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Introducation

Nursing is the most trusted profession in the United States. Since polling firm Gallup began its survey of Americans on the “Honesty and Ethical Standards in Professions” in 1999, nurses topped the list every year but one. The only year that nurses did not top the ranking was in 2001 when firefighters held first place following the 9/11 attacks.

Numbering almost 300,000 in Texas and over 3 million nationwide, nurses are the face of health care. Wherever you receive care — in a hospital, emergency room, home, community, or retail clinic — nurses are there spending more time with their patients than any other health care worker. Nurses not only treat patients, but also get to know them and advocate for their best interests in some of the most intimate, joyous, and sorrowful experiences of their life.

The Texas Nurses Association (TNA) is the oldest and largest nursing association in Texas, advocating for nurses since the first Nursing Practice Act was passed in 1909. Since then, TNA has continuously worked to promote positive practice environments and patient advocacy protections enabling nurses to do what they do best: take good care of their patients.

This legislative year, we all need to work to ensure that Texas has an adequate supply of nurses to care for its citizens. We need to continue to fund the increased production of registered nurses while ensuring quality education and practice. We need to support efforts that incentivize nursing faculty. We need to ensure the safety of work environments so that nurses stay in the profession. And we need to ensure that all nurses are able to function to the full extent of their education and licensure to address access and quality care needs of Texans.

The Texas Nurses Association stands ready to work with all stakeholders, legislators, nurses, and health care consumers to make these priorities a reality.

Jeff Watson, DNP, RN-BC, NEA-BC, NE-BC, CRRN  
President  
Texas Nurses Association
Get to Know Your APRN:
The Four Roles of Advanced Practice Nursing

**Nurse Practitioner**
15,482
NPs are licensed to practice in Texas.
Diagnose illness, treat illness, prescribe meds, order and interpret tests.
Bring a comprehensive approach to health care, can be found in many medical settings.
80% were prepared in primary care, while only 14.6% of physicians entered primary care residency in 2012.

**Clinical Nurse Specialist**
1,348
CNSs are licensed to practice in Texas.
Improve quality, safety, and cost outcomes for patient populations; diagnose and treat illness, promote health, and some prescribe medications.
Provide specialized nursing clinical expertise to patients, nurses, and organizations.

**Certified Registered Nurse Anesthetist**
4,000+
More than 4,000 CRNAs practice in Texas.
Trained to deliver anesthesia care, regardless of whether an anesthesiologist is involved. Practice in every setting where anesthesia is provided.

**Certified Nurse Midwife**
12,000
CNMs attended over 12,000 births in Texas in 2013, 96% of which were in hospitals.
Provide primary care to women, including health promotion, gynecologic and family planning services, care during pregnancy, childbirth, postpartum period, and newborn care.
Advanced Practice Registered Nurses (APRNs)
Advanced Practice Registered Nurses (APRNs)

APRNs are registered nurses who have at a minimum completed graduate coursework (masters degree), passed a national certification exam, and achieved advanced licensure in the state. APRNs include:

- Nurse Practitioners (NPs)
- Clinical Nurse Specialists (CNSs)
- Certified Nurse Midwives (CNMs)
- Certified Registered Nurse Anesthetists (CRNAs)

Despite decades of experience and a near impeccable track record related to patient outcomes, APRNs do not have full practice authority in Texas. That is, APRNs can practice to the full extent of their education and training only when they contract with a physician to "supervise" their practice. Texas is one of the few states that still require such supervision, but it is not “supervision” in the normal sense of the word. When “supervising” an APRN practice, physicians never actually see the patients, but rather merely review charts periodically and sign a form allowing the APRN to practice. In some cases, these contracts can cost close to $60,000 a year for the APRN. Effectively, many APRNs are already practicing to their fullest extent but are paying a physician at least a mortgage payment each month to be able to do so.

Twenty percent of Texans lack access to a primary care provider, and Texas was recently listed as 51st in the nation on access to and affordability of health care by the Commonwealth Fund. The Legislature has the ability to change this statistic by allowing APRNs to practice to the full extent of their education and training without useless physician supervision.

Lower Costs

APRNs are prepared more quickly and less costly than physicians. Texas taxpayers spend on average $160,000 to educate a single medical student, and in 2014, the state spent an additional $32.8 million to finance 6,500 post-graduate residency positions. In contrast, three to twelve nurse practitioners can be educated for the price of one physician and in a fraction of the time.

Full practice for APRNs provides an economic boost across the board. In 2008 nurse practitioners earned an average of $92,000 while primary care physicians earned an average of $162,500. Since then, physician wages have risen faster in full-practice states than in restrictive-practice states, because as APRNs assume a more independent role as primary care providers, physicians are able to focus their expertise on more complex and thus more costly cases.

Access to Care

The Texas Medical Association estimates that Texas has approximately 43,000 physicians to care for 23 million people. But by 2025, there will be a shortage of 44,000 to 46,000 primary care physicians nationwide. Texas already ranks 42nd in physicians per population and will account for nearly one-fourth of the national shortage (10,000 short of demand in Texas).

Additionally, Texas has 226 regions designated as Medically Underserved Areas (MUAs). Twenty-five Texas counties have no physician, and nearly 20% of Texans, or 4.6 million people, lack access to a primary care provider. And yet, in a survey of recent medical school graduates, only 2% chose to practice in primary care. This choice was attributed to high educational debt and relatively low salaries when compared to specialty fields.
The lack of primary care has a significant impact on rural areas with limited access to care. Patients in underserved areas needing specialty care go to a robust specialty center in an urban setting. Primary care, however, needs to be accessible within the individual's community. Elimination of unnecessary physician supervision of APRNs would increase access to primary care in rural communities.

When Texas APRNs were asked whether they would be willing to work in underserved areas if they were free from physician supervision requirements, 75% said that they would be extremely (28%), very (22%), or somewhat (25%) willing to do so. The Texas Legislative Budget Board agrees that NPs and CRNAs are more likely to practice in rural locations when given more practice authority.

**Consumer Choice and Better Patient Outcomes**

Full practice authority for APRNs has been linked to greater access and fewer avoidable hospitalizations, readmissions, and emergency department visits. Consistently, studies demonstrate that NPs have as good or better outcomes than physicians. CNSs specializing in prenatal care fare better than their physician counterparts when treating women with a high risk of a low-birth-weight baby, and demonstrate shorter hospital stays and reduced costs in acute settings. CNMs have lower Cesarean rates than physicians and use 12% less hospital resources than physicians.

Recent literature lauds the use of team-based patient-focused care models in which all providers (nurses, physicians, pharmacists, physical therapists, dieticians) work as a team and exchange patient care leadership based on patient needs. Within this model, the utilizations of APRNs are encouraged by the American College of Obstetricians and Gynecologists, stating that all providers should “function to the full extent of their education, certification, and experience” and that collaboration in teams must be between autonomous individuals.
Texas and the Nation

Full practice authority laws are well tested. Currently 22 states grant full practice authority for APRNs and a handful more have legislation pending. Most recently, West Virginia passed a full practice authority bill in March 2016. Every state immediately bordering Texas offers greater practice authority for APRNs than Texas. In fact, the New Mexico governor recently launched an advertising campaign to recruit APRNs to New Mexico where APRNs have long enjoyed full practice authority. As long as Texas restricts APRN practice, we will continue to struggle to attract and keep APRNs.

