OHWRC
Oral Health Workforce Research Center

RESEARCH BRIEF
August 2026

State-Specific Dental Hygiene Scope of Practice: Updating the Professional Practice Index

Sage Shirey, MA | Theekshana Fernando, MBBS, DrPH, CHES® | Simona Surdu, MD, PhD | Jean Moore, DrPH, FAAN

BACKGROUND

State-based scope of practice (SOP) laws, regulations, and policies play a critical role in shaping dental hygiene practice. These policies define the services that dental hygienists are authorized to perform and the supervision requirements under which they may provide those services.[1] Variation in these laws across states can impact access to oral health care and contribute to workforce shortages in states with more restrictive regulations.[2]

For over 25 years, the Oral Health Workforce Research Center (OHWRC) has studied state dental hygiene scope of practice (DH SOP) laws and their implications for access to oral health care. In 2001, the OHWRC developed the Dental Hygiene Professional Practice Index (DHPPI) to measure variation in state-level DH SOP policies. The index was used to assess DH SOP across all US states in 2001 and 2014 and was subsequently revised and updated in 2016 to reflect changes in the dental hygiene practice environment.[3] Multiple studies have used the DHPPI to evaluate the impact of DH SOP on access to oral health care. Findings suggest that less restrictive SOPs, as reflected by higher DHPPI scores, are associated with improved oral health outcomes, increased utilization of oral health services, and reduced costs.[4,5]

The proposed objectives were as follows:

- Update the DHPPI scoring tool to reflect the current SOP for dental hygienists in community-based settings, informed by findings from key informant interviews and a review of the literature
- Assess DH SOP in each state using the updated DHPPI and state laws, regulations, rules, and policies
- Update OHWRC's DH SOP infographic depicting variation in DH SOP across states
- Examine changes in DH SOP over time by comparing 2026 DHPPI scores and infographic findings with those from prior assessments

POLICY HIGHLIGHTS

- Expanding state DH SOP policies will enable dental hygienists to provide preventive services to the full extent of their education and training
- Reducing unnecessary supervision requirements would increase the availability of dental hygiene services in community-based settings and communities with limited access to oral health care
- Direct Medicaid reimbursement for dental hygienists can improve access to care and support full-scope practice
- Participating in the Dentist and Dental Hygienist Compact would help address provider shortages in high-need communities

CHWS Center for Health Workforce Studies
www.oralhealthworkforce.org

University at Albany State University of New York | College of Integrated Health Sciences

Oral Health Workforce Research Center
@ Center for Health Workforce Studies
College of Integrated Health Sciences
University at Albany | State University of New York
Pine Bush 316 | 1400 Washington Avenue | Albany, NY 12222

METHODS

To explore the professional landscape and better understand how recent developments have influenced dental hygiene practice, particularly in community-based settings, OHWRC researchers conducted key informant interviews with 5 dental hygienist leaders from the American Dental Hygienists' Association (ADHA) Board of Directors. Interview transcripts were thematically analyzed using inductive and deductive coding.[6] The analysis identified 4 main themes: 1) regulatory constraints and representation on dental boards, 2) barriers to care in underserved communities, 3) impact of technology, and 4) strategic recommendations for expanding SOP. Researchers integrated findings from the thematic analysis with evidence from the current literature on DH SOP to update the DHPPI scoring tool. Scores assigned to each variable were designed to reflect its relative importance in enabling dental hygienists to provide oral health services, with a possible composite score ranging from 0 (most restrictive) to 100 (least restrictive). The variables were grouped into 4 domains: regulation, supervision, tasks, and reimbursement.

After updating the DHPPI scoring tool, researchers reviewed state policy documents, including state practice acts, state dental board rules, and other relevant materials. Researchers evaluated each variable for every state and assigned scores based on applicable laws and regulations. Once consensus was reached on all variable scores, representatives from state dental hygiene associations were contacted to verify the researchers' interpretations of state regulations. The final scores were summed across variables to calculate each state's 2026 DHPPI composite score as well as separate domain-specific scores for the 4 domains listed above. Exploratory and confirmatory factor analyses were conducted for each domain and for the full instrument to assess whether the domains represented distinct dimensions of DH SOP and whether, collectively, they measured a cohesive underlying construct.

To visualize state variation in DH SOP, the OHWRC infographic highlights 8 DHPPI variables reflecting dental hygienists' professional autonomy: 1) ability to make a dental hygiene diagnosis, 2) prescriptive authority, 3) authority to administer local anesthesia, 4) authority to supervise dental assistants, 5) direct Medicaid reimbursement, 6) authority to develop dental hygiene treatment plans, 7) authority to administer sealants without prior examination, and 8) direct access to prophylaxis from a dental hygienist. For the 2026 infographic update, researchers assessed whether dental hygienists in each state were allowed to perform each of the functions depicted in the infographic. The 2026 DHPPI and infographic were compared with those from previous years to identify changes in DH SOP across states.

