Solution to the Shortage? Collaboration.

When it comes to the state of the health care workforce, one prominent, national organization is telling it like it is, and it isn’t pretty. The tale which includes a stark warning that current, health workforce policies in the U.S. will not avert a health workforce crisis was delivered loud and clear by the Association of Academic Health Centers (AAHC) in a July 2008-released report, *Out of Order, Out of Time: The State of the Nation’s Health Workforce*.

The report, funded in part by the Josiah Macy, Jr. Foundation, asserts that “we are out of time to address what is out of order in our health workforce.” It recommends that “all public and private stakeholders work together” to make the U.S. health workforce a priority domestic policy issue. By creating a national health workforce planning body to engage public and private, federal and state stakeholders, the report concludes, we can better ensure the nation’s health and economic well-being.

The clear need for a new, collaborative and coordinated, national health workforce planning initiative is what drove the research. Continuing on our historic path of decentralized, incremental and piecemeal approaches to solving the national workforce shortages — coupled with looming, socioeconomic forces (increased demand, decreased supply) — predicts dire consequences and calls for immediate action. In a nutshell, the time is now for all public and private stakeholders to work together. A collaborative approach is what’s truly best for patients.

**Texas nursing shortage**

According to Clair Jordan, MSN, RN, executive director of the Texas Nurses Association, the nursing shortage is the current driving force of all aspects of nursing. Since the Texas Legislative Session of 2001, Texas Nurses Association with a list of collaborative partners worked each biennium (2001, 2003, 2005, 2007) to focus lawmakers’ attention on closing the gap between supply and demand for nurses. Lawmakers responded.

Over those four legislative sessions, $37.4 million in special funding was appropriated to increase the capacity of Texas’ professional nursing programs; $17.1 million was dedicated from tobacco lawsuit settlement funds for research and pilot programs to explore innovation in nursing education; the Texas Center for Nursing Workforce Studies was established to collect better nursing workforce data; and the practice environment was improved through adoption of first-in-the-nation safe patient handling legislation, and a strengthening of nurse patient advocacy protections.

Those legislative actions were in addition to initial adoption of hospital nurse staffing rules in 2002 by the Texas Department of State Health Services, and hospital and schools of nursing efforts to graduate more RNs and secure more faculty yielded results:

Continued on page 8
TNA Districts and Presidents

1: Connie Barker
   Phone: 915/584-0051
   Email: connie.barker@sbcglobal.net

2: Paula Antognoli
   Phone: 806/351-5103
   Email: patoland1@utdallaslink.net

3: Sandi McDermott
   Phone: 727/566-7187
   Email: sandi.mcdermott@hcahealthcare.com

District Staff: Renee James
   Phone: 815/249-5071
   Email: tna3@usapathway.com

Web site: www.tna3.org

4: Colleen Hines
   Phone: 972/348-1614
   Email: cmhteh@flash.net
   Phone: 800/862-2022 ext. 129
   Email: pfreier@covhs.org

District Staff: Pat Pollock
   Phone: 972/435-2216
   Email: dita@flash.net

Web site: www.tna5.org

5: Kim Belcik
   Phone: 512/990-8987
   Email: kbelekik@gmail.com

6: Ellarene Duis
   Phone: 409/772-8390
   Email: egduis@utmb.edu

Web site: www.tna6.org

7: Megan Mosley
   Phone: 254/766-8548
   Email: megalou14@gmail.com

Web site: www.tna7.org

8: Gayle Dasher
   Phone: 210/705-6266
   Email: gdasher@satx.rr.com

Web site: www.texasnurses.org/districts/08

9: Mary Holt Ashley
   Phone: 812/566-2010
   Email: maryashley2@comcast.net

District Staff:
   Melanie Truong
   Phone: 713/523-3619
   Email: tn@tnadistrict9.org

Web site: www.tnadistrict9.org

10: Barbara Hills
    Phone: 254/420-1231
    Email: TNADistrict10@gmail.com

11: Connie Beddingfield
    Phone: 940/221-5406
    Email: cbeddingfield@grahamrnc.com

12: Patricia Morrell
    Phone: 936/212-7222
    Email: patricia.morrell@mhbhs.org

13: Vacant

14: Joe Lacher
    Phone: 956/882-5089
    Email: joe.lacher@utb.edu

15: Andrea Kerley
    Phone: 325/670-4230
    Email: akerley@bendrickhealth.org

Web site: www.texasnurses.org/districts/15

16: Martha Steulet
    Phone: 325/942-2060 ext. 258
    Email: martha.steulet@angelo.edu

17: Nancy Goodman
    Phone: 361/825-2607
    Email: nancy.goodman@tamucc.edu

Web site: www.texasnurses.org/districts/17

18: Patty Freier
    Phone: 806/797-8120
    Email: pfreier@ccvhhs.org

Web site: www.texasnurses.org/districts/18

19: Nina Wallace-Gross
    Phone: 903/877-5102
    Email: nina.wallace@uthet.edu

Web site: www.texasnurses.org/districts/19

20: Kathleen Elliott
    Phone: 361/552-3063
    Email: stormyhill@yahoo.com

21: Sherrie Harris
    Email: sherrem@hughes.net

22: Toni McDonald
    Email: michnm@consolidated.net

25: Shirley Aycock
    Phone: 903/646-3745
    Email: saycock@gmc.org

26: Carolina Huerta
    Phone: 956/383-7365
    Email: chuerta@utpa.edu

28: Kim Penny
    Phone: 903/832-5565 ext. 3205
    Email: kpenry2@aol.com

29: Sally Durand
    Phone: 281/756-3634
    Email: sudurand@aldvincollege.edu

40: Contact TNA
    Phone: 800/862-2022 ext. 129

TEXAS NURSING Voice
A publication of Texas Nurses Association
October, November, December 2008
Volume 2, Number 4

Editor-in-Chief—Clair B. Jordan, MSN, RN
Managing Editor—Joyce Cunningham
Creative Communications—Deborah Taylor
Circulation Manager—Belinda Richley

Editorial Contributors
Becky Altbaus, PhD, RN, CCC, Millie Arnold, BS, RN,
OCN, CCRC; Joyce Cunningham; Toni Inglis, MSN,
RN, CNS; Laura Lema, MSN, RN; Fran Martin, MSN,
RN; and Cindy Zolnier, MSN, RN

Editorial Advisory Board
Stephanie Woods, PhD, RN, Dallas, (Chair)
Jone Alejandro, MSN, RN, MBA, CCM, Dallas
Patricia Allen, EdD, RN, CNE, ANP, Lubbock
Sandra Kay Cesario, PhD, RN, C, Pearland
Jennifer D. M. Cook, PhD, MSN, RN, San Antonio
Anita J. Coyle, PhD, RN, CHES, Sanger
Thelma Davis, LYN, Odessa
Anita T. Farrish, RN, MHSN, NC-BC, Waco
Patricia A. Goodpastor, RN, The Woodlands
Patricia Holder-Hutchon, RN, DSM, Denton
Tara A. Patton, BSN, RN, Palestine
Dianna Lipp Rivers, RN, CNAA, BC, Beaumont

Executive Officers
Susan Sportman, PhD, RN, TNA President
Margie Dorman-O’Donnell, MSN, RN, TNA Vice President
Rebecca Krepper, PhD, MBA, CNA

Regional Directors of Texas Nurses Association
Kleante Caruso, MSN, RN, CNAA, CCHP—North Region
Jennifer D.M. Cook, PhD, MBA, RN, TNA—South Region
Dana Danaher, MSN, RN, CPHQ—Central Region
Viola Hebert, MA, BSN, RN, East Region
Joy Rake, MSN, RN—West Region

Executive Director
Clair B. Jordan, MSN, RN

Advertising:
Arthur L. Davis Agency, 577 Washington St.
P.O. Box 236, Cedar Falls, Iowa 50613
319.277.2414, E-mail: sales@alddash.com

Texas Nurses Association and the Arthur L. Davis
Publishing Agency reserve the right to reject any advertisement.
Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

Acceptance of advertising does not imply endorsement or approval by Texas Nurses Association (TNA) of products advertised, the advertisers, or the claims made. Rejection of an advertisement does not imply a product offered for advertising is without merit, or that the manufacturer lacks integrity, or that this association disapproves of the product or its use. TNA and the Arthur L. Davis Publishing Agency shall not be held liable for any consequences resulting from purchase or use of an advertiser’s product. Articles appearing in this publication express the opinions of the authors; they do not necessarily reflect the views of the staff, board, or membership of TNA or those of the national or local associations.

Copyright © 2008 by Texas Nurses Association.
Six States Enact Staffing Laws

Research consistently demonstrates that adequate nurse staffing is essential for good patient care and positive outcomes. A nursing shortage can make adequate staffing difficult if not impossible.

In the last years, 12 states across the U.S. have attempted to protect staffing patterns in the midst of a nursing shortage by establishing staffing requirements through legislation or regulation. Texas was the first.

None, two general approaches to staffing are used nationally: 1. Mandating staffing plans (seven states including Texas use this method); 2. Mandating fixed ratios (only California has implemented this approach to staffing).

