CHAPTER 3

Defining the Doctor of Nursing Practice: Current Trends

Dianne Conrad and Karen Kesten

CHAPTER OVERVIEW

The purpose of this chapter is to define doctoral preparation for nursing and describe nursing practice doctoral education and its role in transforming health care. Current trends in doctor of nursing practice (DNP) education will be explored on how the practice doctorate is evolving to meet the competencies as outlined in *The Essentials for Doctoral Education for Advanced Nursing Practice* (American Association of Colleges of Nursing [AACN], 2006).

CHAPTER OBJECTIVES

After completing the chapter, the learner will be able to:

1. Define "doctor of nursing practice"
2. Describe the state of DNP education
3. Differentiate between the research and practice doctorate degrees
4. Discuss how the practice-based doctorate and the research-based doctorate will collaborate to impact nursing and health care

DEFINING THE PRACTICE DOCTORATE IN NURSING

The time is now for the practice doctorate in nursing. Nursing education has evolved to meet the needs of society in preparing nurses throughout history. The emergence and dramatic growth of DNP programs in the United States reflect this country's demand for highly competent providers to improve the health care of its people.

In 2001, the Institute of Medicine (IOM) outlined aims for healthcare improvement in *Crossing the Quality Chasm: A New Health System for the 21st Century,* which included care that is safe, effective, patient centered, timely, efficient, and equitable. To provide that care, the IOM (2003), in *Health Professions Education: A Bridge to Quality,* called for a change in how healthcare providers are prepared to meet these challenges. Healthcare providers in all professions are to attain the following core competencies:

- Provide patient-centered care
- Work in interdisciplinary teams
- Employ evidence-based practice
- Apply quality improvement
- Utilize informatics

By 2010, the IOM's report *The Future of Nursing: Leading Change, Advancing Health* responded with these key messages:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners with physicians and other healthcare professionals in redesigning health care in the United States.
- Effective workforce planning and policy making require better data collection and information infrastructure.

These important documents reflect the changing societal needs for a highly educated workforce prepared to meet the complex challenges of health care in the 21st century and beyond. In response to these challenges, nursing as a profession has developed an educational program at the doctoral level to prepare individuals for advanced nursing practice. The purpose of practice-focused doctoral programs is to *prepare experts in specialized advanced nursing practice,* as defined by the AACN (2006). The programs are to *focus heavily on innovative and evidence-based practice, reflecting the application of credible research findings*.

See **Table 3-1** for a comparison of IOM recommendations on healthcare improvement, the competencies of healthcare professionals, and clinical nursing doctoral preparation *Essentials.*

Table 3-1 Comparison of Institute of Medicine Recommendations on Healthcare Improvement, Competencies of Healthcare Professionals, and Clinical Nursing Doctoral Preparation

Six Aims for Healthcare Improvement (IOM, 2001)	Core Competencies of Healthcare Professionals (IOM, 2003)	The Essentials of Doctoral Education for Advanced Nursing Practice (AACN, 2006)
	DNP Essential VIII *Advanced Nursing Practice*	
Safe: Avoiding injuries to patients from the care that is intended to help them	*Apply quality improvement *Work in interdisciplinary teams	I. Scientific underpinnings for practice II. Organizational and systems leadership for quality improvement and systems thinking VI. Interprofessional collaboration for improving patient and population health outcomes
Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit	*Employ evidence-based practice *Utilize informatics	I. Scientific underpinnings for practice II. Organizational and systems leadership for quality improvement and systems thinking III. Clinical scholarship and analytical methods for evidence-based practice IV. Information systems/technology and patient care technology for the improvement and transformation of health care V. Health care policy for advocacy in health care
Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions	*Patient-centered care	V. Health care policy for advocacy in health care VII. Clinical prevention and population health for improving the nation's health
Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care	*Work in interdisciplinary teams *Apply quality improvement *Employ evidence-based practice	II. Organizational and systems leadership for quality improvement and systems thinking VI. Interprofessional collaboration for improving patient and population health outcomes

(*Continued*)

Table 3-1 Comparison of Institute of Medicine Recommendations on Healthcare Improvement, Competencies of Healthcare Professionals, and Clinical Nursing Doctoral Preparation (*Continued*)

Six Aims for Healthcare Improvement (IOM, 2001)	Core Competencies of Healthcare Professionals (IOM, 2003)	The Essentials of Doctoral Education for Advanced Nursing Practice (AACN, 2006)
	DNP Essential VIII *Advanced Nursing Practice*	
Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy	*Work in interdisciplinary teams *Utilize informatics *Apply quality improvement	I. Scientific underpinnings for practice III. Clinical scholarship and analytical methods for evidence-based practice IV. Information systems/technology and patient care technology for the improvement and transformation of health care V. Healthcare policy for advocacy in health care VI. Interprofessional collaboration for improving patient and population health outcomes
Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status	*Patient-centered care *Apply quality improvement *Utilize informatics	II. Organizational and systems leadership for quality improvement and systems thinking VII. Clinical prevention and population health for improving the nation's health IV. Information systems/technology and patient care technology for the improvement and transformation of health care

Reprinted with permission from American Association of Colleges of Nursing. (2006). The essentials for doctoral education for advanced nursing practice. Washington, DC: Author; Institute of Medicine. (2003). Health professions education: A bridge to quality. Retrieved from http://www.nap.edu/openbook.php?record_id=10681&page=45

The DNP is a *degree,* not a *role.*

The clinical doctorate for nurses, the DNP, is a *degree*, not a *role*. There are many roles in advanced practice nursing. The AACN (2004) defined advanced practice nursing as "any form of nursing intervention that influences healthcare outcomes for individuals or populations, including the direct care of individual patients, management of care for individuals and populations, administration of nursing and healthcare organizations, and the development and implementation of health policy" (p. 2).

