



Lawrence F. Alwin, CPA
State Auditor

An Audit Report on

Internal Controls and Financial Processes at the Texas State Board of Dental Examiners

June 5, 2002

Members of the Legislative Audit Committee:

We are concerned that weaknesses in the Texas State Board of Dental Examiners' (Board) complaint resolution process impair the Board's ability to protect the health of Texas dental consumers. The Board's inconsistent application of rules and policies and flawed investigation process severely weaken its oversight of dental professionals. The Board has an ongoing history of weaknesses in its complaint resolution process. Prior State Auditor's Office reports issued in August 1997 and March 2000 made recommendations to the Board to strengthen controls over enforcement. We found that certain weaknesses we identified in these reports continue to exist.

The Board does not consistently enforce policies regulating dental professionals. As a result, dental professionals who have committed similar infractions have received different sanctions or no sanctions at all. The Board also does not complete investigations regarding complaints about dental professionals in compliance with its own policies for evidence and timeliness. Staff investigators lack the authority and medical qualifications that could expedite the investigation process, particularly for high priority complaints involving death or injury.

Examples of the specific weaknesses we identified in the Board's complaint resolution process include:

- The Board has failed to consistently apply criteria and policies for sanctions and evidence requirements related to complaints.
- The Board lacks controls to ensure that enforcement actions are promptly implemented.
- The Board closed 22 percent of the quality of care complaints we reviewed without obtaining the records of a subsequent treating or second dental professional. Board policy requires investigators to obtain the records of a subsequent treating or second dental professional when they investigate cases involving quality of care.
- The Board is not completing complaint investigations within the time frames established by its own policies. In fiscal year 2001, the Board took an average of 201 days to investigate cases based on a sample of 54 complaint investigations. Board policy states that cases should be investigated within 60 days (for Priority 1 complaints involving death or injury) or 120 days (for relatively less serious Priority 2 complaints).
- The Board does not have a licensed dental professional on staff. Three of four other Texas health profession licensing agencies have licensed professionals involved in complaint investigations.
- The Board's Enforcement Database, which is used in the tracking, processing, and investigation of complaint cases, does not have adequate controls in place to ensure that complaint data is accurate and reliable.

It should be noted that our review of the Board's licensing process indicates that this process is timely and efficient. Although we found no issues associated with the licensing process itself, our findings regarding the complaint process indicate that the effectiveness of licensing is impaired when sanctions regarding license revocation are not implemented.

We tested certain financial processes at the Board for accuracy and compliance with state rules and regulations. Nothing came to our attention that indicated the Board had violated either the State's three-day deposit rule or the State's travel regulations. We also tested the accuracy of two performance measures. We were unable to certify the

SAO Report No. 02-050

Members of the Legislative Audit Committee
June 5, 2002
Page 2

Board's reported average time for complaint resolution. We certified with qualifications the Board's reported average licensing cost for individual licenses issued.

The attachment to this letter provides additional detail regarding our audit. The Board generally agrees with our recommendations, but it does not agree with all of our conclusions. We added follow-up comments to further support our conclusions. The Board's responses are included in the attachment. We appreciate the assistance and cooperation of the Board throughout this project. If you have any questions, please contact Valerie Hill, Audit Manager, at (512) 936-9500.

Sincerely,

Lawrence F. Alwin, CPA
State Auditor

ejm/khm

Attachment

cc: Chair and Members of the Texas State Board of Dental Examiners
Mr. Jeffrey R. Hill, Executive Director, Texas State Board of Dental Examiners

The Board Does Not Consistently or Promptly Enforce Policies Designed to Protect Texas Dental Consumers

We are concerned that weaknesses in the Texas State Board of Dental Examiners' (Board) complaint resolution process could impair the Board's ability to protect the dental health of Texas citizens. These weaknesses include:

- Inconsistent enforcement of sanctions and evidence requirements and insufficient controls that do not ensure the Board implements sanctions against dental professionals.
- The Board's continuing inability to complete complaint investigations within the time frames required by its own policies.
- Inadequate controls to ensure the integrity of data in the Enforcement Database.

