The Doctor of Nursing Practice: A national workforce perspective

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**Abstract**

In 2004, the American Association of Colleges of Nursing (AACN) adopted a position statement concerning the future of advanced practice nursing education. A target date of 2015 was articulated as the point by which master's preparation for advanced practice nurses would be replaced by doctoral level education. Seismic shifts in the realities surrounding nursing education and practice have occurred since the proposal to require a Doctor of Nursing Practice (DNP) degree for entry into advanced practice nursing was proposed. Unprecedented economic challenges have resulted in significant budget downturns for all sectors, including higher education. The consequent cutbacks, furloughs, and restructuring in educational operations of all types have placed enormous demands on faculty, staff, and students across the country. In addition, the growing incidence and earlier onset of chronic disease, a rapidly aging population, health care reform agendas, a shortage of primary care practitioners, and projected severe shortages of nursing faculty have raised fundamental questions about the capacity of nursing education to produce the numbers of advanced practice nurses needed. This article addresses the changing realities and growing concerns associated with the future of advanced practice nursing. Recommendations to ensure continuing development of advanced nursing practice that serves the interests and needs of the public now and in the future are presented within the context of a national workforce perspective.

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At no time in the history of the United States has attention to health workforce development been more intense or crucial. This year’s passage of national healthcare reform through the Patient Protection and Affordable Care Act and the subsequent amendment by the Health Care and Education Reconciliation Act has introduced a significant variable into the already challenging policy equation of ensuring that this nation has the capacity to meet the demand for health services for all citizens. The healthcare reform agenda translates into significantly greater access to health care for vulnerable and underserved populations at a time when there is already a shortage of key healthcare providers.

Nurses have a distinguished history of providing care for all who need care, but particularly those with the greatest need and the least access. Advanced practice registered nurses (APRNs) have consistently filled major gaps in healthcare by providing care to those living in rural and inner city areas, as well as to the disenchanted, such as people who are homeless, immigrants, migrant workers, and others for whom services are unavailable. Advanced practice nurses also provide much needed preventive and primary care to the American population, and they are a valuable resource for meeting the growing need for primary care practitioners.

The evolution of education and credentialing of APRNs reflects the progression of their acceptance and integration into the healthcare system, and masters’ level preparation and certification by an external professional body have been the hallmarks of the APRN and the requirements for entry into practice in recent decades. Studies evaluating the impact and effectiveness of advanced practice nurses have demonstrated that they have made important contributions to access, quality, and cost of health services since their early development. During the past decade, new types of clinical doctorates, referred to as Doctor of Nursing Practice (DNP or DrNP) were developed with the intent of preparing nurses with the competencies needed to improve health care systems through administrative leadership and advanced practice roles.

In October 2004, the American Association of Colleges of Nursing (AACN) adopted a resolution that the DNP degree become the educational requirement for entry into APRN practice by 2015. The proposed position statement generated significant national attention and debate. Although this resolution reflected the intentions of the AACN membership at that time, the context for health care and health workforce development has changed dramatically since its passage. In addition to national healthcare reform efforts, the nation has experienced a dramatic downturn in the economy, increasing shortages of nursing faculty and other key categories of health professionals, transformations in access to and utility of knowledge and information, increased needs for more cost-effective ways to deliver health services, and continued pressure to increase nursing student enrollments at both undergraduate and graduate levels. The fundamental question of what constitutes an appropriate nursing workforce, given this dramatically changed profession landscape, is in the forefront of discussions in professional, policy, practice, education, research, and economic sectors.

A Public Good/Nursing Workforce Perspective

In this article, we examine the development and implementation of the nursing practice doctorate in light of changing US health and economic contexts. The underlying assumption held by the authors is that nursing is a public good. We believe this to be the case because of the crucial contributions that nurses at all levels make to societal well-being and because of the significant governmental investment in nursing workforce development at state and national levels.

At this time in particular, the public’s good with respect to health is defined through this nation’s concentrated focus on the need for health care reform. For this reason, the workforce analytic framework that we are using reflects the fundamental questions associated with healthcare reform, including goals related to quality, access, cost, and sustainability.