Therefore, advanced nursing practice encompasses such roles as nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife (CNM), nurse anesthetist, nurse administrator, nurse informaticist, and nurse health policy specialist. This list of roles is not inclusive because nursing entrepreneurs continue to pioneer advanced practice roles to meet patient needs in a variety of settings.

There is a special definition of the roles of the advanced practice registered nurse (APRN). In 2008, a report titled *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education* was completed through the work of the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee (APRN Joint Dialogue Group, 2008). This group defined four specific APRN roles—certified registered nurse anesthetist (CRNA), CNM, CNS, and certified nurse practitioner—for the purpose of standardizing licensure language across the country. However, the group acknowledged that "many nurses with advanced graduate nursing preparation practice in roles and specialties (e.g., informatics, public health, education or administration) that are essential to advance the health of the public but do not focus on direct care to individuals and, therefore, their practice does not require regulatory recognition beyond the Registered Nurse license granted by state boards of nursing. Like the four current APRN roles, practice in these other advanced specialty nursing roles requires specialized knowledge and skills acquired through graduate-level education" (p. 5).

Though the APRN consensus document did not specify the practice doctorate as the education level for these advanced practice roles, graduate-level education was a requirement. Any of these roles benefit from education at the doctoral level to prepare nurses for the challenges of today's healthcare arena. These advanced practice roles are oriented toward providing quality care and improving patient outcomes.

The *Essentials of DNP Education* (AACN, 2006) give these doctorally prepared nurses the tools and competencies they need to carry out their role at the highest level (see **Figure 3-1**).

The AACN (2004) further delineates the benefits of a practice-focused doctorate to:

- develop the needed advanced competencies for increasingly complex practice, faculty, and leadership roles;
- enhance knowledge to improve nursing practice and patient outcomes; and
- enhance leadership skills to strengthen practice and healthcare delivery (p. 4).

Most important, the DNP prepared nurse is able to translate scientific evidence into practice in a timely fashion.

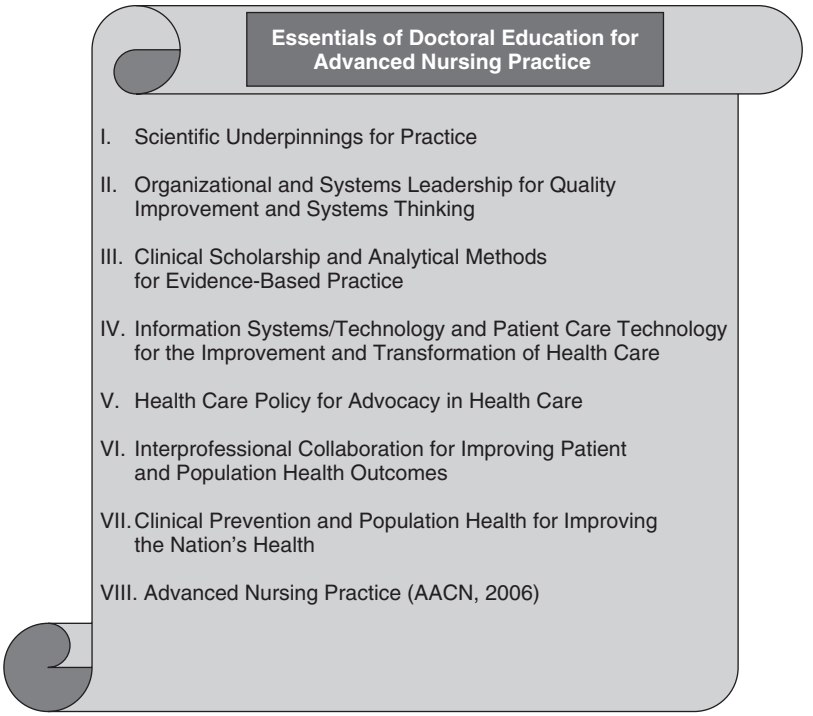

FIGURE 3-1 Essentials of doctoral education for advanced practice nursing.

Data from American Association of Colleges of Nursing. (2006). The essentials for doctoral education for advanced nursing practice. Washington, DC: Author.

COMPARISON OF THE DNP AND PHD IN NURSING

Doctoral preparation in nursing currently has two paths: the research-based doctorate that began in 1934 at New York University and flourished in the 1970s (Chism, 2016), and the current practice doctorate, the DNP, that has been defined and developed by the AACN since 2002. See Chapter 4, Scholarship in Practice, for a discussion of the evolution of the practice doctorate.

The two doctoral programs according to the AACN (2006) are different in their goals and in the competencies of their graduates. The practice doctorate (DNP) and the research doctorates (PhD and Doctor of Nursing Science [DNS]) offer complementary, alternative approaches to attaining the highest level of educational preparation in nursing with rigorous and demanding programs of study. The profession of nursing benefits from scholar leaders who are committed to the advancement of the science and practice of nursing.

A comparison of nursing doctoral programs is outlined in **Table 3-2**.