The comparison chart below provides a quick overview of staffing provisions enacted throughout the country as of September 15, 2008. Additional information on the topic is available from the American Nurses Association at http://www.safetystaffingsewaxvios.org/WhatsANADoing/StaffingLegislation/StaffingLaws.aspx.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. COMMITTEE COMPOSITION</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• 50% staff nurses</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Staff nurses elected by peers</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• CNOs on committee</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>2. COMMITTEE ROLE</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Develops staffing plan for hospital</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Advisory</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>3. STAFFING PLAN COMPONENTS</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Identifies factors to be considered in development of plan (e.g., census, admissions/discharges, skill mix, care intensity)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Plan sets minimum staffing levels per unit</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Plan reflects standards established by professional organizations</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Plan in mass-based</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Plan is shift-based</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Process for adjusting plan identified</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>4. INPUT AND FEEDBACK FROM NURSES</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>5. NON-REGULATORY AND WHISTLEBLOWER PROTECTIONS FOR NURSES REPORTING STAFFING CONCERNS</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>6. REPLACEMENT STAFF FOR COVERAGE ADDRESSED</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>7. REVIEW OF PLAN</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>8. STAFFING PLAN QUALITY INDICATORS</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>STATES WITH STAFFING LEGISLATION OTHER THAN STAFFING COMMITTEES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NV (2003): calls for a subcommittee to conduct an interim study on staffing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CA: requires nurse to patient ratios (passed 1999, implemented 2004)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RI (2005): requires a staffing plan to be filed annually with the department of health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR (2007): re-established requirement for monitoring nursing quality data</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FL (2006): enacted staffing requirements for LTC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VT (2006): gives public access to information related to staffing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Texas Childhood Immunization Rates Hit 5-Year High in National Survey

Early in September, the Texas Department of State Health Services (DSHS) announced that according to statistics released September 4, 2008, by the U.S. Centers for Disease Control and Prevention (CDC), immunization rates for Texas children increased 19 percent over the past five years to reach a record high in 2007. The Texas rate was 77.3 percent for 2007, up from 65 percent in 2002.

“The progress that Texas has made is the result of aggressive and sustained efforts of state and local partners along with families,” said Dr. David Lakey, commissioner of DSHS, through a published statement. Lakey stressed that it takes continued effort to see continued improvement. The 2007 Texas rate is a 3.5 percent increase over 2006 numbers, and ranks Texas as 22nd in the country—the highest ranking Texas has ever reached.

The CDC’s National Immunization Survey also provides statistics for four metropolitan areas in Texas:

• The Houston rate increased 4.3 percent from 70 percent to 73 percent.
• The El Paso County rate increased 12.3 percent from 68.9 percent to 77.4 percent.
• The Bexar County rate increased 7.4 percent from 70 percent to 73 percent.
• The Dallas County rate decreased 1.9 percent from 73.3 percent to 71.9 percent.

The CDC’s National Immunization Survey provides vaccination coverage estimates for children 19 through 35 months of age. State numbers are based on the percentage of children completing the 4:3:1:3:1 series of immunizations. This series includes four doses of diphtheria, tetanus and pertussis (DTaP), three doses of polio vaccine, one dose of measles-containing vaccine, three doses of Hib vaccine, three doses of hepatitis B vaccine and one dose of varicella vaccine. ★
“There aren’t enough caffeinated energy drinks in the world to get me through the overtime I have to work. Instead of limiting hours, they want to lecture us on fatigue.”

ANOTHER OVERTIME SHIFT, ANOTHER THREE ENERGY DRINKS.

TNA’S CONNECTED, SO YOU DON’T HAVE TO BE WIRED.

TOO MUCH OVERTIME ISN’T SAFE for nurses or their patients. That’s why in 2001, TNA negotiated hospital staffing rules to improve the practice environment, including policies to limit or eliminate mandatory overtime and floating. Built by Texas nurses for Texas nurses, no other organization knows how to lobby for change in the Texas Legislature like TNA. After all, we’ve been doing it for more than 100 years.
The hammer comes down this month. Beginning in October (the start of the federal 2009 fiscal year), Medicare will no longer reimburse hospitals at the higher rate for complications unless those conditions were present on admission. In addition, hospitals cannot bill Medicare for any wrong surgery (wrong patient, wrong site or wrong procedure).

Why is Medicare reimbursement so important? Because it is a major source (more than 40 percent) of hospital revenue; it's the largest source of revenue in the United States for nursing homes and other long-term care facilities. Because private insurers/payers take Medicare's payments, the quality of care fell short of its potential. The hammer comes down this month.

Will hospital nurses influence their organization’s reimbursement? You bet we will. The clinical care we give on the frontlines will directly affect the financial stability of our hospitals. First, some background:

A little history and primer

1965: To defuse physician and hospital opposition to the creation of Medicare in this year, the program’s congressional architects selected payment mechanisms designed to preserve the status quo.

1983: The Health Care Financing Administration (predecessor to CMS, the Centers for Medicare & Medicaid Services) adopted the starting point for current Medicare payments for inpatient care based on diagnosis-related groups. The payment system is considered prospective in that the amount paid to a hospital for a patient is fixed in advance and depends only on the diagnoses and major procedures reported at discharge (which map to a specific DRG).

In reality, payments have never been completely prospective, being influenced by what happens to an individual patient during a hospitalization. The system is called inpatient prospective payment system.

1999: The Institute of Medicine published To Err is Human, revealing that as many as 98,000 people die in any given year from medical errors in hospitals. The landmark report broke the silence in the United States surrounding medical errors and their consequences and called into question the overall value of healthcare services, clearly demonstrating that the quality of care fell short of its potential. The jaw-dropping report launched a drive to create a culture of patient safety within the national healthcare community.

2001: An IOM follow-up report, Crossing the Quality Chasm, called for restructuring the healthcare system, recommending aligning public and private payment methods to build incentives for quality enhancement.

2003: With the passage of the Medicare Prescription Drug Act, Congress recognized that much of the increase in healthcare spending would shift from the private sector and Medicaid to Medicare, raising concerns about the value received for Medicare dollars. Policy-makers sought to reframe these expenses as public investments that should be designed to leverage higher levels of quality and performance. Congress thus asked the IOM to conduct a study to identify and prioritize options for aligning performance with payment in the Medicare program.

2005: CMS announced the Reporting Hospital Quality Data for Annual Payment Update program, the first step toward “value-based purchasing” or “pay for performance.” Initially focused on 10 quality measures (now more than 30, plus patient satisfaction), hospitals submitting the required data would receive the full update to their Medicare DRG payments.

Nurses are familiar with many of these quality or “core” measures: acute myocardial infarction, congestive heart failure, the Surgical Care Improvement Project, etc.

2006: The Deficit Reduction Act of 2005 was signed into law requiring CMS to choose hospital-acquired conditions proposed for reduced payment in FY 2009. Some of the conditions were selected from a list of “never events” or conditions that had been identified by the National Quality Forum, a nonprofit organization created to develop and implement a national strategy for healthcare quality measurement and reporting.

“Never events” are serious reportable events that should never have happened and could have been prevented.

Criteria for the selected hospital-acquired conditions were that they: a) be associated with a high cost of treatment or high occurrence rates within hospital settings, b) result in higher payment to the facility when submitted as a secondary diagnosis, and c) can reasonably be prevented by adoption and implementation of evidence-based guidelines.

2008: After consultation with the Centers for Disease Control and Prevention and the NQF, CMS finalized the first set of hospital-acquired conditions:

1. object inadvertently left in after surgery;
2. air embolism;
3. blood incompatibility;
4. catheter-associated urinary tract infection;
5. pressure ulcer (decubitus ulcer);
6. vascular catheter-associated infection;
7. certain types of falls and trauma;
8. mediastinitis (infection in the chest) after coronary artery bypass graft surgery;
9. surgical site infections following elective procedures including certain orthopedic surgeries and bariatric surgery for obesity;
10. certain manifestations of poor control of blood sugar levels; and
11. deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures.

About the author

Toni Inglis, MSN, RN, CNS, is editor and NICU staff nurse, Seton Medical Center Austin, Seton Family of Hospitals, Austin, Texas. She is also a long standing member of Texas Nurses Association.

As pay-for-performance standards have encompassed patient outcomes, nursing’s contribution is prominent. Nurses can play a huge role by ensuring that their patients:

• are fully and properly assessed upon admission;
• receive the clinically appropriate, high-quality nursing care for their condition to keep patients safe and to prevent unnecessary complications (core measures, falls prevention, urinary catheter use reduction, good central line maintenance, hand hygiene, isolation precautions, etc.); and
• have a positive, healing experience.

Core measure and patient satisfaction data are publicly available on the federal Hospital Compare Web site at hospitalcompare.hhs.gov.
Media Campaign to Increase Breast/Ovarian Cancer Inquiries

by Becky Althaus, PhD, RN, CGC and Millie Arnold, BS, RN, OCN, CCRC

It's likely that nurses across Texas could experience an increase in patient inquiries about testing for the breast and ovarian cancer genes, BRCA1 and BRCA2. A marketing campaign sponsored by the genetic testing lab, Myriad Genetic Laboratories, was launched this fall with radio and TV ads directed toward consumers. The campaign was intended to increase awareness about genetic testing and to refer interested consumers to their health care provider for further discussion.

