

# MODEL DENTAL THERAPIST RULE

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Composed by  
**The National Model Dental Therapy Rule Panel**

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## DENTAL THERAPY ADMINISTRATIVE RULEMAKING

### Introduction, guidance and best practices for stakeholders and state government leaders

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#### Introduction and Overview

Dental therapists are skilled dental professionals, similar to nurse practitioners or physician assistants in medicine. They work as part of a dental team alongside dental hygienists and dental assistants under the supervision of a dentist. They provide preventive and routine restorative procedures, including exams and fillings, to children and adults. They work in a variety of settings, but are trained to extend care into underserved areas, such as rural communities, nursing homes, and schools. Dental therapists have been practicing around the world for 100 years, and in the U.S. since 2005, beginning in Alaska Native communities. There is an extensive body of literature and research on dental therapy's history and outcomes showing that dental therapists provide safe, high-quality, cost-effective care to patients in Tribal health systems, nonprofit community clinics, traditional private practices, and other healthcare and community settings. Dental therapists are authorized by law or Tribal authority to practice in all or part of 13 states, but there is variation from state to state regarding their scope of practice, practice setting limitations, and other occupational parameters.

Health occupations are generally regulated by states and, in some instances, Tribal governments. State statutes or Tribal regulations commonly detail dental therapists' scope of practice, education, licensing and supervision requirements, and any limitations on where dental therapists may practice. Common regulatory provisions applicable to regulated occupations, such as license renewal and fees, discipline, and documentation of continuing education requirements, may be applied to dental therapists by statute or delegated to the regulatory agency and applied in rule. State statute usually assigns administration of dental therapy regulations to the board of dentistry or occupational licensing agency.

A major milestone in building the infrastructure for dental therapy took place in 2015, when the Commission on Dental Accreditation (CODA) adopted national accreditation standards for dental therapy education programs.<sup>1</sup> CODA is the national organization in the U.S. that evaluates and accredits education programs for all dental professions. In 2020, CODA accredited the country's first dental therapy program at Iḷisaġvik College in Utqiagvik, Alaska.

Another milestone occurred in 2019, when the National Dental Therapy Standards Consortium, a consortium of individuals and organizations with extensive experience with the dental therapy profession, published the National Model Act for Licensing or Certification of Dental Therapists (the Model Act).<sup>2</sup> The Model Act provides guidance to policymakers, legislative staff, state agencies, licensing boards, oral health professionals, and consumer organizations working on legislation to authorize dental therapists in the U.S.

## National Model Rule and Best Practices Guide

This Model Rule and Best Practices Guide represents another building block in the development of a standard state-level infrastructure and a shared knowledge base for dental therapy practice in the U.S. As with the Model Act, this publication will provide guidance to policymakers, state agencies, licensing boards and agencies, dental and nonprofit organizations, state governments, and other interested parties in states that enacted dental therapy legislation and are planning licensing and regulatory efforts. The model rule language will be useful to those drafting the regulations and participants in the regulatory process as they move through the rulemaking steps.

Administrative regulation is usually required following legislative enactment before licensing can begin. Practical regulation is important to safe and orderly dental therapy professional practice and to achieving dental therapy's potential to improve both access to dental services and oral health.

As a young health profession in the U.S., there is a relatively small body of common, professionally vetted experience to draw from as states consider developing dental therapy laws and regulations. Although the Uniform Law Commission provides states with "non-partisan, well-conceived and well-drafted legislation that brings clarity and stability to critical areas of state statutory law,"<sup>3</sup> there is not a comparable reservoir of reference/standard administrative rules.

To fill that gap, this Model Rule and Best Practices Guide was developed through a consensus process by an expert panel comprised of national leaders in dental therapy, administrative rulemaking, and dental workforce regulation. In developing the guide and model rule, the National Model Rule Expert Panel drew from:

1. Experience and expertise of dental board and state agency leaders and of interested parties who have participated in dental therapy rulemaking to date.
2. Reference materials and sources, including state rule drafting manuals and literature on regulatory principles and best practices.
3. State dental therapy laws and dental therapy administrative rules adopted to date.

In contrast to the goal of legislation, which is to set public policy direction, the goal of administrative rulemaking is to effectuate the implementation of state statute consistent with law as efficiently as possible. Thus, the Model Rule and Best Practices Guide are focused on the technical and administrative aspects of launching and managing state licensing and regulation of dental therapists, rather than the substantive aspects of dental therapy legislation and statute.

## National Model Dental Therapy Rule Expert Panel

The Model Rule and Best Practices Guide were developed and endorsed by a multi-disciplinary panel of national experts. Individuals were identified to serve on the review panel based on the following criteria:

- All panel members have expertise with the dental therapy profession, other oral health occupations, state administrative rulemaking, or with dental therapist rules and licensing.
- Panel membership is multi-disciplinary, representing boards of dentistry and other state regulatory agencies, state oral health programs, professional associations, and public interest organizations.

The panel approved, by consensus, the Best Practices in Dental Therapy Administrative Rulemaking and the National Model Dental Therapist Rule in the next sections. Staff support was provided by Mark Schoenbaum, MSW, consultant to states on dental therapy implementation.

National Model Dental Therapy Rule Panel members:

- Bridgett Anderson, LDA, MBA, Executive Director, Minnesota Board of Dentistry
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- Kim Russell, MHA, Executive Director, Arizona Advisory Council on Indian Health Care
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- Amy Zaagman, MPA, Executive Director, Michigan Council for Maternal and Child Health

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## BEST PRACTICES IN DENTAL THERAPY ADMINISTRATIVE RULEMAKING

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### **Administrative Rule Defined**

An administrative rule is “an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy...Rules that fall within the scope of authority delegated to the agency have the force and effect of law.”<sup>4</sup>

Rules are developed and adopted (“promulgated”) following enactment of legislation by executive branch boards or agencies in accordance with each state’s Administrative Procedures Act (APA).