Through the lens of this public good/workforce perspective, we examine the origins, current status and possible future scenarios for development of the practice doctorate in nursing. Conclusions and recommendations are made for the purpose of informing and engaging policy, educational, and professional practice sectors in public dialogue about the future development of the DNP as part of the nation’s overall nursing workforce portfolio.

The perspective that nursing is a public good is one that is not only embedded in nursing’s own social contract, but resides as well in federal and state governmental roles related to health professions workforce planning, funding, and regulation. Society looks to nursing to play a crucial role in advancement of the health of the public. Implicit in this perspective is the notion that the evolution of the profession, through the mechanisms inherent in education, research, practice, and policy, serves to enhance the good of the public. This perspective also serves as the rationale for public investment in the nursing profession and for holding accountable the institutions and leaders who contribute to the development of the nation’s health workforce.

Advanced Practice Nursing in the United States

The development of advanced practice nursing in the United States is rooted in a public and professional
response to societal needs. The idea that evolved into the nurse practitioner (NP) role had its origins in a community need identified by a nurse and a physician. Drs. Loretta Ford and Henry Silver are credited with starting the first nurse practitioner certificate program at the University of Colorado in 1965. Ford had more than 12 years experience with visiting nursing and public health nursing services, where nurses often practiced beyond traditional boundaries as compared to hospital nurses. Ford and Silver proposed the nurse practitioner role to solve the problem of not enough providers to staff the child health clinics of the public health departments in their state. In the 1960’s, the physician shortage was seen as a threat to the health of American citizens, and nurse practitioner programs were often supported by Schools of Medicine across the country as a way of addressing this shortage. In 2008, after significant federal and other investment in the education and evaluation of the nurse practitioner workforce, approximately 155,000 nurse practitioners represented about 62% of the APRN workforce.

The Clinical Nurse Specialist (CNS) role is over 50 years old and traces its origins to Rutgers University where Dr. Hildegard Peplau created the first master’s degree program in psychiatric nursing. The CNS movement evolved at the master’s degree level in response to the increasing need for specialized care, the opening of intensive care units, and other advances in health care and hospital systems, as well as the physician shortage of the 1960’s. Clinical nurse specialists, approximately 42,500 in number in 2008, are primarily employed in hospitals to provide staff and patient education and consultation and to lead in improving systems to support evidence-based practice.

The nurse anesthetist was the first advanced practice role to be developed. Nurse anesthetists have been the principal providers of anesthesia in combat areas of every US war since the Civil War, again a reflection of nurses responding to a significant societal need. Alice Magaw, known as the “mother of anesthesia” at what became the Mayo Clinic, both practiced as a nurse anesthetist and published in scientific journals. The first formal education program dates back to 1909, and in 1914 Agatha Hodges and Dr. George Crile assisted in planning care for the sick and wounded soldiers of the Allied Forces in France. In 2008, there were 34,000 certified registered nurse anesthetists (CRNAs).

The certified nurse midwife advanced practice role began as a response to the alarming rate of infant and maternal mortality in the 1920’s and had its roots in a public health need in rural underserved areas. Mary Breckenridge developed the Frontier Nursing Service in the Appalachian Mountains of Kentucky using English-educated public health nurses who delivered maternity services on horseback to patients living in the remotest areas of Appalachia. The first nurse midwifery certificate program in the United States began in 1932 at the Maternity Center Association of New York City. In 2008, there were 40 accredited programs (ACNM) across the United States and 18,100 nurse-midwives in practice.

The Evolution of Professional Doctorates in Nursing

The concept of a practice-focused doctoral degree (sometimes referred to as a professional or clinical doctorate) in nursing is not a recent development. The first such program was a Doctor of Nursing (ND) degree established at Case Western Reserve University in 1979 and offered as an entry-level nursing degree. During the 1980’s, several practice-focused doctoral programs and degree titles emerged, but the momentum in nursing nationally was to establish research-focused doctorates (PhDs) to place the discipline of nursing in equal status among academics, scientists, and other knowledge-generating fields.

