

SUNSET ADVISORY COMMISSION

STAFF REPORT WITH COMMISSION DECISIONS

State Board of Dental Examiners



2016–2017
85TH LEGISLATURE

SUNSET ADVISORY COMMISSION

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Cover Photo: The iron perimeter fence was installed in the 1890s, a few years after the completion of the Texas State Capitol. The fence surrounds approximately 22 acres of the Capitol Grounds but only on the east, west, and south sides due to the addition of the Capitol Extension to the north in the early 1990s. Photo Credit: Janet Wood

STATE BOARD OF DENTAL EXAMINERS

SUNSET STAFF REPORT WITH COMMISSION DECISIONS

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HOW TO READ SUNSET REPORTS

Each Sunset report is issued *three times*, at each of the three key phases of the Sunset process, to compile all recommendations and action into one, up-to-date document. Only the most recent version is posted to the website. (**The version in bold is the version you are reading.**)

1. SUNSET STAFF EVALUATION PHASE

Sunset staff performs extensive research and analysis to evaluate the need for, performance of, and improvements to the agency under review.

FIRST VERSION: The *Sunset Staff Report* identifies problem areas and makes specific recommendations for positive change, either to the laws governing an agency or in the form of management directives to agency leadership.

2. SUNSET COMMISSION DELIBERATION PHASE

The Sunset Commission conducts a public hearing to take testimony on the staff report and the agency overall. Later, the Commission meets again to vote on which changes to recommend to the full Legislature.

SECOND VERSION: **The *Sunset Staff Report with Commission Decisions*, issued after the decision meeting, documents the Sunset Commission's decisions on the original staff recommendations and any new issues raised during the hearing, forming the basis of the Sunset bills.**

3. LEGISLATIVE ACTION PHASE

The full Legislature considers bills containing the Sunset Commission's recommendations on each agency and makes final determinations.

THIRD VERSION: The *Sunset Staff Report with Final Results*, published after the end of the legislative session, documents the ultimate outcome of the Sunset process for each agency, including the actions taken by the legislature on each Sunset recommendation and any new provisions added to the Sunset bill.

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———— **SUNSET COMMISSION DECISIONS**

SUNSET COMMISSION DECISIONS

Summary

The following material summarizes the Sunset Commission's decisions on the staff recommendations for the State Board of Dental Examiners, as well as modifications and new issues raised during the public hearing.

For a relatively small agency, the dental board has been buffeted by more than its share of problems due to high turnover among its leadership ranks. At 15 members, the dental board itself is oversized compared to its shrinking duties, leading to board involvement in operational matters well beyond its proper role and the agency's needs. Dentist board members have pursued high profile rule packages that appear more motivated by business interests than demonstrated concern for public safety; all the while other emerging problems like regulating the administration of anesthesia went largely unaddressed.

In light of high-profile media cases exposing gaps in the board's regulation of dental anesthesia, the commission's recommendations aim to strengthen anesthesia regulation through clear enforcement tools, improved training and education requirements for permit holders, and broader avenues for stakeholder input. These recommendations are consistent with the findings of a blue ribbon panel commissioned by Sunset to assess the dental anesthesia problems. Other changes would address deficiencies in the agency's regulation of dental assistants and update licensing and enforcement processes that have not kept up with best practices. The Sunset Commission recommends continuing the agency for 12 years.

ISSUE 1

The Unusually Large Dental Board Inappropriately Focuses on Issues Unrelated to Its Public Safety Mission.

Recommendation 1.1, Modified — In lieu of the staff recommendation, sweep the board and reduce the size of the board from 15 to 11 members, including six dentists, three hygienists, and two public members. To allow for staggering of terms, the recommendation would provide that all current board member terms expire on September 1, 2017, with the governor making initial appointments as specified below. Current members would be eligible for re-appointment if so determined by the governor to maintain needed expertise. Board members serving on August 31, 2017 would continue to serve until a majority of new appointments are made.

- Two dentists and one dental hygienist to initial terms expiring February 1, 2019.
- Two dentists, one dental hygienist, and one public member to initial terms expiring February 1, 2021.
- Two dentists, one dental hygienist, and one public member to initial terms expiring February 1, 2023.

Recommendation 1.2, Adopted — Allow the board's statutory advisory groups to expire and direct the board to establish clearer processes for stakeholder input in rule.

Recommendation 1.3, Modified — Clarify the use and role of board members at informal settlement conferences and strike language in the Dental Practice Act regarding informal settlement conferences

(Texas Occupations Code, sections 263.007, 263.0075, and 263.0076) and replace with more detailed language on structure and conduct of informal proceedings. *(See Adopted Language, page A7)*

- **Dental review committee.** Create a state Dental Review Committee consisting of nine governor-appointed members, including six dentists and three dental hygienists, to serve at informal settlement conferences on a rotating basis.

ISSUE 2

State Regulation of Dental Assistants Is Unnecessary to Ensure Public Protection and Is an Inefficient Use of Resources.

Recommendation 2.1, Modified — In lieu of the staff recommendation, combine the board's four dental assistant certificate programs into one registration for dental assistants. *(See Adopted Language, page A9)*

ISSUE 3

The Board Lacks Key Enforcement Tools to Ensure Dentists Are Prepared to Respond to Increasing Anesthesia Concerns.

Recommendation 3.1, Modified — Authorize the board to conduct inspections of dentists administering parenteral anesthesia in office settings. Provide four levels of anesthesia permits and require the board to establish minimum standards, education, and training for dentists administering anesthesia. Allow additional limitations on anesthesia administration for high-risk or pediatric patients. *(See Adopted Language, page A10)*

- **Blue ribbon panel.** As a management action, Sunset directed the board to quickly establish an independent 5- to 10-member blue ribbon panel that reviewed de-identified data, including confidential investigative information, related to dental anesthesia deaths and mishaps over the last five years, as well as evaluate emergency protocols. The Committee made recommendations to the Legislature and the Sunset Commission at its January 11, 2017 meeting.

Recommendation 3.2, Modified — As a statutory instead of a management recommendation, direct the board to revise rules to ensure dentists with one or more anesthesia permits maintain related written emergency management plans. Also provide that level 2–4 sedation/anesthesia permit holders' emergency plans must include current Advanced Cardiac Life Support (ACLS) rescue protocols and advanced airway management techniques. For level 2–4 sedation/anesthesia permit holders treating pediatric patients emergency management plans must include current Pediatric Advanced Cardiac Life Support (PALS) rescue protocols and advanced airway management techniques.

ISSUE 4

Key Elements of the State Board of Dental Examiners' Licensing and Regulatory Functions Do Not Conform to Common Licensing Standards.

Recommendation 4.1, Adopted — Require the board to monitor licensees for adverse licensure actions.

Recommendation 4.2, Adopted — Authorize the board to deny applications to renew a license if an applicant is not compliant with a board order.

Recommendation 4.3, Adopted — Authorize the board to require evaluations of licensees suspected of being impaired and require confidentiality for information relating to the evaluation and participation in treatment programs.

Recommendation 4.4, Adopted — Remove unnecessary qualifications required of applicants for licensure or registration.

Recommendation 4.5, Adopted — Direct the board to make data on the board's enforcement activity information publicly available on its website. (Management action – nonstatutory)

Recommendation 4.6, Adopted — Direct the board to stagger registration and certificate renewals. (Management action – nonstatutory)

ISSUE 5

A Continuing Need Exists for the State Board of Dental Examiners.

Recommendation 5.1, Adopted — Continue the State Board of Dental Examiners for 12 years.

Recommendation 5.2, Modified — Update the standard Sunset across-the-board provision regarding conflicts of interest and apply the newly updated Sunset across-the-board recommendation on board member training.

ADOPTED NEW ISSUES

Dental Anesthesia

Advisory committee. Create a standing advisory committee on dental anesthesia to advise the board on the development and revision of rules related to dental sedation and anesthesia:

- Require the board chair to appoint nine members to include, but not be limited to: dentists, dentist anesthesiologists, oral and maxillofacial surgeons, pediatric dentists and physician anesthesiologists. The board chair may not appoint an active dental board member to the advisory committee.
- Require the board to provide the committee with a board attorney who will act as counsel to the committee members. The board attorney shall be present during committee meetings and the committee's deliberations to advise the committee on legal issues.
- Require the committee to report their recommendations and other findings to the dental board on an annual basis, or more frequently as necessary to provide input on rulemaking and make this information available on the board's website.

Data reporting. Direct the board to track and quarterly report anesthesia-related data and to make publicly available on its website aggregate enforcement data by fiscal year and type of license. (Management action – nonstatutory; *see Adopted Language, page A10*)

Emergency preparedness. Require the board to develop rules establishing minimum emergency preparedness standards necessary prior to administering sedation/anesthesia including requirements related to

- having an adequate, unexpired supply of necessary drugs and anesthetic agents;
- having an onsite automated external defibrillator (AED) immediately available;
- periodic equipment inspections in a manner and on a schedule determined by the board; and
- maintenance and retention of an equipment readiness log that shall be made available to the board upon request and to board staff during inspections.

Portability permits. Provide for the following statutory changes to portability requirements:

- Define “portability” as the ability of a permit holder to provide permitted anesthesia services in a location other than a facility or satellite facility, consistent with the definition in rule.
- Require the board to establish in rule requirements and methods for a dental sedation and anesthesia permit holder to obtain a portability permit.
- Require the board to establish advanced didactic and clinical training requirements necessary for a portability permit, with consideration for additional requirements for those using their portability permit to treat pediatric and/or high-risk patients.

Prescription Monitoring Program

Dentist requirements. Beginning September 1, 2018, require dentists to search the Prescription Monitoring Program and review a patient’s prescription history before prescribing opioids, benzodiazepines, barbiturates, or carisoprodol. A dentist who does not check the program before prescribing these drugs would be subject to disciplinary action by the dental board.

Dental board requirements. Require the dental board to query the Prescription Monitoring Program on a periodic basis for potentially harmful prescribing patterns among its licensees. The dental board would work with the pharmacy board to establish potentially harmful prescribing patterns that the dental board should monitor by querying the database for dentists who meet those prescribing patterns. Based on the information obtained from the Prescription Monitoring Program, the dental board would be authorized to open a complaint for possible non-therapeutic prescribing.

Fiscal Implication Summary

Overall, the Sunset Commission’s recommendations would result in a positive fiscal impact to the General Revenue Fund of approximately \$47,900 annually from reducing the size of the board and enhancing licensing and enforcement efforts.

The recommendation to decrease the number of board members by four would result in a small annual savings of about \$8,300 to the General Revenue Fund resulting from decreased travel costs. Requiring nine members to attend informal settlement conferences on a rotating basis would cost approximately \$5,400 per year in travel costs, assuming each member attended informal settlement conferences two times per year.

The recommendation to authorize the board to inspect dental offices administering anesthesia would not have a significant fiscal impact to the state, though actual implementation would have costs associated with extra staff, travel, and equipment. These costs could be mitigated by an adjustment to existing anesthesia permitting fees.

The recommendation to query the National Practitioner Data Bank would require a \$3 increase in licensing fees to cover the board's cost and would result in a small revenue gain of approximately \$45,000 annually. This gain would result from applicants paying the fee who ultimately do not meet the standards for licensure and thus do not require of queries the data bank.

ADOPTED LANGUAGE

Recommendation 1.3

Modification Language

Include the following as statutory changes.

Informal Proceedings

- The board by rule shall adopt procedures governing informal disposition of a contested case. Rules must require that
 - (1) not later than the 180th day after the date the board's official investigation of the complaint is commenced, the board shall determine a future date on which to hold an informal settlement conference to consider disposition of the complaint or allegation, unless good cause is shown by the board for scheduling the informal settlement conference after that date;
 - (2) the board give notice to the licensee of the time and place of the meeting not later than the 45th day before the date the informal settlement conference is held;
 - (3) the complainant and the licensee be provided an opportunity to be heard;
 - (4) the board's legal counsel or a representative of the attorney general be present to advise the board or the board's staff; and
 - (5) a member of the board's staff be at the meeting to present to the Informal Settlement Conference Panel the facts the staff reasonably believes it could prove by competent evidence or qualified witnesses at a hearing.
- An affected licensee is entitled to reply to the staff's presentation and present the facts the licensee reasonably believes the licensee could prove by competent evidence or qualified witnesses at a hearing.
- After ample time is given for the presentations, the Informal Settlement Conference Panel shall recommend that the investigation be closed or shall make a recommendation regarding the disposition of the case, unless applicable concerning contested cases requires a hearing.
- If the license holder has previously been the subject of disciplinary action by the board, the board shall schedule the informal settlement conference as soon as practicable but not later than the 180th day after the date the board's official investigation of the complaint is commenced.
- Notice must be accompanied by a written statement of the nature of the allegations and the information the board intends to use at the meeting. If the board does not provide the statement or information at that time, the license holder may use that failure as grounds for rescheduling the informal meeting. If the complaint includes an allegation that the license holder has violated the standard of care, the notice must include a copy of the report by the expert dentist reviewer. The licensee must provide to the board the licensee's rebuttal at least 15 business days before the date of the meeting in order for the information to be considered at the meeting.
- The board by rule shall define circumstances constituting good cause for not meeting the 180-day deadline, including an expert dentist reviewer's delinquency in reviewing and submitting a report to the board.

- The board by rule shall define circumstances constituting good cause to grant a licensee's request for a continuance of the informal settlement conference.
- Information presented by the board or board staff in an informal settlement conference is confidential.
- On request by a licensee under review, the board shall make a recording of the informal settlement conference proceeding. The recording is a part of the investigative file and may not be released to a third party unless authorized. The board may charge the licensee a fee to cover the cost of recording the proceeding. The board shall provide a copy of the recording to the licensee on the licensee's request.

Board Representation in Informal Proceedings

- Define the informal settlement conference panel to include members of the Board and the Dental Review Committee.
- In an informal settlement conference, at least two Informal Settlement Conference Panel members shall be appointed to determine whether an informal disposition is appropriate. At least one of the panelists must be a dentist.
- Pursuant to Board rules, one panelist must be physically present at the ISC, but one panelist may appear by video conference.
- An informal settlement conference may be conducted by one panelist if the affected licensee waives the requirement that at least two panelists conduct the informal proceeding. If the licensee waives that requirement, the panelist may be either a dentist, dental hygienist, or a member who represents the public.
- Only one panel member is required in an informal settlement conference proceeding conducted by the board to show compliance with an order or remedial plan of the board.

Roles and Responsibilities of Participants in Informal Proceedings

- An informal settlement conference panel member that serves as a panelist at an informal settlement conference shall make recommendations for the disposition of a complaint or allegation. The member may request the assistance of a board employee at any time.
- Board employees shall present a summary of the allegations against the affected licensee and of the facts pertaining to the allegation that the employees reasonably believe may be proven by competent evidence at a formal hearing.
- A board attorney shall act as counsel to the panel members and shall be present during the informal settlement conference and the panel's deliberations to advise the panel on legal issues that arise during the proceeding. The attorney may ask questions of participants in the informal settlement conference to clarify any statement made by the participant. The attorney shall provide to the panel a historical perspective on comparable cases that have appeared before the board, keep the proceedings focused on the case being discussed, and ensure that the board's employees and the affected licensee have an opportunity to present information related to the case. During the panel's deliberations, the attorney may be present only to advise the panel on legal issues and to provide information on comparable cases that have appeared before the board.
- The panel and board employees shall provide an opportunity for the affected licensee and the licensee's authorized representative to reply to the board employees' presentation and to present

oral and written statements and facts that the licensee and representative reasonably believe could be proven by competent evidence at a formal hearing.

- An employee of the board who participated in the presentation of the allegation or information gathered in the investigation of the complaint, the affected licensee, the licensee's authorized representative, the complainant, the witnesses, and members of the public may not be present during the deliberations of the panel. Only the members of the panel and the board attorney serving as counsel to the panel may be present during the deliberations.
- The panel shall recommend the dismissal of the complaint or allegations or, if the panel determines that the affected licensee has violated a statute or board rule, and that violation supports action by the board, the panel may recommend board action and terms for an informal settlement of the case.
- The panel's recommendations must be made in writing and presented to the affected licensee and the licensee's authorized representative. The licensee may accept the proposed settlement within the time established by the panel at the informal meeting. If the licensee rejects the proposed settlement or does not act within the required time, the board may proceed with the filing of a formal complaint with the State Office of Administrative Hearings.