The Mission of the Texas State Board of Dental Examiners

To safeguard the dental health of Texans by developing and maintaining programs to:

- Ensure that only qualified persons are licensed to provide dental care
- Ensure that violators of laws and rules regulating dentistry are sanctioned as appropriate.

Source: Texas State Board of Dental Examiners

Chapter 1.1

The Board Does Not Have Controls to Ensure Consistent Assignment of Sanctions Against Dental Professionals or to Ensure that Staff Carry Out Sanctions

The Board has an ongoing history of weak controls over its enforcement function. Prior State Auditor's Office reports issued in August 1997 and March 2000 made recommendations to the Board to strengthen controls over enforcement (see *1997 Small Agency Management Control Audit*, SAO Report No. 97-086, August 1997, and *2000 Small Agency Management Control Audit*, SAO Report No. 00-023, March 2000). However, we found that significant weaknesses continue to exist.

Frequency of Board Disciplinary Actions

The Board assigned disciplinary actions for 6.9 percent of the 405 complaints resolved in fiscal year 2000.

Source: State Auditor's Office analysis of Texas State Board of Dental Examiners data.

The Board does not have controls to consistently enforce regulatory criteria outlined in its policies. As a result, some dental professionals have received substantially different sanctions for similar infractions. In addition, the Board has closed some cases without obtaining the evidence required by Board policy. The Board also lacks controls to ensure that its recommendations are promptly implemented. These weaknesses impair the Board's ability to investigate or hold dental professionals accountable for violations of laws and rules regulating dentistry.

Contents

The Board Does Not Consistently or Promptly Enforce Policies Designed to Protect Texas Dental Consumers	1
Board Staff Lack the Authority and Qualifications Necessary to Adequately Assist the Board in Resolving Complaints.....	10
The Board Processes Financial Transactions Properly	13
One Performance Measure Could Not Be Certified; Another was Certified with Qualifications.....	14

Failure to Enforce Criteria Impairs Consistency.

For the complaint cases we tested spanning 1996 through 2001, we noted inconsistencies in the Board's assignment of sanctions and its compliance with evidence requirements.

For example, during a 1996 investigation, the Board determined that a dentist administered nitrous oxide anesthesia without a permit. The Board's investigators obtained evidence from the dentist and his insurance company indicating that the dentist had administered this type of anesthesia on numerous occasions. However, the Board did not issue a fine in this case. In contrast, in a 1997 investigation of a different case, the Board found that a dentist administered nitrous oxide anesthesia without a permit; the Board fined the dentist \$1,000. There were no documented criteria in these case files to explain the inconsistency in the Board's disciplinary action.

In our sample of quality of care complaint cases the Board closed in fiscal year 2001, 22 percent of those cases were closed without the Board obtaining the records of a subsequent treating or second dental professional. The Board's *Enforcement Division Operating Manual* (Manual) requires investigators to obtain the records of either a subsequent treating or second dental professional when investigating cases involving quality of care. Such records are crucial to the vast majority of complaint cases.

Additionally, while the Board adopted specific guidelines for sanctions in 2001, these guidelines are not codified in the Texas Administrative Code. Codifying these options for sanctions related to serious or repeat infractions would lead to greater consistency and effectiveness in the Board's enforcement and provide citizens with a clearer understanding of available remedies and efforts.

Inadequate controls fail to ensure that sanctions are promptly implemented.

The Board also lacks controls to ensure that enforcement recommendations are promptly implemented. The Board's November 1999 recommendation to revoke the license of a dentist who had been charged with sexual assault, a second-degree felony, was not implemented on a timely basis. After considering the evidence obtained by the investigator, the board member reviewing the case recommended that the Board "move to revoke this license ASAP. This doctor is a risk to any female he treats and therefore is an immediate threat to the citizens of Texas." However, the Board delayed a formal hearing in anticipation of a criminal trial. The dentist continued to practice dentistry and was arrested again in October 2000 on a criminal charge of lewd conduct, a Class C misdemeanor. In both instances, the alleged misconduct took place as the dentist was conducting a dental examination. After the second incident, the Board found that the dentist's actions constituted unprofessional and dishonorable conduct and asked for the license to be voluntarily surrendered in advance of the criminal trial. The dentist agreed. The license was surrendered in December 2000. The Board ultimately took action without having the results of a criminal trial, but the recommended action for this high-risk case was delayed for a year.