States adopting full practice authority encompass a broad range of characteristics — from those considered more conservative than Texas (e.g. Utah, Alabama, West Virginia, and Tennessee) to extremely liberal states (e.g. Delaware, Connecticut, and Oregon). Not one state that has adopted full practice authority has ever reverted to more restricted practice.

TNA Position

The Texas Nurses Association supports full practice authority for APRNs in all four roles — without burdensome government restrictions and anti-competitive supervision by another profession. TNA urges the Legislature to consolidate all regulatory authority of nurses, including APRNs, under the Board of Nursing.

Legislative History

**HB 1885** (2015 - Left pending in Public Health)
- Would have granted full-practice authority to the four roles of APRNs.

**SB 406** (2013)
- Created the current Prescriptive Authority Agreement system.
- Created an exception for APRNs to prescribe Schedule II substances in hospital facilities.

**SB 846** (2011 - Left pending in Finance)
- Would have allowed APRNs to provide limited health services independent of a physician in sites serving medically underserved populations.

**SB 532** (2009 - Passed by Patrick)
- Authorized a physician to delegate the carrying out or signing of certain prescription drugs.
- Increased the number of APRNs that a physician may delegate to from three to four.
- Provided that physician supervision is adequate when the physician is on site at least 10% (down from 20%) of the hours of operation, the physician reviews 10% of the APRN’s medical charts electronically, and the physician is available for consultation.
- Allowed the Texas Medical Board to waive the limitation on the number of APRNs that physicians may delegate to.

**SB 800** (2007 - Left pending in Health and Human Services)
- Would have increased the number of APRNs that a physician may delegate to from three to six.
- Would have eliminated requirements that physicians be on site with the APRN at least 20% of the time.

Texas taxpayers spend on average $160,000 to educate a single medical student. Three to 12 nurse practitioners can be educated for the price of one physician and in a fraction of the time.
Discharge Prescriptions

Issue Background
In the language of SB 406, passed in 2013, physicians were given the ability to delegate the ordering and prescribing of Schedule II controlled substances to APRNs in a hospital facility-based practice. Shortly after passage, an interpretive FAQ surfaced from the state agencies overseeing implementation of the statute stating that APRNs may prescribe Schedule II medications to patients only if the prescription is filled in the hospital’s pharmacy, which effectively changed the plain meaning of the statute.

What It Means For Texas
State agencies are required to provide notice and hold public hearings for any rule that affects the practice of their regulated community. The FAQ circumvents the requirement to hold public hearings on rules that interpret statute and obscures the plain meaning of the statutory language. The interpretation prevents APRNs at hospitals without a pharmacy from acting within their statutory authority to issue discharge prescriptions as clearly allowed by SB 406. It causes confusion and favors some practitioners and some pharmacies over others.

TNA Position
Texas Occupations Code, Section 157.0511 (b-1) states that an APRN may prescribe Schedule IIs in a hospital. The law does not say that the prescription must be filled only in a hospital pharmacy. If the patient feels more comfortable going to their local pharmacy to fill their prescription, then state boards should not prohibit them from doing so.

TNA recommends that the Legislature clarify this statute to remove any doubt regarding the interpretation, and allow all APRNs to issue discharge prescriptions for patients, regardless of the pharmacy the patient chooses.

Legislative History
HB 2602 (2015 – Left pending in Calendars)
- Would have allowed community pharmacies to fill discharge prescriptions from APRNs in hospital facility-based practices.

SB 406 (2013)
- SB 406 (2013) stated, “a physician may delegate the ordering and prescribing of CSIIs [to APRNs] ... in a hospital facility-based practice ...”
Signatures

Issue Background
Physicians have long been solely responsible for signing health care-related documents like birth and death certificates, orders for handicap placards, jury duty and immunization waivers, and worker’s compensation forms. But as APRNs provide increasing proportions of primary care, the requirement of physician authorization has become a barrier to practice.

What It Means For Texas
APRNs serve an integral role in providing primary care. Requiring a consumer to see a physician solely for an authorization signature is a waste of time for both patient and physician — when the physician's time would be better spent on clinical issues. There is no reason why an APRN should not be able to meet with patients to sign a form that is well within their scope of training. This barrier only serves to further burden patients with costly and time-intensive physician visits.

TNA Position
TNA recommends that the Legislature allow APRNs to lower costs and serve consumers by amending outdated laws that prevent APRNs from authorizing certain forms (statutory references listed below):

- Section 38.001(c), Education Code - Immunization waivers for elementary and secondary schools
- Section 51.933(d), Education Code - Immunization waivers for institutions of higher education
- Section 51.9192(d), Education Code - Bacterial meningitis vaccination waivers
- Sections 62.109(b) and (f), Government Code - Jury duty exemptions
- Section 89.011(a), Health and Safety Code - Certifications of completed tuberculosis screening at correctional facilities
- Sections 192.003(a) and (c), Health and Safety Code - Birth certificates
- Sections 193.005(a), (b), and (c), Health and Safety Code - Death certificates
- Section 504.201(d), Transportation Code - Statements authorizing specialty license plates
- Sections 681.003(c) and 681.004(d), Transportation Code - Disabled parking placards
- Section 408.025, Labor Code - Worker’s compensation documents

Legislative History
HB 1473 (2015 - Left pending in Public Health)
- Would have allowed the signing of multiple types of forms by both APRNs and PAs.

HB 1185 (2015 - Left pending in Public Health)
- Would have allowed the signing of multiple types of forms by APRNs only.

SB 466 and HB 3913 (2015 - Left pending in Judiciary Affairs)
- SB 466 and HB 3913 would have allowed APRNs to sign jury duty exemptions.

Requiring a consumer to see a physician solely for an authorization signature is a waste of time for both patient and physician ...
Nursing Education
Recent data from the Texas Center for Nursing Workforce Studies (TCNWS) within the Department of State Health Services (DSHS) confirms the worst-kept secret in nursing workforce research — there is, and will continue to be, a shortage of nurses in Texas. In fact, TCNWS estimates that supply of nurses will fall short of demand such that by 2030, the shortage will more than quadruple, and Texas will be 60,000 nurses short of what is needed to meet health care demands.¹

More than 50% of Texas baby boomers will be eligible for retirement by 2020. Nationwide, 40% of all RNs are 54 years old or older, and of those, 62% are planning to retire in the next 3 years.² In Texas, 41% of both RNs and APRNs were over the age of 50 in 2013. The aging of our population will create an increased demand for health care services at the same time we face a huge exodus of nurses from the workforce.

Texas cannot afford to relax its efforts to ensure an adequate nursing workforce. Schools of nursing have made considerable progress in addressing the existing demand; however, lack of clinical training capacity and faculty shortage issues pose significant challenges to meeting the projected demands of an aging population. To increase capacity, the Texas Higher Education Coordinating Board administers innovative grant awards, which enable schools of nursing to develop alternative approaches to clinical training.