Recommendation 2.1

Modification Language

In lieu of the staff recommendation, remove the separate certification provisions for dental assistants from law and require one registration for dental assistants who provide the following dental support services to a licensed dentist: dental x-rays, pit and fissure sealants, coronal polishing, and nitrous oxide monitoring. A dental assistant would not be authorized to perform any of the four services above without first obtaining registration from the board.

Services provided by a registered dental assistant would be performed under the direct supervision of a licensed dentist, but not to be construed to authorize a dental assistant to practice dentistry or dental hygiene. Dentists remain responsible for acts delegated to the registered dental assistant. These changes would not affect the board's authority to determine which acts a licensed dentist may delegate to non-registered dental assistants. This recommendation would establish registration requirements for dental assistants, as follows:

- A person may not practice as a dental assistant to perform the four dental support services listed above after September 1, 2018 unless the person has registered with the board and received a certificate of registration.
- The board, by rule, shall establish minimum education requirements for registration as a dental assistant. Requirements must include a high school diploma or equivalent; and a course of instruction and examination to demonstrate competency in the following dental support services: dental x-rays, pit and fissure sealants, coronal polishing, and nitrous oxide monitoring; and training in basic life support, infection control, jurisprudence, and any other requirements the board determines necessary.
- The board could consider approving courses of instruction and examinations provided by outside entities such as the Dental Assisting National Board to qualify for this registration.
- Dental assistant registrations shall be renewed biennially on a staggered basis, as established by the board.

- The board shall establish continuing education requirements as a condition of renewing registration as a registered dental assistant.
- The board shall establish standards for taking disciplinary action against a registered dental assistant.
- The board shall establish fees for initial registration and renewals to cover the cost of regulation.

Recommendation 3.1

Modification Language

Include the following as statutory changes.

- **Definitions.** Define “pediatric” as patients ages 0–12. Define “high-risk patient” as patients with an American Society of Anesthesiologists (ASA) rating of level 3 or 4 or older than 75.
- **Permitting.** Require an annual permit for each of the four different levels of anesthesia, defined based on the depth of the intended procedure to alter the patient’s mental status and the method of drug delivery.
 - Level 1: Minimal Sedation
 - Level 2: Moderate Sedation (Enteral)
 - Level 3: Moderate Sedation (Parenteral)
 - Level 4: Deep Sedation or General Anesthesia

Require the board to develop rules establishing minimum standards for training, education, and other standards for different permit levels. For level 2–4 permit holders, education/training requirements must include training on pre-procedural patient evaluation including the evaluation of the patient’s airway and physical status as currently defined by the ASA, ongoing monitoring of sedation and anesthesia, and management of emergencies.

Require level 2–4 permit holders to provide proof of additional training for the treatment of pediatric and/or high risk patients including advanced didactic and clinical training requirements. Dentists would not be allowed to treat pediatric and/or high-risk patients without proof of specialized education.

Allow the board to establish additional limitations on the administration of anesthesia on pediatric and/or high risk patients.

- **Inspections.** Allow the board to conduct pre-permit, random, and compliance inspections. Require the board to determine an appropriate risk-based inspection schedule for on-site inspections of dental offices of dentists with a level 2, 3 or 4 permit. Allow the board to stagger inspections as long as all relevant offices are inspected at least once every 5 years. Allow the board to determine education and training requirements for inspectors. Require the board to maintain records of inspections.

Data Reporting New Issue

Adopted Language

Direct the board to track and report the following data. All information related to an investigation is confidential, except that the agency shall provide the following information on a quarterly basis to the

board and the standing advisory committee on dental anesthesia, and to legislative offices upon request: de-identified, case specific data reflecting information about jurisdictional, filed complaints resolved during the reporting period related to anesthesia/sedation including the following.

1. Source of initial complaint: public, other agency, self-report of death, self-report of hospitalization, or initiated by the board
2. Information about licensee:
 - a. Whether respondent is Medicaid provider
 - b. Respondent's highest sedation/anesthesia permit level
 - c. Whether respondent holds portability privileges
 - d. Respondent's self-reported practice area
3. Information about patient:
 - a. Patient ASA rating (identified in respondent's dental records and/or determined by dental review panel)
 - b. Patient age: 12 and under, between 13 and 18, between 19 and 75, and over 75
 - c. Location of treatment investigated by the agency: dental office, hospital, ASC, office of other practitioner
 - d. Level of sedation/anesthesia administered: local, nitrous, level I, level II, level III, level IV (determined by dental review panel)
 - e. Sedation/anesthesia administrator: respondent, other dentist, doctor of medicine, certified registered nurse anesthetist (determined by dental review panel)
 - f. Whether treatment investigated by the agency was paid by Medicaid
4. Information about investigation:
 - a. Allegation categories identified in preliminary investigation
 - b. Disposition of official investigation — dismissed by enforcement, dismissed by legal — no violation, dismissed by board vote, closed by administrative citation/remedial plan/disciplinary action
 - c. If disposition is public action (administrative citation, remedial plan, or disciplinary action), the violations identified in the public action resolving the official investigation

The board must make publicly available on their website aggregate data by fiscal year and type of license about the following areas:

1. Number of licensees at the end of the fiscal year
2. Total number of complaints against licensees originating in that fiscal year
3. For all resolved complaints in that fiscal year, break down the resolution by each type of action taken (nonjurisdictional, dismissed, warning, probation, suspension, revocation, etc.)

4. For all resolved complaints in that fiscal year, break down the resolution by the nature of the complaint allegation (standard of care, impairment, dishonorable conduct, continuing education violation, etc.)
5. Number of cases open longer than one year
6. Average administrative penalty assessed
7. Number of cases referred to informal settlement conferences
8. Number of cases resolved in informal settlement conferences
9. Number of cases referred to the State Office of Administrative Hearings (default + non-default)
10. Number of contested cases heard at the State Office of Administrative Hearings
11. Number of cases that went on to district court
12. Average number of days to resolve a complaint from complaint received to investigation completed
13. Average number of days to resolve a complaint from complaint received to final order issued
14. Average number of days to issue a license
15. Number of cases involving mortality and morbidity
16. Total number of anesthesia complaints against licensees originating in that fiscal year by permit level
17. For all resolved anesthesia complaints in that fiscal year, break down the resolution by each type of action taken (dismissed, warning, probation, suspension, revocation, etc.) by permit level
18. For all resolved anesthesia complaints in that fiscal year, break down the resolution by type of complication that violated the standard of care by permit level.

SUMMARY OF SUNSET STAFF RECOMMENDATIONS

SUMMARY

For a relatively small agency, the State Board of Dental Examiners has had more than its share of problems over the years. The agency infamously was abolished through its 1993 Sunset review amid a legislative skirmish not of its own making. After its re-creation in 1995, the agency was placed under another Sunset review out of its regular order in 2003 because of concerns about serious enforcement deficiencies. In its last five years, the agency has been buffeted by high turnover among its leadership ranks, going through four executive directors and general counsels in that time.

While the older events do not necessarily explain the current situation at the agency, they do provide an important historical context. Of greater significance is the more recent history of employee turnover and the effect it has had on the agency and the governing board. The revolving door of executive directors and general counsels means that senior staff must constantly play catch-up to gain a complete understanding of the basic elements of the job. The agency loses institutional knowledge for how and why policies and procedures were developed, lessons learned, and what works and what does not. Most important, however, the agency loses the vision to see emerging problems and the leadership to help address strategic agency needs, qualities that take time to develop. With experience in the job and time to see things through, senior staff can work more effectively with the board to ensure that the agency has the resources — both staff and systems — and the tools and statutory authority to do its job well. Finally, sound agency leadership gives confidence to the Legislature that the resources and tools will be used appropriately to protect the public.

Turnover among the agency's leadership ranks has had a significant effect on the agency and governing board.

In such an environment of high turnover at the top of the organization, the board itself would understandably emerge to fill the void and take on a larger role in running the agency. Further, because board members typically have longer tenure than the agency's senior staff, they would understandably play a larger role in calling the shots for the agency. However, at such a disadvantage to the board, staff is far less likely to take initiative and far more likely to defer to the board on matters even when the board may need to hear staff's more objective voice.

The issue of board involvement in agency operations is not new to the dental board. Sunset staff raised the issue in the last review of 2002, noting that the board no longer developed and administered its own dental examination and thus had less need for its then-18 members to do its job. Sunset staff's initial recommendation to reduce the board size to 11 members was changed to the current 15 members through the legislative process.

In the current review, this situation of an oversized board has only continued. The board has even less to do because of legislation from 2013 eliminating its role in reviewing standard of care complaints, though dentist board members still find ways to get involved in such cases. Dentist board members have also pursued high profile rule packages that appear more motivated by business interests than demonstrated concern for public safety; all the while other emerging problems like regulating the administration of anesthesia went largely unaddressed.

This Sunset review occurs at an opportune time for the board. Positive signs are emerging from the current efforts of the agency's senior staff, implementing the Legislature's 2013 operational changes and other initiatives such as new approaches for engaging stakeholders. While these changes have occurred with the blessing of the board, the same dynamic that has governed the agency in recent years is still in place. At the time of this review, the executive director has only been in that position seven months; the general counsel, less than two years; and the dental director, less than two and a half years. Key departures could still threaten the progress made.

Structural changes to reduce the size of the board are needed to focus it on its public protection mission and help ensure the ongoing effectiveness of the agency. Other changes would better focus stakeholder processes for dental hygienists and dental laboratories; address deficiencies in the agency's regulation of dentists' administration of anesthesia; deregulate dental assistants by eliminating the unworkable patchwork of certificate programs that provides little public protection; and update licensing and enforcement processes that have not kept up with best practices. Sunset staff recommends continuing the agency for 12 years.

The following material summarizes all of the Sunset staff findings and recommendations on the State Board of Dental Examiners.

Issues and Recommendations

Issue 1

The Unusually Large Dental Board Inappropriately Focuses on Issues Unrelated to Its Public Safety Mission.

A shift in responsibility for technical complaint reviews to a panel of contracted experts in 2013 significantly decreased the workload for dentist board members. With less to do, the board, at the behest of dentist members, pursued significant rule changes more related to business practices than demonstrated public safety problems and despite widespread concern by stakeholders and other interests and a lack of broad consensus. Dentist members also continue their involvement in case resolution, ultimately undermining those efforts. Better aligning the number of dentist board members with the amount of technical expertise needed by the agency will help focus the board squarely on issues of public protection and make better use of staff resources.

In addition, board processes for stakeholder input hold promise for improved involvement, eliminating the need for two statutorily created advisory committees, the Dental Hygiene Advisory Committee and the Dental Laboratory Certification Council. Removing advisory committees from statute will allow the board more flexibility to convene more diverse groups of stakeholders for input on an as needed basis.

Key Recommendations

- Reduce the size of the board from 15 to nine members and adjust its composition to consist of four dentists, two dental hygienists, and three public members.
- Allow the board's statutory advisory groups to expire and direct the board to establish clearer processes for stakeholder input in rule.

Issue 2

State Regulation of Dental Assistants Is Unnecessary to Ensure Public Protection and Is an Inefficient Use of Resources.

The board's regulation of dental assistants has expanded over the past 25 years to consist of four separate certificate programs for commonly delegated tasks, though assistants can legally perform some work without holding any certificate. In fiscal year 2015 the board issued 50,469 dental assistant certificates, more than all other board issued credentials combined.

State regulation of dental assistants is not needed to protect public safety. Dental assistants can only work under the delegated authority of the dentist, who remains responsible for patient care and safety. Because they can only perform reversible tasks, they have very low volume of meaningful complaint and enforcement activity, little, if any, of which relates to standard of care. In addition, gaps in regulatory requirements undermine the very promise of public safety the regulations were supposed to provide. The regulatory program wastes licensing and legal resources and diverts board and staff focus from higher-risk agency responsibilities. Ultimately, addressing deficiencies to fix these regulations is not an option without dramatically expanding the scope of their practice, because the risk to the public relating to the current practice is so low. National credentialing and private market forces can provide any training or oversight of dental assistants desired by employers or the public. Removing regulatory responsibility for dental assistants from the board will allow the agency to focus on licensees that pose a higher risk to patients and the public.

Key Recommendation

- Discontinue the board's dental assistant certificate programs.

Issue 3

The Board Lacks Key Enforcement Tools to Ensure Dentists Are Prepared to Respond to Increasing Anesthesia Concerns.

Dentists administer anesthesia for a variety of dental procedures. In recent years, the board has seen an increase in related complaints involving serious patient harm and sometimes death. The board lacks the authority and resources to routinely inspect the offices of dentists providing some anesthesia services and does not require written emergency action plans for any dentist administering anesthesia to help ensure thoughtful planning and readiness for the unexpected. Dentists in other states and Texas doctors administering anesthesia in offices are subject to related routine inspections, and office-based Texas physicians providing anesthesia must maintain written emergency action plans. Allowing the board to conduct inspections of dentists administering anesthesia in office settings and requiring related written emergency management plans of dentists providing anesthesia will incentivize dentists to be prepared for anesthesia-related complications and train support staff accordingly.

Key Recommendations

- Authorize the board to conduct inspections for dentists administering parenteral anesthesia in office settings.
- Direct the board to revise rules to ensure dentists with one or more anesthesia permit and maintain related written emergency management plans.

Issue 4**Key Elements of the State Board of Dental Examiners' Licensing and Regulatory Functions Do Not Conform to Common Licensing Standards.**

In reviewing the board's regulatory authority, Sunset staff found that certain licensing and enforcement processes do not match model standards or common practices observed through Sunset staff's experience reviewing regulatory agencies. Specifically, the board does not do enough to ensure licensees are free from disciplinary action in other states or have complied with past board orders before renewing their licenses. The board is also unable to require evaluations for licenses suspected of impairment due to substance abuse or mental illness, and cannot protect the confidentiality of licensees participating in assistance programs.

Key Recommendations

- Require the board to monitor licensees for adverse licensure actions in other states.
- Authorize the board to deny applications to renew a license if an applicant is noncompliant with a board order.
- Authorize the board to require evaluations of licensees suspected of being impaired and require confidentiality for information relating to the evaluation and participation in treatment programs.
- Direct the board to make data on the board's enforcement activity information publically available on its website.

Issue 5**A Continuing Need Exists for the State Board of Dental Examiners.**

Regulating the practice of dentistry and supporting functions continues to support the state's interest in protecting the public. Alternative organizational structures, including the transfer of regulatory programs to other agencies, offer no substantiated benefit at this time. Continuing the board in its current form will provide an independent agency responsible for ensuring quality, safe dental care.

Key Recommendation

- Continue the State Board of Dental Examiners for 12 years.

Fiscal Implication Summary

Overall, recommendations in this report would result in a negative fiscal impact to the General Revenue Fund of approximately \$1,402,000 over the next five years. The impact comes from ending the occupational licensing programs for dental assistants, reducing the size of the board, and enhancing licensing and enforcement efforts.

Issue 1 — Decreasing the number of board members by six would result in a small annual savings of about \$13,000 to the General Revenue Fund resulting from decreased travel costs.

Issue 2 — The recommendation to deregulate dental assistants would have a negative impact to the General Revenue Fund of about \$1.46 million per year resulting from the loss of fee revenue collected from dental assistants in excess of the cost of regulation.

Issue 3 — Providing the authority for the board to inspect dental offices administering anesthesia would not have a significant fiscal impact to the state, though actual implementation would have costs associated with extra staff, travel, and equipment. These costs could be mitigated by an adjustment to existing anesthesia permitting fees.

Issue 4 — These recommendations would result in a small revenue gain of approximately \$45,000 annually, associated with the \$3 increase in licensing fees to cover the board's cost to query the National Practitioner Data Bank. This gain would result from applicants paying the fee who ultimately do not meet the standards for licensure and thus do not require of queries the data bank.

