The National Dental Practice-Based Research Network

Welcome to the National Dental PBRN Enrollment Questionnaire

If this is the **first time** you are completing the National Dental PBRN Enrollment Questionnaire, please enter your email address and last name below and click the "Submit". If you have any questions before completing the online questionnaire, please email us for help at nationaldpbrn@uab.edu.

Email Address:

Last Name:

Submit

If you have **already completed** the Enrollment Questionnaire and need to update your information, contact your Regional Coordinator for assistance by clicking here for contact information.

Dear Colleague:

As part of a major effort by the National Institute of Dental and Craniofacial Research (NIDCR) to lead the nation in advancing dental practice-based research, we invite you to complete this questionnaire to help establish The National Dental Practice-Based Research Network (National Dental PBRN). This consortium of participating practices and dental organizations is committed to advancing knowledge and improving dental practice.

We are requesting that all colleagues, including those who may have previously participated in a dental practice-based research network (such as Dental PBRN, NW PRECEDENT, or PEARL), complete this new questionnaire so that current information about your practice or dental organization is on file. **We estimate that completing this survey will take approximately 30 minutes. After participating in this questionnaire, you may be contacted regarding future research projects.**

Your participation and responses will remain confidential. Only authorized study personnel will have access to data. All information, both electronic and paper, will be stored in a secure manner. **Your information will not be sold, used for any reason other than research, released to any insurance company, or released to any other similar interest.**

Results may be published for scientific purposes, but your identity will not be revealed. Only statistical summaries will be presented. The University of Alabama at Birmingham Institutional Review Board (IRB) maintains the authority to inspect completed questionnaires to ensure compliance with IRB procedures.

If you have any additional questions, please contact Andrea Mathews, National Dental PBRN Program Manager, by email at nationaldpbrn@uab.edu or by telephone at (205) 934-2578.

If you have questions about your rights as a research participant, you may contact the IRB at (205) 934-3789 or (800) 822-8816. Press option #1 for the operator and request extension 4-3789 (M-F, 8:00 AM - 5:00 PM Central Time).

With regards,

Gregg Gilbert, DDS, MBA, FAAHD, FICD
National Network Director
The National Dental Practice-Based Research Network

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Questionnaire Instructions

The following instructions will help you complete this questionnaire.

- Most multiple choice questions only allow for one answer. Click on the button next to your "best" answer or enter your response.
  - If you need to change your answer, click on your new answer and your response will change, or re-type your response.
  - To totally delete your answers to a question, double click on the answer or highlight and delete your answer.
- Some questions will allow multiple answers, and are noted by "Check All That Apply."
- Use the "Continue" and "Previous Page" buttons to move forward and backward throughout the survey.
- **DO NOT use the forward and back arrows at the top left corner of your internet browser screen.**
- For survey questions that require percentages (questions 8, 9, 10, 11, 12, 36), whole numbers (e.g. 10) or numbers with one decimal point (e.g. 10.1) can be entered.
- On occasion, if you forget to answer a question or provide an answer that is inconsistent, you may see a message highlighted in yellow that provides information on how to fix the problem. If you prefer to skip the question, click on the "Continue" button.
- Press the "Save and Continue Later" button if you wish to save your answers and complete the survey at a later time. You can come back to the survey by returning to https://www.ndpbrn-research.org/Enrollment/ and re-entering the same email address and last name you used when starting the survey. You will automatically return to the last screen you were on.
- The survey will "time out" after 15 minutes of no activity. Follow the instructions on how to get back into the survey. The next time you log in, you will be returned to the last screen you were on.

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1. If you are a DENTIST and currently practicing, answer the following questions: name/degree(s)/email, A, B, C1/D1 (and C2/D2, C3/D3, if applicable), and 1-31.
2. If you are a DENTAL HYGIENIST/DENTAL THERAPIST/LICENSED ASSISTANT and currently practicing, answer the following questions: name/degree(s)/email, A, B, C1/D1 (and C2/D2, C3/D3, if applicable), 1-22, and 32-37.
3. If you are NOT CURRENTLY PRACTICING (for example, student, educator, clinical researcher, retired, awaiting licensing in the U.S., between jobs, etc.), answer the following questions: name/degree(s)/email, A, Preferred Address and Phone Numbers (Name of Institution, if applicable), 1-4, 19-21, and 38.
4. If you are an OFFICE SUPPORT STAFF (for example, dental assistant, office manager/administrator or other office staff) answer the following questions: name/degree(s)/email, A, B, C1/D1 (and C2/D2, C3/D3, if applicable), 1-4, and 19-21.
5. If you are currently practicing outside of the U.S. (INTERNATIONAL), answer the following questions: name/degree(s)/email, A, Preferred Address and Phone Numbers (Name of Practice/Institution, if applicable), C1/D1 (and C2/D2, C3/D3, if applicable), 1-4, and 19-21.

