MHC insight

DENTAL HYGIENE PROGRAM SURVEY

2025

RESULTS
& ANALYSIS

Introduction

This report highlights results from a 2024 survey of dental hygiene degree programs across the United States (U.S.). 328 schools were surveyed regarding their clinical rotation experiences, with 157 responses recorded, or 48 percent of programs. The sample size is representative – meaning it accurately reflects the characteristics of the national dental hygiene program population. The results have been aggregated for analysis. We sought a systematic understanding of the nature of diversifying recruitment – both of students and faculty – across dental hygiene, a profession that is 95 percent female and 77 percent white.[1]

About MHC

Michigan Health Council (MHC) is a solutions-oriented nonprofit with an eight-decade track record of developing sustainable programming for healthcare employers, educators, and professionals. A partner in building healthcare workforce capacity, MHC is the force behind MHC Insight — Michigan's preeminent resource for data, analysis, and labor market intelligence on critical issues facing Michigan's healthcare workforce. MHC Insight collects and disseminates healthcare workforce data and research to support stakeholders' efforts to develop systems-level approaches to building healthcare workforce capacity. MHC Insight can help organizations address their specific issues but prioritizes solutions to societal needs that cannot be solved in silos — like bolstering access to care, reducing health inequities, and increasing Michigan's healthcare workforce diversity. The first step in this process is creating a shared understanding of what current data tells us about our workforce.

