The Institute of Medicine of the National Academies (IOM) announced on October 5 the availability of a long-awaited, new report: The Future of Nursing – Leading Change, Advancing Health. The announcement was made at a public briefing/press conference held in Washington, D.C., and also heard by more than an estimated 2300 others via telephone briefing and live webcast. The 500-page plus report of evidence-based findings and recommendations culminates the two-year Initiative on the Future of Nursing, a collaboration of the IOM and Robert Wood Johnson Foundation (RWJF).

Six of the report’s authoring members from the Committee on the RWJF Initiative on the Future of Nursing, at the IOM, served as panelists during the press conference. They addressed key points and took questions. They were: Donna Shalala, PhD, FAAN, committee chairman, and president, University of Miami, Miami, Fla.; Linda Burns Bolton, PhD, RN, committee vice chairman, and vice president of nursing, Cedars-Sinai Medical Center, Los Angeles, Calif.; William Novelli, MA, former chief executive officer, AARP, Washington, D.C.; Rosa Gonzalez-Guarda, PhD, MSN, MPH, RN, assistant professor, School of Nursing and Health Studies, University of Miami, Miami, Fla.; John Rowe, MD, professor, Department of Health Policy and Management, Columbia University Mailman School of Public Health, New York City; and Catherine Dower, JD, associate director, Health Law and Policy, Center for Health Professions, University of San Francisco, San Francisco, Calif.

Not all – in fact, not most – of the Committee members are nurses. Yet it was widely recognized that “nurses are central to the core goals of the report.” Noted Burns Bolton, “It is not a report about nursing rather it is, how do we take the largest health care workforce and provide it with enhanced capacity to improve access (to care) and deliver the type of care people want?” It speaks to the American people, she said.

Early on, in his introduction of this landmark report, Harvey Fineberg, MD, PhD, president of the IOM, stated that “passage of the Affordable Care Act earlier this year represents the most profound opportunity for change in health care and nurses are one critical factor.” He called it a “time to take stock; a time to look ahead.”

Join the Texas Nurses Association Today!

Application on page 18.
Texas Nurses Association Districts and Presidents

Presidents of the 28 state-wide Districts of Texas Nurses Association, as well as some District offices, are listed below. They invite you to contact them with questions or comments about TNA District membership and involvement.

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Texas Supreme Court has adopted a uniform definition of “good faith” for whistle-blower cases that does not involve motive but is instead based upon having an honest and reasonable belief.

- TNA’s nurse advocacy legislation for 2011 will propose making “good faith” – as defined by the Texas Supreme Court – the standard for all protected reporting.

When two nurses in Winkler County, Texas, were fired from their hospital jobs and charged with a criminal offense for reporting a physician to the Texas Medical Board – a protected patient advocacy activity – the nursing community was outraged. Many asked, how could this happen? To lessen the chances it could happen again, TNA will propose in the 2011 Texas Legislative Session nurse advocacy legislation for addressing issues raised by the “Winkler County nurses” case.

Lessons Learned From the Winkler County Case

In a bizarre twist of the law, Anne Mitchell, RN and Vicki Galle, RN were arrested and criminally charged with “misuse of official information” when they disclosed patient medical record numbers to the Texas Medical Board in a complaint about patient care concerns. Few probably would have imagined that nurses would need protections from criminal liability for patient advocacy activities; but this case illustrates that even the unthinkable is possible.

- TNA’s nurse advocacy legislation for 2011 would extend liability immunity for required or permitted reporting to include immunity from criminal liability.

After Mitchell and Galle made their complaint, the hospital fired them. TNA believed this action to be an illegal retaliatory action for making a report to the Texas Medical Board (TMB) and reported the hospital to its licensing agency, the Texas Department of State Health Services (DSHS). DSHS substantiated the complaint and imposed on the hospital the maximum fine allowed – $650 per nurse! Clearly, the fine needs to be large enough to be a deterrent.

- TNA’s nurse advocacy legislation for 2011 would give licensing agencies the authority to impose significant fines ($25,000) for retaliation against a nurse who engages in protected patient advocacy activities.

In the “Winkler County nurses” criminal trial, the prosecutor based his argument on the belief that Mitchell and Galle acted “with malice” when they made their report to the Texas Medical Board. Currently, both “good faith” and “without malice” are used as a standard for protected reporting by nurses. The Texas Supreme Court has adopted a uniform definition of “good faith” for whistle-blower cases that does not involve motive but is instead based upon having an honest and reasonable belief.

- TNA’s nurse advocacy legislation for 2011 will propose making “good faith” – as defined by the Texas Supreme Court – the standard for all protected reporting.

In defending himself against Mitchell and Galle’s subsequent federal civil lawsuit, the physician who was reported asserted that because he did not employ the nurses, he could

Nurse Advocacy Legislation continued on page 8
New Staffing Rules Implementing the Hospital Safe Staffing Law!

by Cindy Zolnierek, PhD(c), MSN, RN, Director of Practice, Texas Nurses Association

When a new law is passed, existing regulations often require updating for consistency with the new legislation. So it is with the Hospital Safe Staffing Law which passed the 81st Texas Legislature in 2009 and became effective September 1 of that year.

Since 2002, Texas has had nurse staffing regulations in its hospital licensing rules (Title 25, Texas Administrative Code, Chapters 133 & 134) that required hospitals to have staffing plans and nurse staffing advisory committees. In addition, hospitals were required to ensure that nurses were oriented to all units to which they are assigned and that assignments were congruent with documented competency. Finally, if mandatory overtime (OT) was used as a means for meeting staffing needs, the hospital was required to justify the use of mandatory OT and have a plan of action to reduce or eliminate it.