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Enrollment Form

Prefix:

First Name:

Middle Name:

Last Name:

Suffix: (e.g, Sr., Jr.)

Degree(s):
(e.g., DDS, DMD, BSDH, RDH)

Preferred Email for National Dental PBRN communication:

Additional Email:

A. Are you currently licensed in the U.S. to treat patients, and do you actually treat patients in the U.S. on a recurring basis?

- Yes
- No - office support staff (dental assistant, office manager/administrator or other office staff)
- No - student, retired, awaiting licensing in the U.S., between jobs, educator, researcher, or other
- No - Non-U.S. practitioner

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Questionnaire Instructions

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B. At how many locations do you see patients?

- One location
- Two locations
- Three locations
- More than 3 locations

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Questionnaire Instructions

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Site 1

C1. Name of Practice/Institution:

Physical/Office Address line 1:

Physical/Office Address line 2:

City:

State:

Zip code:

☐ **Check if your mailing address is different than your physical/office address above.**

Office phone number: - -

Alternative phone number: - -

Fax number: - -

Website address (if applicable):

D1. Please check all the types of dentists who practice at this location.

- ☐ Endodontist
- ☐ General Practitioner
- ☐ Oral/Maxillofacial Surgeon
- ☐ Orthodontist
- ☐ Pediatric Dentist
- ☐ Periodontist
- ☐ Prosthodontist
- ☐ Other (please specify below)

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Questionnaire Instructions

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Site 2

C2. Name of Practice/Institution:

Physical/Office Address line 1:

Physical/Office Address line 2:

City:

State:

Zip code:

Office phone number: - -

Alternative phone number: - -

Fax number: - -

Website address (if applicable):

D2. Please check all the types of dentists who practice at this location.

- Endodontist
- General Practitioner
- Oral/Maxillofacial Surgeon
- Orthodontist
- Pediatric Dentist
- Periodontist
- Prosthodontist
- Other (please specify below)

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Questionnaire Instructions

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Site 3

C3. Name of Practice/Institution:

Physical/Office Address line 1:

Physical/Office Address line 2:

City:

State:

Zip code:

Office phone number: - -

Alternative phone number: - -

Fax number: - -

Website address (if applicable):

D3. Please check all the types of dentists who practice at this location.

- [ ] Endodontist
- [ ] General Practitioner
- [ ] Oral/Maxillofacial Surgeon
- [ ] Orthodontist
- [ ] Pediatric Dentist
- [ ] Periodontist
- [ ] Prosthodontist
- [ ] Other (please specify below)

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Questionnaire Instructions

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Preferred Address and Phone Numbers

Name of Institution (if applicable):

Address line 1:

Address line 2:

City:

State:

Zip code:

☐ **Check if your mailing address is different than your preferred address above.**

Primary phone number: - -

Alternative phone number: - -

Fax number: - -

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Preferred Address and Phone Numbers

Name of Practice/Institution (if applicable):	
Address line 1:	
Address line 2:	
City:	
State:	
Zip/mail code:	
Country:	
Primary phone number:	

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Questionnaire Instructions

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1. What is your gender?

- Male
- Female

2. What is your year of birth?

3. Are you of Hispanic or Latino origin?

- Yes
- No

4. What is your racial identification?

- White or Caucasian
- Black or African-American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Other (please specify below)

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5. Do you consider your primary practice location to be:

- Inner city of urban area
- Urban (not inner city)
- Suburban
- Rural

6. Do you practice full-time or part-time (including all sites at which you practice)?

- Full-time (32 or more hours per week)
- Part-time (less than 32 hours per week)

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Questionnaire Instructions

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FOR QUESTIONS **7 - 17:** IF YOU PRACTICE AT MORE THAN ONE SITE, ANSWER FOR THE **MAIN SITE ONLY**

7. Please indicate, on average, how long a patient in your practice has to wait:

For a new patient exam appointment		days
For a treatment procedure appointment		days
In the waiting room after arriving for an appointment		minutes

8. Please indicate the approximate percentage of patients in your practice who are:

Children & Teenagers (1 to 18 years)		%
Young adults (19 to 44 years)		%
Middle aged adults (45 to 64 years)		%
Older Adults (65 or older)		%

Please make sure your total adds up to 100%

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Questionnaire Instructions

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9. Please indicate the approximate percentage of patients in your practice who are of Hispanic or Latino ethnicity.