Mutations in the BRCA1 and BRCA2 genes are linked to hereditary breast, ovarian and other cancers. The presence of a deleterious BRCA mutation in a woman results in an 87% risk of breast cancer and up to a 44% risk of ovarian cancer. In a best case scenario, health care providers will screen the patient to determine if testing is warranted, and then refer the patient to a genetics nurse or genetics counselor for preparation and testing.

Similar direct-to-consumer marketing campaigns in other areas of the country have increased patient demand for cancer genetic services and genetic testing among low-risk individuals, many of whom are not appropriate candidates for testing. Federal oversight of genetic tests and advertisements for genetic tests is limited and as a result, direct-to-consumer advertisements usually overstate the benefits and utility of genetic testing (particularly for the general population) while failing to adequately address the risks, limitations, and uncertainties inherent in genetic testing. The advertisements also encourage consumers to contact the commercial laboratory directly, hence minimizing the role of health care providers.

The health care provider may find it necessary to educate the patient that BRCA mutations are rare (1 in 300-800 people of non Ashkenazi Jewish heritage, and 1 in 40 of Ashkenazi Jewish heritage), are responsible for only about 10% of breast cancers, and that the laboratory test is expensive ($3,120.00). Guidelines published by multiple medical societies recommend only testing people who are at increased risk of carrying a BRCA gene mutation. In addition, it is most informative if testing is first performed on the family member diagnosed with breast or ovarian cancer. Therefore, testing is generally indicated for people with a personal or family history of:

- Breast cancer diagnosed before age 45-50
- Breast cancer diagnosed in both breasts
- Multiple cases of breast cancer on the same side of the family
- Ovarian cancer in a family with breast cancer
- Male breast cancer
- The combination of breast, ovarian, and/or pancreatic cancer on the same side of the family or in a single individual
- Jewish ancestry and breast or ovarian cancer

Note: Most third-party payers, including Medicare, have guidelines for coverage. About 90% will cover the testing at 80-90% of the cost if the patient falls within the specific company's guidelines. A person diagnosed with a deleterious mutation in a cancer predisposition gene is protected from later discrimination in determination of coverage, or premium rate setting in group health insurance plans by a provision in the Health Insurance Portability and Accountability Act (HIPPA) and in the state of Texas law 75RH. HIPAA also prevents the use of a genetic test result to set an insured person's premium rate. The Federal Genetic Information Nondiscrimination Act (GINA, to be enacted Spring 2009) will protect the patient from discrimination in employment and all health insurance rate settings, including individual health insurance policies.

Because hereditary breast cancer may be caused by mutations in any one of a number of genes including BRCA1 and BRCA2, genetic evaluation can be very complex requiring extensive patient education and counseling. Genetic trained nurses and genetic counselors are available throughout the state of Texas to conduct hereditary risk assessment and educate patients about the benefits and limitations of genetic testing.

The genetic nurse/counselor will evaluate family history, explain the contribution of heredity to cancer risk, review the benefits and limitations of genetic testing, risks associated with a gene mutation, medical management options, possible uncertain test results, insurance coverage, and laws that prevent health insurance and employment discrimination. In addition, the cancer genetic nurse/counselor is well versed in the language of genetic tests and can thoroughly interpret the laboratory results. To locate a genetics professional in your area or to learn more about hereditary cancers, contact the National Cancer Institute at www.cancer.gov (search under 'cancer genetics services directory').

The Myriad Genetics direct-to-consumer campaign presents both an opportunity and a challenge. It will greatly increase awareness concerning genetic testing for hereditary cancer and hopefully lead to life-saving interventions in people who may not have had the opportunity prior to viewing the advertisements. The challenge will be in providing responsible use of limited health care resources by testing appropriate high-risk individuals for BRCA mutations and providing the best possible care for the individuals who may benefit.

About the contributing authors
Becky Althaus is a nurse with over 30 years experience in medical genetics. She is certified as a genetic counselor by the American Board of Medical Genetics and currently works as a nurse/genetic counselor at Presbyterian's Hospitals of Dallas and Plano.

Millie Arnold has 24 years experience in oncology nursing. She currently works at Baylor University Medical Center as a research nurse for Dr. Rick Boland, an authority in hereditary colon cancer.

To earn FREE CNE on Hereditary Breast and Ovarian Cancer, go to www.nuep.org and click on Continuing Education. This course, appropriate for nurses in all fields of practice, includes an in-depth discussion on the benefits and limitations of genetic testing for these cancers. Presented by the Nurse Oncology Education Program (NOEP), a project of the Texas Nurses Association Foundation funded by the Cancer Prevention and Research Institute of Texas.
Ever since members of the Texas Nurses Association first traveled to Austin in early 1909 to present their State Nurses’ Registration Bill to the Texas Legislature, nurses have been voicing their opinions at the Texas Capitol. Even before legislative action in 1918 permitted women the right to vote in state primary elections, TNA had already appointed its first Legislative Committee and missioned it with passing a nurse licensing law.

The method used in 1909 for TNA members to gain a legal structure for regulating nursing practice and education was popularly termed “petticoat lobbying” by the male legislators. Women’s activism of that time — and the women’s vote that eventually backed it up — led to reforms of significance in causes of interest to women, such as education and mother/child health. Into the 1990s, legislators soon discovered that attention must be paid to areas of interest to women, such as education and mother/child health. In the 1990s, legislators soon discovered that attention must be paid to issues that concerned their female constituents.

Fast forward 100 years to activism of the 21st century. Known now as grassroots activity, today’s activism is still powerful and still commanding of legislative attention. Today, with the touch of a computer keyboard — and a click on Texas Nurses ‘n Action Center (within Advocacy for the Profession) at www.texasnurses.org — nurses from across the state can easily voice their opinions to legislators on issues important to nursing and health care — and not leave home to do it.

Although TNA member contact information for this upcoming 2009 Legislative Session is automatically updated in the Texas Nurses ‘n Action Center, all nurses in Texas are welcomed — and encouraged — to sign up for TNA’s Internet-based, grassroots advocacy system. It’s as easy as going to the Web site and telling us how to contact you. If you’ve signed up in the past, make sure your contact information is still current and still in the system. You wouldn’t want to miss the opportunity to speak your opinions for nursing in Texas.

How does it work?

Once signed up, you’ll receive e-mailed information and Legislative Updates during the Session on important nursing issues. When there’s direct action to be taken, Action Alerts will come your way with relevant background information on the issue.

Come on, what are you waiting for? Join nursing legislative activism in the 2000s. Get your voice heard. Get your opinions known, on the issues important to nursing. Take action today to sign up. Visit the Texas Nurses ‘n Action Center at www.texasnurses.org.

Independent Contractor Opportunities to Participate in Special Statewide Projects

Money Follows the Person Quality of Life Survey (MFP QoL) for Registered Nurses, Licensed Vocational Nurses or Social Workers

We are seeking 50 interviewers for a project that runs from September 2008 until September 2010. This temporary work is in conjunction with the Texas Department of Aging and Disability Services (DADS). Independent contractors hired for the projects will visit and interview randomly selected consumers with disabilities or long-term illnesses who are transitioning from institutionalized care to a care setting in the community. Information collected in the interviews will be used by DADS for research purposes. Work hours are flexible and will be on weekdays and/or weekends.

Minimum qualifications: a current and in good standing Texas license in applicable area of practice, with one year of verifiable experience working in a nurse facility (includes small group homes, foster care, community clinics, hospice and home health experience) with people with cognitive disabilities (e.g., mental retardation, Alzheimer’s disease, dementia, autism, pervasive developmental disability).

Nursing Facility Quality Review Project (NFQR) for Registered Nurses

We are seeking 40 interviewers for a project that runs between February 2008 and May 2008. It is temporary, part-time work in conjunction with the Texas Department of Aging and Disability Services (DADS). Independent contractors will visit nursing facilities in their area to gather data for DADS research. Most work is weekdays during business hours. Excellent opportunity for retirees.

Minimum qualifications: a current Texas RN license in good standing, and one year of verifiable experience working in a nursing home facility.

Long-Term Service Support Quality Review Project (LTSSQR) for Registered Nurses, Licensed Vocational Nurses or Social Workers

We are seeking 50 interviewers for a project that will begin December 2008 and run until February 2009. This is temporary, part-time work in conjunction with the Texas Department of Aging and Disability Services (DADS). Independent contractors will visit and interview randomly selected consumers with disabilities. The information collected will be used by DADS for research purposes. Work hours are flexible and will be on weekdays and/or weekends. Excellent opportunity for retirees.

Minimum qualifications: a current Texas license in good standing, with one year of verifiable experience working in a nursing home (includes small group homes, foster care, community clinics, Hospice and home health experience) with people with cognitive disabilities (e.g., mental retardation, Alzheimer’s disease, dementia, autism, pervasive developmental disability).

To submit your résumé, receive an application, or request further information, please send an e-mail to mmock@texasnurses.org. You may also fax to (512) 533-9825 or call Michelle Mock, recruiter at (512) 467-0615, ext. 178.