Additionally, incentives are needed to attract and retain nursing faculty to train new students to become nurses. Nursing faculty shortages largely result from a pay scale that fails to compete with the private sector.

The Texas Nurses Association works closely with nurse educators, university and community college systems, and legislative and regulatory staff to identify concrete solutions to issues in nursing workforce supply and demand.
Nursing Shortage Reduction Program

Issue Background
The Professional Nursing Shortage Reduction Program (PNSRP) was passed into law in 2001 in response to a reemerging nursing workforce shortage in Texas. The law gives the Texas Higher Education Coordinating Board (THECB) the ability to provide dedicated funds to nursing education programs that demonstrate an ability to increase enrollment and graduates. The program has been funded every year since 2001, and currently 106 academic institutions utilize the program.

The current program consists of three “pots of funds” distributed by the THECB to nursing programs within public and private independent colleges and universities that are able to increase their nursing graduates.

1. Regular Program
   All nursing programs are eligible to participate. Pro-rata funds are distributed after the fact based on the number of increased graduates over the previous year.

2. Over 70 Program
   Only nursing programs with graduation rates of 70% or higher are eligible to participate. Funds are distributed each biennium in advance (at $10,000 per student), based on projected increases in prelicensure enrollments of 12% for the first year and an additional 18% for the second year. If the targets are not met, the school repays the pro-rata share of the money advanced.

3. Under 70 Program
   Eligible nursing programs are 1) programs with a graduation rate below 70% and 2) new programs that do not have a previous year graduation rate. Funds are distributed in advance based on the programs agreeing to increase prelicensure graduates by a specific number set by the program.

Why It Matters to Texas Nurses
The program has worked very well, increasing the annual number of pre-licensure nurse graduates (new nurses) from 4,500 in 2001 to 16,204 in 2015. Due to Texas’ ability to withstand the recession that began in 2008, the high number of people moving to Texas each day, and the looming retirement of baby boomers, nurses continue to be in high demand. In fact, a report from the Texas Center for Nursing Workforce Studies this year reveals that the current nurse workforce shortage is expected to more than quadruple to 60,000 nurses short of demand by 2030 if nothing is done. It is more critical than ever that Texas maintain its PNSRP and keep it adequately funded to meet future demands.

TNA Position
In the 84th legislative session, the Legislature appropriated $33.75 million to the Professional Nursing Shortage Reduction Program. The Texas Nurses Association engaged the THECB, Texas university and community college systems, and nursing educators in extensive discussions regarding the PNSRP. All of these groups agree that the PNSRP should continue in its current form with the same appropriation to keep up with high demand for nurse graduates. TNA urges the Legislature to continue its commitment to Texas citizens by fully reinvesting in the PNSRP in the 85th legislative session.

<table>
<thead>
<tr>
<th>Year</th>
<th>Appropriation</th>
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<tbody>
<tr>
<td>2001</td>
<td>Established PNSRP with no appropriation</td>
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<tr>
<td>2005</td>
<td>$6 million appropriated for 2006-2007</td>
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<tr>
<td>2009</td>
<td>$47.2 million appropriated for 2010-2011</td>
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<tr>
<td>2013</td>
<td>$33.75 million appropriated for 2014-2015</td>
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<tr>
<td>2015</td>
<td>$33.75 million appropriated for 2016-2017</td>
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<tr>
<td>2011</td>
<td>$30 million appropriated for 2012-2013</td>
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<tr>
<td>2007</td>
<td>$14.7 million appropriated for 2008-2009</td>
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<tr>
<td>2003</td>
<td>Established the Texas Center for Nursing Workforce Studies within DSHS; $5.8 million appropriated for 2004-2005</td>
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Community College Baccalaureate Programs

Issue Background

Graduates of associate degree (ADN), diploma, or baccalaureate degree nursing (BSN) programs are eligible to sit for the same professional nursing licensure exam (NCLEX-RN), which is designed to measure basic competency as a registered nurse (RN). Despite the differences in preparatory educational levels, individuals from these various programs demonstrate similar pass rates on the NCLEX-RN.

Substantial research over the past 15 years has consistently demonstrated that nurses prepared at the BSN level achieve better patient outcomes than those initially prepared with an ADN or diploma. The evidence is so convincing that in 2010 in its landmark Future of Nursing: Leading Change, Advancing Health report, the Institutes of Medicine recommended that 80% of RNs have a BSN by 2020. This is no small challenge — in 2007 only 45.6% of Texas RNs were BSN prepared. However, following the report, nurse educators launched a number of initiatives to facilitate the articulation of ADN and diploma graduates into BSN programs.

In 2011, the Consortium for Advancing Baccalaureate Education in Texas (CABNET) emerged to reduce duplication in BSN completion programs (RN-to-BSN) and ADN curricula. CABNET establishes agreements between community colleges and universities to enable seamless transition for students who first complete an ADN and continue on to complete their BSN. In 2012, Texas was awarded a $300,000 Academic Progression in Nursing grant from the Robert Wood Johnson Foundation to continue this work. The grant was renewed for an additional two years in 2014. Currently, 24 Texas community colleges have established agreements with 12 universities.
These cumulative efforts have successfully increased the number of RNs with a bachelor's degree from 45.6% to 55.4% in the last eight years.

Additionally, following the IOM's challenge, a number of universities in Texas and other states have launched online BSN completion programs that accommodate the working nurse's schedule and facilitate achievement of a BSN. There are no reports that BSN completion programs are at or near capacity.

These cumulative efforts have successfully increased the number of RNs with a bachelor's degree from 45.6% to 55.4% in the last eight years.

What It Means for Texas
In 2013, the Texas Legislature created a study to consider giving community colleges the authority to grant bachelor's degrees in the fields of applied science and nursing. Consequently the RAND Corporation conducted a study and proposed several options in July 2014. Based on this report, the THECB recommended that if community colleges were to offer baccalaureate degrees, specific standards should be required, such as accreditation by a national nursing organization, to ensure quality in nursing education.

In 2015, the Texas Legislature considered a proposal to allow community colleges to expand their academic scope and provide either a full four-year baccalaureate degree program or an RN-to-BSN completion program. However, RN-to-BSN completion programs do not address the nursing shortage as they do not produce additional pre-licensure graduates. They only address the goal of increased educational preparation of RNs who are already in the workforce.

Additionally, there is no data in Texas that definitively shows that community colleges can take on the burdens — including funding, infrastructure, faculty employment levels, and clinical site access issues, all of which already impact universities — of providing bachelor's degrees. Without this necessary data, there is no way to know that allowing baccalaureate programs in community colleges will positively impact the nursing workforce in Texas.

TNA Position
The Texas Nurses Association supports academic progression for all nurses, particularly RN to BSN programs. Further, TNA supports continued growth in the existing higher education strategies, which include participation in THECB incentive programs and articulation agreements between community colleges and universities that allow associate degree and diploma nursing students to seamlessly continue their baccalaureate education.