Table 3-2 Comparison of Doctoral Nursing Programs

	Practice Doctorate DNP	Research Doctorate PhD/DNS
Common Characteristics	• Rigorous and demanding expectations • Scholarly approach to the discipline • Commitment to the advancement of the profession	
Program of Study	Prepares leaders at highest level of nursing practice to improve patient outcomes and translate research into practice	Prepares nurses at the highest level of nursing science to conduct research to advance the science of nursing
Students	• Commitment to practice career • Oriented toward improving outcomes for patient care and population health	• Commitment to research career • Oriented toward developing new nursing knowledge and scientific inquiry
Program Faculty	• Practice or research doctorate in nursing, and expertise in area teaching • Leadership experience in area of role and population practice • High level of expertise in practice congruent with focus of academic program	• Research doctorate in nursing or related field • Leadership experience in area of sustained research funding • High level of expertise in research congruent with focus of academic funding • High level of expertise in research congruent with focus of academic program
Resources	• Mentors and/or preceptors in leadership positions across practice settings • Access to diverse practice settings with appropriate resources for areas of practice • Access to financial aid • Access to information and patient-care technology resources congruent with areas of study	• Mentors and/or preceptors in research settings • Access to research settings with appropriate resources • Access to dissertation support dollars and financial aid • Access to information and research technology resources congruent with program of research

(*Continued*)

Table 3-2 Comparison of Doctoral Nursing Programs (*Continued*)

	Practice Doctorate DNP	**Research Doctorate PhD/DNS**
Program Assessment and Evaluation	• Program outcomes: Healthcare improvements and contributions via practice, policy change, and practice scholarship • Receives accreditation by nursing accreditor	• Program outcomes: Contributes to healthcare improvements via the development of new knowledge and scholarly products that provide the foundation for the advancement of nursing science • Oversight by the institution's authorized bodies (i.e., graduate school) and regional accreditors

Modified from American Association of Colleges of Nursing. (2014). Key differences between DNP and PhD/DNS programs. Retrieved from: http://www.aacn.nche.edu/dnp/ContrastGrid.pdf

The challenges of healthcare delivery in the 21st century will necessitate the collaboration of interdisciplinary teams (IOM, 2003). Partnering of the research doctorate with the practice doctorate will demonstrate cooperation within nursing that can advance the profession. Lamb (2012) described building collaboration "readiness" with the combination of the PhD in nursing and DNP. She stated that the PhD in nursing brings:

- more minds, more tools, more innovation
- a broader range of theories and more explanatory theoretical models
- an expanded toolkit for research design and methods
- the opportunity for more competitive grants

The DNP brings the following to the team:

- better teamwork, leading to better outcomes
- the contribution of a broader range of evidence
- greater opportunities to accelerate nurse-led and interprofessional practice models

The benefits of interprofessional and intraprofessional collaboration will be discussed further in Chapter 7, Interprofessional and Intraprofessional Collaboration in the Scholarly Project.

CURRENT TRENDS IN DOCTORAL EDUCATION

One of the concerns about beginning a practice doctorate for nursing was the ability of the profession to produce doctoral-level graduates. *The Future of Nursing* report (IOM, 2010) called for the doubling of doctorally prepared nurses by 2020. Rapid growth of DNP programs has occurred since the AACN's work on defining and developing the practice doctorate *Essentials* in 2004. The number of DNP programs has increased from 20 in 2006 to 268 in 2015, with many more programs in development (AACN, 2015a). The concern that the practice doctorate would decrease the number of nurses pursuing a research doctorate in nursing appears to be unfounded. The AACN tracks the number of nursing education programs as well as graduates of those programs. The data show that since 2003, the number of PhD students enrolled in the United States has increased from 3,229 to 5,290 in 2014. During the same period, the enrollment in DNP programs increased dramatically, from 70 in 2003 to 18,352 in 2014 in 264 DNP programs across the country (AACN, 2015b). The number of PhD programs in nursing has also increased, from 106 in 2006 to 134 in 2014 (AACN, 2015a) (see **Figure 3-2**).

IOM *Future of Nursing* report calls for a doubling of doctorally prepared nurses by 2020.

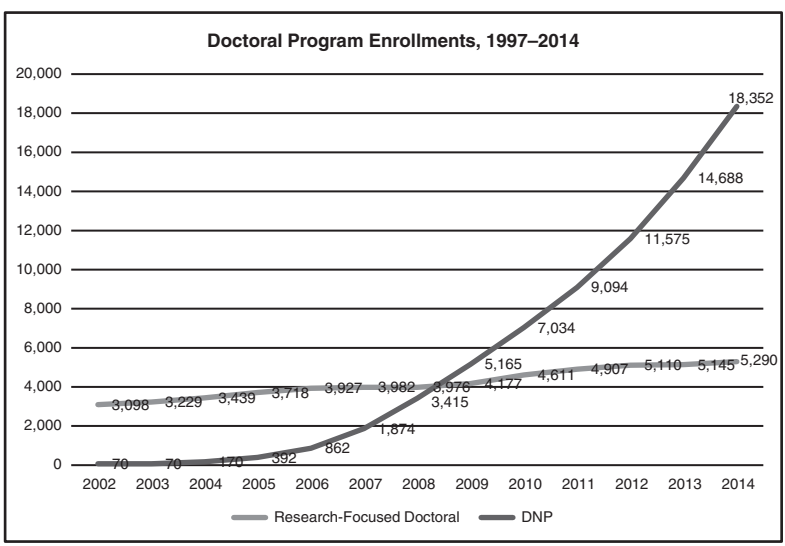

FIGURE 3-2 Doctoral program enrollments 1997–2014.

