INDIANA UNIVERSITY
SCHOOL OF MEDICINE
Bowen Center for Health Workforce Research and Policy

2020 Dentist Re-Licensure Survey Instrument

1. Sex
    a. Male
    b. Female

2. Are you of Hispanic or Latino origin?
    RADIO BUTTONS
    a. Yes
    b. No

3. What is your race? Mark one or more boxes.
    MULTI CHECK BOX
    a. White
    b. American Indian or Alaska Native
    c. Native Hawaiian/Pacific Islander
    d. Black or African American
    e. Asian
    f. Some Other Race

4. Where did you complete your dental education that first qualified you for your U.S. dental license?
    DROP DOWN LIST
    a. Indiana
    b. Michigan
    c. Illinois
    d. Kentucky
    e. Ohio
    f. Another State (not listed)
    g. Another Country (not U.S.)

5. Please indicate your highest level of training in dentistry.
   CHECK BOXES
   a. Dental School-No residency completed
   b. Residency-Advanced Education in General Dentistry Programs (AEGD)
   c. Residency-Advanced General Dentistry Education Programs in Dental Anesthesiology
   d. Residency-Advanced General Dentistry Education Programs in Oral Medicine
   e. Residency-Advanced General Dentistry Education Programs in Orofacial Pain
   f. Residency-Dental Public Health
   g. Residency-Endodontics
   h. Residency-General Practice Residency
   i. Residency-Oral and Maxillofacial Pathology
   j. Residency-Oral and Maxillofacial Radiology
   k. Residency-Oral and Maxillofacial Surgery
   l. Residency-Orthodontics and Dentofacial Orthopedics
   m. Residency-Pediatric Dentistry
   n. Residency-Periodontics
   o. Residency-Prosthodontics
   p. Residency-Other

6. What is your employment status?
   DROP DOWN LIST
   a. Actively working in a position that requires a dental license
   b. Actively working in a field other than dentistry
   c. Unemployed and seeking work in the field of dentistry
   d. Unemployed and not seeking work in the field of dentistry
   e. Retired

7. Which of the following best describes your practice of dentistry? Please select only one. If this does not apply, please select "not applicable."
   DROP-DOWN LIST OR RADIO BUTTONS
   a. General dental practice
   b. Dental public health
   c. Endodontics
   d. Oral and maxillofacial pathology
   e. Oral and maxillofacial radiology
   f. Oral and maxillofacial surgery
   g. Orthodontics and dentofacial orthopedics
   h. Pediatric dentistry
   i. Periodontics
   j. Prosthodontics
   k. Other
   l. Not applicable

8. Please identify the position title that most closely corresponds to your primary role. If this does not apply, please select "not applicable."

DROP-DOWN LIST OR RADIO BUTTONS

a. Dental Educator (Academia)
b. Practicing Dentist (General Dentist or Specialist)
c. Dental/Insurance Industry Consultant
d. Dental Researcher
e. Federal Services Professional
f. Other – Dental Related
g. Other – Non-Dental Related
h. Not applicable

9. What is the street address of your principal practice location? If this does not apply, please indicate "N/A"

TEXT-BOX (64 CHARACTER LIMIT)

10. In what city is your principal practice location? If this does not apply, please indicate "N/A"

TEXT-BOX (64 CHARACTER LIMIT)

11. In what state is your principal practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select "N/A"

DROP-DOWN LIST

Please include all states' 2-letter postal abbreviation along with an option for N/A

12. What is the 5-digit ZIP code of your principal practice location? If this does not apply, please indicate "N/A"

TEXT-BOX (5 CHARACTER LIMIT)

13. Which best describes the type of setting that most closely corresponds to your principal <u>direct patient care</u> practice location(s): If this does not apply, please select "not applicable."

