



To the Honorable Chair and members of the Healthcare Workforce Taskforce,

The Texas Nurses Association (TNA) appreciates the opportunity to share information about the state of the nursing workforce in 2024. This letter contains a summary of TNA’s recommendations after listening to the feedback of task force members and participants in the several meetings and workgroup sessions.

**I. Education Funding**

Texas is in the middle of a nursing education revitalization program charted by Senate Bill 25 from the 88<sup>th</sup> Regular Session. The bill streamlined existing programs and created several new programs. Rules for these programs were finalized and adopted by the Texas Higher Education Coordinating Board (THECB) in summer of 2024 and funds will be distributed in the FY24-25 academic year. The following table lists each program and associated funding from the General Appropriations Act (GAA).

**Table 1: State Spending at a Glance**

<b>State FY 23-25 General Appropriations Act</b>	
<b>Nursing Scholarship Program</b>	\$12.5M
<b>Nursing Loan Repayment Program</b>	\$12.5M
<b>Nursing Faculty Loan Repayment Assistance Program</b>	\$7M
<b>Nursing Innovation Grant Program</b>	\$6M by rider; \$3.7M from Texas Tobacco Lawsuit Settlement Fund
<b>Nursing Shortage Reduction Program</b>	\$46.8M

State spending details:

- **Nursing Scholarship Program (See Texas Education Code, Sec. 61.652):** This program created new scholarship opportunities for Texans attending nursing school, with \$12.5M in funding to be distributed in this biennium.
- **Nursing Loan Repayment Program (See Texas Education Code, Sec. 61.652):** This program created new loan repayment opportunities for Texas nurses as a retention



mechanism for keeping nurses practicing in the state, with \$12.5M in funding to be distributed in this biennium.

- **Nursing Faculty Loan Repayment Assistance Program (See Texas Education Code, Chapter 61, Subchapter JJ):** This program incentivizes graduate-prepared nurses to serve as full- or part-time faculty in schools of nursing in Texas, with \$7M in funding to be distributed in this biennium.
  
- **Nursing Innovation Grant Program (See Texas Education Code, Sec. 63.202 (f) and (g)):** this program provides grants to schools of nursing that develop or expand new activities and projects that promote innovation in the preparation of initial RN licensure nursing students and of faculty who may teach in initial RN licensure programs. The program is funded with proceeds from the Texas Tobacco Lawsuit Settlement (\$3.7M in this biennium), but also received \$6M in funding from Article III, Rider 64 in the 88<sup>th</sup> Regular Session. Examples of grants include funding for simulation training programs, which can alleviate the burden on clinical sites for providing clinical education. Under Board of Nursing rules, schools of nursing may provide 50% of clinical training through simulation.
  
- **Professional Nursing Shortage Reduction Program (See Texas Education Code, Chapter 61, Subchapter Z):** this is a highly flexible program, which has evolved significantly since the Legislature first established the program in 2001. The GAA, by rider, directed \$46.8M in funding into three tiers:
  - o **Growth Teir:** \$28M of the \$46.8M appropriated for the program goes into this tier of funding. THECB will distribute funds under this tier in an equitable manner among nursing programs based on increases in the number of nursing students graduating.
  
  - o **Production Tier:** \$8M of the \$46.8M appropriated for the program goes into this tier of funding. THECB will distribute funds under this tier in an equitable manner among nursing programs based on the total number of nursing students graduating from a program each year.
  
  - o **Faculty Tier:** \$10.8M of the \$46.8M appropriated for the program goes into this tier of funding. THECB will distribute funds under this tier in an equitable manner among nursing programs based on the total number of doctoral level and master's in nursing education students graduating from a program each year.

These programs and associated funds open bottlenecks at various stages of the education pipeline. They target admissions, faculty shortages, and clinical education, and one program financially incentivizes the retention of nurses in Texas. Some of these programs have been in



existence for decades and, historically, they have been remarkably successful. New programs were created in recognition of gaps or needs that were not served by existing programs.