State Board of Dental Examiners

Fiscal Year	Loss to the General Revenue Fund	Change in the Number of FTEs From FY 2017
2018	\$1,402,000	-3
2019	\$1,402,000	-3
2020	\$1,402,000	-3
2021	\$1,402,000	-3
2022	\$1,402,000	-3

AGENCY AT A GLANCE
APRIL 2016

AGENCY AT A GLANCE

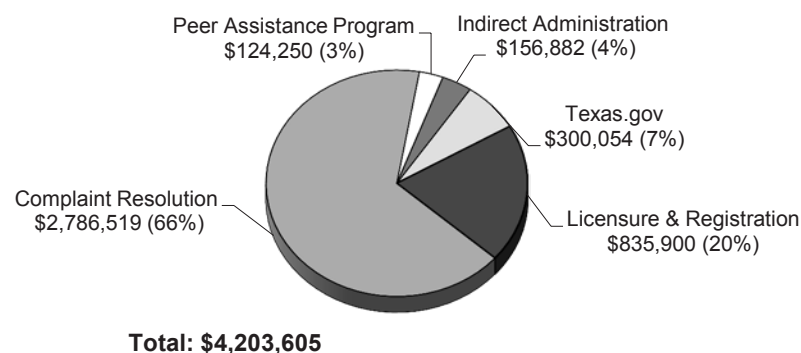
The State Board of Dental Examiners (the board) seeks to safeguard public health and safety by regulating dental care in Texas, a responsibility the board has had since its creation in 1897. To meet its mission of ensuring high quality and safe dental care, the board

- licenses dentists and dental hygienists and registers dental assistants, laboratories, and mobile dental facilities;
- enforces the Dental Practice Act and board rules by investigating complaints against licensees and registrants and taking disciplinary action against violators;
- monitors compliance of disciplined licensees and registrants; and
- provides a peer assistance program for licensees and registrants who are impaired.

Key Facts

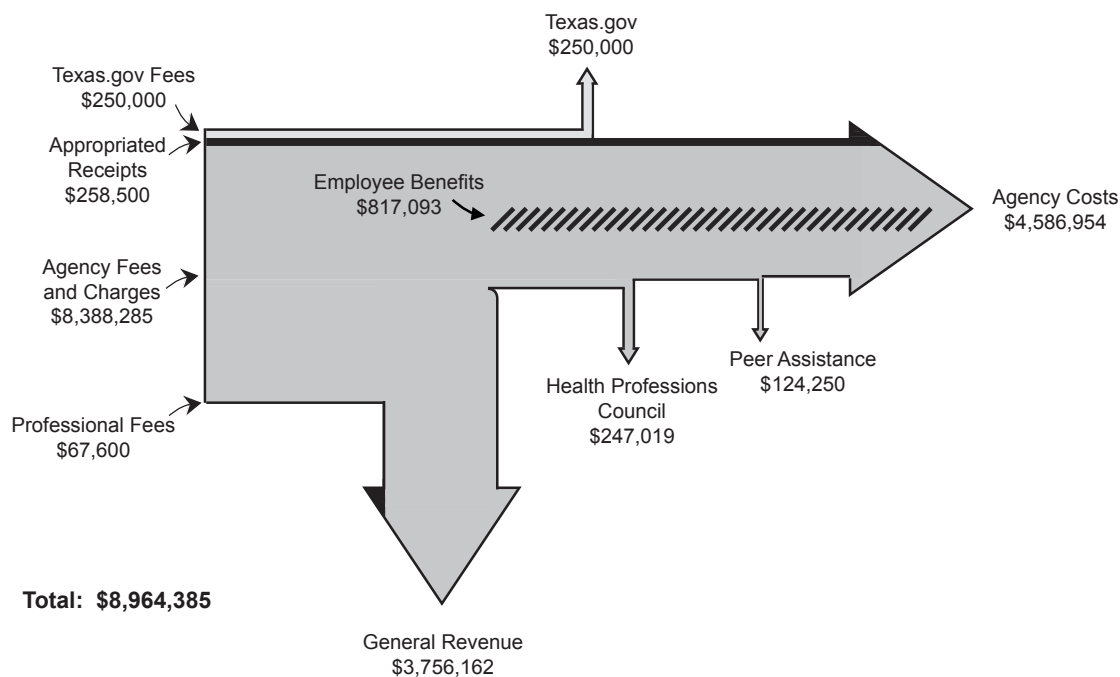
- **State Board of Dental Examiners.** The board consists of 15 members: eight dentists, two dental hygienists, and five public members. All members are appointed by the governor, with the advice and consent of the Senate, for no more than two six-year terms. The presiding officer is chosen by the governor and must be a dentist; the board annually elects a member to act as secretary. Two statutorily created advisory committees assist the board. The Dental Hygiene Advisory Committee is composed of three dental hygienists and two public members appointed by the governor, as well as one dentist appointed by the board, but not a member of the board. The Dental Laboratory Certification Council consists of three certified dental technicians appointed by the board.
- **Funding.** In fiscal year 2015, the board operated on a total budget of \$4,203,605 with 93 percent of its funding coming from the General Revenue Fund and the remainder from appropriated receipts. Revenue generated through fees paid by dentists, dental hygienists, dental assistants, and other entities regulated by the board is deposited in the General Revenue Fund and more than covers the board's operating costs. The pie chart, *State Board of Dental Examiners Expenditures by Program*, shows the board's expenditures in each major program area. Investigating and resolving complaints accounts for almost two-thirds of total board expenditures.

**State Board of Dental Examiners Expenditures by Program
FY 2015**



Historically, the board has generated revenue through various fees and charges far in excess of what is needed to cover agency expenditures. In fiscal year 2015, the board generated revenue of \$11,814,143, including more than \$3 million from the professional fee paid by dentists directly to the General Revenue Fund and the Foundation School Fund. Although the Legislature discontinued this professional fee in 2015, the board is still expected to bring in almost \$3.8 million more from its operating fees in fiscal year 2016 than budgeted to run the agency and pay for employee benefits, as shown in the chart, *Flow of State Board of Dental Examiners Agency Revenue and Expenditures*. A description of the board's use of historically underutilized businesses in purchasing goods and services for fiscal years 2013–2015 is included in Appendix A, *Historically Underutilized Businesses Statistics*.

***Flow of State Board of Dental Examiners Agency Revenue and Expenditures
FY 2016 (Budgeted)***



- Staffing.** The board had 58 authorized positions at the end of fiscal year 2015 and actually employed 55 individuals. Most employees work in the central office in Austin, with 16 investigators and inspectors working in field offices throughout the state. Additionally, the board is a member of the Health Professions Council, which provides supplemental information technology staffing for the board and other health professional licensing agencies. A comparison of the board's workforce composition to the percentage of minorities in the statewide civilian workforce for the past three fiscal years is included in Appendix B, *Equal Employment Opportunity Statistics*.
- Licensing and Registration.** The board processes initial applications, renewals, and reinstatements for three regulated dental occupations and two facility types. The table on the following page, *Licenses or Registrations by Type*, shows credentials issued by type by the board in fiscal year 2015. Since 1994, the board has outsourced responsibility for administering licensing examinations for dentists and dental hygienists to the Western Regional Examining Board. In addition to these licenses and registrations, the board issues permits for dentists using anesthesia. In calendar year 2016, the board

will begin monitoring professional involvement with dental service organizations through a cooperative agreement with the secretary of state.

- **Complaints, Investigations, and Enforcement.** The board is responsible for receiving and investigating complaints against licensees. The board resolves complaints by dismissing those in which no violation is found or proven, or when a violation is found, by issuing a recommendation for education or practice changes, imposing a remedial plan as a non-disciplinary action, or ordering disciplinary action. The table, *Board Enforcement Data*, details the number of complaints received, subject of complaints, and disposition of complaints resolved in fiscal year 2015. In the same year, the board averaged 447 days to resolve a total of 943 complaints.
- **Compliance.** Staff monitors licensees' compliance with disciplinary actions and remedial plans to ensure that the terms and conditions of board orders are actually met. The board has two staff responsible for ensuring compliance of 354 total open cases at the end of the fiscal year 2015.
- **Peer Assistance.** The agency contracts for peer assistance services for licensees who may be impaired by substance abuse or dependence or mental illness. Through this program, dentists, dental hygienists, and dental assistants are evaluated to determine if they are safe to practice, and if not, may be subject to treatment and monitoring before being allowed to practice. Eighty-nine practitioners participated in the peer assistance program in fiscal year 2015.

Licenses or Registrations by Type FY 2015

Dentist	17,540
Dental hygienist	13,740
Dental assistant	50,469 ¹
Dental laboratory	847
Mobile dental facility	62
Total	82,658

Board Enforcement Data FY 2015

Complaints Received*	
From the public	1,127
Initiated by staff	109
Total	1,236
Subject of Complaints Received*	
Dentist	1,137
Dental hygienist	21
Dental assistant	41
Regulated facility	5
Unregulated entity	32
Disposition of Complaints Resolved*	
Dismissed	710
Remedial plan	46
Warning or reprimand	128
Administrative penalty	5
Probation	23
Suspension	4
Voluntary surrender	8
Revocation	3
Cease-and-desist order	6
Other	10
Total complaints resolved	943

* Does not include enforcement actions initiated after criminal history reviews or for non-jurisdictional cases.

.....

¹ This number represents the total number of dental assistant registrations issued in fiscal year 2015 for four separate certificate programs and does not reflect the total number of unique dental assistants registered with the board.

ISSUES

ISSUE 1

The Unusually Large Dental Board Inappropriately Focuses on Issues Unrelated to Its Public Safety Mission.

Background

The structure of the State Board of Dental Examiners governing body was last changed following the 2002 Sunset review of the agency, when the number of board members decreased from 18 to 15. The board now consists of eight dentists, two dental hygienists, and five public members.

Four standing committees support the board: the Executive, Licensing, Enforcement, and Quality Control committees. The presiding officer appoints ad hoc committees to work on special projects or potential rulemaking efforts. Eight ad hoc committees have been created since 2013 to focus on issues such as advertising, strategic planning, and ownership of dental practice. Every ad hoc committee created in recent years has consisted entirely of board members, with mostly dentist board members participating. Rules allow the board to appoint committees of various stakeholders to advise the board about contemplated rulemaking.¹ The first work group in recent history with stakeholder members was established in February 2016 to examine anesthesia permitting and related inspections.

Two statutorily created advisory groups also work with the board: the Dental Hygiene Advisory Committee and the Dental Laboratory Certification Council. The committee advises the board, reviews and comments on proposed rules, and may recommend rules related to the practice of dental hygiene. The council reviews applications for laboratory registration and may also recommend rules related to laboratories to the board. The *Board Advisory Group Composition* textbox lists the membership of each group.²

Board Advisory Group Composition

Dental Hygiene Advisory Committee

- Three dental hygienists appointed by the Governor
- Two public members appointed by the Governor
- One dentist member appointed by the board

Dental Laboratory Certification Council

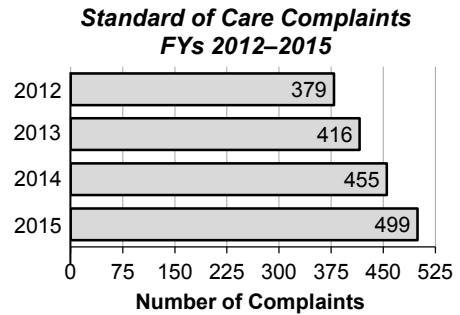
- Three members who must be dental technicians or owners, managers, or employees of a registered dental laboratory, appointed by the board

Findings

A decline in board duties requiring dental expertise has left dentist members of the board with less to do.

The board's oversized number of dentist members is a holdover from when members had a much larger role in daily agency operations and is no longer necessary to conduct agency business. In 2013, the Legislature reassigned standard of care complaint review from the board's dentist members to a panel of expert dentists and dental hygienists designated by the board.³ This process removes dentist board members from serving as both investigator and judge in enforcement matters, a position which would affect their ability to render impartial decisions. These expert reviewers also represent a much broader range of dental specialty than is possible on the board. The continuous availability on a contract basis of the 130 expert reviewers enables a much faster

turnaround of reviews for the growing number of incoming standard of care complaints shown in the accompanying chart. The use of panels has relieved dentist board members of hundreds of hours of work each year, sped up the investigative process, and helped the board make progress on its persistent backlog of enforcement cases.



The board has shown a propensity to push business-oriented matters without clear evidence of patient harm.

With fewer requirements to consume their time, dentist board members have focused on matters that do not have a demonstrated public safety impetus, undermining the agency's processes and wasting its resources.

- **Ill-fated rule packages.** At the behest of dentist members, the board has shown a propensity to push business-oriented matters without clear evidence of patient harm. Two recent rulemaking efforts show the board's disregard for stakeholder concerns, legislative and legal interests, and the lack of broad support and consensus.

One set of such proposed rules, regarding dental office ownership arrangements, purported to address patient care relating to non-dentist owners of dental offices, although the board lacks data to suggest that practice models or ownership arrangements are associated with a higher incidence of complaints alleging compromised patient safety or demonstrated harm. Yet, the board's related ad hoc committee repeatedly promoted rule

revisions addressing the perceived issue in both 2014 and 2015. The board persisted in this matter even in the face of pointed criticism from the Federal Trade Commission, opposition from numerous stakeholders, and requests by six members of the Legislature to defer to the Legislature on the issue. Federal attention to state agency rulemaking is unusual; the textbox, *Federal Trade Commission Comments*, highlights some of its comments on the proposed rules.⁴ The rules were ultimately withdrawn, but not before the effort consumed five board meetings, six ad hoc committee meetings, and countless hours of staff support between May 2014 and May 2015.

Federal Trade Commission Comments

"Proposed regulations to limit commercial relationships between dentists and non-licensed entities should be carefully examined to determine if they are based on credible and well-founded safety, quality, or other legitimate justifications."

"The proposed rules appear unnecessary to address any concerns about the independent judgment of dental professionals... we urge the Board to consider the potential anticompetitive effects of the proposed rules, including higher prices and reduced access to dental services... and to reject both proposed [rules]."

The other notable rulemaking effort regarding specialty advertising has a considerably longer history. The rules reflect the board's long reliance on a national association for advertising specialty designations. Although the rules were not challenged for several decades, the regulatory climate shifted. In 2011, the board began another review of its advertising rules, an effort spanning numerous board and ad hoc committee meetings. Ultimately, the board re-adopted rules restricting the advertising of dental

specialties in 2012 and 2013 without clear evidence of patient harm from an alternative approach to regulating advertising and despite unfavorable trends in litigation on the subject.⁵ The board was sued over the rules and recently lost, drawing the rebuke of a U.S. District Court in January 2016. As evidenced by the textbox, *Specialty Advertising Court Decision*, Federal District Court Judge Sam Sparks' opinion questioned the board's motivation for re-adopting the rules.⁶ Despite numerous opportunities to address the issues raised in the lawsuit and in the court's ruling, as suggested by agency staff and stakeholders, the board continues to pursue its own course, with little apparent concern for the legal liability and potential financial impacts its actions could bring on the agency.

Specialty Advertising Court Decision

"Defendants have produced no evidence of actual deception associated with advertising as specialists in non-ADA [American Dental Association]-recognized fields, there is no evidence to suggest any of the Plaintiffs' fields are illegitimate or unrecognized, and there has been no accusation any of the Plaintiffs' organizations are shams."

"Defendants do not offer any competent evidence to substantiate these fears and admit they did not review any studies, surveys or other evidence regarding the impact of specialty advertisements before promulgating the Rule. Instead, Defendants appeal to their own professional judgment and "vast experience dealing with customers of dental services." The State Dental Board's collective common sense is not a substitute for the "tangible evidence" required..."

"The right to advertise as a specialist in Texas is undoubtedly a financial boon to dentists in the state. While ostensibly promulgated to protect consumers from misleading speech, it appears from the dearth of evidence [the Rule's] true purpose is to protect the entrenched economic interests of organizations and dentists in ADA [American Dental Association]-recognized specialty areas."