____ %

10. Please indicate the approximate percentage of patients in your practice whose race is:

White or Caucasian	%
Black or African-American	%
American Indian or Alaska Native	%
Asian	%
Native Hawaiian or Other Pacific Islander	%
Other, please specify **race** below	%

Please make sure your total adds up to 100%

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11. Please indicate the approximate percentage of patients in your practice who are:

Covered by a private insurance program that pays for part/all of their dental care	%
Covered by a public program that pays for part/all of their dental care	%
Not covered by any third party and pays out of pocket for dental care	%
Receiving free care or substantially reduced fees courtesy of this practice	%

Please make sure your total adds up to 100%

12. Please estimate the following for your patient population:

Patients who come for **one visit only**	%
Patients who come **occasionally, only** when they have an emergency or specific problem/concern	%
Patients who come **irregularly** whether or not they have a problem/concern	%
Patients who come **regularly** as recommended whether or not they have a problem/concern	%

Please make sure your total adds up to 100%

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13. In my practice setting, we have (check all that apply):

- ☐ Internet access for administrative staff
- ☐ Internet access in the operatories (chairside)
- ☐ Internet access for clinical staff outside the operatories (e.g., break-room, dentist's office)
- ☐ Wi-Fi (wireless) internet
- ☐ We do not have internet in the practice

14. Do you use electronic patient records to manage clinical/patient care data (as opposed to billing/scheduling)?

- ○ Yes (If yes, answer Question 15)
- ○ No (If no, answer Question 16)

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Questionnaire Instructions

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15. What brand of electronic patient records software do you use?

- Dentrix
- Soft Dent
- Eagle Soft
- Eagle Dental
- Practice Works
- GSD Works
- Axium
- Other, please specify below

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Questionnaire Instructions

Skip to Question 17.

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16. Within the next two years, how likely are you to begin using electronic patient records to manage clinical patient data?

- Very likely
- Somewhat likely
- Not likely
- Not sure at this time

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Questionnaire Instructions

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17. Please indicate how you store clinical information. If you store information on both paper and computer, please check <u>both</u> categories.

Type of Information	Paper	Computer
medical history	☐	☐
dental history	☐	☐
progress notes	☐	☐
completed treatment	☐	☐
radiographs	☐	☐
other images or photographs	☐	☐
appointments	☐	☐

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18. Individual members of the network participate at various levels. Please indicate below your desired level of participation.

- **Informational**: receive newsletters/correspondence **only**
- **Limited participation**: receive newsletters/correspondence AND participate in surveys/questionnaires
- **Full participation**: receive newsletters/correspondence AND participate in surveys/questionnaires AND participate with in-office research

19. When receiving a notice of new network results and information (e.g., study findings, notice of publications, newsletters), how do you prefer to receive this information?

- By e-mail
- Printed, sent by postal mail

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20. Future network studies will focus on topics that are important to a dental practice. We have identified 10 areas that seem to be of most concern. Please select any of the following 10 areas on the next several screens that are most relevant to you.

In the blank text field of the selected area(s), please state what research question you would like the network to answer. Please be as specific as possible. For example, state what clinical question you want answered, what clinical outcome would be measured, what the intervention and control groups or comparison groups would be, how the data might be collected, etc.

- [ ] 1. General Restorative Dentistry Issues:
- [ ] 2. Preventive Dentistry Issues:
- [ ] 3. Demand for Dental Care and Access to Care Issues:
- [ ] 4. Business Aspects of Dental Practice and Efficiency of Practice Issues:
- [ ] 5. Periodontal Conditions:
- [ ] 6. Amalgams and Composites:
- [ ] 7. Safety of Dental Office:
- [ ] 8. Diagnostic Methods:
- [ ] 9. Occlusion:
- [ ] 10. Systemic Health Issues related to Oral Health:
- [ ] 11. Other:

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Questionnaire Instructions

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21. During the period 2005-2012, were you a member of any of these dental practice-based research networks?

- The Dental PBRN, administratively based at UAB
- NW PRECEDENT, based at University of Washington and OHSU
- PEARL, based at NYU
- None of these
- Not sure

22. Are you a dentist or a dental hygienist/dental therapist/licensed assistant?

- Dentist
- Dental hygienist/dental therapist/licensed assistant (this will take you to Question #32)

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Questionnaire Instructions

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23. Which one category best describes your main or primary dental practice?