### **Overview**

#### **Dental Therapy Background**

As of 2021, dental therapists are authorized to practice in all or part of 13 states by law or Tribal authority. State statutes or Tribal regulations commonly detail dental therapists’ scope of practice, education, licensing and supervision requirements and any limitations on practice settings. Common regulatory provisions applicable to regulated occupations, such as license renewal and fees, discipline, and documentation of continuing education requirements, may be applied to dental therapists by statute or delegated to the regulatory agency and applied in rule. Statute usually assigns administration of dental therapy regulations to the board of dentistry or occupational licensing agency.

#### **Rulemaking Background**

Following enactment of a statute, rulemaking is generally initiated by the relevant board or executive branch agency to provide the details needed to implement the statute. Health professions rules typically include licensing and application details, fees, continuing education details, disciplinary procedures, code of conduct, and use of title expectations. Sometimes they also include requirements for educational institutions proposing to conduct dental therapy education in the state, advertising requirements or restrictions, and other provisions.

State APAs prescribe rulemaking steps, standards and timelines. APAs commonly detail requirements for public notice and participation, including providing for contested case hearings before an administrative law judge in certain circumstances. Requirements for a written rationale or cost estimate by the proposing agency and for maintaining an official rulemaking record may also be included in an APA.

Rulemaking is subsidiary to state statute as a form of law. As such, its limited purpose is to allow effective implementation of public policy decided by the legislature and signed into law by the governor. In other words, rulemaking is concerned with the process of implementing laws (the “how”), not the content (the “what”), unless there is a gap in

the law critical for its administration. Rulemaking should never cross the line into new deliberation and lawmaking by regulators, and APAs are designed to assure agency regulation stays within its implementation boundaries. Rule language that is proposed in response to statements such as, “Wouldn’t it be a good idea if...” may raise a red flag that a proposal is in danger of exceeding statutory intent or the plain language limits of the law.

Rules that go beyond simply implementing statute can be rejected at the final approval or review step, which, depending on the state, may be the Attorney General, Secretary of State or a legislative body. Rules adopted that include language that strays too far from law can lead to additional legislative action following adoption to bring rules in line with legislative intent.

Dental therapists’ scope of practice – what they can and cannot do – is most often explicitly detailed in statute. The accreditation standards by the Commission on Dental Accreditation (CODA) list the minimum procedures and services in which dental therapists must be proficient, and statute may reference these standards. Statute may also include procedures that are not part of the CODA standards.

Reviewing laws and rules for comparable advanced practice providers, such as advance practice registered nurses, physician assistants or clinical pharmacists may be informative.

## Principles Regarding Rule Contents

### Brevity, Clarity & Germaneness

1. Rules should generally include only provisions essential to implement the law as it was enacted.
2. Terms that have been defined in statute should not be redefined in rule. Administrative law attorneys often prohibit repetition of statutory language, except by reference as needed. “Reinventing the wheel” in rule is generally discouraged or prohibited. Language that was discarded in lawmaking and substantive provisions that were not addressed legislatively should not be included.
3. Language already in statute should not be repeated in rule. If statute later changes, duplicate statutory language in rule can require rule revisions that could have been avoided. In some states the practice is to list terms or provisions from statute with a citation or reference to the item’s source.

4. Similarly, rules should use flexible language when there's a need to discuss topics like license examinations or continuing education details and courses. For example, rather than specifying a competency testing agency, use broader language requiring the use of a “board-approved clinical examination” or “competency-based clinical examination developed and scored by a board-approved clinical testing agency” or something similar, rather than naming a specific testing agency or exam. Although dental testing agencies such as the Commission on Dental Competency Assessments (CDCA) and Central Regional Dental Testing Services (CRDTS) administer dental therapist clinical exams, and other testing agencies, such as the Western Regional Examining Board (WREB), may develop dental therapist exams, this is an evolving aspect of dental therapist licensing. Naming a specific agency or test in rule may prevent a board from adjusting as the field evolves.
5. The responsibility of the board or rulemaking agency is to clarify and explain the legislation only to the extent needed to license and regulate the occupation as provided by the law. The deliberative policy process has been conducted and completed by the legislature before a rulemaking begins, and rulemaking should not be used to make or revise substantive policy.
6. Unnecessary provisions risk creating new regulatory burdens on regulated parties or artificial barriers to entry and should be minimized or avoided.
7. Regulators should seek uniformity with comparable rule provisions in other states so that, where applicable, license portability or reciprocity is straightforward.
8. Rule writers should use plain and direct language, including following any required construction and vocabulary standards, and avoiding double negatives. Avoid outdated terms now considered biased. Rules should be as short and straightforward as possible.

### **Need and Reasonableness Standard**

Some states require regulators to justify and explain proposed rules or analyze costs and other burdens a proposed rule may create on regulated entities and state and local government. Regulation approval authorities (e.g., attorneys general, secretaries of state, agency commissioners, rule review panels) in the executive or legislative branch review these rationales as they conduct their final steps. Whether required or not by the APA or elsewhere in law, the exercise of articulating and defending a proposed rule can be helpful.

Core questions to ask and answer can include:

1. Is this provision, or a provision on this topic, necessary for implementation of the statute?

2. If more detail is needed for implementation on this topic, is the proposed provision a reasonable method for meeting the need?
3. Is the proposed provision consistent with the law's plain language or with legislative intent?
  - a) Attempting to interpret legislative intent can be a fraught exercise and is best avoided, if possible. In some states, there may be judicial standards for determining intent, or there may be an explicit prohibition against executive branch agencies inferring intent at all. The most developed approaches to attempting to understand legislative intent are found in the judicial branch. As summarized by the Congressional Research Service, "judges often begin by looking to the ordinary meaning of the statutory text. Second, courts interpret specific provisions by looking to the broader statutory context. Third, judges may turn to the canons of construction, which are presumptions about how courts ordinarily read statutes. Fourth, courts may look to the legislative history of a provision. Finally, a judge might consider how a statute has been—or will be—implemented."<sup>5</sup> Again, this exercise is best avoided, and sticking by the ordinary meaning of the statutory text is the simplest and most easily defensible approach.