- **Clinical Site Nurse Preceptor Grant Program (See Texas Education Code, Sec. 61.9642):** This program is designed to award grants to clinical sites to support the use of nurse preceptors in providing clinical training to nursing students. Preceptors are practicing nurses who assist in the education of nursing students in the clinical setting. Often, preceptors will take on the burden of training students in addition to their already burdensome workload. This additional burden can dissuade qualified nurses from serving as preceptors when the incentives are not sufficiently aligned, or they lack support for that additional workload. This program could be used to provide support for preceptors in various ways and grant awardees would be able to develop best practices to share more broadly among the nursing profession.
- **Clinical Site Innovation and Coordination Program (See Texas Education Code, Sec. 61.9643):** This program is designed to award grants to clinical sites that create and operate innovative pilot programs that will support nursing performed at clinical sites in this state by increasing the number of nurses, improving the working environment for nurses, improving the retention of nurses, addressing workplace safety, and coordinating with other clinical sites any solutions found to address common nursing concerns. These pilot programs could then be shared more broadly in the nursing profession to develop best practices and advance the profession's commitment to quality care.
- **Nursing Faculty Grant Program – Part-Time Positions (See Texas Education Code, Sec. 61.9644):** This program is designed to award grants to institutions of higher education to provide funding for qualified nursing staff working at clinical sites who serve as part-time nursing faculty at those institutions. Clinical faculty can increase and extend clinical capacity, much like preceptors. Unlike preceptors, clinical faculty work for the educational institution instead of the clinical site. Board of nursing regulations provide different rules for clinical faculty and preceptors; however both are essential to extend the utility and availability of clinical education.
- **Nursing Faculty Grant Program – Clinical Training (See Texas Education Code, Sec. 61.9645):** This program is designed to award grants to clinical sites who provide additional clinical training to nursing faculty. The grants would improve the quality of clinical education by incentivizing greater collaboration between clinical faculty and the clinical sites they use to train nursing students.

TNA recommends continuing investments in these programs, and funding clinical programs that were created last session but not funded. Depending on the availability of funds, the Texas Legislature should consider repeating its investments from the 88<sup>th</sup> Regular Session while also investing in previously unfunded clinical programs.



**Table 2: Estimated Funding Costs**

<b>State FY 25-27 General Appropriations Act</b>	
<b>Nursing Scholarship Program</b>	\$12.5M
<b>Nursing Loan Repayment Program</b>	\$12.5M
<b>Nursing Faculty Loan Repayment Assistance Program</b>	\$7M
<b>Nursing Innovation Grant Program</b>	\$6M by rider; \$3.7M from Texas Tobacco Lawsuit Settlement Fund
<b>Nursing Shortage Reduction Program</b>	\$46.8M
<b>Clinical Site Nurse Preceptor Grant Program</b>	\$82M
<b>Clinical Site Innovation and Coordination Grant Program</b>	\$32.8M
<b>Nursing Faculty Grant Program – Part-Time Positions</b>	\$33.8M
<b>Nursing Faculty Grant Program – Clinical Training</b>	\$5.2M

These investments are critical if Texas is to reverse the nursing shortage in Texas. Eliminating the shortage will expand access to care, lower the cost of care, and increase the quality of care.

## **II. Nurse Staffing**

### **A. Nurse Staffing Policy Models Generally**

Staffing is the number one issue nurses identify as contributing to burnout and nurses leaving the profession. We see this trend in national data as well as TNA’s own membership surveys. Many specialty organizations publish recommended nurse-to-patient ratios for their specialty. These are broadly considered the standard of care for nurse staffing.

States vary on how they promote or require compliance with these standards. There are three general policy models used by states: (1) the staffing committee model, (2) mandatory nurse-to-patient ratio model, and (3) the public disclosure model. State legislatures are increasingly blending these models, with components of each employed in an overlapping fashion. Following is a list of the models used and which states used them:



- Staffing committees (enacted in CT, IL, NV, NY, OH, OR, TX, and WA);
- Public disclosure of staffing levels (enacted in IL, NJ, NY, RI, and VT); and
- Nurse-to-patient ratios (enacted in CA, MA, NY, and OR).

Legislation on staffing is pending in several states, with recent proposals to create or amend nurse staffing statutes being raised in PA, GA, MA, IL, and NJ.