FINDINGS

The updated 2026 DHPPI included new variables and revised scoring criteria to reflect the current dental hygiene practice environment and factors affecting dental hygienists' ability to provide oral health services in community-based settings. Based on the information gathered in the key informant interviews and the literature review, researchers added 2 new variables to the scoring tool:

1) Licensure Portability (Regulation): The state has signed on to the Dentist and Dental Hygienist Compact, which would allow dental hygienists licensed in any participating state to practice dental hygiene in any other participating state without having to apply for a new license.[7]
2) Nitrous Oxide Administration (Tasks): Dental hygienists in the state are permitted to administer nitrous oxide when they have obtained the required education, training, and credentials.

As of the 2026 DHPPI update, 13 states have signed the licensure compact and 39 states allow dental hygienists to administer nitrous oxide.

Total composite scores for the 2026 DHPPI ranged from 10 (Alabama) to 97 (Oregon), with a median score of 56, suggesting wide variation in DH SOP across states. Factor analyses supported the validity of the DHPPI as a multidimensional measure of DH SOP, with the 4 domains representing distinct but related dimensions of a cohesive underlying SOP construct.

Comparisons of DHPPI scores across 2001, 2014, 2016, and 2026 indicated that DH SOP has generally expanded over time, although progress has varied across states. Oregon, New Mexico, Colorado, California, and Maine consistently ranked among the most supportive practice environments, whereas Alabama, Georgia, Mississippi, and North Carolina remained among the most restrictive. Similarly, a comparison between the 2017 and 2026 DH SOP infographics indicated overall expansion across the 8 key practice indicators, although changes were not uniform across policy areas. For example, the number of states that authorized prescriptive authority increased from 6 in 2017 to 15 in 2026, while the number of states that allowed direct Medicaid reimbursement increased from 18 in 2017 to 19 in 2026. The 2026 updates to DHPPI and infographic tools also indicated broad DH SOP in areas such as public health dental hygiene, patient assessment, and provision of sealants, while other areas such as dental hygiene diagnosis, independent practice, and supervision of dental assistants remain limited.

CONCLUSIONS

State-based DH SOP laws have a significant impact on dental hygiene practice. Studies have shown that expanded SOP for dental hygienists improves oral health outcomes and reduces costs.[4,5] While DH SOP continues to expand over time, change often occurs in a non-linear fashion and substantial variation between states persists. The DHPPI scoring tool and infographic enable clinicians, regulators, researchers, and other stakeholders to measure the impacts of DH SOP on access to care and care quality, as well as to track changes in these policies over time. Regulatory changes are needed to enable dental hygienists to provide the services that they were trained to perform and to increase their autonomy as preventive oral health care professionals.

REFERENCES

1. Nasseh K, Bowblis JR, Wing C. How do dental practices respond to changes in scope of practice regulations? *Health Econ*. 2024;33(11):2508-2524. doi:10.1002/hec.4878
2. Dower C, Moore J, Langelier M. It is time to restructure health professions scope-of-practice regulations to remove barriers to care. *Health Affairs*. 2013;32(11):1971-1976. doi:10.1377/hlthaff.2013.0537
3. Langelier M, Baker B, Continelli T. Development of a New Dental Hygiene Professional Practice Index by State, 2016. Oral Health Workforce Research Center, Center for Health Workforce Studies, College of Integrated Health Sciences (formerly School of Public Health), University at Albany; 2016. Accessed June 3, 2026. https://oralhealthworkforce.org/wp-content/uploads/2016/11/OHWRC_Dental_Hygiene_Scope_of_Practice_2016-1.pdf
4. Akinlotan MA, Ferdinand AO, Maxey HL, Bolin JN, Morrisey MA. Dental hygienists' scope of practice regulations and preventable non-traumatic dental emergency department visits: A cross-sectional study of 10 US states. *Community Dent Oral Epidemiol*. 2022;51(2):274-282. doi:10.1111/cdoe.12737
5. Chen J, Meyerhoefer CD, Timmons EJ. The effects of dental hygienist autonomy on dental care utilization. *Health Econ*. 2024;33(8):1726-1747. doi:10.1002/hec.4832
6. Bingham AJ. From data management to actionable findings: A five-phase process of qualitative data analysis. *Int J Qual Methods*. 2023;22. doi:10.1177/16094069231183620
7. DDH dentist and dental hygienist compact. Dentist and Dental Hygienist Compact. 2026. Accessed February 2, 2026. https://ddhcompact.org/

OHWRC is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of an award totaling $450,000 with 0% financed with non-governmental sources. The content of this document is reported by the authors and does not necessarily represent the official views of nor an endorsement by HRSA, HHS, or the US government. For more information, please visit HRSA.gov.