In 2004, when the American Association of Colleges of Nursing (AACN) developed its position paper on the DNP, there were only 8 clinical doctoral programs in existence or in the approval stage in US schools of nursing. These doctoral programs were emerging without common educational goals, so AACN charged a taskforce to identify a unified approach to a nursing practice doctorate and determine potential implications for current programs designed to prepare advanced practice nurses.

Two national issues had significant impact on the work of the AACN taskforce. First, the Institute of Medicine (IOM) had issued a number of reports about the quality and safety of American health care. A 2003 report, Health Professions Education: A Bridge to Quality, called for “all health professionals to be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics.” Another, Keeping Patients Safe: Transforming the Work Environment of Nurses, called for educational preparation of nurse executives and managers that would ensure these leaders were ready to participate in executive leadership within healthcare organizations.

In its report, the AACN DNP Taskforce noted that nurses prepared at the doctoral level with a blend of clinical, organizational, economic, health care improvement, and leadership skills were most likely to be able to design and continuously improve systems of care delivery based on best evidence. They advanced the argument that adding or integrating content on leadership, organizational management, and economics to existing master’s level programs would better prepare graduates for clinical or administrative leadership roles in healthcare systems.
A second driving force for the development of the practice doctorate in nursing was the increasing number of didactic and supervised clinical practice hours that were being added to master’s programs by schools of nursing, state boards of nursing, or accreditation agencies. Many APRN master’s programs exceeded 60 credits, due primarily to application of university guidelines that called for academic credit to be awarded in a 1:3 clinical hours ratio. The observation that the length of master’s programs in nursing exceeded that of other master’s programs was evidence of the robustness of the APRN’s academic and clinical education, but it was also viewed as a justification for awarding doctoral degrees for educating APRNs.

In October, 2010, the Institute of Medicine released the report, The Future of Nursing: Leading Change, Advancing Health. The growth in numbers of DNP programs and the mandate of professional organizations to transition to requiring the DNP for entry into advanced nursing practice were noted. The committee concluded, however, that “while the DNP provides a promising opportunity to advance the nursing profession, and some nursing organizations are promoting this degree as the next step for Advanced Practice Registered Nurses (APRNs), the committee cannot comment directly on the potential role of DNP nurses because of the current lack of evidence on outcomes.”

In the sections that follow, we present perspectives on 2 aspects of the workforce issues created by the emergence of programs and professional policies related to the DNP; namely, the impact of the degree itself and the impact of the decision to require the DNP for entry into advanced practice.

Impact of a New Doctoral Degree on International Nursing

One of the “goods” of American nursing, which extends beyond a United States-focused public good, is the contribution that schools of nursing have made to the advancement of health and caring around the world. This good has had an important positive impact on the health of people worldwide, and on the professional relationships that the United States has had with other countries. Because US schools of nursing have played a key role in the advancement of nursing education globally, our international colleagues often look to us as a model of education and practice, making choices about use of scarce resources in the advancement of their nation’s nursing education. In turn, US schools engaged in global nursing workforce development have worked to ensure that what is “exported” is of real value, relevance, and utility within the receiving countries.

The AACN position statement on the DNP has created confusion and ambivalence about doctoral education not only in our own country, but for our colleagues internationally. While Master of Science (MS) and Doctor of Philosophy (PhD) degrees are understood globally, a new type of practice doctorate increases the confusion among key global partners. Although the PhD is regarded as the accepted degree for university faculties worldwide, a high percentage of initial DNP graduates in the United States are entering or returning to faculty positions. Will universities across the world accept an entry-level advanced practice degree as sufficient for faculty status? This question is a particularly important consideration, given the fragile status of nursing in the academic context of many countries (and, one might also say, in some of our own universities).

The confusion surrounding doctoral degrees is exacerbated if the meaning of master’s education changes fundamentally, as is currently being proposed by AACN. If, instead of adopting the proposed change, US nursing continued to require the MSN for entry into APRN practice (with the option of subsequent practice or research doctorates as desired by students and the health care marketplace), nursing’s international communities would continue to share greater commonality. This advantage of a post-master’s DNP degree is one of many, the rest of which we discuss in the following sections concerning our second topic—the proposal to require the DNP for entry into advanced practice.

