal requirements and procedures binding on the public.*

   *Many rules have been changed or are in the process of being changed and have not appeared in the current rules package. Due to the inordinate amount of time it takes to change a rule through the rulemaking process and the speed in which technology and continuing education platforms change the Board is continuously looking to modify and update the rules. The Board desires to make rules clearer and more concise but is heavily dependent on the OPLC for support. Since CY 2019, 60 percent of the Board has changed and the Board has had three different administrators and various legal counselors. The high turnover and lack of continuity has presented serious challenges.*

4. *We concur with actively overseeing renewal license processes and ensuring OPLC practices conform to statute and rules.*

*The Board currently actively oversees the continuing education audits. The Board would note, however, that the transition to online license renewal presents challenges that are largely out of the Board's control.*

5. *We concur with ensuring delegations of renewal licensing processing responsibilities conform with statute, are clearly made and in writing.*

   *The Board is certainly willing to collaborate and work with the OPLC to implement improved processes for licensing in order to improve the Board's efficiency and effectiveness while continuing to protect public health, safety, and welfare.*

6. *We concur with conducting substantive review of applications.*

   *The current process involves a review by both OPLC staff and the Board.*

   *The Board acknowledges the need to consistently require the proper attestation by the licensee on the renewal form as a way to address the need for some assurance that the statements on the renewal form are true.*

   *The Board would like to respond to the inconsistent waiving of fees in CY 2020 and the fact that the LBA states the "good cause" should be defined. It should be noted that had that been previously "well defined", it is certain that "global pandemic" would not have made the list of "good causes". A significant portion of this audit occurred during the unprecedented COVID-19 pandemic, which presented unique and unforeseeable challenges.*

   **LBA Rejoinder: Since CY 2000, the Board had authority to define "good cause." It never adopted relevant rules. The Board was not expected to foresee a global pandemic and *specifically* account for such an event in rules. Good cause should have and could have been clearly defined in rules and not been left to various members' changeable beliefs and interpretations. The Board's response avoids the key issue that it was responsible for consistently applying statute and rules. Late fee waivers were inconsistently approved, and the Board had no oversight of related processes.**

7. *We concur with ensuring approval of complete applications from qualified applicants occurs prior to license issuance.*

8. *We concur with ensuring maintenance of a complete record of all renewal transactions.*

   *However, the maintenance of proper records is ultimately the OPLC's responsibility. However, the Board acknowledges that the transition from hardcopy to online license renewal is responsible for much—if not all—of the apparent lack of controls over license renewals and inadequate renewal application records. While this process is cumbersome, it will ultimately lead to a more timely and accurate process that the Board believes will provide improved public service and protection.*

9. *We concur in part with developing, implementing, monitoring, and refining goals, objectives, and targets tied to expected licensing outcomes.*

   *The Board will collaborate with the OPLC on these issues.*

10. *We concur in part with establishing data requirements and reporting frequencies on performance.*

    *The Board will collaborate with the OPLC on these issues.*

### *Verifying Credential Holder Compliance With Continuing Education Requirements*

Proper protection of the public was dependent, in part, on credential holders having a working knowledge of recent developments and techniques used in their occupations. Continuing education requirements with clear definitions, criteria, and timeframes for meeting requirements could have helped ensure credential holders maintained current professional knowledge. Requirements should have been implemented at the minimum level necessary to protect the public. Requirements should not have imposed undue costs upon credential holders.

The Board was required to adopt rules on credential holder continuing education requirements. It had to verify credential holder compliance and audit a sample of active licensee records to monitor compliance. To maintain competency and renew a credential, credential holders were required to meet biennial continuing education requirements. Each biennium, dentists and hygienists with an active license were required to obtain 40 or 20 continuing education units, respectively. Active licensees had to report completion of continuing education units by April 1 of their renewal year. However, if it was the licensee's first renewal, they had a temporary education or research license, they obtained a hardship waiver, or they were provided an extension, requirements could be altered.

Additionally, while EFDAs were required to complete ten continuing education units, they were excluded from reporting and review procedures. Temporary volunteer licensees were required to meet a subset of regular license continuing education requirements. There were no continuing education requirements for dentists and hygienists with an inactive license. However, to reactivate a license, inactive licensees had to complete continuing education requirements that were dependent upon the number of years they were inactive. Licensees who held certain, but not all, supplemental credentials were required to meet other continuing education requirements specific to the expanded scope of that credential. They were not subjected to review procedures.

**Observation No. 32**

**Improve Continuing Education Controls**

Board controls over continuing education did not consistently ensure credential holders maintained current professional knowledge. Implementation of continuing education requirements, monitoring, and decision-making processes were informal and underdeveloped. Nothing demonstrated requirements were implemented at the minimum level necessary to protect the

public. Board-developed compliance review requirements were perfunctory and lacked substance, consistent verification, and enforcement of compliance. Reviews were improperly delegated. Lack of formal processes and controls led to ad hoc rulemaking, improvised practices that were inconsistent with rules, and ambiguous requirements. This limited transparency.

OPLC administration of relevant recordkeeping and other administrative and clerical operations was incomplete. There were no formal procedures, and staff created informal guides encompassing improvised practices. Practices relied upon ad hoc rules. Neither the Board nor the OPLC developed a means to measure outcomes or performance to demonstrate processes effectively and efficiently implemented and controlled continuing education requirements.

**Imposition Of Additional Requirements**

Some extra-legal continuing education requirements were imposed without underpinning statute or rule, resulting in ad hoc rulemaking. EFDAs were required to obtain ten hours of restorative dentistry continuing education each biennium. However, in October 2018, the Board informally added a requirement for two continuing education units in infection control and three units of basic life support for healthcare providers. The Board adopted rules in April 2020 requiring medical emergency training for regular active dentist and hygienist license renewals. However, the requirement was also imposed upon temporary volunteer licensees.

**Minimum Standards Inconsistently Established**

The Board inconsistently established continuing education requirements to ensure ongoing credential holder competency. Some credentials were inconsistently subjected to biennial continuing education requirements or compliance verification.

- Temporary education and research licensees could perform clinical dental procedures, but the Board did not establish relevant minimum continuing education standards.

- Temporary volunteer licensees were required only to maintain basic life support for healthcare providers certification and obtain two continuing education units in infection control each biennium.

- The Board was required to, but did not, establish an appropriate number of continuing education units for dentists to renew a general anesthesia and deep sedation permit. Conversely, moderate sedation permittees, with a narrower scope of practice and lower risk, were required to document six cases per year or four hours of continuing education per biennium to renew their permit. However, compliance was not apparently verified.

- CPHDHs were afforded a broader scope of practice with more independence than noncertified hygienists. However, the Board imposed no commensurate continuing education requirements to maintain the certificate.

- Hygienists could obtain a permit to administer local anesthesia or nitrous oxide minimal sedation. However, the Board imposed no commensurate continuing education requirements to maintain either permit.

The Board did not demonstrate certain continuing education requirements it established would protect the public at the minimum level necessary. In addition to requiring a basic life support for healthcare providers course, the Board required active dentists and hygienists earn two continuing education units in medical emergency training each biennium. However, the basic life support for healthcare providers and medical emergency training continuing education requirements were not sufficiently defined in rule or distinguished from each other. Rules were ambiguous and the Board opted to not define or set specific guidelines for medical emergency training. Clarification occurred during Board meetings, but unclarity persisted and the improvised clarifications resulted in ad hoc rulemaking.

**Inconsistent Rule Application And References**

The Board inconsistently applied rule-based standards, and some standards it applied were unclear. Continuing education standards should have rested on clear definitions and requirements to facilitate consistency and compliance. While Board rules outlined certain continuing education requirements, at times the Board made decisions contrary to its rules. Some forms and external instructions also inaccurately referenced requirements.

- The Board approved continuing education, and subjectively issued five continuing education units, for a licensee's attendance at a seminar. The seminar itself was not sponsored by an organization from which licensees could earn continuing education. Mere attendance was not an approved mode for earning continuing education units. The licensee was a Board member at the time of approval.

- ASEC members could earn up to three continuing education units annually for performing facility inspections or comprehensive evaluations, in addition to receiving honorarium. External instructions outlining continuing education requirements indicated this was also applicable to hygienists. However, hygienists were not, and could not have been, ASEC members.

- The Board approved an exemption from the medical emergency training requirement for licensees who completed two specific courses. However, the Board could neither preapprove courses nor exempt continuing education requirements without a hardship waiver petition.

- Hardcopy renewal forms for regular dentist and hygienist licenses contained inaccurate references to continuing education rules.

- Rules were internally inconsistent, containing inaccurate references to basic life support for healthcare providers continuing education requirements.

**Inadequate Control Of Preapprovals**

The Board's controls over continuing education preapprovals were inadequate. Ad hoc rulemaking occurred, Board decisions were inconsistent, and the Board was noncompliant with State policy and its own rules. Board rules enumerated specific continuing education requirements and acceptable sponsors of continuing education courses. Unless the continuing education course was an online course covering certain opioid-related topics for prescribers with a DEA registration number, the Board could not preapprove courses. However, the Board did not:

- timely adopt and fully incorporate opioid prescribing continuing education in rules,
- follow State policy for preapproving prescriber continuing education,
- follow its own rules prohibiting preapprovals of other continuing education courses, or
- ensure preapproved courses for prescribers were published.

**Inadequate Control Of Continuing Education Extensions And Waivers**

Board controls over continuing education extensions and waivers were inadequate. The Board inconsistently followed its own rules. Continuing education extensions and waivers appeared to only be available to licensees, not for other credential holders.

Licensees could request an extension to the deadline to complete continuing education requirements until April 30 of their renewal year. However, the Board issued extensions for reasons other than what rule provided. Rules lacked criteria for extension eligibility. Rules and internal guidance for extensions were limited, and there were no extension processes in procedures or external instructions.

Alternatively, licensees could request a hardship waiver of continuing education requirements. However, the Board inconsistently provided waivers and did not clearly define waiver criteria in rules. There were no waiver processes in procedures or external instructions. If a licensee did not complete continuing education requirements by April 1 of their renewal year, they could submit a petition outlining the reasons for not completing requirements and request a waiver. There was a formal, general process to waive a specific, substantive rule. However, the Board did not follow this process for continuing education waivers. Instead, the Board informally waived requirements during its meetings. Waiver records were incomplete, but where requests were present, they contained varying amounts of information in no specific format.

A waiver had to be granted if the Board determined the licensee's explanation was allowed under one of three provisions in rule: 1) severe illness, 2) incapacity, or 3) other hardship. However, without established criteria as to what constituted a severe illness, incapacity, or other hardship, the Board risked inconsistently waiving requirements. While our audit work was not designed to identify all instances of noncompliance, we identified six cases demonstrating inconsistent results:

- three waiver requests appeared to be for hardship-related reasons, but two were approved and one was denied;
- two waivers were approved for reasons other than the three rule-based provisions; and
- one waiver was approved for a permittee who was not licensed.

**Inadequate Control Of Continuing Education Verification**

Board controls did not provide assurances that verification of continuing education requirement compliance was effective. Records and monitoring of remediation of noncompliance were inadequate. Individuals with credentials other than regular licenses, such as temporary licenses, permits, or certifications, were not subjected to verification. The Board established no alternate controls to ensure these individuals met renewal eligibility requirements.

Rules required the Board review a randomly selected sample of at least three percent of renewing active licensees each biennium to verify compliance with continuing education requirements. A licensee had 30 days after being notified of a review to submit documentation demonstrating their compliance. If requirements were not met, the licensee was supposed to be notified of a hearing before the Board.

The Board inappropriately delegated verification responsibilities to staff and individual Board and DHC members. The Board also suspended verifications during CY 2020. Except for informal updates provided during meetings, the Board was not involved with continuing education verification and did not review or finalize results. Informal practices mooted rule-based requirements, preempted rule-based deadlines, and subjected licensees under review to ad hoc rule requirements.

***Uncontrolled Samples And Preemptive Notification***

Review samples were poorly controlled. Sampling occurred before the actual continuing education reporting deadline. This practice subjected licensees to ad hoc rules by requiring individuals under review to meet continuing education requirements earlier than rule required. Additionally, the required sample size did not demonstrate it was representative of the licensed population or that it was sufficiently large to serve as an effective deterrent to licensee noncompliance.

Reviews were to occur during the biennium in that followed license renewal. In practice, notification occurred before the continuing education reporting deadline of April 1. This made compliance with continuing education requirements within 30 days of notification impractical. Rule provided licensees chosen for review would receive a notice that their continuing education would be verified after their registration and renewal application was received. Applications were due by April 1. However, staff obtained review samples and began notifying licensees in January of the renewal year. This was at least 60 days before the April 1 deadline to submit renewal applications and report continuing education compliance.

Additionally, reviews were to be conducted for active licensees only. Preemptive sampling and notification prevented staff from ensuring individuals in the sample were actually renewing their license for active status. Preemptive sampling did not accommodate individuals who held an inactive license but were requesting reactivation, because the sample was only of active licensees. Furthermore, it was not clear first-time renewals, exempted from continuing education requirements, were automatically excluded from the sample or if there was an informal practice to substitute another, valid renewal applicant. Without formalized processes and controls, it was

unclear whether the number of reviews completed actually met the target of three percent of active licensees.

### *Ad Hoc Extensions Of Review Deadline*

Staff attempted to verify continuing education compliance before licensees had to meet the requirements. To remedy this, the Board undertook ad hoc rulemaking by granting continuing education review extensions. There were no specific rule-based provisions to extend the 30-day requirement to submit continuing education documentation for review. Rule provided extensions were only available if the April 1 continuing education completion and reporting deadline would not be met. However, in practice, the Board granted extensions of the 30-day limit, notification for which often occurred well before the April 1 continuing education completion and reporting deadline.

In CY 2019, the Board received extension requests from licensees who would have met the April 1 completion and reporting deadline. Some licensees reported being unaware of, and dissatisfied with, the ad hoc obligation to meet continuing education requirements before the rule-established completion and reporting deadline. In February 2019, the Board extended the deadline for licensees to complete continuing education requirements to April 1, returning the ad hoc deadline to the rule-established deadline. The Board also prospectively – and inappropriately – approved any future continuing education review extension requests, purportedly due to a higher volume of requests it received that year.

### *Inadequate Monitoring Of Noncompliance And Discipline*

The Board lacked monitoring and reporting of, and disciplinary procedures for, noncompliance with continuing education requirements. External instructions available to licensees also lacked relevant information. The Board did not implement its rules requiring licensees under review be notified and appear before the Board for a hearing if supporting documents did not meet requirements. Instead, staff followed informal procedures to communicate with licensees and remedy noncompliance. Additionally, the Board reportedly also followed up on noncompliance directly with the licensee, also without formal procedures.

Without adequate records, we were unable to determine the extent of continuing education noncompliance or how continuing education noncompliance was addressed. Staff were reportedly unaware of any continuing education noncompliance during the audit period.

### *Biennial Reviews Not Conducted*

The Board did not conduct required biennial review of dentists with active licenses in CY 2020. Purportedly, a May 2020 emergency order waived review requirements. However, the order exempted licensees from continuing education requirements, not review requirements. Regardless, licensees should have already submitted renewal applications and reported their continuing education units prior to the emergency order. The order was issued more than a month after the

April 1 completion and reporting deadline and on-time renewal deadline, and several days after the April 30 late renewal deadline.

**Recommendations:**

**We recommend the Board improve controls over continuing education, and:**

1. **discontinue imposing continuing education requirements using ad hoc rules;**
2. **evaluate current continuing education requirements to determine appropriate standards for protecting the public at the minimum level necessary, including requiring all credential holders to complete continuing education commensurate with their scope of practice;**
3. **address inaccurate references to rule and ensure rules are promulgated for all continuing education requirements;**
4. **ensure opioid prescriber course preapprovals conform to statute and decline other preapprovals of continuing education courses;**
5. **fully incorporate opioid prescriber education requirements into rules, including preapproval requirements;**
6. **discontinue inappropriate extensions and ensure deadline extensions are only provided to licensees who do not meet requirements by April 1;**
7. **develop and formalize the continuing education waiver process in rule, clarify and establish criteria for determining whether submitted waivers are compliant with rule, document the reason for denying or approving waivers, and ensure continuing education waiver processes are publicly available;**
8. **develop and formalize extension subprocesses in rule and establish criteria for requesting extensions outside of renewal;**
9. **discontinue delegating continuing education review responsibilities, or change rules and formalize delegation of review responsibilities;**
10. **develop and formalize continuing education review processes including sampling, monitoring, reporting, noncompliance, and disciplinary action;**
11. **ensure sampling and review notification occurs after the April 1 renewal deadline;**
12. **follow rules requiring a hearing for continuing education review noncompliance;**
13. **assess whether a three percent sample is sufficient to monitor compliance with continuing education requirements;**
14. **assess whether review practices ensure the sample obtained is valid and includes the required percentage of all active credential holders; and**
15. **monitor and improve audit processes to help ensure effectiveness.**

Board Response:

*We concur in part with the recommendations.*

1. *We concur with the recommendation to discontinue imposing additional continuing education requirements using ad hoc rules.*

*Statute grants the Board the authority to adopt rules regarding how a license or certification issued by the Board shall be renewed. The Board will use their authority to create continuing education rules.*

2. *We concur with the recommendation to evaluate current continuing education requirements to determine appropriate standards for protecting the public at the minimum level necessary, including requiring all credential holders to complete continuing education commensurate with their scope of practice.*

   *The Board will ensure continuing education rules are in place per statutory requirements. The Board will continue to review the current continuing education requirements and adjust them if necessary. The purpose of requiring continuing education is to protect the public, and the Board will continue to do so.*

3. *We concur with the recommendation to address inaccurate references to rule and ensure rules are promulgated for all continuing education requirements approved by the Board.*

   *The Board is aware that a complete review of its rules to clarify and update the continuing education requirements is important. The Board intends to initiate this process as soon as possible.*

4. *We concur in part with the recommendation to ensure opioid prescriber course preapprovals conform to statute and declining other preapprovals of continuing education courses.*

   *The Board currently preapproves continuing education only for opioid prescribing courses because of statute. However, a complete review of its rules with subsequent rulemaking changes, when necessary, is a priority for the Board.*

5. *We concur with the recommendation to fully incorporate opioid prescriber education requirements into rules, including preapproval requirements.*

   *The Board will begin the rulemaking process.*

6. *We concur with the recommendation to discontinue audit extensions and ensure deadline extensions are only provided to licensees who do not meet requirements by April 1.*

   *The Board agrees that the actual audit should not occur until after the renewal deadline and will take every step to adhere to this process.*

7. *We concur with the recommendation to develop and formalize the continuing education waiver process in rule, clarify and establish criteria for determining whether submitted waivers are compliant with rule, document the reason for denying or approving waivers, and ensure continuing education waiver processes are publicly available.*

*The Board concurs that a review of the waiver process is important and is committed to initiating that process as soon as reasonable. To the extent that the rules need to be amended or changed, the Board will engage in that process.*

8. *We concur with the recommendation to develop and formalize extension processes in rule and establish criteria for requesting extensions outside of renewal.*

9. *We concur in part with the recommendation to discontinue delegating continuing education audit responsibilities, or change rules and formalize delegation of audit responsibilities.*

   *The Board is committed to collaborating with OPLC regarding the licensing and audit responsibilities to streamline the licensing and renewal process.*

10. *We concur with the recommendation to develop and formalize continuing education audit processes including sampling, monitoring, reporting, noncompliance, and disciplinary action.*

    *The Board concurs that a clearly defined continuing education audit process should be in place and followed.*

11. *We concur with the recommendation to ensure sampling and audit notification occurs after the April 1 renewal deadline. The Board will work with OPLC to ensure compliance with this recommendation.*

12. *We concur with the recommendation to follow rules requiring a hearing for continuing education audit noncompliance.*

    *The Board notes that currently all hearings are, and will continue to be, conducted in compliance with all applicable statutes and rules.*

13. *We concur with the recommendation to assess whether a three percent audit sample is sufficient to monitor compliance with continuing education requirements.*

    *The Board will begin reviewing this requirement and consider whether a ten percent rotating audit sample would over time ensure that all active licensed dentists and hygienists are in compliance and provide increased safety for the public.*

14. *We concur with the recommendation to assess whether audit practices ensure the sample obtained is valid and includes the required percentage of all active licensees.*

    *The Board will consider whether a ten percent across-the-board random sampling would represent a more valid cross section of licensees.*

15. *We concur with the recommendation to monitor and improve audit processes to help ensure effectiveness.*

*The Board is committed to engaging in ongoing monitoring and assessment of the audit processes to ensure effectiveness.*

## Managing Complaints

A complaint was an allegation of licensee misconduct. Complaints were to be in writing and signed, or could be submitted anonymously. Staff triaged complaints; judged complaint severity, which dictated the complaint's priority; determined whether complaints required a response from the accused licensee; obtained responses from accused licensees; presented complaints to the Board; and ensured follow-up occurred. The Board was required to investigate all complaints based on the allegations presented, unless it was an anonymous complaint. Anonymous complaints were to be investigated if the Board determined the: 1) allegations had merit, 2) public welfare was at risk, and 3) complainant had reasons for complaining anonymously. Licensees subject to complaints were to respond within 20 days from the date they received notice from the Board. If the Board accepted the complaint and determined there was potential basis to the allegations, licensees could be subject to investigation, adjudicative proceedings, and disciplinary action.

We identified 109 matters indicating potential noncompliance that the Board treated like a complaint from July 2018 through February 2021, when we concluded audit work on this topic.

**Observation No. 33**

### Improve Complaint Management Controls

Controls over complaint management were inadequate, at times compromising the Board's ability to effectively protect the public. There were gaps between State policy, rules, and practice. Rules were incomplete and internally inconsistent. Board oversight was inadequate, lacking procedures and processes to consistently manage complaints effectively. Because of inadequate rules, EFDA permittees who did not concurrently hold a license were excluded from the complaint framework altogether. Related OPLC procedures, practices, and support to the Board were informal, inadequate, and inconsistent. Nothing demonstrated complaint management efficiently achieved expected outcomes or complaints were timely addressed.

Although our audit work focused on Board controls and was not designed to identify all instances of noncompliance, we did find cases demonstrating how inadequate controls adversely affected complaint processing and Board decisions. Additionally, inconsistent processes and inadequate records management made some controls unauditable. Internal communication was inadequate and customer service was inconsistent. We were unable to: 1) definitively quantify the total number of complaints, 2) the Board's timeliness in managing them, or 3) verify all complaints were addressed by the Board.

## Inadequate Controls

The Board lacked controls over complaint processing and monitoring, instead relying on staff to manage complaints within an improvised and changing framework. Staff were generally responsible for processing complaints, presenting complaints to the Board, obtaining responses,

conducting follow up, and maintaining records. There was no formal specification of the level of service the OPLC would provide the Board. Although there were intermittent efforts to develop controls, there was no holistic or consistent approach to administering and monitoring complaints. At times, controls devolved due to a lack of formalized processes and loss of institutional knowledge as members and staff changed. This made previously implemented controls irrelevant.

The Board was required to meet statutory 30- and 60-day time limits for complaint processing and deciding to investigate or dismiss a complaint, or commence an adjudicatory hearing. The OPLC purportedly had an informal target of resolving complaints within 90 days. However, due to inadequate monitoring and recordkeeping, we were unable to assess overall timeliness. Nonetheless, Board members and staff reported concerns that complaints were not consistently addressed in a timely manner. Stakeholder-reported concerns included the Board dismissing complaints because of insufficient resources and staff, failing to address all complaints received, and making uninformed decisions due to lack of licensee complaint histories. We reviewed 26 complaints the Board received from CYs 2015 through 2020, that were subjected to Board action during the audit period. Of the 26, 21 cases (80.8 percent) indicated concerns about insufficient resources and decision making without complaint histories were valid. However, we were unable to consistently locate auditable complaint records and could not verify all complaints were even addressed by the Board.