Texas Nurses Association NACES Plus Foundation, Inc. 7600 Burnet Road Suite 440 Austin Texas 78757 www.nacesplus.org
The Center has two priorities: the education and the retention of nurses. It will serve as a focal point for bringing together influential voices that can champion the relationship between nursing and quality patient care, as well as address the growing nursing shortage by seeking funding (state and national) to support expanded nursing education programs and prepare more faculty. Thousands of qualified applicants were turned away from nursing programs nationally — 7,000-plus applicants in Texas in 2007.

Worse than the prospect of increasing nursing education capacity, nursing programs are being challenged to revise their curriculum. Producing more graduates means more clinical settings for students to practice, expanded use of experienced nurses as preceptors, and innovative teaching methods such as simulation centers. The National League for Nursing estimates that 3,500 nursing faculty will retire in 2009; 28,000 in 2023.

To address education — specifically the challenge of insufficient nursing education capacity — RWJ commissioned a white paper, Blowing Open the Bottleneck: Designing New Approaches to Increase Nurse Education Capacity. The paper was to serve as background for participants attending a national Nursing Education Summit in June 2008 in Washington, D.C. The Summit was intended to bring together multi-stakeholders to identity creative solutions to the nurse faculty shortage that is forcing nursing schools to turn away qualified applicants each year. It focused on among other things increasing nursing education capacity through strategic partnerships, and education redesign. It was hosted by: Robert Wood Johnson Foundation; the U.S. Department of Labor, Employment and Training Administration; the Center to Champion Nursing in America; and the U.S. Department of Health and Human Services, Health Resources and Services Administration.

Participation in the Summit had to be earned through application. Ultimately, 18 state teams were selected from 49 applications; Texas was one of them (as was Alabama, California, Colorado, Florida, Hawaii, Illinois, Massachusetts, Maryland, Michigan, Mississippi, North Carolina, North Dakota, New Jersey, Oregon, South Carolina, Virginia and Wisconsin).

The multi-stakeholder representing Texas in the collaborative effort were: Texas team leader Alexia Green, PhD, RN, representing the Texas Governor’s Office (Texas Health Care Policy Council) and Texas Tech University Health Sciences Center School of Nursing; Bonnie Gonzales, RN, Workforce Solutions; Chris Fowler, Texas Higher Education Coordinating Board; Kathy Thomas, MN, RN, Texas Board of Nursing; Clair Jordan, MSN, RN, Texas Nurses Association; Elizabeth Sjoberg, RN, JD, Texas Hospital Association; Aileen Kishi, PhD, RN, representing the Texas Board of Nursing; Texas Center for Nursing Workforce Studies; Beth Mancini, PhD, RN, University of Texas at Arlington; Scheleen Walker, representing Texas State Rep. Donna Howard; Sandra Fleming, El Centro College; and Bob Jackson, AARP Texas office.

Pioneering solutions
Collaborate until it hurts was the overriding message at the Summit. It is the only way. Summit leaders insist, to change the status quo; to pioneer workable solutions that will constantly improve the quality and safety of health care for all Americans. It will take leaders from nursing, hospitals, industry, government and philanthropy to join forces to work creatively for solutions.

In Texas, like in other parts of the country, retaining nurses in the workforce and educating more is critical to balancing nurse supply and demand. Besides the philanthropic support of RWJ and AARP with their choice of Texas as a pilot state to build capacity in its nursing education system, another external group is assisting. The Nursing Workforce Shortage Coalition has been created by a broad group of stakeholders to bring business and health care together to close the gap of supply and demand for nurses. In the coalition are: Texas Nurses Association; Greater Houston Partnership; Deans and Directors Organization of Texas’ Schools of Nursing; Texas Hospital Association; Texas Association of Business, and eight chambers of commerce. Members of the coalition will collaborate until it hurts so that Texas is on track to have nurse supply meet demand by 2020.

If health care in the U.S. is out of time to address what’s out of order, then Texas is at least unique in its progress to date of meeting the shortage head on. Quality health care for all citizens can best be realized through broad collaborative efforts — nurses leading working with policy makers who are working with business, industry and health care organizations who are hearing the voices of health care consumers. ★

LVNAT Fall Convention
Thursday October 30 through November 1, 2008
Wingate by Wyndham Hotel & Conference Center
1209 North I-35, Exit 253
Round Rock, TX

LVNs of Texas — don’t miss the Fall 2008 Convention of the Licensed Vocational Nurses Association of Texas (LVNAT). Come meet LVNs from around the state. You can attend educational sessions, earn continuing education hours, and meet with your LVN state representatives so they can hear your voice on the issues important to you.

The hotel and conference center is located in Round Rock, just north of Austin and close to many of the area’s popular attractions. Phone the hotel for room reservations at 512-341-7000. Rates are $85 per night for single/double occupancy plus applicable state and sales taxes. Refer to LVNAT Fall Convention when making reservations.

For additional information, phone Thelma Davis of LVNAT at 979.542.2763, or visit www.wingateroundrock.com.
“I’m busy trying to keep people alive and you want me to attend a meeting?”

I DON’T HAVE THE TIME.

WHILE YOU TAKE CARE OF PATIENTS, WE TAKE CARE OF YOU. TNA has been working hard for Texas nurses for more than 100 years, helping to pass legislation on personal protection rights, workplace safety and safe patient handling, negotiating rules affecting mandatory overtime and floating, and assisting in securing $35 million for nursing schools to address the shortage. And you don’t have to attend meetings to be a part of TNA. Convenient tools such as email alerts, online forums and surveys make it easy to stay informed and give feedback. TNA membership is not only easy it’s essential.
The Texas Higher Education Coordinating Board (THECB) was established in 1965 to provide leadership and coordination to the higher education system in Texas. While the Texas Board of Nursing (BON) historically played an extensive role in the approval of nursing programs, Sunset legislation in 2007 modified this role. The BON is now responsible for selecting national accrediting agencies for nursing programs, such as the National League for Nursing Accrediting Commission and the Commission on Collegiate Nursing Education. The THECB establishes requirements for accrediting the governing institution for a school of nursing.

In 2008, THECB established an Advisory Committee on RN Nursing Education (ACORN). ACORN is comprised of nurses from various settings and practice areas, including faculty from ADN and BSN programs, nurse executives, and clinicians. Many committee members are active in the Texas Nurses Association, including chairperson LeAnn Wagner (TNA Education Committee member), Beth Mancini (TNA Education Committee chairperson), Regina Jones Johnson (TNA Governmental Affairs committee member), Mary Beth Thomas (Director of Nursing for the BON and TNA Education Committee member), and Debora Simmons (TNA Practice Committee co-chairperson). ACORN will assist with:

- Developing statewide initiatives for meeting the goals of the Texas Higher Education Plan: Closing the Gaps
- Developing strategies for implementing recommendations on nursing education
- Responding to directives from the Legislature
- Recommending future directions for THECB and institutions on nursing education

In addition, ACORN is charged with overseeing implementation of Senate Bill 139 which requires THECB together with the BON to conduct a study and identify methods to improve the curricula of professional and vocational nursing programs. Recommendations from the completed report are intended to construct a new curriculum framework for nursing education which will:

- Emphasize current patient safety competencies
- Facilitate articulation between RN programs and mobility among different levels of education (LPN, ADN, BSN)
- Utilize competency-based testing and evidence-based practice
- Integrate classroom and clinical content with new instructional technology
- Promote student completion and transition from nursing student to practicing nurse

An external consultant, Brenda Cleary PhD, RN, FAAN, was selected to complete the study. She provided a preliminary report to ACORN in August and is expected to submit an updated draft this fall. The preliminary report recommended using as a framework the five competencies outlined in the 2003 report of the Institute of Medicine, Health Professions Education: A Bridge to Quality. These competencies include: patient-centered care, interdisciplinary teamwork, evidence-based practice, quality improvement, and use of information technology. A standardized curriculum implemented across all nursing programs is proposed to improve quality, facilitate educational mobility, and use resources more effectively and efficiently (A New Curriculum Model for RN Nursing Education in Texas — DRAFT, August 2008, Academic Affairs and Research, THECB). A residency program for newly licensed registered nurses is also recommended. More information is available on the THECB website: http://www.thecb.state.tx.us/AdvisoryCommittees/ACORN/.

★
Thousands of nurses across Texas show support of nursing by carrying the Texas Nurses Association WorldPoints® Platinum Plus® MasterCard® credit card issued through Bank of America. Other nurses have opened a TNA personal checking account so they can show pride in their profession every time they use their TNA Check Card or personal checks.

As a way to invest in the community of nursing it serves, Bank of America announced on September 17, a disaster relief program for qualifying customers in 29 Texas counties (and 14 parishes in Louisiana) most heavily impacted by Hurricane Ike. Under the relief program, customers may qualify to:

- Receive emergency credit line increases on their existing Bank of America Visa® or MasterCard®.
- Modify, defer or extend payments on loans, credit cards or lines of credit.
- Access a new home equity loan through the bank’s special loan program, with no fees and with preferential pricing below the current rate (available only in Texas).
- Purchase a new primary residence through the bank’s special mortgage program with waived loan fees and an expedited loan process.
- Avoid bank early withdrawal penalties on certificates of deposit.