The Hospital Safe Staffing Law (SB 476) changed the status and function of what had been an advisory staffing committee in the rules. Although no changes were made to orientation and competency requirements, the law now prohibits the use of mandatory overtime. These changes created a need to update the existing hospital licensing rules to be consistent with the new legislation.

Rule Promulgation Process

Legislation is passed.

† Responsible agency (DSHS) drafts proposed rules to implement new law.

† Proposed rules are presented to agency council for publication approval; if approved.

† Proposed rules are published in the Texas Register for a public comment period of 30 days.

† Agency prepares responses to public comment and revises proposed rules as necessary.

† Proposed rules are presented to Executive Commissioner for approval; if approved.

† Final rules are published in Texas Register.

Recommended rule changes

A summary of TNA/THA recommended changes to the rules is provided below (new rule language is underlined; new rule language offered by TNA/THA is also italicized and bolded).

1. Amend §133.41(o)(2)(E) by adding a sentence so that it reads:

The nursing staff shall develop and keep current a nursing plan for each patient which addresses the patient’s needs. The nurse shall accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse’s educational preparation, experience, knowledge, and physical and emotional ability.

Rationale: This change is consistent with Standards of Nursing Practice (Board of Nursing Rule 21T311(1)(T)) relating to the duty of nurses to accept only those assignments for which they are fit for duty. This duty applies regardless of whether the staffing plan permits the nurse to accept the assignment or whether the assignment would be permitted overtime. A nurse may invoke safe harbor nursing peer review if the nurse questions the safety of an assignment.

EXAMPLE: Recommended Rule Change #2

Hospital ABC is a small hospital that operates four OR suites from 0700-1600 Monday – Friday. A rotating on-call team covers off-hour and weekend emergencies. Due to hospital size and number of OR staff, the hospital is unable to guarantee that on-call staff have a day off following an on-call shift, even if the on-call staff have to come in and work much of the night. The hospital's staffing committee developed a plan to call in staff for voluntary overtime to cover staff who may be fatigued from working on-call.

2. Amend §133.41(o)(2)(GI)(ii)(II) by adding a phrase so that it reads:

(The staffing plan shall)

Include a method of adjusting the staffing plan shift to shift for each patient care unit based on factors, such as, the intensity of patient care and time off for nurses who have worked extended hours within a certain period of time at that facility, to provide staffing flexibility to meet patient needs.

Rationale: One of the questions that hospitals and nurses have asked is how hospitals should address the situation when a nurse has worked extended hours within a given time period. This has been
a difficult question to answer because of the number and variety of situations that can occur. The suggested change does not mandate how specific situations should be handled, but instead requires that the staffing plan address the issue. This will permit individual hospitals and the nurses at those hospitals the flexibility to address the issue in the manner that works best for the facility:

**EXAMPLE: Recommended Rule Change #3**

Census fluctuations and existing position vacancies in the ICU at Hospital XYZ has challenged the hospital's ability to maintain planned nurse to patient staffing levels. Until vacant positions were filled, the Nurse Staffing Committee decided to implement on-call for ICU nurses such that each nurse would be required to sign-up for one on-call shift in addition to regularly scheduled shifts. On-call nurses would only be required to come in to work if needed, as determined by the charge nurse. Nurses would be paid for their on-call time and receive time-and-one-half if required to come in. The Nurse Staffing Committee planned to solicit feedback from ICU staff regarding the new on-call system and monitor indicators related to adequacy of staffing and nurse satisfaction to evaluate the effectiveness of the on-call system.

3. Add a new subdivision §133.41(o)(92)(G)(iii)(IV) that reads:

   (The staffing plan shall):

   **Include how on-call time will be utilized in meeting staffing needs and the process to be used in assigning on-call time.**

   **Rationale:** Hospitals and nurses have questioned how to implement the law's provisions related to mandatory overtime and the use of on-call time. The questions reveal how differently hospitals use on-call time. On-call is too complex of an issue to address with a single mandate that would apply to all hospitals. The suggested change requires that the staffing plan address the use of on-call time. This will permit individual hospitals and the nurses at those hospitals the flexibility to address the issue in the manner that works best for each facility. It will also provide transparency for how on-call is used and what nurses can expect.

4. Amend the definition of “mandatory overtime” in §133.41(o)(3)(Al)by adding a sentence so that it reads:

   “mandatory overtime” means a requirement that a nurse work hours or days that are in addition to the hours or days scheduled, regardless of the length of a scheduled shift or the number of scheduled shifts each week. In determining whether work is mandatory overtime, prescheduled on-call time or time immediately before or after a scheduled shift necessary to document of communicate patient status to ensure patient safety is not included. For the purposes of determining mandatory overtime, work time includes hospital-required attendance at in-service, continuing education, and meetings.

   **Rationale:** Required attendance at in-service, continuing education and meetings should be considered in calculating time worked for mandatory overtime purposes. The suggested change does this by amending the definition of “mandatory overtime” to include required in-service, continuing education, and meetings. Doing so is consistent with how the federal wage and hour law requires such time at such activities to be considered for purposes of overtime pay.

5. Amend §133.41(o)(3)(E)(iv) so that it reads:

   (The prohibitions on mandatory overtime do not apply if):

   The nurse is actively engaged in an ongoing medical or surgical procedure and the continued presence of the nurse through the completion of the procedure is necessary to ensure the health and safety of the patient. Adding elective procedures to the established schedule that require the nurse to stay involuntarily beyond the end of the nurse’s scheduled shift constitutes prohibited mandatory overtime.

   **Rationale:** The proposed change takes into account that, while there may be emergency cases that necessitate requiring a nurse to stay beyond a scheduled shift, adding on elective cases would require an alternate staffing strategy.