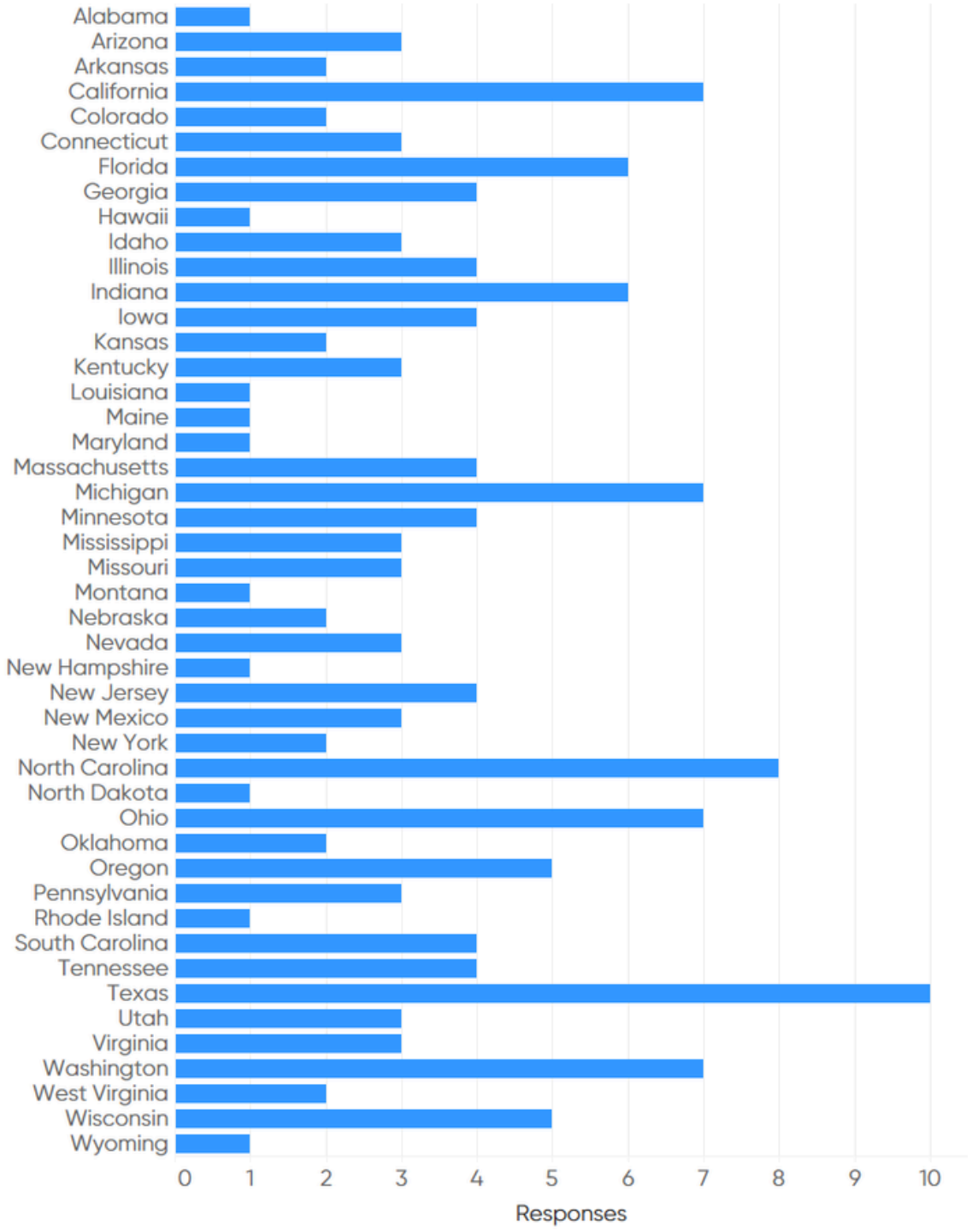
Methodology

This report utilizes both primary survey data and supplementary labor market information from Lightcast.

- **Survey Data:** Together with the Delta Dental Foundation (DDF), MHC Insight prepared a survey that sought to clarify how to increase and diversify class sizes at dental hygiene programs across the country. The survey was released in November 2024 and closed in January 2025. 157 responses were recorded, with nearly every state in the U.S. represented in the responses, except for Alaska, Delaware, D.C., North Dakota, South Dakota, and Vermont. The sample size is representative – meaning it accurately reflects the characteristics of the national dental hygiene program population at a 95 percent confidence interval with a 5.67 percent margin of error.

[1]Lightcast

Figure 1: Responses by State



- **Lightcast:** Lightcast gathers and integrates economic, labor market, demographic, education, profile, and job posting data from dozens of government and private-sector sources, creating a comprehensive and current dataset that includes both published data and detailed estimates with full U.S. coverage. Occupation data presents employment and wage information categorized by worker type — Registered Nurses, Welders, Web Developers, etc. Occupation job counts are generated by taking industry job counts from the Bureau of Labor Statistics' (BLS) Quarterly Census of Employment and Wages (QCEW) and combining them with staffing patterns from the BLS Occupational Employment Statistics (OES) dataset. Staffing patterns are unique to industries and show the percentage breakout of each industry into its component occupations. Lightcast regionalizes OES staffing patterns, creating location-specific staffing patterns that take into account the region's particular industry mix. The result is tailored staffing patterns that generate location-specific occupation employment data. Basic occupation earnings data come from OES as well. Lightcast unsuppresses earnings data where necessary and models the Metropolitan Statistical Area (MSA) level earnings native to OES down to the county level. Although OES is not published as a time series, Lightcast has developed one using historical OES data. This time series offers several benefits, including historical occupation earnings back to 2005, reduced volatility between years of published OES data, and the ability to use historical years of OES to unsuppress the latest year OES data. Occupation employment data goes back to 2001 and is also projected ten years into the future. Projections are generated by applying projected staffing patterns to Lightcast's projected industry employment data.

Analysis

Findings

Dental Hygienists are one of the most in-demand professions in healthcare, growing by 12 percent in the next ten years across the U.S. Federal data says that the United States needs nearly 21,000 more Dental Hygienists to meet current needs. By 2037, the country will be short nearly 30,000 Dental Hygienists. Overall, healthcare jobs are expected to grow by 14 percent in the same time period, indicating that Hygienists are largely keeping pace with the growth of the healthcare industry. Within oral health specifically, Hygienists are projected to experience more growth than Dental Assistants and Dentists. Vermont is projected to experience the lowest growth over the next ten years (two percent), while Texas is estimated to show the highest growth (25 percent). Median hourly wages vary across the U.S., with the U.S. median being $42.01 per hour. The lowest wages are in Alabama, at $27.59, while the highest wages are in the state of Washington, at $61.02. See **Table 1** for more information.