**No Process To Establish Patterns Of Potential Noncompliance**

The Board lacked processes to establish and monitor patterns of behavior that may have constituted misconduct. The rule-based complaint retention period to establish patterns of potential noncompliance exceeded the statute of limitations for taking disciplinary action on such complaints. The Board's ability to develop controls to identify potential patterns of noncompliance was hindered, in part, because the OPLC lacked retention procedures to ensure complete complaint records were adequately maintained. Records were incomplete and missing basic documentation. Fifteen of 26 cases (57.7 percent) lacked the initial complaint and 21 of 26 (80.8 percent) lacked the licensee's response to the complaint. One case later resulted in subsequent allegations being submitted to the Board. The record of these subsequent allegations also lacked five complaints and four licensee responses to complaints.

The Board could not undertake disciplinary proceedings more than five years after the date: 1) on which the alleged noncompliance occurred, or 2) the Board could have reasonably discovered the noncompliance. However, rule established a ten-year retention requirement for complaints not resulting in disciplinary action. Rule also allowed for discretionary retention time periods longer than ten years if the complaint was potentially part of a developing pattern of behavior. This discretionary retention requirement was ambiguous and left to interpretation by the Board. Letters were issued to individuals with dismissed complaints stating the Board would retain complaints for a minimum of ten years, to be addressed again if a pattern developed. Additionally, letters of concern reportedly could be issued to establish a pattern of behavior that may have constituted misconduct. However, the Board lacked processes or controls to ensure identification and monitoring of, and enforcement against, those individuals with patterns of behavior constituting misconduct.

At least one other State regulatory agency had a framework consistent with the five-year statute of limitations. An investigation was required into any licensee the subject of three malpractice or insurance claims, written complaints, or other actions for injury resulting from treatment, or any combination thereof, within any consecutive five-year period. If the Board had adopted and implemented similar requirements, 13 of 26 complaints (50.0 percent) would have contained a pattern of potential noncompliance and subjected the licensee to an investigation. For example, one licensee's complaint history included 20 complaints spanning 26 years and should have prompted further review. Instead, complaints against the licensee were managed on an isolated, complaint-by-complaint basis. While the complaints against the licensee alleged various issues of noncompliance, 12 complaints (60.0 percent) were allegations of misconduct. The licensee's most recent, and twenty-first complaint, was brought before the Board in CY 2021. However, this complaint was unauditable. The record did not include the complaint, licensee response, or Board actions. We could not verify the Board received the complete complaint and disciplinary history.

**Inappropriate Delegation Of Board Responsibilities**

The Board adopted standing orders that were beyond the scope of its statutory authority. It improperly delegated certain Board responsibilities to the OPLC and the APU. During the audit period, the Board had authority to obtain legal counsel, investigators, and other assistance and make agreements for the performance of administrative or similar services. The Board could not delegate statutory decision-making responsibilities. Board orientation and OPLC training materials indicated OPLC management and the Board were aware of these limitations. Regardless, after the OPLC created and began operating an improvised Enforcement Division in Fall 2020, the Board adopted OPLC-proposed standing orders affecting complaint and enforcement processes. The standing orders contained improper delegations of discretionary responsibilities or provisions contrary to State policy or Board rules, including:

- authorizing the APU to issue subpoenas,
- extending the response time for licensees to address a complaint without Board approval or the Board waiving or changing relevant rules,
- authorizing the improvised Enforcement Division to determine whether complaints required a response from the licensee, and
- delegating authority to the Board president to provide an extension of the time to respond to complaints upon request.

Subsequently, the Board revoked approval of the initial standing order extending the complaint response timeframe from 20 to 30 days but readopted an amended version. To remedy noncompliance with Board procedural rules, the amended version was presented as a petition to waive the Board rule that required responses within 20 days. However, the change amounted to ad hoc rulemaking, circumventing the rulemaking process altogether, at the request of staff. Furthermore, implementation of all the standing orders preceded the OPLC's statutory authority to reorganize and operate an Enforcement Division.

## Incomplete And Inconsistent Rules

Board rules lacked certain complaint filing requirements, were internally inconsistent, or were not adopted as statutorily required. This led to noncompliance with State policy and rules and the imposition of ad hoc requirements.

### *Rules Did Not Fully Incorporate Forms And External Instructions*

Forms and external instructions on filing complaints imposed ad hoc rule requirements. In CY 2021, the OPLC undertook an agency-wide effort to streamline its website and standardize certain processes. Before website changes were finalized in March 2021, the complaint form and external instructions were Board-specific. After March 2021, the OPLC posted its own form to be used for all complaints regardless of the responsible agency. However, neither form was adopted in Board or OPLC rule, and the OPLC lacked relevant rulemaking authority during the audit period. Both forms and Board external instructions included additional ad hoc requirements for filing a complaint.

In July 2021, the Board's authority to adopt forms in rules was rescinded. The OPLC obtained statutory authority to adopt procedural rules governing complaint administration for all assigned agencies. However, the Board was unaware of legislative changes. As of August 2021, when we concluded audit work on this topic, there was no indication OPLC rules, and related forms, were in development. Neither was there evidence that the Board was involved in complaint process redesign to ensure its needs were met.

### *Internal Inconsistencies In Rules And Practice*

Two rules established time limits for licensees to respond to complaint allegations. However, rules were internally inconsistent. One rule required licensees to respond within 20 days from the date the complaint was received by the respondent, unless otherwise ordered by the Board. A second rule required the presiding officer to order the licensee to respond within 20 days of the complaint being filed with the Board.

In practice, the Board started the 20-day time limit from when the complaint was received by the respondent, as provided in the first rule. It was unclear how the Board could have implemented the 20-day time limit based on the date the complaint was filed with the Board, as provided in the second rule. The Board met monthly and was dependent on the presiding officer timely issuing an order. Additionally, the second rule did not allow the Board to amend the time limit. Instead, rule required disciplinary sanctions be imposed if the respondent missed the deadline. While the Board in practice allowed respondents additional time to respond without imposing disciplinary sanctions, licensees nonetheless risked being subject to a disciplinary sanction while the rules remained inconsistent.

## Reports Of Adverse Events Inappropriately Dismissed

The Board did not manage reports of adverse events according to State policy, or adopt required rules. Since August 2018, dentists were required to report any significant adverse health care

events occurring while administering general anesthesia or deep or moderate sedation. The Board was required to conduct a root cause analysis of each event. The licensee had to either implement a corrective action plan or report the reasons for not taking corrective action. However, the Board did not adopt required rules for reporting adverse events, analyzing root causes, or implementing corrective actions plans.

- In December 2018, the Board received an adverse event report and was aware of the requirement to conduct a root cause analysis. Without rules or procedures to implement State policy, the Board dismissed the report in a similar manner to an unfounded complaint. No root cause analysis was conducted to determine whether corrective action was necessary.

- The Board received two adverse event reports in CY 2019. One of the two reports was submitted by a then-serving Board member. The Board did not conduct required root cause analyses on either report.

We did not review these cases to determine potential effects or outcomes as a result of the Board's decisions.

**Improper Use Of Letters Of Concern To Dismiss Complaints**

Board rules inappropriately broadened the applicability of letters of concern beyond statutory provisions. The Board improperly issued letters of concern to licensees to dispose of complaints. The use of letters of concern in some cases compromised achievement of expected outcomes. State policy provided the Board could issue a non-disciplinary letter of concern to a licensee only if they failed to notify the Board of a change in address within 30 days. However, improperly broadened rules defined a letter of concern as non-disciplinary and provided they could be sent to a licensee following an allegation of misconduct, a complaint, or an investigation. Letters of concern were used to draw a licensee's attention to specific acts or omissions that could place the licensee at risk of future disciplinary action.

In practice, the Board regularly used non-public letters of concern to acknowledge potential noncompliance, dismiss complaints, and, in some cases, impose sanctions on noncompliant credential holders. OPLC legal staff informed members that letters of concern could also be used to establish a pattern of potentially noncompliant behavior, indicating staff were aware of how letters of concern were being used in practice. We identified 35 letters of concern issued between July 2018 and February 2021. None were for a failure to timely notify the Board of a change of address. Instead, reasons included unprofessional behavior, advertising noncompliance, inadequate recordkeeping, failure to disclose sanctions from another jurisdiction, Pharmacy Board inspection violations, and inadequate billing procedures. Some letters of concern indicated further inadequacies in Board controls and oversight.

- Two letters of concern appeared to be related to matters outside the Board's jurisdiction. Three other letters of concern were issued, in part, for potential noncompliance that also appeared to be outside the Board's jurisdiction.

- Three letters of concern were issued as a direct result of the Board's lack of resources to either further investigate complaints or hold an adjudicatory proceeding.

- One letter of concern was issued to a licensee for violating a settlement agreement, one year after the agreement had ended.

- One licensee received three letters of concern over the course of one year for the same type of noncompliance. This indicated letters of concern were not always effective at deterring noncompliance and were not always used to establish a pattern of misbehavior resulting in disciplinary action.

- One letter contained a disciplinary sanction requiring the licensee to submit proof of remedial education. Rule did not permit the Board to impose sanction-like requirements through letters of concern. The final disciplinary action was not made publicly available as required.

- Two letters of concern required licensees address deficiencies and submit proof of remediation to the Board. Rule did not permit the Board to impose sanction-like requirements through letters of concern.

Legislative changes, effective in January 2022, allowed the Board to use letters of concern for the expanded purpose defined in rules.

**Recommendations:**

**We recommend the Board improve controls over complaints, and:**

1. **discontinue improper delegations of authority;**
2. **determine administrative needs to effectively manage complaints, establish expectations of support services, and formalize service-level and performance expectations in rules or by an agreement with the OPLC;**
3. **monitor complaint processing to ensure substantive and procedural consistency, including timeliness;**
4. **develop processes to monitor for and establish patterns of potentially noncompliant behavior, while incorporating procedures and criteria for addressing noncompliant behavior based on patterns established within the statute of limitations;**
5. **incorporate complaint histories into Board considerations when reviewing any potential credential holder noncompliance;**
6. **adopt rules to address inconsistencies and encompass all credential holders;**
7. **discontinue dismissing reports of adverse events as though they were unfounded complaints;**
8. **discontinue issuing letters of concern for purposes beyond what current statute allows, until revised legislation becomes effective and revised rules are promulgated; and**
9. **monitor performance and demonstrate achievement of expected outcomes.**

Board Response:

*We concur with the recommendations.*

**The Board's lengthy, detailed response and associated rejoinders are in Appendix B.**

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## CHAPTER FIVE
## ENFORCEMENT

The Board was responsible for protecting public health, safety, and welfare from unqualified, unscrupulous, or impaired dentists and hygienists by ensuring credential holders met and maintained qualifications to practice. Well-controlled enforcement processes could have increased the likelihood the Board efficiently and effectively achieved expected outcomes. Public protection relied upon safeguards established through credentialing requirements, monitoring of regulatees' ongoing compliance with eligibility maintenance requirements, and enforcement processes. This included processes to investigate potential noncompliance, adjudicate contested cases, and sanction noncompliant credential holders to bring them back into compliance, or revoke their credential and ability to practice.

- **Investigations** should have been appropriate, consistent, and completed timely. Investigations could have been formal or informal, depending on the nature of the allegations. The Board was authorized to investigate alleged misconduct it identified within its jurisdiction. The Board was also required to investigate patterns of noncompliance and any licensee subject to three malpractice claims or legal judgments within a five-year period. The Board was responsible for initiating and overseeing investigations. The Board could use – and was largely dependent on – third-party support to conduct investigations. This included the Department of Justice's (DOJ) Administrative Prosecutions Unit (APU) staff, Office of Professional Licensure and Certification (OPLC) staff, contracted investigators, and expert reviewers. Investigations were to result in a report concluding whether there was reasonable basis for the Board to seek discipline.

- **Adjudicatory proceedings** should have been standardized and consistent to help ensure due process. Adjudicative proceedings were required for any matter considered to be a contested case to determine legal rights, duties, or privileges. This included: 1) determining initial and renewal applicants' qualifications; 2) refusing to issue or renew a license for, or imposing sanctions on, a licensee; 3) evaluating complaints against licensees; and 4) determining whether to impose sanctions against a licensee sanctioned by another jurisdiction. The Board could have resolved issues: 1) during an adjudicatory proceeding, 2) through an investigation, 3) when a licensee failed to respond, 4) by settlement agreement, or 5) by consent order. Board decisions could have been appealed to the Supreme Court.

- **Sanctions** should have been graduated and commensurate with the severity of the violation, and should have timely remediated noncompliance. Sanctions should have been monitored to ensure requirements were met. The Board had authority to sanction noncompliant licensees by reprimand, or by limiting, restricting, revoking, or suspending a license. The Board could have required a licensee to obtain remedial education; participate in care, counseling, or treatment; or practice under supervision. The Board could also have imposed fines against licensees. Additionally, when there was imminent danger to life or health, the Board was required to suspend a license or

other privilege, such as other statutorily-established primary or supplemental credentials. Suspension was to be for no more than 60 days, or until a hearing was held, whichever occurred first.

The OPLC was responsible for related administrative, clerical and business processing duties, including maintaining records and developing related procedural rules.

**Controlling Investigations**

The Board was responsible for investigating possible misconduct by licensees or other matters under its jurisdiction. This included misconduct alleged in complaints and potential misconduct identified by other means. A majority vote of the Board specifying the type, form, and extent of the investigation was required to commence an investigation. Rule limited informal investigations to requests for additional information or records from the complainant, and face-to-face meetings with potential witnesses and interested persons. Formal investigations allowed the Board to subpoena documents, record testimony, and gather other information. Formal investigations required the Board to issue an order of investigation. The Board could retain legal counsel, advisors, or other investigators through the OPLC to assist with investigations. Investigators had to be appointed by the Board. Although some investigations may have taken longer than others, timely completion of investigations was integral to effective investigation management. Clear timeliness goals and time limits on investigative procedures could have helped facilitate consistent resolution and improve efficiency. Unreasonably long investigations could have prolonged public risk exposures and disrupted a licensee's practice.

We were unable to quantify the total number of investigations that occurred during the audit period. Neither could we establish the Board's timeliness in managing them. No performance information was consistently available, such as the type of investigations undertaken, referrals made, status and resolution, and investigators' recommendations to the Board.

**Observation No. 34**

**Improve Investigation Management Controls**

Controls over investigations were inadequate, compromising the Board's ability to effectively protect the public. There were gaps between State policy, rules, and practice. Rules were incomplete and extra-legal requirements were imposed. The Board lacked procedures and monitoring processes to consistently conduct and oversee investigations effectively. Related OPLC procedures, practices, and support to the Board were informal and inconsistent. Board investigators were underutilized, and rule-based investigative procedures were undeveloped. The Board lacked controls to ensure investigations progressed as expected. Nothing demonstrated investigation management efficiently achieved expected outcomes, that timeliness was of sufficient concern to be monitored formally by the Board or the OPLC, and actions were taken to ensure timely investigations. Five of 21 licensee records (23.8 percent) subjected to enforcement activity that we reviewed included both the date of referral and the date the Board received investigative information. Those five investigations lasted from 22 to 575 days. Deficient controls were also due, in part, to the lack of agreements with supporting agencies and investigators;

inadequate records management, which made some controls unauditable; inadequate internal communications; and inconsistent OPLC customer service.

Our audit focused on Board controls and was not designed to identify all instances of noncompliance. However, we found cases demonstrating how inadequate controls adversely affected investigations and Board decisions.

**Noncompliance With State Policy And Rules**

The Board made decisions that were noncompliant with investigative procedures provided in State policy and rule. The Board lacked sufficient means to monitor the progress of investigations, resulting in a lack of accountability. The Board had to vote to commence an investigation and specify the type, form, and extent of the investigation. Formal investigations required a Board order containing:

- the statutory authority for the investigation,
- the statutes or rules believed to have been violated,
- the identity of the licensee subject to investigation,
- the nature of the conduct being investigated,
- the identity of the investigator,
- the date by which the investigator had to report to the Board,
- special authority provided to the investigator, and
- other unique provisions.

The Board, OPLC staff, and internal guides lacked controls over orders of investigations. There was no evidence the Board issued orders of investigations when required. In practice, the Board referred investigations to available investigators without specifying the type, form, extent, or other particulars. OPLC staff then referred investigations to external investigators by email or memorandum. OPLC staff purportedly also sent a confidential memorandum to the OPLC's then-improvised Enforcement Division to request it undertake a formal investigation. However, referrals to the division were informal, lacked required elements of an order of investigation, and were inconsistently recorded. Additionally, statute creating the Enforcement Division was effective July 1, 2021, but the OPLC began operating it approximately nine months earlier, in Fall 2020.

**Lack Of Comprehensive Rules**

Investigation-related rules were incomplete, and some were unimplemented. The Board was noncompliant with statute. Controls were not developed to ensure statutorily-required investigations occurred and expected outcomes were achieved. Inspection and expert reviewer processes were inconsistent, lacked transparency, and could not be enforced by the Board. Efficiency was undermined.

- Statute required the Board to investigate licensees who were the subject of three malpractice claims or legal judgments in five years. The Board's rule-based malpractice committee was to review claims and judgments and refer them to the

Board. However, rules were incomplete. In practice the committee did not exist. Instead, the Board informally delegated monitoring to OPLC staff and conducted claim or judgment reviews in isolation. Some required investigations did not occur. The OPLC lacked formal processes to monitor claims and judgments to help ensure licensees were investigated when required.

- Statute required the Board to conduct root cause analysis of reports of adverse events resulting from the use of general anesthesia or deep or moderate sedation. The Board was aware of the requirement but lacked required rules. The Board did not analyze the three adverse outcome reports it received in State fiscal year (SFY) 2019 and SFY 2020 that we identified.

- There were no inspection-related rules to facilitate consistent treatment of licensees and timely remediation of deficiencies during an investigation. The Board had an inspection form that was reportedly used by an investigator for unannounced inspections. However, the form: 1) was not adopted in rule, 2) contained ad hoc rule requirements, and 3) was not publicly available after March 2021.

- Expert reviewers could be any qualified professional or Board member appointed to assist with an investigation. Expert reviewers were required to sign a confidentiality agreement containing a limited set of instructions for conducting timely reviews. However, there were no rules addressing, for example, expert reviewer qualifications, methods to assign cases, grounds for reviewer removal, or time limits. The agreement was not adopted or required in rules.

- At any point in an investigation, the Board could defer disciplinary action and refer a matter to mediation. Depending on the results, the Board could discontinue its investigation or commence an adjudicative proceeding. Properly implemented, qualified mediator processes could have made certain investigations more efficient. However, the Board never developed controls over qualified mediators, related rules were not comprehensive, no relevant processes existed, and no mediators were evidently used.

In July 2021, statutory authority to adopt rules on investigative procedures was transferred from the Board to the OPLC. The Board's rules were to expire in July 2022. The OPLC was required to commence rulemaking to amend rules no later than 90 days after the change was effective. However, the Board was reportedly unaware of the legislation. There was no indication OPLC rules were in development as of October 2021, when we concluded audit work on this topic.

**Lack Of Procedures**

The Board lacked comprehensive procedures for determining when and how to undertake investigations. It also lacked controls for conflicts of interest and member recusals, which adversely affected the Board's ability to obtain investigators. Inadequate controls also increased the potential risk of inconsistent investigations being conducted. Board support was inconsistent

and informal throughout the audit period, and no formal processes existed to manage resources. The Board and the OPLC lacked a system to monitor investigations and investigator performance.

***No Formal Investigation Management Processes***

The Board inconsistently conducted preliminary research into matters, considered licensee complaint histories, or conducted unannounced inspections to inform its decisions. Neither did it develop investigative plans once it decided to investigate a matter. The Board was required to "fairly" investigate matters within its jurisdiction whenever it had a "reasonable basis for doing so." It was the Board's responsibility to appoint investigators and determine the scope of the investigation. To better inform decisions on whether a matter merited investigation and to ensure an investigation was fair, the Board should have gathered background information about the complainant and licensee, considered the licensee's complaint and discipline histories, and potentially conducted unannounced inspections.

Investigative plans could have facilitated consistent and credible investigations. Plans should have specified the scope of the investigation, resources allocated, evidence to obtain, documentation available, and individuals to interview. In practice, staff inconsistently provided licensee complaint and discipline summaries to the Board when reviewing potential noncompliance. Members reported summaries were provided with each complaint as a matter of routine during part of the audit period. However, the practice was discontinued by staff. Thereafter, the Board had to request licensee complaint and discipline summaries. The Board also regularly referred matters for investigation to staff without plans or oversight of ensuing investigations. No controls or processes existed to refer matters outside the Board's jurisdiction to the appropriate authority, resulting in some allegations not being fully addressed.

Board members reported lack of information and communication negatively affected decisions to investigate matters, and the Board's ability to effectively monitor investigations. While inadequate records management prevented us from identifying the total number of cases potentially affected during the audit period, we did identify three cases corroborating members' concerns.

- A calendar year (CY) 2017 complaint was referred to an external investigator. The Board conducted no follow up for nearly two years, and not until the licensee received another, unrelated complaint in CY 2019. Reportedly, the CY 2017 complaint was never investigated and would not be investigated by the assigned investigative agency. The Board subsequently dismissed the uninvestigated CY 2017 complaint, inappropriately, with a letter of concern. The letter did not fully address the allegations.

- In a five-year period, one licensee failed a subsequent comprehensive re-evaluation for their anesthesia and sedation permit and received two complaints, indicating a potential pattern of noncompliance. However, the Board was not provided a complaint and discipline summary with the results of the failed comprehensive re-evaluation. The Board could have opened an investigation and conducted unannounced inspections to determine whether there were broader noncompliance issues. It instead entered into a preliminary agreement not to practice anesthesia or sedation, allowing the licensee to continue to otherwise practice without further investigation.

- A CY 2017 complaint resulted in multiple investigations, adjudicatory proceedings, and settlement agreements as additional complaints and findings were received throughout the four-year enforcement process. As of August 2021, the case was still open, but was transferred from the APU to the OPLC, without complete investigative files.

***No Formal Processes To Manage Potential Conflicts Of Interest***

Lack of controls over potential conflicts of interest hindered the Board's ability to manage investigations effectively and fairly. Because investigative support was inconsistent throughout the audit period, Board members had to conduct some investigations or expert reviews themselves. Additionally, expert reviewers could also be a non-member licensee appointed by the Board. Consequently, formal control of the risk potential conflicts of interest could bias investigations was essential to help ensure disciplinary action could be taken when warranted. Board members and staff reported three cases in which investigations were negatively affected due to lack of formal controls over potential conflicts of interest. We identified three additional cases.

- A former member actively served on the Board for nearly six months while under investigation by another agency – purportedly without the full Board's knowledge – before resigning. Thereafter, the full Board became aware the former member had been investigated during their term on the Board. Two months later, the Board determined that the matter was within its jurisdiction and warranted a Board investigation.

- A former Board member purportedly was recused to conduct an expert review when an external expert reviewer could not be retained. However, the member was a potential economic competitor of the investigated licensee. The Board did not become aware of this until after the review was conducted.

- A CY 2019 complaint prompted the Board to order an unannounced inspection of a licensee's office. A recused Board member and the Board's then-serving, informally-retained investigator were to conduct the inspection. Two months later, the inspection had not occurred due to insufficient APU investigative support, as well as safety and legal concerns. The Board decided to assign the investigation to their new investigator, after a contract was in place. However, 15 months later, the new investigator reported a conflict of interest. The case was dismissed 23 months after the complaint was received, without evidence an inspection or formal investigation ever occurred.

- An CY 2017 complaint was corroborated by subsequent complaints and ensuing investigations. However, 45 months later, the Board permanently dismissed the case, barring the matter from being revived, citing inadvertent member communications without all parties present that purportedly compromised the Board's impartiality. The APU moved to continue the matter, seeking disciplinary action. The matter was still open in September 2021, when we concluded audit work on this topic.

- Unsure how to manage a CY 2019 complaint against a dental assistant, the Board referred the investigation to the supervising dentist. This was the same dentist who could have been disciplined had there been sufficient evidence for the Board to take further action. However, there was no report of investigation, and records mismanagement made the case unauditable. However, the record did show the Board dismissed the complaint approximately one month after referral.