Regulatory boards clearly have flexibility to pursue matters they reasonably believe are within their mission to protect the public, and they should be given some forgiveness when they miss the mark. However, while this board was pursuing these two dead-end rule packages — and still has another regarding sleep apnea being challenged in court — it missed numerous signs that it was on the wrong road. More importantly, while these matters were occupying the board's time, it missed opportunities to address issues much more clearly related to patient harm, such as a rise in anesthesia-related complaints. As discussed in Issue 3, board guidance for strengthening agency oversight of dental anesthesia had been largely lacking until the board established a work group in February 2016, at the suggestion of the board's new executive director, after a spate of media attention elevated the concern.

The board's recent misadventures in rulemaking highlight another concern about obtaining public and stakeholder input on difficult, contentious issues. The board follows the Administrative Procedure Act and properly posts rule changes in the *Texas Register*, but without doing more to include

The board missed opportunities to address issues more clearly related to patient harm, such as anesthesia-related complaints.

stakeholders earlier in the rulemaking process, the board gave an appearance that it had already determined its course of action and was not concerned with the effect of its policies and regulations on stakeholders. In February 2015, agency staff put a process in place for stakeholders to provide input on proposed rules earlier, in their formative stages, where they can raise potential problem areas or identify blind spots that can result without such a broad perspective. This new process offers promise, but must continue to focus the board's rulemaking efforts and ensure that they best serve its public safety mission.

*Reviewing work
of appointed
experts slows
case resolution
for little practical
result.*

- **Effect on case resolution.** Involvement in the case resolution processes reflects the difficulty dentist board members have had accepting the board's diminished role. Through the board's Quality Control Committee, these members revisit standard of care complaint cases recommended for dismissal by expert panel reviewers. While the review of dismissed cases is within the board's purview, having a standing committee expressly created to review the work of its appointed experts slows down the resolution of enforcement cases for little practical result, as detailed in the textbox, *Quality Control Committee Case Review*. Of the 10 cases returned to the expert panel from the Quality Control Committee, only three have resulted in additional action — requiring nondisciplinary remedial plans. Ultimately, the committee reflects the dentist members' antipathy for its own dental review panel, whose members the dentist board members pointedly refuse to call *expert* reviewers, despite the designation in law.⁷

***Quality Control Committee Case Review
September 2014–February 2016***

- **290** – Number of cases reviewed
- **7-8** – Weeks, on average, cases wait for committee review
- **10** – Cases returned to expert review panel for additional examination
- **6.7** – Months, on average, added to case resolution for re-reviewed cases
- **2** – Cases dismissed following committee initiated re-review
- **3** – Cases closed by remedial plan following committee initiated re-review
- **5** – Cases pending action following committee initiated re-review

Through informal settlement conferences, board members and agency staff seek to resolve complaints without going to contested case hearings at the State Office of Administrative Hearings. Most settlement conferences are attended by dentist members to clarify technical issues and questions. However some dentist board members question the findings of their own expert review panel that was designed to provide specific expertise regarding the specialty of the dentist subject to the complaint. Such freelancing has the effect of revisiting the facts of the case and revising the agency's position, which is not the role of board members at the conferences. It can also result in less consistent and potentially unfair outcomes for those

accused, ultimately undermining the settlement process. Some dentist board members involve themselves more than others; for example, of six informal conferences not settled from September 2014 to January 2016, five had the same dentist presiding. The regulatory process should work more consistently and predictably to ensure the fairness and overall effectiveness of enforcement activities.

- **Staff turnover.** Significant turnover in the executive director and general counsel positions has left stakeholders and staff without a consistent vision for agency operations. From 2011 to 2015, the board employed four separate executive directors and general counsels. Increased funding for the executive director position in the 84th Legislative Session should help promote stability for the position. However, board behavior has an undeniable impact on agency staff in terms of morale and motivation to do the difficult work of regulating dentistry. Ultimately, the board must foster an environment to maintain the consistency in leadership and legal support necessary to focus the board and the agency squarely on clear issues of public safety and protection.

Board behavior has an impact on staff morale and motivation.

Recent events highlight the heightened expectations on occupational licensing boards to adhere to a higher standard of behavior to protect the public.

- A recent U.S. Supreme Court ruling put a spotlight on state occupational licensing board behavior that may be considered anticompetitive.⁸ The impact of the ruling has been to focus attention on board actions that do not have clear public safety implications, especially actions by active market participants who may be motivated to act in their self interest. Board members must clearly show their decisions focus on the agency's mission to protect the public.
- In the 84th Legislative Session, in the heat of the board's maneuvering on the dental office ownership issue, a bill was introduced to single out the dental board as needing training on the scope and limitations of its rulemaking authority and establishing a code of conduct.⁹ While the bill was not pursued, the perceived need for such a directed measure indicates an awareness that existing board training has not resonated with current board members. The inappropriate actions of dentist board members begs for a refocusing effort directed toward issues of clear public protection supported by board licensing and enforcement data.

Recent court rulings have focused attention on board actions that do not have public safety implications.

Statutorily created advisory groups are no longer necessary to conduct board business and receive input.

- The Texas Sunset Act states that advisory committees are abolished on the date set for abolition of an agency unless the committee is expressly continued by law. The Act also directs the Sunset Commission and staff to make recommendations on the future of agency advisory committees using

the same criteria to evaluate both committees and their host agencies.¹⁰ The Dental Hygiene Advisory Committee and the Dental Laboratory Certification Council do not efficiently support the board and could be removed from statute without a negative effect on licensees or the public.

- The board's advisory groups have outlived their necessity and are no longer necessary as separate statutorily created entities for effective input to the board. The Dental Hygiene Advisory Committee has met just four times in three years and has not prompted any original rulemaking activity in that time. The Dental Lab Certification Council also seldom meets — typically just once annually as required by law. The board and specially convened stakeholder groups can provide any necessary expertise instead.
- Advisory groups duplicate existing board and staff activity and could be eliminated from statute without negatively affecting regulatory productivity. Dental hygienist board members already offer professional expertise to the full board more efficiently than the committee simply by attending board meetings. Meanwhile, the council's review of the laboratory registration applications is also redundant; council members' expertise is unnecessary to determine whether an application is complete and meets registration criteria and the process duplicates the work of agency licensing staff. Should heightened input regarding the regulation of either dental hygiene or dental laboratories be required, the board has the authority to convene working groups including broader interests than are currently represented by the committee and council.¹¹

The board can convene working groups with broader interests than represented by the committee and council.

The board has more members than many other Texas health occupational licensing boards.

Similar Texas health occupational licensing boards function with fewer members, some while regulating more licensees. The Texas Board of Chiropractic Examiners has a nine member board; the Texas State Board of Pharmacy has an 11 member board; and the Texas Board of Nursing has a 13 member board.

Recommendations

Change in Statute

1.1 Reduce the size of the board from 15 to nine members and adjust its composition to consist of four dentists, two dental hygienists, and three public members.

This recommendation would decrease the size of the State Board of Dental Examiners by six members. Four dentist members and two dental hygienists on the board would provide necessary professional expertise in collaboration with the agency's dental director. The remaining three members would represent the general public. No workload or special experience needs exist that require a 15-member board. A nine-member board is large enough to provide professional insight regarding policy and represent the board in settlement conferences while more appropriately matching dentist representation and overall board size with workload.

Because the board is not structured to represent all areas of dental specialty, it has already had to seek outside expertise for helping carry out its regulatory responsibilities, as seen in its expert review panels that review dental standard of care complaints and through its stakeholder process when addressing other specific issues. With the reduction in dentist members the board would continue its use of expert panels and stakeholder groups as resources to gain needed insights beyond its experience or knowledge when addressing specific issues.

To allow for staggering of terms, the recommendation would provide that all current board member terms expire on September 1, 2017, with the governor making initial appointments as specified below. Current members would be eligible for re-appointment if so determined by the governor to maintain needed expertise. To maintain a functioning board and conduct necessary business, board members serving on August 31, 2017, would continue to serve until a majority of new appointments are made.

- One dentist, one dental hygienist, and one public member to initial terms expiring February 1, 2019.
- One dentist, one dental hygienist, and one public member to initial terms expiring February 1, 2021.
- Two dentists and one public member to initial terms expiring February 1, 2023.

1.2 Allow the board's statutory advisory groups to expire and direct the board to establish clearer processes for stakeholder input in rule.

In accordance with the Sunset Act, this recommendation would allow the work of statutorily created advisory groups to occur more effectively and efficiently through existing board members and informal advisory groups. Allowing the Dental Hygiene Advisory Council and the Dental Laboratory Certification Council to expire would give the board more flexibility to convene working groups to receive input on related topics on an as needed basis instead of forcing unnecessary annual meetings to meet statutory requirements. Dental hygienists will retain the opportunity to comment on proposed rules concerning the practice of dental hygiene through the two dental hygienist members on the board or an ad hoc advisory group if needed. Application review and approval for dental laboratories would continue by licensing staff.

As a management action, this recommendation would direct the board to improve and clarify its use of ad hoc committees and working groups. The board should revise its rules to include a variety of representation in ad hoc committee and working group membership, including public and dental hygienist board members, professional associations, interest groups, and other non-industry stakeholders as appropriate. Stakeholder input should be proactively sought in the development of board rules and policies. The board should ensure ad hoc committees and working groups are established and working to meet clearly defined objectives relevant to the board's mission to protect the public.

1.3 Clarify the use and role of board members at informal settlement conferences.

This recommendation would specify in statute that board members present at informal settlement conferences are only to make recommendations for the disposition of a complaint or allegation and not to revisit the findings of expert reviewers. This recommendation would also direct the board to revise rules to require all board members, on a rotating basis, to attend informal settlement conferences to accommodate the workload. Settlement conferences typically occur only a day or so each month. The board's dental director and staff hygienists could provide technical dental and dental hygiene expertise as needed for informal settlement conferences attended by a public or dental hygienist board member.

This recommendation would support the work of the legislatively designed expert review panel, make better use of informal settlement conferences as a complaint resolution tool, and provide a fairer process to licensees in the enforcement process.

Fiscal Implication

While these recommendations would result in a small savings of \$12,800 due to an estimated decrease in board member travel expenses, the purpose of the recommendations is to enhance efficiency, reduce unnecessary bureaucracy, and improve stakeholder input.

¹ 22 T.A.C. Section 107.60(e).

² All citations to Texas statutes are as they appear on <http://www.statutes.legis.state.tx.us/>. Sections 262.051, 266.051, and 266.052, Texas Occupations Code.

³ Chapter 709 (H.B. 3201), Acts of the 83rd Texas Legislature, Regular Session, 2013.

⁴ Letter from Federal Trade Commission Office of Policy Planning, Bureau of Competition, Bureau of Economics to Simone Salloum, Assistant General Counsel, State Board of Dental Examiners, October 6, 2014.

⁵ See *Ardt v. Ill. Dept. of Prof'l Regulation*, 607 N.E.2d 1226 (Ill. 1992); *Bingham v. Hamilton*, 100 F. Supp. 2d 1233 (E.D. Cal. 2000); *Borgner v. Brooks*, 284 F.3d 1204 (11th Cir. 2002), *cert. denied*, 537 U.S. 1080 (2002); *Douglas v. State*, 921 S.W.2d 180 (Tenn. 1996); *Parker v. Ky. Bd. of Dentistry*, 818 F.2d 504 (6th Cir. 1987); *Parmley v. Mo. Dental Bd.*, 719 S.W.2d 745 (Mo. 1986) (en banc); *Simm v. La. State Bd. of Dentistry*, No. 01-CV-2608-R (E.D. La. 2002), *aff'd*, No. 02-30304 (5th Cir. 2003), available at <http://www.ca5.uscourts.gov/opinions/unpub/02/02-30304.0.wpd.pdf>.

⁶ *Am. Acad. of Implant Dentistry v. Parker, et al.*, 2016 U.S. Dist. LEXIS 6956 (W.D. Tex. 2016).

⁷ Section 255.065, Texas Occupations Code.

⁸ *N.C. State Bd. of Dental Exam'rs v. Fed. Trade Comm'n*, 135 S. Ct. 1101, 191 L. Ed. 2d 35 (2015).

⁹ S.B. 357, 84th Texas Legislature, Regular Session, 2015.

¹⁰ Sections 325.011, 325.012, and 325.013, Texas Government Code.

¹¹ 22 T.A.C. Section 107.60(e).

ISSUE 2

State Regulation of Dental Assistants Is Unnecessary to Ensure Public Protection and Is an Inefficient Use of Resources.

Background

Dental assistants perform a variety of functions in dental offices, from office management to assisting dentists in oral surgeries. Since 1991, statute has authorized dentists to delegate tasks to dental assistants as long as the supervising dentist believes the individual can properly and safely perform the procedure and the actions do not violate other provisions in law.¹ The State Board of Dental Examiners maintains four separate certificate programs, outlined in the table, *Dental Assistant Certificates*, regulating specific duties commonly delegated to dental assistants.² The X-Ray, Pit and Fissure Sealant, and Coronal Polishing Certificates are established in statute; the Nitrous Oxide Monitoring Certificate was created by board rule.³ Unregistered dental assistants may still assist in dental procedures by only performing duties that do not require a certificate.

Dental Assistant Certificates

Certificate	Requirements	Renewal	Total Active Certificates FY 2015*
X-Ray	<ul style="list-style-type: none"> • Basic life support training • Board approved course and exam • Jurisprudence test 	Annual	34,610
Pit and Fissure Sealant	<ul style="list-style-type: none"> • Basic life support training • Board approved course • Jurisprudence test • Two years' experience as a dental assistant 	Annual	2,353
Coronal Polishing	<ul style="list-style-type: none"> • Basic life support training • Board approved course • Jurisprudence test • Two years' experience as a dental assistant 	None	2,959
Nitrous Oxide Monitoring	<ul style="list-style-type: none"> • Basic life support training • Board approved course and exam • Jurisprudence test 	None	10,547

* Reflects number of certificates, not individual certificate holders.

The Sunset Act contains rigorous requirements for evaluating licensing and regulatory functions of state agencies. As summarized in the textbox on the following page, *Sunset Questions for Occupational Licensing*, statutory criteria guide Sunset reviews in determining if an occupation presents a clear threat to public health, safety, or welfare, and whether ongoing regulation can be justified.⁴

Sunset Questions for Occupational Licensing

- Does the occupational licensing program serve a meaningful public interest?
- Does the program provide the least restrictive form of regulation needed to protect the public interest?
- Could the program's regulatory objective be achieved through market forces, private certification and accreditation programs, or enforcement of other law?
- Are the skill and training requirements for a license consistent with a public interest, or do they impede applicants, particularly those with moderate or low incomes, from entering the occupation?
- What is the impact of the regulation on competition, consumer choice, and the cost of service?

Findings

State regulation of dental assistants does not improve public safety.

Complaints involving patient care and safety attach to the dentist, not the dental assistant.

- **Dentists are ultimately responsible for patient care and safety.** Dentists are responsible for the quality of all dental care their patients receive. As detailed in the textbox, *Statutory Responsibility*, statute is clear that dentists are accountable for the consequences of all delegated tasks, including those performed by dental assistants and regardless of the assistant's registration status with the board.⁵ Complaints involving patient care and safety and resulting enforcement actions attach to the responsible dentist and not the dental assistant. Accordingly, the regulation of dental assistants by the state does not offer additional avenues of recourse to patients who receive substandard care. The dentist has the responsibility to ensure the proper performance of delegated acts.

Statutory Responsibility

"A delegating dentist is responsible for a dental act performed by the person to whom the dentist delegates the act."

Dental assistants have no direct role in the administration of anesthesia.

- **Dental assistants are limited to performing low risk tasks.** The opportunity for dental assistants to cause serious patient harm is minimal, because all procedures performed by dental assistants must be reversible or capable of correction.⁶ For example, dental assistants have no direct role in the administration of anesthesia. State law also prohibits dental assistants from cutting hard or soft tissue, a stipulation significantly limiting the opportunity for in-mouth work by dental assistants.⁷ These limitations reflect the functional relationship between the dental practitioners; dental assistants perform tasks complementary to dentists' technical work and at their direction, but cannot act independently and are therefore unlikely to injure patients.
- **Regulation produces little meaningful enforcement activity.** The board receives very few complaints against dental assistants, suggesting a lower risk of harm compared to other related regulatory programs. Not one of

the 26 complaints against dental assistants made by the public in fiscal year 2015 alleged standard of care violations, and most involved professional conduct or unlicensed practice violations. Additional information about the board's complaint and enforcement activity concerning dental assistants is available in Appendix C, *State Board of Dental Examiners Comprehensive Enforcement Data*. The low volume of complaints and regulatory activity concerning dental assistants' patient care reflects the minimal level of public risk associated with the vocation.