6. Add a new Subdivision §133.41(o)(92)(G)(iii)(IV) that reads:

   **Work being permitted mandatory overtime under this Subdivision (3) does not relieve nurses of their duty under Subsection (o)(2)(E) not to accept assignments not commensurate with the nurse’s physical and emotional ability, e.g. because overly fatigued.**

   **Rationale:** Just because a scheduled assignment may be legal (not prohibited mandatory overtime) does not mean it is necessarily safe for the patient or the nurse. The nurse’s first duty is to the patient and that duty requires fitness. If the nurse believes s/he is too fatigued to perform safely, the nurse has an obligation under the Standards of Nursing Practice (Board of Nursing Rule 217.111(1)(T) not to accept the assignment. The nurse may request safe harbor nursing peer review in such a situation in order to maximize individual protections as well as bring the issue forward for problem resolution by the peer review committee.

**Implementation of new hospital licensing rules**

The new rules become effective 20 days after the final rules are posted in the Texas Register. The Hospital Safe Staffing Law became effective one year ago (September 2009). Recommendations to the proposed hospital licensing rules seek to provide further clarification to the law to facilitate compliance, particularly around mandatory overtime and on-call policies. Current information about rules and regulations is available on the DSHS Web site http://www.dshs.state.tx.us.
National Health Care Workforce Commission Appointed: Buerhaus Named Chairman.

As RN spouses lost their jobs or thought they had to leave nursing, the findings revealed the effects of economic downturns on nursing workforce numbers. As RN spouses lost their jobs or thought they might, hospital employment of RNs increased significantly and nurses close to retirement stayed in their positions. ★

Second no later than October 1, 2011. The April report will review current and projected health care workforce supply and demand and include at a minimum one high priority area of topics:

1. Integrated health care workforce planning that identifies health care professional skills needed and maximizes them across disciplines.
2. Workforce demands for the enhanced information technology and management workforce.
3. Analysis of how to align Medicare and Medicaid graduate medical education policies with national workforce goals.
4. Education and training capacity, projected demands and integration of professionals in nursing, oral health care, mental and behavioral health care, allied and public health care, emergency medicine, and the geographic distribution of providers as compared to state and regional needs.

The report due no later than October 1 of each year is to contain results of reviews and recommendations on specific topics, such as:

1. Current workforce supply and distribution with projected demands during the subsequent 10- and 25-year periods.
2. Workforce education and training capacity with projected demands during the subsequent 10- and 25-year periods.
3. Education loan and grant programs.
4. Implications of new and existing federal policies that affect the health care workforce.
5. Workforce needs of special populations, i.e., minorities, rural populations, medically underserved, etc., with recommendations for meeting the needs; and
6. Recommendations creating or revising national loan repayment and scholarship programs to provide all medical students to serve in their home communities.

The Commission

The Patient Protection and Affordable Care Act requires that Commission members are appointed for three-year terms, staggered terms for the first 15 appointees. They are to be individuals with national recognition for expertise in health care labor market analysis who will provide a combination of perspectives, broad geographic representation, and an urban, suburban, rural, and frontier balance.

Dr. Peter Buerhaus, chairman of the Commission, is the Valere Potter Distinguished Professor of Nursing at the Vanderbilt University School of Nursing, and director for the Center for Interdisciplinary Health Workforce Studies for the Institute for Medicine and Public Health at VUMC. He is a renowned nursing economist and researcher who is well known for his research on the nursing shortage, trends in employment and earnings of nurses, implications of the aging nursing workforce, and how changes in health care are affecting patients. His recent research findings revealed the effects of economic downturns on nursing workforce numbers. As RN spouses lost their jobs or thought they might, hospital employment of RNs increased significantly and nurses close to retirement stayed in their positions. ★

The National Health Care Workforce Commission is required to submit two annual reports to Congress and the President. The first annual report is due no later than April 1, 2011; the second no later than October 1, 2011. The April report will review current and projected health care workforce supply and demand and include at a minimum one high priority area of topics:

1. Integrated health care workforce planning that identifies health care professional skills needed and maximizes them across disciplines.
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4. Education and training capacity, projected demands and integration of professionals in nursing, oral health care, mental and behavioral health care, allied and public health care, emergency medicine, and the geographic distribution of providers as compared to state and regional needs.
Nurses have long recognized that their first duty is to the patient. Texas Nurses Association honors that duty and recognizes that everybody benefits when nurses can raise concerns about patient care without fear of retaliation. For over 20 years TNA has successfully engaged the legislative process to win advocacy protections for Texas nurses.

**Protections from Retaliation**

- **1987** Legislated protections from retaliation for nurses who report a licensed health care practitioner or facility to their licensing agency.
- **1995** Legislated protections for nurses who refuse to engage in reportable conduct. That is, it became illegal to retaliate against a nurse who refused to accept an assignment that the nurse believed would violate his/her duty to the patient.
- **1997** Safe harbor nursing peer review legislation was passed. This law strengthened protections established in 1995 by establishing a process of nursing peer review for resolving the question of whether requested conduct (e.g., assignment) may violate the nurse’s duty to the patient. The nurse requesting safe harbor would be protected in two ways:
  1. Retaliation against the nurse for requesting safe harbor would be illegal; and
  2. A nurse may not be disciplined by the Board of Nursing for engaging in the requested conduct (e.g., accepting the assignment).
- **1999** Protections from a negative job reference for nurses who engage in patient advocacy activities such as safe harbor requests.
- **2002** Protections in hospital licensing rules for nurses who raise staffing concerns.
- **2003** Protections for nurses who raise patient care concerns within a facility. All protections extended to LVNs in addition to RNs.
- **2005** Protections established for nurses who report concerns to a regulatory body.
- **2007** Protections extended to nurses who advise nurses on safe harbor nursing peer review; remedies for retaliation clarified.
- **2009** Protections for nurses who raise staffing concerns and who refuse to work prohibited mandatory overtime were legislated.