Inadequate controls over the disposition of complaints also resulted in certain complaints not being investigated at all. While reviewing a 1997 complaint alleging

a dentist's insufficient standard of care and dishonorable conduct for prescribing unnecessary treatment, investigators were provided additional information by a subsequent dentist alleging that this same offense had occurred involving several other patients. Although the subsequent dentist provided dental records for consideration, the Board did not investigate these other cases. Without consistent investigation of complaints, the Board's efforts to enforce laws regulating the practice of dentistry are less effective.

Weaknesses in the complaint process could impair the licensing process.

Our review of the Board's licensing process indicates that the process is timely and efficient. The cycle time to issue a license is an estimated two weeks. Although we found no issues associated with the licensing process itself, our findings regarding the complaint process indicate that the effectiveness of licensing is impaired when sanctions regarding license revocation are not implemented.

Recommendations

The Board should:

- Codify in the Texas Administrative Code a table of suggested sanctions the Board may levy against license holders or unlicensed individuals for specific infractions. Include in the table a list of serious infractions, the related citation, and a suggested sanction.
- Consistently follow the criteria established in the *Enforcement Division Operating Manual*.
- Develop a system of controls to ensure that staff members properly carry out all Board decisions regarding enforcement actions.

Management's Response

Codify in the Texas Administrative Code a table of suggested sanctions

The disciplinary guidelines will be adapted to rule form and presented to the Board for adoption. When the guidelines were approved the Board specifically declined to put them into rule. Thus management cannot state that they will be set out in rules, but management will make the proposal and explain that it is in response to a recommendation from the State Auditor.

Management's Response

Consistently follow the criteria established in the Enforcement Division Operating Manual

Management agrees that agency enforcement staff should consistently follow the operations manual and management asserts that they do. This recommendation in part is based on the auditor's review of selected FY 2001 quality of care cases. The report indicates that the Enforcement Division's Operating Manual "requires"

records from either a subsequent treating or second dental professional and that staff had conducted and closed investigations in such cases without obtaining such records. That statement is not an accurate reflection of what the manual provides. While it stresses the importance of obtaining such records, it does not require them when they do not exist. The manual at page 17 describes the investigation process for standard of care cases. It provides that "when the records are received from the respondent and the 2OP dentist/s a short report form will be written...." At the bottom of the page the manual recognizes that "sometimes the complainant is not in a position to afford a second opinion...." Further, page 8 which defines reports and report writing, as amended by memo dated March 9, 2001, states that "no investigation will be considered complete without a copy of the respondent's records, if such records are applicable to the case." The memo then states that "the same holds true for copies of subsequent treating dentists, second opinion dentists, and expert opinion dentists." The manual is not understood by board staff to require such records if there are no subsequent treating dentists.

Nonetheless, the manual will be amended to make it absolutely clear that when such records do not exist, they will not be required. It would be unreasonable for the board to refuse to complete an investigation simply because the patient has not gone to another dentist after having been treated by the dentist he has complained about. In those cases where there is only the treating dentist's records, a dentist Board Member can review the treating dentist's records and make a recommendation to proceed or direct that it be dismissed. Should the matter proceed to hearing before the SOAH, the Board will have to obtain an expert opinion in order to meet its burden of proof. Board staff are not necessarily violating the manual by completing investigations without having obtained second opinions.

The recommendation is also based in part on a case that was dismissed by a Settlement Conference Panel of Board Members. It is also based in part on a comparison with another case that was not dismissed and the auditors have identified these as similar cases treated inconsistently. The facts do not support that conclusion.

