SCHOOL OF MEDICINE
BOWEN CENTER FOR HEALTH
WORKFORCE RESEARCH & POLICY

2024 Indiana Dentist License Renewal Information Fields

1. Sex
    a. Female
    b. Male

2. Are you of Hispanic, or Latina/o, or Spanish origin?
    RADIO BUTTONS
    a. Yes
    b. No

3. What is your race? Mark one or more boxes.
    MULTI CHECK BOX
    a. American Indian or Alaska Native
    b. Asian
    c. Black or African American
    d. Native Hawaiian/Pacific Islander
    e. White
    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 anesthesiology
   c. Dental public health
   d. Endodontics
   e. Oral and maxillofacial pathology
   f. Oral and maxillofacial radiology
   g. Oral and maxillofacial surgery
   h. Orthodontics and dentofacial orthopedics
   i. Pediatric dentistry
   j. Periodontics
   k. Prosthodontics
   l. Other
   m. 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. 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

10. Please provide the following information regarding your principal practice location. If this does not apply, please indicate N/A
    Street Address: [Free text]
    City: [Free text]
    Zip Code: [Free text]
11. 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 (3-5 Dentists)
d. Dental office practice – Group (6-10 Dentists)
e. Dental office practice – Group (11-20 Dentists)
f. Dental office practice – Group (21+ Dentists)
g. Hospital/Clinic
h. Federal government hospital/clinic (includes military)
i. Health center (CHC/FQHC/FQHC look-alike)
j. Long-term care/nursing home/extended care facility (non-hospital)
k. Home health setting
l. Local health department
m. Other public health/community health setting
n. School health service
o. Mobile unit dentistry
p. Correctional facility
q. Indian health service
r. Headstart (including early Headstart)
s. Staffing organization
t. Teledentistry
u. Other setting
v. Not Applicable

12. Which of the following characteristics describes your relationship to the business or organization at your principal practice location? If this does not apply, please select “not applicable.”
MULTI SELECT

a. Practice Owner
b. Sole proprietor
c. Partner
d. Employed (employee)
e. Independent contractor
f. Volunteer
g. My practice is supported by a Dental Service Organization.
h. Not applicable

13. 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

14. 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

15. 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

16. 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

17. 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

18. 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

19. 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

20. Please provide the following information regarding your secondary practice location. If this does not apply, please indicate N/A
Street Address: [Free text]
City: [Free text]
Zip Code: [Free text]
i.

21. 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 (3-5 Dentists)
d. Dental office practice – Group (6-10 Dentists)
e. Dental office practice – Group (11-20 Dentists)
f. Dental office practice – Group (21+ Dentists)
g. Hospital/Clinic
h. Federal government hospital/clinic (includes military)
i. Health center (CHC/FQHC/FQHC look-alike)
j. Long-term care/nursing home/extended care facility (non-hospital)
k. Home health setting
l. Local health department
m. Other public health/community health setting
n. School health service
o. Mobile unit dentistry
p. Correctional facility
q. Indian health service
r. Headstart (including early Headstart)
s. Staffing organization
t. Teledentistry
u. Other setting
v. Not applicable

22. Which of the following characteristics describes your relationship to the business or organization at your secondary practice location?
MULTI SELECT
a. Practice Owner
b. Sole proprietor
c. Partner
d. Employed (employee)

e. Independent contractor
f. Volunteer
g. My practice is supported by a Dental Service Organization.
h. Not applicable

23. 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

24. 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

25. 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

26. 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

27. 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. Administer immunizations
    b. Administration or Use of Silver Diamine Fluoride
    c. Dental sealants
    d. Diabetes screening
    e. Hold access practice agreement with dental hygienist(s)
    f. HIV screening
    g. Hypertension screening
    h. Oral cancer screening
    i. Screening for substance use/addiction (ex: SBIRT)
    j. Tobacco cessation counseling
    k. None of the above

28. Please indicate the population groups to which you provide services:
    CHECKBOXES
    a. Newborns (0-12 months)
    b. Children (ages 13-24 months)
    c. Children (ages 25-35 months)
    d. Children (ages 36 months-10 years)
    e. Adolescents (ages 11-19)
    f. Adults
    g. Geriatrics (ages 65+)
    h. Pregnant Women
    i. Individuals who are incarcerated
    j. Individuals with disabilities
    k. Individuals in recovery
    l. Veterans/Individuals who have served in the military
    m. None of the above

29. Do you use telehealth to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; “telehealth" means the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), including: (1) secure videoconferencing; (2) store and forward technology; or (3) remote patient monitoring technology; between a provider in one (1) location and a patient in another location)?)

RADIO BUTTONS
a.Yes
b.No

30. What are your employment plans for the next 2 years?
    RADIO BUTTONS
    a. Increase hours
    b. Decrease hours
    c. Seek non-clinical job
    d. Retire
    e. Continue as you are
    f. Unknown