Reprinted with permission from American Association of Colleges of Nursing. (2015b). Custom report on doctoral Program Enrollments, 1997–2014. Washington, DC: AACN Research and Data Services.

REPORTS AFFECTING DNP EDUCATION

The Rand Corporation Report: The DNP by 2015: A Study of the Institutional, Political, and Professional Issues that Facilitate or Impede Establishing a Post-Baccalaureate Doctor of Nursing Practice Program.

In 2004, member schools of the American Association of Colleges of Nursing (AACN) voted to endorse the *Position Statement on the Practice Doctorate in Nursing*, which called for moving the level of preparation necessary for advanced nursing practice from the master's degree to the doctorate by the target year of 2015 (AACN, 2004). Over the past 10 years, colleges of nursing have made great strides in moving toward this target. Currently, the majority of schools with APRN programs, the largest subset of all advanced nursing practice programs, either offer or are planning to offer a DNP at the post-baccalaureate and/or post-master's level.

While the number of DNP programs for APRNs has grown significantly and steadily over this period, not all colleges of nursing have been able to fully transition their master's-level APRN programs to the practice doctorate by 2015 and many are electing to maintain both master's and DNP options to prepare APRNs. To better understand the issues facing colleges of nursing moving to the DNP, the AACN board of directors commissioned the RAND Corporation to conduct a national survey of nursing schools with APRN programs to identify the barriers and facilitators to offering a post-baccalaureate DNP (Auerbach et al., 2014). The report includes recommendations for next steps that AACN can take to help schools accelerate programmatic change and overcome challenges.

For the purposes of this study, the RAND Corporation was commissioned by AACN to focus on only the APRN master's degree program transition to the DNP. This study was undertaken between October 2013 and April 2014 to investigate schools' progress toward transitioning to the DNP for APRN programs as well as the barriers and/or facilitators to nursing schools' full adoption of the DNP. The RAND Corporation used a mixed-method approach, which included surveys and qualitative interviews to investigate schools' progress toward the adoption of the DNP. Data were analyzed from an online survey developed specifically for this project, as well as qualitative interviews with deans and directors of 29 nursing schools.

A summary of the report findings (Auerbach et al., 2014) showed:

- The number of schools with a DNP program has grown 10-fold in the past 7 years. Schools of nursing have made great progress in transitioning to the DNP by the target date of 2015. Currently, DNP programs, at either

the post-baccalaureate (BSN-DNP) or post-master's (MSN-DNP) level, are offered at more than 250 schools nationwide.

- Approximately 30% of nursing schools with APRN programs now offer the BSN-DNP, and this proportion is anticipated to climb to greater than 50% in the foreseeable future.
- Schools in the West and Midwest and schools in states with a high density of existing nurse practitioners (NPs) were considerably more likely to offer BSN-to-DNP programs.
- Faculty enthusiasm and administrative support within the university are strong facilitators toward offering the BSN-to-DNP.
- The value of the added content of the DNP education is almost universally agreed on. Fully 93% of survey respondents offering or planning on offering the BSN-to-DNP cited the "value of the DNP education in preparing for future healthcare needs" as very important or critical to their decision.
- AACN endorsement and recommendation of the DNP also factored strongly in many schools' decisions to offer the BSN-to-DNP, as did a desire to expand into doctoral-level education.
- Schools continue to adopt the DNP, both as an option to be completed for practicing master's-level APRNs (the MSN-to-DNP) and as an entry-level APRN option for those with a bachelor of science in nursing (BSN) degree (the BSN-to-DNP).
- The schools interviewed perceived that employers are unclear about the differences between master's-prepared and DNP-prepared APRNs and could benefit from information on outcomes connected to DNP practice as well as exemplars from practice settings that capitalize on the capabilities of DNP-prepared nurses.
- Student demand for the DNP on the part of currently practicing APRNs appears robust, given the proliferation of MSN-to-DNP programs.
- Student demand for the BSN-to-DNP is growing.
- Schools cited faculty resources as constraints to the development of DNP programs.
- Costs and budgetary concerns are a key barrier to many schools, particularly those that are not freestanding or autonomous schools.
- Securing clinical sites and preceptors, similar to MSN APRN programs are cited as a restraining factor.
- Faculty resources for managing DNP projects were cited by schools as a potential barrier.
- Requirement of the DNP for certification and accreditation would accelerate the transition to BSN to DNP programs.

The Rand Corporation Report (Auerbach et al., 2014) recommended that the AACN should:

1. Conduct, and collaborate with others to conduct, outcome studies of DNP practice to better understand the impact of DNP graduates on patient care.
2. Provide outreach data to help employers and healthcare organizations understand the comprehensive competencies and capabilities of DNP-educated APRNs.
3. Focus on understanding and documenting successful strategies in overcoming barriers to offering BSN-to-DNP programs of departments or divisions within larger universities, since they may face greater hurdles to offering BSN-to-DNP programs.
4. Document and showcase examples of collaborative partnerships between schools and hospitals or other healthcare organizations for the purpose of providing clinical practice sites.
5. Provide greater clarity and guidance related to requirements for the DNP project.
6. Continue with ongoing efforts to assist schools in overcoming challenges to offering the BSN to DNP.