### **Best Practices**

1. Study the technical and legal aspects of rulemaking in your state.
2. Become familiar with your state's APA.
3. The "personality" of rulemaking varies from state to state, as do points for public involvement, input, decision making and review. Learn the processes and structure for rulemaking in your state.
  - a) Whether you are an advocate or state staff new to rulemaking, seek out someone who understands how the process usually flows and the impact points where decisions are made, such as in early informal input sessions, at the comments stage and in contested case hearings. Some boards of dentistry have standing rules committees that develop proposed rules. Some boards have formed ad hoc committees for dental therapy rulemaking. These committees may include non-board members.
  - b) If your state agencies usually add in rule only minimal and essential language clearly absent from statute and clearly required for agency implementation, communicate the expectation that dental therapy rules follow this approach. If rules in your state often duplicate language from statute, that's probably the approach to be expected in dental therapy rulemaking.

4. Learn how rulemaking authorities communicate about the steps in the process and opportunities/methods for involvement and input. Sign up for listservs, official notification lists, and State Register notices. Be prepared to share information with your networks and engage them in providing feedback through public comment, public hearings, and at coalition and other meetings.
5. Some states produce a formal or informal/official or unofficial guide to rulemaking. Familiarize yourself with it if one is available in your state.
6. Learn the range of rule types (emergency, temporary, permanent) and rulemaking options (negotiated, non-contested, and contested) in your state to understand the procedures that will apply to the rules you're interested in.
7. Engage with stakeholders, and with regulators as appropriate, as early as possible.
8. Where essential details not provided in the statute must be added, consult the Model Act for guidance and consensus language. The Model Act includes detailed consensus language for provisions such as:
  - Reciprocity/licensing by credential,
  - Grandfathering pre-CODA accreditation graduates, and
  - Licensing standards for unique state scope items outside of core CODA curriculum.

## TRIBAL REGULATION OF DENTAL THERAPISTS

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Dental therapy in the U.S. began in 2005 under Tribal authority in Alaska, independent of any action by the state of Alaska and despite the absence of a state dental therapist licensing law. As of 2021, dental therapists are authorized to work in 13 states, including multiple states that only permit dental therapists to work in Tribal communities and facilities.

Tribal health and Tribal authority often intersect with state law and rules. The overview below is intended to alert those involved in rulemaking to be aware of and become familiar with these interactions so that Tribal and state dental therapy implementation occurs smoothly and without state/Tribal regulatory contradictions. State regulatory agencies are strongly encouraged to consult with Tribes throughout the rulemaking process.

Tribal governments have interest in and authority similar to that of states to regulate health occupations. Tribes as sovereign nations have a government-to-government relationship with the United States, and states do not have jurisdiction over Tribes except as delegated by Congress or determined by federal courts. In the area of health care, the federal government has a legal obligation through the trust and treaty responsibility to provide health care services to Tribes. The federal government created the Indian Health Service (IHS) to be the primary provider of this responsibility, and in the 1990s, Tribes began operating their own health care programs if they chose to do so. Now there are 132 self-governance agreements. In addition, federal law preempts state law when “state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.”<sup>6</sup>

Such is the case in Congress’ establishment of the Community Health Aide Program (CHAP) in the Indian Health Care Improvement Act (IHCIA) in 1968. The IHS establishes education and practice standards for midlevel medical, behavioral, and dental health practitioners, including dental health aide therapists or dental therapists, who are certified by a CHAP Certification Board. Community health aides have worked in Alaska since the 1960s to combat unmet health needs in rural villages. Dental Health Aide Therapists in Alaska were added to CHAP through federal action in 2003.

Recognizing the success of these providers, under the 2010 amendment to IHCIA, Congress authorized the creation of a national CHAP to allow the use of community health aides for Tribes throughout the country. However, Tribes in the Lower 48 states are prohibited from employing dental therapists under CHAP unless located in a state where dental therapy services are authorized under state law. In these cases, dental therapists must comply with federal CHAP training and certification requirements, so Tribal coordination and involvement in state rulemaking is essential.

Tribes planning to implement dental therapy have options to provide the regulatory and public protection functions that usually accompany health occupational licensing and practice, including but not limited to:

1. Establish an area certification board and process under the federal CHAP Program. Currently, the Northwest Portland Area and Alaska Area operate CHAP Area Certification Boards, and the Billings Area has a CHAP Area Certification Board in development.
2. Establish reciprocity options to accept the certification of dental therapists certified by other CHAP Area Certification Boards.
3. Assert Tribal sovereignty and implement Tribal regulations for the practice of dental therapy. These services would only be available on Tribal lands and in Tribal facilities unless state law includes a provision that allows statewide practice for Tribally licensed or CHAP - certified dental therapists. Operating outside of state regulations and the IHS CHAP program may create challenges securing Medicaid or other reimbursement for dental therapist services. It would also exclude the providers from liability coverage under the Federal Tort Claim Act (FTCA).
4. Take no action. Dental therapists working for Tribes and Tribal facilities would be required to meet state licensing requirements.

The advantages and disadvantages of each option will vary by state and by Tribe.

The IHCIA establishes a multi-level regulatory structure for providers certified by CHAP, including dental therapists. Below is a brief overview of the CHAP regulatory structure, summarized from [Indian Health Service Circular No. 20-06](#).

Certification Boards. Certification boards are the regulatory bodies for CHAP. All providers who wish to provide services under the CHAP must be certified by one of the following boards:

1. CHAP National Certification Board (NCB). The NCB is a federal board chaired by the IHS Chief Medical Officer (CMO) or his or her delegate and may be comprised of Federal and Tribal representatives from each Area Certification Board. Functions of the NCB and board composition are addressed in Circular No. 20-06's Standards and Procedures.
2. CHAP Area Certification Boards (ACBs). The ACBs are federal certification boards located in the contiguous 48 states and may be comprised of Federal and Tribal representatives. Their membership must include at least one

federal representative appointed by the respective IHS Area Director. The ACB establishes board composition in its standards and develops the procedures of each respective board to certify individuals as providers.

Standards and Procedures. In CHAP, Standards and Procedures serve the same functions as a medical or dental practice act and administrative rule.

