2016 Registered Nurse Licensure Renewal Survey:

The ongoing collection of health care workforce data enables the Department of Public Health to assess, forecast, and inform workforce development to meet the needs of Massachusetts residents. Please provide an answer for all required questions, which are denoted with an asterisk (*) at the end of the question. You will not be able to submit a survey until all required questions have been answered.

		Section 1: Dem	ographics
1.	Zip Code of Primary Residen	ce*	
2.	Sex* Male Female Other Decline to Answer		
3.	Year of Birth* □□□□		
4.	Are you Hispanic/Latino/Spanic	anish?*	
5.		ics or similar social and g Native	ne group or groups that you identify with as having eographic origins. Check all that apply.*
6.	ancestry, or sometimes the comparison African American American Asian Indian Brazilian Cambodian Cape Verdean Caribbean Islander Chinese	ountry where you or you Cuban Dominican European Filipino Guatemalan Haitian Japanese	ity refers to your background, heritage, culture, r family were born. Check all that apply.* Laotian Mexican, Mexican American, Chicano Middle Eastern Portuguese Puerto Rican Russian Salvadoran Vietnamese Other
	☐ Colombian	Korean	Decline to Answer

7.		s) (other than English), are you fluent enough to provide
	adequate care for and speak with patients? Chec	
	None	Italian
	Albanian	☐ Khmer
	American Sign Language (ASL)	Korean
	☐ Arabic	Portuguese
	☐ Cape Verdean Creole	Russian
	Chinese	Somali
	Farsi	Spanish
	French	Vietnamese
	Greek	Other
	Haitian Creole	
	· -	
8.	Are you currently engaged in active duty in the a	rmed services?*
	☐ Yes	
	∐ No	
	Section	n 2: Education
9.	What time of pureing degree (gradential qualified	you for your first U.S. registered nursing license?*
٦.	Diploma	you for your mist o.s. registered hursing needse:
	Associate Degree	
	Baccalaureate Degree	
	Master's Degree	
	Doctoral Degree	
4.0		
10.	Where did you obtain the degree that qualified y	ou for your first U.S. registered nursing license?*
	Massachusetts Other US State	
	Other US State	
	U.S. Territory Foreign Country	
	Foreign Country	
11.	Were you ever licensed as an LPN or LVN?*	
	Yes	
	∐ No	
12.	What is the highest level of nursing education yo	u have completed?*
	Diploma	•
	Associate Degree	
	☐ Baccalaureate Degree	
	Master's Degree	
	Doctoral Degree (e.g. PhD, EdD)	
	Practice Doctorate (e.g. DNP)	
13.	What is the highest level of non-nursing education	n you have completed?*
	☐ Not applicable	
	Associate Degree	
	Baccalaureate Degree	
	Master's Degree	
	☐ Doctoral Degree	

14. If you have APRN authorization in Massachusetts, please identify your certification specialty (ies). Check
all that apply. *
☐ I am not authorized to practice in the advanced role
Acute Care
Adult
Adult Acute Care
Adult – Gerontology
Adult – Gerontology Acute Care
Adult – Gerontology Primary Care
Adult Health
Adult Psychiatric Mental Health
Certified Nurse Midwife
Certified Registered Nurse Anesthetist
☐ Child/Adolescent Psychiatric Mental Health
☐ Critical Care
Gerontology
Home Health
Neonatal
Pediatric
Pediatric Acute Care
Psychiatric Mental Health
Public/Community Health
School Nurse
☐ Women's Health
15. If you are currently working as an APRN, which of the following credentials do you hold? Check all that apply. If you are not currently working as an APRN, check "Not Applicable".
☐ Not Applicable

Primary Care Provider designation in insurer provider directory
Finnary care Frovider designation in historer provider directory
16. With regard to your current practice as an APRN, which of the following represent barriers to your
practice? Check all that apply.
■ Not applicable
☐ Employer mandated restrictions
Fee charged by physician for supervision-related activities
Inability to secure hospital privileges
☐ Inability to locate a supervising physician to sign mutually developed and agreed upon prescriptive
<u>gu</u> idelines
Medicare reimbursement restrictions
Medicaid reimbursement restrictions
Private insurer reimbursement restrictions
None of the above

Section 3: Employment

17.	How many years have you been practicing nursing in the United States?* Less than 1 year 1-5 years 6-10 years 11-15 years 16-20 years 21-30 years More than 30 years
18.	What is your current employment status? Check all that apply.* Full-time in field of Nursing Part-time in field of Nursing Per Diem in field of Nursing Volunteering in field of Nursing Employed in Non-Nursing field Unemployed Retired
	If not employed in nursing, please indicate the major reason(s). Check all that apply.* Not Applicable Attending school Cannot find nursing position Disabled Laid off Not interested in nursing Taking care of home/family Retired Other Decline to answer
20.	Considering all positions you currently fill in the field of nursing, how many hours per week do you work on average? If not currently working in nursing, please select 0.* (Drop down of 0-79, and then "80 or more")
21.	Considering all positions you currently fill in the field of Nursing, approximately what percentage of your working hours do you personally spend on the following activities? (Answers for 21a through 21d should equal 100%. If not currently working in nursing, please enter 0% for each question.) a. Direct Patient Care (including patient education and care coordination)*