These laws differ in several ways. For example, some states' nurse-to-patient ratios may focus on a particular specialty, with ICUs being a common focus, while other state laws may set ratios for a broad list of specialties, with California being the case-study of this model. Evidence supporting one model or the other is mixed, and academicians continue to debate the efficacy and superiority of each model.

## **B. Nurse Staffing Policy in Texas**

In Texas, the nurse staffing statute is found in Chapter 257 of the Texas Health and Safety Code. In Sec. 257.002, the Legislature detailed findings about the public health implications of proper staffing and how adequate staffing increases the retention of nurses. Those findings remain relevant and supported by research to this day.

The statute requires hospitals to create nurse staffing committees, primarily made up of nurses, who determine staffing policies and plans for the facility. Those policies and plans are provided to the governing body of the organization who then adopts or modifies the policies and plans as needed. Hospitals are required to report compliance with the statute to the Department of State Health Services (DSHS).

The backstop to the nurse staffing statute is the prohibition on mandatory overtime for nurses, which immediately follows in Chapter 258 of the Texas Health and Safety Code. Under that law, hospitals are prohibited from requiring nurses to work mandatory overtime. This prohibition is meant to force hospitals to adequately staff their units because if they do not, they would need to ask nurses to work mandatory overtime in violation of Chapter 258.

Importantly, Chapter 258 contains an exception that is triggered by emergency health declarations. Over the course of the COVID-19 pandemic, this exception was in effect for nearly 3 years. As a result, nurses did not receive the protection of the statute they typically would enjoy. In the wake of the COVID-19 emergency orders, TNA's members have broadly reported a breakdown in the regular order of the nurse staffing statute and mandatory overtime prohibition.

State data shows approximately 5% of Texas hospitals tell the state they are not complying with the nurse staffing statute. *See Appendix, Attachment 1: Nurse Staffing Data.* However, state enforcement records show there is no connection between reported noncompliance and enforcement actions. *See Appendix, Attachment 2: HHSC Enforcement Records.* Chapter 257 requires hospitals to report compliance to DSHS, while enforcement actions are taken by HHSC. HHSC only initiates an enforcement action when a complaint is filed. As a result, a hospital can



report noncompliance to DSHS without any inquiry into or punishment of the hospital's noncompliance.

## **1. Recommended Statutory Reforms**

The Legislature could vastly improve the performance of the nurse staffing statute by considering the following amendments to the statute:

- Amend the nurse staffing statute to require DSHS to share data with HHSC for enforcement purposes, as well as requiring HHSC to investigate hospitals that report noncompliance and establish a corrective action plan or issue penalties when appropriate;
- Amend the law to require certification of the accuracy of information submitted and create a mechanism for penalizing hospitals that knowingly submit false statements of compliance with the nurse staffing statute;
- Amend the statute to require HHSC to establish a penalty schedule for infractions of the nurse staffing statute that better reflect the associated costs to the public interest and better align the incentives of the system to support best practices;
- Amend the statute to require HHSC to create a dedicated portal for reporting staffing statute violations and violations of the prohibition on mandatory overtime;
- Amend the statute to create an explicit, statutory antiretaliation standard and enforcement mechanism instead of simply requiring hospital policy to include an antiretaliation statement; and
- Amend the statute to require a state study of nurse staffing in Texas and report to the Legislature on the implementation of these statutory amendments, as well as the conditions of nurse staffing in Texas healthcare facilities. The state study should assess and recommend ongoing data collection needs to monitor nurse staffing in Texas.

These amendments would increase the help restore the regular order of nurse staffing in Texas by boosting the utility of the statute, increasing accountability with hospitals in the state, and promoting the retention of nurses.

## **2. Recommended Funding Incentives**

One of the distinct disadvantages of mandating nurse-to-patient ratios as a state policy is the potential to increase the regulatory costs of labor so significantly that hospitals would face budget shortfalls. In Texas, that could potentially lead to the closure of rural hospitals or other facilities that are operating on thin margins.



Nonetheless, adequate staffing is essential for Texans' health outcomes. The nurse staffing statute explicitly requires nurse staffing committees to establish staffing plans that “reflect current standards established by private accreditation organizations, governmental entities, national nursing professional associations, and other professional organizations...” (see Texas Health and Safety Code, Sec. 257.003(b)(1)).