- During CYs 2019 and 2020, one Board member was inconsistently recused from decision making on whether to take further action on three complaints alleging misconduct against one licensee. The member was recused from a vote to dismiss one complaint, but not from votes to dismiss the other two complaints. The member was also recused from a vote to refer the first complaint for investigation, but not from a similar vote on the third complaint. There was no record on why the member needed to be recused from some votes but not from others.

***No Formal Processes To Manage Resources***

The Board lacked processes to manage investigative resources, and Board support throughout the audit period was inconsistent and informal. Resources were at times insufficient, and processes underdeveloped or disused. The Board retained primary responsibility for investigative outcomes and for overseeing investigations. However, no formal agreements existed between the OPLC and the DOJ until July 2021, and the Board never had a support agreement with either agency. Certain Board investigative and enforcement responsibilities were improperly delegated to staff and the OPLC's then-improvised Enforcement Division. The Board and the OPLC inconsistently contracted or made arrangements for assistance with, or the conduct of, investigations during the audit period. Inadequate control over contracted investigators resulted in ineffective Board monitoring, insufficient communication, informal processes, and decisions that compromised public safety.

- Board Support – Third-party support services obtained were insufficient, and Board expectations were unclear and, at times, informal. Board members reported some investigations could not be pursued due to lack of support and resources. These resources were supposed to be available either from the OPLC or through contracts or other arrangements. Although we could not determine how many investigations were affected by incomplete records, in three cases the Board was unable to timely pursue an investigation due to inadequate investigative resources. Two of the three cases were dismissed without an investigation.

- Board Investigators – A lack of monitoring and inadequate oversight led to underutilization of Board investigators. For part of the audit period, the Board informally retained an investigator to conduct inspections, assist with investigations, and manage investigative records. Reportedly, the investigator was unable to fulfill certain duties, at times, because additional APU support was unavailable. The OPLC did not formalize what would have reportedly been a defective contract with the first investigator. Subsequently, another investigator was contracted with, for one year.

Inadequate controls persisted, and administrative expectations and deliverables specified in the second contract were unfulfilled.

- Expert Reviewers – Lack of controls led to inefficient and untimely expert reviewer appointments. In one case, the Board did not obtain an expert reviewer until eight months after the APU requested one be appointed. The expert reviewer's findings were subsequently provided five months later. In another case, the Board appointed an expert reviewer and requested findings be provided within 60 days. The final report was not submitted to the Board until 188 days later. The report also lacked a required recommendation to the Board as to whether the allegations warranted further disciplinary proceedings.

In CY 2021, legislation created the OPLC's Enforcement Division to conduct investigations, and removed certain Board service contracting authority. The Board was aware of OPLC intentions to create an Enforcement Division. However, it was reportedly never made aware of the proposed legislation or the scope and nature of its effects on the Board's independence and authority. Lacking relevant rules or a formal agreement, the Board had no way to effectively oversee investigations or ensure OPLC services met expectations. The OPLC also lacked controls to ensure the Board received necessary services to effectively manage investigations. The OPLC never examined the scope and nature of Board operations to understand required service levels. Through October 2021, when we concluded audit work on this topic, there were no strategy or plans to assess legislative changes impacting Board authority and responsibilities, evaluate Board support needs, and structure controls over the investigative process.

**Recommendations:**

**We recommend the Board and OPLC management:**

1. **collaboratively review CY 2021 statutory changes to rulemaking and other investigations-related authority;**
2. **differentiate between discretionary Board duties and nondiscretionary OPLC responsibilities for investigations, inspections, and retaining legal counsel, investigators, or other assistance;**
3. **promulgate rules, develop related procedures and necessary forms, and clarify the terms and conditions of the Board's and OPLC's relationship by formalizing Board administrative needs to effectively manage investigations, expectations of support services, delegations of administrative functions, and service-level and performance expectations; and**
4. **establish information requirements that will allow the Board to monitor and report on compliance and efficiency.**

**We further recommend the Board:**

5. **develop and adopt rules for expert reviewers, mediation and qualified mediators, conflicts of interest, referrals to other jurisdictions, and investigating three malpractice claims or legal judgements received within five years;**

6. **discontinue informally referring investigations and develop procedures for preparing and issuing orders of investigation;**
7. **develop and formalize procedures on voting for the type, form, and extent of an investigation, and incorporate results into an investigative plan to facilitate Board oversight and control;**
8. **establish time limits on investigative procedures;**
9. **monitor the progress of investigations and review the resulting reports to ensure consistency and compliance with statute, rules, and orders of investigation;**
10. **ensure complete records are readily available for review and incorporate procedures for reviewing records when there is any potential credential holder noncompliance to consider whether an investigation may be warranted; and**
11. **monitor performance and demonstrate expected outcomes are being achieved.**

Board Response:

*We concur with the recommendations.*

1. *We concur with the recommendation to collaboratively review CY 2021 statutory changes to rulemaking and other investigations-related authority*

   *The Board is in the process of collaborating with the OPLC to review and revise the Den 200 rules, which pertain to complaints, investigations and the disciplinary/adjudicatory process.*

2. *We concur with the recommendation to differentiate between discretionary Board duties and nondiscretionary OPLC responsibilities for investigations, inspections, and retaining legal counsel, investigators, or other assistance.*

   *The Board incorporates its previous answer into this response. After reviewing a complaint, the Board has the authority to vote to refer the complaint to the OPLC's Enforcement Division for investigation. The Board and the OPLC's Enforcement Division are collaborating to clarify the role of the Enforcement Division and the appropriate processes and procedures to be followed for complaints to be referred to the OPLC's Enforcement Division for investigation and/or disciplinary action, which will further clarify and differentiate between Board duties and OPLC responsibilities.*

3. *We concur with the recommendation to promulgate rules, develop related procedures and necessary forms, and clarify the terms and conditions of the Board's and OPLC's relationship by formalizing Board administrative needs to effectively manage investigations, expectations of support services, delegations of ministerial functions, and service-level and performance expectations.*

   *The Board's previous responses are incorporated into this response.*

4. *Establish information requirements that will allow the Board to monitor and report on compliance and efficiency.*

*It is the Board's understanding that the OPLC is in the process of procuring an improved electronic tracking and reporting software that will facilitate improved communication between the OPLC's Enforcement Division and the Board regarding the status of complaints that are referred to the Enforcement Division for investigation and/or disciplinary action.*

5. *We concur with the recommendation to develop and adopt rules for expert reviewers, mediation and qualified mediators, conflicts of interest, referrals to other jurisdictions, and investigating three malpractice claims received within five years.*

6. *We concur with the recommendation to discontinue informal referrals of investigation and develop procedures for preparing and issuing orders of investigation.*

7. *We concur with the recommendation to develop and formalize procedures on voting for the type, form, and extent of an investigation, and incorporate results into an investigative plan to facilitate Board oversight and control.*

8. *We concur with the recommendation to establish time limits on investigative procedures.*

   *The Board recognizes the importance of implementing processes to facilitate a more timely resolution of complaints.*

9. *We concur with the recommendation to monitor the progress of investigations and review the resulting reports to ensure consistency and compliance with statute, rules, and orders of investigation.*

   *The Board has already started requesting frequent updates from the OPLC's Enforcement Division regarding the status of investigations and complaints. The Board itself would like to complete these processes in a timely manner but is dependent on the resources supplied by the OPLC.*

   *However, the Board cannot set expected outcomes in any complaint because that would be prejudging an issue, which would prevent the licensee from receiving a full and fair investigation and adjudicatory hearing.*

   **LBA Rejoinder: The Board conflates the results of an adjudicative hearing with our recommendation that focused on monitoring the investigative *process*. Nowhere do we suggest the Board taint investigations or hearings. It needs to control and monitor processes managed by third parties, for example by ensuring reports of investigation are *timely* and *complete*, to ensure they contribute to producing expected outcomes.**

10. *We concur with the recommendation to ensure the Board receives complete records and has access for review, and to incorporate procedures for reviewing records when there is any potential credential holder noncompliance to consider whether an investigation may be warranted.*

*Currently, any irregularity in an application for initial licensure or renewal is reviewed by the Board during a meeting and a decision is made regarding how to proceed with the licensee's application.*

11. *We concur with the recommendation to monitor performance and demonstrate expected outcomes are being achieved.*

OPLC Response:

*We concur with the recommendations.*

*The OPLC's plans to address the recommendations are as follows:*

1. *Collaboratively review CY 2021 statutory changes to rulemaking and other investigations-related authority.*

   *The OPLC is currently conducting an inventory of all OPLC and Board statutory requirements. As part of this process, the OPLC will collaboratively review the CY 2021 changes and seek necessary modifications. Once inventoried, the OPLC will be working with the boards to assess the current rules to determine whether the rules properly implement the statutes. As part of its overall initiative to establish internal controls within the agency, and to assist boards in establishing internal controls, the OPLC will be working to draft policies and procedures.*

   *The OPLC is hiring three additional attorneys to assist with this work. OPLC senior leadership meet twice per week to work on internal controls. Nonetheless, with current staffing constraints and resources, the OPLC anticipates establishing basic internal controls in the next biennium.*

2. *Differentiate between discretionary Board duties and nondiscretionary OPLC responsibility for investigations, inspections, and retaining legal counsel, investigators, or other assistance.*

   *As part of its initiative to establish internal controls, and to clarify the relationship between the Board and the OPLC, the OPLC is drafting a memorandum of understanding for all boards, councils, and commissions. The OPLC has just completed a first rough draft and is seeking internal input. Once finalized, the memorandum of understanding will differentiate between Board duties and OPLC duties as it relates to all OPLC and Board functions, including investigations.*

3. *Promulgate rules, develop related procedures and necessary forms, and clarify the terms and conditions of the Board's and OPLC's relationship by formalizing Board administrative needs to effectively manage investigations, expectations of support services, delegations of ministerial functions, and service-level and performance expectations.*

   *The OPLC has recently filed an initial proposal to establish procedural rules regarding investigations, adjudications, and complaints, among other things. Additionally, as noted*

*above, the OPLC is working to establish internal controls and differentiate between Board and OPLC duties via a memorandum of understanding.*

4. *Establish information requirements that will allow the Board to monitor and report on compliance and efficiency.*

   *The OPLC is working with the DOJ to determine what information should be shared with the Board to permit them to monitor and report on compliance and efficiency, while at the same time maintaining neutrality. Once identified, policies and procedures will be established to share consistent information with the Board on a regular basis. Additionally, the OPLC is procuring a new case management system. One requirement of such a system is to facilitate the provision of data and other reports to the Board.*

### *Controlling Adjudicatory Proceedings And Hearings*

The Board was required to commence adjudicatory proceedings for any contested case. Adjudicatory proceedings were used to determine culpability and consider potential disciplinary action for noncompliance. To facilitate consistency, equity, and due process, statute established a framework of general requirements for adjudicative proceedings, such as required rules, time limits, documentation, and procedures. Held in public, hearings also helped ensure Board decisions were publicly transparent. If the Board found an applicant or licensee had engaged in misconduct, it was to provide notice and hold a hearing before denying an initial or renewal license application or imposing sanctions against a licensee. The Board also required hearings when licensees were identified as being disciplined in another jurisdiction or potentially noncompliant with continuing education requirements during a continuing education review. The Board also adopted rules requiring non-adjudicatory hearings in certain circumstances. A prehearing conference could also be held if it would aid in the disposition of the adjudicatory proceeding.

We were unable to quantify the total number of adjudicatory proceedings or hearings during the audit period, or measure the Board's timeliness in managing them.

**Observation No. 35**

**Improve Adjudicatory Proceedings And Hearings Controls**

Controls over adjudicatory proceedings and hearings were inadequate, compromising the Board's ability to effectively protect the public. Extra-legal requirements were imposed. The Board lacked procedures and monitoring processes to consistently manage and conduct adjudicatory proceedings effectively and in compliance with statute and rule. Related OPLC procedures, practices, and support to the Board were informal and inconsistent. Nothing demonstrated management of adjudicatory proceedings efficiently achieved expected outcomes or that timeliness was of sufficient concern to be monitored formally by the Board or OPLC. Deficient controls were due, in part, to inadequate Board oversight, the lack of agreements with supporting agencies, and gaps between statute, rules, and practice. Other factors included inadequate internal communication and inadequate records management. Records and transactions were at times

unauditable, transparency was compromised, and the Board could not effectively monitor adjudicatory proceedings or ensure compliance with requirements.

Although our audit focused on Board controls and was not designed to identify all instances of noncompliance, cases nonetheless demonstrated how inadequate controls adversely affected adjudicatory proceedings and Board decisions.

**Noncompliance With Regulatory Framework**

The Board inadequately controlled the adjudicative proceedings framework and improperly delegated certain statutory responsibilities.

- December 2020 and June 2021 standing orders improperly delegated certain Board enforcement responsibilities to the OPLC's then-improvised Enforcement Division. This predated the OPLC's statutory authority to operate such a division, which began in July 2021.

- A February 2020 standing order purportedly authorized the APU to issue subpoenas on behalf of the Board. However, subpoenas could only be issued by the Board after a majority vote.

- In February 2020, the Board authorized OPLC staff to sign preliminary agreements not to practice. However, the delegation did not clearly indicate Board approval was required before staff could sign agreements. Additionally, although no other formal delegation of signature authority existed, staff finalized and signed hearing notices, settlement agreements, limited confidential agreements, subpoenas, investigative agreements, and orders for continued hearings.

Board practices inconsistently complied with statute and rule, which subjected the public to ad hoc rules and compromised transparency.

- A minimum of 15 days' advance notice was required for a respondent to comply with a subpoena requesting records. However, three of five subpoenas (60.0 percent) issued in one enforcement case we reviewed imposed time limits of less than 15 days.

- Hearings could either be public or nonpublic, depending on the circumstances. However, the Board did not always post public notices for, or record minutes of, these meetings.

- The Board held collective discretionary decision-making authority. However, the Board President or a presiding officer made approvals outside Board meetings. This included extensions of the time allowed to comply with subpoenas and respond to complaints.

- Motions for a continuance that occurred outside of a hearing could be granted by order of the presiding officer, provided the delay "would assist in resolving the case fairly."

However, while some continuances were informally approved outside of Board meetings, approvals were not always in the case record and orders were inconsistently issued.

- Reports of investigation had to conclude whether there was a "reasonable basis" for the Board to conduct further proceedings. While State policy established grounds for misconduct, the Board lacked rules describing what constituted a "reasonable basis." Instead, the Board included some informal criteria in expert reviewer agreements, and excluded any criteria or guidance in referrals to the APU.

**Required Hearings Inconsistently Occurred**

The Board inconsistently held required hearings.

- Hearings on license applications where applicants were identified as potentially being noncompliant with one or more requirements were inconsistently held. The Board was to determine applicant qualifications. We found nine of 26 initial license applications (34.6 percent) had potential conduct issues. However, only two of the nine applications (22.2 percent), which were initially denied, had a formal finding, notice, and a hearing.

- Hearings when a licensee was disciplined in another jurisdiction were not held. Instead, during nonpublic meetings, the Board variously opted to: 1) obtain more information, 2) dismiss another jurisdiction's sanctions in a manner similar to a complaint, 3) impose additional monitoring requirements, or 4) treat reported discipline as informational. In one case, we found the Board attempted to initiate the hearing process by issuing a notice of hearing. However, it was unable to proceed due to lack of APU support. The Board instead inappropriately dismissed the case by using a letter of concern.

- Hearings did not occur when a licensee under a continuing education review did not fulfill the biennial continuing education requirement. Staff reported the Board followed up on continuing education noncompliance directly with the licensee. However, the Board lacked rules or formal procedures and did not monitor continuing education noncompliance. The OPLC did not retain relevant records.

**Informal Agreements And Inconsistent Resources**

There were no formal mechanisms to ensure the Board had sufficient support to carry out proceedings it deemed necessary. The Board was wholly reliant upon the OPLC and the DOJ to hold hearings. Support was inconsistent throughout the audit period, however. This compelled volunteer Board members to navigate a complex legal structure without comprehensive or effective controls, including training. The Board lacked formal procedures to facilitate the adjudicative process. Some Board members reported there were no processes to monitor adjudicatory proceedings, APU support was insufficient, and communication between supporting agencies and the Board was inadequate. Board oversight was ineffective.

Current and former OPLC management reported staff and members of assigned agencies lacked the background, education, and training necessary to properly adjudicate cases, resulting in some members refusing to participate in adjudicating cases. Current and former Board members also expressed unwillingness to conduct hearings without legal support. While the DOJ periodically offered administrative law training for Board members, attendance was neither required nor recorded. This led to some adjudicatory proceedings not being conducted. This may have compromised public safety or credential holders' due process rights.

When the Board did decide to conduct an adjudicatory hearing, support was inconsistent. We identified three cases in which the APU was unable to provide sufficient support. This resulted in one hearing being delayed by five months and two case dismissals without adjudicatory proceedings having occurred. Additionally, a CY 2017 case improperly dismissed by the Board in May 2021, was appealed. It remained open as of September 2021, when we concluded audit work on this topic. The licensee had been subjected to adjudicatory proceedings for four years. The case risked reaching the five-year statute of limitations within which the Board had to take disciplinary action.

The Board was authorized during the audit period to retain qualified persons to assist with adjudicatory proceedings through the OPLC. However, there were no formal arrangements for support for adjudicatory proceedings. In July 2021, the OPLC formalized a support agreement with the DOJ, which placed primary enforcement responsibilities with the OPLC. However, the OPLC never examined the scope and nature of Board operations to understand required service levels. There was no formal agreement between the Board and the OPLC establishing expectations. The OPLC lacked a strategy, plans, and rules implementing related CY 2021 legislative changes. The Board reported it was unaware of the legislation removing its authority to retain legal counsel, investigators, or other assistance through the OPLC, and to adopt rules for disciplinary proceedings.

Additionally, the CY 2021 legislation affecting Board adjudicative processes was not comprehensive, statutory authority overlapping between the Board and OPLC was not defined, and the resulting effect on Board operations and statutory duties was not clear. As of January 1, 2022, rulemaking authority for "hearings" and "disciplinary proceedings" was transferred to the OPLC. However, broader "adjudicatory proceedings" were not clearly transferred. It was not clear whether "hearings" encompassed other types of Board hearings, such as prehearing conferences and continuing education review hearings, for which the Board may have retained rulemaking authority.

**Incomplete Records**

Records for cases resulting in adjudicatory proceedings were incomplete and inconsistently contained required documentation. Neither the Board nor the OPLC had formal records management controls. A case record was to include a docket file containing specific records. A docket was to provide an overview of the docket file's content. The docket file was to be an accurate record of proceedings available for public inspection, although a complete file could also contain confidential information exempt from public disclosure. Required documentation included orders, motions, objections, rulings, notices, evidence, findings, reports, decisions, and opinions.

Informal OPLC guides reflected these requirements. We reviewed records for four licensees subjected to adjudicatory proceedings from January 2017 through August 2021 and whose case was active during the audit period. All four records were incomplete and inconsistently contained required documentation. For example, one record lacked:

- five complaints,
- four licensee responses to complaints,
- four recordings of hearings,
- three orders of investigation,
- three letters of concern,
- two approvals for complaint response extensions,
- one petition to return to practice,
- one subpoena,
- one pre-hearing conference meeting minutes, and
- one notice of hearing.

None of the four records contained a separate docket file available for public inspection, or a docket outlining the contents of a docket file.

**Recommendations:**

**We recommend the Board and OPLC management:**

1. **collaboratively review CY 2021 statutory changes to rulemaking and other adjudicative hearings-related authority;**
2. **adopt rules, develop related procedures, and clarify the terms and conditions of the Board's and OPLC's relationship by formally establishing Board administrative needs to effectively manage adjudicative procedures and hearings, expectations of support services, delegations of administrative functions, and service-level and performance expectations; and**
3. **establish information requirements that will allow the Board to monitor and report on compliance and efficiency.**

**We further recommend the Board:**

4. **hold rule required hearings;**
5. **develop procedures and checklists to facilitate compliance with requirements;**
6. **require members attend annual administrative law training and obtain additional training as needed;**
7. **ensure approvals of extensions, motions, and continuances are formally approved by the appropriate authority;**
8. **monitor case progress to ensure substantive and procedural consistency, including timeliness; and**
9. **monitor performance and demonstrate expected outcomes are being achieved.**

Board Response:

*We concur in part with the recommendations.*

1. *We concur with the recommendation to collaboratively review CY 2021 statutory changes to rulemaking and other adjudicative hearings-related authority.*

   *Collaboration with OPLC management is necessary to review CY 2021 statutory changes to rulemaking and other adjudicative hearings-related authority.*

2. *We concur with the recommendation to promulgate rules, develop related procedures, and clarify the terms and conditions of the Board's and OPLC's relationship by formally establishing Board administrative needs to effectively manage adjudicative procedures and hearings, expectations of support services, delegations of ministerial functions, and service-level and performance expectations.*

   *Part of the service level and ministerial functions come under the guidance of OPLC administrative staff and not totally under the Board's guidance.*

3. *We concur with the recommendation to establish information requirements that will allow the Board to monitor and report on compliance and efficiency.*

4. *We concur with the recommendation to hold rule required hearings.*

   *The Board will continue to work with the OPLC to evaluate which adjudicative hearings are necessary to align with statutory responsibilities.*

5. *We concur with the recommendation to develop procedures and checklists to facilitate compliance with requirements.*

   *The Board is taking steps to ensure that the adjudicatory process and hearings are conducted in a more consistent manner by utilizing the services of a Hearings Officer.*

6. *We concur with the recommendation to require members attend annual administrative law training and obtain additional training as needed.*

   *The Board will discuss the need for Board members to attend annual administrative law training and any additional training that is needed.*

7. *We concur in part with the recommendation to ensure approvals of extensions, motions, and continuances are formally approved by the appropriate authority.*

   *The Board agrees that it is ultimately responsible for ensuring that proper procedures are followed during the disciplinary process. However, it disagrees with the finding that the presiding officer in disciplinary matters did not have the authority to rule on motions without first obtaining a collective vote by the Board. The Board takes the position that the presiding*

*officer was authorized to make those decisions pursuant to Board rules on continuances and prehearing conferences. Going forward, the Board has the opportunity to have adjudicatory hearings conducted by a Hearings Officer, which will alleviate many of these perceived issues.*

**LBA Rejoinder: Rules provided a motion for a continuance could be granted on the order of the presiding officer. The Board lacked controls over the approval process, and some continuances were informally approved outside of Board meetings *without* an order or without any record at all. Extending the amount of time to respond to a complaint or comply with a subpoena required a *Board* decision. However, the Board President or presiding officer inappropriately made such approvals at times.**

8. *We concur with the recommendation to monitor case progress to ensure substantive and procedural consistency, including timeliness.*

9. *We concur in part with the recommendation to monitor performance and demonstrate expected outcomes are being achieved.*

   *The Board will continue to collaborate with OPLC administrative staff and the OPLC's Enforcement Division to establish improved communication regarding the status of open complaints, investigations and disciplinary matters.*

   *While the Board understands the importance of improving the timeliness for resolving disciplinary matters, it does not agree that "expected outcomes" are appropriate in disciplinary matters. The Board is charged with deciding each case based upon the evidence and testimony presented during the hearing without forming a preconceived opinion or expected outcome.*

   **LBA Rejoinder: The Board was responsible for implementing and administering State policy regulating dentists and hygienists to protect the public health, safety, and welfare from unqualified, unscrupulous, and impaired practitioners. This was the Board's *expected outcome*. Conflating *expected outcomes* with the formation of a *preconceived opinion* on the *results* of individual adjudicatory proceedings or hearings is unsupported by the observation. The Board needs to control and monitor adjudicative processes, for example by ensuring they are timely and substantively and procedurally complete, to ensure they contribute to producing expected outcomes.**

OPLC Response:

*We concur with the recommendations.*

*See OPLC Response to Observation No. 34.*

### *Controlling Disciplinary Process And Sanctions*

Systematic processes establishing equitable and progressively stringent discipline could have helped ensure the public was adequately protected. Effective processes required a well-developed and transparent framework. The framework should have included: 1) a system of graduated sanctions commensurate with the severity of the violation, 2) proactive and reactive monitoring of compliance with agreements, 3) established time limits for deciding on disciplinary actions and imposing sanctions, 4) enforcement-related cost recovery, 5) publication of final disciplinary actions and sanctions, and 6) reliable records.