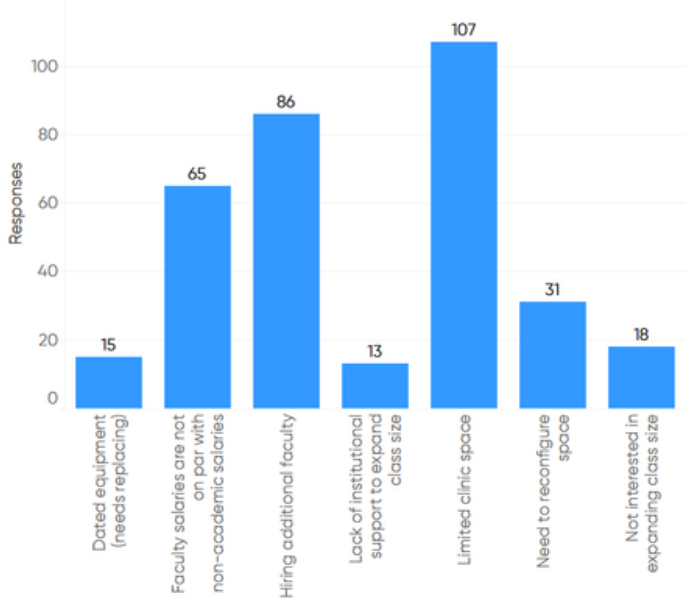
Table 1: Dental Hygienist Labor Market Information Across the U.S.[2]

	Jobs (2024)	Jobs (2034)	Job Change %	Median Hourly Wages
United States	223,623	251,432	12%	$42.01
Alabama	3,236	3,506	8%	$27.59
Alaska	642	710	11%	$58.82
Arizona	5,200	6,121	18%	$45.11
Arkansas	1,900	2,092	10%	$37.58
California	26,311	30,419	16%	$57.75
Colorado	4,988	5,640	13%	$49.79
Connecticut	3,293	3,478	6%	$45.44
Delaware	740	835	13%	$46.49
District of Columbia	288	327	14%	$57.52
Florida	13,884	15,880	14%	$38.69
Georgia	7,844	9,031	15%	$38.54
Hawaii	1,242	1,446	16%	$45.52
Idaho	1,516	1,794	18%	$39.70
Illinois	8,013	8,518	6%	$39.38
Indiana	4,913	5,296	8%	$39.52
Iowa	2,333	2,518	8%	$38.96

	Jobs (2024)	Jobs (2034)	Job Change %	Median Hourly Wages
Kansas	2,167	2,358	9%	$37.78
Kentucky	2,345	2,500	7%	$36.14
Louisiana	2,397	2,731	14%	$39.55
Maine	914	985	8%	$38.25
Maryland	3,800	4,061	7%	$49.00
Massachusetts	5,296	6,203	17%	$48.38
Michigan	8,598	9,064	5%	$37.40
Minnesota	5,081	5,404	6%	$44.78
Mississippi	1,625	1,840	13%	$30.37
Missouri	3,666	4,075	11%	$38.42
Montana	1,011	1,159	15%	$43.29
Nebraska	1,640	1,817	11%	$39.40
Nevada	2,379	2,824	19%	$46.84
New Hampshire	1,526	1,633	7%	$44.80
New Jersey	6,487	7,189	11%	$47.75
New Mexico	1,182	1,289	9%	$45.58
New York	12,849	14,673	14%	$44.93
North Carolina	6,838	7,644	12%	$39.02
North Dakota	742	817	10%	$39.31
Ohio	8,712	9,022	4%	$38.30
Oklahoma	2,380	2,694	13%	$46.67
Oregon	3,053	3,328	9%	$50.73
Pennsylvania	8,110	8,533	5%	$37.29
Rhode Island	774	793	3%	$40.36
South Carolina	3,331	3,794	14%	$37.57
South Dakota	638	735	15%	$38.82
Tennessee	4,948	5,808	17%	$36.40
Texas	12,756	16,008	25%	$42.76
Utah	3,235	3,961	22%	$38.18
Vermont	575	587	2%	$45.60
Virginia	4,435	5,033	13%	$43.80
Washington	7,129	8,189	15%	$61.02
West Virginia	1,179	1,260	7%	$32.17
Wisconsin	5,024	5,292	5%	$38.13
Wyoming	456	519	14%	$38.02

[2]Lightcast

Figure 2: Barriers to Expanding Current Class Size



Dental hygiene is one of the *least diverse* professions within healthcare.

Across healthcare occupations, Dental Hygienists have the highest percentage of females working (95 percent) and the fifth highest number of white individuals (77 percent). Overall, healthcare in the U.S. is 79 percent female and 54 percent white; dental hygiene is one of the least diverse professions within healthcare. At a time when demand for Hygienists is high, increasing the supply of talent is a critical component of growing the profession. Intensifying efforts to expand class sizes and recruit students from underrepresented populations is a key step toward bolstering the talent pipeline.