The dismissal of the case where there was evidence of a nitrous oxide permit violation was in keeping with board procedures. In 1996 and 1997, while conducting investigations on other matters, the Board often would discover that a dentist was administering nitrous oxide without a permit. When questioned nearly all dentists would indicate they thought they were permitted and they would mention that when they completed nitrous oxide training in dental school they were told that they could legally administer it. They were mistaken, but it appeared they believed themselves to be legally administering nitrous oxide. Because there were more than a few of these cases, the Board members would not prosecute a dentist if certain criteria were met. They were: (1) that the dentist had been trained to administer nitrous oxide; (2) that no claim of harm to a patient related to administration of nitrous oxide was on file; and (3) the dentist immediately applied for and obtained a permit. The dentist in this case met those criteria. In fact, he had obtained the permit long before he appeared before the Board.

The second case also involves the discovery through investigation that the respondent was administering nitrous oxide without a permit. The underlying complaint was a fee dispute and the dentist had not violated the statute or rules in that matter. In this

1997 case the Board reprimanded the respondent and imposed a \$1,000 fine because the dentist did not meet the criteria set out above. The dentist, upon being informed of the permit requirement, did not immediately get a permit. The Board's records indicate that she was informed in October 1997 of the permit violation and again in January 1999. The dentist did not obtain a permit until March 26, 1999.

State Auditor's Follow-Up Comment

It is the Board's responsibility to obtain second opinions in quality of care cases, but it did not obtain second opinions in 22 percent of the quality of care cases that we tested. To obtain a second opinion the Board can ask a second dentist to review a patient's records. The second opinion does not have to include a second patient examination and therefore would not necessarily incur additional costs for the patient.

The Board cites criteria for determining when penalties are warranted for administering nitrous oxide without a permit. However, these criteria are not documented in the Board's disciplinary guidelines, the Texas Administrative Code, or the case files in question. Therefore, there continues to be significant risk that Board sanctions will be inconsistent for dentists that commit the same offense.

Additionally, the Board indicates that one of the criteria for evaluating whether sanctions are appropriate for administering anesthesia without a license is whether a claim or complaint is on file regarding the dentist. As a regulatory agency, the Board's standard for disciplinary action should be satisfied once the dentist's noncompliance with anesthetic permit requirements is proven, regardless of whether a patient has previously filed a complaint.

Management's Response

Develop a system of controls to ensure that staff carry out Board enforcement actions

Management recognizes that there has been undue delay in some cases when a Board Member has recommended disciplinary proceedings, as in one of the cases cited as an example. In that case, which will be discussed below, there were reasons for the delay, but in others not mentioned in the report there have been long periods of time between the recommendations and staff taking action. This has happened because the Enforcement and Legal Divisions have not been sufficiently held accountable. Quarterly reports made to the Board and the Executive Director by the divisions have not included information needed to fully assess performance. The reports have been more focused on what the divisions have produced each reporting period while not listing each case in the divisions and reporting work done on a case-by-case basis. Beginning in May 2002, and each month thereafter, the divisions are required to report by the 10th day for the preceding month showing each case, date it came in, and dates of actions. Further, the agency will review the Enforcement Manual to make certain that controls are in place to avoid a reoccurrence of the 1997 event referenced in the second case described below.

The first case referenced a Board Member's direction to set the matter for hearing before SOAH and his observation that the agency should revoke the license. The case was not immediately set for hearing because the dentist was scheduled to be tried for the criminal charges in February. Had he been convicted of a crime, especially if it was committed while practicing dentistry, revocation proceedings could have gone forward on the basis of the conviction. The matters that the Board would have to have proved were the same as those the district attorney would have to have proved. There were also allegations about his having provided drugs, but there was nothing in the information provided by the Travis County Sheriff's office concerning those matters. It seemed wise and expeditious to wait until the criminal trial. But in February, it was moved to April 2000 and even then it was not tried. At that point, staff was instructed to move forward with a hearing. It proved very difficult to locate any of the individuals who, while in jail, had complained of the dentist. On August 25, 2000, the Board asked for and obtained a hearing date in this case to be tried before SOAH. It was set for December 6, 2000. Before the hearing, the dentist was arrested again and the Board moved on that case to force the dentist to surrender his license.