The Texas counties included in the disaster relief program include: Angelina, Austin, Brazoria, Chambers, Cherokee, Fort Bend, Galveston, Grimes, Hardin, Harris, Houston, Jasper, Jefferson, Liberty, Madison, Matagorda, Montgomery, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Trinity, Tyler, Walker, Waller and Washington.

Louisiana parishes that are part of the program include: Acadia, Beauregard, Calcasieu, Cameron, Iberia, Jefferson, Jefferson Davis, Lafourche, Plaquemines, Sabine, St. Mary, Terrebonne, Vermilion and Vernon.

Bank of America customers may apply for assistance under the program through October 31, 2008, in any of the banking centers or by phoning 1-800.831-5586. For assistance with your credit card account, phone the number on the back of your card or on your statement.

Offers through the disaster relief program are subject to credit approval and current credit standards apply. Bank of America, N.A., equal housing lender. Member FDIC. Insurance is required for mortgage and home equity loan products.

For full details and terms, please contact Bank of America or visit www.bankofamerica.com.
The Nursing Shortage: A “Perfect Storm”

by Cindy Zolnierek, MSN, RN

Introduction
Nursing shortages have been cyclic events since World War II (WWII). Various market forces including population growth, the explosion of treatment modalities, and emergent nursing roles have driven an increased demand for nurses and a resultant shortage at various times throughout the last century.

The current shortage, however, is significantly different from those past. A reduced supply of nurses, related to the aging of the nursing workforce, is coupled with an unprecedented growth in demand as Baby Boomers age — thus creating a “perfect storm:” a unique convergence of factors creating a once-in-a-lifetime storm of great magnitude and violence. Because all nurses are in the midst of this storm, all nurses need to be aware of projections, opportunities, and threats related to the shortage.

What is a Nursing Shortage?
This appears to be a basic question, but the answer can become quite complex. Based on a supply-and-demand model (Table 1), a shortage occurs when the demand exceeds supply — in this case, of nurses. The supply of nurses is influenced by a number of factors including nursing school enrollments and graduations, number of hours worked by nurses, and nurses’ flow in and out of the workforce (Clarke & Cheung, 2008). Historically, demand has been created by population growth (including increased longevity), new technologies, and new roles for nurses outside the traditional bedside nurse position (see Table I). As demand increased, schools typically enhanced enrollments to produce more nurses. This approach has had limited short-term success as nursing shortages have plagued nursing throughout the past century.

Historical Perspectives
The first nursing shortage described in the literature occurred during WWII when 25% of the country’s nursing workforce entered the military, thus significantly reducing the supply of nurses to the civilian population (Bollough & Bollough, 1966). At the same time, new technologies (radiology and laboratory), treatments (antibiotics), and payment systems (insurance) created a new and heightened demand for hospital-based nurses. No longer was the hospital a place for the poor who could not afford private duty nursing, or those needing a place to die; instead, the hospital became a place to access the most advanced treatment available (Sandelowsky, 2000). Hospitals needed more nurses to provide these new treatments.

In addition, the nurse’s role in industries supporting the war flourished, thus creating new demands. The equation of increased demand and reduced supply created the first recognized shortage of hospital nurses.

The country responded to the nursing shortage with congressional appropriations for nursing education — funding for schools to increase enrollments, as well as programs to cover the costs of nursing education for individuals, e.g., the Cadet Nurse Corps was introduced. A proposal to draft nurses, largely supported by the public, was withdrawn in 1945 after aggressive recruitment efforts were successful in attracting nurses (Kalish & Kalish, 2004). Also in response to the shortage, a new level of caregiver was introduced: an assistant to the nurse. Rather than provide direct care, the nurse became responsible to see to it that the patient was nursed (Saunders, 1954). The debut of the nursing assistant would forever change the role of the hospital nurse.

Though a surplus of nurses was anticipated after WWII, the nursing shortage persisted. Longer life expectancy, population growth, and an increased demand for public health nurses contributed to a growing demand for nurses. Despite this demand, nurses returning from the war were reluctant to accept the poor working conditions and low pay in hospital environments as compared with their previous military roles — positions in industry and physician offices were more desirable. Additionally, many nurses returning from the war married and left the workforce. Absent the patriotic call to serve occasioned the demand for women in the workplace, nursing fell in popularity. School enrollments plummeted. In an attempt to replenish the void of registered nurses, another level of caregiver was defined: the practical nurse (Kalish & Kalish, 2004).

The nursing shortage was characterized as critical in the 1950s: hospitals had to close wards and could not provide new services. Demand
### Table 1: Factors Affecting Supply and Demand of Nurses

#### FACTORS AFFECTING SUPPLY OF RNS

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing education</td>
<td>Attraction of nursing as a profession to potential students (career options, wages, working conditions, employment rates)</td>
</tr>
<tr>
<td></td>
<td>Currently qualified students turned away due to capacity limitations (faculty shortages, shortage of clinical space)</td>
</tr>
<tr>
<td></td>
<td>20-35% nurses do not successfully complete the nursing program</td>
</tr>
<tr>
<td>Hours worked</td>
<td>Economic factors</td>
</tr>
<tr>
<td>(full time, part time, per diem)</td>
<td>• General economy: when economy slows, nurses tend to return to the workforce</td>
</tr>
<tr>
<td></td>
<td>• Wages and benefits</td>
</tr>
<tr>
<td></td>
<td>Non-economic factors</td>
</tr>
<tr>
<td></td>
<td>• Job characteristics</td>
</tr>
<tr>
<td></td>
<td>• Quality of work environment</td>
</tr>
<tr>
<td></td>
<td>• Personal situation (continued education, child/elder care, age of RN)</td>
</tr>
<tr>
<td>Departures/re-entry to hospital workforce</td>
<td>Especially for nurses &gt; 40 looking for less physically demanding jobs</td>
</tr>
<tr>
<td></td>
<td>Baby boomer nurses expected to retire…</td>
</tr>
<tr>
<td></td>
<td>Temporary departures</td>
</tr>
<tr>
<td></td>
<td>Dependent on economy and personal situation: childcare, eldercare, continued education</td>
</tr>
<tr>
<td></td>
<td>Re-entry</td>
</tr>
<tr>
<td></td>
<td>Plays a small role; re-entry from extended time away is difficult</td>
</tr>
<tr>
<td>Immigration</td>
<td>Continued significant growth</td>
</tr>
</tbody>
</table>

#### FACTORS AFFECTING DEMAND OF RNS

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population requiring hospital services</td>
<td>Continued significant growth</td>
</tr>
<tr>
<td>Hospital RN workforce</td>
<td>Continued significant growth; research trends supporting hospital RN staffing relationship to patient outcomes, continued advances in treatment requiring complex care</td>
</tr>
<tr>
<td>Non-RN hospital providers</td>
<td>Currently low use</td>
</tr>
<tr>
<td>Non-hospital based RN demand</td>
<td>Significant need (faculty; growth in outpatient services, long-term care)</td>
</tr>
</tbody>
</table>

Factors affecting supply and demand of nurses (Sources: Clark & Cheung, 2008; Buerhaus, Auerbach, & Staiger, 2007) From: http://www.nursecredentialing.org/Magnet/ProgramOverview/ForcesofMagnetism.aspx accessed 9/10/08.
The Nursing Shortage: A “Perfect Storm”
(Continued from page 15)

had exploded due to growth and aging of the population, extension of hospitalization, and increased use of new medicines and treatments. Use of nurses in long-term hospitals reporting RN vacancies of 20-30% in 1961. Nursing compared poorly with the wages and working conditions of other predominantly female professions such as teaching. A report from the Surgeon General’s Consultant Group on Nursing concluded that a 75% increase in nursing graduates was needed to reach the projected need for nurses in 1970. Subsequently, Congress passed The Nurse Training Act of 1964 authorizing millions of dollars for nursing education—grants for special projects, nursing school construction, administration of programs, and nursing student loans.

During the 1970s, beds in long-term hospitals (i.e., psychiatric facilities) were reduced by 40% while acute care beds increased by 10%. Outpatient visits increased by 62%. Although health care worker wages continued to be below the all-industry average, numbers of workers grew by 55% (Kalish & Kalish, 2004). There were more nurses than ever: nursing school admissions had doubled from 1959 to 1979, and increased in numbers of hospital-based births. A significant number of nurses dropped out of the workforce within three years of graduation to marry and raise families. Efforts to recruit students into nursing schools were organized by hospital associations and insurance companies. Efficient utilization of the Hospital Nurse became a priority and the industrial model of mass production so successful in product manufacturing was applied to nursing. This model became known as “team nursing” where the nurse became the manager of care for a group of patients. Also in the 1950s, a five-year research project to prepare bedside nurses at a faster pace and move nursing into the overall system of higher education was implemented: the associate degree nurse was born (Kalish & Kalish, 2004).