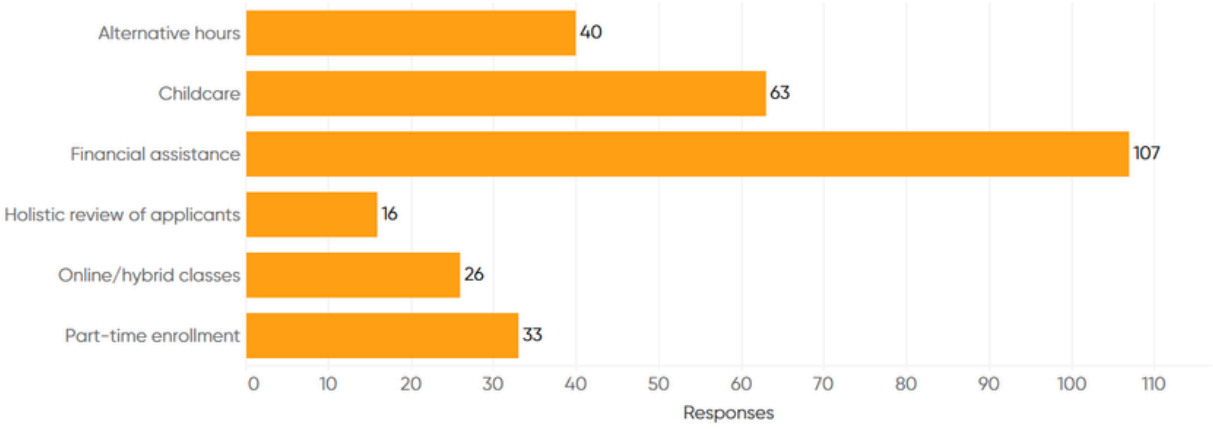
However, many dental hygiene programs across the U.S. may not have the capacity to increase their class sizes for a variety of reasons. When surveyed, the most common barrier for most programs was "Limited clinic space" (107 programs, or 76 percent of the 140 responses to this question). This was followed up by "Hiring additional faculty" and "Faculty salaries not on par with non-academic salaries." See **Figure 2** for more.

Programs were also asked how many additional seats they would be willing to add if those barriers were removed. 40 percent of respondents indicated six to ten seats, while 31 percent indicated one to five seats. 25 percent said 11-20 seats and only three percent were interested in adding more than 20 seats.

As part of expanding, programs were also asked if they were looking to add different degree offerings to those currently available - and 74 percent of programs indicated they were not looking to add additional degree offerings. Of the 26 percent that were interested in adding new degrees, the most common response for what kind of additional degree was a B.S. or baccalaureate degree.

When asked what resources would improve recruitment efforts for historically or systemically underrepresented or disadvantaged students, 93 percent of programs indicated financial assistance, and 55 percent indicated childcare. See **Figure 3**.

