2021 Minimum Data Set Information Fields for Indiana Health Professions

1. What is your employment status?
   RADIO BUTTONS
   a. Actively working in a position that requires this license
   b. Actively working in a field that does not require this license
   c. Not currently working
   d. Retired

2. What best describes your employment plans for the next 2 years?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. Increase hours in a field related to this license
   b. Decrease hours in a field related to this license
   c. Seek employment in a field unrelated to this license
   d. Retire
   e. Continue as you are
   f. Unknown

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

5. Where did you complete the education that first qualified you for this license?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. Indiana
   b. Michigan
   c. Illinois
   d. Kentucky
   e. Ohio
   f. Another State (not listed)
   g. Another Country (not U.S.)

6. What type of degree/credential qualified you for this license?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. High school graduate (or equivalency)
   b. Some college, no degree
   c. Technical/Vocational Certificate
   d. Associate's Degree
   e. Bachelor's Degree
   f. Master's Degree
   g. Professional/Doctorate Degree
   h. Not applicable

7. What is your highest level of education (which may or may not be related to this license)?
   DROP-DOWN LIST
   a. High school graduate (or equivalency)
   b. Some college, no degree
   c. Technical/Vocational Certificate
   d. Associate’s Degree
   e. Bachelor’s Degree
   f. Master’s Degree
   g. Professional/Doctorate Degree

8. Please indicate which of the following services you routinely provide or support 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. Cancer screening
   b. Dementia/Alzheimer’s care
   c. Diabetes screening
   d. Hepatitis C Treatment/Management
   e. High-risk pregnancy services
   f. HIV/AIDS Treatment/Management
   g. Labor and delivery services
   h. Obesity screening and/or counseling
   i. Post-natal services
   j. Pre-natal services
   k. Screening for substance use or behavioral health conditions (ex: SBIRT)
   l. Screening for high-risk pregnancy
   m. STD screening
   n. Tobacco use counseling
   o. None of the above

9. Please indicate the population groups to which you provide services:
   CHECKBOXES
   a. Newborns
   b. Children (ages 2-10)
   c. Adolescents (ages 11-19)
   d. Adults
   e. Geriatrics (ages 65+)
   f. Pregnant women
   g. Inmates
   h. Disabled individuals
   i. Individuals in recovery
   j. None of the above

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

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

12. In what state is your primary 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

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

14. Which of the following categories best describes the practice setting at your primary practice location? If this does not apply, please select "not applicable."
    DROP-DOWN LIST
    a. Educational/Academia Setting
    b. Federal Government Hospital
    c. Federal/State/Community Health Center(s)
    d. Home Health Setting
    e. Hospice Care
    f. Hospital – Inpatient
    g. Hospital – Outpatient
    h. Hospital – Emergency Department
    i. Local Health Department
    j. Nursing Home or Extended Care Facility
    k. Office/Clinic
    l. Research Laboratory
    m. School-based Health
    n. Telemedicine
    o. Volunteer in a Free Clinic
    p. Other
    q. Not applicable

15. Estimate the average number of hours per week spent at your primary 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

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

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

18. 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

19. 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)

20. 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
    a. Educational/Academia Setting
    b. Federal Government Hospital
    c. Federal/State/Community Health Center(s)
    d. Home Health Setting
    e. Hospice Care
    f. Hospital – Inpatient
    g. Hospital – Outpatient
    h. Hospital – Emergency Department
    i. Local Health Department
    j. Nursing Home or Extended Care Facility
    k. Office/Clinic
    l. Research Laboratory
    m. School-based Health
    n. Telemedicine
    o. Volunteer in a Free Clinic
    p. Other
    q. Not applicable

21. 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
    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