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

2020 Dental Hygienist Re-Licensure Survey Instrument

1. Sex
   DROP DOWN
   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. What type of dental hygiene degree/credential qualified you for your first U.S. dental hygiene license?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. Vocational/Practical certificate – dental hygiene
   b. Diploma – dental hygiene
   c. Associate degree – dental hygiene
   d. Baccalaureate degree – dental hygiene
   e. Master's degree – dental hygiene
   f. Doctoral degree – dental hygiene

5. Where did you complete the dental hygiene degree/credential that qualified you for your first U.S. dental hygiene 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.)

6. What is your highest level of education?
DROP-DOWN LIST OR RADIO BUTTONS
   a. Vocational/Practical certificate – dental hygiene
   b. Diploma – dental hygiene
   c. Associate degree – dental hygiene
   d. Associate degree – other field
   e. Baccalaureate degree – dental hygiene
   f. Baccalaureate degree – other field
   g. Master's degree – dental hygiene
   h. Master's degree – other field
   i. Doctoral degree – dental hygiene
   j. Doctoral degree – other field

7. What is your employment status?
RADIO BUTTONS
   a. Actively working in a position that requires a dental hygiene license
   b. Actively working in a dental hygiene related field that does not require a dental hygiene license
   c. Actively working in a field that does not require a dental hygiene license
   d. Not currently working, disabled
   e. Not currently working, seeking work in a position that requires a dental hygiene license
   f. Not currently working, seeking work in a position that does not require a dental hygiene license
   g. Student
   h. Leave of absence or Sabbatical
   i. Retired

8. How many months did you work in dental hygiene in the past year?
DROP-DOWN LIST OR RADIO BUTTONS
   a. I did not work in dental hygiene in the past year.
   b. Less than 3 months.
   c. More than 3 months but less than 6 months
   d. More than 6 months but less than 9 months
   e. More than 9 months, up to 12 months

9. Please indicate in which field you spend the majority of your time. If this does not apply, please select "not applicable."
DROP-DOWN LIST OR RADIO BUTTONS
   a. Direct Patient Care – dental hygiene
   b. Direct Patient Care – other
   c. Research – dental hygiene
   d. Research – other
   e. Education – dental hygiene
   f. Education – other
   g. Administration – dental hygiene
   h. Administration – other
   i. Other
   j. Not applicable

10. Are you currently working as many hours as you would like in dental hygiene?
    DROP-DOWN LIST OR RADIO BUTTONS
    a. Yes
    b. No

11. If NO, how many more hours a week would you like to be working in dental hygiene? If this does not apply, please select "not applicable."
    DROP-DOWN LIST OR RADIO BUTTONS
    a. Less than 8 additional hours per week
    b. Between 9 and 16 additional hours per week
    c. Between 17 and 24 additional hours per week
    d. Between 25 and 32 additional hours per week
    e. Between 33 and 40 additional hours per week
    f. More than 40 additional hours per week
    g. Not applicable

12. What are your employment plans for the next 12 months?
    DROP-DOWN LIST OR RADIO BUTTONS
    a. Increase hours in patient care
    b. Decrease hours in patient care
    c. Seek employment in a field outside of patient care
    d. Leave direct patient care to complete further training
    e. Leave direct patient care for family reasons/commitments
    f. Leave direct patient care due to physical demands
    g. Leave direct patient care due to stress/burnout
    h. Retire
    i. Continue as you are
    j. Unknown

13. Is your primary practice located in the state of Indiana *(the position in which you spend the majority of your time)*? If this does not apply, please select "not applicable."
    RADIO BUTTON
    a. Yes
    b. No
    c. Not applicable

14. If located in Indiana, what is the county of your primary practice location? If this does not apply, please write "N/A"

    ____ *(free text)*

15. If located in Indiana, what is the zip code of your primary practice location? If this does not apply, please write "N/A"

    ____ *(free text)*

16. How many hours do you spend in direct care per week at your principal practice site? 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

17. Which best describes the type of setting that most closely corresponds to your principal direct patient care practice site: 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. Specialty Practice
    e. Hospital/Clinic
    f. Federal Government Hospital/Clinic (includes Military)
    g. Health Center (CHC/FQHC/FQHC look-alike)
    h. Long Term Care/Nursing home/Extended Care Facility (non-hospital)
    i. Home health setting
    j. Local health department
    k. Other Public Health/Community Health Setting
    l. School health service
    m. Mobile Unit Dentistry
    n. Correctional Facility
    o. Indian Health Service
    p. Headstart (including early Headstart)
    q. Staffing organization
    r. Other setting
    s. Not applicable

18. If you hold more than one position in dental hygiene, is your secondary practice located in the state of Indiana? If this does not apply, please select “not applicable.”
RADIO BUTTON
    d. Yes
    e. No
    f. Not applicable

19. If located in Indiana, what is the county of your secondary practice location? If this does not apply, please write "N/A"

    ______________________________________ *(free text)*

20. If located in Indiana, what is the zip code of your secondary practice location? If this does not apply, please write "N/A"

    ______________________________________ *(free text)*

21. How many hours do you spend in direct care per week at your secondary practice site? 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

22. Which best describes the type of setting that most closely corresponds to your secondary <u>direct patient care</u> practice site: 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. Specialty Practice
    e. Hospital/Clinic
    f. Federal Government Hospital/Clinic (includes Military)
    g. Health Center (CHC/FQHC/FQHC look-alike)
    h. Long Term Care/Nursing home/Extended Care Facility (non-hospital)
    i. Home health setting
    j. Local health department
    k. Other Public Health/Community Health Setting
    l. School health service
    m. Mobile Unit Dentistry
    n. Correctional Facility
    o. Indian Health Service
    p. Headstart (including early Headstart)
    q. Staffing organization
    r. Other setting
    s. Not applicable

23. 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. Administration of local dental anesthetics
b. Dental sealants
c. Diabetes screening
d. HIV screening
e. Hypertension screening
f. Oral cancer screening
g. Preventive dental hygiene services directly to patients under an access practice agreement
h. Screening for substance use/addiction (ex: SBIRT)
i. Tobacco cessation counseling
j. None of the above

24. 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