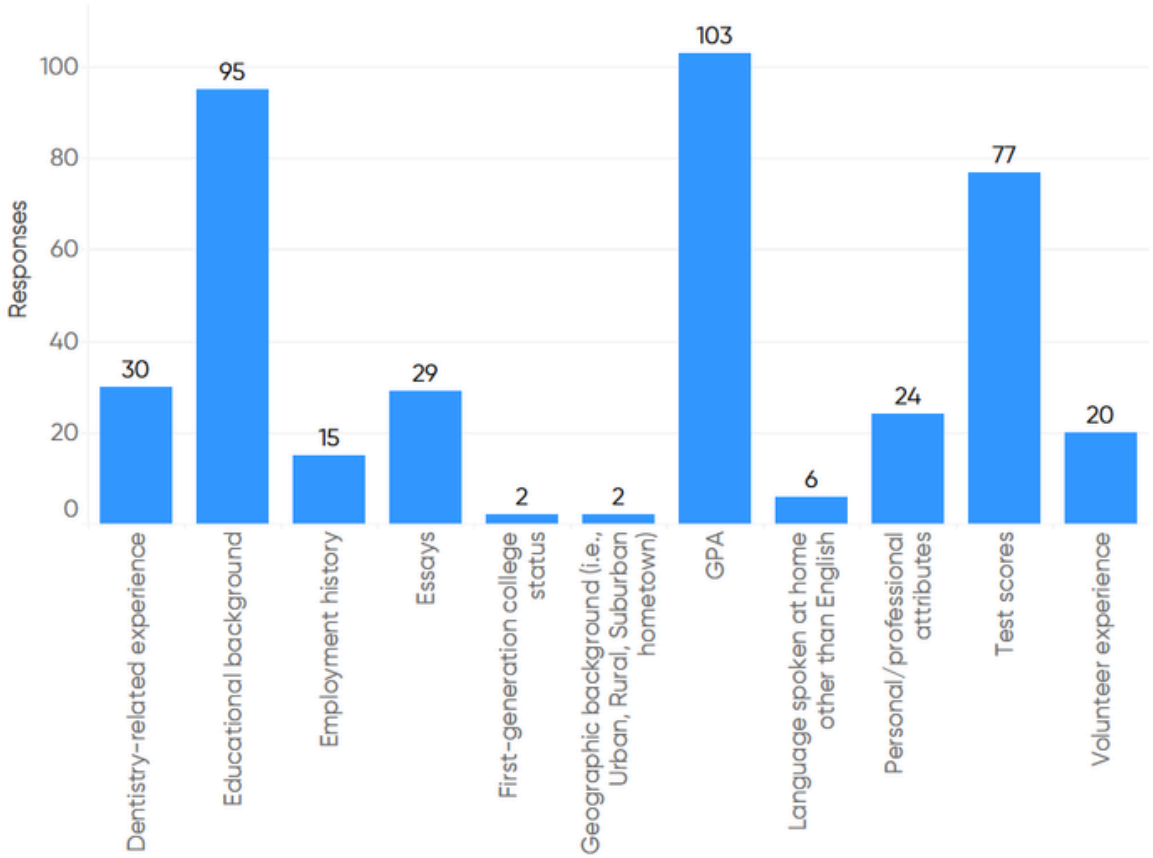
Figure 3: Resources to Improve Recruitment



But, when asked if their programs had grants or financial assistance available to male or BIPOC students, two-thirds of programs responded "No." This was also true of academic support, where 57 percent of programs responded "No." Many programs indicated that financial and academic support was available to all students, but nothing specific for Black or BIPOC students. 80 percent of programs also collaborate with community organizations or K-12 schools to promote dental hygiene careers to historically or systemically underrepresented or disadvantaged groups. The most common method for doing so was reported as career fairs or outreach to local high schools in other formats. In addition, many programs reported on diverse clinical rotation opportunities (see page 10 for more) that was geared towards promoting dental hygiene as a career.

Programs were also asked what factors are considered in a potential student's application during the admission process. Grade point average (GPA), educational background, and test scores were the three most popular answers, at 84 percent, 77 percent, and 62 percent, respectively. See **Figure 4**.