**What if retaliation occurs for protected activities?**

The Texas Nursing Practice Act sets out the remedies available to nurses who are retaliated against. It authorizes a civil lawsuit for damages (minimum recovery of $5000), attorney fees, and exemplary damages. It also creates a presumption that any disciplinary action taken against a nurse within 60 days of the nurse’s reporting the conduct or raising the patient care concern was taken in retaliation against the nurse. The facility then has the burden of proving otherwise. A nurse also can report the facility or any individual health care practitioner involved in the retaliation to the appropriate licensing agency which may take corrective action such as fines and/or discipline.

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**History of Nurse Advocacy Protections in Texas**

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**Join the discussion:**

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Nurse Advocacy Legislation continued from page 2

not be liable for retaliation under the whistleblower laws. The Texas Nursing Practice Act (NPA) prohibits retaliation against a nurse for engaging in protected patient advocacy activities. However, the terminology is not always consistent and may be read as implying that an employer-employee relationship is necessary for retaliation to occur.

For example, one section of the NPA (§301.412) refers to “retaliatory action,” yet another section (§301.413), reads “suspend, terminate or otherwise discipline or discriminate against.” Certainly, as in the Winkler County case, nurses can be retaliated against by persons or entities other than their employer.

- TNA’s nurse advocacy legislation for 2011 would clarify that the prohibition on retaliation for protected patient advocacy activities applies to any person in a position to retaliate and not only to the nurse’s employer.

  Mitchell and Galle worked for a county (public) hospital. Their federal civil lawsuit against the hospital, prosecutor, sheriff, and others was limited by sovereign immunity — a doctrine that protects the state from lawsuits. Even though nurses employed publicly and privately enjoy the same protections from retaliation for patient advocacy activities (i.e., retaliation is illegal), the remedies available to a nurse differ.

  Currently, publicly-employed nurses who are retaliated against for protected patient advocacy activities can sue for damages only under the Texas Public Employees Whistleblower Act. That law only permits a lawsuit if the retaliation occurs against the nurse for making an external report (e.g., regulatory agency) and not for reporting internally (within the facility). However, the Texas Nursing Practice Act permits privately-employed nurses to file a lawsuit based on retaliation for internal reporting as well as external reporting.

- TNA believes ALL nurses should have the right to file a lawsuit for the injuries suffered because of retaliation for patient advocacy activities. TNA’s nurse advocacy legislation for 2011 would provide for a limited waiver of sovereign immunity when publicly-employed nurses are retaliated against for making a protected report. That is, publicly-employed nurses would have the same right to file a lawsuit for retaliation as privately-employed nurses.

**Public employers of nurses** include county, district, and state hospitals; public schools; the prison system; and state agencies, among others.

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Other enhancements to nurse advocacy protections

Current law protects a nurse who advises another nurse about the nurse’s rights and protections as a patient advocate only when the advising concerns safe harbor nursing peer review.

- TNA’s proposed nurse advocacy legislation for 2011 would extend non-retaliation protections to all situations in which a nurse advises another nurse on the nurse’s right to engage in protected patient advocacy activities.

- Nurse advocacy legislation would clarify that nursing peer review confidentiality and immunity protections apply to Nurse Advocates participating in a nurse advocacy program designed to assist nurses regarding their rights and protections as patient advocates.

**Never again**

Everybody benefits when nurses speak up about patient care concerns, and no nurse should be retaliated against for patient advocacy activities. Lessons learned from the “Winkler County nurses” case have shaped TNA’s nurse advocacy agenda for the 82nd Texas Legislative Session. Look for ongoing updates during the upcoming legislative session in future issues of the Texas Nursing Voice.
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Highlights: 10th Annual Nursing Leadership Conference of Texas Nurses Association
September 23 and 24, 2010
Austin, Texas

Even though health care reform wasn’t exactly the featured topic of this year’s 10th Annual Nursing Leadership Conference of Texas Nurses Association, it certainly was a prominent thread. There was little doubt at the late September conference that nursing – and all of health care – is poised for major, needed change.

Throughout the two full days of the conference, featured speakers and prominent panelists spoke to the possible changes coming. Perhaps it was anticipation of the Institute of Medicine /Robert Wood Johnson Foundation’s October 5 release of the long-awaited report, The Future of Nursing – Leading Change, Advancing Health. Or maybe it was that this year’s featured speakers had been contributors of the evidence that became part of the report. Whatever it was, Leadership Conference attendees - as it turned out - got a glimpse of what was coming in the milestone IOM report, delivered personably and interactively by nursing’s experts.

One of those experts is researcher Linda H. Aiken, PhD, FAAN, FRCN, RN. Considered an authority on effective nurse staffing, Dr. Aiken captivated the audience on the topic of staffing – particularly making sense of the evidence. With nurse staffing being about 40 per cent of a hospital’s operating budget, it was a topic of interest to many. Bottom line: ‘Better work environments are key to getting the most benefit from investing in nurse staffing.’

While nurses and hospitals in Texas await publication of the final, updated nurse staffing rules, hospitals across Texas are already implementing requirements of the Hospital Safe Staffing Law, passed by the 2009 Legislature.
A panel discussion was part of the Conference with nurse leaders from small to large hospitals discussing their own strategies for implementing the Texas approach to safe staffing. (See related story on New Staffing Rules, page 4.)

A second panel discussion explored interprofessional collegiality. Panelists represented the fields of nursing, medicine and pharmacy and in discussion, considered the barriers to and the advantages of interdisciplinary care.