**Observation No. 36**

**Improve Disciplinary Process And Sanction Controls**

The Board lacked adequate controls to ensure disciplinary processes were consistent, timely, and transparent. Support expectations were not established and the support the Board received was inconsistent. Statute and rules were not comprehensive, and rules were inadequate. This resulted in improvised Board decisions and substantive and procedural noncompliance, including extra-legal actions. Related OPLC procedures and practices were informal and inconsistent. Records were deficient. A system to consistently recover full costs of Board enforcement actions was never developed. Although there were intermittent efforts to develop controls, there was no holistic or consistent approach to administering and monitoring sanctions. At times, controls devolved due to a lack of formalized processes and loss of institutional knowledge as members and support staff changed, making previously implemented controls irrelevant. Nothing demonstrated sanctions efficiently achieved expected outcomes or that timeliness was of sufficient concern to be monitored formally by the Board or OPLC. Inadequate control compromised public safety, and exposed the Board to potential federal antitrust scrutiny.

**No Sanction Framework Established**

The Board did not establish criteria to ensure the sanctions it issued were consistent. There was no system of graduated sanctions that could have facilitated consistent and transparent disciplinary processes regardless of instability in the Board's operating environment as membership and staffing changed. Rules were not comprehensive, procedures and practices were informal, and ad hoc rules were relied upon for certain sanctions and processes. The Board never established administrative fines in rule.

- State policy permitted the Board to sanction licensees for any administrative or criminal conviction involving "moral turpitude." Rules ambiguously defined moral turpitude as "baseness, vileness, or dishonesty to a high degree." Vague clauses such as this required each substantive word to be subjectively interpreted by each member to determine whether sanctions were warranted. Rules themselves were to be the specific interpretation of the Board's authority, and not be an opportunity for ad hoc rulemaking. Furthermore, rules containing ambiguous terms could not be enforced.

- Rules were internally inconsistent. One rule allowed more than 20 days for licensees to respond to complaints, while another required the Board impose sanctions for failure to respond within 20 days. We identified four cases in which responses to complaints were submitted past the deadline. There was no evidence the Board imposed required sanctions for failure to respond timely.

- Informal OPLC guides stated the Board could require continuing education reviews of licensees as a sanction. However, continuing education reviews were not a statutorily-permitted sanction, and there were no rules formalizing how reviews would be used as a sanction.

- Although the Board reviewed similar cases of noncompliance, such as failure to timely register with the Prescription Drug Monitoring Program or notify the Board of sanctions imposed in another jurisdiction, licensees were inconsistently sanctioned. Board members reported some cases were treated inconsistently due to insufficient support and lack of resources. We identified six cases dismissed reportedly due to insufficient enforcement support.

- The disciplinary framework limited Board sanctions to licensees by authorizing the Board to restrict, revoke, or suspend a license. This did not apply other credentials, such as permits or certificates. The only way the Board could affect another credential was through a 60-day emergency suspension of a privilege. To do so, the Board had to initiate disciplinary proceedings after issuing an order suspending the license of an accused credential holder. Neither statute nor rules accommodated sanctioning or temporarily suspending other credentials, even though Board-issued permits and certificates were part of its regulatory program. Nonetheless, the Board at times suspended other privileges, instead of licenses, outside its existing statutory and regulatory framework.

The Board should have determined what sanctions and administrative fines to apply based on complaint and disciplinary history, seriousness of the noncompliance, and the threat to the public. Instead, the Board inconsistently:

- considered past noncompliance;
- relied on the APU to propose terms of agreements;
- informally sanctioned licensees, such as by issuing letters of concern;
- dismissed potential noncompliance cases based on reported resource constraints and not due to a finding the licensee was in compliance; and
- imposed fines with no objective basis for the amount in relation to the noncompliance.

As a result, Board sanctions were inconsistently commensurate with the violation, and it could not ensure sanctions imposed remained consistent over time. Nothing demonstrated sanctions effectively deterred noncompliance or helped the Board achieve expected outcomes. For example, in one of 26 complaint cases (3.8 percent) subject to Board action from SFYs 2019 through 2020 that we reviewed, Board disciplinary efforts appeared to be inconsequential and wasteful. The Board pursued disciplinary action for over two years. The underlying complaint had been

investigated and settled by the DOJ before the Board became involved or pursued disciplinary action. The complaint contained allegations mostly outside the Board's jurisdiction and did not contain allegations concerning public safety. The Board's investigation uncovered no additional noncompliance. After sanctions were imposed, the Board inadequately monitored the licensee for compliance with the sanctions imposed.

**No Triage Process To Identify Complaints Requiring Immediate Board Action**

The Board lacked rules, and the OPLC lacked procedures or formal processes for triaging and referring complaints requiring immediate action to the Board. The Board could suspend a license or other statutorily-authorized privilege for up to 60 days in cases involving imminent danger. OPLC management reported staff needed to be able to recognize when issues needed to be escalated to the Board or management, but no controls were formalized. Matters of public safety were inconsistently brought to the Board's immediate attention. We reviewed 26 complaints, four (15.4 percent) of which appeared to involve imminent danger to life or health. They were handled inconsistently.

- The first complaint was forwarded to Board counsel, not the Board. Counsel determined an expedited investigation would be conducted. Two days later, the complaint was brought to the Board for review during an emergency meeting, and an order of emergency suspension was issued.

- The second complaint was brought to the Board within one week of being received, resulting in a referral for an expedited investigation.

- The third complaint was sent to OPLC management for guidance, but they did not respond. It was then sent to the Board President, who decided to review the complaint during the Board's regular meeting, nearly three weeks after the complaint was received. The Board then referred the complaint to an investigator.

- We could not determine the date of review in the fourth case due to insufficient records, but the Board referred the matter to an investigator 11 days after the complaint was received.

**Inadequate Monitoring Controls**

The Board lacked rules and monitoring controls to timely implement disciplinary actions and ensure compliance with sanctions. The OPLC lacked procedures and formal processes structuring a system to monitor noncompliance cases and resulting sanctions. The OPLC inconsistently implemented improvised practices to monitor noncompliance cases. Sanctions might have included remedial education, monthly monitoring reports, participation in a professionals health program, or submitting evidence noncompliance was remediated. Ineffective monitoring and communication potentially compromised public safety. We found inconsistent handling of the 26 complaints we reviewed, four (15.4 percent) raised significant public protection concerns.

- In the first case, the Board was reportedly unaware a licensee was monitored by the Professionals Health Program for two years. However, the monitoring agreement was in the licensee's file held by the OPLC. The Board was reportedly unable to accept a proposed settlement agreement, in part because it contained monitoring requirements the Board lacked resources to implement. Furthermore, the Board did not request additional monitoring information available from the Professionals Health Program.

- In the second case, a licensee was under a five-year agreement with the DOJ. The Board entered into a settlement agreement with the licensee with 29 months left on the DOJ agreement. Some Board sanctions were contingent upon compliance with the DOJ agreement. However, the Board received its last periodic monitoring report eight months later, with 21 months left on the agreement. The record lacked evidence that full compliance was ever obtained.

- In the third case, the Board relied on monthly out-of-state professionals' health program reports to provide it compliance information. However, reports were inconsistently provided, reviewed by the Board, and retained in the record. Passive Board monitoring resulted in noncompliance being repeatedly identified weeks or months after it occurred. Ultimately, the license was voluntarily surrendered, nearly three years after the complaint was received.

- In the fourth case, the Board issued a final order in outlining requirements for license reinstatement. However, Board and OPLC communications intended to enforce this agreement twice erroneously referenced different agreements. The Board did not actively monitor compliance and no other communication was in the record after the final communication was sent 28 months later. Additionally, the licensee was noncompliant with a separate Professionals Health Program agreement. The Board was unaware of this noncompliance for two years.

**Inadequate Knowledge Management**

The Board lacked adequate controls over knowledge management. Efforts to mitigate the loss of institutional knowledge were inconsistent, compromising Board effectiveness in achieving expected outcomes. Board member and staff turnover, combined with inadequate controls, contributed to informal, inconsistent, and, at times, untimely disciplinary processes and practices while sanctions were under consideration. Board members relied substantially on staff to possess sufficient knowledge of Board responsibilities, processes, and prior decisions. Members recognized the impact of overreliance on staff and other control deficiencies. Members noted difficulties following up on prior decisions and adequately monitoring sanctions to ensure compliance. Regardless, sanctions were inconsistently implemented, monitored, and published.

The Board also lacked rules and the OPLC lacked procedures and formal processes to ensure required reporting of final disciplinary actions and sanctions occurred. Final disciplinary actions and sanctions were required to be made publicly available. Upon taking a final disciplinary action, the Board was also required to report sanctions to certain entities. This included other states in which the disciplined individual was licensed, the National Practitioner Data Bank, and the

American Association of Dental Boards' Clearinghouse. While a dated, informal procedural guide contained steps to ensure reporting requirements were met, the guide became disused. By CY 2021, staff reported there were no processes to ensure compliance.

We did not audit whether the Board met third-party disciplinary reporting requirements. However, we did identify five licensees whose disciplinary history contained sanctions, but none were published. We reviewed an additional case in which one of four final disciplinary actions and sanctions was not published. Except for one case, wherein staff cited a data entry error, neither the Board nor staff explained why sanctions were not consistently published as required by State policy.

**Extra-legal Use Of Cease-and-desist Letters**

The Board exceeded its statutory authority by improperly issuing cease-and-desist letters. The Board could: 1) petition a superior court for an injunction against individuals practicing dentistry without a license, or 2) pursue formal disciplinary action against licensees for providing services beyond their authorized scope of practice. The Board had no authority to issue cease-and-desist letters.

Neither the Board nor the OPLC had an inventory of cease-and-desist letters issued during the audit period. However, staff located two and we identified a third. Two letters were issued for providing dental services without a license. There was no indication an injunction was sought in either instance, or that criminal sanctions were pursued. A third letter was issued to a business whose employees were purportedly providing a specific service. In the letter, the Board recognized it did not have jurisdiction or regulatory authority over the business or the services provided. The Board knew it could not take such actions but nonetheless ordered immediate cessation, which was potentially abusive and exposed the Board to potential federal antitrust scrutiny.

**Recommendations:**

**We recommend the Board:**

1. **identify gaps in and refine statute underpinning its disciplinary framework, ensuring it accommodates all credential holders and regulatees;**
2. **adopt rules on administrative fines and criteria to triage complaints and rules detailing a graduated and equitable system of sanctions, reporting requirements, and monitoring procedures;**
3. **ensure rules specify how to determine when disciplinary action is warranted;**
4. **develop procedures and checklists to facilitate compliance with requirements;**
5. **consistently address noncompliance based on criteria established;**
6. **discontinue issuing cease-and-desist letters and other sanctions beyond its statutory authority;**
7. **establish information requirements to allow monitoring and reporting on compliance and efficiency;**
8. **actively monitor disciplinary action progress and sanctions to ensure substantive and procedural consistency, including timeliness; and**

**9. monitor performance and demonstrate expected outcomes are being achieved.**

Board Response:

*We concur in part with the recommendations.*

1. *The Board concurs to identify gaps in and refine statue underpinning its disciplinary framework, ensuring it accommodates all credential holds and regulatees.*

   *The Board plans to undertake a complete analysis of current rules and statues and will seek changes needed to accomplish this recommendation.*

2. *We concur with the recommendation to promulgate rules for administrative fines, establishing criteria to triage complaints and implement a graduated and equitable system of sanctions, reporting requirements, and monitoring procedures.*

   *The Board agrees that a clear, well-defined system for applying sanctions, when warranted, be developed and applied consistently.*

   *The Board will adopt rules regarding administrative fines.*

   *Pursuant to* Dentists and Dentistry*, the Board has the discretionary authority to make decisions regarding sanctions on a case-by-case basis. The Board is not opposed to considering some form of general guidance to ensure consistency, while continuing to retain the ultimate authority to decide each disciplinary matter based on the facts and circumstances of each case.*

3. *We concur with the recommendation to ensure specificity in rules for determining when disciplinary actions are warranted.*

   *The Board will review the existing applicable statutes and rules and make amendments and revisions as needed. To the extent that it is appropriate, the Board will consider developing a complete list of actions when requiring discipline of sanctions.*

4. *We concur with the recommendation to develop procedures and checklists to facilitate compliance with requirements.*

   *Now that the administrative support staff is stable, this process can be consistently monitored.*

5. *We concur with the recommendation to consistently address noncompliance based on criteria established.*

   *Noncompliance with established requirements should be addressed in a timely fashion and warranted action taken.*

6. *We concur with the recommendation to discontinue issuing cease-and-desist letters and other sanctions beyond our statutory authority.*

   *The Board has already addressed this issue, and all cease-and-desist letters must be reviewed and approved by the DOJ.*

7. *We concur with the recommendation to establish information requirements to allow monitoring and reporting on compliance and efficiency.*

   *The collection of necessary information is essential for monitoring and reporting. As previously stated in other responses, the OPLC is in the process of procuring software that will address this issue.*

8. *We concur in part with the recommendation to actively monitor disciplinary action progress and sanctions to ensure substantive and procedural consistency, including timeliness.*

   *Good communication channels between the Board, OPLC and the DOJ are necessary to monitor disciplinary action in progress.*

   **LBA Rejoinder: The Board's response does not describe how it will exert oversight and control to ensure relevant communications occur as necessary or when required. Deferring responsibility to the OPLC or the DOJ without adequate Board oversight was the prevailing condition during the audit period. The Board does not clarify how perpetuating that condition will produce improved results.**

9. *We concur with the recommendation to monitor performance and demonstrate expected outcomes are being achieved.*

   *Ongoing monitoring and good record keeping practices with periodic review to evaluate outcomes should be part of the discipline process.*

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## APPENDIX A
## SCOPE, OBJECTIVE, AND METHODOLOGY

In August 2019, the Fiscal Committee of the General Court adopted a joint Legislative Performance Audit and Oversight Committee (LPAOC) recommendation to conduct a performance audit of the Board of Dental Examiners (Board). We held an entrance conference with representatives of the Board and staff from the Office of Professional Licensure and Certification (OPLC) in December 2020. At its March 2021 meeting, the LPAOC voted to terminate a performance audit of the OPLC, with the understanding that the approved Board audit would address OPLC-related topics.

### Scope And Objective

We designed the audit to answer the following question:

> ***How efficiently and effectively did the Board administer its responsibilities and operations regulating the professions of dentistry and dental hygiene during State fiscal years (SFY) 2019 and 2020?***

We also planned to examine: 1) management controls and other relevant matters outside the audit period when they affected Board operations during and after the audit period and 2) OPLC and other agencies' management controls when they directly affected Board operations.

### Methodology

To address the audit question, we examined Board and OPLC management controls and functions. Given the interconnectedness of control systems among Board and OPLC functions, the proper interoperation of each control was necessary for their effective operation. Our audit work focused on:

- six management control systems – strategy, risk, compliance, organization, performance management, and knowledge management;
- three Board functions – credentialing, monitoring, and enforcement; and
- two OPLC functions – business processing support and administrative and clerical support.

#### *Responsible Officials' Views*

To understand member, manager, and staff perspectives on Board, subordinate entity, and OPLC operations, we:

- interviewed select members of the Board and subordinate entities;
- attended 11 Board and nine subordinate entity meetings that occurred during our audit work;
- interviewed select OPLC management and staff with relevant responsibilities; and
- obtained input from other relevant officials when necessary.

***Review Of Records***

To understand the agencies' operating environment, we obtained, reviewed, and analyzed relevant third-party records, including:

- State and federal laws, rules, regulations, declaratory rulings, opinions, executive orders, emergency orders, audits, plans, procedures, guidance, and similar materials;
- audits, studies, guidance, and related materials from other states, academia, interest groups, national organizations, and other entities;
- financial disclosure statements filed by members of the Board and its subordinate entities; and
- expense reimbursement statements filed by members of the Board.

We also obtained, reviewed, and analyzed relevant public and nonpublic records of the Board, its subordinate entities, and the OPLC, including:

- procedures, orders, forms, plans, reports, financial data, budget requests, supplemental job descriptions, guidelines, agreements, informational publications, organizational charts, and similar materials;
- Board and subordinate entity meeting minutes;
- the OPLC's credentialing database management system; and
- various improvised OPLC databases.

To understand control effectiveness and efficiency, we conducted three file reviews supporting the audit's objectives.

*Initial Regular License Application File Review*

To understand initial license application processes, we judgmentally sampled and reviewed 26 application files. Files were analyzed for compliance with statute and rule, consistency and timeliness, efficiency, and effectiveness of Board and OPLC processing and decision-making during SFYs 2019 and 2020. The original sample included 24 files, two of which were not in the electronic credentialing database, while records for a third were inaccessible. We selected three replacement files. However, database records for one of the three new files were inaccessible, as were some records for the second new file. Records accessibility issues were addressed by the OPLC two months later, and the file review was subsequently updated to include all five files with previously inaccessible records. Notwithstanding, records were incomplete. Electronic records resided in a dynamic database that lacked adequate controls to ensure reliability and did not retain records of specific actions taken on each application. Consequently, we cannot provide assurances related to OPLC and Board initial regular licensing practices, lacking reliable records.

Additionally, to understand processes for handling initial applications received close to the renewal period, we judgmentally sampled and reviewed 60 application files submitted during December through March of renewal years CY 2018 through CY 2020. Files were reviewed for compliance with statute and rule and consistency. Reliability issues also affected these records, and we cannot provide assurances related to relevant OPLC and Board practices.

*Regular License Renewal Application File Review*

To understand renewal license processes, we planned to review renewal licensing records for dentists and hygienists. We planned to examine renewal-related license processing controls, records, and practices to evaluate compliance with statute and rules, timeliness, consistency, efficiency, and effectiveness of Board and OPLC processing and decision-making during SFYs 2019 and 2020. We selected a judgmental sample of 15 renewal applications submitted during either the CY 2019 or 2020 renewal cycles, and reviewed available information. However, records in the electronic credentialing database management system were inadequate. They did not allow for a review of renewal applications and licensing decisions, in part because the credentialing database was dynamic and lacked adequate controls to ensure reliability. Consequently, we cannot provide assurances related to OPLC and Board renewal licensing practices, lacking reliable records.

*Noncompliance File Review*

To understand enforcement management processes, we judgmentally sampled and reviewed 21 licensee noncompliance records containing 26 initial complaints with allegations of potential licensee noncompliance. Each was subjected to Board action during SFYs 2019 and 2020. Because records lacked management controls and due to reported OPLC efforts to convert hardcopy records to electronic format and develop a system for records management, we did not have direct access to records. We were provided electronic records compiled by OPLC staff. To help ensure electronic records provided by the OPLC met audit standards, OPLC management was asked to attest to the procedures it used to assemble the records and other basic information, such as confirming no inventory or other system existed during the audit period to identify the total number of licensees subjected to a complaint due to potential noncompliance. However, the attestation was incomplete, and we found some records were inconsistent, incomplete, or otherwise unreliable. Consequently, we cannot provide assurances related to OPLC and Board monitoring or enforcement management practices, lacking reliable records.

***Surveys***

To obtain member and external stakeholders' perspectives, we conducted two surveys.

*Board And Subordinate Entity Member Survey*

To obtain member perspectives, we sent surveys to 36 current and former members of the Board, Dental Hygienists Committee, Anesthesia and Sedation Evaluation Committee (ASEC), and ASEC Advisory Subcommittee. We received 20 (55.6 percent) complete responses.

The results of this survey are in Appendix D.

*Board Stakeholder Entity Survey*

To obtain stakeholder perspectives, we subjectively-selected stakeholders and sent surveys to 11 stakeholders and received eight (72.7 percent) complete responses. The results were used to inform

audit work. However, due to the subjective nature of how stakeholder entities were selected and surveyed, and to protect the anonymity of respondents, results are not included in this report.

***Prior Audits***

To understand previously-identified OPLC control deficiencies, we reviewed the OPLC's remediation of conditions leading to prior audits' findings. We re-examined observations from three prior LBA audits of OPLC-assigned agencies issued in CY 2017 that directly related to Board support.

The results of this analysis are in Appendix E.

**Audit Work Outside The Audit Period And External To The Board**

The audit period included SFYs 2019 and 2020. However, audit work was not limited to the audit period where management control deficiencies outside the audit period affected Board operations during and after the audit period. Neither was audit work limited to the Board, as we examined OPLC management control systems affecting Board operations.

**Limitations And Qualifications**

The scope of our work was limited, and we were compelled to qualify our results.

- Records were insufficiently reliable to consistently form definitive assessments. While we did not examine general or application controls over OPLC information technology systems, we found records within those systems were at times inaccurate, incomplete, and in a few cases, altered. Some records were not held by the State and instead were inappropriately held by a subordinate entity of the Board at a private facility. Consequently, we qualify our use of, and conclusions that rest upon, the incomplete records we obtained.

- Many management controls affecting the Board's operation were undeveloped. Processes and practices were generally undocumented. Descriptions of processes supporting Board operation, including those operated by subordinate entities or the OPLC were at times incomplete, inconsistent, or inaccurate. This led to iterations of investigation intended to uncover actual practices. However, turnover and other factors compromised the reliability of attestations and, consequently, we may not have uncovered all informal practices bearing on our audit objectives.

- In planning the audit, we anticipated assessing control maturity. However, the Board's and the OPLC's operating environments were poorly controlled. We found: 1) responsible agencies did not recognize that many processes and practices required control; 2) where process control was attempted, most controls lacked discernible designs and were undeveloped; and 3) control maturity may have devolved over time in many cases where some form of control had been developed.

# APPENDIX B
# BOARD OF DENTAL EXAMINERS RESPONSE TO AUDIT

State of New Hampshire
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF LICENSING AND BOARD ADMINISTRATION
New Hampshire Board of Dental Examiners
7 Eagle Square, Concord, NH 03301-4980
Phone: 603-271-2152

LINDSEY B. COURTNEY
Executive Director

JOSEPH G. SHOEMAKER
Director

November 7, 2022

This audit was a great opportunity for the board to reassess policies and procedures. The board would like to express its willingness to make changes based on this audit and has already begun to address various issues raised. The board desires for rules and statutes to be congruent. This will be a long process which will not only need multiple meetings to assess and amend but will also require legislative support to achieve. The board is committed to invest the time and energy to achieve positive outcomes. The board plans on prioritizing the changes that directly impact patient care and public safety.

We would like to make you aware that the majority of the current board members were not present on the board during the focus of this audit. This has been a traumatic and discouraging experience for all the board members as the tone set by the auditors was adversarial at best. The formation of OPLC in 2015 was implemented poorly and the constant turnover of staff created loss of much institutional knowledge and continuity. Some data in this report, references a period prior to the formation of OPLC and prior to the tenure of any of the current board members. This fact made the board responses hard to formulate. On many occasions when the board pushed back on some assertions by the auditors, we were told that the evidence said otherwise, yet we were never presented the evidence.

Ad hoc rulemaking is referenced many times in this report, yet the board believes that it had authority to act as it did. It is important to note that the board was not given legal counsel consistently (at times the board was told that due to worker shortages there was not availability). It is also important to understand that due to lack of support it was difficult to acquire legislator willingness to put forth legislative changes to bring rules and statutes into alignment. The time that it takes to institute a statute or rule change can at best take 18-24 months. The practice of dentistry evolves quickly, and the board feels that public safety can not be at times put on hold till bureaucracy catches up. The board hopes that the legislature will keep in mind that the sole mission of the board is to protect the public from harm.

The board requested that criminal background checks become part of the requirements for licensure. The statute change was adopted in 2017, however the board was repeatedly told by OPLC that there was not infrastructure in place to do them. When COVID-19 shutdowns occurred, we were not able to implement them until April 2022. The assertion of the auditors that the board should not have approved licenses until Criminal background checks were available is unrealistic and not in the public's best interest as we already have a dentist shortage.