As a response to these recommendations, follow-up and active steps taken by AACN include the formation of two task forces to further improve DNP education: the Implementation of the DNP Task Force and the APRN Clinical Training Task Force. Each task force has produced white papers that address some of the barriers identified in the RAND Corporation study.

To find out more about these task forces and their charges, see www.aacn.nche.edu/about-aacn/committees-task-forces.

AACN Report on APRN Education: The APRN Clinical Training Task Force Report

Much attention has been paid to the Institute of Medicine's (IOM) 2010 *The Future of Nursing* report that APRNs be allowed to practice to "the full extent of their education and training" (p. 29). APRNs have a potential opportunity to contribute to the delivery of care to the additional 16.4 million *newly insured* patients due to healthcare reform (Office of the Assistant Secretary for Planning and Evaluation (ASPE), 2015). Nationwide, APRN education programs are experiencing increased demand for APRN enrollment and many programs report

challenges in expanding enrollment to meet this demand. Colleges of nursing cite inadequate numbers and quality of clinical training sites and preceptors for APRN students.

In May 2013, AACN convened the APRN Clinical Training Task Force to develop a white paper that would re-envision clinical education and training for APRNs. Limited resources, including sufficient and diverse clinical sites, patients, and preceptors to prepare APRNs for contemporary practice is a frequently cited challenge. New regulatory requirements and changes in healthcare environments present increasing challenges for practitioners who serve as preceptors and for colleges of nursing preparing the next generation of providers.

Following nearly two years of consulting with experts within and outside the discipline of nursing, reviewing the literature, exploring new models of clinical education and competency development, reflection and discussion by the APRN Clinical Training Task Force, a report brief and a white paper were released in March, 2015 (AACN, 2015c).

The AACN Task Force (AACN, 2015c) concluded that the current methods of providing clinical education for APRNs needs to be re-envisioned in order to expand the pool of opportunities available to contemporary students and to reduce strictures in the pipeline to educating the APRN workforce in sufficient numbers to meet societal demand for these valuable services. Variability among APRN programs, particularly for Nurse Practitioners and Clinical Nurse Specialists, exists in the clinical competencies expected at various points throughout the curriculum and evaluation processes and tools. Increasingly, new models of care are emerging with a greater emphasis on interprofessional practice and education. Advances in technology both within healthcare delivery and education have created opportunities for APRNs to lead the effective integration of technologies into healthcare delivery. Academic practice partnerships are important to all APRN clinical education to ensure that students have access to patients, healthcare professional teams, and current data and experiences. Partnerships are increasingly important when considering interprofessional education, transition to practice for new graduates, implementation of new clinical education models, and the rapid changes that are occurring in healthcare systems. Across higher education, there is an increased interest and emphasis on examination and implementation of competency-based education and assessment models in a variety of disciplines and more specifically in the health professions (Carraccio et al., 2002; Carraccio & Englander, 2013).

The AACN Task Force made the following recommendations:

I. **Simulation should be used to enhance APRN clinical education, and the use of simulation to replace more traditional clinical experiences should be explored.**
   - Seek funding for five demonstration projects that are designed to study the impact of various methods along the continuum of simulation learning approaches as one component of APRN clinical education and assessment.
   - Funding and other resources should be provided at both the national and local levels for the development and use of simulation for learning and assessment, including funding for a national center of faculty innovation and faculty preparation and certification.
   - A national repository should be created and maintained for reliable/valid APRN simulation education materials.
   - Simulations should be developed and tested for assessment of the APRN common competencies.

II. **AACN-American Organization of Nurse Executives (AONE) principles for academic-practice partnerships should be adopted by all APRN programs.**
   - APRN programs, including face-to-face and distance education programs, should implement expectations described in Section II regarding the development and maintenance of APRN clinical experiences and student oversight.
   - Encourage and support the development of innovative partnerships for APRN clinical education as well as the use of a variety of incentives for practice sites and preceptors, e.g., adjunct faculty status, joint appointments, participation on curricular committees, research support, continuing education credits, and academic credit toward graduate degrees.
   - Support the development and testing of innovative APRN academic/practice regional consortia that reflect geographic and institutional diversity.
   - Develop and implement an accessible repository for APRN preceptor orientation materials.

III. **APRN clinical education and assessment should be competency based.**
   - Establish a common language or taxonomy by adopting definitions for competence, competencies, and competency framework that are recognized by APRN organizations and other health professions.

- Identify common, measurable APRN competencies that cross all four roles and build on or reaffirm the APRN core competencies (AACN, 2006).
- Progression of competence or milestones should be identified and defined across each of the common competencies.
- Develop a standardized assessment tool to be available to faculty and preceptors to use for formative and summative evaluation of the common APRN competencies.

IV. Support the development of alternative or innovative APRN clinical education models

- Encourage regulatory bodies to support or allow APRN education programs to develop and test innovative or less traditional clinical models.
- Encourage APRN programs to explore, implement, and test innovative or less traditional clinical models, including interprofessional learning experiences and use of technology.
- Seek funding to support the development and evaluation of alternative or innovative APRN clinical training models.