Another popular speaker was Linda Cronenwett, PhD, RN, FAAN, professor in the School of Nursing at the University of North Carolina at Chapel Hill. Personable and engaging, Dr. Cronenwett contrasted the opportunities and challenges for nursing education programs to respond to the demands for advanced practice RNs. There is an urgency for change and plenty of evidence that shows a strong primary care component in a health care system can provide safe, quality, efficient care. The IOM/RWFJ report on the Future of Nursing echoed Cronenwett’s conclusion that “nurses can very capably deliver safe, quality primary care.”

The 2011 Annual Nursing Leadership Conference is scheduled for September 22 and 23 in Austin. The conference attempts every year to provide for attendees meaningful information, unique perspective and inspiration.

Panelists in the Implementing Staffing Legislation (in Texas) discussion are, left to right: Judith Krupala; Jo Rake; Joyce Batcheller; and moderator Cindy Zolnierek.

Dr. Ken Shine (left) moderated a second panel discussion on Models of Care — Interprofessional Collegiality. Joining him as panelists to represent various professions were: Alexia Green, Suzanne Escudier, and William McIlroy.
Nurse practitioners (NP) are registered nurses (RN) educated to diagnose, prescribe and treat a variety of patient populations. The majority of NPs provide primary care, while others care for acutely ill patients. Whether in clinics, hospitals or long-term care facilities, NPs are high-value providers.

In order to practice, NPs must complete a master’s degree, pass a national certification exam, and be licensed by the Board of Nursing (BON) in one of nine NP population focus areas. Primary care NPs provide about 90 percent of the services needed by most people, while improving patient satisfaction and reducing costs by 20 percent. They meet patients’ needs in lower cost settings and improve patient outcomes. NPs have been shown to reduce non-emergency ER visits, hospitalizations and lengths of stay (Woolbert 2009).

Nurse practitioners achieve these results by following evidence-based guidelines, improving patient communication, and encouraging healthy behaviors. You can’t take the ‘nurse’ out of nurse practitioner and as nurses, they emphasize patient education and coordinate care.

Although diagnosing and prescribing are essential components of NP education, Texas law unlike the laws in 35 other states, requires physicians to delegate diagnosis and prescriptive authority. Additionally, NPs in Texas practice with sight-based restrictions and do not have authority. In 41 states and the District of Columbia, NPs are permitted to prescribe Schedule II Controlled Substances (Pearson 2010, Phillips 2010). Clearly, Texas law is far behind the vast majority of states at a time when Texas is facing an unprecedented health care delivery crisis. At least 25 counties in Texas have no physician and 16 counties have only one (Texas Medical Board 2010; Texas Department of Rural Affairs 2010). With an estimated 6 million Texans soon to be covered by health insurance, 2.2 million of them by Medicaid, Texas must change laws now to make health care more accessible.

CHANGE NEEDED: Amend the Texas Nursing Practice Act to grant NPs the authority to diagnose and prescribe. This amendment is consistent with model legislation adopted by the National Council of State Boards of Nursing (NCSBN) and would allow Texas NPs to practice to the full extent of their education, certification and training (Woolbert 2010).

Nurse practitioners are not asking to expand their scope of practice. They are already diagnosing and prescribing safely, and the BON limits NPs to caring only for the population of patients they are educated to serve whether it practice in one of the 16 independent prescriptive authority states or in restrictive states such as Texas. NPs are simply asking to remove restrictive legal barriers that prevent access to health care.

This change is needed now. Texans’ health care needs continue to grow as the population increases, becomes more diverse, and ages. NPs are more likely than MDs to practice in rural areas and with vulnerable populations so they are an important part of the solution to the health care delivery crisis (Hooker 2010).

Texas needs every health care provider practicing to the full extent of their education, certification, and training. Changing Texas law to allow this is Texas Nurse Practitioners’ (TNP) legislative agenda priority. TNP looks forward to partnering with Texas Nurses Association and all other Texas nursing organizations to win this battle to improve health care in Texas.

About the Author
Alison Mitchell, MSN, RN, ACNP is immediate past president of Texas Nurse Practitioners, a state-wide membership organization of nurse practitioners (www.inp.org). She works at the Methodist Hospital in Houston. Educated at Texas Tech University and the University of Texas – Houston, Mitchell received a BSN and MSN respectively. She practices as an inpatient acute care nurse practitioner on the NP Program Medicine service. She “moonlights” as an internal medicine hospitalist and in the Medical Intensive Care Unit.

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Be a Part of Change!

Where there is change – there is opportunity and there has never been a more exciting time to be a nurse in Texas. When you become a member of Texas Nurses Association and Texas Nurse Practitioners, you become part of the change.

TNA and TNP are working together to get your voice heard. TNP, as your specialty organization, provides you a voice on issues directly affecting NP practice – TNA as a generalist organization provides NPs a voice on the broader issues affecting nursing and health care. Both voices are important.

TNA and TNP working together join thousands of Texas nurses in redefining our profession; gaining recognition and professional satisfaction all nurses deserve. If you are currently not a member of TNA or TNP we invite you to join at a special introductory rate. Already a member of one of the organizations – then take advantage of this limited time offer to join the other. You are eligible for a promotional price of membership in both organizations. Become a member of TNA for $89 and/or a member of TNP for $99. To join simply complete the membership application(s) and mail in to the respective organizations before December 31, 2010.

(See Joint TNA/TNP membership application on page 15).

Join your professional organizations and become part of the change that will be impacting nurses for generations.
Diagram of Delegated-Site-Based Prescriptive (Rx) Authority for APRNs in Texas

**STEP 1: TEXAS BOARD OF NURSING REGULATES APRNs**
BON Verifies Education and National Certification & Issues Rx Authority Number to Qualified APRNs

**STEP 2: TEXAS MEDICAL BOARD REGULATES DELEGATING PHYSICIANS**
Is Physician Willing to Delegate Prescriptive Authority and Meet Supervision Requirements from 1 of 4 Categories?