<p style="text-align: center;">Case Definitions</p> <p>Priority 1 cases involve serious allegations of violations including patient death, patient injury, practicing without a license, and unsanitary conditions.</p> <p>Priority 2 cases involve less serious threats to the public welfare such as record-keeping and advertising violations.</p> <p>Source: Texas State Board of Dental Examiners</p>

The second referenced case was a 1997 complaint that was dismissed. The investigation resulted in the file containing information from a dentist about three other patients treated by the respondent whom the dentist alleged were misdiagnosed. No investigation concerning these allegations was opened when it is certainly arguable that one should have been conducted.

State Auditor's Follow-Up Comment

The Board had sufficient evidence, including videotape of the offense, which compelled a board member to call for immediate revocation of the dentist's license. The Board indicated that it delayed taking action after the first offense in anticipation of a criminal trial and a hearing. However, after the second offense the Board took action to "force the dentist to surrender his license" before any trial or hearing took place regarding either offense. It is unclear why immediate disciplinary action could not be taken based on the Board's initial recommendation. The Board's delayed actions did not protect subsequent patients.

Chapter 1.2

The Board Continues to Fail to Complete Investigations Within the Time Frames Required by Its Own Policy

The Board is not completing complaint investigations within the time frames required by its own policies. The Board took an average of 201 days to investigate a sample of 54 complaint investigations in fiscal year 2001.

According to the Board's policies and procedures, Priority 1 cases should be investigated within 60 days and Priority 2 cases within 120 days. Because the Board is not meeting these time frames, dental professionals that should not be allowed to practice could continue to operate and provide substandard services to the citizens of Texas.

The Board also requires dental professionals to provide patient records to investigators within 15 days after notification. In our sample of cases closed in fiscal year 2001, it took 51 dental professionals an average of 40 days to submit patient records. When dental professionals exceed established time frames for submitting patient records, the complaint investigation process is impeded.

In August 1997, we made recommendations to the Board to expedite the time required to complete investigations and the Board agreed to implement measures to streamline the process (see *1997 Small Agency Management Control Audit*, SAO Report No. 97-086, August 1997).

Recommendation

We continue to recommend that the Board comply with its policies and procedures regarding time to complete complaint investigations. In addition, the Board should consider evaluating the complaint resolution process to identify improvement that would make the process more efficient.

Management's Response

After the 1999 review, the Board reviewed its time lines for completing investigations and determined that the time frames for completion of investigations should remain at 60 days for priority one and 120 days for priority two cases. The agency views those time lines as targets, not requirements. The time lines are not established by statute or rule; they are for internal use by the agency.

With regard to production of records, the Board in making demand for records states that records should be provided within 15 days. Management proposes to include a statement in letters to respondents stating that failing to meet the 15 days will cause the filing of another charge of having failed to provide records as demanded as set forth in Rule 108.8(f).

The agency will review the complaint resolution process through the Enforcement Committee during its meetings on June 6, 2002 and August 22, 2002 to identify improvements to make the process more efficient. Also, there are proposed statutory changes that may be made by the Sunset Advisory Commission as part of its review of the agency.

State Auditor's Follow-Up Comment

The Board established its policies for the timing of investigations to ensure that consumer complaints are addressed promptly. The fact that these are internal policies does not make these enforcement objectives any less significant.

Controls Over the Board's Enforcement Database Cannot Ensure the Reliability of Records Maintained on Dental Professionals

The Board's Enforcement Database, which is used in the tracking, processing, and investigation of complaint cases, does not have adequate controls in place to ensure data integrity. According to a November 2001 report from an independent consultant hired by the Board and interviews we conducted with agency staff:

- The initial development of the Enforcement Database application was not documented. Over time, users have modified, updated, or deleted components of the application without properly documenting the changes. Without proper documentation, it may not be possible to support and maintain the Enforcement Database. In the event of a disaster, recreating the system without proper documentation may not be possible.
- Changes to the Enforcement Database application are not tested in a test environment prior to implementation. As a result, the Board risks losing enforcement data if changes to the application are not carried out correctly.
- Users interpret data fields in the Enforcement Database inconsistently. As a result, different users record different information in the same data field.