A new decade saw little change in the intensity of the nursing shortage with hospitals reporting RN vacancies of 20-30% in 1961. Nursing compared poorly with the wages and working conditions of other predominantly female professions such as teaching. A report from the Surgeon General’s Consultant Group on Nursing concluded that a 75% increase in nursing graduates was needed to reach the projected need for nurses in 1970. Subsequently, Congress passed The Nurse Training Act of 1964 authorizing millions of dollars for nursing education—grants for special projects, nursing school construction, administration of programs, and nursing student loans.

During the 1970s, beds in long-term hospitals (i.e., psychiatric facilities) were reduced by 40% while acute care beds increased by 10%. Outpatient visits increased by 62%. Although health care worker wages continued to be below the all-industry average, numbers of workers grew by 55% (Kalish & Kalish, 2004). There were more nurses than ever: nursing school admissions had doubled from 1959 to 1979, and employed nurses tripled between 1950 and 1962 (Aiken, 1983). President Carter vetoed the 1978 Nurse Training Act claiming an adequate supply of registered nurses, a decision heavily criticized by the nursing community. Anecdotal evidence revealed a severe national shortage of registered nurses, particularly in acute care, related to geographic maldistribution, low pay, expanded need especially for those with advanced education, shortage of faculty, and large number of inactive nurses (70% of nurses were in the workforce: 60% working full time and 40% part time) (Cunningham, 1979). The Nurse Training Act was reauthorized in 1979, and a study by the Institute of Medicine (IOM) was commissioned by Congress to resolve the debate over the existence of a nursing shortage.

The IOM report was released in 1983. It concluded that, while the shortage had peaked in 1979 at a 14% hospital vacancy rate, the supply and demand of nurses was balanced and expected to remain so through the 1980s. How did the shortage turn around so quickly? Economic forces such as double digit inflation and salary increases lured nurses back into the workforce. Demand was also reduced as unemployment rates climbed, workers lost health insurance benefits, and hospital occupancy rates fell (Aiken, 1983). By 1984, hospital nurse vacancy rates reached an all time low. However, by 1986, the shortage again reared its head and continued throughout the remainder of the decade. The supply of nurses was impacted by reduced enrollments—a smaller pool of college-aged individuals, and among them, fewer numbers were choosing nursing. Yet, the demand for nurses continued to rise (Aiken, 1987).

Changing economic forces affecting care delivery and the use of health care providers surfaced in the 1990s. Reimbursement models for health care moved away from fee-for-service (payment based on cost of providing care) toward shared risk models (monetary limits regardless of costs of care; fixed or capitated payment systems such as diagnostic related groups [DRGs] and managed care (health maintenance organizations)). The hospital business imperative was to reduce operating costs (e.g., labor and supplies) and control resource utilization (length of hospital stay) while achieving positive patient outcomes. Hospitals struggled for financial survival; hospital mergers and closures occurred. Because nurses were part of the hospital cost formula and viewed as expensive, they became a prime target for change initiatives. Re-engineering, a process borrowed from outside the health care industry, was introduced to improve operational efficiency and reduce costs. In most hospitals this resulted in the introduction of multi-skilled workers and changes in the role of the registered nurse. Hospital demand for nurses declined and the shortage waned. Nursing schools reduced enrollments and fewer nurses entered the workforce. From 1996 to 2000, the annual increase in employed RNs slowed to 1.0% per year (as compared with 3.3% between 1988 and 1996, and 2.4% from 2000-2006 (HRSA, 2006). This lull would later be recognized as an early warning of an impending storm.

A 1990 report by the U.S. Department of Health and Human Services was perhaps the first to recognize the potential impact of the tremendous change in demographics expected to occur in the new millennium. In 1990, the median age of an RN was 39 years with only 16% of RNs being under 30 — the percentage of employed RNs over 50 years old was expected to double by 2020. A shift in demographics would cause the pool of hospital graduates to shrink, resulting in even fewer candidates for nursing school. Additionally, demand was expected to grow based on historical trends and expert projections (News, 1990). Yet, during the 1990s, as nurses struggled with staffing reductions and hospitals expected 1-2% vacancy rates, it was difficult to envision such dramatic changes in the supply-demand equation in a few short years. The warning was largely ignored.

The Perfect Storm Develops

By the late 1990s, some began to question whether another nursing shortage may loom over the millennium horizon. Shifts in the delivery of care to outpatient settings in the 1990s left hospitals with patient populations of increased severity requiring more intense and highly skilled care. As hospitals improved on efficiency and cost measures, the target moved toward quality outcomes — most dramatically showcased in the 1999 IOM report, To Err is Human, which indicated that as many as 98,000 patient lives were lost annually due to medical errors. Nurses complained of working conditions, and an interest in the relationship between nurse staffing and patient outcomes surfaced. The increased concern about quality, together with the increasing acuity of patients, began to offset the reduced nursing demand experienced earlier (Buerhaus, 1998). Nurses were needed and demand began to escalate. The supply side of the equation would be largely driven by the aging of the nursing workforce. “[T]he coming RN shortage will be driven by fundamental, permanent shifts in the labor market that are unlikely to reverse in the next few years” (Buerhaus, 2000, p. 2953). Nursing schools traditionally derived their students from a candidate pool of young women. In the 1980s, this pool declined in number and nursing schools had to compete with growing career opportunities for college-aged women. Thus,
fewer nurses were produced, resulting in a lopsided age distribution of practicing nurses: in 2004 the median age of the registered nurse population was 46.8 years and only 26.3% were under 40 (HRSA, 2006). The largest cohorts of nurses are in their 50s and 60s. There are not enough new graduates to fill the workforce vacancies created as these nurses begin to reduce their hours and retire, resulting in a very different kind of shortage than ever before experienced.

In 2000, the supply of nurses in 2020 was forecast to be 20% less than national demand (Buerhaus et al., 2004). The immediate ramifications in the shortage projection should be interpreted with caution: “We have reduced the magnitude of the future shortage hurricane from a Category Five, on a huge amount of steroids, down to a Category Three ... But that can still kill you ... (If) it were to move along the coast of America it would do most of the system and cause care to be rationed.” (Peter Buerhaus, PhD, RN, FAAN as quoted by Roman, 2008).

Texas, familiar with the fierce devastation caused by hurricanes, is not immune from three types of shortages: generations, and recovery. The estimates indicate an existing shortage of 21,800 nurses, and predict a shortage of 76,600 nurses by 2020 (CNW, 2006). Fortunately, Texas is actively involved in many efforts and on several levels to stem the current shortage and mitigate dire predictions.

Strategies for Addressing the Nursing Shortage

Major storms like Hurricane “ Ike” and the current situation in nursing, come with warnings and are tracked by experts, who monitor level of force and potential dangers, and advise regarding preparations and recovery. The warnings and potential dangers of nursing’s perfect storm are clear. Past strategies in and of themselves will not be adequate. New approaches targeting all aspects of the nursing workforce — work environment, workplace efficiencies, workforce development, practice initiatives — will be required.

Work environment. It is no surprise that the work environment is linked to nurse satisfaction and retention. Hospitals with positive practice environments are more likely to attract nurses and keep nurses longer. Research conducted by the American Nurses Association (ANA) in 1983 identified 14 characteristics in hospitals that were successful in attracting and retaining nurses. In the early 1990s, the American Nurses Credentialing Center (ANCC) developed the Magnet Recognition Program® to distinguish hospitals with excellent professional practice environments. The 14 characteristics became known as “forces of magnetism” and their expression became the criteria upon which hospitals were evaluated (Table 2). Based on a statistical analysis of data from Magnet facilities, a new model was introduced this year (2008).

The new model replaces the 14 forces of magnetism with five components which contain the forces:

- Transformational Leadership
- Structural Empowerment
- Exemplary Professional Practice
- New Knowledge, Innovation & Improvements
- Empirical Quality Results

As hospitals compete to fill nurse vacancies, interest in Magnet recognition—a badge of practice environment excellence—has increased. Prior to 2006, the first Magnet hospital was designated, until 2000, less than ten facilities per year were recognized as Magnet.

Corresponding with the awareness of a nursing shortage after 2000, Magnet designations dramatically increased, reaching a peak of 75 awards in 2005 alone. Currently, 293 hospitals nationally carry Magnet designation (ANCC, 2008).

Texas has been a leader in the development of programs to support the best practices in the work environments of nurses. Texas was first in the nation (2001) to have regulations addressing nurse staffing. Regulations requiring hospitals to have policies on safe patient handling and abuse/harassment protections were established in 2005. Most notably, the Texas Nurses Association developed the Nurse-Friendly™ hospital...
Technology won’t fix existing system problems, but does offer potentially productive tools to support efficiencies in nursing practice. Other strategies for wise use of nursing resources include environment and process design, such as the location and availability of supplies and equipment, the organization and layout of the physical environment, and procedures for implementing care. The number and type of clinical support staff available to the nurse also affects how the nurse organizes and spends his/her time. The goal of workplace efficiencies is to optimize the time nurses spend in value added care requiring their level of expertise and licensure.