- **Owner** of a private practice
- **Associate or employee** of a private practice
- HealthPartners Dental Group
- Permanente Dental Associates
- Other managed care or preferred provider organization
- Public health practice, community health center, or publicly-funded clinic (but not a federal facility)
- Federal government facility (e.g., VA, Department of Defense, Public Health Service)
- Dental school, academic dental institution, or facility staffed by the dental school

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Questionnaire Instructions

If you are the owner of a private practice or associate or employee of a private practice, provide the total number of dentists in the practice including yourself: _____

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24. What year did you graduate from dental school?

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25. Did you graduate from a dental school in the United States, Canada, or some other country?

- United States
- Canada
- Other

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Questionnaire Instructions

Provide the name of the United States, Canadian, or other dental school you attended:

_____

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26. Are you a general practitioner or a specialist?

- General practitioner (If General practitioner selected, answer Question 26a)
- Specialist (If Specialist selected, answer Question 26b)

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26a. Please check which item or items apply to you:

- [ ] I have not completed any type of formal advanced training program after dental school
- [ ] I completed an Advanced Education in General Dentistry (AEGD) program
- [ ] I completed a General Practice Residency (GPR) program
- [ ] I am a Fellow of the Academy of General Dentistry (FAGD)
- [ ] I completed Mastership in the Academy of General Dentistry (MAGD)
- [ ] I completed some other advanced training program (please specify below)

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26b. Please check all specialty training

- ☐ Endodontist Year: _____
- ☐ Pediatric Dentist Year: _____
- ☐ Periodontist Year: _____
- ☐ Prosthodontist Year: _____
- ☐ Oral/Maxillofacial Surgeon Year: _____
- ☐ Orthodontist Year: _____
- ☐ Other (please specify below) Year: _____

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27. In which of the following dental organizations are you currently a member? (Check all that apply)

- [ ] American Dental Association/state dental association/local association
- [ ] Academy of General Dentistry/state academy of general dentistry
- [ ] Other (please specify)
- [ ] Other (please specify)
- [ ] Other (please specify)
- [ ] Other (please specify)
- [ ] Other (please specify)
- [ ] None

Please specify:

Please specify:

Please specify:

Please specify:

Please specify:

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NOTE: IF YOU PRACTICE AT MORE THAN ONE LOCATION, PLEASE INCLUDE ALL THESE LOCATIONS WHEN ANSWERING THE FOLLOWING QUESTIONS

28. How many patients do YOU personally treat during a typical work week? (Do NOT include patients seen by a hygienist even if you see the patient for a routine 'recall' examination)

_____ patient visits in a typical week

29. Please indicate the frequency with which YOU personally perform the following procedures in a typical month. If you always refer these procedures to other practitioners, please record not at all. (This may include examinations on patients scheduled with a dental hygienist/dental therapist/licensed assistant.)

	Not at all	Occasionally	Routinely
Non-implant restorative (amalgams, composites, crowns, veneers, bridges, posts, foundations, etc.)	○	○	○
Implants (prosthetic and surgical procedures for implants)	○	○	○
Removable Prosthetics (full and partial dentures)	○	○	○
Extractions (surgical and non-surgical)	○	○	○
Periodontal therapy (non-surgical; includes scaling/root planing that you do personally)	○	○	○
Periodontal therapy (surgical)	○	○	○
Endodontic therapy (anteriors/premolars)	○	○	○
Endodontic therapy (molars)	○	○	○
Procedures for esthetic reasons only (composites, crowns, veneers, etc.)	○	○	○
Orthodontic treatment	○	○	○

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30. Would you be willing to use data from your computer system for network studies, where feasible and allowed by confidentiality regulations, instead of having to enter them separately by hand or sending them to your regional data center?

- Yes
- Maybe, it depends on the study
- No
- I do not have a computer system at this time

31. Have we left out anything important to your practice? Please use the space below for any additional comments.

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32. Please indicate the educational setting for your dental hygiene/dental therapist/licensed assistant training.

- Technical or community college
- Four-year college
- Alabama Dental Hygiene Program (ADHP)
- Other (please specify below)

33. What year did you initially become licensed as a dental hygienist/dental therapist/licensed assistant?

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34. What is the highest degree you have obtained?