- **Primary Practice**
  - Physician onsite 50.1% of the time or APRN seeing physician's patients in a Licensed Hospital, Long-Term Care Facility, Adult Daycare Facility, Patient's Residence, School-Based Clinic, Patient's Residence, or any place physician is present.
  - Physician onsite 10% with APRN/month.

- **Alternate Practice**
  - Within 75 miles of physician's practice or residence; Services similar to physician's primary site; Physician onsite 10% with APRN/month.

- **Facility-Based Practice**
  - 2 Long-Term Care Facilities or 1 Licensed Hospital.

- **Site Serving Medically Underserved Population (MUP)**
  - Public Health Clinic, Rural Health Clinic, Located in HPSA, Located in MUA, DSHS-determined MUP.

**Supervision**
- Limited to 3 MUP sites
- Onsite 1x every 10 business days
- 10% chart review & co-signs
- Keeps log of onsite activities
- Receives daily report on problems
- Available for emergencies by phone
- Reviews & signs delegation protocol

- **Primary Practice**
  - 10% chart review & co-signs
  - Keeps log of onsite activities
  - Available by phone for referral, consultation or emergencies
  - Reviews & signs delegation protocol

- **Alternate Practice**
  - 10% chart review (electronic or onsite)
  - Keeps log of onsite activities
  - Available by phone for referral, consultation or emergencies
  - Reviews & signs delegation protocol

This diagram demonstrates the complexity of the process for delegated site-based prescriptive authority for APRNs in Texas. It is reprinted with permission of the Coalition for Nurses in Advanced Practice (CNAP).
FREE CNE FOR EVERY NURSE

• Learn to recognize the subtle signs and symptoms associated with ovarian cancer
• Understand the basics of ovarian cancer treatment
• Hear stories presented by ovarian cancer survivors

Ovarian Cancer CNE:
TWO free programs at www.noep.org.

Evidence-Based | Interactive | Earn 2.0 Contact Hours | Printable Certificate

These CNE activities are grant-funded through a Centers for Disease Control (CDC) cooperative agreement number 1U36/DP000024-06.
Texas Nurses Association/Foundation Provider Unit is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.
The Ovarian Cancer Education Program (OCEP) is part of Texas Nurses Association/Foundation Provider Unit.

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Why TNA Direct Membership? For many registered nurses, influencing nursing in Texas where they practice is their main interest. That’s why TNA offers the TNA Direct Membership. TNA Direct, a state-level only TNA option, is a great membership choice for APRNs who are involved in TNP but still want to have an influence on the broader nursing issues in Texas.

TNP members join TNA Direct now and save! From now until December 31, 2010 current members of Texas Nurse Practitioners or nurses who are joining TNA Direct and TNP concurrently can save $10 off their 1st year’s membership. That’s right! Join TNA Direct now for $89.00.

Application for Membership TNA Direct:
Fill out the requested information and mail with payment to Texas Nurses Association, 2600 Burnet Road, Suite 450, Austin, TX 78757-1932 or FAX with credit card information to 512-492-0646. Questions? Call 1-800-862-1022 ext. 129 or email tna@texassnurses.org.

☐ I am currently a member of Texas Nurse Practitioners
☐ I am joining TNP and TNA Direct concurrently

LAST NAME  FIRST NAME  MI
BASIC NURSING EDUCATION:  Associate  Bachelor’s  Master’s
HIGHEST NURSING EDUCATION:  Associate  Bachelor’s  Master’s  Doctorate
CURRENT CREDENTIALS (eg. RN, MSN, FNP)  BIRTH DATE (mm/dd/yyyy)
HOME ADDRESS
CITY  ST  ZIP  DAY PHONE (home, work, cell – check one)  EVENING PHONE (home, work, cell – check one)
COUNTY OF RESIDENCE  RN LICENSE NUMBER
EMAIL ADDRESS (home, work – check one)
EMPLOYER NAME/CITY
PAYMENT OPTIONS
☐ I’ve enclosed my check made payable to Texas Nurses Association for $89.00
☐ Charge my  ☐ Visa  ☐ MasterCard  ☐ American Express card for $89.00
Print Name on Card:
Card No.   __________   __________   __________   __________  Card Exp. Date _____/____
(Billing Address If Different than above – include street, city, state and zip)

To be completed by TNA:  DATE  /  /  State  District  Exp Date  /  /  Amt. Enclosed  ______ Approved  ______

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TNP MEMBERS
JOIN TNA DIRECT
FOR $89!
Offer ends 12/31/2010

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Help Improve Cancer Education for All Nurses. You Could Win $100!

Complete the needs assessment survey at www.noep.org and be entered into a drawing to win one of twelve $100 cash awards.

ALL nurses and nursing students are eligible to enter the drawing.
Survey answers are anonymous.
Winners will be notified by January 15, 2011.

NOEP is a co-evaluation project of the Texas Nurses Association, Foundation funded by the Cancer Prevention and Research Institute of Texas.

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TNSA Logo

TNSA Logo

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Texas Department of State Health Services

NOEP Logo

Texas Nursing Voice • Page 15
The following individuals recently completed Texas Nurses Association's Nurse Advocacy Certificate Program and were awarded a certificate for demonstrated competence as a facility-based expert in protections for nurses who engage in patient advocacy activities in Texas. Congratulations!