1. National CHAP Standards and Procedures. Adopted in part from the Alaska CHAPCB Standards and Procedures to outline the minimum program standards for all CHAP provider types operating outside of Alaska. The National CHAP Standards and Procedures include, but are not limited to, the minimum training, training equivalency, supervision, and scope of practice requirements.
2. Area Standards and Procedures. At a minimum, the Area Standards and Procedures must include the National CHAP Standards and Procedures and may have additional supplemental requirements above and beyond the national standards that are specific to the cultural considerations of the region and community specific needs, as well as the health care delivery system.

Under CHAP, individual Tribes cannot amend or change the Standards and Procedures. Each regional board will have the ability to modify the National CHAP Standards and Procedures in order to address the specific needs in their area of the country, but these modifications will be subject to evaluation by the National CHAP Certification Board in order to ensure the modifications are in keeping with the spirit and character of the original Standards and Procedures.

Tribes and Tribal health organizations wishing to add dental therapists to their dental team should start by contacting their regional IHS Area Office.

As seen by this brief introduction, Tribal regulation of dental therapy and the interplay between Tribal and state regulation are complex issues, and an in-depth discussion is beyond the scope of this document. For additional resources, please see the appendix and the [Tribal Oral Health Initiative of the National Indian Health Board](#).

## MODEL DENTAL THERAPIST RULE

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### Conventions used in this document:

- “State-name” is the generic placeholder term where a specific state name would generally be used.
- “Board of Dentistry” and “Board” are used as placeholder names in this document for state dental or professional licensing regulatory agencies.
- Where the document shows examples of existing language edited to apply to dental therapists, proposed new language is underlined, and language proposed for removal is printed with ~~strikethroughs~~. Unchanged language appears without underlines or strikethroughs.
- Example references to a state’s existing rules or statutes use the format “State-name Statute, section 123,” “State-name Statutes, sections 123.456-789.012,” etc. Official drafters in each state will modify these model rules for each state’s format and construction requirements.
- “[Guidance]” is used to preface and identify recommendations from the National Model Rule Panel on a topic.

### Overview

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[Guidance] This model rule is constructed for use when an existing Board of Dentistry or other regulatory agency rule is being amended to add dental therapist licensing and regulatory provisions will be added. As such, it includes common health professional licensing and regulatory categories, with examples to illustrate the addition of dental therapists. It also includes new provisions that may be unique to dental therapist licensing and regulation.

1) SUPERVISION. [If not in statute]

2) LICENSURE BY EXAMINATION.

a) An applicant for dental therapist licensure by examination shall submit a completed application, on a form provided by the board, together with the requisite fee and shall meet all of the following requirements:

- (i) Graduate from a dental therapy educational program that meets the standards in section 123.456.
- (ii) Pass a comprehensive, competency-based clinical examination developed and scored by a board-approved clinical testing agency.



[GUIDANCE] Definitions of supervision levels should only be included if undefined in relevant statute or rule. Incorporation by reference may be appropriate; e.g., “General supervision has the meaning as defined in [add citation].”



[GUIDANCE] If limitations on the number of allied dental personnel a dental therapist may supervise are prescribed in statute, they need not be repeated in rule. If not in statute, such restrictions may go beyond legislative intent and should not be included.



[GUIDANCE] Arrangements and details for dentist supervision of dental therapists or dental therapist supervision of allied dental personnel may fit best in a collaborative agreement rather than in rule.

### 3) EXAMINATION OF DENTAL THERAPISTS.

a) Subp. 1. The examination of applicants for a license to practice dental therapy shall be sufficiently thorough to test the fitness of the applicant to practice dental therapy.

b) Subp. 2. Clinical examination. An applicant must pass a **board-approved clinical examination** designed to determine the applicant's clinical competency.

c) Subp. 3. Additional examination content. All applicants shall be examined for general knowledge of the act and the rules of the board. Additional written theoretical examinations may be administered by the board.

### 4) SCOPE OF PRACTICE. [If not in statute]



[DEFINITION] Use “board-approved clinical examination” or “competency-based clinical examination developed and scored by a board-approved clinical testing agency.” Avoid naming specific testing agencies or exams, because this is an evolving aspect of dental therapist licensure.



[CAUTION] Naming a specific agency or test in rule may prevent a board from adjusting as the field evolves.



[DEFINITION] Scope of practice for dental therapists is detailed in statute in most states. Do not duplicate in rule language already found in statute. If state practice or stakeholder interest requires inclusion, use: “The scope of practice of a licensed dental therapist is set out in (cite Statute).”



[GUIDANCE] If scope of practice is not part of the statute and must be defined in rule, the scope found in the Model Act and the required services and procedures in the CODA standards can serve as a minimum scope of practice on which scope can be based.

5) LICENSURE BY ENDORSEMENT. [If not in statute, or if additional administrative details are required to implement]

6) COLLABORATIVE PRACTICE AGREEMENT. [If not in statute]



[GUIDANCE] Licensure by endorsement (or credential) for dental therapists should parallel rule language for dentists and dental hygienists. Because of variability in dental therapy licensing requirements, education standards, scope of practice, and terminology across jurisdictions, additional documentation may be needed to ensure applicants have received substantially equivalent training and experience as required by your state law. Consider language from the Model Act: “Licensing by credential is authorized for an applicant who holds a license or certification as a dental therapist, dental health aide therapist, or comparable professional in another state or Tribal jurisdiction.”



[GUIDANCE] Collaborative practice agreement requirements and content may be detailed in statute. If so, add only necessary administrative requirements, if any (e.g. structure, filing instructions, and notifications). Rules should not be used to limit agreements in ways not explicitly provided in statute.

If collaborative practice language is needed, consult the collaborative agreement language in the Model Act, page 21.

## Model Rule Language for Provisions Commonly Found in Dental Licensing and Regulation Administrative Rules

Applying standard licensing and regulation provisions can be as simple as adding the term “dental therapists” to existing language. In some instances, a parallel provision or section may need to be added, such as to specify dental therapist application details, fees or continuing education requirements. Some examples for common provisions are listed below.