- **Regulatory gaps undermine the promise of public safety.** Exceptions to the initial requirements for dental assistant certificates challenge assurances of the education, training, and other competency standards for dental assistants. By law, dental assistants can take x-rays for up to one year without registering with the board.⁸ The one-year exemption is tied to the employer, so dental assistants, a highly mobile population, may remain unregistered indefinitely simply by changing employers annually. This loophole significantly undermines the registration requirement for dental assistants, because the board has no way to know when a dental assistant began employment or began taking x-rays, nor, for that matter, would patients. As a result, the process largely relies on the honor system between the dentist and dental assistant to inform the board.

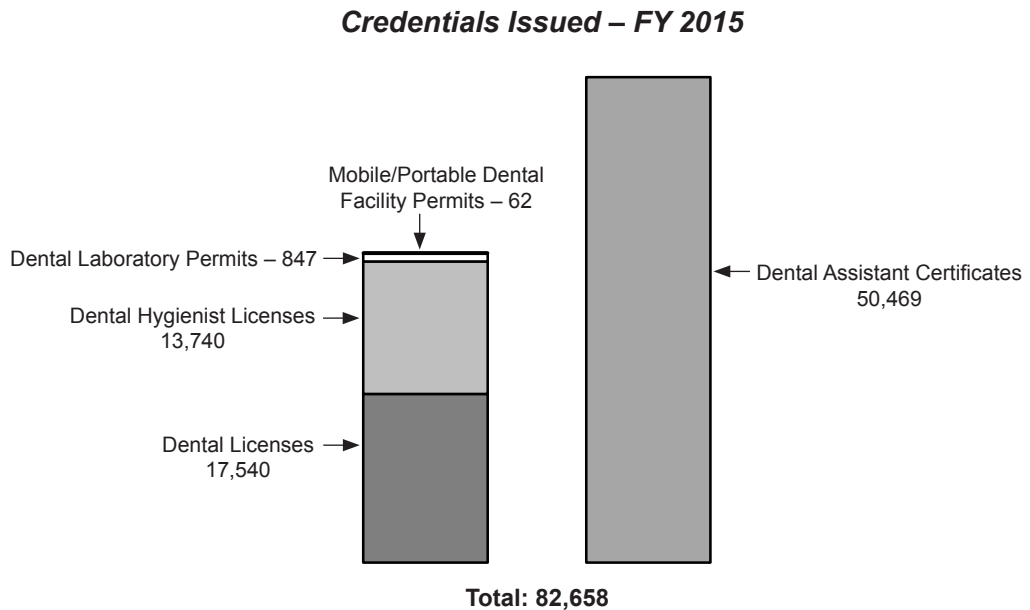
In addition, continuing education provisions do not ensure the ongoing competency of dental assistants. While continuing education requirements are clearer for those with the X-Ray and Pit and Fissure Sealant certificates, which are renewed annually, dental assistants do not have to submit documentation of continuing education courses to renew certificates, and the board does not audit compliance. As above, this process ultimately relies on the honor system for dental assistants to obtain the ongoing training needed to stay current with the latest developments in the field. Continuing education could be better enforced by the employing dentist without state regulation.

Dental assistant certificates are an unwieldy patchwork of regulation and waste limited board resources.

- **Dental assistant certificate programs divert licensing resources.** Board resources supporting the dental assistant certificate programs would be of better use supporting higher risk professional licenses. As illustrated by the chart on the following page, *Credentials Issued*, the board issued more dental assistant certificates in fiscal year 2015 than all other types of credentials combined. Managing the application materials for the four distinct dental assistant certificate programs requires the equivalent of three staff positions because of separate application processes and different requirements. In contrast, the same number of employees is able to support the processing of licensing materials for dentists and dental hygienists, professions with more complex training and education requirements and a greater potential to cause patient harm.

Dental assistants can take x-rays for up to one year without registering with the board.

Staff support for dental assistant certificate programs would be better used on higher risk licenses.



- Board action on dental assistant certificates wastes limited legal resources.**
 Board action based on applicants' criminal history needlessly diverts limited legal resources away from higher priority enforcement responsibilities. Dental assistants are not subject to background checks before licensure. However, self-disclosure of criminal convictions on certificate applications prompts legal review, investigation, and often the issuance of a consent order with a certificate. The majority of reported criminal history involves misdemeanors unrelated to the duties or responsibilities of dental assistants and often occurred years before submitting an application. The impact of this process on legal staff is out of proportion to the risk; staff attorneys reviewed about 600 dental assistant applications and prepared 139 associated consent orders in fiscal year 2015, requiring significant legal staff time. Issuing consent orders in response to dated criminal histories of dental assistant applicants is an especially ineffective use of resources compared to the legal division's responsibility to prosecute complex enforcement cases against dentists and its ongoing efforts to work through a backlog of complaints.

Having a single certificate for dental assistants would not address the issue that the regulation is unnecessary.

Addressing the deficiencies in the state's approach to certifying dental assistants would not enhance public protection.

- Strengthening the regulation of dental assistants is not justified.**
 State regulation of dental assistants through a simplified or more robust regulatory program would not improve patient care and would extend already unnecessary regulatory oversight. Streamlining the existing registration processes onto one application or consolidating the certificates into a single license would not address the fundamental issue that the state's regulation of dental assistants is unnecessary to protect the public. Further, to do so would erect an even higher barrier to the profession for a group that may be overwhelmed by the expense of required training and coursework,

agency fees, and continuing education requirements. Establishing a more comprehensive regulatory system is not needed for someone who can only perform reversible tasks delegated by a highly trained, and ultimately accountable, dentist.

- **Other states do not provide a clear model for regulating dental assistants.** Six states license dental assistants, 26 states use registration or certificate systems to credential dental assistants in some way, and 18 states do not regulate dental assistants at all.⁹

National credentialing and private market forces can provide desired oversight of dental assistants.

Existing credentialing programs and private market forces already offer consumers and employing dentists standards and oversight for dental assistants' training and practice, rendering the state's certification programs redundant. The American Dental Association recognizes the Dental Assistant National Board (DANB) as the national certification board for dental assistants.¹⁰ Credentials from DANB are recognized in 46 states, including 32 states that require or recognize its certifications for certain dental assisting privileges. Certification through DANB requires education, examinations, and continuing education, as well as the disclosure of felony criminal history and disciplinary actions by occupational licensing boards. Dental assistants are disciplined by DANB for unprofessional, dishonest, or fraudulent behavior.

Statute and market forces motivate dentists to employ well trained dental assistants.

Using national certification standards would increase market accessibility for dental assistants looking to relocate to Texas, which already accepts DANB certification as meeting the education requirements for the X-Ray, Pit and Fissure Sealant, and Coronal Polishing Certificates. Motivated by statutory responsibility for all patient care and market forces, dentists are encouraged to employ only well trained and competent dental assistants, and can rely on certification through the private DANB as a means to evaluate potential staff without state interference.

Recommendation

Change in Statute

2.1 Discontinue the board's dental assistant certificate programs.

This recommendation would eliminate three dental assistant regulatory programs from statute: the X-Ray, Pit and Fissure Sealant, and Coronal Polishing certificates. As a management action, this recommendation would also direct the board to discontinue the Nitrous Oxide Monitoring certificate in rule. Removing the X-Ray Certificate from statute would require clarification of the Medical Radiologic Technologist Certification Act to ensure the ability of dental assistants to continue to perform x-rays under the authority of the dentist without having to register with the board.¹¹ Under this recommendation, the board's regulatory functions related to dental assistants would cease on the effective date of the provision in the resulting Sunset bill.

This recommendation would not interfere with the existing ability of dental assistants to perform delegated, reversible tasks under a licensed dentist's supervision, nor would it alleviate the responsibility of dentists to ensure dental assistants have the proper training, such as that provided by private organizations. As a management action, the board would be directed to clarify the tasks dentists may delegate to dental assistants in rule. Implementation of this recommendation is intended to allow the board to focus on the higher risk regulatory programs for dentists and dental hygienists and redirect enforcement resources to complaints concerning licensees responsible for patient harm.

Fiscal Implication

Because of the effect of licensing fee revenue on the General Appropriations Act, deregulation of occupations in Texas generally has a negative impact on the General Revenue Fund. This recommendation would have a negative impact to the General Revenue Fund of \$1.46 million per year. Licensing and administrative fee collections for the dental assistant certificate programs totaled about \$1,568,000 in fiscal year 2015. This recommendation would eliminate three full-time positions at the board associated with administering the certificate programs, which would save about \$108,000 in salary and benefit expenditures, for a net estimated revenue loss to the state of \$1,460,000 annually. Given the continued backlog of complaints, the board could request the positions and resources associated with the dental assistant certificate programs to support regulation and enforcement of higher risk licensee groups and continue working through a backlog of cases.

State Board of Dental Examiners

Fiscal Year	Loss to the General Revenue Fund	Change in the Number of FTEs From FY 2017
2018	\$1,460,000	-3
2019	\$1,460,000	-3
2020	\$1,460,000	-3
2021	\$1,460,000	-3
2022	\$1,460,000	-3

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- ¹ All citations to Texas statutes are as they appear on <http://www.statutes.legis.state.tx.us/>. Section 258.002(a), Texas Occupations Code.
 - ² Section 4.04, Chapter 1470 (H.B. 3507), Acts of the 77th Texas Legislature, Regular Session, 2001; Section 25, Chapter 17 (S.B. 263), Acts of the 78th Texas Legislature, Regular Session, 2003; Section 6, Chapter 476 (S.B. 455), Acts of the 81st Texas Legislature, Regular Session 2009; 22 T.A.C. Section 114.4; (Tex. State Bd. of Dental Exam'rs, Extension of Duties of Auxiliary Personnel--Dental Assistants) *adopted* 32 Tex. Reg. 627 (2007) (proposed December 1, 2006).
 - ³ Sections 265.004-.006, Texas Occupations Code; 22 T.A.C. 114.4.
 - ⁴ Section 325.0115(b), Texas Government Code.
 - ⁵ Sections 258.002(a) and 258.003, Texas Occupations Code.
 - ⁶ Section 265.0001(2)(C), Texas Occupations Code; 22 T.A.C. Section 114.1.
 - ⁷ Section 258.001(3)(B), Texas Occupations Code.
 - ⁸ Section 265.005(l), Texas Occupations Code; 22 T.A.C. Section 114.11.
 - ⁹ American Association of Dental Boards, *The Composite*, 26th ed. (Chicago: American Association of Dental Boards, 2015), 83–84 and 90–92.
 - ¹⁰ “About DANB,” Dental Assistant National Board, Inc., last modified December 6, 2015, <https://www.danb.org/en/About-DANB.aspx>.
 - ¹¹ Sections 601.152 –153 and 601.252, Texas Occupations Code. The State Board of Dental Examiners would need to be exempt from Section 601.252(c), Texas Occupations Code, to fully discontinue the X-Ray Certificate program. Additionally, Section 601.153(2), Texas Occupations Code, would need to be deleted or modified to permit delegation to supervised, but unregistered, dental assistants.

ISSUE 3

The Board Lacks Key Enforcement Tools to Ensure Dentists Are Prepared to Respond to Increasing Anesthesia Concerns.

Background

Dentists administer varying levels of anesthesia to perform procedures ranging from routine preventive care to invasive corrective treatment. Patients typically receive anesthesia in dental office, ambulatory surgical center, or hospital settings using two techniques described in the textbox, *Methods of Anesthesia Administration*. The State Board of Dental Examiners has issued separate permits allowing dentists to administer anesthesia since 2001.¹

Methods of Anesthesia Administration

- **Enteral** anesthetic is absorbed through the intestines, nose, mouth or skin; delivery is typically through pills and liquids.
- **Parenteral** anesthetic is absorbed through intravenous or intramuscular injection; delivery is typically through intravenous therapy or localized injections.

The board's anesthesia permitting structure, depicted in the table, *Dental Anesthesia Permits*, is tiered based on the intended level of consciousness, method of administration, and amount of practitioner training. Dentists must hold a separate permit for each type of anesthesia administration they want to perform, so the numbers include duplicate permit holders. With nitrous oxide permits most numerous, 69 percent of Texas dentists hold at least one anesthesia permit. Level III and IV permit holders can apply separately for portability permits, allowing provision of anesthesia services in locations other than a dentist's primary office.² Dentists with portability permits often administer anesthesia for other dentists who do not have the same credentials. Nearly 700 Texas dentists held one or more portability permits in fiscal year 2015.

Dental Anesthesia Permits – Fiscal Year 2016

Type	Number*	Application/Renewal Fees
Nitrous Oxide/Oxygen inhalation sedation	12,086	\$32 / \$10
Level I: Minimal sedation	7,357	\$60 / \$10
Level II: Moderate sedation limited to enteral routes of administration	3,075	\$60 / \$10
Level III: Moderate sedation which includes parenteral routes of administration	1,668	\$60 / \$10
Level IV: Deep sedation or general anesthesia	558	\$60 / \$10

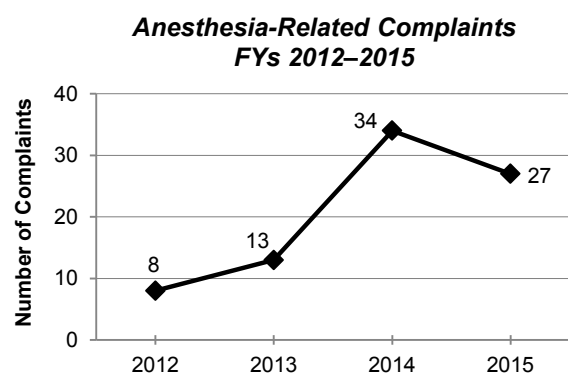
* Counts reflect individual permits issued, not individual permit holders.

Parenteral administration of anesthesia was once the only way to achieve deep sedation in patients, but advances in pharmacology now allow deep sedation using enteral anesthesia delivery. As a result, method of administration of anesthesia is less indicative of patient level of consciousness than it once was. Because individuals respond differently to anesthesia, the board requires all permit holders to have certain equipment to rescue patients experiencing adverse reactions or patients who enter a deeper state of sedation than intended.³

Findings

Anesthesia can be high risk to patients, and related complaints to the board have increased.

As highlighted by recent media coverage, complications from dental procedures using anesthesia have caused serious harm to Texas patients, including death.⁴



To provide a more complete picture of this situation, a manual examination of standard of care complaints received by the board from fiscal year 2011 to mid-fiscal year 2016 was performed for this review. Even without the assurance that the resulting data set is comprehensive, the number of complaints involving anesthesia has increased in recent years, as illustrated by the chart, *Anesthesia-Related Complaints*. In addition, the 17 complaints received midway through fiscal year 2016 were on pace to equal the previous high number of anesthesia-related complaints in 2014.

Anesthesia can cause serious harm even if correctly administered and supervised. Of the 100 anesthesia-related complaints compiled in the review, 41 involve a patient death during or shortly after a dental procedure involving anesthesia. Board reviewers ultimately determined that most of these deaths were unrelated to the supervising dentist's performance, but at least 13 of the 41 death cases were found to include violations of the dental standard of care, including inappropriate preparation for or response to anesthesia-related emergencies. The textbox, *Selected Texas Anesthesia-Related Complaint Cases*, offers details of specific harm to patients from recent complaint cases involving dental procedures using anesthesia.

Anesthesia-related complaints received midway through fiscal year 2016 were on pace to equal the previous high.

Selected Texas Anesthesia-Related Complaint Cases

The State Board of Dental Examiners investigated and found:

Case One: A child suffered severe, irreversible brain damage following moderate enteral sedation in a dentist's office. The treating dentist sedated the patient using oral medications and nitrous oxide to remove decayed teeth. The child began experiencing seizures after administration of the anesthesia, but the dentist did not contact emergency medical services for hours. Instead, the dentist attempted to manage the seizures using oral medications while the child's oxygen saturation dropped and was not supplemented. As of the release of this report, the dentist's license was temporarily suspended. Additional enforcement action is expected from the board.