The Enforcement Database supports the Board in complying with record-keeping requirements found in the Dental Practice Act and is used in calculating certain performance measures. The Enforcement Database also assists the Board in complying with a requirement that the Board notify complainants and respondents at least quarterly of the status of a case.

The Board should have had a project development plan for the Enforcement Database. A project development plan is used to communicate project requirements and provide an organizational and management tool to effectively administer the project and facilitate a successful outcome. In addition, the Board should have procedures to create a permanent record of the application modifications, updates, and deletions for future use by programmers.

Because of the weak controls over the Enforcement Database application, we were unable to rely on the data in the system to perform analysis of the complaint resolution process. Instead, we relied on manual reviews of complaint files and other data.

Recommendations

The Board should:

- Develop a secure control environment for the Enforcement Database and use the Department of Information Resources' security policies, standards, and guidelines to address and document its overall information system environment.

- Adopt definitions and associated controls for information stored in the Enforcement Database and complaint files. These definitions should be communicated to all employees who use data from the Enforcement Database.

Management's Response

- *Management agrees and prior to receipt of this report arranged with DIR for it to review in May agency systems and make proposals for security. Those recommendations will be implemented, including adoption of written procedures.*
- *Management has made efforts in this direction in the past only to discover that the problem is more widespread than shifting definitions of data files. There is a serious lack of documentation about all aspects of the database, including data files and instruction sets. The agency has secured the services of a consultant to review the matter and make recommendations on two levels. The first was to address the entire database and its usage to determine if it needed adjustments. The conclusion was that it would not be cost effective to repair and adjust the current program. Development of a new, but unspecified program was suggested. The agency is currently engaged in gathering information needed to determine what it needs and will then request suggestions and proposals from various entities including Northrop Grumman who is under contract with DIR. The second level of review was to address specific problems with the database that were preventing it from operating correctly. Temporary repairs were made so that it can be used, but it does need replacement. Even though the agency has sought to upgrade the database without requiring capital budget approval, replacement of the entire database will require capital expenditures, though costs have not yet been identified.*

Board Staff Lack the Authority and Qualifications Necessary to Adequately Assist the Board in Resolving Complaints

The efficiency and consistency with which the Board resolves complaints is hindered by the fact that the Board has not given staff investigators the authority to make recommendations for enforcement actions. For investigators to be able to make recommendations, the Board needs to have a licensed dental professional on its investigative staff.

Chapter 2.1

The Board's Investigators Lack the Authority to Make Recommendations for Disciplinary Action

The Board's staff investigators do not have the authority to make recommendations for sanctions. Instead, cases are assigned to individual members of the Board's Enforcement Committee to dismiss a case based upon their review of a staff investigation. This practice places the power to dismiss a case or pursue sanctions in the hands of one individual.

Allowing staff investigators to recommend sanctions or dismissals to the Board would promote a system of checks and balances and allow Board members to use their time more efficiently by concentrating on the most significant complaint cases. Having a subcommittee of Board members collectively review cases and related recommendations before dismissal would further strengthen controls and ensure consistency in decisions. Board members would still have the authority to accept, amend, or reject staff recommendations. In addition, having more than one Board member review cases before dismissal would decrease the risk that Board members could be perceived as having conflicts of interest.

While agency boards are responsible for communicating, enforcing, and evaluating policies, it is agency management and staff's responsibility to carry out board policies, direct daily operations, and provide boards with necessary information.

Recommendation

The Board should consider redefining its responsibilities and the responsibilities of staff involved in the complaint resolution process to give investigators the authority to recommend sanctions to the Board. The Board should also consider having the Enforcement Committee review and endorse an individual Committee member's decision to dismiss a case.