DROP-DOWN LIST OR RADIO BUTTONS

a. Dental office practice – Solo Practice
b. Dental office practice – Partnership
c. Dental office practice – Group Practice
d. Hospital/Clinic
e. Federal government hospital/clinic (includes military)
f. Health center (CHC/FQHC/FQHC look-alike)
g. Long-term care/nursing home/extended care facility (non-hospital)
h. Home health setting
i. Local health department
j. Other public health/community health setting
k. School health service
l. Mobile unit dentistry
m. Correctional facility
n. Indian health service
o. Headstart (including early Headstart)
p. Staffing organization
q. Teledentistry

r. Other setting
s. Not Applicable

14. Estimate the average number of hours per week spent at your principal practice location. If this does not apply, please select "not applicable."
    DROP-DOWN LIST
    a. 0 hours per week
    b. 1 – 4 hours per week
    c. 5 – 8 hours per week
    d. 9 – 12 hours per week
    e. 13 – 16 hours per week
    f. 17 – 20 hours per week
    g. 21 – 24 hours per week
    h. 25 – 28 hours per week
    i. 29 – 32 hours per week
    j. 33 – 36 hours per week
    k. 37 – 40 hours per week
    l. 41 or more hours per week
    m. Not applicable

15. Estimate the average number of hours per week spent in direct patient care at your principal practice location. If this does not apply, please select "not applicable."
    DROP-DOWN LIST OR RADIO BUTTONS
    a. 0 hours per week
    b. 1 – 4 hours per week
    c. 5 – 8 hours per week
    d. 9 – 12 hours per week
    e. 13 – 16 hours per week
    f. 17 – 20 hours per week
    g. 21 – 24 hours per week
    h. 25 – 28 hours per week
    i. 29 – 32 hours per week
    j. 33 – 36 hours per week
    k. 37 – 40 hours per week
    l. 41 or more hours per week
    m. Not applicable

16. Estimate the percentage of Indiana Medicaid patients at your principal practice location. If this does not apply, please select "not applicable."
    DROP-DOWN LIST OR RADIO BUTTONS
    a. I do not accept Indiana Medicaid
    b. I accept Medicaid but have no Medicaid patients
    c. Indiana Medicaid accounts for >0% - 5% of my practice
    d. Indiana Medicaid accounts for 6% - 10% of my practice
    e. Indiana Medicaid accounts for 11% - 20% of my practice
    f. Indiana Medicaid accounts for 21% - 30% of my practice
    g. Indiana Medicaid accounts for 31% - 50% of my practice
    h. Indiana Medicaid accounts for greater than 50% of my practice
    i. Not applicable

17. Are you currently accepting new Indiana Medicaid patients at any or all of your practice locations?
    DROP-DOWN LIST OR RADIO BUTTONS
    a. Yes
    b. No

18. If you selected no on the previous question, but you are enrolled as an Indiana Medicaid provider, please describe barriers to participation.
    TEXT BOX
    PLEASE MAKE THIS QUESTION VOLUNTARY

19. Estimate the percentage of patients on a sliding fee scale at your principal practice location. If this does not apply, please select "not applicable."
    DROP-DOWN LIST OR RADIO BUTTONS
    a. I do not offer a sliding fee scale
    b. I offer a sliding fee scale but have no patients on this payment schedule
    c. Sliding fee patients account for >0% - 5% of my practice
    d. Sliding fee patients account for 6% - 10% of my practice
    e. Sliding fee patients account for 11% - 20% of my practice
    f. Sliding fee patients account for 21% - 30% of my practice
    g. Sliding fee patients account for 31% - 50% of my practice
    h. Sliding fee patients account for greater than 50% of my practice
    i. Not applicable

20. What is the street address of your secondary practice location? If this does not apply, please indicate "N/A".
    TEXT-BOX (64 CHARACTER LIMIT)

21. In what city is your secondary practice location? If this does not apply, please indicate "N/A".
    TEXT-BOX (64 CHARACTER LIMIT)

22. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select "N/A"
    DROP-DOWN LIST
    Please include all states' 2-letter postal abbreviation along with an option for N/A

23. What is the 5-digit ZIP code of your secondary practice location? If this does not apply, please indicate "N/A".
    TEXT-BOX (5 CHARACTER LIMIT)