Case Two: An adult patient died after receiving deep parenteral sedation for a root canal procedure. The dentist administering the anesthesia was using a portability permit to provide services in another dentist's office. When the patient stopped breathing during the procedure, an assistant had to run to the dentist's car to retrieve resuscitation equipment. The final cause of death was determined to be heart disease, which complicated the effect of the anesthesia on the body. But the board still found that the dentist administering anesthesia violated the standard of care by failing to recognize the patient's deteriorating situation, have rescue equipment at hand, and immediately call emergency medical services. As a result, the board suspended the dentist's anesthesia permits until the dentist met a number of requirements including 320 hours of continuing education and an office inspection.

Gaps in regulatory authority and a lack of leadership have left the board unprepared to address anesthesia-related problems.

- Limited inspection authority.** Data from the review of more than five years of complaints related to anesthesia indicates parenteral delivery of anesthesia is involved in nearly two-thirds of such complaints, as shown in the accompanying chart. However, the board only has statutory authority to perform inspections of dental offices, equipment, and documents related to *enteral* anesthesia administration. The invasive nature and demonstrated risk of parenteral delivery, combined with a higher number of associated complaints to the board, suggests a greater need for similar inspection authority related to parenteral delivery as it already has for enteral administration of anesthesia. Without inspection authority, the board is left to react to problems after they have occurred through its complaint process and cannot prevent problems and possible tragedies before they occur by ensuring dentists are ready to respond to an emergency should the need arise.

**Anesthesia-Related Complaints
by Method of Administration
FYs 2012–2016 Year to Date***

Method	Complaints
Parenteral	63
Enteral	25
Unknown or under investigation	12

* Reflects anesthesia-related complaints received in only one-half of fiscal year 2016.

- Lack of board leadership on anesthesia issues.** Although it has had authority since 2001 to routinely inspect the offices of dentists administering enteral anesthesia, the board has never had or sought the financial resources to do so. Until very recently, the board has not even tracked anesthesia-related complaints to fully understand the extent of related issues. This inaction may relate to many factors that have affected the board in recent years, including significant turnover in key staff positions and the board's interest in other projects, as described in Issue 1 of this report. After media attention to dental anesthesia and at the suggestion of the new executive director at the February 2016 board meeting, the board appointed a work group to consider potential inspection criteria, revisions to permit applications, and other efforts intended to improve the board's oversight of anesthesia administration. More of this kind of preventive action is needed to better ensure the safe delivery of anesthesia in the dental context.
- Inconsistent regulation of dental anesthesia administration due to practice location.** Dentists providing anesthesia services in office settings are not subject to the same preventive and oversight measures as their hospital — and ambulatory surgical center-based peers, even though the board has regulatory authority over dentists practicing in both settings.

Inspections. The Department of State Health Services or private accrediting bodies routinely inspect all hospitals and ambulatory surgical centers in the state to ensure safety and anesthesia emergency preparedness. As a result, the workspace of dentists administering anesthesia in those settings is subject to greater oversight through checks for equipment and written protocols to help ensure readiness to address anesthesia emergency situations in a way that does not exist for dentists administering anesthesia in a typical office setting.

Without inspection authority, the board cannot ensure readiness to respond to emergencies.

Plans force practitioners to consider the role of every office member in an anesthesia-related emergency.

Emergency Action Plans. Dentists administering anesthesia in office settings are required to maintain the equipment, drugs, and training necessary to respond appropriately to an anesthesia-related emergency. However, the board has not required dentists practicing in offices to pull all of these efforts together in a written, actionable plan as is required in more sophisticated medical facilities or required of physicians administering moderate anesthesia in office settings. The distinction is important and without a basis, considering the equal inherent risk of anesthesia delivery to patients regardless of treatment location and the danger from mishandling anesthesia-related complications in office settings as described in the tragic cases earlier in this report. Written procedures alone will not save a patient in distress. But, the exercise of developing and writing out a plan forces practitioners to consider the role of every office member when reacting to anesthesia-related emergencies and identify gaps in preparedness. Plans also offer references for support staff that can be used for training, an activity conducive to timely and appropriate reactions should the unexpected occur.

- **Risk-based regulation.** Another way of noting the risk associated with the administration of anesthesia in an office setting is that 69 of 100 recent anesthesia-related complaints resulted from procedures performed in such settings, as noted in the table, *Anesthesia-Related Complaints by Location of Treatment and Method of Administration*. By comparison, 20 complaints emerged from procedures performed in ambulatory surgical centers and hospitals in the same period. With the noted increase in anesthesia-related complaints, and the understanding that more of those complaints come from procedures performed in offices than in other settings, the board has

***Anesthesia-Related Complaints by Location
of Treatment and Method of Administration
FYs 2012–2016 Year to Date****

Location of Treatment	Method of Administration
69 Office	43 Parenteral
	20 Enteral
	6 Unknown or under investigation
7 Ambulatory surgical center	7 Parenteral
	0 Enteral
	0 Unknown or under investigation
13 Hospital	11 Parenteral
	1 Enteral
	1 Unknown or under investigation
11 Unknown or under investigation	2 Parenteral
	4 Enteral
	5 Unknown or under investigation

* Reflects anesthesia-related complaints received in only one-half of fiscal year 2016.

the opportunity to direct additional attention to these practice settings and not wait for additional complaints involving serious patient harm to address current regulatory shortcomings.

Dentists in other states and Texas doctors administering anesthesia in offices are subject to related routine inspections.

- **Most other states require office inspections for dentists delivering parenteral anesthesia.** The inability of the board to routinely inspect the offices of dentists practicing parenteral anesthesia administration methods puts Texans at more risk than patients in most other states. Thirty-nine states require and three states allow office inspections for dentists administering parenteral or general anesthesia, indicating the majority of states have determined the privilege to administer parenteral anesthesia should be accompanied by an additional level of oversight beyond the licensing review of credentials.⁵
- **The Texas Medical Board inspects physicians' facilities providing office-based anesthesia services.** Since 2001, the medical board has had authority to perform inspections related to the provision of anesthesia in outpatient settings, regardless of method of administration.⁶ With funding from the Legislature in 2013, the medical board conducted 239 office anesthesia provider inspections in fiscal year 2014, but had to suspend its inspections later that year to resolve implementation challenges. The medical board has since revised related rules and expects to resume inspections again in fiscal year 2016.

Most states see the need for extra oversight of dentists administering parenteral anesthesia.

Recommendations

Change in Statute

3.1 Authorize the board to conduct inspections of dentists administering parenteral anesthesia in office settings.

This recommendation would eliminate the term and related definition of “enteral” in existing statute to clearly authorize the board to conduct routine, non-complaint based inspections of office sites and documents of the practices of dentists providing all methods of anesthesia administration. The recommendation would not extend existing board inspection authority to licensed hospitals, licensed ambulatory surgical centers, and other facilities or the dentists performing anesthesia procedures exclusively in those settings, because these facilities are already subject to inspections through the Department of State Health Services or other accrediting bodies.⁷ However, the board would retain all existing authority over dentists in those settings. As a management action, the board should adopt rules to support a risk-based inspection schedule, detailing the framework and procedures for inspections of the offices and documents of licensed Texas dentists holding any level of anesthesia permit.

Management Action

3.2 Direct the board to revise rules to ensure dentists with one or more anesthesia permits maintain related written emergency management plans.

This recommendation would direct the board to adopt rules requiring dentists with one or more anesthesia permit to maintain and annually update written policies and procedures incorporating existing equipment, drug, and training requirements for responding to emergency situations involving anesthesia. Similar written procedures are already a part of inspections of licensed hospitals, licensed ambulatory surgical centers, and other facilities conducted by other entities. Requiring written emergency action plans will encourage dentists administering anesthesia in all settings to develop actionable, coordinated responses to adverse reactions or other complications and offer a basis for meaningful related staff training.

Fiscal Implication

Providing the authority for the board to inspect the offices and documents of dentists administering anesthesia parenterally would not have a significant fiscal impact to the state. Implementation of inspections would have a cost, which could be mitigated by an adjustment to existing anesthesia permitting fees, listed in the table *Dental Anesthesia Permits*, on page 27. The board estimates three full-time staff positions would be necessary to coordinate and support inspections as well as an unidentified amount of funding for the inspections themselves and related equipment. Depending on whether the inspections were performed by board staff or contracted reviewers, the board could need additional staff positions. By comparison, the Texas Medical Board has a \$210 biennial fee for physicians offering Level II or higher office-based anesthesia services. As registered office-based anesthesia providers, 2,527 physicians are technically subject to inspections by the medical board in fiscal year 2016, though the Board inspects providers on a four-year cycle.

¹ All citations to Texas statutes are as they appear on <http://www.statutes.legis.state.tx.us/>. Section 258.155, Texas Occupations Code.

² 22 T.A.C. Section 110.7.

³ 22 T.A.C. Section 192(c) and (i); 22 T.A.C. Section 110.3(c)(7); 22 T.A.C. Section 110.4(c)(7); 22 T.A.C. Section 110.5(c)(7); 22 T.A.C. Section 110.6(c)(8).

⁴ Brooks Egerton, "Deadly Dentistry" *Dallas Morning News*, December 9, 2015; Larson, Jace, *Deaths at the Dentist*, (Houston, TX: KPRC Channel 2), February 11, 2016.

⁵ American Association of Dental Boards, *The Composite*, 26th Ed., (Chicago: American Association of Dental Boards, 2015), 64–65.

⁶ Section 162.106(a), Texas Occupations Code.

⁷ Section 162.103, Texas Occupations Code.

ISSUE 4

Key Elements of the State Board of Dental Examiners' Licensing and Regulatory Functions Do Not Conform to Common Licensing Standards.

Background

The mission of the State Board of Dental Examiners is to protect the public's health and safety by ensuring dental professionals are qualified, competent, and adhere to established professional standards. To accomplish its mission, the board licenses dentists and dental hygienists, registers dental assistants and facilities, and enforces the Dental Practice Act by investigating complaints and taking disciplinary action when necessary.

The Sunset Advisory Commission has a long history evaluating licensing agencies, as the increase of occupational regulation served as an impetus behind the creation of the commission in 1977. Since then, the commission has completed more than 100 licensing agency reviews, documenting standards to guide reviews of licensing agencies. While these standards provide a guide for evaluations, they are not intended for blanket application. Sunset staff continues to refine and develop standards, reflecting additional experience and different or changing needs, circumstances, or practices in licensing agencies. The following material highlights areas where the board's statute and rules differ from model standards and common practices by comparable agencies, and describes the potential benefits of conforming to standard practices.

Findings

Nonstandard licensing and enforcement practices detract from the board's ability to protect the public.

- **Underutilization of national disciplinary data bank.** Licensing agencies should consult enforcement information compiled by national or federal data banks to monitor disciplinary actions against practitioners licensed or seeking licensure in Texas who are also licensed in other states. Federal law requires each state dental board to report disciplinary actions to the National Practitioner Data Bank.¹ The data bank provides agencies the information necessary to decide if licensees disciplined in other states should be allowed to practice in Texas or if enforcement action is warranted based on violations that reflect a practitioner's inability to safely perform their job. The intent is to ensure a licensee's mobility cannot be used to evade discipline.

Currently, all applicants for initial licensure must request a self-query from the data bank and provide the results to the board, but these reports only provide a snapshot of applicants' disciplinary history and are not updated to reflect subsequent activity. Additionally, applicants for renewal must only self-disclose disciplinary actions and do not submit data bank reports to the board as confirmation. The cost of receiving continuous feedback

The intent of the data bank is to ensure a licensee's mobility cannot be used to evade discipline.

from the data bank typically prevents agencies like the board from being able to obtain up-to-date disciplinary history about licensees. However, reliance on self-disclosure allows too many gaps for potentially dangerous licensees to skip through, as demonstrated in the textbox *Failure of Current Self-Disclosure Requirements*.

Failure of Current Self-Disclosure Requirements

- In February 2014, a dentist licensed in Texas and Nevada was disciplined by the Nevada State Board of Dental Examiners after two patients died following the dentist's administration of anesthesia during treatment.
 - In October 2014, the dentist failed to self-disclose the Nevada disciplinary actions on his Texas renewal application.
 - The dentist was able to treat patients in Texas until November 2015, when the board discovered the omission and issued a temporary suspension based on the action taken by Nevada and for having fraudulently obtained a Texas dental license.
 - Between the renewal in 2014 and license suspension in 2015, a patient was hospitalized following the dentist's mismanagement of an anesthesia-related emergency in Texas.
-
- **No statutory authority to deny renewal applications for noncompliance.** The authority to deny renewal applications for failure to comply with previous board orders bolsters agencies' enforcement efforts and ensures that disciplined licensees have fulfilled their responsibilities and show a commitment to safe practice. Without authority to deny renewals for noncompliance, the board must instead open another enforcement case. Having to pursue a new case in these instances requires additional resources and time, allowing noncompliant licensees to continue to work and possibly putting the public at risk.
 - **Insufficient authority to require evaluations for allegedly impaired licensees.** Most agencies that regulate practitioners with access to controlled substances have the authority to require licensees suspected of being impaired due to substance abuse or a physical or mental health condition to submit to a peer assistance evaluation to determine if they pose a risk to patient safety.² To balance that authority with practitioners' legitimate concerns for privacy, these agencies protect the confidentiality of information relating to evaluations and participation in treatment programs.³ Confidentiality also provides an incentive for licensees to participate in peer assistance programs. These agencies allow disclosure in enforcement proceedings or as otherwise necessary to protect the public, but participants' medical information remains private.⁴

The board has no authority to require the evaluation of potentially impaired licensees.

Unlike other health licensing agencies, the board has no authority to require the evaluation of licensees to see if a suspected impairment affects their ability to safely practice. Without the results of an evaluation, the board

typically lacks evidence to prove that the person's addiction or condition affects the person's ability to practice safely. The inability to practice safely is already specified as grounds for discipline under the Dental Practice Act.⁵ The act also does not protect the confidentiality of information related to participation in peer assistance programs, potentially deterring licensees from cooperating with board efforts to get them into treatment, and ultimately affecting the board's ability to protect the public.

Confidentiality provides an incentive for licensees to participate in peer assistance programs.

Nonstandard board procedures could affect the agency's efficiency and accountability in regulating the dental industry.

- **Subjective qualifications for licensure and registration.** Qualifications for licensure or registration should not overburden applicants or unreasonably restrict entry into practice. Statute requires applicants for licensure or registration to be of "good moral character," which in practice requires boards to review applicants' criminal history.⁶ Chapter 53 of the Occupations Code governs licensing agencies' use of criminal history information, requiring generally that a crime directly relate to the duties of the licensed occupation with additional stipulations related to the nature and timing of the crime.⁷ While the board generally adheres to the requirements of Chapter 53, its disciplinary matrix specifies that it will consider certain crimes unrelated to dentistry regardless of mitigating factors or rehabilitative efforts.⁸ The statutory requirement for licensees to be of "good moral character" and the board's guidance for applying disciplinary action are overbroad and vague, and can unfairly affect entry into the field.
- **Insufficient reporting of enforcement data.** Licensing boards should maintain adequate information about enforcement activity, including detailed statistics about complaints received and cases resolved each year, to improve awareness of trends and areas for improvement. This information should be readily accessible to policymakers, staff, and the public in reports to provide greater awareness of an agency's activities and maintain accountability for performance. The board receives regulatory data at each quarterly meeting, but reports are fragmented and limit a complete analysis of the overall enforcement effort to show agency performance and identify possible problem areas in the industry. None of this information is currently included on the board's website.
- **Inconsistent renewal procedures.** Staggering the renewal of credentials balances staff workload and ensures timely processing. The board renews most licenses, registrations, and permits on a staggered basis, but renews dental facility permits on January first annually.⁹ The influx of renewals for dental laboratories, mobile dental facilities, and portable dental units can overwhelm agency operations during an already busy month.

Enforcement data should be readily accessible to policymakers, staff, and the public.