The rules regarding ASEC are dated as far back as 1990, the board has since been relying on that precedent. As soon as the board was made aware of the problems with the formation and function of ASEC, immediate and comprehensive action was taken, and a complete overhaul of the composition and function of sedation providers is in process.

The auditors also suggest that the Board of Dental Examiners and its associated Committees should not be comprised solely of licensees because of a conflict of interest. While the Board remains cognizant of the importance of public representation, the Board feels strongly that clinical representation should comprise the majority of each Board or Committee. This is necessary to protect the safety of the public as

it is vital that the Board remain up to date on the current trends and issues facing the dental industry, allowing them to proactively address potential risks to the public. Dental professional members on the Board of Dental Examiners are part of the clinical Board process nationally, and it is important that New Hampshire is represented in this process.

The board looks forward to working with OPLC to review and improve licensing application and CE audit procedures. Since the board does not have to rely on DOJ for investigations any longer and can work directly with OPLC, we believe this will provide us the ability to conduct hearings and investigations in a timely manner. Implementing the changes suggested in the audit will require significant resources and time. The board looks forward to this process.

Puneet Kochhar, President

Muhenad Samaan, Vice President

**This section of Appendix B contains lengthy, detailed Board responses and associated LBA rejoinders.**

**Observation No. 2**

**Develop Strategic Management Controls**

*We concur in part with the recommendations.*

1. *We concur in part with the recommendation to develop a risk-based, data-informed strategy and supporting plans in concert with strategic partners and key stakeholders, and incorporate relevant statewide objectives and recommendations into strategic and implementing plans, to help ensure expected outcomes are achieved and related efforts harmonized statewide.*

   *There was definitely no written strategy or operational plans. However, what was always present for all of the dentists and the dental hygienists on the Board was their deep core belief in always adhering to their professional code of ethics for the wellbeing of the public and the patients.*

   **LBA Rejoinder: The Board does not clarify whether, how, and when it will develop a comprehensive strategy and implementing plans to establish effective controls that help ensure it achieves expected outcomes, implements and enforces all of its State policy obligations, avoids extra-jurisdictional and extra-legal acts, preserves individuals' rights, and avoids regulatory capture.**

   *It is impossible for any one dentist or dental hygienist to systematically monitor the dental industry for changes that could affect public health, safety, or welfare, or otherwise affect the Board's regulatory program. The Board's supporting entities should be responsible for making the Board aware of statute and industry change that could affect public health, welfare, and safety.*

   **LBA Rejoinder: The Legislature created the Board and assigned it collective responsibilities. The Board was the agency with the duty to monitor the industry and implement State policy through an effective regulatory program. While others may have had a supporting role to play, the Board was responsible for specifying that role and effectively regulating the industry.**

   *The Board does have a statutory purpose, and its statutory duties are enumerated in* Dentists and Dentistry*, which notably does not include establishing goals, objectives or targets. That being said, having measurable goals and timeline for completion would help the Board evaluate its effectiveness.*

   **LBA Rejoinder: The Board operated in a complex interagency, intergovernmental environment. Its responsibilities were much broader than those enumerated in *Dentists and Dentistry*. Measuring Board performance against established goals, objectives, and**

**targets was integral to understanding Board performance, the effectiveness of its regulatory program, and whether it achieved expected outcomes.**

*The Board does acknowledge that further training to improve communication between the Board and the Office of Professional Licensure and Certification (OPLC) would be valuable. The Board cannot ensure that the supporting agency will execute the Board's strategy and plan without statutory changes. The Board would like to seek legislative changes to make the supporting agency accountable.*

*The Board does directly receive stakeholder feedback during the public portion of its meeting. In addition, all stakeholders have access to the Board through its administrator. Evidence shows the Board had minimum or no support from the supporting agency for the past few years.*

**LBA Rejoinder: The Board should establish a control framework that includes accountability for supporting entity performance.**

2. *We concur with the recommendation to incorporate into the strategy and plans measurable goals, objectives, targets, and timelines for completion, assigning accountability to the Board, our subordinate entities, or support staff for implementation.*

   *It is impossible for any one dentist or dental hygienist to know of every single proposed legislation affecting the Board's operations or the dental industry.*

   *The Board would benefit to establish procedures to identify pending legislation that affects the Board and New Hampshire.*

   *The dentists and dental hygienists are dentists and dental hygienists. It should not be their responsibility to know federal antitrust laws and related U.S. Supreme Court rulings. Not all lawyers know of all federal antitrust laws and related U.S. Supreme Court rulings. Thus, it is very unreasonable and impossible for the members of the Board to know of federal antitrust laws and related U.S. Supreme Court rulings. As stated before, the Board's supporting agency should keep the Board apprised of any legislative changes, which it has recently begun to do.*

   **LBA Rejoinder: Board members became public officials upon their appointment. They became responsible for ensuring the Board achieved expected outcomes and complied with laws, including federal antitrust laws, while doing so. The Department of Justice (DOJ) and OPLC management were aware of federal antitrust laws and related rulings. In calendar year (CY) 2015, the DOJ notified regulatory agencies of a relevant federal ruling affecting them. Annual DOJ training purportedly addressed federal antitrust issues since. However, no relevant Board control was ever devised.**

   **Additionally, federal antitrust risks arose, in part, from the Board's lack of controls to ensure State policy consistently underpinned its actions. Had the Board complied with relevant State laws, some federal antitrust risks might have been avoided.**

**Lastly, our recommendations focus on devising controls to avoid future risk exposures. The Board is now well aware of federal antitrust issues. It has not; however, described how it plans to control this or other risks in the future.**

3. *We concur with the recommendation to ensure subordinate entities and supporting agencies execute the portion of Board strategy and plans for which they have responsibility, to help ensure expected outcomes are achieved.*

   *We acknowledge that the Board needs to establish better communication and collaboration with the OPLC. The Board cannot ensure that the supporting agency will execute the Board's strategy and plan without statutory changes. The Board would like to seek legislative changes to make the supporting agency accountable.*

4. *We concur with the recommendation to incorporate remediation of current audit findings into strategy and supporting plans, and develop, implement, monitor, and refine a resourced, time-phased plan to timely remediate findings.*

5. *We concur with the recommendation to develop performance measures tied to strategic goals and plans, regularly and formally monitor performance, and refine the strategy and plans as warranted.*

6. *We concur with the recommendation to periodically report publicly on performance and attainment of expected outcomes, goals, objectives, and targets.*

**Observation No. 4**

**Control The Board's Statutory, Regulatory, And Procedural Framework**

*We concur with the recommendations.*

1. *We concur with the recommendation to exert control over our statutory, regulatory, and procedural framework.*

   *The Board plans to systematically review statutes on a consistent basis so necessary changes can be implemented as soon as possible. The Board will set a schedule to review the statues and rules to make sure they are harmonious, relevant, clear, and concise.*

2. *We concur with the recommendation to ensure uncontrolled processes and practices upon which the Board and its subordinate entities depend are adequately controlled through comprehensive and clear rules and procedures.*

3. *The Board concurs with the recommendation that it should not engage in "improvised regulation, including overreach and ad hoc rules."*

*However, to the extent that the LBA is asserting that the Board has been and/or is engaged in ad hoc rulemaking, the Board disagrees. The LBA's interpretation of the applicable statutes and rules does not match the Board's interpretation of its practice act and rules. The Board denies that it has engaged in improper regulation, overreach, and ad hoc rulemaking.*

*In order to engage in reviewing and revising the Board's statutes and rules, the time it takes to implement a rule or statute change must be shortened. The Board must always be able to be somewhat flexible during the interim that the rule is in the process of being implemented to protect the public.*

**LBA Rejoinder:**

**We identified over 120 sources of ad hoc rules in the Board's control framework. Some sources contained multiple ad hoc rule requirements. We also identified several instances where the Board knew it applied ad hoc rules.**

**The Board claims it can either comply with law or protect the public. The Board was obligated to do both – complying with law protected the public. Enforcement of ad hoc rules, whether couched as flexibility ostensibly needed in some ambiguous interim period before rule adoption or otherwise, was prohibited.**

*The rules for all three categories of temporary licenses are already adopted, and which abide by statue so there are no ad hoc rules being imposed. There is no legislative action needed to pursue any other types of temporary primary credentials.*

**LBA Rejoinder: Numerous ad hoc requirements were imposed. Furthermore, one primary credential, the Expanded Function Dental Auxiliary (EFDA) permit, and all supplemental credentials were not addressed by temporary license statutes or rules. The Board does not describe why EFDAs should not be eligible for temporary credentialing or why the scope of services covered by supplemental credentials should not be subjected to temporary credentialing requirements.**

*The Board is interpreting and following the applicable statutes and rules with respect to initial, renewal, and reinstatement license applications to ensure timeliness and consistency. To the extent that the Board has imposed any "ad hoc" rules, it will discontinue the imposition of those rules immediately.*

**LBA Rejoinder: The Board asserts it "interprets" its rules. However, rules were already the Board's interpretation. Rules should have been clear and coherent and not have required additional interpretation. Rules requiring clarification or interpretation were not sufficiently detailed and led to ad hoc rulemaking. The Board should have applied its rules in specific cases, not re-interpreted requirements and engaged in ad hoc rulemaking.**

*To the extent that rules need to be revised, the Board is initiating that process.*

Dentists and Dentistry *provides broad authority to the Board to establish and obtain assistance from a committee to provide the Board with information pertaining to general anesthesia and deep sedation.*

*RSA 317-A:4, I(d): Provides statutory authority "To obtain…such other assistance as may be required; to make…arrangements for the performance of administrative and similar services; and to establish compensation therefore through the OPLC"*

*RSA 317-A:4, I(e): Provides statutory authority "To establish fees …for other services"*

*RSA 317-A:12, XII-a: Provides statutory authority for the Board to adopt rules specific to ASEC for credentialing, fees (including for the site inspections and comprehensive evaluations), and required credentials.*

*Rule Den 304 "Use of General Anesthesia and Sedation by Dentists" contains rules pertaining to the specific issues identified in RSA 317-A:12, XII-a.*

**LBA Rejoinder: The Board overreaches. The Board's theory applied would provide no limit to the agencies the Board could create using only rules. The Board purports its own rules provide it authority to create agencies. However, the Board cannot provide itself such authority.**

**a. The Board's theory details no authority to create a regulatory agency or advisory committee. The Board does not have the same amount of authority as the Legislature, and more authority than a departmental commissioner. The Board was not allowed to act beyond its delegated authority. Such actions truncated the separation of powers and encroached on legislative prerogative to set State policy. Without necessary statutory authority, creation of the ASEC and the ASEC Advisory Subcommittee (ASEC-AS) constituted overreach.**

**Power was separated among the three branches of government. The Legislature established State policy, while the Executive Branch implemented and administered State policy. Creation of State agencies was a legislative prerogative. Limited authority was delegated to Executive Branch commissioners to establish advisory committees with approval of the Governor. Even commissioners were not authorized to create agencies to administer programs or functions, or set policy.**

**The ASEC reportedly dated to at least CY 2002. In CY 2009, the Legislature sunset all non-regulatory boards, advisory committees, and similar bodies created by Executive Branch agencies, effective June 2011. Such entities could only be reinstated by the Legislature or Governor. In CY 2011, the Legislature established one entity subordinate to the Board – the DHC – to provide advice to the Board on hygienist-related matters. No other subordinate entities were established by statute or Executive Order.**

**b. The Board's theory cites incorrect authority and ignores common meanings of words.**

**Rules creating the ASEC purported to implement three statutes: RSAs 317-A:12, X; 317-A:12, XIII; and 541-A:16, I(a). None provided the authority claimed.**

- **RSA 317-A:12, X – Before its July 1, 2021, repeal, this required the Board to adopt rules on investigations and adjudicative proceedings. This authority was unrelated to dentist anesthesia and sedation permitting. A requirement to adopt rules on *investigations* and *adjudicative proceedings* was not authorization to *create* an agency or advisory committee.**

- **RSA 317-A:12, XIII – This required the Board to adopt rules on prescribing controlled drugs. This authority was unrelated to dentist anesthesia and sedation permitting. A requirement to adopt rules on *prescribing* drugs was not authorization to *create* an agency or advisory committee.**

- **RSA 541-A:16, I(a) – This required the Board to adopt rules containing a description of its organization and stating the general course and method of its operations. A requirement to adopt rules containing a *description* of its organization and stating the *general course* and *method* of its operations was not authorization to *create* an agency or advisory committee.**

**The Board purports three additional statutes provided it with authority, but which were not cited in rules. None provided the authority claimed.**

- **RSA 317-A:4, I(d) – Before its July 1, 2021, repeal, this allowed the Board to obtain legal counsel, investigators, and other assistance using contracts and arrangements for the performance of administrative and similar services. Authority to obtain *administrative* and *similar services*, was not authorization to *create* an agency or advisory committee.**

- **RSA 317-A:4, I(e) – Before its July 1, 2021, repeal, this allowed the Board to establish fees specifically authorized by statute. Authority to *establish fees*, including dentist anesthesia and sedation permitting fees, was not authorization to *create* an agency or advisory committee.**

- **RSA 317-A:12, XII-a – This required the Board to adopt rules on: 1) the *use* of general anesthesia and sedation, 2) *permitting* requirements, and 3) *practice* requirements. A requirement to adopt rules on dentist anesthesia and sedation *use*, *permitting*, and *practice* was not authorization to *create* an agency or advisory committee.**

**The Board also cites Den 304 as authority. This part of rule operationalizes RSA 317-A:12, XII-a, does not mention the ASEC or ASEC-AS, and does not provide authority for the Board to create a subordinate entity. The rule purports to implement two statutes the Board claimed provide it authority: RSAs 317-A:12, XII-a, and 317-A:20, II. Neither provided the authority claimed.**

- **RSA 317-A:12, XII-a – As discussed above.**

- **RSA 317-A:20, II – This required dentists wishing to administer general anesthesia or deep or moderate sedation to apply for a permit, and allowed the Board to adopt rules on competency and competency maintenance requirements. A requirement to implement dentist anesthesia and sedation *permitting* and *adopt rules* was not authorization to *create* an agency or advisory committee.**

**c. The Board's theory derives, in part, from statutes repealed on July 1, 2021. It is unclear how the Board can justify continuing to operate the ASEC, if statutes the Board purports provided it authority to create the ASEC are no longer in effect.**

**The Board mischaracterizes the role its extra-legal entities. The ASEC and the ASEC-AS did not simply provide information on dentist anesthesia and sedation. The entities actively engaged in direct regulation of applicants and permittees without substantive oversight. Lacking articulated State policy and substantive oversight, the Board, ASEC, and ASEC-AS exposed the State to potential federal antitrust scrutiny.**

*However, the Board does agree that there should be a clear and transparent process and procedure established for all types of anesthesia and sedation permits, including all forms to be required as part of that process. The Board agrees that increased oversight of the ASEC is needed in order to ensure that it remains in compliance with all State statutes and ethics laws, and the Board has already initiated this process.*

*The Board is authorized to make rules regarding procedures that may be assigned to dental assistants. The Board believes that it has done so. The Board disagrees with the characterization of these rules as being extra-legal, informal, or improvised regulation. However, in order to fulfill its duty to protect the public, the Board recognizes that regulating dental assistants may be necessary.*

**<u>LBA Rejoinder</u>: The Board overreaches.**

**Board rulemaking authority was more limited than its response indicates. The Board's statutory authority was limited to adopting rules on the "[p]rocedures which may be assigned by a licensed <u>dentist</u> to…dental assistants…." [emphasis added] However, Board adopted and ad hoc rules went beyond this authority. For example, rules:**

- **defined four types of dental assistants, definitions which were neither reflected in statute nor a procedure a dentist could assign;**
- **established dental assistant qualifications by type, which were not procedures a dentist could assign;**
- **allowed supervision by hygienists, contrary to the statutory limitation that rules could prescribe procedures to be assigned by dentists; and**
- **limited duties based on training and education requirements, requirements it lacked authority to establish.**

**Some rules simply adopted third party standards. The Board never demonstrated its permitting requirements were integral to patient safety. Furthermore, compliance was unmonitored, and the Board could not enforce its standards or remedy dental assistant noncompliance directly.**

4. *We concur with the recommendation to include elements in our strategy and plans to continually ensure statutes reflect the current operating environment, rules interpret and implement statutes, and Board and OPLC procedures operationalize all internal practices without affecting the public.*

   *This will indeed take quite a bit of time to achieve given the time it takes from making a change to a rule (even if it is just to clarify or make the rule clearer) to when the rule goes through all the channels necessary to make the change.*

5. *We concur with the recommendation to simplify the statutory, regulatory, and procedural framework.*

   *Please see the Board's response to Recommendation #1.*

6. *We concur with the recommendation to monitor and refine statute, rules, and internal policies to ensure relevance and accuracy.*

   *The Board plans to design a schedule to systematically review current rules as to their clarity and alignment with statute.*

**Observation No. 25**

**Improve Hygienist Anesthesia And Sedation Permit Controls**

*We concur with the recommendations.*

*We concur with the recommendation to examine the costs and benefits of the local anesthesia and nitrous oxide permit control framework and eliminate the permit requirements if they cannot be objectively demonstrated to contribute to achieving expected outcomes.*

*The ability of a dental hygienist to administer local anesthetic and nitrous oxide minimal sedation in a dental practice can greatly improve the delivery of dental care to the public.*

*Requiring permits for all hygienists and establishing the framework for adequate and necessary continuing education is critical for public safety.*

**LBA Rejoinder: The Board conflates hygienist competency to administer local anesthesia or nitrous oxide minimal sedation being integral to patient safety with requiring a Board permit to perform such procedures. The Board never demonstrated its permitting requirements were integral to patient safety.**

*Active monitoring practices with defined record keeping and performance metrics can demonstrate how permitting contributes to expected outcomes.*

1. *We concur with the recommendation to seek legislative changes to provide the Board statutory authority for requiring the permits.*

   *The Board already has statutory authority to promulgate rules regarding permits. See RSA 317-A:12, XII-b and XII-c; Den 304.06; and Den 302.05(i) through Den 302.05(p). To the extent required, the Board agrees to seek legislative changes to provide the Board statutory authority to require local anesthesia and nitrous oxide sedation permits. The Board agrees to seek the necessary legislative and rule making changes to support revising and updating those rules to better protect public safety.*

   **LBA Rejoinder: The Board overreaches.**

   **a. The Board's theory applied would provide no limit to the credentials the Board could create using only rules. The Board purports its own rules provide it authority to create permitting requirements. However, the Board cannot by rule provide itself such authority. Extra-legal permitting is contrary to statutory protections of an individuals' right to pursue an occupation.**

   **b. The Board's theory details no authority to create a hygienist permit. Imposing credentialing requirements was a Legislative prerogative. The Board was not allowed to act beyond its delegated authority. Such actions truncate the separation of powers and encroach on Legislative prerogative to set State policy.**

   **c. The Board's theory cites incorrect authority for its extra-legal creation of hygienist permits and ignores common meanings of words and phrases.**

      **The Board purports two statutes provided it authority. Only one was purportedly operationalized by the cited rules.**

      - **RSA 317-A:12, XII-b – Cited by rules, this required the Board to adopt rules on procedures which dentists could assign to hygienists. This authority was unrelated to permitting. A requirement to adopt rules on delegation of procedures by dentists was not authorization to create a permitting requirement.**

      - **RSA 317-A:12, XII-c – Not cited by rules, this required the Board to adopt rules on *dentists'* use of minimal anesthesia during the practice of dentistry and related permits. This authority was unrelated to *hygienists*. A requirement to adopt rules on *dentists' use* of minimal anesthesia was not authorization to *create a permit* for *hygienists*.**

      **The Board also purports certain rules provided it authority.**

- **Den 304.06 – Addressed dentists administering minimal sedation. The rule and underpinning statutes exclusively pertained to dentists and were inapplicable to hygienists.**

- **Den 302.05(i)-Den 302.05(p) – Addressed hygienist qualifications in specific areas. Underpinning statues required the Board to adopt rules on: 1) *license* applicant qualifications and 2) duties *dentists* could delegate to hygienists. Neither statute authorized the Board to create permit requirements.**

  - **Den 302.05(i)-302.05(k) addressed *administration* of local anesthesia, which was part of hygienists' scope of practice, including qualifications and the procedures a dentist could assign to a hygienist. The rules also addressed permits and fees without statutory authority.**

  - **Den 302.05(l)-302.05(m) addressed hygienists' *monitoring* of nitrous oxide minimal sedation administration by a dentist and lacked any relationship to hygienist permits.**

  - **Den 302.05(n)-302.05(p) addressed *administration* of nitrous oxide minimal sedation, part of hygienists' statutory scope of practice, including training, a qualifying examination, and the procedures a dentist could assign to a hygienist. They also addressed permits and fees without statutory authority.**

**Rules also purported to implement three additional statutes, none of which authorized hygienists' permits.**

- **RSA 317-A:12, III – This required the Board to adopt rules on qualifications applicants applying for licensure or other statutory privileges had to meet. Statute provided for neither a hygienist local anesthesia permit nor a nitrous oxide minimal sedation permit.**

- **RSA 317-A:12, XII-a – This required the Board to adopt rules on dentists' use of general anesthesia, deep sedation, and moderate sedation, and on permits for dentists. This authority was unrelated to hygienists.**

- **RSA 317-A:20, II – This defined the practice of dentistry, including dentists' administration of general anesthesia, deep sedation, or moderate sedation, and permits. This authority was unrelated to hygienists.**

**d. Lacking articulated State policy, the Board exposed the State to potential federal antitrust scrutiny. Permitting requirements were imposed by the Board, which was controlled by active market participants. The Board lacked an authorizing State policy. There was essentially no State oversight of the Board's extra-legal decision to**

**impose permitting requirements, and no procedure provided for a veto of the Board's decision to ensure the Board conformed to State policy.**

2. *We concur with the recommendation to discontinue imposition of ad hoc rule requirements.*

   *Please see our response to Observation No. 4.*

3. *We concur with the recommendation to follow rules and discontinue requiring permits for hygienists who were determined qualified to administer nitrous oxide prior to January 2018, or change rules.*

   *The Board recognizes the need to re-examine the rules prior to and after CY 2018 and revise them for consistency.*

4. *We concur with the recommendation to revise rules to require permitting for hygienists qualified in local anesthesia.*

5. *We concur with the recommendation to actively oversee local anesthesia and nitrous oxide credentialing processes and ensure OPLC practices conform to statute and rules.*

   *The Board recognizes that more Board oversight is necessary. The Board is in the process of revising procedures and rules to address this issue. The Board will work with OPLC management to ensure conformity with all applicable statutes and rules.*

6. *We concur with the recommendation to approve applications and ensure an auditable record is created.*

   *The Board will review and revise recordkeeping protocols for accuracy.*

7. *We concur with the recommendation to implement requirements for licensees to maintain qualifications and permits, including continuing education standards.*

   *The Board considers this recommendation to be a high priority and critical for public safety.*

8. *We concur with the recommendation to establish monitoring practices to ensure compliance with requirements, including through continuing education audits.*

   *The Board intends to collaborate with the OPLC to increase monitoring efforts by auditing renewal applications and maintaining accurate records.*

9. *We concur with the recommendation to establish performance goals, objectives, and targets to demonstrate how permitting contributes to achieving expected outcomes.*

   *This area needs to be developed and will certainly demonstrate the effectiveness of licensing and permitting of dental hygienists for the administration of local anesthesia and nitrous oxide sedation in the delivery of dental care.*

10. *We concur with the recommendation to establish data requirements and reporting frequencies on performance metrics*

    *This area needs to be developed and will certainly demonstrate the effectiveness of licensing and permitting of dental hygienists for the administration of local anesthesia and nitrous oxide sedation in the delivery of dental care.*