**Congratulations to the Inaugural Class of TNA’s Nurse Advocate Certificate Program!**

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<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Location</th>
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<tbody>
<tr>
<td>Denice Black, MSN, RN, ACNS-BC, CCRN</td>
<td>Texas Health Harris Methodist Southwest</td>
<td>Fort Worth</td>
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<tr>
<td>Shelby Garner, MSN, RN, CNE</td>
<td>Grayson County College</td>
<td>Denison</td>
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<tr>
<td>Sharon Glentzer, BSN, RN, NE-BC</td>
<td>Bellville General Hospital</td>
<td>Bellville</td>
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<tr>
<td>Judy Ong Ho, MSN, APRN, CS</td>
<td>St. Luke’s Episcopal Hospital</td>
<td>Houston</td>
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<tr>
<td>Renee Jones, MSN, RN-C, WHCNP</td>
<td>Texas Health Presbyterian Hospital</td>
<td>Dallas</td>
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<tr>
<td>Geraldine Jones, MS, RN-BC</td>
<td>St. Luke’s Episcopal Hospital</td>
<td>Houston</td>
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<tr>
<td>June Marshall, MS, RN, NEA-BC</td>
<td>Texas Health Presbyterian Hospital</td>
<td>Dallas</td>
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<tr>
<td>Chika Nwordu, BSN, RN</td>
<td>St. Luke’s Episcopal Hospital</td>
<td>Sugar Land</td>
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<tr>
<td>Lupe Puente, RN</td>
<td>Shannon Medical Center</td>
<td>San Angelo</td>
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<tr>
<td>Jennifer Purdon, BSN, RN</td>
<td>University Medical Center</td>
<td>El Paso</td>
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<tr>
<td>Lenora Sevcik, MSN, RN</td>
<td>Midland Memorial Hospital</td>
<td>Midland</td>
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<tr>
<td>Jo Teichman, MSN, RN, CWOCN</td>
<td>Corpus Christi Medical Center</td>
<td>Corpus Christi</td>
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<tr>
<td>Maria Yoes, BSN, RN</td>
<td>Hendrick Health System</td>
<td>Abilene</td>
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<tr>
<td>Aziza Young, MS, RN</td>
<td>UT Southwestern Medical Center</td>
<td>Dallas</td>
</tr>
<tr>
<td>Jennifer Zirkle, MSN, RN, CCRN, NE-BC</td>
<td>University of Texas Medical Branch</td>
<td>Galveston</td>
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The second program to prepare individuals for the Nurse Advocate Certificate will be offered on November 4 and 5 in Austin. For more information, go to [www.texasnurses.org](http://www.texasnurses.org) > Advocacy or contact Gretchen Birdwell at gbirdwell@texasnurses.org.
Antiviolence Legislation – The Time is Now

by Mary Leblond, MSN, RN, CEN, SANE,
Chair, Government Relations, Texas Emergency Nurses Association

Metal detectors, glass or plastic safety barriers closing off the open triage window, patient care areas behind secured doors, and security guards stationed at many doors greet patients, their families, and healthcare workers when they arrive at hospitals today. Hospitals should be viewed as a place where help is given, protection is found, and solace received in times of a personal health crisis. In an attempt to provide safe care, however, healthcare staffs find these protective measures taken to protect their safety as creating barriers between them and the patients. When did it become more difficult to provide healthcare because of the threat of violence? What cultural shifts occurred to make all these changes necessary? What can nurses do to make their workplace safe for patients, families, themselves, and their co-workers without putting up barriers between them? The answer to these questions lies in the recognition that change has to occur to insure everyone is safe and yet still allows them to receive the quality, kind, and compassionate care nurses want to provide to their patients.

Violence is an infectious disease which is spreading into all areas of the hospital. Once experienced primarily in the emergency departments or psychiatric units, violence now occurs on all units. Tough economic times, the closing of mental health facilities, and funding reductions for addiction and counseling services have forced more of the population to seek primary care health services from emergency departments and other hospital units. There is an increase in drug and alcohol related incidents which bring patients to the hospital. The combination of drugs and alcohol along with the tough economic times (and its consequence) sets the stage for increased hospital violence.

Experiencing pain as a patient or watching a family member in pain is difficult enough, but often these patients wait long hours to receive care in the emergency setting. There is limited capacity (beds, physicians, and nurses) to handle the volume of patients presenting to the emergency department (ED) for care. As patient volume increases, waiting time lengthens. While experiencing waits in the ED, the potential that patients and family members project their frustrations on health care workers increases.

The Emergency Nurses participated in a survey conducted on workplace violence. Nurses reported approximately 25% experienced physical violence more than 20 times in the past three years, and almost 20% experienced verbal abuse more than 200 times during that same period. Nurses often do not report incidents because they consider it “part of their job,” or they fear reprisal if they do report. (Journal of Nursing Administration: July/August 2009 - Volume 39).

The change needed to help decrease these additional staff burdens lies in laws that need to be passed to protect staff. Legislators must be challenged to pass laws protecting health care workers and enforcing and/or increasing penalties for those who assault any health care provider. Currently, no federal laws are in place to protect nurses and impose increased penalties against those who assault nurses. In the next legislative session, the Honorable Roland Gutierrez will present legislation to enhance the penalty for assault on a nurse from a misdemeanor to a felony. This is one small step on the road to making the health care system a place to find help, to seek protection, and to receive solace in times of a personal health crisis.

To reach Mary Leblond for further comments or information, email littlemommanurse@aol.com.

About the Author
Guest contributor Mary Leblond, MSN, RN, CEN, SANE, is president of the San Antonio Emergency Nurses Association and chairman of government affairs for the Texas Emergency Nurses Association. An ER nurse for over 32 years, she currently works as a staff nurse at the Methodist Hospital Emergency Department in San Antonio and is also a Sexual Assault Nurse Examiner at Methodist Specialty and Transplant. She has been a nursing educator, and taught the ENA Forensic course among her many accomplishments. She was also the 2009 recipient of the Ruth Stewart Imagemaker award.
selecting your membership

When joining Texas Nurses Association, you can choose from two membership options:

• TNA Tri-Level Membership that includes a state membership in Texas Nurses Association (TNA), national membership in American Nurses Association (ANA), and a more local District membership.