Until Texas has definitive data on the realistic ability of Texas community colleges to take on the financial and administrative burden that would come with four-year baccalaureate programs, the legislature should focus its resources on developing and championing the current proven pipeline between community colleges and universities through articulation agreements like CABNET.

Legislative History
HB 1384 (2015 – Left pending in Calendars)
- Would have authorized THECB to allow certain community colleges to offer bachelor's degrees.

SB 414 (2013)
- Mandated a study to consider giving community colleges the authority to grant bachelor's degrees in the fields of applied science and nursing.
Nursing Faculty Loan Repayment Program (NFLRP)

Issue Background
Experienced, qualified faculty members for nursing schools are extremely difficult to find due to the vast differences in pay scales for nursing faculty versus clinical settings. A 2015 study found that the top reasons that nursing education programs are not hiring new faculty members are: “insufficient funds to hire new faculty” and “noncompetitive salaries.” The national vacancy rate for nursing faculty positions has been between 7-8% since 2010. In Texas, our nursing faculty vacancy rate has grown from 7.8% in 2011 to 10.9% in 2015, and our faculty turnover rates in Texas nursing programs are now at 21.1%.

The NFLRP was funded in 2013 in response to the continued lag in nursing workforce supply over the last decade and the need to provide an incentive to bring qualified instructors into higher education faculty. The funding mechanism for the program is tied to the Physician Education Loan Repayment Program (PELRP), and is only funded if there are excess funds leftover in the physician program. The PELRP is currently appropriated with $33 million per biennium, with all excess funding above that appropriation going to the Comptroller’s office in a General Revenue-Dedicated account.

Why It Matters to Texas Nurses
The NFLRP was originally intended to provide an incentive for practicing nurses to go into faculty positions and increase capacity for nursing school expansion, which would in turn work towards reducing the overall nursing shortage in Texas. However, without any guarantee of funds until all other PELRP hands have been fed at the end of the fiscal year, the THECB is not able to market the program to nurses or provide any kind of incentive for funds since there may be differing amounts from year to year, or simply none available.

TNA Position
The Texas Nurses Association recommends that the Legislature set aside a dedicated account to fund the NFLRP. Only with a dedicated funding source will the program be able to reliably incentivize nurses to become faculty and assist in the nursing shortage reduction efforts.

Legislative History
HB 7 (2015)
• General taxation bill — amended funding formula for PELRP to add Tax Code Sec. 155.2415(a)(3)(B) and 155.2415(b) to allow the proceeds to direct to the General Fund if the Comptroller determines that the PELRP appropriated amount ($33.8M) is sufficient to continue the program.

SB 1258 (2013)
• Provided funding mechanism for the NFLRP established in 2004. Provided loan repayment assistance for nurses if money is left over from PELRP at the end of the fiscal year.

HB 4583 (2009)
• Budget Consolidation bill — set up revenue for the Physician Education Loan Repayment Program so that a percentage of tax receipts from smokeless tobacco are dedicated to the property tax relief fund with the remainder going to the PELRP.
Board of Nursing & Regulatory Issues
Board of Nursing and Regulatory Issues

The Texas Board of Nursing (BON) is the regulatory body that licenses and disciplines advance practice registered nurses (APRNs), registered nurses (RNs), and licensed vocational nurses (LVNs). Currently, Texas has 16,800 APRNs, 285,945 RNs (an increase of 13,000 since 2014), and 101,314 LVNs (an increase of 2,000 since 2014). However, the Texas Center for Nursing Workforce Studies within DSHS reports that the nursing workforce shortage will quadruple by 2030 — leaving Texas 60,000 licensed nurses short of demand. 1

The BON is currently undergoing Sunset review. The last review was in 2007, when it received nine recommendations from the Sunset Commission and three more from the Legislature. As a result, the BON promoted innovations in nursing education, including concept-based curriculum, active-learning strategies, high-fidelity simulation, and alternative clinical sites to improve education and increase graduation rates. Additionally, the BON clarified the peer assistance program process and completed criminal background checks on all licensees. Finally, the BON implemented a system to resolve minor offenses through corrective action rather than formal orders.

This legislative session, the Sunset Commission will consider a number of issues, including the BON’s disciplinary process, a recent antitrust precedent, the revised nursing licensure compact, and educational standards.

Legislative History

HB 2154 (2015)
- Authorized the BON to take informal action on default dismissal from State Office of Administrative Hearings.

SB 1058 (2013)
- Granted confidential status to Board orders requiring an individual to participate in an approved peer assistance program.
- Mandated criminal background check prior to entering a school of nursing rather than prior to taking the nursing examination.

SB 1415 (2009)
- Created a pilot program for deferred adjudication in lieu of formal sanctions, during which the nurse must complete conditions imposed by the Board. Allows the BON to dismiss a complaint if the nurse successfully meets those conditions. The bill requires the Board to appoint an advisory committee to oversee the pilot program and authorizes the Board to contract with a third party for evaluation.
- Added a provision to the BON’s “corrective action,” allowing a fine, remedial education, or both, in lieu of a formal board sanction.

HB 2426 (Previous Sunset bill, 2007)
- Streamlined the Board’s process for approving nursing education programs by removing unnecessary complexity, eliminating duplication, and changing the delivery of nursing education.
- Encouraged innovation to promote capacity in nursing programs and address the nursing shortage.
- Required the Board to clarify its use of criminal history and arrest information during licensure and discipline.
- Modified the Board’s advisory committees to ensure objective, independent advice on functions and policies.
- Recommended adoption of the Advanced Practice Registered Nurse Multistate Compact to make it easier for nurses to practice in Texas.
- Improved the Board’s ability to consider impaired practice.
- Strengthened the Board’s oversight of continuing education to make it workable for the Board and beneficial for the nurse.
- Conformed key elements of licensing to common licensing practices.
Issue Background
The original Nurse Licensure Compact (NLC) was developed in 1999 to address concerns about the portability of RN and LVN licensure. The Compact enhanced communication among states and established a system of uniform licensure to allow nurses to move freely across state lines. Texas is already a member of the Nurse Licensure Compact, along with 24 other states. But, in an era of instant communication, licensure models must evolve to keep up with the marketplace. The newly updated Compact will need to be considered by the Legislature in 2017.

Details
In an interstate compact, state licensing boards issue multistate licenses that are valid in other compact states. Texas is already a member of 31 interstate compacts including the Driver License Compact, the Texas Low-Level Radioactive Waste Disposal Compact, and the existing NLC. Approval of the new NLC will facilitate telehealth and case management across state lines, and require all states to have these standards for licensees:

1. Graduate from a qualified education program and be proficient in English;
2. Possess a valid social security number;
3. Complete a criminal background check;
4. Have no felony convictions on record.

What It Means For Texas
The NLC may incentivize nurses to relocate to Texas by streamlining the licensing system and allowing nurses to come to Texas to work without the necessity of multiple state licenses. This ability, coupled with telehealth capabilities, will further help Texas address the nursing workforce shortage. NLC will support nursing's continued engagement in telehealth which encompasses telemedicine, telemonitoring, and telenursing. A burgeoning industry, many may not realize that nurses, especially those who work in mental health or criminal justice, already utilize telehealth.