Figure 4: Factors Considered in Application Process

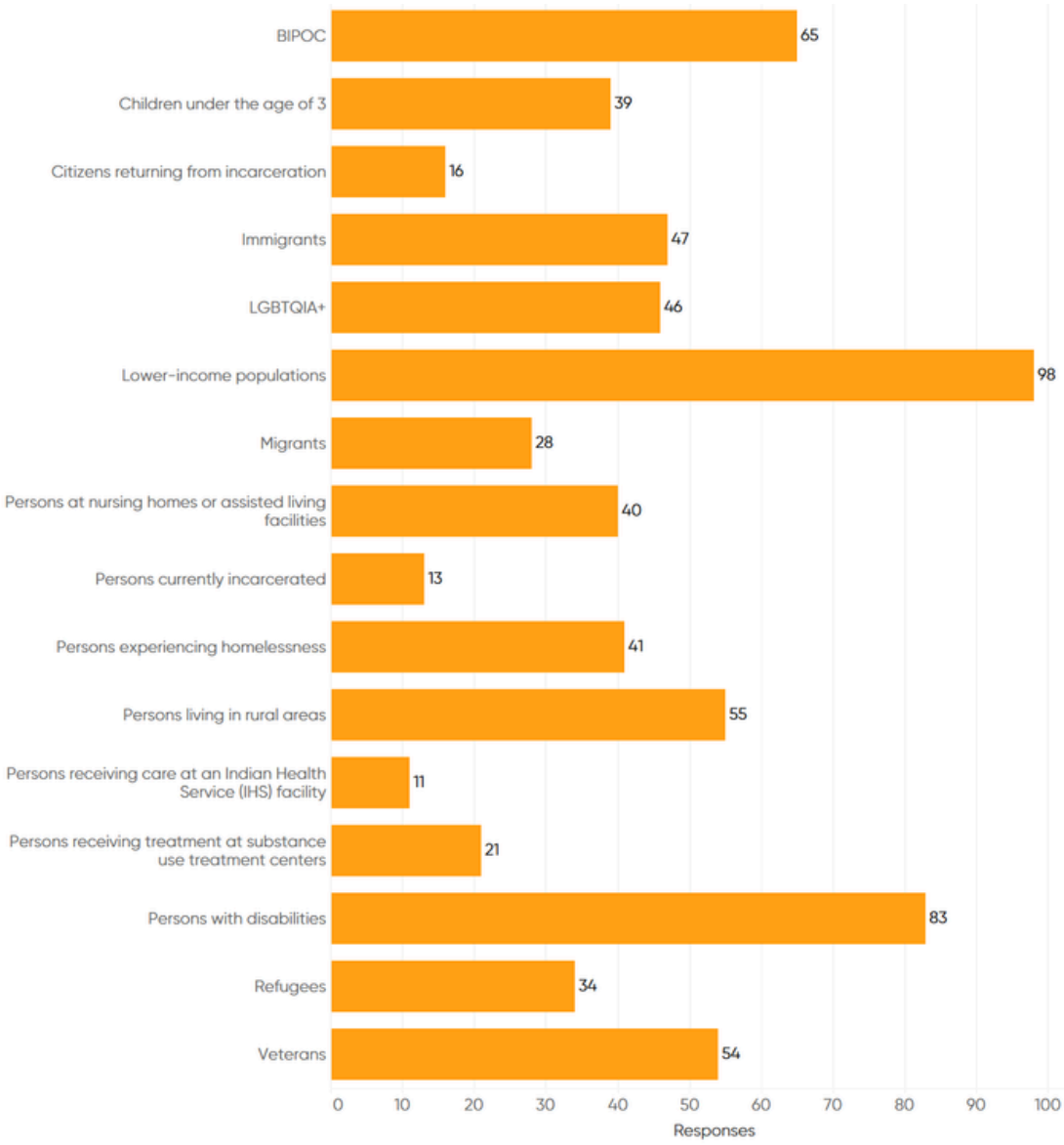


84% Grade point average (GPA) was the most popular factor considered during the admission process.

Programs were also asked what percent of their faculty was male and BIPOC, with the averages being eight and 11 percent, respectively. 46 percent of all programs also provide implicit bias training (not required by their state), with another 19 percent doing so in states that require it. 64 percent of programs also provide diversity, equity, inclusion, and belonging (DEIB) training (not required by the state) with another 18 percent doing so in states that require the training. 87 percent of programs also provide training or professional development opportunities for faculty to support diversity and inclusion.

When asked about the opportunities for community-based clinical rotations, 90 percent of programs indicated that there are many options for their students. Moreover, 70 percent of programs offer the chance to both observe and provide patient care during these rotations. The most common kind of community-based rotation offered serves lower-income populations (94 percent), but many other diverse clinical community rotations are typical among hygiene programs. See **Figure 5** (programs could select all that were available).

Figure 5: Rotations Serving Diverse Patient Populations



Conclusion

Most programs still need support.

Dental hygiene is a fast-growing profession across the U.S. and in many states individually. By addressing barriers with creative solutions, hygiene programs can continue to expand an important and growing profession.

Dental hygiene is a fast-growing profession across the U.S. and in many states individually, and having a healthy talent pipeline for the jobs that will become available over the next ten years means thinking about how to bring new populations into the talent supply to support the occupation's growth. Of the 157 respondents to the dental hygiene program survey, 80 percent collaborate with their local communities – through either community rotations or career fairs – to promote dental hygiene as a career to systemically or historically underrepresented students.

However, findings from the free response section of the survey indicate that most programs still need support – either financial or logistical – as they work to increase awareness of dental hygiene among male and BIPOC students. Perhaps then, it is time to revisit some of the strategies currently employed by dental hygiene programs for increasing recruitment. In particular, our survey showed that the resources that would most likely lead to improved recruitment for historically or systemically underrepresented or disadvantaged students were scholarships (93 percent) and childcare (55 percent). DDF just launched new financial aid options for Michigan, Ohio, and Indiana; these opportunities could be ripe for expansion to other states if it is clear they are effective.