**Practice development.** Many of the strategies for nurturing a desirable workplace (identified above, e.g., Magnet designation), also support practice development. Additionally, the nursing shortage prods nurses to examine practice patterns: levels of collaboration with team members, use of evidence-based practices, models of care delivery, and scope of practice. Health care organizations are recognizing the important role of teamwork in achieving safe and effective patient care. TeamSTEPPS™ (AHRQ, 2008), originally published in 2006 and recently revised, offers an evidence-based framework for teamwork which optimizes performance and safety. This model is built upon principles of team leadership, situation awareness, mutual support, and communication to enhance all team member roles. Collaborative team models enhance the practice environment for nurses, thereby supporting their satisfaction with the workplace.

Evidence-based practice refers to activities that are backed by science and research. Traditionally, much of nursing practice has not necessarily had a scientific basis. Evidence-based practice requires knowing the research or scientific literature, and, if a “best practice” has been identified, it is used (e.g., incorporated in policies, procedures, and practices). When nurses follow best practices, patients are receiving more efficacious care and nurses are thereby more efficient in their practice.

Historically, nursing models of care delivery were driven by market forces and mimicked strategies employed in other industries, e.g., apprenticeship model in early 1900s, functional nursing (production model), team nursing (industrial model), patient focused care (business model). The primary care model introduced in the 1980s was the first to come from a professional practice perspective and reflect professional values. The current and projected future nursing shortage offers nurses an opportunity to proactively create a new nursing model of care based on evidence and linked to outcomes. Research convincingly supports a relationship between nurses and patient outcomes within the context of the hospital environment and culture. The delivery model of nursing care can be the context that supports the kind of nursing practice that can achieve positive outcomes. This is a time for nurses to design and measure structures and processes to deliver care.

Finally, the shortage of nurses and other health care workers require policy makers to take a fresh look at workforce planning. Out of Order, Out of Time (AAHC, 2008) warns that the lack of national uniformity in scopes of practice restricts the mobility and practice of health professionals thus contributing to existing workforce shortages. The report calls for transformative change through the development of innovative policies.

**Workforce development.** Workforce development is perhaps the most consistent and traditional response to nursing shortages. In virtually every era, additional funding for nursing education has played a major role in responding to the shortage of nurses and other health care workers. However, too often the focus has been on quantity, not the quality of nurses. Through policy, nurses, other health care providers, and students can work together to ensure the best possible delivery of care for patients.

**Table 3: Texas Nurses Association — Leading Efforts to Address the Nursing Shortage**

**PROMOTING POSITIVE WORK ENVIRONMENTS**

**Advocacy and Whistleblower Protections**


**Nurse Staffing**

In 2002, Texas was the first in the country to implement staffing regulations thanks to TNA’s successful and collaborative effort with key stakeholders.

**Safe Patient Handling and Workplace Safety**

First again! TNA achieved legislation to require hospitals and nursing homes to adopt policies minimizing manual lifting and protecting nurses from violence in the workplace (2003; 2005).

**Nurse-Friendly™ Hospital Designation**

TNA introduced a recognition program for hospitals who had implemented essential elements of the ideal nursing practice environment as identified by nurses and research.

**ESTABLISHING WORKPLACE EFFICIENCIES**

**Licensure Mobility**

Thanks to TNA, Texas was among the first four states to participate in the Nurse Licensure Compact which permits nurses to move and practice in participating states with minimal hassle and expense (1999, 2007).
The Nursing Shortage: A “Perfect Storm” (Continued from page 18)

to the shortage. This time, appropriations will be a necessary but insufficient response; the most critical barrier to producing more nurses is limited capacity of nursing schools related to lack of faculty and saturation of clinical sites. The development of novel solutions to this challenge will be key in addressing the need to produce large numbers of nurses.

Innovative approaches have centered on partnerships outside the normal spheres of likely nursing partners — strategic partnerships include professional/membership associations (TNA, Texas Hospital Association, AARP), schools of nursing, governmental agencies (BON, Texas Higher Education Coordinating Board), business and industry (Greater Houston Partnership, Chambers of Commerce), hospital councils, hospitals and health care institutions, and philanthropy. Communities are utilizing centralized clinical placement systems to maximize use of available clinical sites, and schools are subsidizing clinical education with simulation technology in clinical learning labs.

Individual schools and hospitals have established relationships to maximize use of clinical sites and share staff as faculty (e.g., joint appointments, preceptorships). Schools have designed creative strategies to retain students and promote their successful completion of the nursing program, and hospitals are implementing evidence-based new grad programs (such as the Versant RN Residency Program) to support transition and retention of newly graduated nurses. Responses to the faculty shortage include addressing salary disparities, providing loan forgiveness programs to graduate students who plan to teach, training staff nurses to provide clinical education, and standardizing curriculum. Nursing programs have been designed with specific student populations in mind: fast track or accelerated programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance learning programs for individuals with bachelor degrees in other fields, online/distance leaning programs for nurses in rural or working students, and programs targeting specific cultural groups (e.g., Hispanic students). The Texas Center for Nursing Workforce Studies (TCNWS) was established in 2004 to monitor nursing workforce data, develop priorities, and guide policy around the nursing shortage. The TCNWS maintains a database rich in information about Texas nurses. Recent surveys (available at http://www.dshs.state.tx.us/chs/cnws/default.shtm) include Long Term Care Nurse Staffing (2008), and Hospital Nurse Staffing (third survey completed in 2008), as well as the 2007-released report, Professional Nursing Education in Texas Demographics and Trends (2006). The data collected and tracked by the TCNWS provides nursing with a “weather map” and forecast of the progression of the nursing shortage.

Conclusion

“Those that fail to learn from history are doomed to repeat it.” Winston Churchill.

What has the history of the nursing shortage taught us? As a profession, nursing has tended to be reactionary and allow the profession to be shaped by external forces: introduction of new levels of caregivers and the development of models of care were not conceived of nursing determining a better way to care for patients, instead they were driven by shortages. Nursing has an opportunity to proactively and consciously create a context for practice that is best for patient care, including work environments, care processes, models of care, and nursing practices. The historical perspective of nursing shortages can inform nurses, and those who rely on them. Surplus nurses have been a rare and perhaps, artificial occurrence. Ensuring an adequate supply of nurses is an ongoing, long-term process that requires continued focus and commitment. With current and proposed efforts to address the shortage, it is likely there will be some success. Let this success not distract from the commitment to ensure an adequate nursing workforce in the future — or we will be doomed to repeat the very cycle we are attempting to interrupt.★

About the author: Cindy Zolnierek has a broad base of varied nursing experience in hospital practice environments and is currently the director of practice for the Texas Nurses Association.

References
NHS predicts shortage could top 800,000 by 2020. American Journal of Nursing, September, 97, 110.
HHS predicts shortage could top 800,000 by 2020. American Journal of Nursing, October, 1440-1444.
(Continued on page 20)
1. Nursing shortages are related to an imbalance of supply and demand. All of the following factors affect the supply of nurses, EXCEPT:
   a. Nursing school student capacity related to faculty and clinical site availability
   b. Number of non-nurse healthcare providers
   c. Number of hours nurses work
   d. Number of nurses in the workforce

2. Historically, the demand for nurses has grown when:
   a. The population increases due to improved longevity and increased birthrate
   b. Advances in medicine and science create new treatments
   c. People obtained health insurance coverage
   d. All of the above

3. Responses to early nursing shortages have included all of the following EXCEPT:
   a. Funding to support the education of more nurses
   b. Funding for increased faculty salaries to recruit nurses into teaching positions
   c. Introduction of new levels of caregivers
   d. Efforts to recruit students into nursing schools

4. The current and projected nursing shortage differs from previous shortages in that it
   a. Is due to a lack of nurses who want to work in the hospital environment
   b. Can be resolved with the improved use of technology in the workplace
   c. Results from aging of the workforce and the population, resulting in increased demand at the same time supply is reduced due to nursing retirements
   d. None of the above

5. What new trend emerged in a 2007 study which resulted in revised predictions as to the severity of the shortage?
   a. The candidate pool for nursing students expanded to include 2nd career individuals in their 20s
   b. Improvements in work environments had lured unemployed nurses back into the workforce
   c. Nurses were delaying retirements thus enhancing the supply of nurses
   d. All of the above

6. How does the Magnet® Recognition Program contribute to one solution to the nursing shortage—improving the practice environment?
   a. Magnet criteria include hospital characteristics that are successful in attracting and retaining nurses
   b. Nurses who are satisfied with their work environments are likely to stay in the workforce longer
   c. Magnet hospitals demonstrate excellent professional practice environments
   d. All of the above

7. Texas has led the nation in approaches to support best practices in the work environments of nurses. These approaches all of the following EXCEPT:
   a. Nurse staffing regulation and whistleblower protections
   b. Safe patient handling protections
   c. Advocacy and whistleblower protections
   d. None of the above

8. In developing workplace efficiencies, all of the following should be considered, EXCEPT:
   a. Technology can reduce the number of nurses needed
   b. Technology can improve efficiency of nursing work
   c. Organization of the environment is an important aspect of efficiency
   d. Systems to improve availability of supplies and equipment to nurses are important

9. What opportunities does the shortage present for practice development?
   a. Fewer nurses will enable others to take on nursing's role
   b. Models in other industries, such as manufacturing, can help nurses be efficient
   c. Nurses can re-evaluate care delivery models to ensure they are based on evidence based practices and patient outcomes
   d. All of the above

10. Solving the nursing shortage requires:
    a. Partnerships and collaboration among various groups
    b. Multiple approaches (work environment, practice, education)
    c. New and creative strategies
    d. All of the above
The Nursing Shortage: “A Perfect Storm”

TEST QUESTION ANSWER/REGISTRATION/EVALUATION FORM

Send by mail with a self-addressed stamped envelope OR complete online and print certificate of successful completion at http://tnacne.texasnurses.org.