The Legislature should consider linking any clinical education funding to conformity with staffing standards contemplated by Texas Health and Safety Code, Sec. 257.003(b)(1). In order to obtain funds under the Clinical Site Nurse Preceptor Grant Program or the Clinical Site Innovation and Coordination Grant Program, hospitals should be required to demonstrate compliance with staffing standards in grant applications. The Legislature could detail these grant application requirements in budget rider.

Linking this funding with meeting staffing standards would incentivize hospitals to reevaluate their staffing policies and plans, while also addressing an important theme repeatedly raised in task force meetings, which is that precepting students and hosting clinicals is difficult when facilities are already orienting their own new employees and have not hired adequate staff for their units. These incentives would also promote retention of nurses, because nurses report short staffing as a major factor in their decision to leave the workforce.

### **III. Professional Licensing and Discipline**

Recently, across the country, we have seen an increase in the use of criminal law to address medical errors. This is a disturbing new trend with significant chilling impacts on the health care workforce. It also cuts against decades of policy work states have done to treat the health care industry as a high-risk industry that promotes open inquiry into systems errors. Like an employee at a car manufacturer being able to halt the line when a system error occurs, health care professionals need to be able to report issues as they occur without fear of criminal prosecution. This helps keep everyone safe.

Kentucky recently passed a law to provide immunity from criminal liability for health care providers in certain circumstances. The law states, “...a health care provider providing health services shall be immune from criminal liability for any harm or damages alleged to arise from an act or omission relating to the provision of health services...” See *24 RS HB 159/GA, 159th R.S. (2024)*, available at: <https://apps.legislature.ky.gov/lrcsearch>. This immunity does not apply in cases of, “...gross negligence or wanton, willful, malicious, or intentional misconduct.” *Id.*

By passing this law, Kentucky codified long-standing precedent that medical errors are not criminal violations unless they involve aggravating circumstances or an intent to harm. Meaning, a healthcare professional who intentionally administers a deadly drug could be criminally charged, but a healthcare professional who unintentionally administers a deadly drug would be disciplined through their state licensing board.



Texas should similarly codify this framework. Doing so will create certainty among healthcare professionals, promote the growth of organized case law and precedents for professional discipline, and increase efficiency in the investigation and discipline of practice errors.

#### **IV. Support for Allied Health Professions through Better Organized Financing**

Texas has an opportunity to further support allied health professions while better organizing the financing of nursing workforce and allied health workforce development. Currently, the Nursing Innovation Grant Program draws funding from the Texas Tobacco Lawsuit Settlement Fund.

In statute, the program is designed to be dedicated to nurses until a particular expiration date, at which point these funds would become available to allied health and other medical professionals. *See* Texas Education Code, Sec. 63.202(f). For several sessions, the Texas Legislature has passed bills moving the expiration date further and further back to ensure the grants remain dedicated to nursing. Given the longstanding shortage of nurses, the sentiment tends to be that it would be unwise to cut off this essential funding source for nursing education, and therefore the date should be moved back.

This is an inefficient solution. Funding for allied health and nursing should not be tied together. The Nursing Innovation Grant Program should be permanently dedicated to funding nursing education, so long as funds are available, and a separate program should be created to support allied health professions. By separating these programs in statute, the Legislature would avoid the inefficiency of deciding whether to extend the expiration date and would ensure a consistent funding source for allied health professions.

#### **V. Admissions Optimization**

Task force workgroup participants have repeatedly raised the idea of creating a uniform and centralized admissions application process for schools of nursing. Doing so would allow students to submit a single application for each school of nursing they are interested in attending. Texas should consider creating a uniform and centralized application for all state schools of nursing.

Currently, Texas tracks qualified applications not offered admission. We know how many *applications* are submitted, but we do not know how many individual *applicants* there are behind those applications. Centralizing the admissions application system would allow Texas to track individual applicants and reduce duplication in admissions data.

Moving to a centralized application system would also reduce the cost of application if the system were designed to require a single application fee instead of requiring students to pay application fees for each of the schools they apply to. The goal of this system would be to ensure that all available seats at state schools of nursing are filled in each enrollment year, which would increase enrollment and graduation rates.