24. Which of the following categories best describes the practice setting at your secondary practice location? If this does not apply, please select "not applicable."
    DROP-DOWN LIST OR RADIO BUTTONS
    a. Dental office practice – Solo Practice
    b. Dental office practice – Partnership
    c. Dental office practice – Group Practice
    d. Hospital/Clinic

e. Federal government hospital/clinic (includes military)
f. Health center (CHC/FQHC/FQHC look-alike)
g. Long-term care/nursing home/extended care facility (non-hospital)
h. Home health setting
i. Local health department
j. Other public health/community health setting
k. School health service
l. Mobile unit dentistry
m. Correctional facility
n. Indian health service
o. Headstart (including early Headstart)
p. Staffing organization
q. Teledentistry
r. Other setting
s. Not applicable

25. Estimate the average number of hours per week spent at your secondary practice location. If this does not apply, please select "not applicable."
DROP-DOWN LIST
a. 0 hours per week
b. 1 – 4 hours per week
c. 5 – 8 hours per week
d. 9 – 12 hours per week
e. 13 – 16 hours per week
f. 17 – 20 hours per week
g. 21 – 24 hours per week
h. 25 – 28 hours per week
i. 29 – 32 hours per week
j. 33 – 36 hours per week
k. 37 – 40 hours per week
l. 41 or more hours per week
m. Not applicable

26. Estimate the average number of hours per week spent in direct patient care at your secondary practice location. If this does not apply, please select "not applicable."
DROP-DOWN LIST OR RADIO BUTTONS
a. 0 hours per week
b. 1 – 4 hours per week
c. 5 – 8 hours per week
d. 9 – 12 hours per week
e. 13 – 16 hours per week
f. 17 – 20 hours per week
g. 21 – 24 hours per week
h. 25 – 28 hours per week
i. 29 – 32 hours per week
j. 33 – 36 hours per week
k. 37 – 40 hours per week
l. 41 or more hours per week
m. Not applicable

27. Estimate the percentage of Indiana Medicaid patients at your secondary practice location. If this does not apply, please select "not applicable."

    DROP-DOWN LIST OR RADIO BUTTONS

    a. I do not accept Indiana Medicaid
    b. I accept Medicaid but have no Medicaid patients
    c. Indiana Medicaid accounts for >0% - 5% of my practice
    d. Indiana Medicaid accounts for 6% - 10% of my practice
    e. Indiana Medicaid accounts for 11% - 20% of my practice
    f. Indiana Medicaid accounts for 21% - 30% of my practice
    g. Indiana Medicaid accounts for 31% - 50% of my practice
    h. Indiana Medicaid accounts for greater than 50% of my practice
    i. Not applicable

28. Estimate the percentage of patients on a sliding fee scale at your secondary practice location. If this does not apply, please select "not applicable."

    DROP-DOWN LIST OR RADIO BUTTONS

    a. I do not offer a sliding fee scale
    b. I offer a sliding fee scale but have no patients on this fee schedule
    c. Sliding fee patients account for >0% - 5% of my practice
    d. Sliding fee patients account for 6% - 10% of my practice
    e. Sliding fee patients account for 11% - 20% of my practice
    f. Sliding fee patients account for 21% - 30% of my practice
    g. Sliding fee patients account for 31% - 50% of my practice
    h. Sliding fee patients account for greater than 50% of my practice
    i. Not applicable

29. Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purposes of this services list is to gather information on key health issues in Indiana) Please check all that apply.

    CHECKBOXES

    a. Dental sealants
    b. Diabetes screening
    c. HIV screening
    d. Hypertension screening
    e. Oral cancer screening
    f. Screening for substance use/addiction (ex: SBIRT)
    g. Tobacco cessation counseling
    h. None of the above

30. Please indicate the population groups to which you provide services:

    CHECKBOXES

    a. Newborns
    b. Children (ages 2-10)
    c. Adolescents (ages 10-19)
    d. Adults
    e. Geriatrics (ages 65+)

f. Pregnant women
g. Inmates
h. Disabled individuals
i. Individuals in recovery
j. None of the above

31. Do you use telemedicine to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; the delivery of health care services using electronic communications and information technology, including: secure videoconferencing, interactive audio-using store and forward technology, or remote patient monitoring technology between a provider in one (1) location and a patient in another location)?

RADIO BUTTONS
a. Yes
b. No