TNA Position
Texas should adopt the new NLC to avoid unnecessary barriers to practice. New market participants lower costs and increase access to care.

Legislative History
HB 1342 (1999)
- The original bill which authorized Texas to adopt the national Nurse Licensure Compact.
State Action Immunity

**Issue Background**
A recent Supreme Court case made waves across the country, and the Sunset Commission will undoubtedly consider the issue during agency reviews. In North Carolina State Board of Dental Examiners v. Federal Trade Commission, 135 S. Ct, 1101; 574 U.S. ____ (2015), the Supreme Court held that an agency violated the Sherman Antitrust Act by restricting the trade of competing professions. The ruling imposes harsh requirements on agencies seeking state immunity from suit, which could infringe on licensing boards’ rulemaking processes.

**Why It Matters to Texas Nurses**
During the Sunset process, the Legislature may try to address this issue. Any attempt to require that public members make up a majority of an agency board, to create legislative or Attorney General oversight, or to create a new oversight agency would create a bottleneck in the rulemaking process and hamper an agency’s ability to quickly respond to new issues.

**TNA Position**
The Texas Nurses Association urges the Sunset Commission and the Legislature to carefully consider the consequences, both intended and unintended, of changing the rulemaking process in Texas. Changes to the process to artificially create immunity from suit for regulatory agencies will likely not only result in a rulemaking bottleneck, but will also prevent legal recourse for consumers against anti-competitive actions taken by an agency. Texans and the regulated community have the right to challenge their government in a court of law if their industry is unduly restricted by market participants, and TNA recommends continuing to allow this fundamental right of recourse.

APRN Issues

**Issue Background**
As discussed in the section devoted to advanced practice registered nurses (APRNs), TNA supports full practice authority for all APRNs in Texas. Allowing APRNs to practice to the full extent of their education will provide much-needed access to care across the state as well as tremendous economic benefits.

**Why It Matters to Texas Nurses**
In Texas, diagnosing and prescribing are considered “delegated” functions from the physician to the APRN, so both the Texas Medical Board (TMB) and Board of Nursing (BON) currently provide oversight for APRN practice. However, APRNs practice nursing, not medicine.

There are several nonphysician health care professionals who competently diagnose conditions and determine treatment, including prescribing medications without TMB oversight (e.g. podiatrists and optometrists). This same model should be adopted for APRNs. Dual oversight is duplicative and wasteful. Additionally, eliminating dual oversight will ensure that Texas adheres to Supreme Court precedent regarding anticompetitive behavior by competing market participants.

**TNA Position**
The Board of Nursing must have sole regulatory authority over APRNs in Texas to reduce duplication of state resources and anti-competitive practices.
Board of Nursing
Just Culture

Issue Background
The Board of Nursing (BON) receives over 10,000 complaints per year for the almost 400,000 APRNs, RNs, and LVNs in Texas, with only 19% resulting in discipline to the licensee. As a result of the last BON Sunset review in 2007, the Board began to introduce an approach known as “Just Culture.” The approach is designed to balance the need for a non-punitive learning environment that encourages the reporting of errors with the need to hold licensees accountable for their actions. The Just Culture approach attempts to take the context of each individual situation into account rather than instituting across-the-board penalties regardless of circumstances.

Why It Matters to Texas Nurses
The right to a fair disciplinary process should be weighed equitably with duty of the Board to protect the public from bad actors. The system for investigating and enforcing disciplinary rules with the BON should fairly hold nurses accountable for their actions. However, the BON should also consider systemic factors that contribute to nurse errors.

TNA Position
Inevitably, the Sunset Commission will look at the disciplinary process of the BON during its Sunset review. The Texas Nurses Association supports the BON’s Just Culture approach to disciplinary action and would like to see the approach expanded and implemented in all cases where context and disciplinary history allow. Part of the BON’s Just Culture should also allow for a licensee’s record to remain clear when deferred actions are successfully completed, and TNA would like to see this approach incorporated into the Just Culture at the BON.
Excelsior College

Issue Background
This legislative session, the Sunset Commission must recommend either continuation or expiration of a grandfather clause that recognizes a single nursing school operating out of New York, Excelsior College. Excelsior’s nursing program is unique in that it provides no supervised clinical learning experiences during the course of instruction. (Texas schools of nursing offering associate nursing degrees average 651 supervised hours of hands-on clinical practice according to a 2014 Board of Nursing survey). Excelsior has failed to achieve Texas standards and does not meet statutory requirements for continuation.

Why It Matters to Texas Nurses
Occupations Code Section 301.157(d)(8)-(d)(11) will expire on Dec. 31, 2017, unless reauthorized this session. The section allows graduates of professional prelicensure nursing programs that do not meet Texas standards to sit for the NCLEX-RN licensure exam, provided that the program remains in good standing with the Board of Nursing, and provided that the program participates in a research study.

Excelsior College is the only such program in the United States, and the school has consistently not met Texas standards for nursing education. According to the BON, Excelsior pass rates on the NCLEX-RN average 74% — far below the required 80% for Texas schools. Although mandated by HB 3961 (2009), Excelsior College has not participated in the research study required by Section 105.008, Health and Safety Code. The BON does not have jurisdiction to penalize Excelsior College because they operate out of New York.

If Texas were able to regulate Excelsior as it does Texas programs, the program would be subject to notice and extensive review to ensure that the program prepares its graduates as competent practitioners able to achieve licensure and enter into practice.

TNA Position
The Texas Legislature should sunset the grandfather clause that allows Excelsior College, an out-of-state online program, to operate without adhering to nursing education standards in Texas.

Legislative History
HB 3961 (2009)
- Amended the Nursing Practice Act by adding Section 301.157(d)(8)-(11) and Section 105.008 to the Health and Safety Code.
- Under the added sections, the BON continues to recognize graduates of Excelsior until December 2017 while the study under 105.008, H&S Code was conducted, as long as the program didn't change its curriculum and remained in good standing with the Board of Nursing. The study was not conducted.

HB 2426 (2007)
- BON Sunset bill - one of the recommendations was to streamline approval for education programs.
- The BON considered requiring clinical hours prior to licensure, which would have negatively impacted Excelsior, because it offers nursing programs without supervised clinical experiences.

651 Average number of supervised hours of hands-on clinical practice offered by Texas schools of nursing (associate nursing degrees)
Mental Health

The Legislative Budget Board estimates that the 2016-2017 General Appropriations Act allocates $3.6 billion to behavioral health (mental health and substance use) services. Funds are distributed among eighteen agencies that handle facets of behavioral health services.

According to the Texas Board of Nursing (BON), the state had 286,442 registered nurses in 2015. In a voluntary re-licensure survey regarding area of practice, only 7,517 registered nurses reported working in behavioral health practice settings, 545 of whom are advanced practice registered nurses.