	b.	Administration or business-related manners*
		\square 0%
		□ 10%
		□ 20%
		30%
		50%
		<u> </u>
		90%
		100%
		_
	c.	Education of Health Professions Students (including acting as preceptor)
		\square 0%
		<u>20%</u>
		30%
		☐ 40%
		<u>50%</u>
		<u>60%</u>
		☐ 70%
		☐ 80%
		90%
		100%
	d.	Other*
	u.	
		10%
		<u>20%</u>
		☐ 30%
		40%
		□ 50%
		□ 60%
		□ 70%
		80%
		<u> </u>
		<u> </u>
22	. In	the past 12 months, how many weeks did you work in the field of nursing (not counting vacation,
	me	dical leave, etc.)? Answer should be within 0 and 52.*
		rop down of 0-52)
	(D)	op down of 0 52)
23	If t	here was training available to help you care for patients with disabilities, which of the following topics
23		uld you select? Check all that apply. *
	WU	
	\sqcup	Blindness or low vision
		Brain injuries (stroke, traumatic brain injury, etc.)
		Deafness or hard of hearing
		Epilepsy
	一	Intellectual or developmental disabilities
	H	Mental illness
	H	Mobility disabilities (wheelchair users, scooters, etc.)
	ㅂ	
	닏	Not applicable to my work
		I do not need additional training

Instructions: The next group of questions is related to your PRIMARY practice, at the organization where you work the **most hours each month**. If you work an equal number of hours between two practice settings please choose one as your primary and one as your secondary setting. If you do not have a primary practice setting, please select 'Not Applicable'.

24. 5 digit zip code of your primary nursing practice setting. If not currently practicing, enter 00000.*
25. Which of the following best describes your primary practice setting? (Choose one).* Not Applicable Academic Institution Ambulatory Surgical/Emergency Center Assisted Living Facility Community Health Center Correctional Institution Home Health Care Services Hospital, Inpatient Hospital, Outpatient Insurance Organization Mental Health/Sub Abuse - Outpatient Mental Health/Sub Abuse - Residential Nursing Association Occupational Health Site Physician Office Public Health Agency School Health Services Skilled Nursing Facility/Hospice Telenursing Other Outpatient Care Center Other
26. Please identify the role which best describes your primary nursing position.* Not working as a nurse Nurse Executive/Administrator Academic Administrator Nurse Midwife Case Manager Nurse Practitioner Charge Nurse Office Nurse CNS, Psychiatric Researcher CNS, Non-Psychiatric School Nurse Consultant Staff Nurse Instructor/Faculty Supervisor Manager/Director Nurse Anesthetist 27. Please identify the populations you work with in your primary nursing position. Check all that apply.*
 Not working as a nurse Not applicable to my work All ages Neonatal/Infants Children Adolescents/Young Adults Adults Elders

28. Which of the following b	oest describes your a	rea of practice in your primary position?*
Not applicable		Labor & Delivery/Post Partum
Acute Care		Long term care
Administration		Mental Health/Sub Abuse
Anesthesia/Periope	rative	Occupational Health
Case Management		Oncology
Critical Care		Palliative Care
Dialysis		Primary Care
Education		Public Health
Emergency/Trauma		Rehabilitation
Family Practice		School Health
☐ Home Health		Other
Infection Prevention	<u> </u>	other
	L	
secondary practice setting, plea	se select 'Not Applic	
enter 00000.	secondary nursing p	ractice setting. If you do not have a secondary practice ,
30. Which of the following b	est describes vour s	econdary practice setting ? (Choose one).
Not Applicable	sest describes your s	coondary practice beening. (another one).
Academic Institution	n	
Ambulatory Surgica	l/Emergency Center	
Assisted Living Faci	lity	
Community Health (
Correctional Institu		
Home Health Care S	ervices	
Hospital, Inpatient		
Hospital, Outpatient		
Insurance Organizat		
Mental Health/Sub		
☐ Mental Health/Sub And Sub Nursing Association		
Occupational Health		
Physician Office	isic	
Public Health Agenc	v	
School Health Service	-	
Skilled Nursing Faci		
Telenursing	• , •	
Other Outpatient Ca	re Center	
Other		

31. Please identify the role which best describes you	ir secondary nursing position.
☐ Not working as a nurse	☐ Nurse Executive/Administrator
Academic Administrator	☐ Nurse Midwife
Case Manager	☐ Nurse Practitioner
☐ Charge Nurse	Office Nurse
CNS, Psychiatric	Researcher
CNS, Non-Psychiatric	☐ School Nurse
Consultant	☐ Staff Nurse
☐ Instructor/Faculty	Supervisor
☐ Manager/Director	Other
☐ Nurse Anesthetist	
Section	4: Future Plans
(Check all that apply)	next five years do you plan to do any of the following?
(Check all that apply) Work the same as now	next five years do you plan to do any of the following?
(Check all that apply) Work the same as now Increase hours of work	next five years do you plan to do any of the following?
(Check all that apply) Work the same as now Increase hours of work Reduce hours of work	next five years do you plan to do any of the following?
(Check all that apply) Work the same as now Increase hours of work Reduce hours of work Leave nursing practice, but not retire	next five years do you plan to do any of the following?
(Check all that apply) Work the same as now Increase hours of work Reduce hours of work Leave nursing practice, but not retire Retire	next five years do you plan to do any of the following?
(Check all that apply) Work the same as now Increase hours of work Reduce hours of work Leave nursing practice, but not retire	next five years do you plan to do any of the following?
(Check all that apply) Work the same as now Increase hours of work Reduce hours of work Leave nursing practice, but not retire Retire Return to nursing practice	next five years do you plan to do any of the following?
(Check all that apply) Work the same as now Increase hours of work Reduce hours of work Leave nursing practice, but not retire Retire Return to nursing practice Seek additional education in nursing Take a leave of absence Other	next five years do you plan to do any of the following?
(Check all that apply) Work the same as now Increase hours of work Reduce hours of work Leave nursing practice, but not retire Retire Return to nursing practice Seek additional education in nursing Take a leave of absence	next five years do you plan to do any of the following?