**Observation No. 26**

**Improve Certified Public Health Dental Hygienist Controls**

*We concur with the recommendations.*

*We concur with the recommendation the Board examine the costs and benefits of certification. The Board believes that Certified Public Health Dental Hygienists (CPHDH) provide a vital function in institutions and to underserved segments of the population thereby significantly improving the overall dental health and hygiene of the public.*

1. *We concur with the recommendation to actively oversee the initial and renewal certification process, monitor certificate practice, and ensure OPLC practices conform to statue and rules.*

2. *We concur with the recommendation to discontinue imposition of ad hoc rule requirements.*

   *Please see our response to Observation No. 4.*

3. *We concur with the recommendation to seek statutory changes to accommodate procedures created by rules or practice that are objectively determined to produce benefits and result in sufficiently controlled practice.*

4. *We concur with the recommendation to ensure delegations of renewal license processing responsibilities conform with statute.*

5. *We concur with the recommendation to conduct substantive review of, and approve, applications.*

6. *We concur with the recommendation to revise rules to reflect statutory authority and requirements, structure the complete lifecycle of the credential, require continuing education, and comprehensively, clearly, and consistently reflect all requirements and procedures binding on the public.*

7. *We concur with the recommendation to determine which CPHDHs are practicing with or without a collaborative agreement, and ensure they comply with the laws and rules.*

8. *We concur with the recommendation to ensure maintenance of a complete record of all decisions and actions on each application and certificate.*

*The OPLC currently performs this administrative function for the Board.*

9. *We concur with the recommendation to develop, implement, monitor, and refine goals, objectives, and targets tied to expected outcomes.*

10. *We concur with the recommendation to establish information requirements and reporting frequencies to facilitate oversight.*

11. *We concur with the recommendation to demonstrate the credential contributes to achieving expected outcome.*

    *The Board will evaluate data and if the expected outcome is not achieved then will deliberate the need for the credential.*

12. *We concur with the recommendation to formalize the terms and conditions of the Board's relationship with the OPLC.*

    *However, as previously stated and arguably more important is that the Board is collaborating with the OPLC to implement improved processes and procedures to ensure that the necessary functions of the Board are administratively supported by the OPLC.*

**Observation No. 27**

**Rationalize Regulation Of Dental Assistants**

*We concur in part with the recommendations.*

1. *We concur with the recommendation to ensure regulation of dental assistants conforms to the limits of our statutory authority, and discontinue extra-legal, informal, and improvised regulation of dental assistants and dental assisting education and training programs.*

   *Please see our response to Observation No. 4.*

2. *We do not concur with the recommendation to revise rules to limit their scope to that which is authorized by statute.*

   *The Board disagrees with the findings. The applicable rules do not exceed the scope that is authorized by the applicable statute.*

   *Please see our response to Observation No. 4.*

3. *We concur in part with the recommendation to objectively establish the potential risks posed by dental assistants and revise rules to mitigate risks, changing supervision or other requirements to ensure risks are sufficiently controlled, and attenuate jurisprudence examination requirements and outreach efforts to ensure the dental care industry is aware of the regulatory requirements governing dental assistants.*

*To the extent the Board determines regulation of dental assistants is necessary, it will be actively engaged in revising existing rules and making new rules as necessary.*

**LBA Rejoinder: The Board lacked statutory authority to regulate dental assistants.**

4. *We concur with the recommendation to harmonize regulation of dental assistants with the Board of Registration of Medical Technicians (BoRMT) and the Board of Medical Imaging and Radiation Therapy (BoMIRT), clarifying that third-party certified dental assistants are not credentialed by the Board and those DAs are not exempt from BoRMT or BoMIRT regulation, and formalize interagency relationships via written agreement to ensure proper monitoring.*

   *The regulation of dental assistants by the BoRMT was not coordinated with the Board. The requirements of dental assistants with access to controlled substances only pertains to dental assistants who work in an oral surgery office. Most dental assistants work in general dental offices and do not have access to controlled substances, which means they would not be required to register with the BoRMT.*

   *As far as dental assistants being credentialed by the BoMIRT, dental assistants do not perform medical imaging that would be consistent with that certification and they do not perform radiation therapy. That credential was also not coordinated with the Board.*

   *The Board is in the process of doing risk assessment for registering dental assistants, if the Board feels registering the dental assistants will protect the public then it will seek statutory changes to create that credential.*

   *To the extent the existing rules need to be revised, the Board will work with the relevant regulatory agencies to ensure consistency.*

5. *We do not concur with the recommendation to ensure all licensees are aware of their obligations to employ only BoRMT-registered dental assistants if they meet the criteria for credentialing by that agency, are aware of BoMIRT licensing requirements if the dental assistants they employ meet the criteria for licensing by that agency, and develop oversight controls to ensure Board licensees comply with all statutory and rule-based requirements.*

   *The Board's current statutes and rules, as referred to in the response to #1, state the duties a dental assistant may perform and establish the requisite supervision from either a hygienist or a dentist. These rules make clear the licensees' obligations regarding employing dental assistants.*

   **LBA Rejoinder: Statute required individuals performing medical imaging to be licensed by the BoMIRT. The dental assistant scope of practice specified in Board rules encompassed the services regulated by the BoMIRT. Dental assistants could only be exempted from BoMIRT licensure if they were: 1) licensed or certified by the Board and 2) supervised by a licensed dentist. The Board neither licensed nor certified dental assistants, and improperly allowed hygienists to supervise dental assistants.**

**Board rules did not make clear licensees' obligations on employing dental assistants compliant with BoMIRT or BoRMT regulations. Employing or allowing an unlicensed person to practice in a licensee's office was sanctionable misconduct.**

6. *We concur with the recommendation to develop, implement, monitor, and refine goals, objectives, and targets to help demonstrate how our regulation of dental assistants contributes to achieving expected outcomes.*

**Observation No. 28**

**Improve Applicant And Regulatee Monitoring Controls**

*We concur in part with the recommendations.*

1. *We concur with the recommendation to develop a cohesive, evidence- and risk-based monitoring strategy and supporting plans, compliant with statute and rules, and incorporate input from other regulatory agencies and stakeholders.*

   *The Board will work with the OPLC to make sure that all rules conform to statutes and seek legislative changes and rulemaking as needed. Certain aspects of monitoring, for instance investigations, were previously performed by the APU and are currently conducted by the Enforcement Division of OPLC.*

   *The Board relies on those agencies to conduct the investigations, consider past complaints against the licensee and report back with recommendations to the Board. The Board has no control over the availability of resources to these entities, which likely affects their ability to provide the results of investigations to the Board in a timely manner.*

2. *We concur with the recommendation to review entry, practice, and competency maintenance requirements to determine the minimum level and frequency of monitoring necessary to achieve expected outcomes, and develop and implement cost-effective monitoring controls.*

   *Certain events cannot be monitored unless reported to the Board, such as patient mortality, inappropriate delegation of procedures to auxiliaries, noncompliance with other ethical and practice requirements which did not directly relate to public health, and substance abuse.*

3. *We concur in part with the recommendation to ensure all available information is used to inform monitoring efforts and identify patterns of noncompliance.*

   *The Board has been advised that decisions have to be made based on the complaint in front of the Board and that considering past complaints against a licensee may be interpreted as creating bias.*

*The Board does see information from all available sources that is provided to the Board. It does review all information received from other sources, but some information received from other sources has no licensee identifying information, thereby rendering it useless. Some entities, for example the Prescription Drug Monitoring Program, only release information for very specific reasons. For instance, if the Board is investigating a licensee the Prescription Drug Monitoring Program does not release information regarding other licensees registering to the Board on a monthly basis.*

**LBA Rejoinder: The Board was required to consider previous licensee or applicant behavior, including patterns of misbehavior and repeated negligence. It did not do so consistently. Additionally, Board practice during the audit period included issuing letters of concern. These letters were explicitly intended to advise recipients of behavior that could constitute a pattern of noncompliance should it continue and warn them of potential future sanctions. This practice was authorized by statute after the audit period. Lastly, the Board did not act to ensure it received required Prescription Drug Monitoring Program reports or necessary monitoring information from other sources. Instead, it passively waited to receive needed information.**

4. *We concur with the recommendation to ensure monitoring requirements are clearly specified and consistently applied.*

   *The Board monitors licensees through the licensing process at renewal and through complaint and disciplinary process when it receives a complaint or becomes aware of a potential violation. To the extent possible, the Board will work with OPLC to make sure that rules regarding licensing and monitoring of licenses are clearly specified and applied consistently and appropriately. The Board is considering increasing the sample size for the continuing education audits and getting National Practitioner Data Bank (NPDB) queries at the time of license renewal for all licensees.*

5. *We concur with the recommendation to identify information necessary to inform monitoring, establish information requirements for the OPLC, and ensure reliable information is timely collected and reported.*

   *While the Board will work with the OPLC on this, the collection, maintenance and provision of data that is collected by the OPLC in a timely manner to the Board is the responsibility of the OPLC.*

   *Board rules make it clear for the licensees regarding monitoring.*

6. *We concur with the recommendation to routinely review and refine strategy, plans, and controls to identify changes needed to ensure monitoring is effective and helps achieve expected outcomes.*

7. *We concur with the recommendation to delegate ministerial duties to the OPLC via rules, and discontinue delegation of discretionary Board duties.*

8. *We concur with the recommendation to coordinate regulations with other boards and programs with concurrent jurisdiction.*

   *The Board will work to involve other boards when there are matters involving concurrent jurisdiction. The Board will work to identify such issues and seek input while pursuing legislation or rule making.*

**Observation No. 29**

**Improve Verification Of Compliance With Character And Conduct Requirements**

*We concur in part with the recommendations.*

1. *We concur in part with the recommendation to discontinue relying on attestations and independently verify applicant and credential holder compliance with conduct and character requirements.*

   *It is not possible for the Board to independently verify, at the time of renewal, each licensees' compliance of conduct and character requirements.*

   *Attestation is required by all individuals applying for initial licensure and renewing their dental and dental hygienist licenses per Board rules. The Board is utilizing the AADB Clearinghouse to verify the applicant conduct requirement. Going forward, we will be checking the NPBD. As a matter of fact, the OPLC is now providing the Board with NPBD reports for initial applicants.*

   **LBA Rejoinder: The Board was required to make a positive finding each applicant was qualified and no circumstances which would be grounds for disciplinary action existed before issuing a credential – the Board had to verify applicants' qualifications. However, the Board took little to no action to verify any self-reported attestations on character and conduct were valid. The Board did not ensure staff queried the limited AADB Clearinghouse for all initial license applications. None of the 2,906 renewal applications processed during the audit period had an AADB query.**

2. *We do not concur with the recommendation to remedy defective licenses approved without required criminal history records checks.*

   Dentists and Dentistry *provides for a criminal history records check, which is part of the licensure process. For initial licensure, the criminal background check was put into place in 2018 but was never instituted by the OPLC. The Board checked with OPLC multiple times about the status of the background check, but nothing was done. It is impossible to go back four years and reissue those licenses. All of those licenses would have had their second renewal cycle by now. There was no statutory requirement for a criminal background check at the time of license renewal. Therefore, the Board cannot go back four years and have those licensees now go through a criminal background check.*

*The Board acknowledges that during the audit period some criminal history records checks were not performed due to the extraordinary circumstances created by the COVID-19 pandemic.*

*The Board does not agree that these licenses are defective and there is no authority to "remedy defective licenses."*

**LBA Rejoinder: Either conducting the required checks was essential to public protection, and all checks should have been conducted as required, or the Board should have requested statutory changes to remove the requirement. The Board could not have unilaterally waived this requirement. All 430 initial regular licenses issued during the 34-month period between August 2018 and June 2021 lacked required criminal history record checks. This period preceded, encompassed, and followed the 15-month long state of emergency. These licenses did not meet statutory requirements for issuance.**

3. *We concur with the recommendation to seek legislative changes to ensure all primary credentials are required to undergo criminal history records checks.*

4. *We concur with the recommendation to adopt rules on criminal history records checks.*

   *The Board is in favor of beginning the process to adopt those rules changes to mirror* Dentists and Dentistry.

5. *We concur with the recommendation to ensure rules contain all character and conduct requirements for all primary credentials.*

   *The Board is in favor of adopting those rules changes.*

6. *We do not concur with the recommendation to establish procedures to ensure all conduct and character requirements are verified, such as by periodically auditing credentialed practitioners' compliance.*

   *All licensees are required to inform the Board of any misconduct within a reasonable period of time, all renewal applications require attestation of the applications, and the reports from the NPDB.*

   **LBA Rejoinder: The Board lacked comprehensive oversight of credentialing and monitoring processes. Its response presupposes universal compliance with requirements. However, the Board could not determine whether licensees: 1) *timely* reported sanctions or 2) reported sanctions *at all*. We found not all licensees informed the Board of misconduct, or did so within the required timeframe. We also found the Board inconsistently handled such cases, and credentials for ineligible licensees were inappropriately renewed.**

   - **One applicant reported misconduct on a renewal application *eight months* after being sanctioned in another jurisdiction. However, the Board did not recognize**

**the noncompliance until a month later, never sanctioned the licensee for late reporting, and nonetheless approved license renewal with no limitation.**

- **Another applicant reported misconduct on a renewal application *nine months* after being sanctioned in another jurisdiction. Although ineligible, staff nonetheless inappropriately issued a renewed license, without Board oversight. The Board did not identify the late misconduct reporting until eight months after license renewal, and only identified it because another jurisdiction provided the Board relevant information. The licensee was never sanctioned.**

**Additionally, the Board could not have verified whether dentists reported adverse events as required – the NPDB had no role in Board credentialing processes until February 2022.**

7. *We concur with the recommendation to delegate nondiscretionary tasks to the OPLC, and reserve all discretionary tasks for Board action.*

   *Both the OPLC and the Board should be on the same page of delegating those tasks.*

8. *We concur with the recommendation to establish information requirements for OPLC staff to enable Board monitoring of performance.*

   *While the Board does not have the authority or responsibility to oversee and monitor the OPLC's performance, the Board is aware that it needs to collaborate with OPLC and can request information from OPLC to ensure that licensing requirements are being properly followed. The Board may need legislative changes to hold the OPLC accountable.*

9. *We concur with the recommendation to broaden third-party verifications of attestations, such as by reintroducing regular use of NPDB queries.*

   *The Board has been utilizing the NDPB since February 2022 to verify applicant and credential holder compliance.*

**Observation No. 33**

**Improve Complaint Management Controls**

*We concur with the recommendations.*

1. *We concur with the recommendation that we should not engage in inappropriate delegation of authority.*

   *However, we disagree with some of the findings. During the audit period, the Board had statutory authority to:*

   *a. obtain legal counsel, investigators, and other such assistance as may be required;*

*b. retain legal counsel, dental advisors or other investigators to assist with investigations and adjudicatory hearings; and*
*c. commence investigations or an adjudicatory hearing on its own motion, choose the type of procedure, and conduct investigations on an ex parte basis.*

*Furthermore, standing orders did not improperly delegate discretionary responsibilities. Instead, they informed the OPLC of the specific non-discretionary tasks the Board wanted either the Enforcement Division or administrative staff to perform.*

**LBA Rejoinder: The Board held sole discretionary authority to commence an investigation or adjudicatory hearing, and other related responsibilities, both during and after the audit period. While the Board could obtain investigatory and hearing assistance during the audit period, it did not – and does not – have authority to delegate its discretionary authority to individual members, staff, or others. We found the Board inappropriately delegated issuing subpoenas, extending complaint response times, requiring licensees respond to complaints, and extending the time to respond to complaints.**

*Nevertheless, the Board acknowledges that a review of this process would be beneficial and will undertake to do so. The Board notes that to do so will require legal support and assistance with rulemaking, since contrary to the audit's assertion not all Board members received Board orientation and/or OPLC training regarding limitation of authority.*

**LBA Rejoinder: Board orientation materials were reportedly provided to each new member. These materials acknowledged discretionary authority could not be delegated.**

2. *We concur with the recommendation to determine administrative needs to effectively manage complaints, establish expectations of support services, and formalize service-level and performance expectations in an agreement with the OPLC.*

   *The Board notes that a number of these needs have been the subject of discussions between Board members and prior OPLC executive management with assurances of support. The Board hopes that these needs no longer become "irrelevant" as happened with previously implemented controls as described in the audit report.*

3. *We concur that monitoring complaint processing to ensure substantive and procedural consistency and timeliness is necessary.*

   *The Board also recommends that a formal chart showing the specific complaints and their status be included with each Board meeting agenda so that complaints do not fall through the bureaucratic cracks.*

4. *We concur that a process should be developed to monitor patterns of potentially non-compliant behavior and are in agreement that any history of prior complaints, including how they were resolved, should be provided to the Board at the appropriate time.*

*By way of explanation, the Board is ultimately the neutral body that will conduct a full and fair hearing and make decisions regarding what, if any, discipline is appropriate for each complaint. The Board currently receives notice of a licensee's disciplinary history in the report of investigation, including legal analysis regarding whether there is a legal basis and evidence to support a pattern of non-compliant behavior that would constitute misconduct pursuant to* Dentists and Dentistry.

*There is no identified statutory or legal support for the LBA's suggestion that the Board should proactively monitor "patterns of potentially non-compliant behavior." The Board does not have authority to randomly and proactively monitor licensees' practice without a complaint.*

*The Board also concurs with the recommendation of incorporating procedures and criteria for addressing non-compliant behavior based on patterns established within the statute of limitations.*

*The Board currently engages in this process when it reviews and discusses the report of investigation that is provided by the OPLC's Enforcement Division, after the investigation is completed.*

**LBA Rejoinder: We recommend the Board develop processes to monitor for and establish patterns of potentially noncompliant behavior. It should incorporate procedures and set criteria for addressing noncompliant behavior based on patterns established within the statute of limitations. This reflects the *requirement* the Board monitor patterns of potentially noncompliant behavior. It had authority to undertake proceedings to determine applicant qualifications on its own initiative, impose specific credentialing and renewal requirements, and monitor patterns of potential misbehavior and repeated negligence. Additionally, complaints were to be retained for ten years, or longer if they were part of a developing pattern of misbehavior that might constitute professional misconduct, and non-disciplinary letters of concern were used to establish a pattern of licensee noncompliance. These authorities and requirements were inherently proactive.**

5. *We concur that all complaint history should be included into the report provided to Board for consideration when reviewing potential credential holder noncompliance.*

6. *We concur that rules to address inconsistencies including all credential holders should be adopted.*

   *These rules may not be of the same priority as other audit recommendations.*

7. *We concur with the recommendation to discontinue dismissing reports of adverse events as though they were unfounded complaints.*

8. *We concur with the recommendation to discontinue issuing letters of concern for purposes beyond what current statute allows, as revised legislation has become effective and revised rules are adopted.*

9. *We concur with the concept of monitoring performance and demonstrating that expected outcomes are being achieved regarding the processing and timeliness of addressing complaints.*

   *The Board will collaborate with OPLC enforcement and administrative staff to address this issue.*

## APPENDIX C
## OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION RESPONSE TO AUDIT

**State of New Hampshire**
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
7 Eagle Square, Suite 200
Concord, N.H. 03301
Telephone 603-271-2152 · Fax 603-271-0597

LINDSEY B. COURTNEY
Executive Director

November 8, 2022

Stephen C. Smith, MS, CPA
Director of Audits
Legislative Budget Assistant
107 North Main Street
State House, Room 102
Concord, NH 03301

**RE: Performance Audit**
**Board of Dental Examiners**

Dear Director Smith:

Thank you for the opportunity to respond to the recommendations set forth in the audit report for the Board of Dental Examiners ("Board"). The Office of Professional Licensure and Certification ("OPLC") appreciates the work of the Office of Legislative Budget Assistant, Audit Division, in reviewing the operations of the OPLC as it relates to this Board.

OPLC concurs with all the audit's observations and has already begun a systematic review and analysis of OPLC operations to align with the recommendations in the audit. OPLC's efforts are reflected in its current strategic plan and include, among other things, establishing the position of Internal Controls Administrator to assist in remediating the findings of this and prior audits. Additionally, OPLC is currently inventorying all board statutory and regulatory requirements and creating policies and procedures compliant with the law. OPLC collaborated with the Department of Information Technology (DOIT) to obtain funding under the American Rescue Plan Act to procure a new licensing portal that will meet OPLC's needs. Recently, OPLC conducted an analysis of its available licensing data to assess personnel requirements and added additional personnel, where necessary. While the audit focused on one Board, the issues identified in the audit are issues that span all boards, and therefore, OPLC's work to remediate these audit findings will likely take several years.

Although there are many contributing factors to the issues identified in the audit, one understated factor is the independent nature of the boards prior to the creation of OPLC. This lack of oversight resulted in the fiefdom culture of many licensing boards. This culture did not change

overnight in 2015 when OPLC was created and continues to persist today. Although OPLC's regulatory authority is quite limited, any exercise of that authority has been typically met with resistance—not just by some licensing boards, but by external stakeholders, as well. The audit recommendations primarily concern changes in processes—however, OPLC believes cultural changes are also necessary. The State would benefit from a clear pronouncement of legislative policy concerning the expected relationship between the boards and OPLC. The State would also benefit from expanding the scope of OPLC's authority to include an oversight role.

OPLC looks forward to continuing its work to significantly improve office operations. OPLC commends the auditors for their thorough review of the OPLC and the Board throughout the audit process.

Respectfully submitted,

Lindsey B. Courtney
Executive Director
Office of Professional Licensure & Certification

**This section of Appendix C contains a lengthy, detailed OPLC response.**

**Observation No. 14**

**Improve Office Of Professional Licensure And Certification Performance And Customer Service Controls**

*The OPLC concurs with the recommendations.*

*The OPLC's plans to address the recommendations are as follows:*

1. *Identify all customers and what they require.*

   *One of the OPLC's goals within its strategic plan for State fiscal years (SFY) 2023–2025 is to enhance customer service. To do so, the OPLC must necessarily identify all its customers and what they require. The OPLC will be working to accomplish this task as part of its inventory of assigned agency requirements*.