The reality of our behavioral health care system is harsh. Individuals with serious mental illness have a mortality rate that is two to three times higher than the general population and a 13 to 30 year shorter life expectancy.1 Because beds in appropriate facilities are often unavailable, individuals struggling with mental illness or substance use receive care in emergency rooms and general inpatient facilities. In practice, every Texas nurse cares for individuals with behavioral health issues.

The limited nursing workforce dedicated to behavioral health services is of particular concern when considering projections from the Texas Center for Nursing Workforce Studies regarding the nursing shortage. A recent supply/demand study predicts that the nursing shortage in Texas will quadruple by 2030, leaving us more than 60,000 nurses short of demand.2 Access to appropriate behavioral health services for Texas citizens will be severely impaired without an adequate nursing workforce. Access is of particular concern for military veterans who often present with unique behavioral health needs as they return to civilian life.

The Texas Nurses Association urges the Legislature to consider how changes to the behavioral health system will affect the health care workforce. TNA has identified five key areas that affect nurses practicing in mental health.

Because of the state of health care today, realistically every nurse in Texas is a mental health nurse.
Safe Workplace

Issue Background
Currently, it is a felony to commit an act of violence against any emergency department (ED) health care worker. While this protection is important for nurses and all ED workers, violence also occurs in health care environments outside of EDs, such as psychiatric/mental health service settings. Many factors contribute to such violence — e.g. number, experience, and training of staff; environmental factors; and individual patient characteristics. Nurses who experience violence in the workplace are often seriously affected by the emotional trauma — some are unable to return to the workplace.

State psychiatric hospitals and community mental health centers currently cannot prohibit open or concealed carry of firearms. State hospitals, because they are not required to have state licensure, do not fall under the same exception that licensed hospitals have allowing them to prohibit the carrying of weapons onsite.

What it Means For Texas
Between 1993 and 1999, the annual, non-fatal, job-related violent crime rate was 12.6 per 1,000 workers across all occupations. Among physicians and nurses, the rates were 16.2 and 21.9, respectively. Moreover, for mental health professionals, including nurses, the workplace violence rate was an astounding 68.2 per 1,000.3

Although Texas hospitals have no centralized reporting requirement for staff injuries, data are publically reported and aggregated for state psychiatric hospitals. According to the State Hospital Section 2016 Management Plan by Department of State Health Services, there were 2,367 staff injuries in 2015.4 Of these, 536 (more than one in five) occurred as a result of patient aggression.

Staff injuries in mental health facilities occur despite extensive training. Not only does this statistic reflect resources wasted on worker’s compensation and staff replacement, but it also affects the nursing shortage in Texas. Low staff retention and nurses leaving practice due to the high-risk work environment further exacerbate the already palpable shortage.

TNA Position
TNA is sensitive to the concern that increasing penalties for violence against nurses in all settings could have the unintended consequence of bringing more patients with mental illness into the criminal justice system.

TNA believes that two immediate strategies will promote a safer workplace for nurses working in mental health:

- Support legislation to provide nurses employed in all mental health hospitals the same weapons-free work environment already afforded to nurses in licensed hospitals. Support legislation clarifying that the protections the Legislature granted to licensed hospitals apply to all hospitals in Texas.
- Evaluate the feasibility of creating a statewide reporting system for staff injuries in all mental health facilities. This would help the Legislature and others understand the scope of the violence problem.

Legislative History
HB 2696 (2015)
- Requires the Texas Center for Nursing Workforce Studies to conduct a study and publish results of workplace violence against nurses.

HB 910 (2015)
- Allows the open carry of handguns in public places and on property owned or leased by the government by individuals licensed to carry handguns.
- Extends current restrictions on carrying a handgun in licensed hospitals, but does not extend to public mental health facilities.

HB 705 (2013)
- Enhanced protections to nurses and other health care workers who provide care in emergency departments by increasing the penalty for assaults from a Class A misdemeanor to a third degree felony.
Access to Inpatient Care

Issue Background
DSHS currently operates 2,463 beds across 11 state psychiatric hospitals. These beds are categorized by legal status (civil and forensic) as well as age group (child/adolescent, adult, and geriatric). In addition, DSHS has contracts for 456 beds across 13 community settings, resulting in a total in 2015 of 2,919 beds owned or contracted by DSHS in Texas. In 2014, there was a latent or unmet need of 1,376 beds for indigent mental health patients. By 2024, the unmet need will grow to 1,849 beds.

The public sector is serving higher numbers of individuals on criminal commitment (forensic commitments). These individuals require more resources due to elevated levels of supervision and care. As beds are converted to serve individuals on a criminal commitment, fewer beds are available for civil commitments and voluntary admissions. In fact, in 2015 waiting lists at state hospitals included 1,668 persons for forensic-use beds, with an average length of wait time of 102 days for admission into a maximum security unit.

What it Means For Texas
Health care providers, including nurses, are regularly confronted with indigent patients needing inpatient services while resources are unavailable. Patients are sent back to community settings that cannot meet acute needs, resulting in further decompensation — the gradual or sudden decrease in a person’s ability to function due to the re-emergence of psychiatric symptoms — and ultimately, admission in the emergency room. Unnecessary emergency stays are expensive, and they strain nurses and other staff trying to meet the needs of patients with life-threatening medical conditions. Additionally, they make it difficult for staff to maintain a safe environment.

Additional challenges arise in mental health community-service settings. With few resources available for acute conditions, one of two things happens: staff resources intended for existing patients are re-allocated disproportionately to patients with acute symptoms; or, even more unfortunately, the patient with acute conditions must decompensate further until their behavior results in arrest or commitment.

TNA Position
The Texas Nurses Association encourages the Legislature to strengthen language in the Mental Health Code that will facilitate civil commitment of individuals judged to be a danger to self or others. Individuals should not have to severely decompensate or commit a crime to access an inpatient bed. The Legislature should also explore ways to provide mental health services via telemonitoring, telenursing, and telehealth capabilities across all patient settings.
Mental Health Funding

**Issue Background**
In the last legislative session, $3.6 billion was appropriated for mental health services through state agencies and local mental health authorities. Additionally, Article IX, Sec. 10.04, called for the creation of a Statewide Behavioral Health Strategic Plan to coordinate behavioral and mental health services across agencies and delivery methods. The Legislature changed Article IX to: 1) address deficits in funding for mental health services, and 2) promote coordination to improve mental health services.

Although the Legislature passed SB 239 in 2015, providing loan repayment for certain mental health professionals as an incentive to work in the field, the demand for nurses in all settings is outpacing supply. 2016 data from DSHS shows the nursing shortage will more than quadruple by 2030. While SB 239 was an important first step, the Legislature needs to do more to ensure reliable access to quality mental and behavioral health care.

**What it Means For Texas**
When the system is more efficient and effective, nurses can provide better care to those who need it in the most appropriate settings, and innovation in care service to patients can be better utilized.

**TNA Position**
TNA strongly encourages the Legislature to fund programs that will reduce the nursing shortage in Texas. TNA also supports funding increases for community-based mental health services to decrease wait lists and unnecessary referrals, in addition to the need for an increase in Medicaid reimbursement rates for mental health providers. Finally, the Legislature should explore mutually-funded partnerships with the Department of Veterans Affairs to provide community support, including the Veteran Services Provider Network (VSPN) and programs offered through TexVet.