DNP Requirement for Entry into Advanced Practice

Most practice disciplines have options for either research or practice doctorates, and a proposal to standardize the meaning of a practice doctorate in nursing was needed at the beginning of this century. The 2004 AACN Position Statement accurately outlined the need for administrative and advanced practice leaders with stronger preparation in systems-based practice improvement and translational research. These goals are consistent with the IOM Future of Nursing report recommendations to “prepare and enable nurses to lead change to advance health” and to “double the number of nurses with a doctorate by 2020.”

These important goals for the DNP are more likely to be met with post-master’s programs that retain the master’s degree as the requirement for initial APRN certification for reasons we explain further below. We argue that choosing the post-master’s DNP path allows the profession and society to produce the leaders it needs while meeting societal needs for an adequate advanced practice nursing workforce.
Evidence of Effectiveness

First, there is no evidence of the inadequacy of master’s preparation as the basis for initial entry into practice, as affirmed by the recent IOM report. In fact, the APRN has long been identified as a health care professional competent to provide safe and cost-effective health care. In 1986, the US Office of Technology Assessment published a policy analysis of nurse practitioners, physician assistants, and certified nurse midwives and concluded that such providers are safe and effective to deliver approximately 80% of primary care services to adults and 90% of primary care services to children. Since that time, a series of studies has demonstrated that nurse practitioner care enhances outcomes for those with chronic conditions or the elderly. In one of the most widely cited investigations, Mundinger and colleagues demonstrated that patients who were randomized to the care of autonomous nurse practitioner practices had improved diastolic blood pressure compared to those randomized to physician practices. In a follow-up study, Lenz and colleagues documented that NPs were more likely to perform and document provision of diabetes education and A1C tests.

Further studies of NP coordination and care of individuals with type 2 diabetes validated the effectiveness of NP-led care. In primary care settings, NPs were found to effectively adapt and deliver the Diabetes Prevention Program and to reduce diabetes risk in those who had prediabetes. In addition, it was estimated that such NP-managed programs could yield a potential net savings of $150K per patient annually. In a landmark study that led to the incorporation of transitional care by advanced practices nurses being included in the health reform bill of 2010, Naylor and colleagues demonstrated APRN transitional care for hospitalized elders with heart failure was associated with an increased length of time between hospital discharge and readmission or death, reduced total number of rehospitalizations, and decreased healthcare costs.

Thus, the evidence is compelling that masters-prepared NPs provide care to individuals and families that is equivalent, and on some measures better, when compared to usual physician care. Both clinical outcomes and cost are positively impacted by the care of APRNs. These data lend credence to the notion that doctoral preparation is not necessary for high quality clinical care since these studies were conducted prior to the development of the DNP degree.

Parity with Other Health Professions

Another prominent argument for moving to the practice doctorate for entry into advanced practice is parity with other health disciplines. Some other health disciplines (e.g., audiology and pharmacy) have moved to requirements for clinical doctorates. Other health disciplines such as public health have maintained 2 levels of education for advanced practitioners—doctoral and master’s. The accreditation body for physical therapy programs did not develop a policy to phase out master’s program by a certain date, but instead, in 2000, passed its Vision 2020, stating the goal of physical therapy being delivered by doctoral-prepared individuals. This vision statement resulted in a gradual increase in doctoral program enrollment.

Colleagues in other disciplines (e.g., medicine, pharmacy, physical therapy) in addition to nursing find that it is difficult to develop leadership, translational science, and systems improvement competencies while a student is acquiring the didactic and experiential learning required for a new level of clinical practice. The anxiety about whether one has acquired sufficient clinical knowledge and experience to achieve initial certification consumes student attention and results in insatiable demands for individual patient-focused knowledge and skill. Independent project work is difficult to encourage/supervise and has led, within our own field, to significantly reduced expectations of master’s students over the last decades.