2. *Inventory assigned agency and subordinate entity processes and support requirements.*

   *The OPLC's inventory of assigned agency statutory requirements will include an inventory of current processes and support requirements, including knowledge management support needs.*

   *The OPLC is currently working to establish internal controls. The OPLC Director of Finance, Executive Director, and General Counsel meet at least weekly to conduct an inventory of all statutes for all assigned agencies and the OPLC, utilizing the recommendations and tools provided by the Department of Administrative Services. Once statutory directives are identified, the OPLC will be seeking to support its assigned agencies to ensure that all necessary rules have been promulgated. OPLC is presently considering releasing a request for proposal to contract for support in assisting the boards redraft all rules. Thereafter, it will adopt policies and procedures. While establishing internal controls, the OPLC will be conducting an inventory of all tasks performed by assigned agencies and the OPLC. To the extent there is support not capable of being provided by the OPLC, the OPLC will work with the Board to seek the necessary support through contracts.*

   *The OPLC has established temporary attorney positions to assist with inventorying statutes and promulgating rules; however, two positions remain unfilled. Even with such support, the OPLC anticipates that this process will likely exceed one year.*

3. *Develop, implement, monitor, and refine a customer-centric strategy and plan, including developing goals, objectives, and targets, to help ensure business processing, administrative, and clerical support is effective and efficient.*

   *The OPLC has finalized a strategic plan. One of the primary objectives is to enhance customer service by enabling customer self-service, reducing licensure timeframes, decrease customer service response times, develop and implement a communications strategy. Additionally, through the OPLC's efforts to establish internal controls throughout the agency, the OPLC is*

*inventorying all statutory and regulatory requirements to determine what boards require for assistance, among other needs. The OPLC will be monitoring its performance utilizing its performance measure and making necessary revisions to ensure its business processing, administrative, and clerical support is effective and efficient.*

4. *Develop, implement, monitor, and refine agreements between assigned agencies and other support agencies, for services the OPLC does not directly provide.*

   *As noted, the OPLC is currently conducting an inventory of assigned agencies' statutory requirements, which includes an inventory of necessary services. The OPLC is finalizing a memorandum of understanding to set forth what services the OPLC can provide to its assigned agencies and is working with its assigned agencies to procure the services that the OPLC does not provide.*

5. *Support contracting for assigned agency-specific services not accommodated in OPLC rules detailing assigned agency support procedures.*

   *The OPLC does support contracting for Board-specific services. Specific to the Board, the OPLC recommended at the beginning of the audit, that the Board release a request for proposal to seek inspectional services. The Board declined the OPLC's assistance in doing so at that time. With the Board's support, the OPLC released a request for proposal in early calendar year (CY) 2022. The OPLC is currently finalizing the procurement of inspections services and anticipates contracts to be in place in Fall 2022. The OPLC has also sought to contract for services to administer the Board's jurisprudence examination.*

6. *Develop, implement, monitor, and refine compliant and comprehensive procedures addressing all support functions, codifying performance benchmarks and expectations, and formally and routinely communicating minimum service expectations.*

   *Developing compliant policy and procedure directives are an integral part of establishing internal controls, which is part of OPLC's initiatives.*

   *In February 2020, the OPLC began working with the Department of Justice (DOJ) on a project to draft and implement procedures consistent with statute and rules. That project was temporarily placed on hold in Spring 2020, due to the need to shift resources because of the coronavirus disease 2019 (COVID-19) and the OPLC's unexpected physical relocation. The OPLC has re-started this project, which consists of several phases: 1) conducting an inventory of all statutes and rules; 2) promulgating rules for the OPLC that are statutorily required and assisting assigned agencies with required rulemaking; 3) drafting policies and procedures consistent with statute and rules, including codifying permanent expectations and benchmarks. The OPLC anticipates the initial work will be completed by the end of SFY 2025. The OPLC's expectation is that procedure drafting and revision will be ongoing once initial procedures are in place.*

7. *Develop, implement, monitor, and refine a performance management system, including a system to routinely measure and monitor all support services provided, collect customer feedback, and help ensure accountability.*

*Once procedures are in place to establish performance benchmarks and expectations, the OPLC will develop a system to routinely measure and monitor services provided, as well as collect customer feedback.*

*The OPLC is conducting an inventory of all assigned agency functions. Once all functions and statutory requirements are identified, the OPLC will be able to assess whether staff support for each assigned agency is sufficient.*

*As part of its strategic plan for SFYs 2023–2025, the OPLC is working to develop processing goals, objectives, and targets, which should be completed by end of SFY 2023. The OPLC has, through the Department of Information Technology, requested and received funding under the* American Rescue Plan *to procure a new credentialing database management system, which will enable the OPLC to track performance metrics. The OPLC is working with the Department of Information Technology to procure a credentialing database management system and is hopeful that such a system will be in place in SFY 2024. Thereafter, the OPLC will be able to monitor, measure, and routinely report on licensing performance.*

8. *Develop, implement, monitor, and refine a data-based, objective model for workload and staffing allocations based in part on levels of service required and true cost of services, and ensure resources are allocated efficiently and effectively and achieve expected outcomes.*

   *The OPLC recognizes the need to assess and document the time staff spend on support activities for assigned agencies and is working with the Department of Information Technology on potential technological solutions that may capture and report, in detail, staff time and workload.*

   *After the OPLC has completed an inventory of all assigned agency requirements and services and has accurately captured staff activity, it will work to develop a data-based, objective model for workload and staffing allocations. The OPLC sought to create a legislative study committee in SFY 2022 (through Senate Bill 330) to help determine how costs should be allocated within the OPLC. Additionally, OPLC plans to release a request for proposal in Fall 2022 to procure consultants to develop a proposal for cost allocations.*

9. *Routinely report to assigned agencies, the Legislature, and the public on the performance of all support functions and attainment of expected outcomes, goals, objectives, and targets, including consistency, timeliness, and compliance.*

   *Once the OPLC has established the requisite performance goals, objectives and targets, it will report to assigned agencies, the Legislature and the public regarding its attainment of such goals to ensure transparency and accountability.*

   *To monitor and report on performance as it relates to licensing, the OPLC requires a new electronic credentialing database management system that can provide reports. The OPLC is working with the Department of Information Technology to procure a new system, which should be in place sometime in SFY 2024.*

*As noted above, the OPLC has developed a strategic plan, which includes goals, objectives, and performance measures to demonstrate performance across the OPLC. The OPLC anticipates being able to monitor progress and report on progress on a quarterly basis in SFY 2024 and beyond.*

*We further recommend OPLC management improve the effectiveness and efficiency of business processing, administrative, and clerical support.*

*The OPLC is working diligently to improve the efficiency of its tasks, through streamlining requirements (seeking statutory changes as necessary), evaluating workflow, leveraging technology, and training staff, among other things. The OPLC is also working to establish internal controls throughout the OPLC to ensure compliance with statute and rules. After conducting an inventory of all requirements, the OPLC will be able to identify areas that are appropriate to standardize, which may assist with improving efficiencies throughout the agency.*

10. *Ensure business process support complies with statute, OPLC and assigned agencies' rules, and other requirements.*

    *The OPLC is currently conducting an inventory of all OPLC and assigned agency statutory requirements. As part of the OPLC's strategic plan for SFYs 2023–2025, the OPLC is seeking to establish internal controls on behalf of the OPLC, and work with the Board to establish internal controls. The OPLC recently reclassified a vacant position to establish the position of Internal Control and Contract Administrator. This position was filled in June 2022. The position will assist the OPLC in establishing internal controls for the assigned agencies and OPLC to ensure compliance with statutory and regulatory requirements, which will necessarily include developing comprehensive policies and procedures compliant with statutes and rules to ensure practice conforms to statute, rules, and internal requirements.*

11. *Ensure the public has convenient access to all conditions and limitations on credentials and all actions taken to regulate the profession.*

    *The OPLC is working to procure a new credentialing database management system that will be user-friendly and allow easy access to publicly available information. While the OPLC has been challenged by its lack of control over procurement of a new system, the OPLC is hopeful that the customer side of this system to be available in SFY 2023.*

    *The OPLC is promulgating its own rules, which will include rules as to what information is available regarding licensees. The OPLC will then be drafting procedures to implement these rules across the OPLC.*

    *As noted, the OPLC's data is unreliable. Once requirements are established and the OPLC has developed internal controls, it will be able to ensure that all data is reliable after a certain date and all data that must be available to the public is provided to the public in a convenient method.*

12. *Standardize practice for similar administrative and clerical functions across assigned agencies, where practicable.*

*After conducting an inventory of all requirements, the OPLC will be able to identify administrative and clerical areas that are appropriate to standardize, which may assist with improving efficiencies throughout the agency. OPLC will document these functions in policies and procedures.*

13. *Assist assigned agencies in complying with statute, rules, and other requirements by synchronizing its administrative, clerical, and business processing control framework with those of assigned agencies, improving member orientation to help ensure new members adequately understand their roles and responsibilities, and monitoring compliance.*

    *As part of the OPLC's strategic plan for SFY 2023–2025, one of its strategic initiatives is to develop a new member orientation. The OPLC is not able to require assigned agency members complete such orientation and, based on past experiences, is concerned that some assigned agency members may decline to participate.*

    *In addition to establishing internal controls, which necessarily includes creating mechanisms to ensure compliance with statutory and other regulatory requirements, the OPLC has provided dedicated legal support to the Board, through the DOJ, since CY 2021.*

14. *Facilitate assigned agency rulemaking through necessary supervision, coordination, and assistance, and determine how rulemaking support can help mitigate the potential for federal antitrust risk scrutiny.*

    *OPLC concurs with this recommendation.*

    *The OPLC has ongoing concerns regarding the potential for federal antitrust risk scrutiny and is working with the DOJ to determine how to mitigate this risk, including through rulemaking support.*

    *The OPLC presently monitors the expiration dates of rules and notifies its assigned agencies of the same. Additionally, the OPLC is conducting an inventory of all assigned agency statutes to determine whether additional rulemaking by assigned agencies must occur. Upon making such determinations, the OPLC will notify the assigned agencies, if necessary, and aid the assigned agencies with its rulemaking efforts.*

    *The OPLC already facilitates assigned agency rulemaking through its Legal Unit. The OPLC's rulemaking assistance consists of drafting rules, providing legal guidance regarding rulemaking, filing rules, tracking rules, facilitating public hearings, and attending hearings before Joint Legislative Committee on Administrative Rules on behalf of the assigned agencies. The OPLC is working on a draft memorandum of understanding to present to the assigned agencies to clarify its rulemaking support and to establish clear expectations between the OPLC and its assigned agencies.*

    *Despite OPLC's support, the OPLC is challenged by the volume of rulemaking requests from boards, and the limited resources available at the agency. Given the number of assigned*

*agencies that require rulemaking assistance, the OPLC plans to issue a request for proposal to procure legal services, so that all assigned agency rules can be redrafted in a timely fashion. The OPLC understands that there may be additional legislative changes to the OPLC that are sought in House Bill 2 (2022) that will necessitate additional rulemaking; accordingly, the OPLC may seek appropriations for the procurement in its upcoming SFYs 2024–2025 budget. Once internal controls are established, which includes ensuring rules have been drafted that are compliant with statutes, the OPLC's current staffing should be able to meet all rulemaking needs of all assigned agencies; however, this will be determined after the OPLC conducts a staffing assessment.*

15. *Improve support for assigned agency knowledge management.*

    *This is ongoing, through the OPLC's restructuring and documentation of processes and procedures. For example, as soon as the Board notifies OPLC Information Technology of preapproved opioid prescriber courses, it will post them to the website.*

16. *Ensure assigned agencies are made aware of statutory changes which affect their duties, and develop an integrated strategy to implement new requirements.*

    *This issue is resolved, from the OPLC's perspective. The OPLC provides end of session reports to all assigned agencies. For the 2021 legislative session, the report for the Board was run on July 20, 2021, and provided sometime thereafter to the Board. Additionally, the Quarterly Report dated August 9, 2021, contained information regarding key bills, including Senate Bill 58 (2021). Throughout the legislative session, OPLC provides weekly updates to boards regarding the progress of legislation that is tracked by the agency on behalf of each board. For the 2022 legislative session, OPLC attorneys have drafted memoranda to boards concerning legislation impacting the boards. Ultimately, it is the Board's responsibility to consider such information.*

17. *Ensure assigned agencies receive information needed to carry out regulatory duties.*

    *The OPLC will provide the Board with information it requests if it is capable of doing so. The credentialing database management system is an enterprise solution not controlled by the OPLC and has significant limitations in terms of data collection. If the OPLC has information available, it will provide it to the Board upon request.*

    *OPLC staff are now utilizing the National Practitioner Databank to run queries for the Board.*

    *The OPLC is currently working with the Department of Information Technology to procure a software solution that would permit it to run reports and provide updates to the Board. The OPLC anticipates having such software in place in SFY 2024/SFY 2025. As an interim solution, beginning in SFY 2021, all assigned agency investigative information has been captured in one Excel spreadsheet. The complaint spreadsheet has been updated, capturing all relevant statistical information. The Board Administrator and Division of Enforcement reconcile such data to ensure all parties have accurate information.*

*Once all adjudicative information has been consistently captured and the OPLC has developed policies and procedures to ensure data integrity, the OPLC will develop a system to report statistical information regarding adjudications to the Board.*

18. *Comply with all statutory records management requirements, including creation and retention, and ensure records for all applicants and credential holders are auditable and completely document transactions, decisions, and actions.*

    *OPLC is working to establish internal controls, which will necessarily ensure compliance with all statutory requirements, including the management of records. OPLC management was not aware that the credentialing database management system was a dynamic system. The OPLC understands and appreciates the need for a new system, as well as the need for a complete, auditable record, as quickly as possible. OPLC is challenged as it does not control the present system, nor procurement of a new system. However, working with its agency partner, OPLC anticipates having a new system in place sometime in SFY 2024/SFY 2025.*

    *The OPLC has developed and implemented a system to ensure complaint files are accurate and complete, encompassing all records from intake through resolution in a single file, has already been completed.*

    *The OPLC is awaiting approval from the Secretary of State's office for its proposed retention schedule. The OPLC submitted its initial request for approval in November 2021. That request for approval remains pending, despite repeated requests for follow-up communications. Once the retention schedule is approved, OPLC will be drafting and implementing a policy and procedure regarding the maintenance of state records, which necessarily includes the requirement that state records be held by the State.*

19. *Definitively establish administrative completeness dates for credential applications, timely notifying applicants of receipt of a complete or incomplete application, clearly documenting notifications and receipt of additional information or materials, and timely providing administratively complete applications to assigned agencies for substantive review.*

    *One of the OPLC's top priorities is to ensure compliance with statutory processing time limits. The OPLC is drafting some procedural rules for licensing, which addresses how the OPLC will ensure it is compliant with statutory processing time limits.*

    *The OPLC's long-term plan is to transition initial licensing to an electronic system that can capture the date that all licensing documentation and information was submitted. The State's present credentialing database management system is quite limited and does not meet the needs of the OPLC. Until such time as the credentialing database management system can support necessary functions, including ensuring an adequate audit trail is captured, the OPLC does not anticipate migrating additional license types online. OPLC is working with the Department of Information Technology to replace the new system, hopefully sometime in SFY 2024 or SFY 2025.*

20. *Implement controls to assess current data reliability and ensure future data reliability, and once revised controls consistently produce reliable records, establish and publicize a date after which data can be relied upon for decision making.*

    *As noted, the OPLC recognizes its data is not reliable. Once data requirements are established and documented and the OPLC has developed internal controls, it will be able to ensure that all data is reliable after a certain date.*

21. *Migrate decision making away from intuitive practices toward data-driven decision making based on reliable data and objective analyses to guide employment of resources to support assigned agencies.*

    *Once data is readily available and reliable, OPLC will discontinue intuitive practices and utilize data to drive decision making to ensure OPLC is providing adequate support of assigned agencies and is appropriately allocating resources.*

22. *Adopt and implement all statutorily required administrative rules, including rules on interim temporary licenses for reciprocal licensure applicants, supporting assigned agencies Prescription Drug Monitoring Program requirements, and on complaint administration.*

    *OPLC has been working on drafting necessary and statutorily required rules for the agency. Since 2021, OPLC has promulgated the following rules, among others:*

    - *Plc 200—Practice and Procedure, effective August 4, 2022*
    - *Plc 801—Temporary Licensure, effective November 2021*
    - *Plc 802—Expedited Issuance of Temporary Licenses; Conversion of Emergency Licenses-Emergency Rule, effective December 23, 2021*
    - *Plc 803—Emergency Licensure Under Laws of 2021, 121:2-Emergency Rule, effective September 17, 2021*
    - *Plc 1001-Purpose; Applicability; Definitions; Generally Applicable Fees-effective January 27, 2022 (replaces interim rules);*
    - *Plc 1001.08, 1001.14, 1001.15, 1001.16—Professionals' Health Program Fees, Fees for Letter of Good Standing, Warranty Seal, effective July 15, 2022*
    - *Plc 1002—Application-Related Fees Specific to Each Profession, effective August 8, 2022 (replaces interim rules)*
    - *Plc 1003—Per Diem Compensation; Reimbursable Expenses, effective December 22, 2021 (replaces interim rules);*
    - *Plc 1003.02 & Plc 1003.06—Reimbursable Expenses for Board of Registration of Funeral Directors & Embalmers, effective May 226, 2022*
    - *Plc 1100—Reflexologists, Structural Integrators, and Asian Bodywork Therapists, effective May 27, 2022*
    - *Plc 700—Electrologists*

    *Finally, OPLC has several rulemaking proposals being drafted. OPLC is ready to assist the Board of Dental Examiners with rulemaking, upon request.*

## APPENDIX D
## BOARD OF DENTAL EXAMINERS MEMBER SURVEY

In calendar year 2021, we sent a survey link via email to 36 current and former members of Board of Dental Examiners (Board), the Dental Hygienist Committee (DHC), and the Anesthesia and Sedation Evaluation Committee (ASEC). We received 20 (55.6 percent) complete responses. We combined and simplified similar answers to open-ended questions and presented them in topical categories; multipart responses were counted in multiple categories where applicable. Some totals in the following tables may not add up to 100 percent due to rounding, respondents being able to respond multiple times to the same question, or aggregation of responses into categories.

**Question 1. How clear were the following:**

| Answer Options | 5 (Clear) | 4 | 3 | 2 | 1 (Unclear) | Unsure or do not know | Count |
|---|---|---|---|---|---|---|---|
| Board mission | 12 (60.0%) | 3 (15.0%) | 1 (5.0%) | 2 (10.0%) | 0 (0.0%) | 2 (10.0%) | 20 |
| Board goals | 9 (45.0%) | 6 (30.0%) | 1 (5.0%) | 2 (10.0%) | 0 (0.0%) | 2 (10.0%) | 20 |
| Board statute (RSA 317-A, *Dentists and Dentistry*) | 8 (40.0%) | 4 (20.0%) | 6 (30.0%) | 1 (5.0%) | 0 (0.0%) | 1 (5.0%) | 20 |
| Board rules (Den 100-500, *Board of Dental Examiners*) | 5 (25.0%) | 9 (45.0%) | 4 (20.0%) | 0 (0.0%) | 0 (0.0%) | 2 (10.0%) | 20 |
| Policies and practices | 6 (30.0%) | 5 (25.0%) | 4 (20.0%) | 4 (20.0%) | 0 (0.0%) | 1 (5.0%) | 20 |

***respondent answered question*** **20**
***respondent skipped question*** **0**

**Question 2. How effectively did new member orientation address specific requirements of member duties and general obligations as a public official?**

| Answer Options | Count | Percent |
|---|---|---|
| 5 (Effectively) | 5 | 25.0 |
| 4 | 1 | 5.0 |
| 3 | 5 | 25.0 |
| 2 | 1 | 5.0 |
| 1 (Ineffectively) | 3 | 15.0 |
| Unsure or don't know | 5 | 25.0 |

***respondent answered question*** **20**
***respondent skipped question*** **0**

| **Question 3. How effectively did the Board control Board and committee member ethics, such as recusals and conflicts of interest?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| 5 (Effectively) | 11 | 55.0 |
| 4 | 1 | 5.0 |
| 3 | 2 | 10.0 |
| 2 | 2 | 10.0 |
| 1 (Ineffectively) | 1 | 5.0 |
| Unsure or don't know | 3 | 15.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

| **Question 4. If you found the Board's operations or practices to be less than effective, please describe ways in which the Board was less than effective in the space provided. Otherwise, please respond "not applicable."** | |
|---|---|
| **Comments** | **Count** |
| Office of Professional Licensure and Certification (OPLC) and Department of Justice (DOJ) support was lacking, the Board had intermittent legal counsel and Board was told there were not many resources available. | 1 |
| Frequent administration turnover. | 1 |
| The Board allowed member to lobby for acceptance of certain licensing requirements knowing a family member was affected. | 1 |
| I am not sure of guidelines for recusals. | 1 |
| Board members were left to fend for themselves in a chaotic environment, absent direction, legal counsel, and administrative support since inception of OPLC. This hindered the members ability to function properly, as during last five years we had five administrators, three heads of OPLC, scarce investigation support, and overworked administrative staff. Hard to be effective in that environment, but yet the Board is the public face that will be held accountable. | 1 |
| The Board's counsel and the Attorney General's Office did not support us legally for all issues. We had to dismiss a lot of issues due to lack of support. | 1 |
| A recurring public safety concern nationwide regarding the practice of dentistry is the administration of sedation in the dental office, particularly to children. There should always be at least one (if not more) permitted dental anesthesia providers on the Board. Without such Board members, the dental anesthesia and sedation committee can merely make policy recommendations to the Board without knowledgeable insiders present to improve/modify dental anesthesia regulations. | 1 |
| The majority of Board members were very unprofessional, rude to guests in attendance, and did not follow up on several public complaints in years. | 1 |
| The Board was effective. | 1 |
| Excellent staff but, poorly compensated, poorly supported by the executive (OPLC) management. Did not provide a comfortable and stable work environment. | 1 |
| Not applicable. | 10 |
| ***respondent answered question*** | **20** |
| ***respondent skipped question*** | **0** |

| Question 5. How effectively did the Board identify stakeholders? Stakeholders may include licensees, permittees, and other interested organizations and individuals. | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| 5 (Effectively) | 10 | 50.0 |
| 4 | 4 | 20.0 |
| 3 | 0 | 0.0 |
| 2 | 0 | 0.0 |
| 1 (Ineffectively) | 2 | 10.0 |
| Unsure or don't know | 4 | 20.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

| Question 6. How effectively did the Board collaborate with stakeholders to facilitate protection of public safety, health, and welfare? | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| 5 (Effectively) | 9 | 45.0 |
| 4 | 5 | 25.0 |
| 3 | 3 | 15.0 |
| 2 | 1 | 5.0 |
| 1 (Ineffectively) | 1 | 5.0 |
| Unsure or don't know | 1 | 5.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

| Question 7. How effectively did the Board inform stakeholders of changes to and interpretations of the Board's statute, rules, policies, and practices? | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| 5 (Effectively) | 5 | 25.0 |
| 4 | 6 | 30.0 |
| 3 | 4 | 20.0 |
| 2 | 0 | 0.0 |
| 1 (Ineffectively) | 2 | 10.0 |
| Unsure or don't know | 3 | 15.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

| **Question 8. If you found Board customer service to be less than effective, please describe ways in which the Board was less than effective in the space provided. Otherwise, please respond "not applicable."** | |
|---|---|
| **Comments** | **Count** |
| The Board was very slow to respond when lacking a lead person during this time. | 1 |
| When you say Board, I am using the administrative and management staff. Difficult communication, unclear directives and follow up. | 1 |
| The customer service was related to lack of employees to handle the issues. The employees who worked on the Board office were over worked. | 1 |
| Not having means of informing of recent rule and legislative changes. | 1 |
| When HB 1577 was signed into law in CY 2018, several changes were made to *Dentists and Dentistry* (RSA 317-A) regarding dental anesthesia guidelines and requirements. I don't feel that the Board has adequately communicated its interpretation and implementation of these changes to NH dental anesthesia permit holders. | 1 |
| In my opinion, the Board feels that it is up to "customers" professionals, stakeholders to keep up with the Board on their own time. The Board does not indicate that it is their responsibility to provide any customer service. | 1 |
| There was a lot of changes in the administrative staff which lead to a lot of confusion. | 1 |
| I have found the Board to be very helpful when needed. | 1 |
| Funding and staffing issues precluded effective communication with stakeholders. However, the staff were very polite and helpful considering issues previously discussed in this survey | 1 |
| Not applicable. | 11 |
| ***provided comment*** | **20** |
| ***respondent skipped question*** | **0** |

| **Question 9. How effective were initial and renewal credentialing* processes?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| 5 (Effective) | 12 | 60.0 |
| 4 | 5 | 25.0 |
| 3 | 3 | 15.0 |
| 2 | 0 | 0.0 |
| 1 (Ineffective) | 0 | 0.0 |
| Unsure or don't know | 0 | 0.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

*Credentials included licenses for dentists and dental hygienists; permits for General Anesthesia and Deep Sedation, Moderate Sedation, Expanded Function Dental Auxiliary, Nitrous Oxide, and Local Anesthesia; and certificates for Certified Public Health Dental Hygienist.