**Legislative History**

**SB 200 (2015)**
- Prior to SB 200, DSHS operated state hospitals and administered funding for community-based mental health services. Meanwhile, the Department of Aging and Disability Services (DADS) operated state supported living centers (formerly known as special schools and then state schools) and administered state funding for community-based programs for people with intellectual and developmental disabilities.

- SB 200, the Health and Human Services Commission (HHSC) sunset bill, consolidated many health-related agencies under the umbrella of HHSC. The HHSC will absorb substantial parts of the Department of Assistive & Rehabilitative Services (DARS) and DADS. DSHS will continue operating with a narrower scope, focusing on public health functions. This should be completed by Sept. 1, 2017.

**SB 239 (2015)**
- Established a loan repayment assistance program for certain mental health professionals within the Texas Higher Education Coordinating Board with an appropriation rider of just over $2 million.

The demand for nurses in all settings is outpacing supply. 2016 data from DSHS shows the nursing shortage will more than quadruple by 2030.
Texas Peer Assistance Program for Nurses

Issue Background
Mental illness is pervasive, affecting about one in five Americans. Substance use disorder affects about 8.5% of the population nationwide and around 6% of the population in Texas. That means 1.6 million Texans suffer from the disorder, and many more are impacted because the person suffering is a family member or coworker. Prevalence of substance use among health care professionals is similar to that of the general population and is where peer assistance programs have proven efficacy. If left unaddressed, such problems can have dramatic consequences.

For almost 30 years, the BON has contracted with the Texas Peer Assistance Program for Nurses (TPAPN) to provide peer assistance to Texas nurses suffering from substance use disorders and mental health issues. TPAPN is funded by nurse licensure fees — no general revenue is implicated in the funding and operation of TPAPN.

What it Means For Texas
TPAPN provides a non-punitive, voluntary alternative for nurses who seek recovery from substance use or mental health issues. Participants are supported and monitored by professional case managers throughout their recovery. TPAPN facilitates assessment and treatment, offers case management and peer support services, and coordinates closely with the BON.

Nurses may participate in four ways: (1) they may enter the program voluntarily, (2) a third party (usually an employer) may refer them, (3) the BON may refer them to defer disciplinary action pending successful completion, or (4) the BON may order the participant to the program. Licensed case managers regularly monitor participants, and volunteer peer nurse advocates work with participants to encourage success. For nurses with substance use disorders, this monitoring includes random drug screens. The program lasts three years for Registered Nurses and Licensed Vocational Nurses, and five years for Advanced Practice Registered Nurses with substance use disorders.

TNA Position
TNA wants to ensure that TPAPN is able to continue serving the hundreds of nurses per year that participate in the program. The Texas Statewide Behavioral Health Strategic Plan (May 2016) even notes that “use of peer services” is a key gap in mental health service to Texans, and Texas should increase access to programs (like TPAPN) that offer peer support services. TNA recommends that the Texas Legislature, through the sunset review process, continue its 30-year span of support for TPAPN and allow the program to continue helping the nurses that serve patients across Texas.

Historical Background
The Texas Peer Assistance Program for Nurses was founded in 1987 as a program of the Texas Nurses Foundation under Texas Health & Safety Code, Chapter 467. A voluntary program that has operated successfully for the last 30 years, TPAPN facilitates assessment and treatment, offers case management and peer support services, and coordinates closely with the BON.

TPAPN supervises participants’ return to safe practice. Case managers negotiate the application of graduated safety parameters with the employer so participants can demonstrate their ability to practice safely before completing from the program. Completion rates are comparable to similar health care-professional peer assistance programs (approximately 75%).
Workplace Advocacy
Workplace Advocacy

The practice environment for nurses has a major effect on the ability of nurses to do their job and achieve positive patient outcomes. Nurses care for individuals during their most vulnerable moments — during times of great joy and great sorrow, triumph over adversity, and life-changing tragedies. As the care providers who spend the most time with the patient, nurses advocate for their patients to ensure that safety comes first, that the right care is provided at the right time, and that patient wishes are respected. When nurses are supported in doing what they do best, patients benefit.

The nursing role has a cost. Nurses who “rock the boat” have faced retaliation for patient advocacy activities. Nurses work long hours and are often asked to work overtime or extra shifts which can increase their risk for fatigue and related consequences. And, perhaps surprising to most, nurses are at great risk for on the job injury.

In its September 2013 publication, “Facts About Hospital Worker Safety,” the Occupational Safety and Health Administration (OSHA) noted that although the health care industry endeavors to reduce injuries in the workplace, the number of injuries in the U.S. resulting in time away from work is higher for the health care industry than the construction and manufacturing industries combined. In 2015, OSHA noted that of the almost 25,000 workplace assaults between 2011 and 2013, around 70 percent occurred in health care and social service settings.¹

The Texas Nurses Association has long advocated for safe and positive practice environments for nurses and has enjoyed a positive partnership with the Texas Hospital Association on such issues. Texas leads the nation in this area with statutes such as nursing peer review, safe nurse staffing, safe patient handling, prohibitions on mandatory overtime, and patient advocacy protections.

The nursing shortage mandates that Texas continue to take care of its nurses so that they stay in the workforce to take care of its citizens. We must ensure that nurses are able to practice in environments that promote their safety — from injuries due to violence and other causes — and support their patient advocacy efforts so that patients are given the best care possible.
Workplace Violence

Issue Background
Workplace violence is a pervasive issue in the health care industry and has been for many years. The Bureau of Labor Statistics data show that the majority of injuries from assaults at work that required days away from work occurred in health care and social services settings. Specifically, of the almost 25,000 workplace assaults that occurred nationwide between 2011 and 2013, around 70% occurred in these settings. In fact, health care workers are statistically over three times as likely to suffer from an assault injury forcing days away from work than any other private sector job. Often, nurses are victims of patient violence that could have been prevented if proper safety measures were in place.

What It Means For Texas
Obviously, workplace violence has a broad and negative effect on the nurse practice environment. Violence affects not only the person assaulted but bystanders as well. Nurses who experience workplace violence often experience post-traumatic disorders, and many are unable to return to the same work environment; some leave the profession altogether. Texas must adopt policies to reduce the likelihood of violence in health care work environments.

TNA Position
There are opportunities to improve workplace safety for nurses and other health care workers in Texas. HB 2696 (2015) authorized a statewide study to gather Texas-specific data regarding the extent of violence against nurses in the workplace. Data gathered from the study will assist Texas in preventing workplace violence, protecting our health care workforce, and providing safe environments for patients.

TNA urges the Legislature to favorably consider legislation that support efforts of health care facilities to identify and implement measures aimed at reducing violence and enhancing workplace protections for nurses and other health care workers.

Legislative History
HB 2696 (2015)
- Authorizes the Texas Center for Nursing Workforce Studies to conduct a study and publish results on workplace violence against nurses.