### Example 1 - Adding dental therapists to existing rules (from Minnesota rules):

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DEFINITIONS. In [these rules](#):

- a) “Allied dental personnel” means the dentist’s supporting team who receives appropriate delegation from the dentist or dental therapist to participate in dental treatment.
- b) “Approved course” means a course offered by either a dental, dental therapy, dental hygiene, or dental assisting assistant program accredited by the Commission on Dental Accreditation or approved by the Board.
- c) “Dental therapist” means a person licensed under State-name Statutes, Chapter 123, section 123, to provide the care and services and perform any of the duties described in State-name Statutes, Chapter 123, section 12.



[GUIDANCE] Only include definitions not found elsewhere in statute or in Board rules, or terms that have a different meaning when applied to dental therapist regulation or in its meaning in the specific section.

## Example 2 - Adding dental therapists to existing rules (from Minnesota rules):

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### CONDUCT UNBECOMING A LICENSEE.

“Conduct unbecoming a person licensed to practice as a dentist, dental therapist, dental hygienist, or dental assistant, or conduct contrary to the best interests of the public,” as used in State-name Statutes, section 123.456.

(A) shall include the act of a dentist, dental therapist, dental hygienist, licensed dental assistant, or applicant in:

- (i) engaging in personal conduct that brings discredit to the profession of dentistry;
- (ii) gross ignorance or incompetence or repeated performance of dental treatment that falls below accepted standards;
- (iii) making suggestive, lewd, lascivious, or improper advances to a patient;
- (iv) charging a patient an unconscionable fee or charging for services not rendered;
- (v) performing unnecessary services;
- (vi) dental therapists, hygienists, or licensed dental assistants performing services not authorized by the dentist under this chapter or in State-name Statutes, section 123.456.

### Example 3 – Adding a parallel provision (from Vermont rules):

#### Renewal requirements.

(A) **Dentists.** To be eligible for renewal, a dentist must show:

- (i) 30 hours of continuing education, including the emergency office procedures course, CPR course, and opioid-prescribing education where applicable; and,
- (ii) active practice of at least 800 hours or 100 continuing education credits within the previous five years. A combination of practice hours and continuing education credits may be used. An applicant for renewal who has not met minimum practice-hour requirements must complete one of the clinical examinations required for initial licensure.

(B) **Dental Therapists. To be eligible for renewal, a dental therapist must show:**

- (i) **(# of hours in statute, if in statute) hours of continuing education, including the emergency office procedures course and the CPR course; and,**



[GUIDANCE] See the discussion on making conforming changes to existing provisions in the Model Act, page 23, for additional guidance.



[GUIDANCE] If continuing education, fees or other such requirements for dental therapists are not specified in statute, rule makers may want to consider requirements that fall between those required for a dental hygienist and a dentist.

**(ii) active practice of a least (# of credits in statute, if in statute) hours or (# of credits in statute, if in statute) continuing education credits within the previous five years. A combination of practice hours and continuing education credits may be used. An applicant for renewal who has not met minimum practice-hour requirements must complete one of the clinical examinations required for initial licensure.**

(C) **Dental Hygienists.** To be eligible for renewal, a dental hygienist must show:

(i) 18 hours of continuing education, including the emergency office procedures course and the CPR course; and,

(ii) active practice of a least 100 hours or 50 continuing education credits within the previous five years. A combination of practice hours and continuing education credits may be used. An applicant for renewal who has not met minimum practice-hour requirements must complete one of the clinical examinations required for initial licensure.

(D) **Dental Assistants.** To be eligible for renewal, a dental assistant must show 9 hours of continuing education, including the emergency office procedures course and the CPR course. A radiography specialty may be renewed only if the bearer has completed training within the preceding ten years or practiced radiography under the supervision of a licensed dentist within the preceding five years.

## Other Common Provisions: Amending the standard provisions below can be as simple as adding the term “dental therapists” to existing language

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- 1) Approval of dental professions schools; standards; adoption by reference
- 2) Licensing
  - a) Incomplete applications
  - b) Additional information from all applicants
  - c) Terms and renewal of license or permit; general
  - d) Terms and renewal of licensure; limited faculty and resident dentists
  - e) Reinstatement of license
  - f) Fees
- 3) Complaints
- 4) Suspension or revocation of license or registration
- 5) Statutory grounds for discipline
- 6) Conduct unbecoming a licensee
- 7) Voluntary termination of license
- 8) Allied dental personnel
- 9) Dental treatment records; requirements
- 10) Use of title
- 11) Display of license
- 12) Limited licenses; issuance; requirements

## APPENDICES

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  - c. State Dental Therapy Rules Status
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## National Model Dental Therapy Rule Expert Panel – Panel Member Bios

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**Bridgett Anderson, LDA, MBA**, is the Executive Director of the Minnesota Board of Dentistry, with over 20 years of experience in the dental field. Previously she was the Director of Regulatory Affairs with the Minnesota Dental Association. Her expertise ranges from clinical dentistry, previously as a licensed dental assistant and dental office manager, to dental safety, prevention and regulation, and as a lecturer in dental therapy and to providing guidance on regulation of dental therapy to other state boards. She holds an MBA degree from Bethel University, St. Paul, MN.

**Kristen R. Boilini, PhD, MS, MA**, is the managing partner of Pivotal Policy Consulting, a full-service public policy and government relations firm. She brings over 25 years of professional experience in the development and implementation of health care policy and reform efforts, with an emphasis on increasing access to care in tribal and underserved communities. She led the efforts to build the coalition supporting dental therapy (DentalCare4Az) in her home state of Arizona and served as the government relations lead in passing Arizona's dental therapy legislation in 2018. Kristen remains active in implementing Arizona's dental therapy law, including the promulgation of rules for the licensure and regulation of dental therapists, as well as working with educational institutions to develop dental therapy training programs.

For over two decades, Kristen has represented clients within the public policy arena across a diverse range of industries. She first developed her depth, knowledge and unique perspective on public policy serving in two gubernatorial administrations, where she developed agency budgets, created and implemented a variety of public finance and tax policy initiatives, as well as assisted state agencies to streamline and enhance the productivity of government operations. In these roles, Kristen developed a keen, in-depth understanding of state budgeting and the appropriations process, public finance, tax policy and government operations.