Management's Response

Management agrees and through past review of complaint handling process has determined that such input should be accomplished through having an on-staff or on-contract dentist. Of course, additional funding will be needed as addressed below, if a dentist is hired. The Board's investigators are an important part of the complaint resolution process. The agency relies on them to find the facts in each case.

Without someone who knows how to gather data, sort it, and present it in a useful manner, the process would be much longer than it is now. But to propose that non-dentists should determine whether the standard of care has been violated, and then assuming a violation is found, determine the severity of the violations seems to suggest an unjustifiable procedure. If the board's investigators were dentists, implementing the proposal would be justifiable.

Since the Board has adopted guidelines for punishment and since the Enforcement staff had significant input into those guidelines, in a manner of speaking, they have recommended sanctions to the Board.

The Sunset Advisory Commission staff report includes recommendations that Board staff review investigations and make the first level of recommendations that are currently being made by Board Members, and to have staff conduct settlement conferences.

The concern about one individual making a dismissal decision is one the agency shares, and it will consider the recommendations, and others, to seek to alleviate this concern.

State Auditor's Follow-Up Comment

The State Auditor's Office did not recommend that investigators who are not dentists make the final determination on the severity of a violation. We encourage the Board to allow investigators who obtain the evidence to also provide a recommendation for sanctions. Further, we recommend that the Board hire or contract with a licensed dental professional to assist with quality of care investigations (see Chapter 2.2). The Board retains authority to accept or reject an investigator's recommendations.

Chapter 2.2

The Absence of Licensed Dental Professionals on Staff Reduces the Efficiency of Complaint Investigations

The Board's ability to resolve complaints is hindered by the absence of a licensed dental professional on its staff. Neither the Director of Enforcement nor any of the staff investigators, who are responsible for collecting and reviewing evidence (including dental records), are licensed dentists or dental hygienists. As a result, a member of the Board who is licensed in the dental profession must recommend every complaint for closure or disciplinary action.

Results from a review of a random sample of 61 complaint files the Board closed in fiscal year 2001 indicated that the Board's Enforcement Committee returned 11 percent of these complaints to staff for additional investigation. The Board closed a total of 533 cases in fiscal year 2001. Having a licensed dental professional on staff and involved in the complaint investigation could help to ensure investigations are properly completed before the results go to the Board. Although all cases would not require the expertise of a licensed dental professional, those involving quality of care issues would benefit from such oversight.

Three of four other Texas health profession licensing agencies have licensed professionals involved in investigations. For example, investigators at the Board of Medical Examiners are specialized according to a particular type of complaint and hold licenses in a related profession. In addition, our review of nine agencies in other states with functions similar to the Board's indicated that 56 percent of these agencies have investigators who are licensed in their respective professions or have some dental experience.

Recommendations

The Board should:

- Assign specific types of complaints to specific investigators and train investigators on how to properly investigate those complaints.
- Consider hiring or contracting with licensed dental professionals, such as dentists or dental hygienists, to complete or review quality of care complaint investigations.

Management's Response

- *Management agrees that assigning specific types of cases, i.e., fraud, mortality and impairment to investigators who have special training can facilitate the investigation process. The staff will research the availability and costs of specialized training and will present that information to the Enforcement Committee with a recommendation to approve specialized training and assignment of cases to trained investigators. Management does not know at this time what the costs will be, but specialized training for one or more investigators will impact the budget.*
- *Management agrees and has been requesting funding to do this since 1998. The agency will continue to request funding, and if it is not approved will still try to accomplish this. It is a matter of money. Based on a dentist's salary of \$75,000 per year (pay level B18) plus benefits and cost of setting up and maintaining office equipment and support, the annual cost will be approximately \$99,700 the first year and \$95,000 each year thereafter.*

The Board Processes Financial Transactions Properly

Our review indicated that the Board processes license fee revenue and travel expenditure transactions appropriately. Nothing came to our attention that indicated the Board had violated either the State's three-day deposit rule or the State's travel regulations during fiscal year 2001. In addition, nothing came to our attention that indicated the revenue and expenditure transactions we reviewed are not reasonable and appropriate.