- Certificate
- Associate
- Baccalaureate
- Master's
- PhD
- Other (please specify below)

35. In which of the following dental organizations are you currently a member? (Check all that apply)

- American Dental Hygienists Association
- State Dental Hygienists Association
- Study clubs
- Other (please specify below)
- None

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Questionnaire Instructions

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NOTE: IF YOU PRACTICE AT MORE THAN ONE LOCATION, PLEASE INCLUDE ALL OF THESE LOCATIONS WHEN ANSWERING THE FOLLOWING QUESTION

36. In a typical month, for what percentage of patients do YOU personally perform the following procedures? If you do not perform these procedures, please record 0%.

Prophylaxis (i.e., "cleanings" and assessments)		% of patients
Periodontal therapy/scaling/root planing/periodontal maintenance		% of patients
Subgingival antimicrobial placement		% of patients
Restorative functions		% of patients
Local anesthesia (injection)		% of patients
Local anesthesia (subgingival with a gel)		% of patients
Dental sealants		% of patients
Dentinal desensitizers		% of patients
Radiographs		% of patients
Patient education (in-office)		% of patients
Tobacco cessation counseling		% of patients
Dietary counseling		% of patients
Other (please specify below)		% of patients

37. Have we left out anything important to your practice? Please use the space below for any additional comments.

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38. Which category <u>best</u> describes you?

- Dentist - Student
- Dentist - Retired
- Dentist - Awaiting U.S. license
- Dentist - Between positions

- Dental Hygienist/Dental Therapist/Licensed Assistant - Student
- Dental Hygienist/Dental Therapist/Licensed Assistant - Retired
- Dental Hygienist/Dental Therapist/Licensed Assistant - Awaiting U.S. license
- Dental Hygienist/Dental Therapist/Licensed Assistant - Between positions

- Educator
- Researcher
- Other (please specify below)

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Questionnaire Instructions

If you are satisfied that you are finished with the questionnaire, please click the Submit Survey button below. Once you have clicked on this button, your questionnaire is considered complete, and you will not be able to change your responses.

Submit Survey Return to Survey

The National Dental Practice-Based Research Network

Thank you for participating in dental practice-based research! You will receive a confirmation email shortly.

Practitioners who would like to participate in a National Dental PBRN study must complete Orientation Training. One option for completing Orientation Training is to view an orientation video. If you would like to view the orientation video now, followed by a quiz to receive 0.5 continuing education credits* and a Certificate of Completion, click here (estimated duration to complete: 30 minutes including the quiz). After viewing the video, you will need to sign-in to take the quiz and the following information should be entered:

Email address:
Last name:

If you prefer to view the orientation video at another time, you will be sent a follow-up email with further instructions.

*All participants are provided by email a certificate of completion. Continuing education credit awarded may not apply toward license renewal in all states. It is the responsibility of each participant to verify the requirement of his/her state license board(s).

From: National Dental
Sent: Wednesday, July 10, 2013 5:12 PM
To:
Subject: Confirmation of Enrollment Receipt and CE Credit Opportunities

Dear Colleague,

Thank you for completing the Enrollment Questionnaire for the National Dental Practice-Based Research Network (National Dental PBRN). We have received your questionnaire and you are now enrolled in the National Dental PBRN. The Regional Coordinator for your area will be contacting you in the near future to follow up with you about participating in the National Dental PBRN.

If you feel any of your colleagues may also be interested in joining the National Dental PBRN, please forward this email and invite them to join by visiting http://www.nationaldentalpbrn.org/, and then clicking on the link to enrollment.

The network offers free Continuing Education (CE) credit as a membership benefit. The following CE credit opportunities are currently available.

1. *Orientation Training Video:* Practitioners who would like to participate in a National Dental PBRN study must complete Orientation Training. One option for completing Orientation Training is to view an orientation video. If you would like to view the orientation video, followed by a quiz to receive 0.5 CE credits* and a Certificate of Completion, here at any time.
2. *National Dental PBRN Presentation at the Institute for Oral Health (IOH) Meeting Video:* If you would like to view the National Dental PBRN presentation at the IOH meeting in October 2012 video, followed by a quiz to receive 0.5 CE credits* and a Certificate of Completion, click here at any time. This is an optional CE credit opportunity and is not a requirement as part of the enrollment process.

The estimated duration to complete each video is 30 minutes including the quiz. After viewing the video, you will need to sign-in to take the quiz and the following information should be entered:

Email address:
Last name:

Again, thank you for your interest and participation in *the nation's network*.

Gregg Gilbert, DDS, MBA, FAAHD, FICD
National Network Director
The National Dental Practice-Based Research Network

*All participants are provided by email a certificate of completion. Continuing education credit awarded may not apply toward license renewal in all states. It is the responsibility of each participant to verify the requirement of his/her state license board(s).