The Implementation of the DNP Task Force Report: Current Issues and Clarifying Recommendations

The *AACN Position Statement on the Practice Doctorate in Nursing* (AACN, 2004) changed the course of nursing education by recommending that advanced nursing practice education be transitioned to the doctoral level. A decade later, the Doctor of Nursing Practice (DNP) is widely accepted as the preferred pathway for those seeking preparation at the highest level of nursing practice. Considering the changing landscape in health care and higher education over the last ten years as well as the dramatic growth of DNP programs, the AACN Board of Directors convened the Implementation of the DNP Task Force to review the current state of DNP programs, and to provide recommendations to clarify curricular and practice expectations as outlined in the *Essentials of Doctoral Education for Advanced Nursing Practice [DNP Essentials],* AACN, 2006).

Growing evidence exists regarding variability among program requirements for the DNP final scholarly products including the scope of project, level of implementation, impact on system and practice outcomes, extent of collaborative efforts, dissemination of findings, and degree of faculty mentorship/oversight. Similar to other healthcare professions, nursing is faced with competition for

practice sites and preceptors, complex affiliation agreements, and regulatory issues for distance learning modalities when obtaining practice experiences for DNP students. These issues were documented in the RAND report (Auerbach et al., 2014) and thoroughly explored by the task force. The white paper presents clarification as well as new and innovative ways to meet the DNP practice requirements.

The national dialogue reflects an ongoing need for clarification and restatement of the foundational concept of how *advanced nursing practice* is defined.

- *Advanced nursing practice* focuses on the provision of direct care to individual patients or populations, and the provision of indirect care such as nursing administration, executive leadership, health policy, informatics, and population health.
- The task force reaffirms that the discipline of education encompasses an entirely separate body of knowledge and competence (AACN, 2004, p. 13) and is not an area of advanced nursing practice.
- Also, it is important to remember that the DNP is an academic degree and not a role.

Implementation of the DNP Task Force Recommendations:

I. DNP Graduate Scholarship

- Graduates of both research- and practice-focused doctoral programs are prepared to generate new knowledge.
  - practice-focused graduates are prepared to generate new knowledge through
    1. innovation of practice change
    2. the translation of evidence
    3. implementation of quality improvement processes in specific practice settings, systems, or with specific populations to improve health or health outcomes.
- Organizational and systems leadership knowledge and skills are critical for DNP graduates to:
  - develop and evaluate new models of care delivery
  - create and sustain change at the organization and systems levels.
- The delineations in knowledge generation are not a hierarchical structure of importance; both are types of knowledge generating methods.
- DNP and PhD graduates have the opportunity to improve health outcomes.

II. DNP Scholarly Project

- The title of the final product to be "The DNP Project."
- DNP project elements include planning, implementation, and evaluation components.
- All DNP projects should:
  - focus on a change that impacts healthcare outcomes either through direct or indirect care
  - have a systems or population focus
  - demonstrate implementation in the appropriate area of practice
  - include a plan for sustainability
  - include an evaluation of processes and/or outcomes
  - provide a foundation for future practice scholarship.
- As mentioned, the discipline of education encompasses an entirely separate body of knowledge and competence; therefore, the focus of a DNP program, including practicum and DNP project, should not be on the educational process, the academic curriculum, or on educating nursing students.
- Integrative and systematic reviews alone are not considered a DNP project and do not provide opportunities for students to develop and integrate scholarship into their practice.
- A student's portfolio is not considered a DNP project but rather a tool to document learning.
- Group/team projects are acceptable when the project aims are consistent with the focus of the program.
  - Each member of the group must meet all expectations of planning, implementation, and evaluation of the project, and be evaluated accordingly.
  - Each student must have a leadership role in at least one component of the project and be held accountable for a deliverable.
- Dissemination of the DNP project should include a minimum of an executive summary or a written report that disseminates DNP project outcomes.
- Dissemination of the DNP project could take these forms:
  - publishing in a peer reviewed print or on-line
  - poster and podium presentations
  - presentation of a written or verbal executive summary to stakeholders and/or the practice site/organization leadership
  - development of a webinar presentation or video

  - submission and publication to a non-refereed lay publication
  - oral presentation to the public-at-large
  - development and presentation of a digital poster, a grand rounds presentation, and/or a PowerPoint presentation.
- The DNP project team should consist of a student or a group of students with a minimum of a doctoral prepared faculty member and a practice mentor.
- The term "DNP Project Team" should be used to minimize confusion between the PhD dissertation committee and the faculty and mentors who oversee the DNP final project.
- Evaluation of the final DNP project is the responsibility of the faculty.
- A digital repository for the DNP final projects should be used to advance nursing practice by archiving and sharing outcomes.

III. DNP programs:

- Should provide evidence of meeting program outcomes delineated in the *DNP Essentials.*
- Should map student learning objectives to expected program outcomes and *DNP Essentials.*
- A post-baccalaureate full-time program of study should be 3 years including summers or four years on a traditional academic calendar.
- A post-master's program of study should be a minimum of 12 months full-time study to allow for acquisition of the doctoral-level outcomes and completion of the DNP project.
- Should be designed with attention to program efficiency.
- Consider new models and processes for implementing DNP project teams that provide efficient use of resources and support student learning.
- Adopt a process that allows for oversight and evaluation of DNP projects that ensures quality and equity of resources.
- Should provide faculty development to ensure quality student learning outcomes to include:
  - curricular design of DNP programs
  - development of new, innovative teaching strategies
  - development of innovative, new practice opportunities to support achievement of the DNP *Essentials* learning outcomes
  - strategies to support and evaluate the DNP project
  - implementation of quality improvement processes
  - interprofessional education and practice experiences.