Recommendations

Change in Statute

4.1 Require the board to monitor licensees for adverse licensure actions.

This recommendation would require the board to verify, on an ongoing basis, that licensees are not subject to disciplinary actions taken by other states that warrant similar action in Texas. Under this recommendation, the board should request continuous query reports from the National Practitioner Data Bank for each applicant for initial licensure and each renewal applicant to ensure the board receives accurate, timely notice of actions taken by other states or agencies. This recommendation would require an increase in licensing fees of \$3 per licensee to cover the board's cost of querying the data bank. This access to disciplinary information would allow the board to better protect the public by ensuring licensees in Texas are not subject to disciplinary orders in other states that affect their ability to safely care for patients.

4.2 Authorize the board to deny applications to renew a license if an applicant is not compliant with a board order.

Under this recommendation, the board would have the discretion to determine whether noncompliant applicants can safely perform their job or if their renewal application should be denied. Authority to deny renewals would help the board better protect consumers from potentially unsafe practitioners, provide greater incentive for licensees to comply with board orders, and standardize the board's procedures with other health occupational licensing agencies' practices.¹⁰

4.3 Authorize the board to require evaluations of licensees suspected of being impaired and require confidentiality for information relating to the evaluation and participation in treatment programs.

Under this recommendation, the board would be authorized to order a licensee to submit to an evaluation by the peer assistance program based on probable cause that the practitioner is impaired due to substance abuse or a physical or mental health condition. Authority to require an evaluation should be limited to proving or disproving whether grounds for disciplinary action exists under the existing provisions of the Dental Practice Act. This recommendation would also require that any information related to participation in a peer assistance program, including the results of an evaluation, be confidential.

The board would only be authorized to disclose this confidential information in enforcement and other proceedings affecting the persons' license because of the threat to public safety. The board would also be able to disclose that the license of a person ordered to participate in a peer assistance program is suspended, revoked, or otherwise limited by referring to the statutory grounds for disciplinary action, without disclosing the specific impairment or condition that resulted in the board's action. For example, the board would be permitted to disclose the suspension of a license based on probable cause that the licensee is physically or mentally incapable of practicing dentistry safely, but would not disclose the specific condition or impairment that gives the board probable cause for the suspension.¹¹ Ultimately, this recommendation would provide the same tools and license protection as currently available to comparable licensing agencies to protect the public while also protecting the confidentiality of licensees.

4.4 Remove unnecessary qualifications required of applicants for licensure or registration.

This recommendation would remove the requirement that dental practitioners have “good moral character.” As a management action, the board would instead be directed to review applicants’ criminal histories in accordance with the requirements and boundaries of Chapter 53 of the Occupations Code to determine eligibility for licensure or registration. This recommendation would ensure that qualifications for licensure or registration relate more closely to the duties of dental practitioners and do not unreasonably restrict entry into practice.

Management Action

4.5 Direct the board to make data on the board’s enforcement activity information publicly available on its website.

This recommendation would direct the board to synthesize and publish investigative and disciplinary information, providing policymakers, board members, staff, and stakeholders a more complete picture of the board’s enforcement efforts. This information would reflect compiled data from the board’s enforcement program, presented in a clear, organized manner. At a minimum, the board should report

- the number of complaints received in a fiscal year, distinguishing those received from the public from those initiated by the agency, for each type of license, certificate, or registration, further broken out by type of allegation;
- the outcome of cases resolved in a fiscal year for each type of credential, describing the type and number of disciplinary actions taken for each category of violation committed, and the number of cases dismissed and the basis for dismissal;
- the average time to resolve cases, as well as the range; and
- the number and age of all cases open at the end of each fiscal year.

Compiling and posting this information on the board’s website would help the board and policymakers judge the performance of the agency and improve transparency to the public. A summary of the board’s limited enforcement data available for fiscal year 2015 is provided in Appendix C, *State Board of Dental Examiners Comprehensive Enforcement Data*, to demonstrate some of the information that should be publicly available. The information contained in the summary does not show, and the board is unable to currently provide, the level of detail imagined by this recommendation and outlined above.

4.6 Direct the board to stagger registration and certificate renewals.

Under this recommendation, the board would be directed to use a staggered renewal system for dental laboratories, mobile dental facilities, and portable dental units. Staggering renewals is a more efficient use of limited resources and creates consistency in board operations. This recommendation would take advantage of existing authority to stagger renewals to alleviate unnecessary burdens on staff responsible for processing applications.¹²

Fiscal Implication

These recommendations would have a small gain to the General Revenue Fund of about \$45,000 annually. The board's cost to query the National Practitioner Data Bank under Recommendation 4.1 would require increasing licensing fees by \$3 for every applicant, reflecting the cost of receiving continuous query services. This fee would generate excess revenue because more individuals apply for licensure annually than meet the standards for licensure and do not require queries of the data bank. The board would be able to implement the remaining recommendations with current resources.

State Board of Dental Examiners

Fiscal Year	Gain to the General Revenue Fund
2018	\$45,000
2019	\$45,000
2020	\$45,000
2021	\$45,000
2022	\$45,000

¹ Health Care Quality Improvement Act of 1986 (42 U.S.C. Section 11101 et seq.).

² All citations to Texas statutes are as they appear on <http://www.statutes.legis.state.tx.us/>. Section 164.056, Texas Occupations Code (Texas Medical Board); Section 301.4521(b), Texas Occupations Code (Texas Board of Nursing); and Section 565.052, Texas Occupations Code (Texas Board of Pharmacy). See also Section 467.006, Texas Health and Safety Code (general authority); Section 801.401(e), Texas Occupations Code (Texas State Board of Veterinary Medical Examiners); and Section 202.253(a)(15) and (b)–(c), Texas Occupations Code (Texas State Board of Podiatric Medical Examiners).

³ Section 167.010, Texas Occupations Code (Texas Medical Board); Section 301.4521(j), Texas Occupations Code (Texas Board of Nursing); and Section 564.002, Texas Occupations Code (Texas Board of Pharmacy); See also Section 467.007, Texas Health and Safety Code (general confidentiality).

⁴ Ibid.

⁵ Section 263.002(a)(7) and (11), Texas Occupations Code.

⁶ Sections 256.002(a)(2) and 256.053(a)(2), Texas Occupations Code.

⁷ Chapter 53, Texas Occupations Code.

⁸ 22 TAC Section 101.8; State Board of Dental Examiners, *Disciplinary Matrix*, accessed February 9, 2016, pp. 8–10, http://www.tsbde.texas.gov/documents/laws-rules/2015_0603%20Disciplinary%20Matrix.pdf.

⁹ Sections 257.001(a) and 266.102(b), Texas Occupations Code.

¹⁰ Section 155.003(e), Texas Occupations Code (Texas Medical Board); Section 301.452(b)(1), Texas Occupations Code (Texas Board of Nursing); and Section 565.001(a)(17), Texas Occupations Code (Texas Board of Pharmacy).

¹¹ Section 263.002(a)(11), Texas Occupations Code; see also Section 263.002(a)(3) and (7), Texas Occupations Code.

¹² Sections 257.001(a) and 266.102(b), Texas Occupations Code.

ISSUE 5

A Continuing Need Exists for the State Board of Dental Examiners.

Background

Dentistry, as defined by Texas statute includes a range of activities from the diagnosis, treatment or removal of stains and decay from human teeth to surgical and other treatment for disease, pain, injury or physical condition of human teeth, gums, or jaws. Dental hygiene, a supporting function of dentistry, generally includes removal of tarter or calculus build up and polishing of human teeth, along with other functions and tasks delegated by licensed dentists. Dental assistants can perform a number of supporting acts under the delegation and direct or general supervision of a dentist. Dental laboratories generally make, repair, and fit dental appliances such as dentures.

Dental care is one of the longest-standing Texas state regulations, dating back to the creation of the State Board of Dental Examiners in 1897. Sixty years later, the legislature provided for the licensure and regulation of dental hygienists. Dental laboratories were added to the board's regulatory activity in 1973, and four dental assistant certificate programs were established in statute and rule beginning in 1995. Since 1994, the Western Regional Examination Board has administered licensing examinations for dentists and dental hygienists seeking licensure in Texas, allowing the agency to focus on licensing and enforcement functions.

The board seeks to protect public health and safety by issuing licenses and registrations; investigating and resolving complaints relating to the practice of dentistry or supporting functions; and generally enforcing the Dental Practice Act. In fiscal year 2015, the board licensed 17,540 dentists and 13,740 dental hygienists; issued 50,469 dental assistant certificates; and registered 909 facilities.

Findings

The state has a continuing need for regulating the practice of dentistry and supporting functions.

A primary role of the state is to protect the public from harm. For certain professions and occupations, the state seeks to provide this protection through regulation designed to ensure qualified practice and effective enforcement when practice standards are not met.

- **Potential for harm.** For dentistry, the risk to the public is clear. Dental activities can affect the major life functions of eating and speaking, as well as overall health and appearance. Improper practice of dentistry can result in a range of physical harm to patients, from the unnecessary loss of teeth to infection, pain, and even death. Dentistry may involve the use of anesthesia in dental procedures, and this access to drugs heightens the risk to the public. Dentistry also generally involves treatments and diagnoses well beyond a patients' ability to judge need or address on their own. Adverse results can be profound not just to one's health and safety,

Improper practice of dentistry can result in a range of physical harm to patients.

but also to one's financial well-being for the cost of unnecessary treatment or to fix poorly performed treatment.

- **Qualified practice.** State regulation seeks to mitigate the risk to the public by ensuring dental practitioners are qualified to provide dental services and by taking enforcement action to ensure compliance with requirements for safe practice. Requiring practitioners to meet education, training, and other qualifications and to demonstrate competence by passing an examination is an important way for the state to assure the public that licensed practitioners can safely perform dentistry. Regulation also promotes established standards of care and compliance with regulations by providing a mechanism to investigate and, as necessary, discipline and even remove practitioners who fail to meet them.

No substantial benefit would result for transferring the board's functions to another agency at this time.

- **Independent agency structure.** For over a century, the state has regulated dentistry through an independent regulatory agency. This structure reflects the common approach for many health licensing agencies in Texas, especially larger agencies responsible for overseeing complex medical activities that pose a significant and direct risk to public health and safety, such as the medical, pharmacy, and nursing boards.

An independent structure provides focused regulatory attention on dentistry.

This independent structure provides focused regulatory attention on dentistry. Overseen by a board composed of dental professionals and public members, the agency receives technical expertise from practitioners in developing rules and regulations reflecting the complex needs of dentistry and enforcing requirements on those who violate equally complex practice standards.

As an independent agency, the board is collocated with other health regulatory agencies. This location enables the agency to easily access best practices and learn from shared experiences of neighboring agencies. The board also achieves administrative efficiencies among similar regulatory programs through the Health Professions Council. The textbox, *Health Professions Council Functions*, lists the services provided through this collaboration.

Health Professions Council Functions

- Maintenance and security for a shared licensing database
- Web-based programming and design to support the board's website
- Operation of a toll-free complaint hotline
- Risk management services
- Mail center operations and courier services
- Assistance with job posting and advertising
- Board member training

- **Umbrella agency structure.** An alternative approach to having an independent agency is the consolidation of needed regulatory programs under an umbrella structure. The state has long regulated various trades under the umbrella of the Texas Department of Licensing and Regulation (TDLR). However, the only comparable effort for health regulatory programs at the Department of State Health Services (DSHS) was ineffective and largely dismantled last session, with numerous programs moved to TDLR or the Texas Medical Board, while others were deregulated. The rationale for this change was to focus DSHS on its important public health mission by freeing it from its health occupations licensing responsibility.

While this same rationale for moving programs from DSHS does not apply for independent agencies that already focus on licensing, an umbrella structure can still offer advantages in terms of objective, professional regulation. By specializing staff along functional lines, umbrella agencies can provide improved long-term efficiency over smaller, single-shot agencies. In addition, larger umbrella agencies can provide more avenues for developing and retaining staff, helping to insulate them against the institutional loss and disruption that can result from the departure of just a few key personnel in smaller agencies. Umbrella agencies can also provide a more objective regulatory approach, because their broad responsibilities typically require oversight boards comprising public members that rely on advisory committees of practitioners for expertise about the regulated field. This separation helps promote the broader public interest, minimizing the potential for the regulated community to promote its own interest when it controls these oversight boards.

The review considered structural alternatives presumed to provide these benefits, but found pitfalls that call into question whether such a change justifies the upheaval it would cause.

Texas Department of Licensing and Regulation. As noted above, through the 2015 Sunset review of DSHS, the Legislature transferred 13 health-related regulatory programs to TDLR over the next three years. While this experience has introduced TDLR to the regulation of health professions, none of the programs transferred require the kind of technical expertise needed to regulate dentistry, especially from an enforcement standpoint. In addition, the large expansion of authority may well have brought TDLR to the limits of its ability — or at least its current capacity to take on a larger, more complex regulatory program with the level of risk associated with dentistry.

Texas Medical Board. While the Texas Medical Board is not a traditional umbrella agency, it regulates a number of health-related programs including four received through the Sunset review of DSHS. The medical board does not fit the traditional umbrella model because it regulates medical providers under a physician-oriented board instead of a structure that accounts for broader regulatory authority. Aside from the regulated medical practices being significantly different from the practice of dentistry, the oversight

Structural alternatives have pitfalls calling into question whether such change justifies the upheaval caused.

structure would require significant adjustment to accommodate other healthcare professionals such as dentists.

Most states regulate dentistry through independent or semi-autonomous boards.

Texas' use of an independent board exercising all licensing and disciplinary powers to regulate dentistry with the outsourcing of certain administrative functions is an approach similar to most other states. Twenty seven states, including Texas, use independent dental boards to regulate the industry. An additional 18 states have a semi-autonomous regulatory structure for dentistry, wherein boards generally exercise key powers relating to licensing, discipline, and rulemaking, and a central agency provides most administrative services and makes some decisions.¹

Twenty-seven states, including Texas, use independent regulatory boards to regulate dentistry.

The Dental Practice Act does not reflect standard language typically applied across the board during Sunset reviews.

The Sunset Commission has developed a set of standard recommendations that it applies to all state agencies reviewed reflecting “good government” standards designed to ensure open, responsive and effective government. One such standard in the board’s statutes relates to possible conflicts of interest. The board’s statute restricts certain individuals from serving on the board or as a high-level agency employee if they or their spouse is closely affiliated with a nonprofit Texas trade association.² By focusing on *nonprofit* trade associations, the existing language opens the possibility for a person with a conflict because of an affiliation with a for-profit association to serve in such an influential capacity. The standard Sunset provision would prevent such a conflict.

Recommendations

Change in Statute

5.1 Continue the State Board of Dental Examiners for 12 years.

This recommendation would continue the board until 2029 as an independent agency responsible for ensuring quality, safe dental care.

5.2 Update the standard Sunset across-the-board provision regarding conflicts of interest.

This recommendation would delete nonprofit from the definition of “Texas trade association” in the State Board of Dental Examiners enabling statute to ensure that a person with a potential conflict because of an affiliation with any Texas trade association in the field of health care cannot serve on the board or as a high-level agency employee. This recommendation would ensure that both nonprofit and for-profit trade associations are treated equally under statutory conflict of interest provisions and better ensure that agency decisions are made solely in the public interest.

Fiscal Implication

Based on fiscal year 2016 appropriations and employee benefits, continuing the State Board of Dental Examiners would require approximately \$5.2 million in annual costs associated with the agency. These costs are entirely paid for by the licensing and registration fees the agency collects. The state would also continue to receive approximately \$3.8 million collected annually by the board in excess of the agency's costs.

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¹ American Association of Dental Boards, *The Composite* (Chicago: American Association of Dental Boards, 2015), 1-3.

² All citations to Texas statutes are as they appear on <http://www.statutes.legis.state.tx.us/>. Section 252.003, Texas Occupations Code.