Today, Kristen's practice is quite diverse. She is a trusted advisor and advocate, working with a variety of clients in areas ranging from education and higher education to healthcare, tribal and municipal governments, housing and economic development interests, as well as serving clients in the business and non-profit sectors. Clients know and trust her not only for her knowledge and experience, but for the deep passion she brings to their issues. Kristen holds an MS in Economics, an MA in Human Development, and a PhD in Organizational Development.

**Michael Broschinsky, MPA**, is the director of Utah's Office of Administrative Rules. His academic training is in political science (BA 1987, University of Utah) and public administration (MPA 1992, University of Utah). Mike is a member of the Administrative Codes and Registers Section of the National Association of Secretaries of State. He is also an adjunct instructor in political science at Salt Lake Community College. Mike lives with his wife, three daughters, one grandson, and two cats in Taylorsville, Utah.

**Allison Corr, MPH, MSW**, is an officer for the Dental Campaign at the Pew Charitable Trusts. She has more than a decade of experience in federal and state health policy and research. At Pew, she manages efforts to improve access to oral health care, including work to authorize and implement dental therapy in states around the country. Previously, Allison worked on a range of health care issues for the Energy and Commerce Committee of the U.S. House of Representatives. She holds master's degrees in public health and social work from Columbia University and a bachelor's degree in psychology from the University of Virginia.

**Miranda Davis, DDS, MPH**, is the project director for the Native Dental Therapy Initiative at the Northwest Portland Area Indian Health Board. The mission of the Native Dental Therapy Initiative is to connect Tribal communities with innovative approaches to address AI/AN oral health disparities, to remove barriers impeding the creation of efficient, high quality, modern dental teams and to provide opportunities for AI/AN people to become oral health providers. Dr. Davis has provided clinical care with Tribes in the northwest for 15 years, in addition to several years of private practice and international volunteer work. She is passionate about public health, disease prevention, and expanding access to high quality oral health care. Dr. Davis graduated from the University of the Pacific Arthur A. Dugoni School of Dentistry. She holds a master's degree in public health from the University of Washington and a bachelor's degree from the University of California, Los Angeles.

**Christine M. Farrell, RDH, BSDH, MPA**, is the Oral Health Program Director for the Michigan Department of Health and Human Services. She has over 30 years of public service with the MDHHS since 1988 and has been the Oral Health Director since June 2010. She has a wealth of knowledge at both the state and federal levels and a great deal of experience advising public health staff and partners on a vast array of program, financial and administrative issues related to oral health, dental public health, Medicaid, and prevention programs. In addition, her duties include ensuring the oral health program effectively educates the public about oral health issues as well as the implementation of preventive activities to improve the oral health of Michigan residents throughout their lifetime. She is currently the President of the Association of State and Territorial Dental Directors (ASTDD). Chris received both her bachelor's degree in dental hygiene and a master's degree in public administration from the University of Michigan.

**Pamela Johnson** is a project manager for the Native Dental Therapy Initiative at the Northwest Portland Area Indian Health Board, where she leads the advocacy work to establish laws and policies necessary for dental therapists to thrive in Tribal communities across Washington, Idaho, and Oregon. Pam has 30 years of experience advocating for progressive change in environmental and health policy. She is a graduate of Pacific Lutheran University.

**Deborah Kappes, MPH, RDH**, is a staunch advocate of dental therapy in Arizona. As chair of the Arizona Dental Hygienists' Association's Advocacy Committee, Deborah

worked closely with the Dental Care for Arizona Coalition, lobbyists, and legislators to craft and pass dental therapy enabling legislation. Currently, Deborah is serving on the Rules Advisory Group for the Arizona State Board of Dental Examiners developing dental therapy administrative rules for the Board's consideration.

During her professional career, Deborah has been engaged in private practice dental hygiene and retired as a professor at Phoenix College where her primary role was full-time dental hygiene educator and included eight years serving as the dental department chair overseeing the dental hygiene, dental assisting, and continuing dental education programs. As a volunteer, Deborah has collaborated with many organizations to advance oral health including the American Dental Hygienists' Association, the Arizona Public Health Association, the Arizona Dental Association, the Arizona State Board of Dental Examiners, the Arizona Department of Health Services, and the Arizona Oral Health Coalition. Deborah earned a dental hygiene degree from Phoenix College, a bachelor's degree in community health education from Arizona State University, and a master's degree in public health from the University of Arizona.

### **Alida Montiel**

*Inepo Alida Montiel, Anía Voa, tea  
Ínto Hiaki, Maayo, Mexica hamut  
Lios enchim nauwerim*

Ms. Montiel is the Director of Health & Human Services at the Inter Tribal Council of Arizona (ITCA). Since 1990, her principal responsibility is to analyze and address health policy formation at the direction of Tribal Leaders in Arizona, Nevada and Utah served by the Phoenix Area IHS, ranging from federal, state or specific Tribal policies and budgetary issues that affect the AI/AN health care system. In January 2019, she stepped into the management of all health and human service related projects at ITCA. She currently serves as the chairperson of the Arizona Advisory Council on Indian Health Care and is a member of the Arizona Behavioral Health Planning Council. These councils monitor and advocate for services provided to clients through Medicaid, the Children's Health Insurance Program and block grants awarded to the state.

Ms. Montiel has an Associate's Degree in American Indian Studies from Deganawidah-Quetzalcoatl University in Davis, California, a Tribal Management Associates Degree from Scottsdale Community College and a Bachelor's degree in Sociology from Arizona State University. Ceremonial responsibilities encompass Yaqui/Mayo life ways and a teacher of traditional Aztec (Mexico) Dance, a designation received in 1986, from her Elders.

**Christina Peters, MJ**, is the director for the Tribal Community Health Provider Project at the Northwest Portland Area Indian Health Board, where she and her team assist Tribes in Oregon, Washington, and Idaho as they explore opportunities to tackle important social determinants of health such as educational attainment, financial security, and

access to health while improving the system of health care through the implementation of the Community Health Aide Program. The TCHP Project focuses on breaking down barriers to education and care and dismantling the institutionalized and structural racism that denies health equity and educational attainment to Tribal communities. She received a bachelor's degree in economics from the University of Washington and a Master of Jurisprudence from the University of Washington School of Law.