Instead, when doctoral education (PhD or DNP) occurs after entry into APRN practice requirements are met, students bring practice and systems knowledge and experience to their course and independent project work. Because they can work as an APRN while continuing their education, their (almost universal) concurrent employment provides ready access for the application (and sometimes funding) of newly acquired doctoral level knowledge and skills.

Changing Contexts for the Healthcare Workforce

The environmental context for all health professions has changed dramatically over the past decade, from one of economic exuberance to one in which fundamental questions are being raised about the capacity of virtually every sector in society to meet the rapidly shifting needs of this country. One of the most important changes in the United States is the aging of the population. In 2007, there were nearly 38 million residents of the United States over 65 years old, and trends indicate that as people are living longer this number will continue to increase. At the same time, the rates of poor health among the aging population range from 6.4% (for those who need assistance with activities of daily living) to 27% (for those who rate their health as fair to poor). In this population, 22% have diabetes, up to 80% have hypertension, and 12% have diagnosed cardiovascular disease. In addition, diseases such as type 2 diabetes and hypertension have increased in prevalence in childhood, portending even higher rates in the future. Each of these rates is
substantially higher than was true in the 1960s when the NP role was developed.

In addition to the escalating health care needs of an aging population, the provisions of the Affordable Care Act of 2010 may extend coverage to 33 million of the 38 million uninsured Americans within the next 4 years. Many more health professionals, including nurse practitioners, will be required to meet this need. Extension of the time to eligibility for APRN certification in an environment of escalating need is counter-intuitive, as noted recently in reports from the Josiah Macy, Jr., Foundation and the National League for Nursing (NLN).

A potential solution for the increased demand for health services might be to increase the numbers of physicians prepared as primary care providers. A number of physician workforce projections have been conducted over the past decade in light of the anticipated increased demand for services. Although such projections are always complex and controversial, it is clear that the physician supply will not be adequate to accommodate the growing and aging population. The majority of medical school graduates continue to choose careers as specialists rather than in primary care, and according to a recent survey, perceive careers in primary care as uncontrollable and resulting in low-satisfaction and low-income. Thus, increasing the number of medical school graduates will not necessarily meet the needs of the growing population in this country who require primary and preventive care and the coordination of treatments for multiple, complex, chronic conditions.

If the nursing profession decreases the graduation rates and increases the cost of production of APRNs in upcoming decades, increasing the numbers of physician assistants may be viewed as an important and attractive option. The optimal learning environment for DNP education is one in which doctoral-prepared faculty members are actively engaged in teaching, clinical practice, translational science, and systems improvement, preferably within an environment characterized by robust inter-professional learning opportunities. This quality indicator will be costly for schools, as greater numbers of faculty members are needed to cover the educational mission if significant portions of each faculty member’s time is spent in practice. These costs will increase over time if schools in the future are forced to hire newly-certified entry-level DNP graduates who are novice practitioners.

Entry-level DNP students will require more semesters of clinical supervision in addition to their independent projects, many of which will be conducted in clinical sites. Schools cannot assume that health care systems have the personnel and time to supervise students in additional clinical and independent project activities (clinical placements are scarce enough for current master’s student clinical hours). As a result, the number of qualified faculty to be found, hired, and paid the salaries they will expect will be daunting.

Given the economic environment, the tradeoff to accomplish this goal is likely to be diminished output from BSN programs, an outcome contrary to the goal of increasing the proportion of nurses with a baccalaureate degree to 80% by 2020, as recommended in the recent IOM Future of Nursing report. Whether resources are diverted from existing PhD programs, other MSN programs, or programs preparing nurses at the BSN level, the loss of faculty and financial resources to the creation of DNP programs wherever MSN programs currently exist will have a significant impact on overall nursing capacity, quality and sustainability. Any funds or other types of support (including legislative support) that are specifically associated with other programs are at risk if these programs become lesser priorities.

Economic/Cost Considerations

When AACN chose to set its goal that all APRN programs would transition into DNP programs by 2015, the United States was in an economic period of significant and heady optimism. Unfortunately, the recent economic downturn has made it hard for schools to launch new programs and for students to absorb the cost of longer degree programs. We argue that the requirement of a DNP degree for advanced practice has the potential for introducing far-reaching economic hardship to programs, students, and the public. Lacking sufficient fiscal and human resources, the requirement may also result in less than optimal program quality.