We reviewed the Board's processes for depositing license fees, approving travel expenditures, and recording the associated financial transactions. Our review included testing fiscal year 2001 deposit transactions for compliance with the State's requirement that agencies deposit revenues within three business days of receipt. It also included testing fiscal year 2001 travel expenditure transactions for appropriateness and compliance with the State's travel regulations.

One Performance Measure Could Not Be Certified; Another Was Certified with Qualifications

We tested the accuracy of two efficiency measures closely related to the Board’s key business processes. As the table below shows, one of the fiscal year 2001 efficiency measures the Board reported in Automated Budget and Evaluation System for Texas (ABEST) was inaccurate. The other efficiency measure was certified with qualifications.

Texas State Board of Dental Examiners Performance Measure Certification Results - Fiscal Year 2001					
Related Objective or Strategy	Classification and Description of Measure	Target	Reported Results	Certification Results	Auditor Comments
A.1.1	Efficiency Average Time for Complaint Resolution	350 days	310.3 days	Inaccurate	Sample documentation tested resulted in a 21 percent error rate. The Board did not correctly record the case closure dates for all case dispositions.
A.2.1	Efficiency Average Licensing Cost for Individual License Issued	\$7.00	\$7.62	Certified with Qualifications	The Board does not have adequate procedures to calculate its performance measure for the average cost per individual license issued. Auditors were able to recalculate this performance measure, but the process required additional information that was not available through the Board’s procedures.
<p>A measure is Certified if reported performance is accurate within +/-5 percent and if it appears that controls to ensure accuracy are in place for collecting and reporting performance data.</p> <p>A measure is Certified With Qualification when reported performance appears accurate, but the controls over data collection and reporting are not adequate to ensure continued accuracy.</p> <p>Factors Prevented Certification when actual performance cannot be determined because of inadequate controls and insufficient documentation.</p> <p>A measure is Inaccurate when reported performance is not within +/-5 percent of actual performance or if there is more than a 5 percent error rate in supporting documentation.</p>					

Source: Fiscal Year 2001 ABEST Report and Board documentation.

Recommendation

The Board should document comprehensive policies and procedures for the collection, calculation, and review of data before it is submitted to the ABEST coordinator.

Management's Response

Management recognizes that the Enforcement database, which is the source of data used to calculate the average time for complaint resolution is not reliable. As discussed above, management proposes to replace the program based on advice from a consultant. Part of the process for use of the new program will be documentation of what is to be entered into the program and designation of persons responsible for the data entry. Further, even though two divisions of the agency generate data for entry, one manager will be designated as having overall responsibility for the database (this particular feature has been implemented for the current database). When the database is capable of providing reliable information, procedures for calculating this measure will be reviewed to ascertain that the process is clear for both staff and reviewing personnel.

The procedures for calculating the average licensing cost will be reviewed and amended to include all data needed to calculate the measure. Management states, however, that the process is exactly the same as it was in 1999 when the SAO certified the measure.

Summary of Objectives, Scope, and Methodology

The objectives of this audit were to determine if the Board is:

- Making the best use of available resources to deliver mandated services to its client population in a timely manner.
- Using state funds appropriately and accurately accounting for selected transactions.
- Accurately reporting the achievement of selected performance targets.

We focused work related to these objectives on service risk and financial risk by analyzing the cost, quality, and time associated with the licensing and complaint resolution processes.

Information to accomplish our objectives was primarily gathered by interviewing Board employees, obtaining data from peer states and similar Texas state agencies, and testing of agency files. Analysis techniques included workflow mapping, activity analysis, and value-added-activity assessment. In addition, we performed procedures to certify two key performance measures by reviewing calculations for accuracy and consistency with the methodology agreed upon by the agency and the Legislative Budget Board. We analyzed the flow of data used in performance measure calculations to evaluate whether proper controls were in place.

This audit was conducted in accordance with generally accepted government auditing standards.