- Preparation for the nurse educator role:
  - Requires additional coursework in pedagogies
  - Is not an area of advanced nursing practice.

IV. DNP practice hours

- Practice experiences should prepare the post-baccalaureate and post-master's DNP student with the outcomes delineated in all of the DNP *Essentials*.
- Opportunities to integrate all of the *Essentials* into one's practice are imperative for both post-baccalaureate and post-master's students.
- Faculty are responsible for assessing students' learning needs and designing practice experiences that allow students to attain and demonstrate the DNP *Essentials*.
- Programs are expected to demonstrate the synthesis and application of all DNP *Essentials*.
- All DNP students, including those in post-master's programs, are expected to complete a minimum of 1,000 post-baccalaureate practice hours.
- Practice immersion experiences afford the opportunity to apply, integrate and synthesize the DNP *Essentials* necessary to demonstrate achievement of desired outcomes in an area of advanced nursing practice.
- Practice experiences for the DNP student are not intended to be solely direct patient care focused but should include indirect care practices in healthcare related environments.
- Programs must demonstrate that graduates have attained all of the DNP *Essential* outcomes.
- Students who have completed more than 1,000 practice hours in their master's program will need to complete additional hours in the DNP program.
- Practice hours spent in master's nursing programs can be counted as post-baccalaureate practice hours, provided they can be verified.
- Practice experiences should have well defined learning objectives and provide experiences over and above the individual's job responsibilities or activities.
- Schools may credit practice hours to a post-master's DNP student who holds current national certification in an area of advanced nursing practice, as defined in the AACN 2006 *DNP Essentials*, and requires a minimum of a graduate degree.

- Post-master's students must have faculty supervised practice hours in the DNP program that provide the opportunity for the student to integrate all of the outcomes delineated in the DNP *Essentials*.
- DNP programs should not be preparing the nurse educator; therefore the focus of the practicum and DNP project should not be on the academic educational process, the academic curriculum, or on educating nursing students. Practice as a nurse educator should not be included in the DNP practice hours.

V. **Collaborative Partnerships**

- Programs should follow the Academic-Practice Partnership guiding principles developed by the AACN-AONE Task Force on Academic-Practice Partnerships (2012).
- Programs are encouraged to consider a broad range of academic-practice partnerships, e.g. with school systems, prison systems, public health departments, that afford students opportunities to engage in the full planning, implementation, and evaluation of a project that impacts healthcare outcomes.
- Academic and practice partners are encouraged to collect outcome data to demonstrate the added value of DNP graduates.

SUMMARY OF TRENDS

In summary, the trends identified confirm that DNP education is evolving, and change has occurred rapidly in recent years. The major trends relating to the practice doctorate identified are as follows:

- DNP programs are rapidly growing and changing. However, DNP student enrollments are not negatively affecting enrollment in research-focused PhD programs in nursing.
- There is a shift from programs offering only a post-master's level to DNP option to more programs adding the BSN to DNP option.
- The roles identified by DNP students are not only the traditional APRN clinical roles; students are also choosing a focus on nonclinical (indirect care) advanced nursing practice roles, such as nurse executive, health policy specialist, and informaticist.
- Most DNP programs are becoming accredited by organizations such as the CCNE, which ultimately should decrease variability in program standards.

- Academic rigor continues to be defined for the practice doctorate because the definition of rigor can be different from that applied to research-focused doctorates.

In response to the variability in DNP education, the AACN commissioned various task forces, including the Implementation of the DNP Task Force (2015d) to outline recommendations to define and clarify various aspects of DNP education.

SUMMARY

The demands of providing health care in our country to an increasingly complex population of patients require higher levels of nursing education and practice. The clinical doctorate in nursing, the DNP, has emerged to address the competencies that healthcare providers must have in order to apply evidence-based practice in the provision of high-quality patient-centered care in interdisciplinary teams, using such tools as information technology. There is an emerging model of generation of knowledge by both the research and practice nursing doctorates working in teams to develop clinical knowledge and translate that knowledge into practice in a timely fashion. Nonclinical roles (indirect care) for advanced nursing practice and the traditional roles of clinical advanced nursing practice benefit from the competencies attained through doctoral-level education.

With the rapid growth of DNP programs since 2004, standardization of DNP education is emerging along with an increased number of accredited programs. In response to variability in certain aspects of DNP programs, the AACN commissioned the Implementation of the DNP Task Force to clarify recommendations regarding the DNP project, DNP educational program characteristics, DNP practicum hour requirement and encouraging collaborative partnerships between academia and practice. Because the DNP project is the demonstration of attainment of the Essentials of Doctoral Education for Advanced Nursing Practice outcomes, these guidelines from the AACN are necessary to promote high-quality and rigorous standards. The challenges of dealing with complex disease states and the development of a subspecialty advanced practice role are illustrated in the following DNP project exemplar by Dr. Elizabeth Jensen. She describes how obtaining a DNP degree provided her with the knowledge and skill set to emerge as a provider, and nursing practice leader.