TEST QUESTION ANSWERS

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>2</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>3</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>4</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>5</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>6</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>7</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>8</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>9</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>10</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
</tbody>
</table>

ACTIVITY EVALUATION

**Purpose of this activity:** The purpose of this educational activity is to describe the past and current context surrounding the supply and demand of registered nurses and assist nurses in understanding the impact of a nursing shortage and related strategies on their current and future work environment.

Please complete this evaluation questionnaire. Your responses will be used to revise this activity and to plan future educational activities. Circle the number/response that best fits your evaluation of the activity.

1 = Not at all  2 = Somewhat  3 = Almost completely  4 = Completely

1. Rate your achievement of these objectives:
   a. Highlight the historical and social background of nursing shortages in the United States.
   b. Identify at least 3 factors affecting the supply and demand of registered nurses in the workplace.
   c. Describe the unique demographic trends related to the current and projected nursing shortage.
   d. Identify strategies in the areas of work environment workplace efficiencies, practice development, and workforce development proposed to impact the current nursing shortage.
   1 2 3 4

2. Rate the effectiveness of the teaching/learning materials. 1 2 3 4

3. Were the objectives relevant to the overall purpose? 1 2 3 4

4. How long, in minutes, did it take you to complete this activity? (Circle one)
   0–30 minutes 31–60 minutes 61–90 minutes More than 90 minutes

5. List two (2) ways you will integrate what you learned in this activity into your practice and/or employment environment.

   _______________________________________________________
   ____________________________________________________________________________

6. Were the following disclosed prior to the beginning of this activity?
   a. Requirements for Successful Completion
      Yes No
   b. Conflicts of Interest
      Yes No
   c. Commercial Support
      Yes No
   d. Non-Endorsement of Products
      Yes No
   e. Off-Label Use of Products
      Yes No

7. Did you notice any bias that was not disclosed in this activity? Yes No
   If “Yes,” Please describe: _______________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

Additional comments: _____________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

REGISTRATION INFORMATION

Name: ____________________________________________________________________________
Address: __________________________________________________________________________
City: ____________________________________ State: ______________ ZIP: _______________
Phone: ____________________________________________________________________________
Date of Birth (MM/DD): ___ ___/ ___ ___
E-mail: ____________________________________________________________________________
Check one: ___ RN  ___ LVN  ___ Student  ___ Other: _______________________________
Check one: Practice setting: ___ Hospital  ___ LTC  ___ Non-clinical setting. Other: ________
Practice role: ___ Staff Nurse  ___ Manager/Supervisor  ___ Faculty. Other: ________
   ___ Member of TNA/TxNN (TNA District: ________)  ___ Non-member of TNA/TxNN

Mail this completed form to: Texas Nurses Association
7600 Burnet Road, Suite 440
Austin, Texas 78757

Please include a self-addressed, stamped envelope. If all fields are completed on the form and a passing grade of 80% is achieved on the Test for CNE Credit, certificates of successful completion will be sent in 4 to 6 weeks.
2. SELECT YOUR TYPE OF MEMBERSHIP

From the options that follow, then, using the chart below, match your TNA District, type of membership and preferred method of payment to determine correct dues.

- **Full Membership** - Full rights and privileges of membership (all nurses employed more than an average of 20 hours a week).
  - $319.00
  - $309.00
  - $299.00

- **Reduced Dues Membership** - Pay 50% of annual dues (all nurses 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 or older who are working and receiving Social Security).
  - $294.00
  - $304.00
  - $299.00

- **Special Membership** - Pay 25% of annual dues (nurses over 62 years-of-age and not employed, or 100% disabled).
  - $289.00
  - $304.00
  - $299.00

3. COMPLETE APPLICATION

Complete this Application for Membership, and mail with check or fax ($12.452.0648) with credit card information. Secure, online membership payment with credit card is also available at www.texasnurses.org.

---

**APPLICATION FOR MEMBERSHIP**

To be completed by TNA

**Required Information for Payment by Credit Card**

- Card Type: Credit Card
- Exp. Date: 12/22
- Signature: __________________________

**EDPP AUTHORIZATIONS**

To provide monthly electronic payments to American Nurses Association (ANA):

1. This is to authorize ANA to withdraw 1/12 of my annual dues and any additional service fee from my checking account each month on or after the 15th day of each month.
2. ANA will charge a $5.00 fee for any returned drafts.
3. TNN is authorized to change the amount by giving the undersigned thirty (30) days written notice; (4) the undersigned may cancel this authorization upon receipt by ANA of written notification of termination twenty (20) days prior to deduction date as designated above. ANA will charge a $3.00 fee for any returned checks.

Signature: __________________________

---

**MEMBERSHIP DUES RATES - 2008**

<table>
<thead>
<tr>
<th>District</th>
<th>M-Full Membership Dues</th>
<th>R-Reduced Membership Dues</th>
<th>S-Special Membership Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,2,3,4,6,15,16,20</td>
<td>$289.00</td>
<td>$309.00</td>
<td>$319.00</td>
</tr>
<tr>
<td>22,25,26,29,21</td>
<td>$294.00</td>
<td>$304.00</td>
<td>$319.00</td>
</tr>
<tr>
<td>11,12</td>
<td>$299.00</td>
<td>$309.00</td>
<td>$319.00</td>
</tr>
<tr>
<td>1,5,7,20,50</td>
<td>$304.00</td>
<td>$319.00</td>
<td>$319.00</td>
</tr>
<tr>
<td>1,2,3,4,6,15,16,20</td>
<td>$289.00</td>
<td>$309.00</td>
<td>$319.00</td>
</tr>
</tbody>
</table>

**SELECT A PAYMENT PLAN**

Indicate below your preferred method of payment:

- Single Annual Payment (by check, please enclose with application) $319.00
- Single Annual Payment by credit card (complete Required Information for Payment by Credit Card) $319.00
- Monthly Credit Card Draft (complete Required Information for Payment by Credit Card) $319.00

**Texas Nurses Network**

- $319.00
- $294.00

---

**EDPP AUTHORIZATION FOR TNA**

To provide monthly electronic payments to Texas Nurses Network (TNN):

1. This is to authorize TNN to withdraw 1/12 of my annual dues and any additional service fee from my checking account each month on or after the 15th day of each month.
2. ANA will charge a $5.00 fee for any returned drafts.
3. TNN is authorized to change the amount by giving the undersigned twenty (20) days written notice; (4) the undersigned may cancel this authorization upon receipt by TNN of written notification of termination twenty (20) days prior to deduction date as designated above. TNN will charge a $3.00 fee for any returned checks.

Signature: __________________________

---

**EDPP AUTHORIZATION FOR TEXAS NURSES NETWORK**

To provide monthly electronic payments to Texas Nurses Network (TNN):

1. This is to authorize TNN to withdraw 1/12 of my annual dues and any additional service fee from my checking account each month on or after the 15th day of each month.
2. ANA will charge a $5.00 fee for any returned drafts.
3. TNN is authorized to change the amount by giving the undersigned twenty (20) days written notice; (4) the undersigned may cancel this authorization upon receipt by TNN of written notification of termination twenty (20) days prior to deduction date as designated above. TNN will charge a $3.00 fee for any returned checks.

Signature: __________________________

---

**SELECT A MEMBERSHIP OPTION BELOW**

- Full Membership - Membership in the Texas Nurses Association, you must be a licensed registered nurse.
- Reduced Dues Membership - Pay 50% of annual dues (all nurses 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 or older who are working and receiving Social Security).
- Special Membership - Pay 25% of annual dues (nurses over 62 years-of-age and not employed, or 100% disabled).

---

**MEMBERSHIP IN THE TEXAS NURSES ASSOCIATION**

Include below your type of membership. Type of membership and TNA District determine your annual TNA dues rate.

- Reduced Dues Membership - Pay 50% of annual dues (all nurses 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 or older who are working and receiving Social Security).
- Special Membership - Pay 25% of annual dues (nurses over 62 years-of-age and not employed, or 100% disabled).

---

**REDUCED DUES MEMBERSHIP**

- Reduced Dues Membership - Pay 50% of annual dues (all nurses 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 or older who are working and receiving Social Security).
- Special Membership - Pay 25% of annual dues (nurses over 62 years-of-age and not employed, or 100% disabled).

---

**MEMBERSHIP INFORMATION**

- Texas Nurses Association, 7600 Burnet Road, Suite 440, Austin TX 78757-1292 or FAX with credit card information.
- Phone: 800.862.2022 or 512.452.0645
- Fax: 512.452.0648
- Email: info@texasnurses.org

---

**CONFERENCE / WORKSHOP**

- Mail: P.O. Box 8545
- Phone: 800.862.2022 or 512.452.0645
- Fax: 512.452.0648