APPENDICES

APPENDIX A

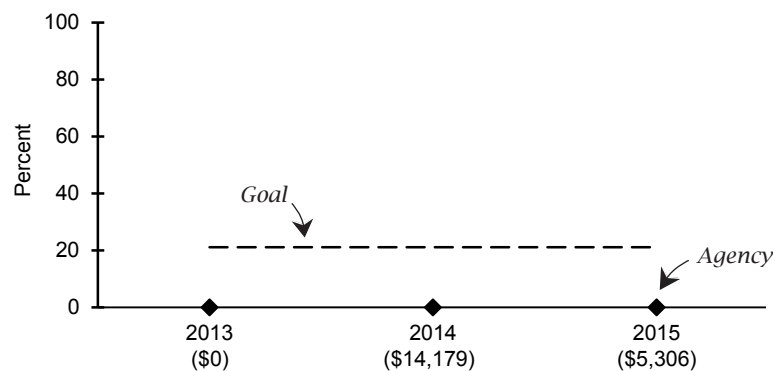
Historically Underutilized Businesses Statistics 2013 to 2015

The Legislature has encouraged state agencies to increase their use of historically underutilized businesses (HUBs) to promote full and equal opportunities for all businesses in state procurement. The Legislature also requires the Sunset Commission to consider agencies' compliance with laws and rules regarding HUB use in its reviews.¹

The following material shows trend information for the State Board of Dental Examiners' use of HUBs in purchasing goods and services. The agency maintains this information under guidelines in statute.² In the charts, the dashed lines represent the goal for HUB purchasing in each category, as established by the comptroller's office. The diamond lines represent the percentage of agency spending with HUBs in each purchasing category from 2013 to 2015. Finally, the number in parentheses under each year shows the total amount spent in each purchasing category.

The board complied with HUB program requirements, but had difficulty meeting several statewide purchasing goals in building construction and other services.

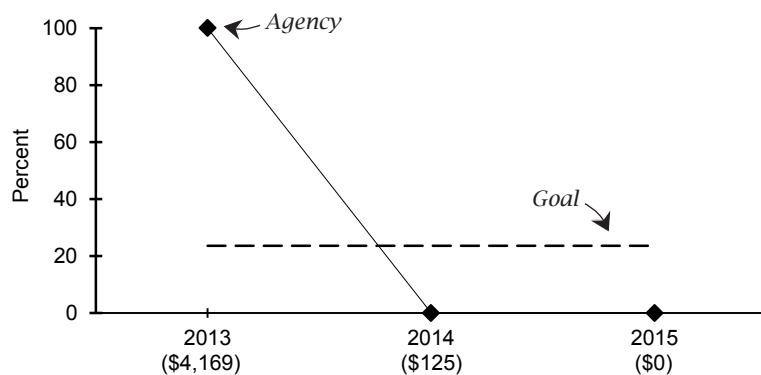
Building Construction



The board failed to meet the statewide goal for the small amount spent on building construction.

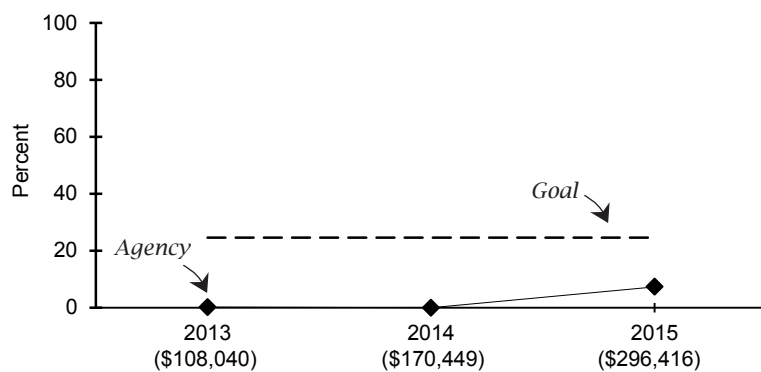
Appendix A

Professional Services



The board met the state goal for the professional services category in fiscal year 2013, but had little or no spending in the same category in fiscal years 2014 and 2015.

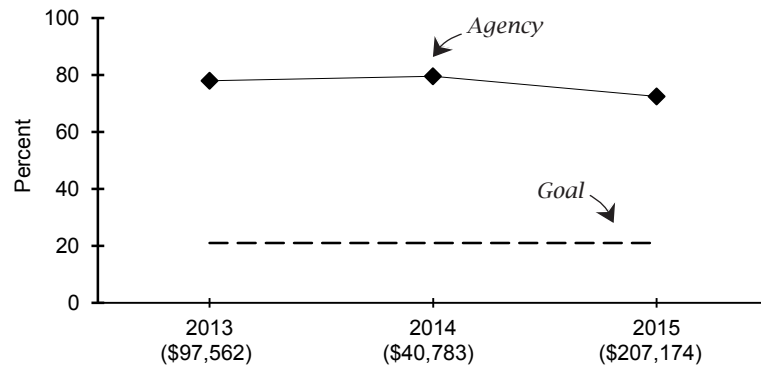
Other Services



The board has not met the state goal in each of the last three fiscal years in this category, comprising a large sole-source contract for the peer assistance program and payments for its dental review panelists, where HUB availability is limited.

Appendix A

Commodities



The agency has far exceeded the state purchasing goal for commodities in the last three fiscal years.

¹ All citations to Texas statutes are as they appear on <http://www.statutes.legis.state.tx.us/>. Section 325.011(9)(B), Texas Government Code.

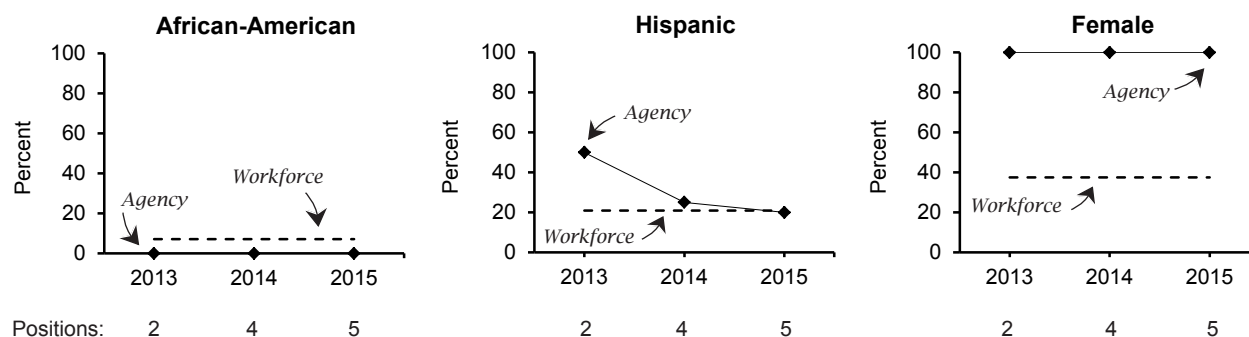
² Chapter 2161, Texas Government Code.

APPENDIX B

Equal Employment Opportunity Statistics 2013 to 2015

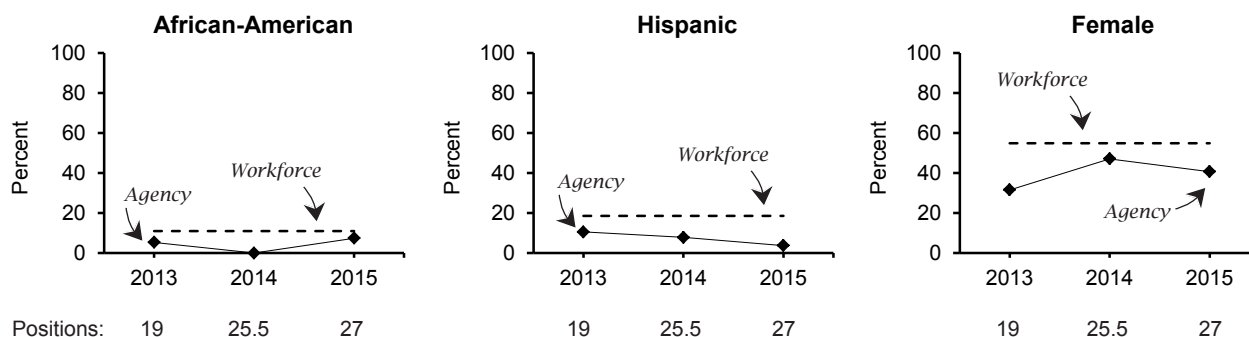
In accordance with the requirements of the Sunset Act, the following material shows trend information for the employment of minorities and females in all applicable categories by the State Board of Dental Examiners.¹ The agency maintains and reports this information under guidelines established by the Texas Workforce Commission.² In the charts, the dashed lines represent the percentages of the statewide civilian workforce for African-Americans, Hispanics, and females in each job category.³ These percentages provide a yardstick for measuring agencies' performance in employing persons in each of these groups. The diamond lines represent the agency's actual employment percentages in each job category from 2013 to 2015. The board met or exceeded several statewide civilian workforce percentages in the last three fiscal years, but fell short on its employment of African-Americans in the categories of administration, professional, and technical, and Hispanics in the professional, technical, and administrative support categories. The board also failed to meet state employment goals for females in the professional category.

Administration



The board has generally met or exceeded the statewide civilian workforce percentages of Hispanics and females for the small number of employees in this category, but not African-Americans.

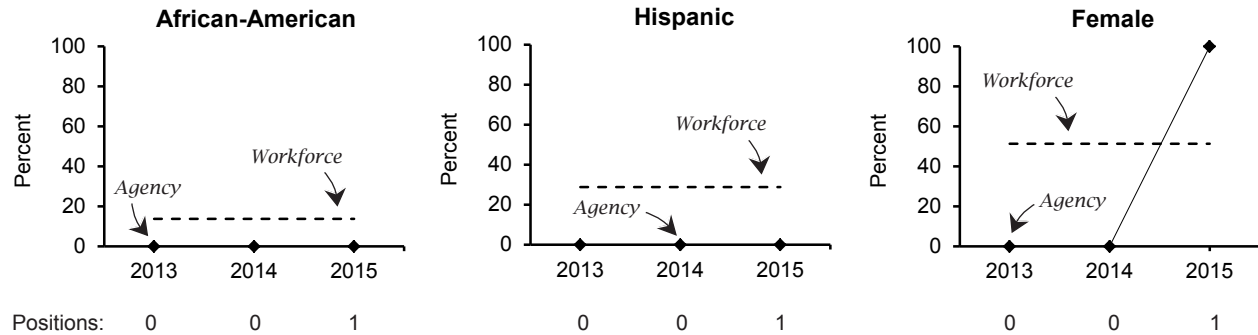
Professional



The board has not met the statewide civilian workforce percentage of African-Americans, Hispanics, and females in the last three fiscal years.

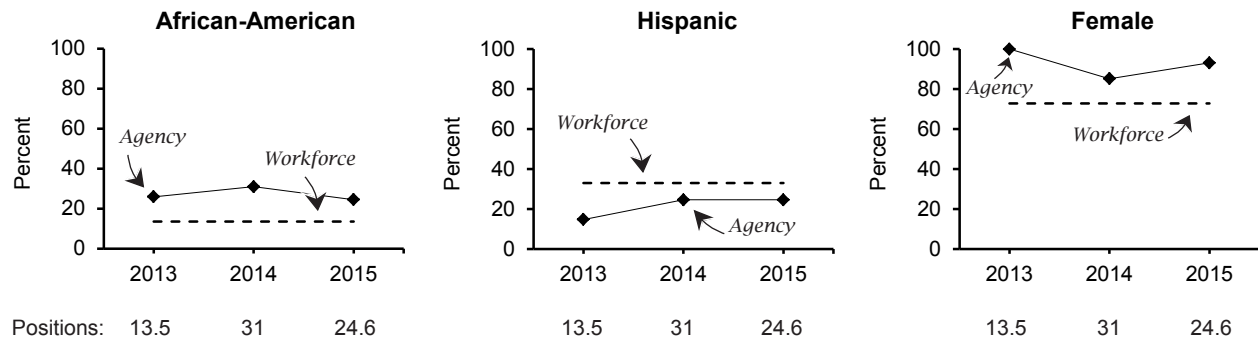
Appendix B

Technical



The board has only had one employee in this job category, exceeding the civilian workforce percentage of females in fiscal year 2015.

Administrative Support



The board exceeded the statewide civilian workforce percentages of African-Americans and females in each of the three years, but not Hispanics.

¹ All citations to Texas statutes are as they appear on <http://www.statutes.legis.state.tx.us/>. Section 325.011(9)(A), Texas Government Code.

² Section 21.501, Texas Labor Code.

³ Based on the most recent statewide civilian workforce percentages published by the Texas Workforce Commission.

APPENDIX C

State Board of Dental Examiners Comprehensive Enforcement Data – FY 2015

The following information presents a summary of the board's enforcement activities for fiscal year 2015. The State Board of Dental Examiners currently does not maintain detailed statistics and data about enforcement activities for use by policymakers, staff, and the public. The following information was hand-counted and organized by Sunset staff into this summary report, and does not provide the level of detail that would be required under Recommendation 4.5.

Complaints Received by Source						
	Dentist	Dental Hygienist	Dental Assistant	Registered Facility	Unregistered Entity	Total*
Public	1,051	13	26	5	32	1,127
Agency	86	8	15	0	0	109
Allegations by License Type						
Standard of Care Violations	573	8	0	1	13	595
Unlicensed Practice	100	3	7	0	16	126
Professional Conduct	304	8	18	2	13	345
Patient Morbidity or Mortality	135	0	0	1	0	136
Impairment, Narcotics, or Drug Diversion	37	0	5	0	0	42
Sanitation	58	1	1	0	5	65
Advertisement Violations	77	0	0	0	3	80
Other/Unreported	145	4	12	2	0	163

* Complaints received by the agency may contain more than one allegation.

Appendix C

State Board of Dental Examiners Comprehensive Enforcement Data – FY 2015

Case Resolutions by License Type						
	Dentist	Dental Hygienist	Dental Assistant	Registered Facility	Unregistered Entity	Total*
Remedial Plan	46	0	0	0	0	46
Warning or Reprimand	120	2	3	3	0	128
Administrative Penalty	4	1	0	0	0	5
Probation	14	1	8	0	0	23
Suspension	4	0	0	0	0	4
Voluntary surrender	7	1	0	0	0	8
Revocation	1	0	2	0	0	3
Cease-and-desist order	0	0	0	0	6	6
Other	6	0	4	0	0	10
Total Disciplinary Actions	202	5	17	3	6	233
Total Dismissed	**	**	**	**	**	710
Total Resolved	**	**	**	**	**	943

* Complaints received by the agency may contain more than one allegation.

** This information is not available.

Cases Dismissed by Reason

Referred to another agency	4
Referred to local law enforcement	2
Dismissed – no violation found	379
Dismissed by legal	262
Dismissed through informal settlement	15
Dismissed – insufficient evidence	1
Dismissed with recommendations/conditionally	18
Dismissed – board vote	29
Total Dismissed	710

Cases Open – FY 15 By Year of Origination

	2012	2013	2014	2015
Under Investigation	0	50	195	566
In Legal	20	49	183	50
At State Office of Administrative Hearings	0	2	0	28
Total Open	20	101	378	644

Days to Cases Resolution

Average	448
Minimum	**
Maximum	**

*** This information is not available.

APPENDIX D

Staff Review Activities

During the review of the State Board of Dental Examiners, Sunset staff engaged in the following activities that are standard to all Sunset reviews. Sunset staff worked extensively with agency personnel; attended board meetings; met with legislative staff; conducted interviews and solicited written comments from interest groups, stakeholders, and the public; reviewed agency documents and reports, state statutes, previous legislation, and literature; researched the organization and functions of similar agencies in other states; and performed background and comparative research.

In addition, Sunset staff also performed the following activities unique to this agency:

- Reviewed agency enforcement case files
- Attended stakeholder meetings concerning contemplated rulemaking topics
- Surveyed state and national interest groups, individual licensees and registrants, dental schools, dental support providers, and other stakeholders
- Attended emergency temporary suspension hearings held by the board and subsequent probable cause and merits hearings conducted by the State Office of Administrative Hearings
- Observed informal settlement conferences of agency enforcement actions
- Attended a meeting of the Dental Laboratory Certification Council and the Dental Review Panel Ad Hoc Committee
- Spoke with staff of the State Office of Administrative Hearings, State Auditor's Office, governor's appointments office, Office of Inspector General, Texas Medical Board, Health Professions Council, and Legislative Budget Board

Sunset Staff Review of the *State Board of Dental Examiners*

————— *Report Prepared By* —————

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