| **Question 10. How effective were credentialing requirements in protecting public safety, health, and welfare?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| 5 (Effective) | 13 | 65.0 |
| 4 | 5 | 25.0 |
| 3 | 1 | 5.0 |
| 2 | 1 | 5.0 |
| 1 (Ineffective) | 0 | 0.0 |
| Unsure or don't know | 0 | 0.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

| **Question 11. How effective were continuing education requirements in helping ensure practitioners maintained relevant professional knowledge?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| 5 (Effective) | 11 | 55.0 |
| 4 | 5 | 25.0 |
| 3 | 4 | 20.0 |
| 2 | 0 | 0.0 |
| 1 (Ineffective) | 0 | 0.0 |
| Unsure or don't know | 0 | 0.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

| **Question 12. Please describe how Board credentialing processes were effective in protecting public safety, health, and welfare. If you are unable to describe effectiveness, please respond "not applicable."** | |
|---|---|
| **Comments** | **Count** |
| A Board member would review credentials when all data was collated. If there was any irregularity or question it was brought to the next Board meeting for discussion. | 1 |
| This is an area of strength with the Board responding to public safety quickly with antibiotic and narcotic continuing education (CE) requirements. | 1 |
| Making sure licensees were credentialed for renewal. | 1 |
| Our commitment followed national guidelines and best practice to ensure public safety. | 1 |
| Credential processes were effective but not timely. | 1 |
| Certain CEs were required. Complaints were carefully read and considered. Behind the door, it is difficult to protect the public from every bad practitioner. | 1 |
| Only applicants who satisfied the educational and examination requirements were granted a license and CE requirements were set in place to make sure that those applying for renewals were keeping up with updating their skills and knowledge. | 1 |
| The Board follows guidelines from the American Association of Oral and Maxillofacial Surgeons for regular dental office anesthesia inspections every five years to maintain a dental anesthesia permit. | 1 |
| Credentialing is clearly spelled out in the rules. Requirements for dental hygienists are sufficient. Dentists OK. There is a major concern for public safety regarding dental assistants and lack of credentials. There is no requirement for all dental assistants to be registered or even educated. Major concern is infection control. Dentists in NH and on the Board are very resistant to this as it may affect their production and income. | 1 |
| Board members reviewed and made sure the applicants had all their proper documentation and credentials. | 1 |
| The Board requirements were reasonable to ensure public safety. | 1 |
| The credential processes were a work in progress and improving. Improved staffing would elevate the process. | 1 |
| Ensuring adequate education and certification. | 1 |
| Not Applicable. | 7 |
| ***provided comment*** | **20** |
| ***respondent skipped question*** | **0** |

| Question 13. If you found Board requirements and processes to be less than effective, please describe ways in which the Board was less than effective in the space provided. Otherwise, please respond "not applicable." | |
|---|---|
| **Comments** | **Count** |
| The Board relies on OPLC to follow the statutes and rules, the constant turnover of OPLC has eroded institutional memory and continuity. This has been the major cause of frustration for the Board and has led to at times a lack of effectiveness. | 1 |
| Confusing with emergency order and what was allowed for renewal. | 1 |
| Board cannot be effective if the Board does not have back up from their counsel. The Board rules and statutes are left for interpretation and counsel did not always think they could stand by these rules. | 1 |
| The every-five-year dental office anesthesia inspections are conducted by two permitted NH dental anesthesia providers who follow an approved checklist. Occasionally, a dentist who is being inspected will fall short of the required equipment/knowledge for safe practice. This has led to interpersonal disagreements in the past, which then must be sorted out by the Board without dental anesthesia providers members on it. | 1 |
| Without proper legal support in the past several years it made it difficult for the Board to make decisions on complaints. | 1 |
| As hard as the staff tried, staffing and funding issues hindered the process. | 1 |
| Not Applicable. | 14 |
| ***provided comment*** | **20** |
| ***respondent skipped question*** | **0** |

| Question 14. How effective was Board monitoring of licensees, permittees, and certificate holders to ensure compliance with requirements and protection of public safety, health, and welfare? | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| 5 (Effective) | 10 | 50.0 |
| 4 | 7 | 35.0 |
| 3 | 1 | 5.0 |
| 2 | 0 | 0.0 |
| 1 (Ineffective) | 1 | 5.0 |
| Unsure or don't know | 1 | 5.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

| **Question 15. How effective was the Board in ensuring licensees who prescribed controlled substances were registered with the Prescription Drug Monitoring Program?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| 5 (Effective) | 7 | 35.0 |
| 4 | 5 | 25.0 |
| 3 | 0 | 0.0 |
| 2 | 0 | 0.0 |
| 1 (Ineffective) | 0 | 0.0 |
| Unsure or don't know | 8 | 40.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

| **Question 16. How effectively did the Board manage complaints?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| 5 (Effectively) | 5 | 25.0 |
| 4 | 8 | 40.0 |
| 3 | 1 | 5.0 |
| 2 | 0 | 0.0 |
| 1 (Ineffectively) | 1 | 5.0 |
| Unsure or don't know | 5 | 25.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

| **Question 17. How effectively did the Board manage investigations?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| 5 (Effectively) | 0 | 0.0 |
| 4 | 4 | 20.0 |
| 3 | 2 | 10.0 |
| 2 | 2 | 10.0 |
| 1 (Ineffectively) | 3 | 15.0 |
| Unsure or don't know | 9 | 45.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

| **Question 18. How effectively did the Board manage disciplinary processes?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| 5 (Effectively) | 1 | 5.0 |
| 4 | 4 | 20.0 |
| 3 | 5 | 25.0 |
| 2 | 0 | 0.0 |
| 1 (Ineffectively) | 0 | 0.0 |
| Unsure or don't know | 10 | 50.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

| **Question 19. Please describe how the Board's monitoring of practice, and complaint, investigation, and discipline management was effective in protecting public safety, health, and welfare. If you are unable to describe effectiveness, please respond "not applicable."** | |
|---|---|
| **Comments** | **Count** |
| The Board cannot investigate as we can only refer complaints for investigation. Once the Board requests an investigation, the Board is at the mercy of manpower issues, etc. Investigations referrals take an inordinate amount of time, but without the investigations the Board cannot effectively act and discipline (when appropriate) in a timely manner. | 1 |
| They were judicious and fair in their consideration. | 1 |
| The Board attempted to follow through with their judgements but was hindered each step of the way by ineffective staffing, slow to respond legal support, and communication with support for hearings. | 1 |
| For a while we did not have someone to investigate. We hired someone and that person was never trained properly and never did any investigations. | 1 |
| For the safety and welfare of the public the Board addressed complaints as soon as it received them, OPLC received and logged complaints so they controlled when they were presented to the board. In the past the Administrative Prosecutions Unit (APU) conducted investigations and Board had no control over them. The Board recruited an investigator but OPLC failed to have a contract signed and then a year later realized that a request for proposal had not been put out so had to start the process over. The Board conducted disciplinary hearings as needed. | 1 |
| The Board requires licensees and permit holders to renew their licenses and permits every two years via an application and random audit of continuing education. Beyond that, I am not privy to how the Board handles complaints, investigations, or discipline. | 1 |
| There was not enough support from the OPLC and the APU to investigate issues of concern. | 1 |
| Because of staffing, funding, and support of the Board, many issues were addressed slower than the Board desired. | 1 |
| The Board responded to complaints in a fair unbiased manner that worked to protect the public but was still fair to the licensee. | 1 |
| Not Applicable. | 11 |
| ***provided comment*** | **20** |
| ***respondent skipped question*** | **0** |

| **Question 20. If you found the Board's monitoring of practice, and complaint, investigation, and discipline management to be less than effective, please describe ways in which the Board was less than effective in the space provided. Otherwise, respond "not applicable."** | |
|---|---|
| **Comments** | **Count** |
| As stated before, the Board was not supported in timely fashion when they wanted to pursue investigation and ask for recommendations from the Attorney General's Office. We were told we needed to conduct our own hearings at one point. This is extremely careless and would have left the State and involved Board members vulnerable as well as not providing the safety we are supposed to be providing the public. | 1 |
| See last answer. [For a while we did not have someone to investigate. We hired someone and that person was never trained properly and never did any investigations.] | 1 |
| OPLC failed to provide legal counsel at all hearings so that sometimes extended the hearings schedule. | 1 |
| The Board interviewed and hired an "investigator." The Attorney General's Office said they were "too busy" to send someone with the investigator, there was no support from the Board nor from any of the Directors or the Executive Director of the OPLC. The new administrator for the Board said that the investigator never officially had a contract and advertised the "investigator" job without notifying the investigator ahead of time but after the fact. I do believe there are complaints from the public that have never been followed up on. | 1 |
| The vast majority of Board members are actively practicing and have limited time and receive poor compensation. Though the staff was diligently working for the Board, staffing was inadequate. | 1 |
| Not Applicable. | 15 |
| ***provided comment*** | **20** |
| ***respondent skipped question*** | **0** |

| Question 21. How effectively did the Board's regulation of the following protect public safety, health, and welfare? | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Answer Options** | **5 (Effectively)** | **4** | **3** | **2** | **1 (Ineffectively)** | **Unsure or do not know** | **Count** |
| Certified Public Health Dental Hygienist certificate holders | 7 (35.0%) | 6 (30.0%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) | 7 (35.0%) | 20 |
| Expanded Function Dental Auxiliary permit holders | 5 (25.0%) | 7 (35.0%) | 1 (5.0%) | 0 (0.0%) | 1 (5.0%) | 6 (30.0%) | 20 |
| General Anesthesia and Deep Sedation permit holders | 8 (40.0%) | 7 (35.0%) | 3 (15.0%) | 0 (0.0%) | 0 (0.0%) | 2 (10.0%) | 20 |
| Moderate Sedation permit holders | 8 (40.0%) | 7 (35.0%) | 2 (10.0%) | 0 (0.0%) | 0 (0.0%) | 3 (15.0%) | 20 |
| Nitrous Oxide permit holders | 8 (40.0%) | 5 (25.0%) | 1 (5.0%) | 0 (0.0%) | 0 (0.0%) | 6 (30.0%) | 20 |
| Local Anesthesia permit holders | 9 (45.0%) | 3 (15.0%) | 2 (10.0%) | 1 (5.0%) | 0 (0.0%) | 5 (25.0%) | 20 |
| | | | | | | ***respondent answered question*** | **20** |
| | | | | | | ***respondent skipped question*** | **0** |

| Question 22. How effectively did Board regulation of the following programs protect public safety, health, and welfare? | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Answer Options** | **5 (Effectively)** | **4** | **3** | **2** | **1 (Ineffectively)** | **Unsure or don't know** | **Count** |
| Dental residency program | 3 (15.0%) | 1 (5.0%) | 1 (5.0%) | 0 (0.0%) | 1 (5.0%) | 14 (70.0%) | 20 |
| Dental student program | 3 (15.0%) | 1 (5.0%) | 1 (5.0%) | 0 (0.0%) | 0 (0.0%) | 15 (75.0%) | 20 |
| Dental program under public health supervision | 5 (25.0%) | 1 (5.0%) | 1 (5.0%) | 0 (0.0%) | 1 (5.0%) | 12 (60.0%) | 20 |
| | | | | | | ***respondent answered question*** | **20** |
| | | | | | | ***respondent skipped question*** | **0** |

| **Question 23. What specific risks posed by the current regulatory framework around dental assistants has the Board identified?** | |
|---|---|
| **Comments** | **Count** |
| Due to the dental assistant shortage in the State, many training programs are starting to form. Since dental assistants are not licensed, the Board has little control | 1 |
| There needs to be a process in which dental assistants are held liable by holding some type of certificate or registration with the Board. | 1 |
| Dental assistants at this point are not identified or registered with the State. They could be performing duties that may present danger to patients, such as intraoral reversible procedures, taking radiographs without proper training, not using proper infection control practices to name a few. If they are not registered, we cannot ensure the safety of services they may be providing as we have no way of monitoring currently. | 1 |
| There were never risks identified but it was clear there was not enough manpower to handle the overload. | 1 |
| There are rules describing dental assistant duties even though the Board has no jurisdiction over them. So, either the rules should be deleted or there should be a legislative change made to register dental assistants. | 1 |
| The need for registering dental assistants for patient safety. | 1 |
| They are continuing to monitor expanded functions. | 1 |
| The Board does not have statutory jurisdiction over dental assistants. | 1 |
| Assistants are minimally regulated. | 1 |
| None. | 1 |
| Not Applicable. | 10 |
| ***provided comment*** | **20** |
| ***respondent skipped question*** | **0** |

| **Question 24. Did the Board objectively quantify the risks it expected to mitigate related to regulating dental assistants?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Yes | 2 | 10.0 |
| No | 6 | 30.0 |
| Unsure or don't know | 12 | 60.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **0** | |

| **Question 25. Please describe how the Board quantified risks it expected to mitigate by regulating dental assistants. If you are unable to describe how risks were quantified, please respond "not applicable."** | |
|---|---|
| **Comments** | **Count** |
| Allowing dental assistants to be regulated allows for public health safety. | 1 |
| All the concerns were about the overload of work it would cause the Board office. | 1 |
| It is still in the discussion stage. | 1 |
| The Board quasi-regulates dental assistants using its authority over dentists. | 1 |
| Not applicable. | 16 |
| ***provided comment*** | **20** |
| ***respondent skipped question*** | **0** |

| **Question 26. How effectively did the Office of Professional Licensure and Certification (OPLC) provide administrative support in the following areas?** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Answer Options** | **5 (Effectively)** | **4** | **3** | **2** | **1 (Ineffectively)** | **Unsure or don't know** | **Count** |
| Customer service | 4 (20.0%) | 2 (10.0%) | 5 (25.0%) | 1 (5.0%) | 2 (10.0%) | 6 (30.0%) | 20 |
| Rulemaking | 4 (20.0%) | 3 (15.0%) | 3 (15.0%) | 1 (5.0%) | 4 (20.0%) | 5 (25.0%) | 20 |
| Record keeping | 6 (30.0%) | 2 (10.0%) | 3 (15.0%) | 2 (10.0%) | 2 (10.0%) | 5 (25.0%) | 20 |
| Fee setting | 3 (15.0%) | 4 (20.0%) | 3 (15.0%) | 1 (5.0%) | 2 (10.0%) | 7 (35.0%) | 20 |
| Licensing and permitting | 7 (35.0%) | 4 (20.0%) | 2 (10.0%) | 1 (5.0%) | 1 (5.0%) | 5 (25.0%) | 20 |
| Complaint processing | 3 (15.0%) | 3 (15.0%) | 3 (15.0%) | 2 (10.0%) | 3 (15.0%) | 6 (30.0%) | 20 |
| Investigations | 1 (5.0%) | 1 (5.0%) | 4 (20.0%) | 0 (0.0%) | 5 (25.0%) | 9 (45.0%) | 20 |
| Adjudications | 2 (10.0%) | 2 (10.0%) | 4 (20.0%) | 0 (0.0%) | 2 (10.0%) | 10 (50.0%) | 20 |
| ***respondent answered question*** | | | | | | | **20** |
| ***respondent skipped question*** | | | | | | | **0** |

| **Question 27. How effectively did the OPLC respond to inquiries made by:** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Answer Options** | **5 (Effectively)** | **4** | **3** | **2** | **1 (Ineffectively)** | **Unsure or don't know** | **Count** |
| The Board | 4 (20.0%) | 3 (15.0%) | 0 (0.0%) | 1 (5.0%) | 4 (20.0%) | 8 (40.0%) | 20 |
| The DHC | 4 (20.0%) | 3 (15.0%) | 1 (5.0%) | 0 (0.0%) | 3 (15.0%) | 9 (45.0%) | 20 |
| The ASEC | 3 (15.0%) | 3 (15.0%) | 1 (5.0%) | 0 (0.0%) | 2 (10.0%) | 11 (55.0%) | 20 |
| The ASEC-AS | 3 (15.0%) | 3 (15.0%) | 1 (5.0%) | 0 (0.0%) | 2 (10.0%) | 11 (55.0%) | 20 |
| Licensees | 3 (15.0%) | 2 (10.0%) | 3 (15.0%) | 2 (10.0%) | 1 (5.0%) | 9 (45.0%) | 20 |
| Other stakeholders | 2 (10.0%) | 2 (10.0%) | 1 (5.0%) | 1 (5.0%) | 2 (10.0%) | 12 (60.0%) | 20 |
| The public | 2 (10.0%) | 2 (10.0%) | 1 (5.0%) | 0 (0.0%) | 2 (10.0%) | 13 (65.0%) | 20 |
| | | | | | ***respondent answered question*** | | **20** |
| | | | | | ***respondent skipped question*** | | **0** |

| **Question 28. If you found OPLC support to be less than effective, please describe ways in which the OPLC was less than effective in the space provided. Otherwise, respond "not applicable."** | |
|---|---|
| **Comments** | **Count** |
| As mentioned previously, I have felt that OPLC's guidance for the Board has been inconsistent, particularly with clarification of responsibilities, follow through with information and directives from Board. Legal support has been grudgingly given and hard to procure. It has also been inconsistent in messaging and seems to be very willing to blame the Board for its mismanagement. | 1 |
| Counsel changed hands every few months, many times they had different protocols for different situations, but many times the Board was told we did not have their support. | 1 |
| Too much staff and legal counsel turnover, record keeping was always an issue. No institutional memory, the Board always had to raise 125 percent of its budget without knowing the expenses incurred for each service. Staff and administrators were assigned to multiple boards at one time making it difficult for them to do their job effectively. Unsure whether OPLC provided any training to them. | 1 |
| I do not know what goes on behind the scenes between OPLC and the Board. It would be helpful to have "back-up" from the OPLC if a disagreement ever arises when inspecting a dental office or dental anesthesia provider. | 1 |
| The OPLC is a disorganized mess with no leadership. No one knew what was going on or was willing to help the Board solve the investigator support problem. | 1 |
| There was a lot of turnover with the administrative staff. Rules that were voted on at Board meetings did not get changed in future documents. | 1 |
| Not Applicable. | 14 |
| ***provided comment*** | **20** |
| ***respondent skipped question*** | **0** |

| **Question 29. How effectively did the Department of Justice (DOJ) provide administrative support in the following areas?** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Answer Options** | **5 (Effectively)** | **4** | **3** | **2** | **1 (Ineffectively)** | **Unsure or don't know** | **Count** |
| Complaint processing | 0 (0.0%) | 0 (0.0%) | 1 (5.0%) | 4 (20.0%) | 3 (15.0%) | 12 (60.0%) | 20 |
| Investigations | 0 (0.0%) | 0 (0.0%) | 2 (10.0%) | 2 (10.0%) | 4 (20.0%) | 12 (60.0%) | 20 |
| Adjudications | 0 (0.0%) | 0 (0.0%) | 1 (5.0%) | 5 (25.0%) | 2 (10.0%) | 12 (60.0%) | 20 |
| Legal counsel | 1 (5.0%) | 0 (0.0%) | 3 (15.0%) | 3 (15.0%) | 3 (15.0%) | 10 (50.0%) | 20 |
| Rule development | 0 (0.0%) | 0 (0.0%) | 1 (5.0%) | 4 (20.0%) | 4 (20.0%) | 11 (55.0%) | 20 |
| | | | | | | ***respondent answered question*** | 20 |
| | | | | | | ***respondent skipped question*** | 0 |

| **Question 30. If you found DOJ support to be less than effective, please describe ways in which the DOJ was less than effective in the space provided. Otherwise, respond "not applicable."** | |
|---|---|
| **Comments** | **Count** |
| Did not have consistent legal counsel. Board was told many times that DOJ did not have resources to support us for investigations. | 1 |
| Investigations that were jeopardizing the public were put off for longer than safely warranted. One investigation took four years to complete and the Board had to demand an accounting. Investigations were held up because we did not have investigators available or properly vetted. When we did have a particularly long set of hearings, legal counsel was silent. At the end of that hearing, during deliberations, we had no guidance on discussion and as a result, we had to dismiss after 40 hours of hearings. | 1 |
| I do not remember working with them ever. | 1 |
| DOJ support at best was poor. No feedback was provided by APU on investigations it was doing on the Board's behalf. | 1 |
| The response from DOJ was "you're on your own. We don't have the resources." | 1 |
| The DOJ was not available to do the investigations needed by the Board. | 1 |
| Constant DOJ staff changes which lead to re-education and poor assistance. | 1 |
| Not Applicable. | 13 |
| ***provided comment*** | **20** |
| ***respondent skipped question*** | **0** |

| **Question 31. Is there anything else you would like us to know about the Board? If so, please share in the space provided.** | |
|---|---|
| **Comments** | **Count** |
| The Board is frustrated. The Board tries its best to render good judgement, but then has to rely on OPLC and DOJ to follow through and be effective. We have no real power to execute oversight yet rely on OPLC and DOJ to be efficient and timely, as well as follow procedures correctly. | 1 |
| The Board for years has had times of major dysfunction for various reasons: leadership, lack of a director most recently. When there is a stable director with good leadership the Board does function extremely well. | 1 |
| Most members of the Board have worked unselfishly to protect the public and secure qualified candidates for licensure. We are not, however paid staff, lawyers or directors of OPLC. We bring our expertise on dentistry, patient care, and desire to make a difference for New Hampshire to our work. We cannot properly fulfill that without the support, clear guidance, professional expertise of a high functioning management. | 1 |
| It was very inconsistent, ineffective. There were dentists being investigated the entire time I was on the Board. It just sat there. I also saw many corrupt dentists not sanctioned that should have been. Practitioners can really do whatever they want since the Board does not have the ability to come down hard on them. | 1 |
| Each Board member is aware that their primary responsibility is the protection of the public by governing and regulating dentistry. Unfortunately, the Board relies 100 percent on the resources provided by the DOJ and OPLC to discharge its duties. So ultimately these entities control how effectively the Board functions. | 1 |
| The regulation of dental anesthesia is a key public safety requirement of the Board. There are many stakeholders, as physician anesthesiologists and nurse anesthetists are also now marketing themselves as itinerant dental anesthesia providers. The Board should always have multiple dental anesthesia providers on it, should have the full enforcement backing of OPLC, and should collaborate with the medical and nursing boards in regulating dental office anesthesia. | 1 |
| I found the majority of the dentists had disdain for the DHC and were resistant to recommendations and decisions made by the DHC. They were rude to guests who sat in on meetings as well as those professionals who were on the schedule. Worse display of professionalism by "professionals" I have ever witnessed. | 1 |
| The Board members are very dedicated individuals and spend a lot of time on Board issues. There needs to be more support for the investigations and legal counsel. | 1 |
| The Board is hard working even under the constraints thrust upon it. The ASEC needs more oversight, statutory rules and organizational rules. The regulation of dental assistants needs to be statutory. So far, the OPLC has been a nightmare. Investigate the funding of all Boards. Find a way to provide support and stability to all Boards. | 1 |
| Not applicable. | 9 |
| ***provided comment*** | **18** |
| ***respondent skipped question*** | **2** |

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## APPENDIX E
## STATUS OF PRIOR AUDIT OBSERVATIONS

We previously reviewed Office of Professional Licensure (OPLC) processes and management controls relevant to the current audit in the calendar year (CY) 2017 *State Of New Hampshire Pharmacy Board Controlled Drug Prescription Health And Safety Program Performance Audit* and the CY 2017 *State Of New Hampshire Office Of Professional Licensure And Certification Naturopathic Board Of Examiners Performance Audit*. We evaluated the OPLC's status towards resolving the recommendations during the audit period for three observations relevant to the current audit, shown in Table 15.

**Table 15**

**Status Of Prior Audit Observations And Status Key**

| Status | Key | Total |
|---|---|---|
| Resolved | ● ● | 0 |
| Resolution in process (action beyond meetings and discussion) | ● ○ | 0 |
| Unresolved | ○ ○ | 3 |

Source: LBA analysis.

A copy of prior audits can be accessed at our website, http://www.gencourt.state.nh.us/LBA/.

### CY 2017 *State Of New Hampshire Pharmacy Board Controlled Drug Prescription Health And Safety Program Performance Audit*

The following is the status of the applicable observation contained in our CY 2017 *State Of New Hampshire Pharmacy Board Controlled Drug Prescription Health And Safety Program Performance Audit*.

| No. | Title | Status |
|---|---|---|
| 12. | Ensure Quorum Requirements Are Met (*See current Observation No. 5*) | ○ ○ |

### CY 2017 *State Of New Hampshire Office Of Professional Licensure And Certification Naturopathic Board Of Examiners Performance Audit*

The following is the status of applicable observations contained in our CY 2017 *State Of New Hampshire Office Of Professional Licensure And Certification Naturopathic Board Of Examiners Performance Audit*.

| No. | Title | Status | |
|---|---|---|---|
| 23. | Improve Compliance With The Financial Disclosure Statute (*See current Observation No. 5*) | ○ | ○ |
| 26. | Prioritize And Timely Resolve Prior Audit Findings (*See current Observation No. 17*) | ○ | ○ |