**Stephen Prisby** has served as the Executive Director for the Oregon Board of Dentistry since 2015 and has been with the Board since 2012. His previous work experience was in higher education where he served in roles as a Campus Director and Director of Enrollment. He is the President of the American Association of Dental Administrators. The state of Oregon recently enacted new legislation - HB 2528 (2021) - that will require the Oregon Board of Dentistry to issue dental therapy licenses and promulgate rules to regulate this new type of licensee. The Oregon Board of Dentistry was created in 1887 and is the oldest health licensing regulatory board in Oregon.

**Kim Russell, MHA**, is of the Bitter Water People, born for the Tangle People. Her maternal grandfathers are of the Coyote Pass Clan and her paternal grandfathers are of the Bitter Water People. Ms. Russell is from Chinle, Arizona, and a citizen of the Navajo Nation. Ms. Russell is the Executive Director of the Arizona Advisory Council on Indian Health Care, an independent state agency whose mission is to advocate for increasing access to high quality health care programs for all American Indians in Arizona. Kim has worked with Tribes, Tribal Organizations, the Indian Health Service, and Urban Indian Health Programs to advance their health agendas and priorities her entire career. Ms. Russell received her Bachelor of Science degree in Biology and a Master's of Health Administration. Kim enjoys spending time with family and traveling.

**Brett Weber, MPA**, serves as a Public Health Policy & Programs Manager in the Public Health Department at the National Indian Health Board. Prior to NIHB, Mr. Weber worked at the United States Senate Committee on Indian Affairs as a Policy Fellow where he worked on health, environmental, energy, and other issues for then Vice Chairman Jon Tester (D-MT). He has also worked as an intern at the White House Office of Public Engagement and Intergovernmental Affairs. Mr. Weber completed his master's degree in Public Administration from the University of Georgia (Go Dawgs!). He also holds a bachelor's degree in Political Science.

**Mary Williard, DDS**, is a commissioned officer with the US Public Health Service/Indian Health Service detailed to the Coquille Indian Tribe in southwestern Oregon, where she is the Dental Director of the new dental clinic in the Ko-Kwel Wellness Center. She graduated from The Ohio State University College of Dentistry in 1994 and completed a 2-year General Practice Residency at the Carolinas' Medical Center in Charlotte, North Carolina in 1996. Dr. Williard's previous work includes having been the director of the first ever CODA accredited dental therapy educational program in the U.S., the Alaska Dental Therapy Educational Program.

**Amy Zaagman, MPA**, is the Executive Director of the Michigan Council for Maternal and Child Health, an organization of diverse partners comprised of hospital systems, statewide organizations, local public health advocates and individuals with an interest in shaping and influencing state policy that promotes the health and well-being of women, children and families in Michigan since 1983. MCMCH was the lead organization of the MI Dental Access coalition that developed and successfully lobbied for the 2018 dental therapy licensing act in Michigan. Amy and MCMCH continued advocacy throughout the rule-making process and are also engaged in ongoing promotion and implementation efforts for dental therapy.

Amy has been with MCMCH since 2009 and is a passionate advocate for improving health outcomes and ensuring equitable access to care and prevention services across the life course. Previously, Amy was the associate director of the state's community mental health association and served for over 13 years in various roles in the state Legislature. She holds a BBA and MPA from Western Michigan University.

**Mark Schoenbaum, MSW**, is a consultant on health workforce issues, working with states, health care organizations, higher education and other stakeholders. He is also Adjunct Health Policy faculty, University of Minnesota.

Mark was in a unique leadership position throughout Minnesota's consideration and development of dental therapy before retiring from a 38-year career in government and public health. As Director of Minnesota's Office of Rural Health and Primary Care from 2005 - 2018 he played an influential role in the process through which dental therapy became law and grew into an integral profession alongside other dental disciplines. He was lead staff to the 2008 Oral Health Practitioner Work Group that developed dental therapy recommendations for the state legislature and represented the Minnesota Department of Health during the 2009 legislative session's enactment of Minnesota's dental therapy law. He built relationships between the health department, the Medicaid agency, higher education and dental stakeholders, sponsored the 2014 report Early Impacts of Dental Therapists in Minnesota, chartered Minnesota's multi-stakeholder Dental Therapy Research Group, and developed toolkits for prospective dental therapy employers.

Mark is recognized as an expert on health workforce, scope of practice, licensing and emerging health professions issues. He directed health care workforce research and development for the health department, staffed the Minnesota Legislative Health Care Workforce Commission and led Minnesota participation in National Governor's Association and National Conference of State Legislatures scope of practice and health workforce Policy Academies. Mark holds an MSW from the University of Minnesota and a BA from Antioch College.

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## Definition and Purpose of Administrative Rules – Some Examples

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### DEFINITION

The APA describes rulemaking as the “agency process for formulating, amending, or repealing a rule.” A “rule,” for purposes of the statute, is defined expansively to include any “agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency.” Rules that are issued in compliance with certain legal requirements, and that fall within the scope of authority delegated to the agency by Congress, have the force and effect of law.

Garvey, T. (2017). Brief Overview of Rulemaking and Judicial Review. Congressional Research Service (CRS R41546). <https://sgp.fas.org/crs/misc/R41546.pdf>

### PURPOSE STATEMENTS

1. The purpose of administrative rules is to accomplish the ends sought by legislation enacted by the General Assembly. Thus, “[r]ules promulgated by administrative agencies are valid and enforceable unless unreasonable or in conflict with statutory enactments covering the same subject matter.”

*State, Ex Rel. Curry, V. Indus. Comm.*, 58 Ohio St.2d 268, 389 N.E.2d 1126 (1979)

2. If an administrative rule either adds to or subtracts from a legislative enactment, it creates a clear conflict with the statute, and the rule is invalid. “A rule that is in conflict with the law is unconstitutional because it surpasses administrative powers and constitutes a legislative function.”