• TNA Direct Membership that is state wide Texas only.

TNA TRI-LEVEL MEMBERSHIP

TNA Tri-Level Membership in ANA/TNA/District gives you the opportunity to influence nursing at every level—national, state and local. TNA Tri-Level members receive all voting privileges, opportunities to grow and connect beyond the workplace through service on committees, task forces and coalitions; unique pathways to professional development, a network of like-minded colleagues, and member discounts on a variety of conferences/workshops, publications and resources, goods and services, as well as ANCC certification.

Dues in TNA Tri-Level Membership are determined by your TNA District. The Type of membership that best describes you (i.e., fully employed, full-time student, retired, etc.); and preferred method of dues payment. See Steps to Tri-Level Membership below.

STEPs TO TRI-LEVEL MEMBERSHIP

1. Find your TNA DISTRICT. Within the Texas map, locate your county of residence or county of employment. The large circled number within the indicated boundary is your TNA District.

2. Select your TYPE of Tri-Level Membership: M-Full membership — for RNs employed more than an average of 20 hours a week.

• R-Reduced Dues membership (50% of annual dues) — for RNs who are unemployed or working less than 20 hours a week, licensed RNs who are full-time students, new graduates from basic nursing education programs joining within 6 months of graduation, and RNs 62-years-of-age and older who are working and receiving Social Security.

• S-Special membership (25% of annual dues) — for RNs over 62-years-of-age and not employed, or 100% disabled.

TNA DIRECT MEMBERSHIP

For many registered nurses, influencing nursing in Texas where they practice is their main interest. That’s why TNA offers the TNA Direct Membership. Perfect for everyday practice in Texas. TNA Direct is a great membership choice for RNs who are interested in influencing nursing practice but have limited time or resources for full involvement. A $9 annual dues rate (or monthly payments of $0.75 through the Electronic Dues Payment Plan) makes this Texas only involvement the perfect connection to professional nursing in Texas and still provides many of the same personal benefits of Tri-Level ANA/TNA/District membership.

PAYMENT METHOD

1. Annually — in a single, annual payment by check or credit card.

2. Monthly — credit card draft or through the Electronic Dues Payment Plan (EDPP) where dues are automatically paid from your checking account. See “Select Payment Method” in Application for Membership.

MEMBERSHIP ELIGIBILITY

To be eligible for TNA Tri-Level or TNA Direct membership, you must have been granted a license to practice as a registered nurse in a state, territory, possession or District of Columbia of the United States, and not have your license under suspension or revocation at any time.

APPENDIX FOR MEMBERSHIP

TNA TRI-LEVEL AND TNA DIRECT

For the requested information and mail with payment to: Texas Nurses Association, 7800 Burner Road, Suite 440, Austin, TX 78757-3332 or fax with credit card information. FAX: 512-452-2644 • Phone: 512-452-2645

APPLICATION FOR MEMBERSHIP

TNA TRI-LEVEL AND TNA DIRECT

Please fill out the requested information and mail with payment to: Texas Nurses Association, 7800 Burner Road, Suite 440, Austin, TX 78757-3332 or fax with credit card information. FAX: 512-452-2644 • Phone: 512-452-2645

SELECT ONE MEMBERSHIP OPTION BELOW

Charge to my This Amount:

TINA DIRECT

【Texas Nurses Association】

Inquire about a type of membership. Type of membership and TNA District determine the annual TNA dues and state. Rates are provided in the Membership Ebenezer (MA). Check one circle below when you fill out your application.

• M-Full membership: 100% reduced rate for RNs employed more than an average of 20 hours a week.

• R-Reduced Dues Membership: 50% of annual dues (please indicate below when you indicate membership type to pay or whether you are a student.

• S-Special membership: 25% of annual dues (please indicate below when you indicate membership type to pay or whether you are a student)

SELECT A PAYMENT METHOD FOR TEXAS NURSES ASSOCIATION MEMBERSHIP

Indicate below your preferred method of payment:

• Single Payment Payment

• Electronic Dues Plan Draft your checking (Texas Nurses Association)

• Select one method of payment and provide information for Payment by Check Only

• Check/Credit Card Draft (Suggested Membership in Payment Draft Only)

• Select one method of payment and provide information for Payment by Electronic Draft

• Select one method of payment and provide information for Payment by Electronic Draft

• Check/Credit Card Draft (Suggested Membership in Payment Draft Only)

• Select one method of payment and provide information for Payment by Electronic Draft

• Check/Credit Card Draft (Suggested Membership in Payment Draft Only)

EDPP AUTHORIZATION

To provide nursing practice appropriate with Texas Nurses Association (TNA) is to be a Texas registered nurse (RN) who is a member in good standing with current dues and fees paid. RNs are required to sign the annual TNA dues and fees authorization form for current membership. If you have any questions, contact the TNA Office at 512-452-2645. RNs applying for Tri-Level membership must have a minimum of 6 months of active nursing experience. RNs applying for TNA Direct membership must have a minimum of 3 hours of active nursing experience. RNs applying for TNA Direct membership must have a minimum of 3 hours of active nursing experience.

To be completed by Texas Nurses Association (TNA) and approved by the RN member. If you are applying for TNA Tri-Level membership, if you are applying for TNA Direct membership, an additional $25 is for a membership card in the American Nurses Association (ANA). The American Nurses Association (ANA) membership card is not deductible as a charitable contribution to a tax-exempt organization. If you are applying for TNA Direct membership, the card is considered a charitable contribution to a tax-exempt organization.