New resources (like additional scholarships) can only go so far when barriers to increasing class size, like limited clinic space, prevent programs from expanding. Indeed, for dental hygiene programs hoping to grow, it may be time to look beyond traditional classroom spaces and encourage the Commission on Dental Accreditation (CODA) to update program requirements. Practically speaking, building - or converting - new clinic space is expensive and time-consuming.

Dental hygiene programs need to be flexible, embracing new pedagogical models that allow their program capacity to ebb and flow as the market dictates. Three proposed changes that programs could embrace include:

1. Online learning, local practice
Dental hygiene programs could allow students to complete their didactic learning online and their clinical rotations in licensed facilities, such as community health centers or VA clinics that are closer to their homes. This model could expand the reach of dental hygiene education and reduce the need for dedicated clinic space and faculty.

Currently, some programs are operating mixed versions of this approach.

The University of the Pacific Arthur A. Dugoni School of Dentistry is constructing a mobile classroom and simulation lab, which will leverage community health centers as clinical education sites. Bringing the classroom to the students has the potential to create opportunities for people who cannot or do not want to leave their communities to seek a dental hygiene education. At the same time, students learn in a public health setting, improving capacity for patient care and developing students as future providers committed to community health.

Dental hygiene programs can also learn from some of the more flexible dental assistant programs. In Michigan, Washtenaw Community College's Dental Assistant Program (Pathway II) offers online courses in tandem with clinical education at community partner sites. Although students do still have on-campus days, there are only a few per month.

2. Flexible or part-time programs
Offering flexible class hours – whether on nights, weekends, or a part-time basis – may help more people with caregiving or work responsibilities pursue careers in oral health without worrying about finding childcare or losing an income stream.

3. Onsite childcare
Offering local, affordable childcare options could help more potential students pursue dental hygiene careers. As an example, Ferris State University has an Early Learning Center, which provides childcare services to children up to age 12 for students, faculty and staff, and community members. Importantly, the Early Learning Center serves a dual purpose: It also helps Ferris State University students gain valuable experience working with young children in an educational setting.

Moreover, faculty salaries (46 percent) - and recruiting faculty in general (61 percent) - were both listed as additional major barriers to increasing class sizes. However, programs could consider a variety of tactics to improve faculty recruitment and retention:

1. Reevaluating terminal degree requirements

CODA requires that dental hygiene program directors meet certain educational and professional requirements, including having a master's degree or higher in a relevant field (CODA, 2025, p. 30). This requirement, and any others set by the college or university, may reduce the number of qualified Dental Hygienists who could be teaching students.

Although revising CODA requirements may be difficult, colleges and universities could enhance their recruiting capabilities by providing comprehensive professional development opportunities. This could include offering free credits toward a higher degree, such as a master's, which could allow qualified dental hygiene professionals to serve as program directors or faculty, so long as they are enrolled in the program.

2. Part-time faculty

Although there are doubtless educators who would prefer to work on a full-time basis, a stable of part-time faculty could give many qualified instructors the opportunity to continue their current work while supplementing their time and income with teaching, especially on nights or weekends. This could also allow people to rotate in and out of the program as needs dictate.

3. Childcare and other benefits

The childcare conundrum is not just a challenge for students - it is a challenge for faculty, too. Providing benefits like childcare and comprehensive professional development opportunities could enhance recruitment and retention efforts. In addition, there are federal loan repayment and forgiveness programs for educators. Increasing the visibility of these opportunities as part of dental hygiene program recruitment campaigns may encourage more individuals to commit to education versus full-time clinical practice.

Finally, it is important for everyone in the field to think about how to better support the dental hygiene profession through the development of career ladders that could offer advancement beyond clinic work. This is a healthcare-wide issue for many occupations, but by working together with DDF and CODA, hygiene programs can make strides in providing strong opportunities for career development that keep people employed longer and will help grow the profession over the long term.

References

Commission on Dental Education. 2025. *Accreditation Standards for Dental Hygiene Programs.* https://coda.ada.org/-/media/project/ada-organization/ada/coda /files /dental_ hygiene_standards.pdf?rev=f0bdab85cf034d748008f29e66ca59e1&hash =8531C92B 7BD 5A587 E12D11F9F2956BCA

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