Improving the Care for Women with Vulvodynia

Elizabeth Jensen, CNM, APN, DNP Graduate
of the Frontier Nursing University

Vulvodynia is a serious women's health concern affecting millions of women in the United States. Many women are unable to find knowledgeable providers who treat vulvodynia, leaving women with vulvar pain disorders in the United States underserved. My DNP project was developed with the goal to improve the care for women with vulvodynia by increasing the numbers of APRNs who are comfortable and confident caring for women with vulvar pain disorders. A 19-item survey was deployed via SurveyMonkey to identify the educational needs of APRNs to care for women with vulvar disorders and determine the APRN's level of interest in addressing this important healthcare need. In total, 597 APRNs responded during the survey period. This national survey identified that APRNs are not comfortable diagnosing and treating vulvar disorders and need further education in vulvodynia, atypical vaginal infections, and vulvar skin disorders. More important, the majority of APRNs who responded expressed an interest in learning more about these topics.

The completion of this scholarly project fueled my interest to continue working in this subspecialty area as a practicing DNP with a goal to educate other APRNs. Shortly after graduation, I applied for a grant from the National Vulvodynia Association (NVA) to receive funds to open a dedicated vulvovaginal service. This grant was awarded to S.H.E. Medical Associates in Hartford, Connecticut, and I currently serve as the director of this service. In this role, I provide gynecological services to women who suffer with vulvar pain disorders, and our service is expanding rapidly. In addition, our service serves as a site for APRN providers and students who wish to expand their skills in this subspecialty. Obtaining a DNP degree provided me with the knowledge and skill set to emerge as a provider, and nursing practice leader in the subspecialty of vulvology.

Key Messages

- The DNP is a degree, not a role.
- Current educational preparation for the DNP is evolving but still reflects the *Essentials* of DNP education.
- The DNP is the practice-based doctorate.
- The PhD and DNS in nursing are the research-based doctorates
- The collaboration between the two doctoral levels of preparation will determine the future of nursing and its impact on health care.
- The definition of the DNP will continue to evolve, and the DNP graduate will be a part of the evolution.
- Nurses must have an understanding of the definition of the DNP and be able to clearly articulate it.
- The *Essentials* are intertwined within DNP education, and the DNP project is the culmination/demonstration of the DNP final product/skill set.

REFERENCES

American Association of Colleges of Nursing. (2004). *AACN position statement on the practice doctorate in nursing.* Washington, DC: Author.

American Association of Colleges of Nursing. (2006). *The essentials for doctoral education for advanced nursing practice.* Washington, DC: Author.

American Association of Colleges of Nursing. (2014). *Key differences between DNP and PhD/DNS programs.* Retrieved from: http://www.aacn.nche.edu/dnp/ContrastGrid.pdf

American Association of Colleges of Nursing. (2015a). DNP fact sheet. Retrieved from: http://www.aacn.nche.edu/media-relations/fact-sheets/dnp

American Association of Colleges of Nursing. (2015b). Custom report on doctoral Program Enrollments, 1997–2014. Washington, DC: AACN Research and Data Services.

American Association of Colleges of Nursing. (2015c). White paper: Current state of APRN clinical education. Retrieved from: http://www.aacn.nche.edu/APRN-White-Paper.pdf

American Association of Colleges of Nursing. (2015d). The doctor of nursing practice: Current issues and clarifying recommendations. Retrieved from: http://www.aacn.nche.edu/aacn-publications/white-papers/DNP-Implementation-TF-Report-8-15.pdf

American Association of Colleges of Nursing-American Organization of Nurse Executives (AACN-AONE) Task Force on Academic-Practice Partnerships. (2012). Guiding principles. Retrieved from https://www.aacn.nche.edu/leading-initiatives/academic-practice-partnerships/GuidingPrinciples.pdf

APRN Joint Dialogue Group. (2008). *Consensus model for APRN regulation: Licensure, accreditation, certification & education.* Retrieved from http://www.nonpf.org/associations/10789/files/APRNConsensusModelFinal09.pdf

Auerbach, D., Martsolf, G., Pearson, M., Taylor, E., Zaydman, M., Muchow, A., . . . Dower, C. (2014). The DNP by 2015: A study of the institutional, political, and professional issues that facilitate or impede establishing a post-baccalaureate doctor of nursing practice program. Retrieved from http://www.aacn.nche.edu/DNP/DNP-Study.pdf

Carraccio, C., & Englander, R. (2013). From Flexner to competencies: Reflections on a decade and the journey ahead. *Academic Medicine, 88*(8), 1067–1073.

Carraccio, C., Wolfsthal, S. D., Englander, R., Ferentz, K., & Martin, C. (2002). Shifting paradigms: From Flexner to competencies. *Academic Medicine, 77,* 361–367.

Chism, L. A. (2016). *The doctor of nursing practice: A guidebook for role development and professional issues.* Sudbury, MA: Jones and Bartlett.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century.* Retrieved from http://www.iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf

Institute of Medicine. (2003). *Health professions education: A bridge to quality.* Retrieved from http://www.nap.edu/openbook.php?record_id=10681&page=45

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health.* Washington, DC: National Academies Press.

Lamb, G. (2012, January). *Interprofessional initiatives in doctoral nursing education: The ASU experience.* Presented at the AACN Doctoral Conference, San Diego, CA.

Office for the Assistant Secretary for Planning and Evaluation (ASPE). (2015). *Health insurance coverage and the affordable care act, September 2015*. Retrieved from https://aspe.hhs.gov/pdf-report/health-insurance-coverage-and-affordable-care-act-september-2015