Programmatic Costs

As schools of nursing attempt to develop DNP programs, significant “tradeoffs” will be necessary to assure fiscal responsibility and accountability. Added courses and doctoral level independent project supervision either place added workload burdens on existing faculty or require new resources for additional faculty (assuming they are available). Although the impact of these tradeoffs varies by institution, launching and sustaining a DNP program may require moving existing resources from current programs to this new purpose, as well as investing in the preparation of existing faculty or hiring new faculty with higher qualifications at higher salaries.

The optimal learning environment for DNP education is one in which doctoral-prepared faculty members are actively engaged in teaching, clinical practice, translational science, and systems improvement, preferably within an environment characterized by robust inter-professional learning opportunities. This quality indicator will be costly for schools, as greater numbers of faculty members are needed to cover the educational mission if significant portions of each faculty member’s time is spent in practice. These costs will increase over time if schools in the future are forced to hire newly-certified entry-level DNP graduates who are novice practitioners.
Alternatively, one can imagine that health care systems and personnel might be willing and able to assist in clinical and independent project supervision activities if DNP students were already credentialed as APRNs and working in their facilities. Keeping the current predominant approach to DNP education (post-master’s) as the preferred future would assist schools in minimizing the costs of offering DNP programs. It also makes it possible for states to invest in fewer DNP programs, while retaining MSN options for preparation of APRNs in other schools, thus lowering the state’s overall higher education costs.

In considering the costs of launching and sustaining DNP programs, another issue is the question of whether DNP education will be a sustainable enterprise over the long haul, an assumption that remains to be tested. It is possible that “pent up” demand for the practice doctorate will subside as a function of satisfying the initial demand from those who wish to become faculty members, there is no basis for acting in societal rather than self-interest. By not delaying DNP education to entry into practice at this point in time (or ever), DNP programs can open commensurate with demand, availability of faculty, and access to the kinds of inter-professional experience and training called for in the IOM report. Most importantly, the overall expenses associated with APRN education remain as cost-effective as possible.

**Student Costs**

Master’s programs have traditionally had fewer resources available for student financial support when compared to undergraduate programs and PhD programs. For students, therefore, DNP education is likely to add significant financial burden. Extra direct educational costs (such as tuition, books, and fees) account for only part of the financial burden for students. If they must obtain a DNP prior to certification to practice, additional costs associated with delayed employment are incurred. Although a doctoral degree is likely to elicit a higher salary for those who become faculty members, there is no basis for assuming that the increased cost of DNP education will be offset by higher paying APRN or nurse executive salaries. Therefore, the financial payoff for students is uncertain.

Instead, if students can pursue the DNP as a post-master’s option, they have the benefit of being able to work as an APRN while continuing their education. Benefits from employers of APRNs are more likely to include scholarship monies that would support doctoral education (assuming it is valued in the health care marketplace). Future students will not have a choice of options and will have less career flexibility if schools offer only BSN to DNP programs.

**Costs to the Profession**

A final area of cost affects not only students, but nursing’s capacity for research-based practice and systems improvement. The important contributions nursing research makes to the health of Americans is crucial now and will be increasingly important in the future. If the DNP is an entry into advanced practice degree, the person who wants to be an APRN and then receive PhD-based research training will incur even greater educational costs due to extension of the time to PhD. Keeping the DNP a post-master’s program eliminates this problem, allowing choice of doctoral degree after APRN credentials are earned.

For the profession, it is crucial to have nurse scientists from both basic and advanced practice backgrounds because they pursue different questions in their research programs. The current composition of the PhD-prepared scientific workforce includes large numbers of APRNs who pursue highly clinically-relevant programs of research. This composition is unlikely to continue if 2 doctoral degrees are required for preparation as a scientist, to the great disadvantage of both society and the nursing discipline.