HB 705 (2013)
- Enhanced the penalty for assault against emergency services personnel from a Class A misdemeanor to a third-degree felony.

SB 718 (2009)
- Required hospitals to adopt policies and procedures to improve workplace safety, reduce the risk of injury, reduce violence, and reduce fatigue.
- Established prompt reporting requirements for violent acts towards nurses.
Fatigue

Issue Background
The link between nurse fatigue and patient safety was stressed in the 2004 Institute of Medicine Report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Extended work shifts and inadequate rest periods result in increased nurse errors, which affect patient care\(^6\) as well as increased health problems among nurses.\(^6\) The environment is challenging — most nurses work 12-hour shifts, and when units are short staffed, nurses are asked to extend hours or add additional shifts. Critical care areas also often place off-duty nurses “on-call” so that they can be available when patient demands are urgent. Additionally, because patients need around-the-clock care, nurses work multiple shifts, which plays havoc with their natural biorhythms. Nurses are often not aware of the effect fatigue may have on their performance.

What It Means For Texas
The nursing shortage in Texas will continue to pressure nurses to work extended and additional hours. Nurses need to become more aware of the risks associated with fatigue and their responsibility for fitness for duty. Likewise, employers need to acknowledge the inherent risks of extended and additional work hours on nurse fatigue and patient care. Employers should collaborate with nurses to develop staffing and scheduling practices that prevent and mitigate fatigue.

TNA Position
TNA firmly believes that nurses and employers must collaborate to reduce the risks of nurse fatigue associated with shift work and long hours. Employers should implement strategies to proactively address nurse fatigue by utilizing staff committees effectively and implementing innovative solutions. Promoting the health, safety, and wellness of nurses ensures optimal patient outcomes.\(^7\)

In 2016 TNA adopted a Resolution on Fatigue that encourages educational efforts, including targeted continuing nursing education and media campaigns to build greater awareness of this issue. TNA urges all nurses to be aware of their professional responsibility to practice healthy behaviors that reduce the risk of working while fatigued.

Legislative History
**SB 476 (2009)**
- Established a joint process for nurses and hospital management to make decisions about nurse staffing.
- Established reporting requirements to the Department of State Health Services.
- Required Staffing Committees with at least 60% direct care staff membership.
- Required increased Board of Trustee involvement and approval of a nurse staffing plan recommended by the Staffing Effectiveness Committees.
- Prohibited mandatory overtime or repercussions regarding refusal of mandatory overtime.

**SB 718 (2003)**
- Required hospitals to adopt policies and procedures to improve workplace safety, reduce the risk of injury, reduce violence, and reduce fatigue.
- Established prompt reporting requirements for violent acts towards nurses.
Safe Staffing

Issue Background
Safe staffing, in hospitals particularly, has been a hot topic nationally. While all would agree that adequate nurse staffing is desirable and necessary for safe and effective patient care, the approach to achieve adequate staffing is hotly contested. Unions, notably National Nurses United, have strongly advocated for strict uniform nurse to patient ratios to achieve adequate staffing (such as were implemented in California in 2004). Other states (including Texas) have adopted statutes requiring hospital based staffing committees — made up of direct care nurses — to determine the appropriate staffing patterns (ratios) for that hospital. Such committees consider the number and unique characteristics of nurses and patients as well as the environment in which care is provided when determining appropriate staffing levels.8

What It Means For Texas
Fifteen years of research consistently demonstrates the positive relationship of adequate nurse staffing and patient outcomes. In hospitals with high patient-to-nurse ratios, patients experience higher mortality and failure-to-rescue rates, and nurses are more likely to experience burnout and job dissatisfaction.9 Implementation of safe staffing protocols deters workplace fatigue, provides a safer working environment, allows nurses to provide optimal patient care, and improves overall quality of life for nurses. Further, nurse staffing committees involve nurses in decisions about their practice. Studies show that when nurses are included in staffing decisions they are more engaged, and hospitals benefit from their experience in the field, leading to reduced injuries and increased patient satisfaction.10

TNA Position
TNA firmly believes in a staffing model in which nurses are empowered to actively participate in determining nurse staffing plans specific to each unit within their work setting. This approach adapts staffing to local needs considering factors unique to the facility (e.g. intensity of patient care, patterns of admission/discharge/transfer of patients, nursing staff experience, unit layout, and resource availability).

TNA believes that mandated fixed nurse-to-patient ratios offer an inadequate and simplistic approach to a complex situation. Instead, TNA continues to advocate for full implementation of existing statute which requires hospital employers to utilize nurse staffing committees to develop staffing plans and report this work to their Board of Directors. Staffing plans should be a collaborative process with direct care nurses, incorporating particular characteristics of the patients, nurses, work environment, and patient acuity demands as well as support a culture of safety.

Legislative History
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End Notes

Advanced Practice Registered Nurses (APRNs)

3. For family and general physicians, wages rose by 5.73% per year in full-practice states and 5.11% per year in restrictive-practice states. For general pediatricians, wages rose by 5.61% per year in full-practice states and 4.34% per year in restrictive-practice states. For surgeons, wages rose by 6.39% per year in full-practice states and 5.61% per year in restrictive-practice states.
6. Arthur Garson, “Texas will need 10,000 new physicians over the next 10 years: True or false,” Houston Chronicle (November 2011).
8. Buerhaus et.al. “Practice characteristics of primary care nurse practitioners and physicians.” Nursing Outlook, 2015. 63, 144-153 [Stating that Nurse Practitioners with full practice authority are more likely to provide key primary care services in rural areas, in a wider range of community settings, and with more Medicaid patients.]
11. Stange K. How does provider supply and regulation influence health care markets?
19. Collaboration in Practice: Implementing Team-Based Care. The American College of Obstetricians and Gynecologists, Vol. 127, No. 3, March 2016. [Supported & endorsed by the American College of Physicians, the Institute for Healthcare Improvement and the Institute for Patient- and Family-Centered Care, among almost 20 more national health care groups]

Nursing Education

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3. Daugherty, Lindsay, Charles A. Goldman, Lindsay Butterfield and Trey Miller. Assessing the Potential to Expand Community College


5. 2015 Nursing Faculty Vacancy data provided by TCNWS

**Board of Nursing and Regulatory Issues**

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**Mental Health**

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4. Health and Human Services, Department of State Health Services, State Hospital Section. 2016 Management Plan, First Quarter 2016. PDF file pg. 240.
5. Texas Department of State Health Services. Analysis for the ten-year plan for the provision of services to persons served by state psychiatric hospitals (SPHs). Developed for DSHS Rider 83 RFP No. 529-14-0066, 2014.
10. Texas Statewide Behavioral Health Strategic Plan, Statewide Behavioral Health Coordinating Council, May 2016

**Workplace Advocacy**

3. OSHA Guidelines at 2.
4. Id.
5. Geiger-Brown et al., 2012; Landrigan et al., 2004; Lockley et al., 2007; Scott, Arslanian-Engoren & Engoren, 2014; Scott, Rogers, Hwang & Zhang, 2006; Trinkoff et al., 2011.

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