*Crawford-Cole v. Lucas County Department of Job & Family Services*, 6th Dist. No. L-11-1177, 2012-Ohio-3506

3. The purpose of administrative rules is to limit the abuse of public power by public administrators either for self-interested or other ends.

Spicer, M. W. (1995). *The Founders, the Constitution, and Public Administration: A Conflict in World Views*. Washington, DC: Georgetown University Press.

4. Purpose of Administrative Rules: Administrative rules are often written to define and describe how legislation will be implemented and enforced.

State of Iowa, Office of the CIO. (n.d.). Administrative Rules Overview - Iowa Administrative Rules. Retrieved January 8, 2021, from <https://rules.iowa.gov/info/rules-overview>

## DENTAL THERAPY STATE RULES STATUS

August 2021

	ALASKA	MINNESOTA	MAINE	VERMONT	WASHINGTON	ARIZONA
<b>Date DT Law Passed</b>	Tribal authorization in 2003	2009	2014	2016	2017	2018
<b>DTs in Practice</b>	36: 1st in 2005	100: 1st in 2011	1: 1st in 2021		8	
<b>Status of DT Licensing and Rulemaking</b>	<p>CHAP Certification Board (CHAPCB).</p> <p>Standards &amp; Procedures — equivalent to combined statute and rules.</p> <p>Alaska Tribal Health Consortium administers the CHAPCB.</p>	<p>DT licensing integrated into existing Board rules in 2011.</p>	<p>Rules adopted in April 2020.</p>	<p>Interim rules in place that allow for licensure.</p> <p>Draft rules submitted to Office of Professional Regulation for formal rulemaking process.</p>	<p>The Swinomish Indian Tribal Community adopted the Tribal Dental Health Provider Licensing and Standards Code in 2015.</p> <p>Law only authorizes practice in Tribal and related settings with CHAP certification.</p> <p>No state rules.</p>	<p>Draft rules under discussion by Board workgroup.</p> <p>State license not required for practice in Tribal and related settings.</p>
<b>Education and Clinical Hour Requirements</b>	<p>No minimum degree requirement.</p> <p>Alaska DHAT Educational Program or program with training equivalent to CODA standards.</p> <p>3 months or 400 hours, whichever is longer, under direct supervision for general supervision.</p>	<p>Bachelor's degree for DT.</p> <p>Master's degree for advanced DT (ADT).</p> <p>2,000 hours under direct supervision to become ADT.</p>	<p>Master's degree.</p> <p>Program that is CODA accredited or approved by BOD rule.</p> <p>2,000 supervised hours for licensure.</p>	<p>No minimum degree requirement.</p> <p>CODA accredited program.</p> <p>1,000 hours under direct supervision for general supervision.</p>	<p>No minimum degree requirement.</p> <p>Alaska DHAT Educational Program or a program with training equivalent to CODA standards.</p> <p>3 months or 400 hours, whichever is longer, under direct supervision for general supervision.</p>	<p>No minimum degree requirement.</p> <p>CODA accredited program.</p> <p>1,000 hours under direct supervision for general supervision.</p>
<b>Notes</b>	<p>Practice limited to Tribal and related settings.</p> <p>Iļisaǵvik College's DT Program received CODA accreditation in 2020.</p>	<p>Practice limited to safety-net, public health, and non-profit settings, or private practices where 50% of DTs' patients are underserved.</p>	<p>On-site ("direct") supervision.</p>	<p>Must be a licensed dental hygienist for initial DT license but not for renewal.</p>	<p>Practice limited to Tribal and related settings.</p>	<p>Must be a licensed dental hygienist for initial DT license but not required for renewal.</p> <p>Practice limited to safety-net, public health, or non-profit settings, or private practices that serve patients referred by community health centers.</p>

## DENTAL THERAPY STATE RULES STATUS

August 2021

	MICHIGAN	NEW MEXICO	IDAHO	CONNECTICUT	MONTANA	NEVADA	OREGON
<b>DT Law Passed</b>	2018	2019	2019	2019	2019	2019	2021 (DT pilot projects began in 2016)
<b>DTs in Practice</b>			1 (pending pathway for pre-CODA graduates)				5
<b>Status of DT Licensing and Rulemaking</b>	Rules adopted in April 2021.	Rules adopted in May 2021.  State license not required for practice in Tribal and related settings.	Rules are in effect as of 2020, pending legislative ratification.  DT practice with state license and is limited to Tribal and related settings.	Rulemaking yet to begin.	No state rules.  Law only authorizes practice in Tribal and related settings with CHAP certification.	Rulemaking process is underway.  Licensure application is published.	Draft rules under discussion by BOD workgroup.  State license not required for practice in Tribal and related settings.
<b>Education and Clinical Hour Requirements</b>	No minimum degree requirement.  CODA accredited program.  500 hours under direct supervision as part of DT education program.	No minimum degree requirement.  CODA accredited program.  1,500 - 2,000 hours for general supervision.	No minimum degree requirement.  CODA accredited program.  500 hours under direct supervision for licensure.	No minimum degree requirement.  CODA accredited program.  1,000 hours under direct supervision for general supervision.	No minimum degree requirement.  Alaska DHAT Educational Program or a program with training equivalent to CODA standards.  3 months or 400 hours, whichever is longer, under direct supervision for general supervision.	No minimum degree requirement.  CODA accredited program.  500-1,500 hours under direct supervision for general supervision.	No minimum degree requirement.  CODA accredited program.
<b>Notes</b>	Practice limited to safety-net, public health, and non-profit settings, or private practices where 50% of DTs' patients are underserved.	Must be a licensed dental hygienist.  Practice limited to Tribal, safety-net, public health, or non-profit settings.	Practice limited to Tribal and related settings.	Must be a licensed dental hygienist.  Practice limited to "public health facilities" as defined in state statute.	Scope limited to preventive services.  Practice limited to Tribal and related settings.  Law sunsets in 2023.	Must be a licensed dental hygienist.  Practice limited to safety-net, public health, and non-profit settings, or private practices where 50% of DTs' patients are underserved.	DTs practicing under pilot authority will be eligible for state license; DTs practicing for Tribes will not be required to get licensed.  DT pilot project authority sunsets in 2025.

## Endnotes

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