**Public Costs**

The greatest potential public cost, if the production of APRNs slows down during a time of increasing societal need, will be an inadequate supply of APRNs to meet the needs of patients in a reformed health care system. For schools that currently offer MSN options for APRN preparation and decide they cannot or do not wish to make the transition to DNP education, the effect will be to diminish access to APRN education, most likely in the geographical areas with the greatest patient need for access to APRN care.

Other costs will be incurred by the public, especially in states where significant public dollars are invested in higher education. Assuming a desire for increased production of APRNs, states will be faced with dramatic cost increases if every public school currently offering master’s preparation in any of the 4 APRN roles is forced to convert to DNP program offerings. It is impossible to imagine how states, at any time in the foreseeable future, could fund requests for the types of funding increases that would be required to create good quality doctoral-level program offerings in place of all current master’s programs. Instead of funding fewer, high quality DNP programs that admit students already certified in APRN roles, our current path to entry-DNP programs will create a future where many programs will have a strong likelihood of failing to
The US healthcare reform agenda translates into significantly increased access to healthcare for millions of vulnerable Americans, requiring more providers and more cost-effective services. Advanced practice registered nurses have a distinguished history as providers who are uniquely well-qualified to meet the requirements of healthcare reform; they have proven their importance to access, demonstrated the quality of their patient outcomes, and offered care at reasonable cost. In short, they have been the answer to meeting the care needs of the very people who will increasingly need to be served, regardless of how US health care systems evolve.

Given the current and emerging realities of health-care and nursing education today and in the future, implementation of the DNP as a requirement for entry into APRN practice is likely to result in serious unintended consequences. Schools are unlikely to be able to educate the same numbers of DNPs per year at the entry level as they currently graduate at the MSN level. Inevitably, therefore, a mandated transition to DNP programs for entry into APRN practice (as proposed by AACN for 2015 and by the American Association of Nurse Anesthetists for 2025) would reduce the production of APRNs at a time when the country is experiencing a dramatic increase in need. The inevitable diminished production of APRNs at a time when major inter-professional panels are calling for the removal of scope-of-practice barriers to APRN practice would be a grievous outcome. In the hope of continuing the conversations started by NLN, we offer the following recommendations:

1. Master’s education should continue to be offered, valued, and accredited as the program that prepares nurses for the 4 APRN roles and 6 nurse practitioner population foci required for entry into advanced practice nursing for the foreseeable future.

2. Certification, licensure, and accreditation policies should sustain their current alignment that supports the master’s degree as the requirement for entry into APRN practice.

3. The number of APRN graduates per year should be increased in a realistic, planned, and cost-effective manner, taking into account educational capacity and budgetary resources.

4. Priorities for federal funding of graduate nursing education should be directed at programs that can increase the number of graduates of APRN programs in alignment with U.S. health care workforce needs while meeting quality indicators for master’s and doctoral education.

5. The federal government (e.g., the new National Health Care Workforce Commission) should undertake workforce analyses to assess trends with respect to APRN graduation rates, practice patterns, care outcomes, and salary costs for MSN- and DNP-prepared APRNs.

6. Focused efforts should be made to locate post-master’s DNP programs in universities that educate other members of the inter-professional team and where sufficient doctoral-prepared faculty with practice expertise are available to mentor DNP students as leaders in systems-based improvement, translational science, and evidence-based practice.

Looking Ahead

Currently, no professional regulations (accreditation, licensure, and certification) require a change in the level of degree required for entry into APRN practice. For a brief time, nursing still has the opportunity to choose to implement post-master’s DNP programs as our preferred future. The profession’s goals for a standardized practice doctorate can be achieved without conversion to entry-level programs. We can retain our cost-effective, strong master’s programs that have proven so effective in meeting societal needs. We can provide 2 types of doctoral education and allow the external environment (societal needs, school budgets, student and employer demand) to help determine, over time, how society and the profession are best served. We urge the nursing community to engage in open dialogue about these recommendations and ensure that our professional goals for continuing development of advanced nursing practice serve the interests and needs of the public now and in the future.

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This article reflects the equal contributions of all authors and, therefore, listing of authors is in alphabetical order.

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