## **VI. Clinicals Optimization**

Task force workgroup participants have repeatedly raised the idea of increased clinical coordination and optimization. Participants were able to identify numerous existing, private organizations that provide clinical coordination for defined regions. Examples include the DFWHC Foundation in the Dallas/Fort Worth metroplex and Workforce Solutions Capital Area in the Austin metroplex.

Since private organizations already exist for this purpose, it is unnecessary to create a centralized, state clinical coordination program. However, the state should consider using Clinical Site Innovation and Coordination Grant Program dollars to improve the regional systems already in existence or develop new regional systems for parts of Texas that do not have clinical coordination support systems. Similarly, these entities may be a good data source for the Texas Center for Nursing Workforce Studies to draw from as the Center studies clinical placements and opportunities for improvement.

We have also heard many task force workgroup participants raise the idea of creating a statewide, standardized clinical affiliation agreement for schools of nursing and clinical sites to utilize. In discussions with individuals knowledgeable about how these agreements are negotiated, we identified a litany of legal reasons why this may not be feasible:

- Different hospitals or hospital systems and their legal teams often think different core terms are necessary in clinical affiliation agreements;
- Vaccination requirements may differ depending on the type of facility;
- Student privacy and patient privacy issues may differ or simply change in state or federal law and regulation;
- Cybersecurity needs of different facilities differ based on the technologies they use or the vendors they contract with, which can cascade into clinical affiliation agreements to ensure students uphold that facility's cybersecurity protocols; and
- Schools of nursing and clinical sites must negotiate the labor involved and commitments each is willing to make regarding who is responsible for what.

There are likely many other complexities not fully captured here, but it has come to our attention that standardized agreements have been attempted on the regional level and often fail due to legal complexities like those mentioned above. To solve this issue via legislation would be immensely challenging and likely is not a good use of state resources given the barriers to success.

The utility of standardizing these agreements is significant, but the barriers are numerous. TNA will continue to research opportunities in this area, however we do not have solutions to offer at this time.



## **VII. State Coordination of Healthcare Workforce Planning**

Task force workgroup participants have repeatedly raised the idea of using state agency resources to better coordinate healthcare workforce planning. The Statewide Health Coordinating Council already creates a state health plan and receives input on workforce concerns. The Legislature should consider adding to the SHCC's health planning responsibilities to use existing resources to detail workforce considerations as part of the state health plan.

To adequately inform the Legislature, the SHCC should produce a report as part of the state's budgeting process that inventories and provides a list of all state agency programs designed to boost the education, training, retention, and employment of health professionals, along with funding provided to each of these programs and a brief description of how that funding has been utilized in the past biennium.

The SHCC should also highlight key data for the Legislature's consideration in budgeting. Of note, the Texas Center for Nursing Workforce Studies periodically releases supply and demand estimates for nursing services. This is an example of a key indicator that should be regularly updated and provided as part of a biennial report on healthcare workforce planning. Additionally, vacancy and turnover rates are key indicators of retention issues throughout the healthcare system that should be noted for workforce planning purposes. To the extent this data is not available for other health professions, the Legislature should consider creating infrastructure necessary to gather such data.

Generally, proper workforce planning should include targets for increases in graduation rates as well as hiring and job creation. These measures will help the state set goals and track whether the goals are being met and why.

In conclusion, we appreciate the opportunity to participate in the many workgroup sessions and provide feedback to the task force. This task force is an excellent example of how the Governor can use the executive branch to investigate policy challenges and offer thoughtful solutions. We extend our gratitude to the Governor, all task force members, and all executive branch staff who have contributed to the work of the task force.

Sincerely,

Jack Frazee, JD  
Director of Government Affairs & General Counsel  
**TEXAS NURSES ASSOCIATION**  
Phone: 512-452-0645 ext. 157  
Email: [jfrazee@texasnurses.org](mailto:jfrazee@texasnurses.org)  
4807 Spicewood Springs Rd.  
Bldg. 3, Suite 100  
Austin, TX 78759-8444



# Appendix



Attachment 1: Nurse Staffing  
Data (*see spreadsheet sent with  
this letter*)



# Attachment 2: HHSC Enforcement Records